Neutral Citation: [2022] EWFC 63

Case Number: ZW21C00023

IN THE WEST LONDON FAMILY COURT

Before His Honour Judge Oliver Jones

Date: 24th March 2022

Between:

London Borough of Z

Applicant

- and -

(1) Mother
(2-7) A, B, C, D, E & F
(By their Children's Guardian, Loraine Hughes)
(8) Maternal uncle

Respondents

Ms Roberts & Ms Suresh, counsel for the London Borough of Z
Ms Langdale QC & Mr Stevenson, counsel for the mother,
Mr. Woodward-Carlton QC, counsel & Ms Piccos, solicitor for the children
The Maternal uncle represented himself

JUDGMENT

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1. These are care proceedings in relation to six siblings:

   - A, who is now 15 years old;
   - B, who is now 10 years old;
   - C, who is now 7 years old;
   - D, who is now 6 years old;
   - E, who is now 4 years old; and
   - F, who is now 3 years old.

2. The case is brought by the London Borough of Z, represented by Ms Victoria Roberts & Ms Srishti Suresh.

3. The mother of all of the children is represented by leading and junior counsel, Ms Rachel Langdale QC, Mr Chris Stevenson and her trainee solicitor Ms Alicia Love. I have not seen any documents formalising a change of name, but I understand that the mother was previously known as Y and at some stage after A was born but before having B she decided to change her name.

4. The maternal uncle has been joined as a party to proceedings. He has represented himself throughout the final hearing.

5. The children are represented through their children's guardian, Ms Loraine Hughes and by their counsel Mr. Damian Woodward-Carlton QC and their solicitor Ms Deborah Piccos.

6. There had been some lack of clarity during the proceedings about the children's names. All the birth certificates have now been obtained.

7. The father of the children has been identified by the mother as X. He is not named on the birth certificates of any of the children. He does not have parental responsibility for any of the children. He has been served and is aware of these proceedings and has at times spoken to social worker and to the guardian, but he has not engaged with the proceedings.

He declined a viability assessment when he spoke to an independent social worker in January 2022.

8. The mother's position at this hearing is that X is the father of all the children. However documents arising from previous proceedings record the mother giving information that contradicts this. At a home visit in February 2006, the mother said when she was pregnant that the father of her unborn child (A) was a 20-year-old man named W who she had met at college. That putative father was never located during those proceedings. In January 2010, the mother told a social worker that A's father had lied to her about his name and identity. The mother's explanation for A's surname is that she chose this at random.

9. When the mother was pregnant with B, she would not disclose the identity of the father but did indicate he was someone she met through friends. The mother explains she choose B's surname because of how he presented when he was born.

10. X was spoken to in January 2022 when he told the social worker that: he is the father of the four youngest children; he is the only father the children have ever known, he ceased to be in a relationship with the mother after F was born; he has met B's father before but had no contact with him since; and that he is not in a position to care for the children and has no family on his side who could.

11. The children's guardian has proposed that as part of their life story work, there should be DNA testing to check whether X is the father of A and B or whether the children are full siblings. It is a shame that was not proposed earlier in the proceedings, but in my judgment it is sensible to gain clarity given the confusion and contradictory information that is presently available.

Issues

12. The issues I am asked to determine are:
    (a) Fact-finding. There is a schedule of findings setting out 17 findings that are sought by the local authority.
    (b) Whether the threshold criteria are established.

(c) The welfare decision about who will care for each of the children.

(d) A placement order application in relation to E and F.

13. The local authority seeks care orders in relation to all 6 children. It plans for A and B to remain placed together in their current foster placement; for C and D to be placed together in foster care; and for E and F to be placed for adoption, together if possible, but with searches for separate adoptive placements to be commenced if no prospective placement is found within 4 months and a time limit of 12 months for family finding after which the plan will change to one of long-term fostering and an application made for the placement order to be discharged.

14. The mother seeks for all six children to be in her care. She identifies support from her family, particularly from her brother and from her father. She welcomes support from the local authority, particularly family support work.

15. The uncle supports the children being placed in the care of their mother. If not, he puts himself forward to care for them. In his closing submissions he wrote that he would adopt the children, but I recognise that he said that without the benefit of legal advice and I understood him during his evidence to be offering to be the children's permanent carer.

16. The children's guardian supports the local authority's position. She made some additional points about the local authority's final care plans which they have agreed to incorporate.

The mechanism of the hearing

17. This hearing was initially listed to be conducted as a hybrid hearing with the intention that the mother and her legal team would be in attendance at court as well as the other advocates. However, a hybrid hearing was attempted at the IRH in December 2021 when the mother and her legal team attended court. Unfortunately, the mother felt unable to come into the courtroom for the hearing and had to join remotely from a conference room in the court building.

18. As a result, it was agreed that the mother would join the hearing remotely and she did so from her solicitor's offices with Ms Love in the same room and with Mr. Stevenson immediately available in another room. A flexible approach was taken, and the option was kept open for the mother to attend at court to give evidence but ultimately, she chose to do so remotely.

19. There have been a series of attempts by the court to engage an intermediary to support the mother through the process. Dr. Garrett's cognitive assessment identified that the mother has a full-scale IQ of 63 and her results indicated her cognitive functioning is in the extremely low range. However, her verbal and perceptual recording skills were above 70 and, on that basis, as well as her clinical presentation she was considered by Dr. Garrett to have sufficient adaptive skill to care for herself and her children. She concluded that the mother does not meet the diagnostic criteria to amount to an intellectual disability.

20. Dr. Garrett identified that the mother's memory and her processing speed are her greatest cognitive weaknesses. She made a series of recommendations about the conduct of work with the mother and recommended the use of an advocate.

21. Subsequently there were three separate attempts at conducting an intermediary assessment. Megan Rowlinson of Communicourt reported in July 2021 about her attempt to engage with the mother over Zoom in July 2021. The mother was in a car with a child present. There were difficulties with the signal and with a lack of charge in the mother's device. The circumstances were not suitable and eventually the assessment was abandoned.

22. In November 2021 Aliyah Wilkinson of Communicourt attempted an intermediary assessment. The meeting took place in person at the mother's solicitor's offices. The assessor struggled as the mother presented as very withdrawn and disengaged. Before it was concluded the mother indicated she had to leave to collect the children. The assessment was terminated because there was significant concern that the mother was "complying rather than consenting" to it; that the mother had "considerable difficulty understanding or demonstrating understanding of the purpose of the assessment"; and the mother's "apparent lack of engagement with the assessment process and ability to provide substantial answers to questions posed to her". Ms Wilkinson concluded that she was unable to discern whether an intermediary would assist the mother.

23. In December 2021 Danni Kitto of Communicourt attempted an assessment over Zoom. The mother did not initially join. When she did so she was in a vehicle but moved to a house. Despite efforts, Ms Kitto was unable to reach the point of securing informed consent to the assessment taking place. The assessment was terminated.

24. Thereafter, the mother's legal team did not seek any further attempts to be made for an intermediary assessment. Ground rules were established to assist the mother. These were set out in an agreed document which identified the sort of linguistic measures with which the court and advocates are now very familiar. The presence of the mother's trainee solicitor and junior Counsel was an important part of the support for the mother. Regular breaks were maintained throughout the trial. When the mother requested additional time, it was given, and long periods of sitting were avoided. The trial was set up so that it did not sit during the middle Wednesday of each week so as to minimise the impact of cumulative tiredness. The mother's legal team were careful to point out any overly complex or inappropriate questions. When it came to the mother's own evidence, questions were drafted in advance and shown to me for approval, and it was agreed that she would only be questioned by Ms Langdale and Ms Roberts.

25. The mother did not attend court on day 8 of the hearing which fell on a Friday at the end of the second week. I was told that she had spent a long time on the phone to her solicitor that morning and was feeling quite overwhelmed and pressured by the process. Although sympathetic to the mother's difficulties, I was concerned about the impact on the timetable of simply adjourning until the mother felt able to re-join the process with no indication as to when that would be. I was concerned that the delay would be harmful for the children and that extending the trial process may be more stressful and difficult for the mother than proceeding. I invited enquiries to be made as to whether the mother would be able to join the hearing from her home by video or possibly to just to listen by telephone. Ultimately, I decided to proceed in the mother's absence with a much-delayed start at 12.30pm with the assurance that her representatives would take a note and would inform her about the evidence. I indicated that if the mother obtained medical evidence, I would be willing to reconsider the application to adjourn. The mother did not take up any of the options to re-join the hearing on day 8, but I am glad to say that when the trial resumed the following week, the mother attended, and she was able to do so on all the other days of the hearing.

26. I have also prepared a Judgment Summary which has been delivered alongside this Judgment in order to assist the mother and uncle so that they can learn my decision and I hope to understand the key reasons behind my decision making.

27. I am grateful for the way all the advocates worked to assist the court to ensure that the mother had the best opportunity to engage fully with the court process. I am satisfied that the process was fair.

Background

28. The mother as a child was diagnosed with asthma, febrile convulsions and received speech and language therapy due to a moderate delay in her expressive language skills. Aged 3 years 9 months she was noted to be selectively mute in certain environments.

29. The mother made allegations about her treatment from family members. In 2004, the police arrested the maternal grandmother for allegedly pushing the mother down the stairs.

30. The mother became pregnant with her first child, A, when she was 16 years old. The identity of his father is a matter of uncertainty. It was alleged at the time that the maternal grandparents were pressuring the mother to have an abortion. She alleged at the time that she was held in a headlock by her brother to get her to say she had been raped. The mother alleged that she was told if she continued with the pregnancy, her parents would disown her.

31. In 2006 there was a pre-birth referral for A. The mother was suffering from a serious eating disorder and was anaemic. She was alienated from her family except for her sisters, not attending appointments, and not paying her rent. A core assessment was completed, and the local authority decided to take no further action. A was born thereafter in 2006.

32. In November 2009, the mother reported feeling low, paranoid and having suicidal thoughts. She alleged physical abuse by her brother, resulting in her falling downstairs but she was uninjured. She was taken to hospital due to mental health concerns. She later

alleged daily verbal abuse from her brother and physical assaults. She reported that she and A had slept rough.

33. In January 2010, the mother was referred to the START mental health team. In February 2010 A was accommodated pursuant to s.20 due to the mother's mental health.

34. In July 2010, a GP diagnosed A with hypermobility. Dr. Magid describes this as a very common condition in children that does not usually lead to serious motor problems in most children. It can be associated with leg pains but does not usually lead to falling.

35. In August 2010, care proceedings were issued in respect of A. In October 2010 A returned to his mother's care following a contested hearing and an interim supervision order was made. In April 2011, the care proceedings concluded with a supervision order for 6 months.

36. In November 2011, A was diagnosed with Beta Thalassaemia trait, a condition according to Dr. Magid where the gene is carried but it has no clinical manifestations or effects.

37. In 2011, B was born.

38. In 2014 there were allegations of domestic abuse by B's father against the mother.

39. In 2014 A had a paediatric review concluding that there was no abnormal neurology, but problems with motor planning. He was seen by podiatry and occupational therapy and continued to have physiotherapy input until 2018.

40. In 2014 C was born. In 2015 D was born.

41. In July 2015, A was diagnosed with hypermobility and motor planning disorder. He was described as doing well in school but struggles with handwriting.

42. In December 2015, the mother reported to the GP that B has ADHD. In January 2016 the mother raised with the GP concerns about B having ADHD, attention seeking, hitting his siblings and threatening A with a knife.

43. In July 2016 B was referred to CAMHS in relation to mother's concerns about behaviour difficulties and possible ADHD.

44. In November 2016, the mother reported to the GP that C had a fainting episode three days earlier. C was taken to A&E. Mother self-discharged C against advice before testing was completed.

45. In January 2017 C was seen by SALT. C presented with delayed receptive and expressive skills. She was discharged in May 2018.

46. In July 2017 during school observations by a doctor, B was seen to be settled in class and able to sit and focus. He was described as happy, calm and appropriately engaged.

47. In October 2017 the mother completed a health form for C's nursery and indicates she has a heart problem.

48. In 2017 E was born.

49. In 2017 concerns were raised that A presented as depressed.

50. In January 2018 in a GP consultation, the mother indicated her view that A needs a special needs school.

51. In February 2018 the mother was seen by her GP for a panic disorder.

52. In February 2018 a GP consultation about A was described as a "very difficult consultation as mother was initially a vague historian". The GP was told that A keeps falling because of hypermobility and had bilateral leg pain since he was a baby. At the end of the consultation the mother enquired about the provision of a letter for disability living allowance.

53. In February 2018 at a GP consultation the mother was making new complaints about A learning facial expressions. His gait when walking was observed to be normal.

54. In March 2018, at a GP consultation, the mother said that A forgets things and it takes him longer to process instructions. He was referred to rheumatology – which Dr. Magid later reported was not indicated.

55. In March 2018, at a GP consultation, the mother requested a letter for school transport and for early pick up from school for A. She alleged that A had been assaulted by another child's parent in the playground.

56. In May 2018 there was a MASH referral due to the family home being overcrowded. A Family Support Worker was allocated. B was reported by the mother and the school to be anxious and unhappy.

57. In May 2018 the mother had a telephone encounter with the GP. She said A has had communication problem for several years.

58. In May 2018, A was seen by a consultant paediatrician at Hospital S. The mother described A as having lots of problems with his movements and he falls over a lot, never moved in utero, was a late walker, diagnosed with hypermobility, struggles to climb the stairs, very forgetful and teased at school due to his movements. On examination A seemed remarkably unstable in walking, had decreased power in all four limbs and was hypersensitive to palpation. Other examination was normal.

59. In May 2018, the mother removed A from T School. He remained out of full-time education until early 2020. The mother says that A was being bullied and beaten by other children and clearly struggling.

60. In June 2018, the consultant paediatrician, saw A in clinic. He presented with apparent neurological symptoms which could not easily fit into any category. Investigations undertaken were inconclusive. He was referred for physiotherapy.

61. In September 2018 the mother reported to the GP that D is presenting with rude and inappropriate behaviour. D is seen by the GP in relation to speech delay, behavioural and social difficulties.

62. From October 2018 until March 2019, B did not attend school. CAMHS reported that he refused to attend.

63. In October 2018, A commenced art psychotherapy sessions. In November 2018 A commenced attending a tuition centre. Engagement with the service was described as minimal.

64. In November 2018, the consultant paediatrician saw A again. The mother reportedly said that she never felt him moving in the womb, he was a very late walker, diagnosed with hypermobility, he struggles to climb stairs and to hold a pencil, has a problem with communication and is currently non-verbal. The physiotherapist reported he presented with a slow gait and mild in-toeing on both sides. Investigations showed A had iron deficiency, anaemia, B Thalassemia trait, normal CK. The paediatrician thought A had a movement disorder (choreoathetosis). He referred A to the paediatric neurology team at GOSH for further investigations. I note Dr. Magid reports his belief that the history of not moving in the womb is an exaggeration as it would indicate a serious problem especially after 24 weeks' gestation.

65. In December 2018, the consultant paediatrician was asked to complete an application that the mother was filling in to obtain a mobility scooter for A. The consultant paediatrician did not consider such a provision to be safe or necessary.

66. In December 2018, A was seen by the GP with suspected congenital hypotonia (poor muscle tone present at birth) and "apparently he has autistic spectrum disorder". Dr. Magid reports that A was never actually diagnosed with either of those conditions and in his report speculates that the mother was possibly fabricating the ASD.

67. In January 2019, A had an x-ray of his knee. It was normal.

68. At a complex strategy meeting in February 2019, T School indicated their view that the mother removed A from school because they challenged her about his health status. They indicated that at school he was able to play football and keep up with his studies.

69. In 2019 F was born.

70. In February 2019, A was admitted to the paediatric ward of Hospital S, after concern from the physiotherapist about an apparent deteriorating neurological condition. No acute problems were identified when he was examined on admission, but significant concerns were raised. He was discharged a few days later. According to the consultant paediatrician's report, during this admission A did not show any abnormal movement problems.

71. In April 2019, A was seen by a clinical fellow in paediatric neurology under Dr. Marios Kaliakatsos, a consultant paediatric neurologist at GOSH. The mother reportedly gave a history that A has shown significant developmental delay from an early age and that there had not been a recent drastic change in his condition: "These problems have been ongoing since childhood and there has not been a recent drastic change in his condition, rather he never seems to have acquired a stable, independent gait…" She reportedly said, "He has never babbled or produced words. A does not follow verbal commands and his mother communicates with him through simple picture cards." A was brought into the examination in a wheelchair and could only manage a few steps before becoming unsteady. Dr. Magid's opinion in his report is that in this assessment, "Mother was exaggerating and fabricating, saying he never babbled or produced words is a fabrication…. There is a discrepancy between the doctor's objective examination and history: normal muscle bulk, power, reflexes all in contrast with the severe picture reported in the history."

72. In May 2019, A was seen by the consultant paediatrician. He did not speak during the clinic and it was reported that the mother said that he does not speak at home. The mother reportedly stated that A had never been verbal. The mother said that he was not receiving any education, that he now has an EHCP and that she was receiving DLA for him. Following the clinic, the consultant paediatrician spoke to the Safeguarding Lead at T School. She indicated she had made four MASH referrals on A. The Safeguarding Lead indicated that prior to his removal from school, A was verbally able, could read and write, had good peer relationships and otherwise was a normal child. The school felt strongly he has regressed. The consultant paediatrician made a referral to social services and indicated that either A has a disorder causing regression and the mother is in denial, or that A has suffered abuse in the form of factitious or induced illness which had led to mutism and

significant physical disability. He considered the latter to be more likely. Dr. Magid's opinion is that this is objective evidence that the mother was fabricating the symptoms and he "fully agrees" with the consultant paediatrician's conclusions.

73. In June 2019, A had an MRI scan of his brain. It showed a minor cerebellar hypoplasia with prominent sulci but otherwise was entirely normal. Dr. Kaliakatsos' view was that "there is no way that this could account for the rapid deterioration between May 2018 and November 2019 of A's condition. It was almost certainly not material to the current problems".

74. In June 2019, CAMHS referred A to the Tavistock Clinic for ASD screening. He remained on the waiting list by February 2021.

75. In June 2019 a Child and Family assessment records the mother stated that A was always mute.

76. In July 2019, the children were made subject to a child protection plan under the category of emotional abuse.

77. In July 2019, the consultant paediatrician wrote a letter to the neurologist indicating that the history in the referral letter and reiterated by mother was incorrect and the history from the school was that when A was in year six at age 10-11 years, he was a perfectly normal child, making good progress, able to talk fully, run around school and play football with peers. Dr. Magid's opinion is that if the information in the letter is correct, it is strong evidence of fabrication in the history given by the mother.

78. In October 2019, A was taken to A&E after a fall 30 minutes earlier on his right knee. He was seen to have slight bruising on his right knee. Dr. Magid reports that this is a minor injury, and he was not sure why A needed to go to A&E for it.

79. In October 2019, A was seen by a paediatric neurologist at GOSH. His mother reported no changes in his condition. He was receiving education through a tuition service and seeing CAMHS, biomechanics and they were applying for a physiotherapy review and speech and language therapy. The mother reported: A will walk, then feel discomfort and

have to sit down; he will use a fork and spoon but not a knife; he has to be dressed and undressed; he still has accidents once or twice a day in terms of toileting; he cannot write his name or words; he cannot properly read yet; he still uses mostly single words. His presentation was described as puzzling, particularly the fluctuation of his walking and his symptoms overall. An MRI scan had not provided an explanation and whole genome sequencing was being sought.

80. In October 2019, microarray genetic testing of A showed no abnormality.

81. At a professionals' meeting in November 2019, both the consultant paediatrician and Dr. Kaliakatsos indicated their belief that they were given false information by the mother about A. Both doctors were of the view that A's presentation is not a normal neurological pattern that has been seen before.

82. In a letter of December 2019, Dr. Kaliakatsos wrote that following his clinic in October 2019 he, "could not make any clear sense of his symptoms, therefore am very much inclined to believe that we are dealing with either a non-organic disorder or factitious illness."

83. In January 2020, a letter from CAMHS indicated that the mother described A as having severe learning difficulty, unable to read or write and struggled to communicate verbally. In the assessment he remained passive, did not respond to any query and had little facial expressions. Mother reported he has hypermobility, struggled to walk for long distances and loses balance. The only thing he enjoys is drawing. It states that the mother withdrew A from school in May 2018 as she felt A was becoming very depressed and had expressed some suicidal ideation.

84. In January 2020, the previous social worker reports a social work visit and raised concerns about poor hygiene in the family home which smelt of urine. A was sleeping in the living room; black bags were observed through the living room and a blanket covered a makeshift bed.

85. In February 2020, A commenced attending Q, a special school.

86. In February 2020, the PLO pre-proceedings process was formally commenced.

87. In March 2020, a psychological report on A was prepared as part of an EHCP application. It states that he presents as extremely low in mood, mute, having difficulties with walking unsupported, motor skills and independence skills. Mother reported that he never moved in the womb, never walked independently or talked.

88. March 2020 saw B's last attended day of school at R School. The mother said B was being bullied at school and was reluctant to attend. The school disputes the mother's accounts and states that B was talking with his peers and happy at school.

89. In March 2020, A was seen by a speech therapist. He was passive during the assessment and did not interact verbally.

90. In April 2020, an attempt at a parenting assessment of the mother did not proceed. The mother stated she did not need an assessment and that discussing it upset her.

91. In April 2020, the mother underwent a psychiatric assessment with Dr. Lyall. She told Dr. Lyall that A would not speak at primary school, has only ever spoken single words at school and there has been no change over time. She described his problems as life-long.

92. In May 2020, C was assessed for ASD. She did not meet the diagnostic criteria, but some mild social difficulties were noted.

93. In August 2020, A was seen for a child protection medical. The mother reported he has hypermobility, asthma, thalassaemia trait, white patches on his skin and wears glasses. A walked into the appointment. She described him as slow to develop. A made no response at all during the appointment and was not physically examined as it was not felt appropriate in the circumstances.

94. At a core group meeting in September 2020, A's headteacher expressed concerns that the mother was requesting access for A to the bus usually provided for wheelchair users to get to school. Nonetheless, the request was approved.

95. In October 2020, a Community Paediatrician diagnosed D with ASD.

96. In January 2021, the mother withdrew A's place at Q School as reportedly she was worried about Covid-19. A week later, A returned to school.

97. In February 2021, during a core group meeting the mother reported that B has not been speaking and that R Primary School had invited her to their office to discuss his lack of verbalising. The school dispute her account and say that he was talking until his removal from school in March 2020.

98. In January 2021, A was seen by a different consultant paediatrician, at Hospital S. This change was at the mother's request. At this appointment, the mother reported that A is receiving physiotherapy at school; has settled in well at school and made friends; speaks only to his mother using single words; does not talk at school; understands only simple commands; has impaired mobility, walking only short distances unaided but then falls over easily; does not run around. On examination he walked in supported by his mother, he was not ataxic (with abnormal uncoordinated movements) but was unsteady. Made no eye contact and did not respond to the doctor's questions. The consultant paediatrician discharged A because he was under the care of another paediatrician at Q School. Dr. Magid's opinion is that A's presentation at this appointment was an example of him "adopting the sick role".

99. In February 2021, Q School wrote indicating that recently they had had a number of significant breakthroughs with A, namely that he will choose to engage with table football at break time and lunchtime and will stand and support himself independently during this activity. He was described also having climbed onto the trampoline by crawling up the steps at the side. They described great progress during that half term and were confident there is more yet to come. They indicated their experience was that, "A is aware of and understands everything that is said to him and that is said around him. Despite this his understanding which is often shown by a response such as laughing at a joke, he chooses to engage through limited signage i.e. thumbs up… or through gesture i.e. touch the object you would like." Dr. Magid's opinion is that this is a "very significant report showing that the level of understanding is much more than the history given to medicals… a picture

totally different of what he presented to medical professionals" and that, "This is objective evidence of FII from mother and that A is adopting the sick role."

100. In February 2021 A and B were made subject of interim care orders and placed in a foster placement together. The removal from the mother's care was emotional and chaotic. The maternal grandmother and uncle were challenging the social worker in the presence of the children as to why they had to leave. The mother was reported to scream that A cannot breathe and insisted an ambulance was called. A was seen by paramedics. B refused to get in the car. The mother was crying hysterically and described as looking to be in physical pain/near collapse.

101. Three days later, the foster carers observed A's balance was improving.

102. In February and March 2021, there were a series of observations of improvement in A. He was getting out of bed, getting dressed, going to the bathroom and showering without assistance. He needed less help on the stairs.

103. In February and March 2021, B was observed to be behaving very well in foster care, making his own bed, showering and cleaning his teeth without prompting.

104. In March 2021, the mother had her first face-to-face contact session with A and B at a contact centre. A few hours after the session, she reported to the police that the foster carers were sexually abusing A and that this had been communicated to the mother through A's drawings. The mother later told Dr. Garrett that the police had concluded that the children had been sexually abused. There is no evidence to support this assertion.

105. In March 2021 A volunteered to go for a walk and walked ¼ mile up and down the quay. Afterwards he reported some pain and applied his own ibuprofen gel.

106. In April 2021, F underwent an assessment with a community paediatrician. He was recorded as having global developmental delay.

107. In June 2021, F and E began to attend O Nursery. F was reported to have significant separation anxiety at the outset but settled by September.

108. In June 2021, the mother had an assessment with Dr. Garrett. The mother was unable to identify any shortcomings or difficulties in her parenting.

109. In July 2021, after contact A walked away from the contact centre. He was persuaded to return then wrote a list of complaints about the foster carers.

110. In July 2021, a police notification was received indicating that the mother had reported her concerns about A in foster care.

111. In July 2021 a referral was made to Childline by A (using his Kindle) alleging emotional abuse by the foster carers.

112. At the end of July 2021, A and B moved to a new foster placement.

113. In August 2021, after contact A refused to get into the car. Instead, he walked and later ran away from his mother and the social worker. He was later found at his maternal grandfather's home and refused to return to the foster carer.

114. A day later, a recovery order was made in relation to A.

115. The next day, the police assisted, and A eventually agreed to go with them. He was met at the police station by the foster carer who took him back to his foster placement.

116. In August 2021, a police report was received that X had attended at the mother's home. The mother called the police to ask him to leave, which he did.

117. In August 2021, the foster carer reported to GOSH that B seems happy most of the time, is generally compliant and does not show anxiety except during contact. He plays well, has good self-care and hygiene and eats well. Although he was previously prescribed melatonin, this has not been needed in his placement.

118. In September 2021, A sent an email to his MP complaining about his social worker and his children's guardian.

119. In September 2021 a support worker, was allocated to work with the mother and the family for 8 hours per week.

120. In September 2021, A started attending a new school, P, a special school local to the foster carer's address.

121. In October 2021, the social worker was able to speak to X who agreed to meet two days later to discuss the children. X does not attend the appointment.

122. In November 2021, P School reported that students had said A was sending voice notes and he was suspected of having a mobile phone.

123. Later in November 2021, A admitted to his foster carer that he has a mobile phone that was given to him by the maternal grandmother during contact without the foster carer knowing.

124. In November 2021, the family support worker reported that D, "started throwing things at my face, kicking, hitting, biting, stamping on me, tried to put a bin bag over my face (and F's earlier in the day) pushing me which he causes a lot of pain to us, and he cannot control himself or calm down no matter how many times we try and distract him."

125. Two days later, it is alleged that the mother was heard shouting and swearing at D outside school.

126. A few days after that, the family support worker reported rough play between D and F where he wrapped plastic around F's face which could suffocate him. The family support worker reported that the mother brushed it off as if it was a normal occurrence.

127. In November 2021, the police were called to the mother's home as X attended uninvited to see the four youngest children and a verbal disagreement arose. Serious concerns were raised over the behaviour and language that D and F showed towards the police.

128. In December 2021, the local authority sought an interim care order for D with a plan to place in him foster care. The children's guardian opposed the application, which was refused.

129. In January 2022, while the family support worker was present, X attended at the mother's home. He barged into the property and became aggressive, shouting and swearing. Mother was not present until later.

130. In January 2022, the social worker met X at his workplace. He stated he is only the father of the youngest four children.

Law

131. I am most grateful to the advocates for agreeing a note on the law applicable in this case. I adopt it entirely:

> "***A.*** ***Working Together with Parents Network Update of the DoH/DfES Good Practice Guidance on Working with Parents with a Learning Disability (2007) (Sept 2016 update)***
>
> §1.2.5 Local protocols should clearly specify responsibilities for assessment and care planning.
>
> Good practice is promoted where there is clear agreement between adult and children's social care as to the circumstances in which single or joint assessments are required and who should take the lead. For example:
>
> - Adult learning disability and children's services jointly co-ordinate assessment and care planning where parents need support in the medium to long term to enable them to meet their children's developmental needs;

- Children's services lead assessment and planning (with specialist input from adult learning disability services) where intervention is required to prevent children suffering impairment to their health or development or significant harm and/or there is a disabled child in the family.

Whatever level of concern there is about children's welfare, practitioners need to be aware of parents with learning disabilities' legal entitlement to timely and appropriate support, and to ensure that they receive the assessment and service response they are entitled to.

§1.3.7 Parents may need emotional support.

Parents with learning disabilities may have low self-esteem and lack confidence because of previous life experiences. They may therefore need support to build their confidence.

Parents may particularly need emotional support when children's social care become involved because of concerns about children's welfare. Fear that children are going to be taken away can make it harder for parents to respond positively to assessments and interventions. In such circumstances, parents need support from someone who they feel is "on their side" and who can help them positively engage with services. Such support is often provided by adult learning disability services, and by independent sector services and advocates.

See also:

- **Section 3: Good practice in commissioning**

- **Appendix A: What do we know about the needs and circumstances of parents with learning disabilities?**

Equal Rights

The UN Convention on the Rights of Persons with Disabilities (CRPD) (adopted 13th December 2006)

Article 1 - **Purpose**

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2 – **Definitions**

…

"Discrimination on the basis of disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

"Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Article 4 – **General obligations**

1. States Parties undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:

…

(c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
(d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
…
(i) To promote the training of professionals and staff working with persons with disabilities in the rights recognised in the present Convention so as to better provide the assistance and services guaranteed by those rights.

Article 23 – **Respect for home and the family**

…
2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.
3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realising these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.
4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except where competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.
…

B. Factitious or Induced Illness ("FII") and Perplexing Presentation ("PP")

§3.2.3 Fabricated or Induced Illness (FII)

FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident.

It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (and in Working Together to Safeguard Children, fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

§4.1 Parent/Caregiver motivation and behaviour

Both clinical experience and research indicate that the mother is nearly always involved or is the instigator of FII. The caregiver may be a single parent, or may be acting alone, unbeknown to the father. The involvement of fathers is variable. The father may be unaware, be suspicious but side-lined or may be actively involved. Rarely, fathers are solely involved. The parent may be actively supported by grandparents and there may be an intergenerational pattern. Rarely, foster carers have been known to be involved in FII. There is currently no data on same sex parental couples.

FII is based on the parent's underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is (when the child has a verified disorder, as many of the children do). FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. There are two possible, and very different, motivations underpinning the parent's need: the parent experiencing a gain and the parent's erroneous beliefs. It is also recognised that a parent themselves may not be conscious of the motivation behind their behaviour. Both motivations may be present although usually one predominates.

(i) In the first, the parent experiences a gain (not necessarily material) from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. There are a number of different gains - some psychosocial and some material. Some parents benefit from the sympathetic attention which they receive; they may fulfil their dependency needs for support, which might include the continued physical closeness of their child. Parents who struggle with the management of their child may seek an inappropriate mental health diagnostic justification in the child such as Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD). Material gain includes financial support for care of the child, improved housing, holidays, assisted mobility and preferential car parking.

(ii) The second motivation is based on the parent's erroneous beliefs, extreme concern and anxiety about their child's health (e.g. nutrition, allergies, treatments). This can include a mistaken belief that their child needs additional support at school and an Education Health and Care Plan (EHCP). The parent may be misinterpreting or misconstruing aspects of their child's presentation and behaviour. In pursuit of an explanation, and increasingly aided by the internet, the parent develops a belief about what is wrong with

their child. In contrast to typical parental concern, the parent exhibiting such behaviour cannot be reassured by health professionals or negative investigations. More rarely, parents may develop fixed or delusional psychotic beliefs about their child's state of health. The parent's need here is to have their beliefs confirmed and acted upon, but to the detriment of the child.

C. Fact finding

1. The standard of proof is the simple balance of probabilities. The burden of proof rests on the party seeking the finding.

2. The court is respectfully referred to the guidance of the House of Lords in the case of **Re B** [2008] UKHL 35 and the oft-cited dicta of Baroness Hale as to fact finding and the binary principle:

> *"31. ... In this country we do not require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day, up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other, and their overall impression of the characters and motivations of the witnesses. The task is a difficult one. It must be performed without prejudice and preconceived ideas. But it is the task which we are paid to perform to the best of our ability.*
>
> *32. In our legal system, if a judge finds it more likely than not that something did take place, then it is treated as having taken place. If he finds it more likely than not that it did not take place, then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other. Sometimes the burden of proof will come to his rescue: the party with the burden of showing*

that something took place will not have satisfied him that it did. But generally speaking a judge is able to make up his mind where the truth lies without needing to rely upon the burden of proof."

3. Findings of fact 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."*

4. 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."*

5. The task of the court is to decide on the evidence before it. It can depart from the view of expert evidence provided sound reasons are given for doing so ***Re B (Care: Expert Witnesses)*** [1996] 1 FLR 667; **M-W (A Child)** [2010] EWCA Civ 12.

6. The court should form an assessment of the credibility and reliability of the parents and any other carers. The court is likely to place considerable weight on the evidence and the impression it forms of them [per Baker J in **Re JS** [2012] EWHC 1370].

7. When assessing the credibility of the parents and other family witnesses, the court must take account of the dictum of Mostyn J in **Lancs CC v R & W** [2013] EWHC 3064 at para 8(xi):

> *"The assessment of credibility generally involves wider problems than mere 'demeanour' which is mostly concerned with whether the witness appears to be telling the truth as he now believes it to be.*

With every day that passes the memory becomes fainter and the imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited. Therefore, contemporary documents are always of the utmost importance: Onassis and Calogeropoulos v Vergottis [1968] 2 Lloyd's Rep 403, per Lord Pearce; A County Council v M and F [2011] EWHC 1804 (Fam) [2012] 2 FLR 939 at paras [29] and [30]."

'Lucas' Directions

8. Given that the truthfulness or otherwise of the witnesses in this case may be an issue, the Court may be assisted by the following excerpt from **Re M (Children)** [2013] EWCA Civ 388, in which the applicability of the Lucas direction to family proceedings was highlighted by Ryder LJ:

> *"7…. A Lucas direction is a criminal direction derived originally from a case on corroboration, R v Lucas [1981] QB 720. It is used to alert a fact-finding tribunal, that is a jury in a criminal trial, to the fact that a lie told by a defendant does not of itself necessarily indicate guilt because the defendant may have some other reason for lying; that is, he may lie for innocent reasons. A witness may lie because she lacks credibility, or because she has an innocent motive for lying. If she lies about the key fact in issue, that is one thing; if she lies about collateral facts, that may be quite another. A judge of fact may not be able to separate out every fine distinction, but may nevertheless conclude that an allegation is proved, despite the fact that the witness has lied about other matters.*
>
> *8. This is often simplified in the circumstances of emotionally-charged allegations remembered through the fog of distress and relationship breakdown as a core of truth surrounded by sometimes exaggerated and sometimes badly recollected or hazy memory. There may also be an overlay of deliberate untruth arising out of the anger and distress of the breakdown and/or the nature of the application before the court, and I remind myself this was a*

strongly disputed application. It is also too frequently the case that a Family Judge is faced with internally inconsistent or even untruthful witnesses who are locked in a battle in which their energies and antagonism have sadly come to be focused on who should look after the children or have contact with them."

9. The court is also referred to the dicta of Macur LJ in **A, B and C (Children)** [2021] EWCA Civ 451 at paragraphs 57 and 58:

> *" 57. To be clear, and as I indicate above, a 'Lucas direction' will not be called for in every family case in which a party or intervenor is challenging the factual case alleged against them and, in my opinion, should not be included in the judgment as a tick box exercise. If the issue for the tribunal to decide is whether to believe A or B on the central issue/s, and the evidence is clearly one way then there will be no need to address credibility in general. However, if the tribunal looks to find support for their view, it must caution itself against treating what it finds to be an established propensity to dishonesty as determinative of guilt for the reasons the Recorder gave in [40]. Conversely, an established propensity to honesty will not always equate with the witness's reliability of recall on a particular issue.*
>
> *58. That a tribunal's Lucas self-direction is formulaic, and incomplete is unlikely to determine an appeal, but the danger lies in its potential to distract from the proper application of its principles. In these circumstances, I venture to suggest that it would be good practice when the tribunal is invited to proceed on the basis , or itself determines, that such a direction is called for, to seek Counsel's submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt. The principles of the direction will remain the same, but they must be tailored to the facts and circumstances of the witness before the court".*

10. In **Re Y (A Child)** EWCA Civ 1337, Macur LJ said, at Paragraph 7(4):

> *"... I consider the case appears to have been hijacked by the issue of the mother's dishonesty. Much of the local authority's evidence is devoted to it. The Children's Guardian adopts much the same perspective. It cannot be the sole issue in a case devoid of context. There was very little attention given to context in this case. No analysis appears to have been made by any of the professionals as to why the mother's particular lies created the likelihood of significant harm to these children and what weight should reasonably be afforded to the fact of her deceit in the overall balance."*

<u>Competence Assessments of the child in proceedings</u>

11. The leading authority in this area is the Judgment of Williams J in ***CS v SBH & Ors [2019] EWHC 634 (Fam).*** This important authority reviews all the caselaw in relation to competence assessments of the child. Williams J concluded in paragraph 79 that in determining whether the child has sufficient understanding to give instructions a number of factors to be considered include;

"

i) ***The level of intelligence of the child***: *she has the intelligence of or slightly above her chronological age.*

ii) ***The emotional maturity of the child*****:** *she lacks emotional maturity, this being evidence by an inability in particular to hold a balanced view of her father or an understanding of her position.*

iii) ***Factors which might undermine their understanding such as issues arising from their emotional, psychological, psychiatric or emotional state*****:** *the extent of her enmeshment with her mother and the emotional harm that she had suffered*

from that is likely to diminish her ability to understand the true nature of the issues.

iv) ***Their reasons for wishing to instruct a solicitor directly or to act without a guardian and the strength of feeling accompanying the wish to play a direct role:*** *I accept that the child has felt her voice has not been listened to or heard but that actually does not reflect the reality given that she has had a Guardian and solicitor both in the original proceedings and recently. Whilst inevitably her reasons for wanting to have a solicitor and appeal will be mixed, arising at least in part from the fact that her solicitor and Guardian did not achieve the outcome she desired I consider that it is also likely that her position has been influenced by her mother and maternal family either directly or indirectly. Although every child is of course different the fact that this child has not been in direct contact with Mr Burrows or Ms Hopkin pushing for information, seeking answers or otherwise proactively pressing her case indicates to me that her desire to have her own solicitor in Ms Hopkin and to pursue the appeal is not particularly strong. Her acceptance of the possible withdrawal of proceedings in summer 2018 is further evidence of this.*

v) ***Their understanding of the issues in the case and their desired outcome any matter which sheds light on the extent to which those are authentically their own or are mere parroting of one parents position*****:** *the child's lack of a full appreciation of the reasons for living with her father in part at least arises from the fact that the issue has not been addressed in therapy although I note that the Guardian understood that the child had knowledge of the reasons but had not processed it. The child's wish to live with her mother was accepted by the Guardian and HHJ Meston QC as a genuine one. Inevitably it is in part a product of influence (whether direct or indirect and see HHJ Pearl's conclusion) but all our views are in part a product of influence of others views. The child's wishes in this case are closer to the authentic end of the spectrum than the parroting end although they probably fall closer to the middle.*

vi) ***Their understanding of the process of litigation including the function of their lawyer, the role of the judge, the role they might play and the law that is applied and some of the consequences of involvement in litigation*****:** *Ms Coyle's*

analysis but also the contents of some of the child's expressed views whether in letters or to the Guardian do not indicate much of an understanding of the court process, the functions of a solicitor, the role and function of a judge or the consequences of having a solicitor acting directly. They emerge as very simplistic and unrealistic. Although neither Ms Hopkin or Ms Coyle specifically addressed the question of the child's understanding of the appeal process, the nature of an appeal is in many ways harder to understand than the first instance process given it is a review of the judge's decision rather than a rehearing of the application.

vii) ***The court's assessment of the risk of harm to the child of direct participation for the risk of harm arising from excluding the child from direct participation and the child's appreciation of the risks of harm*****:** *both the Guardian and HHJ Meston QC considered that the child would accept an outcome that was contrary to her expressed wishes. It is clear from the Guardian's report that continued litigation is contrary to the child's welfare. In particular the burden that it is considered that she carries to promote the mother's position is harmful. Further involvement in litigation in this appeal or otherwise will likely be contrary to her welfare interests. Exposure to sensitive information to a child of this age and with this history will be harmful. Although her actual involvement in this appeal might be limited the process of challenging the judgment would inevitably involve detailed discussions with the child about the evidence. On the other hand, she has expressed a desire to have Ms Hopkin act for her and to appeal. This has endured since HHJ Meston QC's adverse judgment. However it is not pressed proactively and the Guardian and Ms Coyle did not detect any real desire to appeal in any event. Thus preventing the child from engaging directly in this litigation with the effect that it would very probably bring the appeal to a juddering halt is not likely in my view to be perceived by the child as a significant insult to her autonomy as an individual."*

Participation of child in proceedings

12. In **Re Z (Interim Care Order)** [2020] EWCA Civ 1755 (Floyd LJ, Baker LJ, Arnold LJ) an appeal against an ICO in respect of a 15 year old boy with autistic

spectrum disorder under which he was removed from F's care and placed with foster carers pending placement with M was made. The Court had relied on assessment by the child's solicitor that he was not competent to give instructions. That assessment was conducted in private law proceedings in July 2020 and relied upon in public law proceedings in November. No party challenged that course during the hearing. The primary issue in the public law proceedings involved intrusion into the child's family life and an interference with Article 8 rights. Baker LJ observed: "*If, as this Court observed in **Re S (Re S (A Minor)** (Independent Representation) (1993)2 FLR 437, the level of understanding has to be assessed relatively to the issue in the proceedings, Z's understanding of the issues surrounding the proposal that he be removed from the family home may be materially different to his understanding of the issues relating to contact with his mother". Baker LJ referred to the fact that a diagnosis of autistic spectrum disorder meant that Z fell within the protection of the UN Convention on the Rights of Persons with Disabilities 2006. Under Article 13 (1) of the Convention: "State parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages*". The Court of Appeal held that where a 15-year-old boy without disabilities would be able to participate directly in court proceedings, it is incumbent on the Court and professionals working with a disabled 15-year-old boy to take such steps as may be necessary to facilitate his participation in the proceedings, particularly where the proceedings involve a fundamental question such as removal from his home.

Treatment of Expert Evidence

13. There is a significant body of case law which deals with the fact that whilst proper attention should be given to the opinion of medical experts, that those opinions should be considered against a background of all of the other evidence. In **A County Council v K, D & L** [2005] EWHC 144 (Fam) at paras (13) and (44) Charles J stated:

> *"... it is important to remember:*
>
> *i) that the roles of the court and the expert are distinct, and*

ii) it is the court that is in the position to weigh up the expert evidence and gives its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."

14. The judge is the decision-maker, and the expert is not. There are a variety of cases in which expert evidence has been rejected upon the basis that the Court believed the evidence of the parents. Perhaps the most well-known of these is the decision of Charles J in **Lancashire v D & E** [2010] 2 FLR 196. However, similar observations can be seen by Mostyn J in **Lancashire v R** [2013] EWHC 3064 (Fam) and Baker J in **Devon County Council v EB** [2013] EWHC 968 (Fam).

15. When considering a multidisciplinary analysis conducted by a group of medical specialists, 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: **Re A** [2014].

16. The evidence of an expert is not held in any special position and there is no presumption of belief in an expert no matter how distinguished they may be. It is the role of the expert to advise but the decision is that of the judge based on the evidence. The expert is part of the wider canvas of evidence which is to be weighed by the judge against the other evidence. A judge cannot substitute his own views for the views of the experts without some evidence to support what he concludes. It is necessary for a Judge to give reasons disagreeing with the experts' conclusions or recommendations: **Re B (Care: expert Witnesses)** [1996] 1 FLR 667 and **Re D (A Child)** [2011] 1 FLR 447.

17. 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."

18. It is important for the Court always to have in mind that there are cases where the experts get it wrong. Of course there are classic formulations of this in for example the case of **Cannings** and the object lesson as to the effects of changing medical orthodoxy in which Lord Justice Judge (as he then was) said: "What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise should be met with an answering challenge." Similarly, as observed by Dame Elizabeth Butler-Sloss P in **Re U, Re B** [2004] EWCA Civ 567:

> *"The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark."*

19. In **R v Henderson** [22] EWCA Crim. 126, in particular the words of Moses LJ should always be borne in mind when a judge is considering whether any particular allegation of non-accidental injury is made out:

> *"There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken. It is of note that when the Attorney General undertook a review of 297 cases over a 10 year period following the case of R v Cannings [2004] 2 Criminal Appeal Reports 63, 97 were cases of what is known as "shaken baby syndrome". The controversy to which such cases gives rise should come as no surprise. A young baby dies whilst under the sole care of a parent or child-minder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct, as best they can, what has happened. There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be*

resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause. As Cannings (177) teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown".

20. A member of the Court of Appeal in that case was Hedley J who imported the reasoning of Moses LJ in the Court of Appeal in **Henderson** into family law in **Re R (Care proceedings: Causation)** [2011] EWHC 1715 (Fam) in which Hedley J explained that it does not represent forensic failure for a judge to reach a conclusion that the cause is unknown. He explained the reasoning behind unknown cause:

> *"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".*

D. <u>Threshold</u>

21. A court cannot make a care order unless the circumstances at the relevant date are as set out in s31(2) Children Act 1989:

> *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.*

22. In respect of threshold and the disputed findings, the burden is on the local authority to prove the findings on the balance of probabilities.

23. In **Re L (A Child) (Care: Threshold Criteria)** [2007] 1 FLR 2050, Hedley J observed at Paragraph 50:

> *"What about the Court's approach, in the light of all that, to the issue of significant harm? In order to understand this concept and the range of harm that it's intended to encompass, it is right to begin with issues of policy. Basically it is the tradition of the United Kingdom, recognised in law, that children are best brought up within natural families. Lord Templeman, in Re: KD (a minor ward) (termination of access) [1988] 1 AC 806, at page 812 said this:*
>
> > *"The best person to bring up a child is the natural parent. It matters not whether the parent is wise or foolish, rich or poor, educated or illiterate, provided the child's moral and physical health are not in danger. Public authorities cannot improve on nature."*
>
> *There are those who may regard that last sentence as controversial but undoubtedly it represents the present state of the law in determining the starting point. It follows inexorably from that, that society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent. It follows too that children will inevitably have both very different experiences of parenting and very unequal consequences flowing from it. It means that some children will experience disadvantage and harm, whilst others flourish in atmospheres of loving security and emotional stability. These are the consequences of our fallible humanity and it is not the provenance of the State to spare children all the consequences of defective parenting. In any event, it simply could not be done."*

24. Hayden J, in **Re W (A Child)** [2021] EWHC 2844 (Fam), considered the approach to assessing the threshold criteria and, at Paragraph 19, held that:

"It is important to emphasise that the provision "not being what it would be reasonable to expect a parent to give" is not to be regarded as an abstract or hypothetical test but must be evaluated by reference to the circumstances the parent is confronting i.e. what would it be reasonable to expect of a parent in these particular circumstances, recognising that in a challenging situation many of us may behave in a way which might not objectively be viewed as reasonable. The test is not to be construed in a vacuum nor applied judgementally by reference to some gold standard of parenting which few (if any) could achieve. On the contrary, it contemplates a range of behaviour, incorporating inevitable human frailty. The reasonableness of the care given requires to be evaluated strictly by reference to the particular circumstances and the individual child."

E. Welfare

Care Order applications

25. Only if the Court finds the threshold conditions satisfied at the relevant date may it then proceed to make Part IV orders. In assessing whether to do so, the child's welfare is paramount. The court must take into account all of the relevant circumstances in the case, in particular the welfare checklist at s.1(3) CA 1989. The Court must also consider whether it would be better for a particular child to make an order rather than to make no order (s.1(5) CA 1989).

26. In assessing a parent's ability to meet the needs of a child, and where that parent suffers from a learning disability, Sir James Munby P in **Re D (A Child) (No. 3)** [2016] EWFC 1 endorsed the observations of Gillen J (as he then was) in **Re G and A (Care Order: Freeing Order: Parents with a Learning Disability** [2006] NI Fam 8:

"(1) An increasing number of adults with learning difficulties are becoming parents. ... Nonetheless the courts must be aware that surveys show that parents with learning disabilities are apparently more likely than other parents to have their children removed them

and permanently placed outside the family home. ... It is important to appreciate these currents because the Children Order (Northern Ireland) 1995 places an emphasis on supporting the family so that children can remain with them and obligations under disability discrimination legislation make public services accessible to disabled people (including parents with learning difficulties). Moreover the advent of the Human Rights Act 1998 plays an important role in highlighting the need to ensure the rights of such parents under Articles 6 and 8 of the European Convention of Human Rights and Fundamental Freedoms ("the Convention").

(2) ... To that extent courts must take all steps possible to ensure that people with a learning disability are able to actively participate in decisions affecting their lives. They must be supported in ways that take account of their individual needs and to help them to be as independent as possible.

(3) It is important that a court approaches these cases with a recognition of the possible barriers to the provision of appropriate support to parents including negative or stereotypical attitudes about parents with learning difficulties possibly on the part of staff in some Trusts or services. An extract from the Baring Foundation report provides a cautionary warning:

> *"For example, it was felt that some staff in services whose primary focus was not learning difficulties (e.g. in children and family teams) did not fully understand the impact of having learning difficulties on individual parents' lives; had fixed ideas about what would happen to the children of parents with learning difficulties and wanted an outcome that did not involve any risks (which might mean them being placed away from their family); expected parents with learning difficulties to be 'perfect parents' and had extremely high expectations of them. Different*

professionals often had different concepts of parenting against which parents were assessed. Parents' disengagement with services, because they felt that staff had a negative view of them and 'wanted to take their children away' was also an issue, as were referrals to support services which were too late to be of optimum use to the family – often because workers lacked awareness of parents' learning difficulties or because parents had not previously been known to services".

(4) This court fully accepts that parents with learning difficulties can often be "good enough" parents when provided with the ongoing emotional and practical support they need. The concept of "parenting with support" must underpin the way in which the courts and professionals approach wherever possible parents with learning difficulties. The extended family can be a valuable source of support to parents and their children and the courts must anxiously scrutinize the possibilities of assistance from the extended family. Moreover the court must also view multi-agency working as critical if parents are to be supported effectively. Courts should carefully examine the approach of Trusts to ensure this is being done in appropriate cases. In particular judges must make absolutely certain that parents with learning difficulties are not at risk of having their parental responsibilities terminated on the basis of evidence that would not hold up against normal parents. Their competences must not be judged against stricter criteria or harsher standards than other parents. Courts must be acutely aware of the distinction between direct and indirect discrimination and how this might be relevant to the treatment of parents with learning difficulties in care proceedings. In particular careful consideration must be given to the assessment phase by a Trust and in the application of the threshold test.

(7) Children of parents with learning difficulties often do not enter the child protection system as the result of abuse by their parents. More regularly the prevailing concerns centre on a perceived risk of neglect, both as the result of the parents' intellectual impairments, and the impact of the social and economic deprivation commonly faced by adults with learning difficulties. It is in this context that a shift must be made from the old assumption that adults with learning difficulties could not parent to a process of questioning why appropriate levels of support are not provided to them so that they can parent successfully and why their children should often be taken into care. At its simplest, this means a court carefully inquiring as to what support is needed to enable parents to show whether or not they can become good enough parents rather than automatically assuming that they are destined to fail. The concept of "parenting with support" must move from the margins to the mainstream in court determinations.

Placement Order applications

27. In respect of the placement order application, the court's paramount consideration is the child's welfare throughout his life [s.1(2) ACA 2002]. The checklist to be applied is set out at s.1(4) ACA 2002 and comprises:

> *(a) the child's ascertainable wishes and feelings regarding the decision (considered in the light of the child's age and understanding),*
>
> *(b) the child's particular needs,*
>
> *(c) the likely effect on the child (throughout his life) of having ceased to be a member of the original family and become an adopted person,*
>
> *(d) the child's age, sex, background and any of the child's characteristics which the court or agency considers relevant,*

(e)any harm (within the meaning of the Children Act 1989) which the child has suffered or is at risk of suffering,

(f) the relationship which the child has with relatives, with any person who is a prospective adopter with whom the child is placed, and with any other person in relation to whom the court or agency considers the relationship to be relevant, including—

(i) the likelihood of any such relationship continuing and the value to the child of its doing so,

(ii) the ability and willingness of any of the child's relatives, or of any such person, to provide the child with a secure environment in which the child can develop, and otherwise to meet the child's needs,

(iii) the wishes and feelings of any of the child's relatives, or of any such person, regarding the child.

28. As it has always been, adoption is a "last resort", appropriate only when nothing else will do in the interests of the individual child [**Re: B (A Child) (Care Proceedings: Threshold Criteria)** [2013] UKSC 33].

29. The court must evaluate all the realistic options, undertaking a global, holistic and multi-faceted evaluation of the individual child's welfare, taking into account all the negatives and positives of each option. There should be a balancing exercise in which each option is evaluated, weighed and compared before determining which option best meets the duty to afford paramount consideration to the child's welfare. [**Re: BS (Children) (Adoption Order: Leave to Oppose)** [2013] EWCA Civ 1146].

30. "Nothing else will do" is not a slogan to be taken to extremes so as to shy away from permanency or bend over backwards to keep a child in the family if at all possible [Munby P in **Re: R (A Child)** [2014] EWCA Civ 1625]. The court should focus on what are realistic options, on the evidence.

31. When assessing the risk of risk of future harm, it is essential that this is set in context: see Peter Jackson LJ in **Re F (A Child: Placement Order:**

Proportionality) [2018] EWCA Civ 2761, cited also by Peter Jackson LJ in **Re K (Children) (Placement Orders)** [2020] EWCA Civ 1503. The questions the Court should ask itself are:

> *(1) What is the type of harm that might arise?*
>
> *(2) What is the likelihood of it arising?*
>
> *(3) What consequences would there be for the child if it arose?*
>
> *(4) What steps could be taken to reduce the likelihood of harm arising or to mitigate the effects on the child if it did? The answers are then placed alongside other factors in the welfare equation so that the court can ask itself:*
>
> *(5) How do the overall welfare advantages and disadvantages of the realistic options compare, one with another?*
>
> *(6) Ultimately, is adoption necessary and proportionate – are the risks bad enough to justify the remedy?*

F. Human rights/siblings

32. Article 8 and Article 6 of the ECHR are engaged. The child and each parent has a right to respect for their family life. Orders must be necessary and proportionate to the risk of harm.

33. The right to family life exists not only between a parent and child, but between children also: **Akin v Turkey (Application No. 4694/03)** (unreported), 6 April 2010. This was considered by the Supreme Court in **Re XY** [2020] UKSC 26:

> *"29. The Akin case reminds us that article 8 imposes both negative and positive obligations - not to interfere in family life without justification and to take positive steps to maintain and develop family ties. In both cases, the case law under article 8 emphasises the authorities' obligation to have regard to the best interests of the*

child (see Maslov v Austria [GC] [2009] INLR 47 (Application No 1638/03) 23 June 2008, para 82). And the decision-making process must be such as to show that the authorities had a sufficient evidentiary basis for their decisions and that the interested parties, including the children themselves, were able to express their views (see, e.g., Havelka v Czech Republic (Application No 23499/06) (unreported) 21 June 2007). However, the role of a parent, involving, in the absence of intervention by public authorities, the right to decide how a child is to be brought up, is qualitatively different from the role of most siblings. As noted above, a sibling's role can be very important to the well-being and development of a child. But where a child is being cared for away from the family, what matters is the maintenance and development of the relationship between the siblings, whether through placing them together or through staying in regular contact with one another.

...

46. It is important to recognise that there are differences between the relationship of a parent and a child and the relationship between a sibling and a child. People who have parental responsibilities are treated as relevant persons because of those responsibilities and people who have a significant role in the upbringing of a child also have the right to be deemed a relevant person. As the European Court of Human Rights stated in Haase v Germany (2005) 40 EHRR 19, para 82, "the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life". The parents and other people who have a significant involvement in the upbringing of the child are those who make decisions for the child. It is those decisions which are now being made by the public authorities through the CSO. The interference with the article 8 rights of such people is qualitatively different from the interference with the article 8 rights of siblings, which normally will be concerned with maintaining their relationship with the referred child, whether through contact or (if they are both the subject of

CSOs) through being placed together. The conferment of the status of relevant person is an acknowledgement of the gravity of the interference with the family life of the child and the parents and others with that significant involvement in the child's upbringing.

…

52. We nonetheless acknowledge that the initiation of these challenges has served to uncover a gap in the children's hearings system which has had to be adapted to meet the requirements of article 8 in relation to siblings and other family members. There is now a clear recognition of the interest of both the child and the sibling in maintaining a sibling relationship through contact (or through placement if both are subject to CSOs) in most cases. The nature of the sibling relationship will vary from family to family and there needs to be a nuanced approach which addresses the extent of family life in that relationship, the home circumstances, how far the interests of the parents, the sibling and the child coincide and the possibility that the child, the parents and other siblings may have article 8 rights which are in conflict with those of the sibling. There needs, in short, to be a bespoke enquiry about the child's relationship with his or her siblings when the children's hearing is addressing the possibility of making a CSO."

G. <u>Together or Apart Assessments</u>

34. The Court is referred to the "**BAAF Good Practice Guide: Together or Apart? Assessing Siblings for Permanent Placement**" and, in particular:

<u>Personal beliefs of social workers, foster carers, panel members and other professionals</u>

There needs to be an acknowledgement that many workers and others have strong views, often based on their own personal experience, about whether siblings should be kept together at all costs or should ever be separated. Some may find it impossible ever

to contemplate siblings needing to be placed separately, while others may find it impossible to believe that any new family could parent a group of four or five siblings, all of whom are needy in their own right. This can be the case for those who have worked with or, indeed, been part of a large, chaotic, dysfunctional birth family and who have found the experience overwhelming…Training and supervision are both important in enabling people to air and discuss their views and to consider possible alternatives. Clear policies and procedures and group working and decision-making are important checks and balances on personal beliefs.

…

<u>Ethnicity</u>

It is increasingly common for there to be sibling groups which include children of different ethnicities…As with all siblings, the presumption should be that the children will stay together unless there is a good reason to separate them. As with all children, the most appropriate permanent new family is likely to be one which reflects the children's ethnicity as closely as possible.

…However, if this specific link is not possible to achieve, it is particularly important to ensure that each child still has the opportunity 'to positively develop these heritages that are most minimised or devalued in wider society'…

When assessing the holistic needs of each child, it will be important to explore how each one perceives his/her own ethnic identity and that of their sibling…Work with the children separately and together on these issues will be necessary before they can be placed in a permanent new family.

…

Assessing each child's needs

When assessing and planning for a sibling group, it is very important to remember that each child is also an individual with his or her own unique needs. It is essential that each child in a sibling group has a full assessment in their own right. The assessment of their relationship with, and attachment to, their siblings is one component of this, but only one.

Assessment should start from the time of the first referral of a family to the social services or social work department. The Assessment of Children in Need Framework (DOH, 2000) identifies clearly the components of this, i.e. health, education, emotional and behavioural development, identity, family and social relationships, social presentation and self-care skills.

…

It is important to have the depth and range of information about each individual child, which these assessment formats require, when deciding whether the combined range of needs of the children in a sibling group could be met by one permanent family.

…

What does each child understand and feel about what has happened so far and what are their wishes for the future?

It is important that each child in a sibling group has the opportunity for some individual sessions in which they can explore and reflect on their life at home, on the reasons why they are in care, and on what they would wish for in the future. This will include the opportunity for the child to express feelings about brothers and sisters, explore how much they identify with siblings, with whom they would like more or less contact. The potential of disabled children

to communicate their wishes, feelings and views is frequently underestimated but they may need extra help.

…

Assessing a child's attachment to and relationship with each sibling

It is important, even in large sibling groups, to assess each child's relationship with every other child in the group. This assessment should be based on a detailed observation of how the children behave with each other. The observations of people who have seen the children together at different times and in different settings should be gathered. Current and previous foster carers, birth relatives, other siblings, teachers and social workers can all make useful observations, although it is important that these are backed up with concrete examples.

…

What work could be done to improve relationships between siblings?

The decision to separate permanently siblings who have lived or are currently living together should, in our view, be treated with the same seriousness as the decision to separate children permanently from their parents. For siblings, as for parent and child, an assessment of the relationship should be followed in most cases by a time-limited programme of work aimed at improving the relationship and preventing the need for a permanent separation.

…

Identifying who should be placed with whom if a sibling group needs to be split

…

Separating children in permanent placement should only be contemplated following a full assessment of their needs, their wishes and their relationships, and this is likely to indicate who should be placed with whom, or whether they should be placed on their own.

If the "ideal" is to place a large group together, efforts must be made first, albeit within agreed timescales, to recruit a family for the whole group…If children do have to be placed separately in this situation, and should family finding for the sibling group prove unsuccessful, the three key factors should again be:

- *Their individual needs;*
- *Their wishes; and*
- *Their relationships.*

…

Recording

It is very important that the reasons for deciding to separate siblings or to place them together are clearly recorded and evidenced. This record should include the children's own views and the reasons, where applicable, why it was decided to override these…"

Evidence

132. I have been provided with a series of very substantial electronic bundles:

(i) a main bundle of 3,027 pages;

(ii) a bundle of additional documents containing section K of 296 pages;

(iii) an updating bundle containing section N of 224 pages;

(iv) a further updating bundle containing section P of 365 pages;

(v) an education records bundle containing separate sections for each child of 624 pages;

(vi) a medical records bundle of 4,040 pages;

(vii) a bundle of family pictures provided by the mother during the hearing, at my request.

133. I have read the bundles, save for the medical records bundle which I have read selectively from.

134. Between January 2022 and February 2022, I heard evidence from the following witnesses:

135. The allocated social worker was allocated in early 2021, although she started working the family at the end of October 2020. Most of her social work experience was gained abroad and she had recently commenced work in this country when she started working with this family.

136. She told me the mother has a "lot of strengths" and, "loves her children so much". She praised the very positive records of the mother's contact with A and B. She also recognised the mother's positive attitude about the foster carer for A and B. However, the social worker explained the difficulties she had experienced working with the mother, "The meetings were incredibly difficult. Providing we were talking about what was going well, the mother engaged and was able to take part in the meetings, but if it was something that was difficult to hear or anything with assessments or talking about the father, then she became very worked up and emotional and made the meetings incredibly difficult."

137. When challenged about whether it was actually the change to Q school that brought about the improvements in A, the social worker told me that she saw a change in A after he was removed into foster care. She said that he appeared physically frail and could not look at her before his move to foster care, but that after his removal he improved to the extent that by August 2021 he actually ran away from the mother and the social worker at the contact centre, whereas before he was not able to walk. She said there had been progress at Q school, but not much in 2020. It was in early 2021 that the improvement was beginning.

138. She told me that E is turning 5 years old this year, so she is "really on the edge" for adoption. She was realistic about the possibility that an adoptive placement may not be found, and this may mean that E is placed on her own. She said the local authority would look, "very, very seriously for a family who can maintain sibling contact".

139. The social worker saw a parallel between the way that B's behavioural difficulties was initially challenging at home, before escalating and spreading to school, with D's behaviour. She also drew attention to the improvement seen in B since he was removed

into foster care with issues that the mother had previously drawn attention to not being seen. For example, the mother claimed he had sensitivity to sound such that she wanted him to have ear defenders, but in foster care he would turn the sound up on the Xbox and was not bothered by peripheral sound. She expressed the hope that D would show similar improvements to B in foster care but that he would need a lot of attention and C's needs could be overshadowed as a result. She accepted that there was a risk if placing D and C together of the placement breaking down or of the experience being suboptimal for C. She felt it needed to be a home with two carers, and the carers would need to be as sensitive as possible.

140. The social worker demonstrated impressive levels of thought and consideration that had gone into her work on the case. She was challenged about the way she had worked with the mother; however, I formed the view that the difficulties arose not due to inadequate social work but because of the mother's difficulty in working with social services generally and specifically with the social worker responsible for the removal from her care of A and D. I found the social worker to be a reliable and sensible witness and I accepted her evidence.

141. The previous social worker was allocated to the case in January 2020 and his involvement ended in October 2020, although he conceded that his statement was dated January 2021 had been filed later.

142. He explained the difficulties he had working with the mother. He struggled to get access to see the children at the family home. He described the mother becoming, "quite emotional in some meetings, quite angry in other meetings, and very challenging in some meetings. Each of these, she will either walk out or hang up the phone, or stay in the background and refuse to engage."

143. The previous social worker also told me about the positive sides of working with the mother. He said she, "[W]orked with me well when I go in and spent time with her. She was very proud when she cleaned the house to a good standard. I give her credit for that, she's hard working."

144. I found the previous social worker to be a reliable witness and accepted his evidence.

145. I heard from the allocated family finder. He told me that the realistic time frame for identifying an adoptive placement for E and F is 9-12 months. In relation to the guardian's suggestion that the search should be widened to include separate adoptive placements after four months, he said he was thinking of the six-month point, but any time between four and six months is a reasonable suggestion.

146. He told me that he had positive recent experience of placing a sibling groups and children with similar ages and emotional and attachment issues which took 7 months although he accepted those children were of a different ethnicity from E and F. However, he was realistic that despite every effort, there was a realistic chance that a match would not be found.

147. He explained that they would try to match ethnicity as a priority, but if that was not possible, they would explore how the children's heritage would be supported.

148. The family finder recognised the challenges in the family finding process and was appropriately realistic. I found him to be reliable and accepted his evidence.

149. Parenting assessor A is a social worker who is currently employed with Greater London Fostering but at the time of her assessment was working for the a Family Assessment Centre – a London Borough of Z resource. She conducted a parenting assessment of the mother prior to the proceedings, between April 2020 and August 2020. It was not a PAMS assessment although she did use some visual tools such as the "Kids needs" cards.

150. Parenting assessor A's assessment was conducted by video call using WhatsApp and she carried out no home visits, she explained this was due to the mother's reluctance to have home visits during the pandemic. She offered safe socially distanced alternatives, such as going to the park or remaining outside in the garden, but the mother wanted to keep the sessions on WhatsApp.

151. Parenting assessor A identified the positives in the mother's care for the children: that she clearly loves her children; gave good explanations of their routines; the children were

clean and well presented; the mother is a good cook who provided good healthy food; and the mother engaged well with the CAMHS clinician.

152. Parenting assessor A identified a number of areas that the mother was reluctant to discuss with her – issues around support; details relating to the children's father and his role; the mother's own childhood and its effect on her parenting; and the mother's mental health in the past and presently. Parenting assessor A also told me that the mother was unable to go into any depth about A's mutism – the answers would be that he had never really spoken or that he was a quiet shy boy.

153. I found parenting assessor A to be a reliable witness and I accepted her evidence.

154. Parenting assessor B is a social worker from the same Family Assessment Centre. She used a PAMS format for her parenting assessment of the mother which was informed by the psychological assessment by Dr. Garrett and by Dr. Lyall's updating psychiatric report. Her assessment took place between May 2021 and September 2021. She told me that there was no doubt that the mother loves her children dearly and that she is very much aware of their differences and the strengths, weaknesses, likes and dislikes of each of the children.

155. Parenting assessor B identified a number of positives about the mother's care of the children, for example that the children were well-kempt and turned out. She also said that the mother was able to identify some gaps in her parenting. She accepted that at the time of her observations she saw a relaxed household with the children around their mother but balanced that by saying she had read differing reports.

156. Parenting assessor B told me that she was not sure whether the mother was in denial about the deficits in her parenting, or whether she genuinely did not understand why she was being held responsible for her children's presentation. She said that Dr Lyall's report helped her to understand the mother's character a bit more and it seemed to fit in with why the mother was unable to accept criticism and why there was this confusion about what she was doing wrong.

157. Parenting assessor B told me that the mother was not forthcoming to provide X's telephone number. She said the mother was overwhelmed with the number of children she has. Parenting assessor B told me that had taken a gentle and empathetic approach and on reflection during her assessment she may not have challenged the mother as other professionals had done.

158. Ultimately parenting assessor B's assessment was that she could not recommend that A and B should return to the care of her mother, nor could she recommend that C, D, E and F should remain in their mother's care. Parenting assessor B was unshaken in cross-examination. I found her to be a balanced and fair witness, whose use of the PAMS process and whose gentle approach had maximised the mother's ability to engage meaningfully with the assessment process. I found parenting assessor B to be reliable and I accepted her evidence.

159. I heard evidence from the pastoral care and safeguarding lead at R Primary School. She told me about the difficulties the school had working with the mother, in particular that an incident had taken place with B and that the mother was unhappy with the way the staff dealt with it, wanted an apology and kept B off school from October 2019 as she felt he was not safe there. The pastoral care and safeguarding lead said a number of meetings were offered to the mother, but she did not feel they were necessary.

160. The pastoral care and safeguarding lead described the relationship between the mother and school as being "very up and down". There were times when the mother needed support or advice and was open to working with the school to resolve matters. There were other times when the relationship had been challenging, when the mother felt the school was not meeting the children's needs or the school was not reporting the same concerns that she had – that was particularly challenging because the mother felt the school was not telling the truth about its observations.

161. The pastoral care and safeguarding lead was asked about A's experience of bullying at school. She said there were incidents that took place, but there was not a pattern of A being bullied. She accepted that A was having some problems at school and having conflict with his peer group.

162. The pastoral care and safeguarding lead explained that staff at the school had on occasions to restrain B and D due to their behaviour. She explained how "positive handling" was carried out and described a situation when the headteacher had to use physical restraint techniques on B.

163. The pastoral care and safeguarding lead told me that the ASD assessment of D was completed without the assessors contacting the school. Under cross-examination she was quite cautious about this. She had second-hand knowledge from the inclusion manager that the school had not been contacted but accepted that it was possible she was not aware of communication. The community paediatrician who assessed D in her evidence said that the team would have obtained information from the school and subsequently produced a questionnaire completed by D's class teacher at R. Unfortunately, the pastoral care and safeguarding lead had no opportunity to comment on this document. It does appear that for whatever reason, she was incorrect about the ASD assessment having been completed without obtaining information from the school.

164. The pastoral care and safeguarding lead told me about a situation that occurred with D when he was saying he wanted to go home, and she had called the mother but had told the mother she was not expecting her to pick D up. She was sure she did not tell D that his mother was coming to pick him up but that she was going to phone her. However, she conceded that D may have thought his mother was going to come to collect him. Subsequently when D was picked up at the end of the school day, there were reports of the mother shouting and swearing and also saying that the pastoral care and safeguarding lead was a "fucking liar". It appears that the pastoral care and safeguarding lead's approach to that telephone call did not foresee or manage the potential difficulty it could create for the mother when she eventually attended to pick up D at the end of the school day. However, while that was unwise and created a difficult situation, it does not mean the mother bears no responsibility for her actions.

165. The pastoral care and safeguarding lead told me there was a pattern where the school did not experience the problematic behaviours that the mother reported were occurring outside school, but as time went on those difficulties would cross over into the school. She considered that happened with B and D in particular, but that the pattern was present for C

also. She also saw similarities in the approach to uniform wearing – that both B and D were reported to struggle with the sensation of the school clothes and as a result they did not wear the school uniform.

166. In relation to A, the pastoral care and safeguarding lead said that he was able to do PE when at the school. She was not sure to what extent he may have been in discomfort or distress from it, but he was physically able to do PE. The mother had reported that he could not do PE and that she did not want him to take part in physical activities. However, when A had free play, he would go and play some kind of physical activity with his peers.

167. The pastoral care and safeguarding lead had a difficult relationship with the mother, such that other professionals were aware of the problems. Her evidence was not entirely reliable, for instance about the information that was shared with the community paediatrician's team who assessed D. However, overall, I considered that she was more reliable than the mother and where their evidence differed, I preferred the pastoral care and safeguarding lead's.

168. I heard evidence from a Teaching Assistant at R School. She had no direct role with any of the children of the family, although she knew who the school-age children were from seeing them around. Her evidence was unshaken in cross-examination. She had a firm recollection of the events she witnessed after the end of the school day in November 2021 which she felt obliged to report the following day as a child protection concern. I found the teaching assistant credible and reliable, and I accepted her evidence.

169. I heard from the Social Emotional Wellbeing and Interventions Manager at T Secondary School. I found her to be a straight-forward witness. She accepted there had been instances when A had been bullied but also explained that there was no record of him being consistently and persistently bullied and that there were other times when A had been the bully. She told me that there had been 49 detentions given to A in the 2017-2018 academic year, which is a lot. Her evidence was consistent, and I found her reliable. I preferred her account where it differed from the mother's.

170. I heard from an art therapist with 33 years of experience who works for Z CAMHS. There was considerable uncertainty about whether she would give evidence and she was

initially resistant to doing so. A witness summons was served on her and it only on the day that she was directed to attend that it was confirmed that she would attend. It transpired that she had been given some unwise advice from her managers. I put back her evidence so that it would minimise disruption for her clients. Nonetheless there was a degree of defensiveness and brittleness in the way the art therapist answered questions. I was unsure whether this was because of the summons, however I also detected in her that she disapproved of the removal of A and B from their mother's care.

171. The art therapist was effusive in her praise for the mother. She explained her main role was to support A towards obtaining an EHCP and getting him back into education. There was in my judgment a degree of what Mr. Woodward-Carlton described as "mission creep" in that the art therapist and the CAMHS service gave a considerable amount of support to the mother in the hope of bringing about a better outcome for A. That cannot have been made easier by the pandemic which meant that the CAMHS support for a non-verbal child had to be conducted online. I am satisfied that a substantial amount of time was spent talking to and working with the mother.

172. The art therapist told me that the mother, "lived for her children". She said the mother trusted her. She described the mother in child protection meetings finding it very difficult if she disagreed with something - she would interrupt and become quite disruptive. She described the mother being quite overloaded with six children with needs, being pulled in different directions and being overwhelmed.

173. The art therapist described the considerable effort she put into trying to persuade the mother to use T School to complete an assessment on A that could contribute to his application for an EHCP. However, she was unable to get the mother to do so. Ultimately A only got the assessment he needed when it was arranged to take place at Q school (before he became a pupil there).

174. In relation to B, the art therapist's evidence was contradictory about the issue of whether the mother was willing to sign the necessary paperwork for an EHCP. She told me that the mother said she did not want to sign it, but then said she was wanting to sign it. She later explained that she thought the mother did want to sign it but there were ongoing

difficulties between her and the pastoral care and safeguarding lead at R Primary School who had an unhealthy dynamic.

175. The art therapist complained about information not being shared effectively with the CAMHS service by other agencies, in particular by social services and the schools. She appeared frustrated about that, but when she was shown constructive emails from the school opening channels of communication, she said that she had rung a number of times and without success. This did not compare well with the consultant paediatrician's evidence that when he had suspicions about A's presentation, he was able to contact the school without difficulty.

176. The art therapist was taken back to a letter she wrote in February 2021 intending for it to be shared with the court at the contested interim care hearing:

> "It is our opinion in CAMHS that M has made superb efforts to enable a balance happy home life. Her children have their own difficulties a mix or genetic and current circumstances so need network support but I feel M has appropriately attended to her 6 children individual needs and wellbeing in terms of physical health, environment, stimulating toys and activities, exercise, education, celebrations, fun and when possible interaction with family and friends. This is an enormous achievement and with support M is following the beneficial CP plan and attending and cooperating with tasks in a way that enhances and strengthens her own skills and those of her children."

177. The art therapist did not accept Mr Woodward-Carlton QC's suggestion that the letter puts a different slant on CAMHS' experience of the mother and was, "uncritically supportive of the mother and imbalanced when identifying the shared concerns that CAMHS had about her accuracy and honesty". On the basis of the evidence I have heard, I am satisfied that Mr Woodward-Carlton QC was accurate in the way he described the contents of that letter.

178. I have no doubt that the art therapist is a dedicated therapist. In her evidence to me, I formed the impression that although she was aware of discrepancies and inconsistencies in the accounts that the mother had given, she had never sought to look behind the mother's account even when other information available to her obviously called it into question. As

the letter for the court demonstrated, the art therapist's approach was as an uncritical support to the mother. The art therapist's unchallenging and supportive approach is likely to have helped to her foster such a good working relationship with the mother. However, it is also noteworthy that the art therapist's work did not bring about any improvement in A despite the strong working relationship. It is also noteworthy that the mother was not receptive to the art therapist's clear and repeated advice about the best way to obtain an EHCP.

179. Ms N is a children support practitioner for the local authority. Her role is to provide family support work. She worked with the mother and the family for an extended period of time, she started in November 2019 and she has never really stopped. At the moment it is more telephone calls. The last time she called was in January 2022. Her work with the family was affected by the pandemic and the lockdown so that since November 2019 she had made ten face-to-face visits. During the lockdown she made virtual visits or made contact by telephone.

180. Ms N helped the mother with her understanding of issues. She would listen to her, help to write lists and support her in meetings. According to parenting assessor B, the mother felt she was held in mind by Ms N. Ms N told me she had not had any reason to challenge the mother. Ms N provided assistance by way of advice and suggestions rather than simply doing the physical work of cleaning up and tidying. She was praising of the positives she had seen, but it was balanced, for example she recognised that supporting B and D's homework was a struggle for the mother (the other children did not have any).

181. I was impressed by Ms N. She had first-hand experience of life in a large family including adopted children which meant that she had very relevant understanding of what it is like to be part of a large sibling group and what it is like as a parent. It was clear that she had a very positive working relationship with the mother and that the mother found her very supportive. Ms N is an instinctually maternal person and she exuded warmth and kindness. It was not surprising that the mother responded so well to her. Ms N provided a strong example of how well the mother can work with a professional when she feels they are on her side. I found Ms N to be reliable and accepted her evidence.

182. I heard from the family support worker from an outside agency engaged by the local authority. She is relatively inexperienced, with 1¼ years as a family support worker, much of which was during lockdown so at the point she was working with the family she would have had been in her role for about 9 months. She was allocated to the family in September 2021 and attended for 8 hours per week, spread over Monday, Friday and Saturday. Her role was primarily to provide welfare checks, rather than family support in the typical sense. Despite that role, she nonetheless told me that she regularly had stepped in and assisted while she was there, for example looking after the other children while the mother was occupied dealing with D.

183. The family support worker was up front about not having been made aware of the mother's cognitive issues. The family support worker told me about two incidents when she was present when D had put plastic over the face or head of F. She had intervened and considered these to be serious, but when she told the mother, her reaction had been inappropriately unconcerned. There was also a dispute over whether the maternal grandfather had been present at the time – the mother says that she was not there, but he was on one of these occasions; The family support worker was clear that was not the case and remembered that the mother had been elsewhere in the house and she told her afterwards.

184. The family support worker also told me about a number of occasions when D had become verbally and physically aggressive, assaulting both the mother and her. She described neither she nor the mother were unable to contain D nor make any effective interventions at those times. She said that the mother attempted sensible strategies to contain D and that she had a patient, kind and calming effect and she positively reinforced good behaviour. She described the mother as very loving and that when the children are happy, she is happy.

185. There was an issue over the phrase, "intermittent explosive disorder". This is something that the local authority says the mother introduced as a possible explanation for D's presentation. The mother has said it was something that she first learned from the family support worker. When asked about this, the family support worker said that it was first raised by the mother and they had googled it on the phone and gone through the

symptoms. She told me that she did not know what it was until the mother said it, which is why she looked it up.

186. The family support worker was also present when X had attended at the family home and had behaved in a very aggressive and angry way. She could not say whether he was drunk but that is what the grandfather (who was there at the time) had said. There was a suggestion that the mother returned to the property later in the company of X, however under cross-examination the family support worker accepted that she did not know whether they had been together or had simply arrived at the same time.

187. I found the family support worker to be a fair and balanced witness and I accepted her evidence.

188. The consultant paediatrician has now moved to a new NHS Trust. I was impressed by the consultant paediatrician; he was a thoughtful and considered witness who although not instructed as a court expert was careful not to step outside the boundaries of his paediatric expertise. He was unshaken in cross examination and gave a clear explanation of the steps in the chronology that caused him to form the view that A's presentation was as a result of FII. He relied on his notes which appeared to be contemporaneous and detailed. He explained how the picture came together when he spoke to T School who described A's starkly different presentation before he was removed from school, compared with the descriptions that the mother had given during the clinical appointment. He pointed out that the mother had also given the same history when seen at GOSH, which had caused Dr. Kaliakatsos (Consultant Paediatric Neurologist) to also raise similar concerns about FII in a letter dated December 2019.

189. Ms Langdale criticises the consultant paediatrician for having read selectively from the bundle before giving his evidence. The consultant paediatrician was sent a bundle of some 8000 pages during the week before he gave evidence. He was not told whether to read it or not until he received an email the day before his evidence specifying certain documents to be read. He described that he had skimmed through and looked at bits of the bundle. In my judgment, he cannot be criticised for looking at a bundle when he was provided with it, in the absence of any indication as to what he should or should not look at.

190. Ms Langdale submits that the consultant paediatrician has been overly influenced by information provided by schools and other agencies which has not always been reliable. I am not persuaded that is the case. He was clear in his evidence that at the point he became concerned about FII and made a referral he was relying on the information provided by the school about A's presentation prior to being withdrawn from the school. Other information came to his knowledge later and did not influence his opinion. I found the consultant paediatrician to be reliable and I accepted his evidence.

191. I heard from the Community Paediatrician who assessed D. She was not a court-appointed expert but had conducted an ASD assessment in relation to D as part of her clinical duties. There was concern about whether information had obtained from D's school as part of the assessment because it was not mentioned in her assessment report. However, after this community paediatrician completed her evidence, she located and forwarded the questionnaire completed by D's reception class teacher at R Primary School. That questionnaire identifies a large number of difficulties. While I accept that the GOSH assessment has raised concerns about the accuracy of the ASD diagnosis, that does not mean that this community paediatrician's assessment was wrong on the basis of the information available at the time. This community paediatrician had not seen the GOSH report, but she accepted that it would be appropriate for D to be re-assessed as soon as possible, bearing in mind he may need a period of settling in depending on the outcome of the final hearing.

192. This community paediatrician also assessed F as part of her clinical practice. She explained that at the first assessment she had been unable to get F to participate in the assessment in any meaningful way. As a result, he was scored below the threshold levels and was assessed as having global developmental delay. In the second consultation, F's engagement was much improved. The assessment was completed using the Ruth Griffiths developmental scale in which F performed really well and she described a huge improvement. She described F having been assessed as below the 50th centile for speech and language, which amounted to severe speech and language delay, however she also told me that F at the end of the session when offered a sticker said, "I do not want this one". She told me if he had said it during the assessment, he would have scored far higher.

193. I accepted this community paediatrician's evidence. I was slightly surprised by the formulaic approach to the assessment of F – information that arose immediately after the formal assessment was concluded was excluded even though it indicated a far better level of functioning.

194. **Dr. Tanya Garrett** is a psychologist from the University of Birmingham. She assessed the mother's cognitive functioning and later provided a full psychological report and addendum.

195. Dr. Garrett provided a context for the mother's cognitive functioning – notwithstanding the areas of weakness, that the mother did not have a learning disability. Dr. Garrett's view is that it is highly unlikely that the mother would meet the criteria to receive support from the adult learning disability services. However, she did agree that it would be extremely beneficial for the mother to have that sort of support.

196. Dr. Garrett's view was that the mother has significant personality difficulties and inter-personal difficulties. She described the mother having experienced abuse, rejection, attachment issues, lack of boundaries, witnessing domestic abuse between her parents, she went on to develop difficulties with her mental health, with body image, eating and difficulties forming inter-personal relationships. She described that these difficulties that are central to personality disorder have been present throughout the mother's life. Her view was that counselling would not be sufficient, but that the mother would need formal longer-term psychotherapy.

197. As to therapy for the mother, Dr. Garrett did not recommend it. She said that the premise of therapy is that it is going to be an undertaking that will bear fruit. However, regardless of whether the children were in the mother's care, the mother is someone who does not think she needs therapy and has not engaged with psychological services in the past, like IAPT. If therapy were undertaken while the children were in the mother's care, Dr. Garrett expected it to be highly distressing for someone with the mother's background, so she would generally recommend it only if there was another protective adult in the household or available to be with the children. She said she would not hesitate to recommend strongly for therapy if she thought the person was likely to engage well, but she did not think that was the case for the mother.

198. When the mother's case was put that she had described A as a quiet boy but not that he could never speak, Dr. Garrett was clear she had been the explanation she was given – "that's what she said to me".

199. Dr. Garrett explained the efforts she made to ensure that the mother was able to understand the assessment process and the means by which she built rapport. She appeared to have taken sensible steps to maximise the mother's engagement. When asked about the mother subsequently saying to CAMHS that the assessment sessions had been long and stressful, Dr. Garrett accepted that the sessions had been lengthy but with regular breaks, that she is very experienced in this type of work and with pacing assessments particularly with someone with the sort of cognitive functioning that the mother has. She pointed out that the cognitive assessment was conducted very early on in the first session when the mother had been relatively fresh.

200. I found Dr. Garrett to be reliable and I accepted her evidence.

201. **Dr. Marc Lyall**, an experienced Consultant Psychiatrist, gave evidence. He has seen the mother and reported on three separate occasions over a very long period of time: August 2010, April 2020 and September 2021. He was skilfully challenged in cross-examination particularly in relation to his diagnosis of personality disorder. The focus was his differing opinions in his three reports. He explained in his report, "In 2010 I did not believe that there was evidence to support a diagnosis of personality disorder. In 2020 I considered whether [the mother] may suffer from Emotionally Unstable Personality Disorder but did not believe that there was sufficient evidence to make the diagnosis at the time… Having seen the updating evidence, particularly the evidence of Dr Garrett, her summary of the GP medical records, the updating evidence of the Local Authority and having interviewed [the mother] on a third occasion, I think now that there is evidence that she likely meets the diagnostic criteria for an Emotionally Unstable Personality Disorder."

202. I found Dr Lyall's reasoning for the way his diagnosis had developed over time to be sound and evidence based. He was willing to accept alternative explanations for the mother's presentation – the strongest being that it is a state, a straightforward reaction to

being in very stressful legal proceedings, rather than emotionally unstable personality disorder. However, his view was it was a personality disorder because of the history. He explained that evidence is necessarily patchy, that during proceedings there is a lot of observation and a lot of data to work from, but between proceedings the evidence is relatively lacking, relying on self-reporting and other data such as the medical records. He explained that it is the history that shows whether the presentation is something that endures or has just arisen in the moment. He remained unshaken in cross-examination. I found him reliable and accepted his evidence.

203. **Dr. Elhassan Magid** is a Consultant Paediatrician who was instructed within the proceedings. He conducted an assessment of each of the children and an addendum report. He identified those conditions that he considered were present and those he did not. He explained that the hypermobility is very common, it is not a disease or condition which causes any trouble or prevents a person from walking or doing activities. He described it as a variation of normal although some children can get pain at night. He considered it had no role in explaining A's regression with his movement and pointed out the reverse is true – that it affects younger children and improves as they get older

204. Dr. Magid also provided context around A's beta thalassemia trait – that he is a carrier only and it causes no symptoms. He did explain that it can lead to slightly lower levels of haemoglobin which can lead to a wrong diagnosis of anaemia.

205. In relation to A's schooling needs, Dr. Magid thought A was much more capable than a child with special needs and he hoped he could return to mainstream school and it will work for him.

206. In relation to melatonin, Dr. Magid explained it is not a dangerous medicine. It is naturally secreted about thirty minutes before going to sleep. He would prescribe it if a parent says a child is not sleeping. He said that in this case B may have been prescribed it because he was not sleeping, but when he was given boundaries and structure around sleeping, he did not need it.

207. In relation to D's ASD diagnosis, Dr. Magid considered it alongside the GOSH assessment. He said that if he looked at the ASD report in isolation he would accept that

D has ASD, but the GOSH assessment has created doubt about the diagnosis. He recommended a further assessment from the initial team.

208. I found Dr. Magid to be considered and thorough. He was careful to consider alternative explanations and I found him to be fair and balanced. I accepted his evidence.

209. **Dr. Simon Wilkinson** is a Consultant Child and Adolescent Psychiatrist at Great Ormond Street Hospital. The mother took herself off-camera throughout his evidence although I understand she remained in the room. Dr. Wilkinson's role in the GOSH assessment focussed on A and B. Dr. Wilkinson explained that it was extremely unusual for a child of A's age to develop mutism and that this had been an unusual form of mutism that applied in all contexts, which was different to selective mutism seen in younger children who become mute in school as a way of managing anxiety. I found Dr. Wilkinson to be an impressive witness and I accepted his evidence.

210. **Dr. Lucy Sawyer** is the Principal Clinical Psychologist in the Parenting Child Consultation Team at Great Ormond Street Hospital. She took the part of the assessment that focussed on C. The mother was unable to remain and listen to all of Dr. Sawyer's evidence when the questions moved she was asked what trauma should be expected to C if she is removed to foster care and she replied that, "We suspect C is experiencing trauma at home at the moment". She later went on to explain that trauma would not be the right term to describe the impact of a removal but accepted that it would be very difficult, and C would be sad, would miss her mother and be confused to go to a new environment and not be with all her siblings.

211. Dr. Sawyer was carefully cross-examined but was unshaken. She demonstrated balance and thoughtfulness in her evidence. She was clear about what was observation and when theory or hypothesis was being offered. I found her to be an impressive and reliable witness and I accepted her evidence.

212. **Ms Marta Neil** is the Principal Child and Adolescent Psychotherapist in the Child Care Consultation Team at Great Ormond Street Hospital. She took the lead on the assessment of D. Ms Neil had not seen D since the assessment was completed but when asked about the recent problems with D she hypothesised that the strain that the mother had been under

since the conclusions of the GOSH assessment and anticipating a final hearing where she may lose her children could have caused her to become increasingly anxious and overwhelmed which may be contributing to the difficulties at home.

213. Ms Neil was balanced and mindful of the potential negatives as well as the positives of different placement options. She recognised that the recent events made her recommendation of long-term foster care placing D and C together riskier and more difficult. Nonetheless she maintained that recommendation but conceded that if D could not settle down after a period of adjustment and if the children's needs made it clear that they could not be easily parented together then the sensible and most safe option would be to place D and C in separate placements. I found Ms Neil to be a sensible, fair and considered witness. I accepted her evidence.

214. **Catherine Devereux-Evans** is an independent social worker. She was originally instructed to conduct a special guardianship assessment of the maternal uncle, and of the maternal grandfather. However, that was later changed to an assessment of the uncle as a carer for only A and B. Nonetheless, she interviewed the maternal grandfather as the two men live together. Her assessment was negative. Her opinion was that the uncle lacks understanding of the complex needs of the children, in particular their emotional needs. She also expressed concern about the grandfather being quite a dominant figure in the family. She found both men to be very reluctant to reflect on potential parenting issues that may have impacted on A and B's development.

215. She recognised the positives about the uncle. She stressed that he is "extremely well-meaning and sincere" but there was a reluctance for him to dive deeply into the emotional needs of the children. She was keen for him to read the GOSH report as she felt he was not aware of what he was getting himself into.

216. Ms Devereux-Evans considered it significant that when A ran away, he ran to the home of his grandfather and his uncle.

217. I found Ms Devereux-Evans to be reliable and I accepted her evidence which was very in line with my impression of the uncle when he gave evidence.

218. I heard from the maternal uncle. I do not have any doubt about his love for the children and his sincere wish to care for them. He spoke with real affection about each of them and I formed the impression that he is an engaged and engaging uncle. He told me that his bosses are very understanding about him moving to flexible hours and even if he stops work altogether, they will keep his job open.

219. The uncle's preferred option is for all the children to be in their mother's care. He was keen to impress that there was no limit to what he was willing to do to support this option, being present in the mornings and evenings, even staying over "if needs must". In the course of his evidence, he suggested he could move in with the mother and the children, although he had not discussed that option with the mother.

220. The uncle's second preference was that he put himself forward to care for the children. In his written document he used the phrase "adopting" but hearing his evidence I did not form the impression that he was talking about a formal adoption as opposed to simply taking over the care of the children.

221. When it came to his understanding of the children's needs, the uncle showed only a superficial understanding. His responses were general rather than appreciating that these children had any significant levels of additional needs. When asked about A and B's needs, his reply was that they need their mother and their uncle around, to have the love of their parents, to have food, to have people to interact with and to go to college.

222. The uncle maintained the account he had given to Ms Devereux-Evans, that he had never seen the mother struggle or make mistakes with her care of the children. He said he can only go by what he has seen. When asked about the evidence he had heard during the hearing, he repeated that he had not been there. I formed the impression that he was willing to disregard the reports of professionals if they were problematic for the mother's case.

223. The uncle had identified a kick boxing club that he had taken C and D to. Although this is a very recent new activity and according to the text from the instructor, D had been "disinterested" and "ended up not participating", the uncle saw these sporting activities as a good way to direct D's energy.

224. When asked whether A had ever walked or run, the uncle said, "Basically once, quite a long while ago". He said he used to take A and B to the park a few times but he "wouldn't say run around". His evidence about A's ability to write was similarly couched. He said that A had speaking when he was "really, really young, like ten years ago, he was speaking". His evidence about these issues appeared to be in line with the narrative the mother had given to professionals about A. His account of the children being bullied and shy was consistent with the mother's account.

225. I formed the impression that the uncle was being loyal to the mother with his answers. When asked about D's aggression and violence towards the family support worker and the vicious fights between C and D, the uncle said he had never seen the children fight and asked if anyone had to go to hospital. Later on, he said he did not believe the account because he had not witnessed it and "seeing is believing". When asked about the evidence from the school witnesses and the allegation that the mother had been shouting and screaming at D outside school, the uncle said he had not witnessed it.

226. The uncle had not been to see A since his removal into care, nor had he been in touch by phone. He blamed his work commitments which was difficult to understand given the emphasis he had placed on his bosses' flexibility. Later he conceded that "emotion played a part of it, to see them in someone else's care is a bit emotional."

227. When asked about the GOSH report, the uncle admitted that he has "not read it 100%". He explained about difficulties he had encountered with receiving a copy, but later said he had only read a few pages. The GOSH document is a colossal report, almost 200 pages in length, which would be a challenge for many people. However, it was clear that Ms Devereux-Evans had placed a considerable emphasis on the importance of him reading it and to have only read a few pages suggests that there was another issue beyond the magnitude of the task. When asked about the evidence of the consultant paediatrician, the uncle simply answered that he does not know. In my judgment he was unwilling or unable to accept professional views that were problematic for the mother's case.

228. I formed the impression that the uncle was genuine in his wish to care for the children and is an important part of their lives. Unfortunately, however he appeared to have very limited insight into the needs of the children. Although he made generous offers of

sweeping support for the mother, he was unable to recognise what that support would be needed for. I found his views of the children and of the mother were idealised and unrepresentative of the actual issues.

229. The maternal grandfather was listed as a witness. There was considerable uncertainty about whether he would give evidence. In the event, he did not make himself available to do so. He is an important part of the support network around the mother and the uncle, for example he gives a lot of help with collecting the children. There were a number of areas where his evidence would have been relevant, for instance, in relation to the family support worker's observations of D's behaviour when he reportedly gave a contrary account, in relation to the phone that was provided to A in foster care and the notebooks that A provided to his mother and also in relation to his role in supporting the mother and the uncle. The extent to which the court can rely on the maternal grandfather to be a positive support for the mother, or the uncle is undermined by him having not made himself available to give evidence, particularly in circumstances where there were serious questions that he needed to answer.

230. The mother gave her evidence. I have already explained the measures that were taken to assist the mother with the process. The mother's love and pride in her children was made obvious by her smiles and chuckles as she talked about them.

231. When the mother was asked about A, she told me that he has always been able to walk, he just drags his feet and needs prompting and encouragement. She said he would have frequent falls and could run around but not as much as another child. She told me that when A was at R School he would not talk so much, not like another child would. She said that he would talk when he was at T School to people he knew and was comfortable with.

232. The mother denied telling the consultant paediatrician that A had never spoken or was totally mute at primary school. She said her account had been that A's communication, "just needs a bit of help to come out, it's very, very poor." She denied having told the physiotherapist in February 2019 that A had never talked. She also denied having told the art therapist that A was never really able to talk and could just make noises. She said that

the SENCO at T had told lies about A. She denied that there was ever a time that A was not talking, saying that "he was just really down his mood."

233. The mother said that during the period when A was at home he was learning to write. When asked about the notebooks provided by A (which contain lengthy passages of text) she said, "Over time he was getting there. He's really clever, he just needed prompting and encouragement."

234. The mother expressed her willingness to undertake therapy. She has requested from her GP to have multi-systemic therapy, although no one has been in touch about the referral yet. She was not able to say why she needed the therapy. I formed the impression she is doing it because she knows people have said it would help her. Similarly, she was unable to identify anything she could improve about how she cares for the children, although she was keen to do her best and was willing to take on board advice.

235. I have to be careful about the mother's evidence given her cognitive issues, her personality disorder and her anxiety. I am mindful that she felt unable even to enter the courtroom for the attended IRH. I have borne in mind that these issues may have had a significant effect on the mother's ability to give evidence, despite the best efforts of the court and the advocates to maximise her ability to do so. However, I found it difficult to accept her version of events when they contradicted multiple separate but very similar professional reports of her descriptions of A's condition. I have thought carefully about whether this could have been misunderstanding given the mother's issues, or a lack of professional skill in discerning her difficulties, however in my judgment it is simply too unlikely that so many different professionals would have mistakenly drawn the same wrong conclusion from the mother's accounts. I accept that the mother loves her children and genuinely wants the best for them. I also accept that she has tried her best to meet their needs. However, I do not find her to be a reliable historian of events.

236. **Loraine Hughes** is the children's guardian. Her final recommendation was that A and B be made subject to care orders and remain in their current placement, that C and D be made subject to care orders and she recommended serious consideration be given to them being placed in separate foster placements and that E and F be made subject to care and placement orders with a search for an adoptive placement for them together to be

conducted for four months and that if no adoptive placement is found after 9 months for the placement orders to be revoked. Ms Hughes' view is that there is no amount of assistance and support that can be viably provided to enable the children to be cared for safely by the mother. In her oral evidence the guardian stood by her written recommendations.

237. Ms Hughes explained the pattern of involvement she had with the mother – initially it went very well but when she supported the removal of A and B that affected the mother's ability to work with her. Attempts at home visits in June and August were not successful because the mother said she was overwhelmed with assessments and too many professionals. The guardian identified that when she opposed the local authority's proposal to remove the four younger children and later on to remove just D, the mother was then able to engage with her – and home visits then took place in October and November 2021. I noticed that during the guardian's evidence, when the guardian was explaining her view of the mother's difficulties and her inability to show insight into her parenting deficits, the mother walked away from the camera.

238. In her evidence the guardian did not expressly say that for C and D they had to have separate placements, but she did stress that the local authority needed to take a flexible approach and may need to make that decision. The guardian was not persuaded that the difficulties for the mother lay in the stress of the proceedings and in particular the threat of the removal of the children. She stated that there had been child protection plans, PLO, early help services, but none had effected significant change. The guardian was particularly concerned about the impact on the mother if the children were removed, and that there needed to be a plan of support set up to help her.

239. The guardian told me that A had always given a very clear message that he wants to go to his mother and be reunited with his siblings.

240. The guardian was asked about the research on the trajectory for children in care and the very poor outcomes relative to the general population however she considered the risk of harm if the children remain in their mother's care is too significant. The guardian was asked to identify the risks for C and she considered the risk is C will continue to be exposed to the mother's personality difficulties, anxiety and the limits provided by her cognitive

difficulties in terms of the mother not being able to reflect on her own difficulties, and to externalise and blame others. She also told me that the mother has been causing C to see the world as a very dangerous place which will make her feel insecure about going out into the world and interactions with others. The guardian's opinion was that A and B still need reparative parenting, D will need reparative parenting and C, E and F will need optimal parenting.

241. The guardian was considered and balanced in her evidence. Her position in opposing the local authority about key interim decisions demonstrated her independence. She had taken into account the strengths in the mother's parenting and the advantages of being brought up a natural parent as well as the risks and negative impact of being separated and brought up in foster care or as an adopted child; however, her view was the harm that is likely to arise in the mother's care

242. I am grateful to the advocates who prepared written submissions. They had a further opportunity to make oral submissions on 10th February. Given the scale of the task of evaluating all the evidence and preparing this judgment, I then reserved judgment.

Findings of fact

243. I turn now to the schedule of findings of fact.

244. **Paragraph 1** alleges that the mother has an emotionally unstable personality disorder, which impacts upon her parenting. The mother challenges the diagnosis and asserts that her presentation is likely as a result of the high amount of stress she is experiencing during the currency of the proceedings. She relies on Dr. Lyall's assessment in 2010 that concluded that "There is no evidence of a personality disorder".

245. The local authority relies on Dr. Lyall's written and oral evidence. Dr. Lyall told me he stood by his earlier opinion on the basis of the evidence that was available to him at that time, but that since there was more information available which meant that his diagnosis of a personality disorder was appropriate.

246. Dr. Lyall's 2010 report (when the mother was 21 years old) identified that the mother's mood was neither psychologically raised nor depressed. Clinically she seemed of normal intelligence with no gross deficits in her cognitive state and she expressed a reasonable degree of insight into her mental condition. He identified a history of conflict and difficulties between the mother and her family, characterised by high levels of hostility, high levels of expressed emotion and seemingly by a lack of warmth. He identified that the family relationships were likely to have had a significant effect on the mother's emotional development, specifically causing her to develop a poor sense of self-esteem and a low sense of self-regard. He noted a history of moderately severe clinical depression between 2008 and 2010, including suicidal feelings and that the mother had suffered severe agoraphobia as well as an eating disorder and dysmorphophobia, specifically a preoccupation with her skin pigmentation since early adolescence. Dr. Lyall reported that the mother had responded well to anti-depressant treatment and was not suffering depression at the time of the assessment. He was clear that there "is no evidence of personality disorder".

247. Dr. Lyall was reinstructed during the pre-proceedings process. In a report dated April.2020, Dr. Lyall wrote:

"Hence, while I have not seen evidence that the mother meets diagnostic criteria for an Emotionally Unstable Personality Disorder, I wonder about her sense of herself and the degree to which she has sought to conceal information from others. The concealment of information is often associated with a diagnosis of Factitious Disorder imposed on Another. If a diagnosis of Factitious Disorder imposed on Another were confirmed that the mother's poor sense of self might form part of the formulation for her wishing to portray A as being unwell, a possible motivator being a wish to give herself a better sense of purpose and/or agency."

248. Later in the report, Dr. Lyall indicated, "I have not seen that the mother suffers from a mental illness or a personality disorder presently."

249. Dr. Lyall provided an Updating Psychiatric Report dated September 2021. He revisited his earlier opinions about Emotionally Unstable Personality disorder and reiterated his view that in his previous reports he lacked the evidence to make such diagnosis. However,

he explained that having now seen the updating evidence, particularly of Dr. Garrett and the mother's GP records as well as conducting a third interview, he was satisfied that, "now there is evidence that she likely meets the diagnostic criteria for an Emotionally Unstable Personality Disorder." He pointed to the mother's affective instability having been observed by a number of professionals including at Great Ormond Street Hospital, in contact sessions and noted in her GP records. He identified impulsivity on occasions, as evidenced with the mother's historic self-harm. He gave a number of examples of cognitive instability.

250. Dr. Lyall accurately foresaw a potential challenge to the diagnosis – that the mother's difficulties represent a 'state' rather than a 'trait'; in other words, the difficulties are not enduring but have emerged 'de novo' in the context of what are inevitably stressful legal proceedings for her".

251. Dr. Lyall's view is that: "My formulation is that the mother's underlying personality difficulties have become more obvious in the last year or two, likely because of the stress of these proceedings and the stress of being separated from two of her children – the mental state that I observed when I interviewed her on this occasion was more disturbed than I had seen in 2010 and 2020, particularly the depth of her hostility towards social care professionals – but are likely enduring difficulties."

252. When asked at the end of his evidence what factor made the difference between the mother's diagnosis of a personality disorder as opposed to it being a reaction to considerable stress in her life, Dr. Lyall explained that it was the history – whether the problems endure or just arise in the moment.

253. I was persuaded by Dr. Lyall's analysis of the issues and I accepted his evidence. I find that the mother has an emotionally unstable personality disorder. I am also satisfied that the mother's personality disorder has impacted on her parenting, particularly in relation to the way she has at times struggled or not engaged with professionals which has impacted on the children (notwithstanding that at other times she has engaged well).

254. **Paragraph 2** alleges that: "The children have been exposed to the mother's dysregulated behaviour and distress". The mother in her response relies on the earlier

reports of Dr. Lyall and asserts that she is more stressed at present as a consequence of the court proceedings and that she has used strategies to prevent the children from picking up on her distress at A and B's continued removal from her care.

255. I accept that the mother has been more stressed as a result of the proceedings. That was Dr. Lyall's view and it is hard to imagine how a parent in the mother's situation could not have been highly stressed by the process. I also accept that there is evidence of the mother coping well when caring for the children despite considerable parenting challenges and in circumstances where the family support worker also struggled. I accept the positive accounts of Ms N and the family support worker of the interactions that they observed of the mother being considerably challenged in particular by D's behaviour but maintaining a calm and patient parenting approach. I heard about the parenting strategies that the mother used. I accept all that evidence.

256. However, I have also heard a considerable amount of evidence relating to the mother struggling to engage in a positive or constructive way at times with some of the professionals. There was a clear disparity in the way the mother worked with some but not with others. It was suggested that the difference was whether they were challenging to the mother, however I am not persuaded that was the decisive factor. It was put on the mother's behalf that this was a reasonable response by the mother to professionals who had acted in some ways below the standards to be expected or whose decisions had led to negative consequences for the children. However, in my judgment it was the way in which the mother viewed the professional that was determinative. For example, she was able to work constructively with Dr. Lyall and Dr. Garrett despite being challenged; whereas she struggled with the Communicourt assessments which would not have been challenging. The mother's attitude also shifted with certain professionals at different times. Thus, the consultant paediatrician was worked with positively until he raised with professionals his concerns about FII, at which point the mother considered that "he changed" and she withdrew from engaging and sought a different paediatrician. I note that when the consultant paediatrician gave his evidence, the mother removed herself from camera view so he could not see her and presumably she could not see him. A similar approach was also seen in the mother's attitude towards the children's guardian – there was significant level of non-engagement with the guardian after she had supported the removal of A and B at an early stage in the proceedings; however this was followed by a thaw and the mother

being willing to engage towards the end of proceedings after the children's guardian at subsequent hearings urged the local authority against seeking removal of the younger four children and then opposed the removal of D when they sought an ICO with removal into foster care.

257. It is difficult to discern to what extent these responses were ones that the mother had any control about. I did not form the view that these were thought-through decisions about who she liked and who she did not. More that these were emotional responses where the stress of working with someone she did not feel was on her side became so overwhelming that she could not go through with it.

258. The mother becoming overwhelmed and struggling to engage was a pattern that was seen repeatedly throughout the proceedings. I heard evidence from professionals and from the mother about her finding it difficult to engage in meetings with large numbers of professionals present. There are multiple accounts of the mother presenting as angry or distressed in meetings. I am satisfied on the balance of probabilities that around these meetings the children are likely to have been exposed to the mother's anger and distress, particularly after meetings that were attended remotely.

259. During a contact session in March 2021, the mother was shown pictures drawn by A. She interpreted these as being indicative that he had been abused and away from the children suggested it was sexual abuse. In front of the children, she became very distressed, was gasping and walking frantically around the room fanning herself. I recognise that the mother would have been worried by A's drawings, but she demonstrated that she was unable to protect A and B from her upset and emotional response. A was observed to be, "extremely distressed at the end of contact".

260. The assessors from GOSH observed the mother becoming stressed during contact, and then B became distressed.

261. There was an incident at the school in November 2021 when the mother is alleged to have sworn and screamed at D. The circumstances were problematic. D had been left with the impression that his mother was going to collect him early, but the plan had actually been for that not to happen. No doubt it was intended to be a means of calming him down

and keeping him at school, but with hindsight it is easy to understand why D may have become very upset with his mother. There is a dispute about the mother's reaction. I heard evidence from a teaching assistant at R school staff who had never had any direct role with any of the children in the family. She heard what she described as shouting and screaming and saw the mother grab D out of the back of the care and shout, "You're fucking doing my head in" and the pastoral care and safeguarding lead "is a fucking liar". D replied with, "You're making me so fucking angry". D was described as screaming and trying to speak but his mother continued to swear at him at the top of her voice.

262. In her evidence, the mother told me that there was no screaming, but D was "very very upset". She accepted shouting at him. She said that it was the pastoral care and safeguarding lead who was shouting and saying she had had enough. She denied calling the pastoral care and safeguarding lead a fucking liar, saying she would not say that and that she was shocked when she read it.

263. I was not persuaded by the mother's evidence on this point. It is her case that the school has lied about the family and it was clear from her evidence that she sees the pastoral care and safeguarding lead as being at the heart of that. I found the teaching assistant to be reliable and where it differed, I preferred her evidence to the mother's.

264. It would not be proportionate to recount all the examples when issues arose, but on the basis of the situations I have outlined, I find that the children have been exposed to the mother's dysregulated behaviour and distress. I am satisfied on the basis of Dr. Lyall's evidence that the mother's dysregulated behaviour and distress has not emanated as a result of these proceedings but is an enduring form of behaviour that has become more obvious with the current stress of proceedings.

265. **Paragraph 3** alleges that, "The children's awareness of and exposure to the mother's anxiety has contributed to their difficulties and undermined their sense of safety".

266. The mother's response is that A and B have found the proceedings very traumatic and have exhibited signs that they are unhappy in foster care. She asserts that the professionals have not openly communicated with A and B which has led them to determine that they have attachment issues. She asserts that insufficient weight have been given to the trauma

the boys have been through by being separated from the mother and the younger siblings. She asserts there is evidence of positives in the mother's parenting and her relationship with the children.

267. I note that the local authority's allegation is wider than just A and B but covers all six of the children.

268. Great Ormond Street Hospital conducted a multi-disciplinary assessment of the mother and the children. They recognised strengths in the mother's parenting as well as weaknesses: the mother "spoke with warmth and affection for all six of her children, and her intention to understand and to care for them well has been very evident. However, her experiences and the difficulties she has faced, as described, have contributed to the difficulties she has had in providing stable, sensitive care for her children. Sadly, all six children are showing attachment difficulties." [E540]

269. The GOSH assessment concluded that A, B, C and D presented with emotionally insecure attachment patterns.

270. Dr. Wilkinson said that, "We have no doubt about the mother's love for the children, but the point we are making is that is not enough to generate a secure attachment, which needs sensitivity and responsiveness or the other aspects of parenting I mentioned [ability to regulate own emotions, maintain boundaries and provide stimulation] which are also needed. This is where we had concerns." Dr. Wilkinson recognised that the stress of the proceedings must have been incredibly difficult for the mother, but he did not think that the stress of the proceedings had caused the children's attachment difficulties.

271. Dr. Sawyer described observing the mother displaying "extreme anxiety" at times. She described the mother becoming very agitated and distressed as she would flap her hands, and leave the room, returning to smell A's hoodie and hug his lunch box. She also described the mother in a very distressed and anxious state at a number of different points: when talking about A and B being in foster care; when talking about the accident slips that C received from school; and when talking about being misunderstood and not supported by the system or the school. She also described observing the mother to be, "Warm and caring and kind to her children".

272. Dr. Sawyer's view was that C has been frightened or experienced her mother being frightened at home, which would have been distressing. As a result, some of her ability to think or speak has been inhibited, she had learned to internalise those feelings and make herself smaller and less problematic.

273. The GOSH main report states that, the mother's anxiety likely undermined all the children's sense of safety, comfort and security. The mother has communicated to her children that the world is an unsafe place. Her own experience as a child with unmet needs and unrecognised difficulties is likely to have contributed to her belief that her children have needs not recognised by the professionals around them. She was observed to show great motivation to meet her children's needs, but often demonstrates misattuned responses to her children." [E416]

274. I accept the evidence of the GOSH assessors and their conclusions. On the balance of probabilities, I find paragraph 3 of the schedule to be made out.

275. **Paragraph 4** alleges that, "The mother has prioritised her own need to keep the children close to her over their need for separation and individuation." The mother denies this allegation. She explains that the children have spent a large amount of time with her due to the pandemic, but once schools reopened, she ensured the children in her care went to school and nursery.

276. The local authority relies on the evidence of Dr. Garrett who describes this as a concern that has been raised. There is a pattern of the children being withdrawn from school or nursery and of reluctance to return them:

(i) I am satisfied that A was removed from school in May 2018 and he did not return until 2020. This decision was influenced by a number of factors, including concerns raised about bullying and the mother's belief that the school were not meeting his needs adequately.

(ii) B was removed from school for a long period in 2018-2019 and also after March 2020. The CAMHS records for January 2019 record that the mother was concerned

that B was not safe at school, had contacted the governors and wanted an apology from the school.

(iii) According to a professional meeting minute in June 2019, the mother removed D from nursery in November 2018.

(iv) According to the health visitor, the mother was reluctant to send E to nursery in early 2021. E was started at nursery in mid-2021.

(v) In a MASH referral about A completed by T School in January 2019, reports from Head of Year and Reception and Health and Safety officer indicated that, "Mum would come to reception with all the children and has spent up to 4 hours in reception. Mum was unable to detach from [A]. We allowed mum to come to reception for 15 mins a day for two weeks to meet with [A] and speak to him about any concerns regarding his wellbeing in school. [A] would make his way to reception and go back to lesson. This was the way we could manage mum anxiety."

277. I cannot look at these issues without considering the other factors that were present at the time. The mother had concerns about bullying and the safety of the children at school. The Covid-19 pandemic must have played a role with concerns about risk of infection in schools being commonplace amongst parents at the time. The children at different times would have had to cope with transitions at school and nursery and these can be a struggle for lots of children and parents.

278. I am satisfied that the mother removed the children from school and nursery as outlined. I am also satisfied that these absences from educational provision were harmful to the education and social development of the children at the time. In the case of A and B, it was during that period when their symptoms of mutism and in A's case his lack of mobility became most severe.

279. I am not satisfied that the mother was seeking to prioritise her own needs to keep the children close to her over their need for separation and individualisation. It may be that was an element of it, but I am not in a position to be able to determine that. However, on the evidence before me I am satisfied that the various decisions to remove the children from education were in part a response to the mother's pronounced sense of needing to keep the children safe. As the art therapist described it, "we felt the mother might be over-identifying from her own experiences and felt she wanted to protect her children from the

awkwardness and experiences she had growing up." In my judgment, the mother's approach was excessive and disproportionate and caused harm to the children.

280. **Paragraph 5** alleges that, "The mother's preoccupation with her own health issues has led her to develop similar concerns about the children. She has unreasonably rejected professionals' views to the contrary. Her pathologising of the children has impacted significantly on their functioning and development."

281. The mother denies being preoccupied with her own health issues and asserts she has always tried to work with professionals in respect of the children's difficulties. She accepts that has suffered from health issues in the past, including mental health issues, and she has recovered from them. She notes in Dr. Magid's report he considered E and C to have normal health and development. Until the GOSH assessment, the mother had understood that D had a diagnosis of ASD which had been accepted by Dr. Magid in his initial assessment.

282. The local authority relies on a number of situations. Firstly, it points out that the mother previously had a preoccupation with her skin and had concerns about A's skin. Dr. Lyall's 2010 report establishes that the mother was preoccupied with her skin, indeed he diagnosed her with dysmorphophobia, specifically a preoccupation with the pigmentation of her skin. A social worker in the first set of proceedings, wrote in her statement dated August 2010 that the mother was making continuing assertions that there was a problem not only with her own skin but also with A's. It is important to record that the mother's preoccupation with skin appeared to have subsided at least by the time Dr. Lyall saw her again in April 2020.

283. The mother also reported being partially sighted and reportedly received free use of the London Transport system on that basis. Dr. Garrett reports that despite extensive investigations, no physical cause was established for the mother's reported visual difficulties and it may have been psychological. According to the art therapist, in January 2020, the mother reported to CAMHS that at a recent eye test showed that A had an "abnormality in his eye that may correct itself or may require an operation". In his oral evidence Dr. Magid confirmed from the medical records that A had an

ophthalmology consultation in January 2020 that indicated no new problems and treatment was not indicated.

284. The art therapist made a link between the mother reporting A struggles to walk on stairs and uneven surfaces and the mother also having mobility difficulties at times and using a walking stick. She told me that CAMHS formed a view that the mother, "May be over-identifying from her own experiences and felt she wanted to protect her children from the awkwardness and experiences she had had growing up."

285. The local authority seeks to make a link between the mother having anaemia and being worried that A has anaemia. However, A has thalassemia trait and as Dr. Magid explained, this can result in lower red blood cell counts than is normal although the patient is not anaemic. I am not satisfied that the mother's approach to this nuanced difference was unreasonable.

286. As to the suggestion that the mother had asthma as a child and that she told Dr. Garrett that A has asthma, but that he has never used his pump while in foster care. I note that in March 2020 A was seen by the GP for an asthma review. His asthma was described as well controlled at that time. I take judicial notice that asthma is a condition that can change as a person grows, particularly in adolescence, and I do not have sufficient evidence to rule out the possibility that A has simply grown out of it.

287. Overall, I am satisfied that the mother does have a tendency to pathologise her children. While I am not satisfied of all the examples the local authority cites, I am satisfied that there were occasions when the mother identified in her children medical issues that she herself had suffered from despite this not being borne out by medical investigations.

288. **Paragraph 6** alleges that "The mother has been unable to provide stable, sensitive care for the children. As a result, the children each demonstrate attachment difficulties." This is denied by the mother who asserts that she was and is able to provide stable care for the children with appropriate support and that the children are attached to her and

each other.

289. I have already indicated the views of GOSH about the emotionally insecure attachment difficulties observed in A, B, D and C and I accepted that evidence.

290. In relation to E, GOSH identified that there was evidence of insecurity and anxiety including some insecure attachment behaviour, notably over-familiarity with strangers. The children's guardian was particularly clear about this, describing a level of over-familiarity, proximity seeking and over-tactileness with strangers and that it was concerning. When challenged that this was no more than a warm and affectionate nature, the guardian's reply was striking, "I am very accustomed to seeing children in their homes. I am a stranger. I am not accustomed to that level of hugging and proximity, sitting very closely and touching." I accept the Guardian's evidence. In my judgment it is significant that the mother does not appreciate that this behaviour is problematic.

291. GOSH reported their observations that E was able to separate from her mother with support at the nursery and these observations suggest some security in her attachments based on her experience of being cared for. However, they also were of the view that E's over-confidence with strangers suggests attachment insecurity as she is demonstrating an unusual lack of wariness and discrimination towards unfamiliar adults. I accept that evidence.

292. In relation to F, both Dr. Magid and GOSH observed that F likes to be with his mother and seems withdrawn in relation to outsiders. GOSH's report described that, "F sought his mother's proximity and used her emotional support to manage his feelings. He seemed to use his mother as a secure base. F used his mother for regulation but not for play or exploration."

293. However, the GOSH assessment described that F has been able to separate from his mother for brief periods of time, but has managed his "overwhelming anxiety about the separation by shutting down for considerable periods of time after she leaves. This is a

very unusual behaviour for a child of his age and is suggestive of a high level of insecurity in his attachment to his mother." I accept this evidence.

294. There is evidence that the mother at times can show considerable kindness and love towards her children. There have been other occasions, such as when shouting and screaming at D outside school, or when the mother became distressed about A's drawings when the mother's responses are poorly suited to meeting the needs of the children. The local authority submits that the mother misunderstands concerns and misinterprets the children's cues.

295. The mother had told R School that D will not wear school uniform because of sensory difficulties. So, from year 2, D had worn his own clothes to school instead. The same situation had arisen with B who would also wear his own clothes. The school reported they had seen no evidence of D suffering from those sorts of sensory difficulties. When the mother described this during the GOSH assessment, Dr. Sawyer observed that D was at the time wearing a tight-fitting fancy-dress costume over his clothes at the time. Dr. Sawyer's view was that there may have been a time when D did struggle with tight clothes but that the mother's understanding of D had not been updated. This is an example of the mother's lack of attunement to the children.

296. When I consider the expert opinions in the context of these situations, I am satisfied that the children's attachment difficulties arose as a result of the care their received from their mother.

297. **Paragraph 7** alleges that, "A and B's attachment difficulties have contributed to them developing mutism – and in the case of A, functional motor symptoms – as a means of eliciting caring responses from the mother." This allegation is in effect the working hypothesis that GOSH put forward to explain A and B's mutism and A's functional motor symptoms. The mother denies this allegation.

298. I have thought carefully not only about the expert evidence, but also about the context of events. In this regard, I cannot ignore that the period when A's symptoms and B's

symptoms became most pronounced was when they were in the mother's care and not attending school. I appreciate that the pandemic struck in February 2020, but the concerns about mutism arose well before then. I also cannot ignore that since A and B were removed from their mother's care, they have shown a very considerable improvement. The mother's case is that the A's difficulties arose out of problems at school, particularly with bullying and that the improvement came about with the education provision at School Q. However, I am not persuaded by that analysis. If the problem was at the school, firstly, I would have expected the mutism and functional motor symptoms to arise when A was still at school and to have improved when he stopped attending school and stayed at home.

299. In my judgment, I am satisfied on the balance of probabilities that their attachment difficulties and the care from their mother have contributed to A and B developing their unusual form of mutism and for A his functional motor symptoms.

300. **Paragraph 8** alleges that, "The mother has given inaccurate and/or false information about the children's health, diagnoses, presentation and family history. This has resulted in unnecessary assessments and investigations."

301. The mother denies ever having knowingly provided false information and draws attention to whether her learning needs as identified by Dr. Garrett could have led to misunderstandings with professionals who may not have adapted their interactions and communications appropriately. She points out that Dr. Magid described the assessments and investigations of D as appropriate. The mother also points out that the children were subjected to numerous tests during the PLO process and proceedings, and she raised her concerns but felt she had to make them available for fear of being accused of missing appointments.

302. There are numerous examples that have been drawn to my attention of the information given by the mother to professionals about the children having been inaccurate.

303. The mother gave misleading information about A's lack of speech to the art therapist of CAMHS, to T School, to the physiotherapist, and to the consultant paediatrician. In her evidence, the mother denied having claimed that A could never speak. However, I heard from the art therapist, from the consultant paediatrician and from the pastoral care and safeguarding lead of T School. They have notes and records to refer to and I prefer their accounts to those of the mother. Although I did not hear from the physiotherapist, her notes are unambiguous:

> "Mum went on to say [A] was mute and does not communicate with anyone. I asked mum how long he had been mute. Mum replied he had never spoken. I asked her again to clarify saying my colleagues had previously seen him and he spoke with them. Mum denied this would ever have happened."

304. The potential for misunderstanding always exists and it is particularly pronounced in this case given the mother's cognitive functioning. However, I am satisfied that the mother has over a lengthy period of time given misleading and false information, in particular in relation to A's symptoms.

305. I accept the consultant paediatrician's evidence that as a consequence of the inaccurate information, A underwent the stress of investigations at S Hospital and at GOSH to rule out neurological deterioration and regression. He was admitted for inpatient treatment in early 2019; he underwent an MRI scan and blood tests. The consultant paediatrician also explained that this all took a strikingly long period of time for the medics to get any understanding of what was going on during which time A would have been exposed to behaviours and problems at home that ultimately were the cause of his problems. He considered this to be the greater part of the harm caused.

306. **Paragraph 9** alleges that "The mother has provided inaccurate accounts of her children presenting with typical ASD traits and has misreported diagnoses or investigations of ASD and ADHD. The mother provided the primary information for D's ASD assessment. It is likely to have resulted in D being misdiagnosed with ASD."

307. The mother denies this and assets she gave accounts of the children's presentation as she saw them. She asserts that responsibility for any diagnosis lies with the medical professional assessing the child. She points out that in Dr. Magid's initial report he supported D's diagnosis of ASD.

308. I have heard evidence from the community paediatrician who assessed D who was clear that her ASD assessment of D was properly conducted and based on the information that was obtained from the mother, from the school and from her teams' observations of D. I also accept that Dr. Magid in his initial report gave the opinion that D's diagnosis of ASD explains his social communication and behavioural difficulties. In his answers to questions after reading the GOSH report, Dr. Magid amended his opinion to D having suspected ASD and he recommended a new assessment. It is clear that D's presentation was one that needed investigation and initially on the basis of information from a range of sources a diagnosis was made. The fact that diagnosis has been called into question after a more in-depth assessment by GOSH does not mean that the medics involved initially were in error based on the information available at the time. Nor does it mean that the mother must have been responsible for any misdiagnosis. On the evidence before me, I am not satisfied that I should make this finding.

309. **Paragraph 10** alleges that, "A, B and D present with mutism. The mother's preoccupation with their speech predisposed them to developing mutism, which she has reinforced through her parenting by using non-verbal communication. F is a very high risk of following a similar trajectory."

310. The mother's response is that she has always done what she thought was best for the children and followed professionals' advice to encourage the boys' communication.

311. On the basis of Dr. Magid's assessments, I am satisfied that A, B and D present with mutism. I cannot on the evidence available to me determine that the mother's preoccupation with the children's speech predisposed them to developing mutism. I am satisfied that the parenting the children received and their home environment to which they were exposed with all the dynamics it involved was a significant factor in A and

B's mutism.

312. I am satisfied that when the mutism developed it was reinforced through the mother's parenting. This has been seen in the way that the mother interacted with A at a meeting with the school. An email by Mr K from T School dated September 2019 set out that he had had multiple conversations with A about his arguments with other students. Mr K realized that if A was hurried to respond he would get very upset, so he decided to "wait it out" and realised that if A was calmly given time he would begin to talk. Mr. K wrote:

> "I recall having a meeting with his mother who believed that A was being treated unfairly and was a victim in school, so in this meeting I thought it would be a great opportunity to allow A to speak and let mum know this is not the case. mother at this time was catering to her other 3 children which took up most of her attention and would very frequently make it extremely difficult to have a discussion, especially for A. Initially A started off silent and very slow but before he could make a good start his mother started prompting him to reply in a not so calm/patient manner, and when she did not get an immediate response, she would become more panicky and prompt him again or ask another question. Unclear to the mother she was making it very uncomfortable for A to voice anything which made him extremely upset and brought him to tears. At this point I decided to take A into another room to calm him down and not only did he calm down very quickly but he was able to communicate effectively. We spoke and he explained that he doesn't get much time to explain because it is unusually very busy at home with his other siblings. I think took A back to the meeting room and explained to the mother that A would like to talk and that it would be best if he's not rushed as he may take some time to get his words out. A was able to communicate and was more honest about his behaviour however mum was still adamant that something was still wrong."

313. I am also persuaded that the mother's approach, no doubt well-meaning, to using communication cards to assist A, as well as her actions in removing A from school worsened his presentation with mutism because in trying to assist him, she removed the

incentives and structures that were most supporting him to keep talking.

314. When considered alongside the presentations of A, B and D, I accept the local authority's submission that F's presentation with the community paediatrician who assessed D and F should serve as a red flag. F would not interact with the assessment and at the second session when he would not speak and was deemed to have severe speech and language delay, before using a long multi-word sentence when he chose to do so. I am satisfied that the evidence before me establishes that there is a real risk that F's trajectory could be similar to his older brothers.

315. **Paragraph 11** alleges that, "The mother's perception of the children as having limited ability risks the children developing distorted views of themselves and their ability."

316. The mother responds that: "[She] has always encouraged her children in their development. Any distorted view could be dealt with by providing the mother with parenting assistance and ensuring she has understood the children's needs/ diagnoses. The mother has responded to this well in the past with the help of a family support worker. These proceedings have also taken place during the Covid-19 pandemic when the children were stuck at home. They have since started at school and nursery, which will act as a safeguarding factor while also helping in their development."

317. The mother's response does not make any formal acceptance, but it does appear to acknowledge that she might have had a "distorted view" and suggests support and measures that may assist the family.

318. I accept that the mother wants the best for her children and has not intentionally sought to limit the children's development. However, there is evidence of her worries and beliefs about the children having that effect.

a. According to the EHCP Annual Review Summary prepared for A at Q school in July 2020 after he had recently resumed attending school, the mother reported that A needs help to cut up his food, that she washes and dresses him. When he

moved to his first foster placement, despite his unhappiness there, he was able to dress himself and brush his teeth and became more mobile.

b. According to the CAMHS report for B's EHCP in November 2020, the mother said she would like him to join supervised football, but he could not play in a team or keep to the rules. Since his time in foster care, B has represented his school in football tournaments.

319. On the basis of the evidence before me including the report of GOSH, I find paragraph 11 is proved to the necessary standard.

320. **Paragraph 12** alleges that, "A has experienced FII. His younger siblings are at risk of FII. The mother has provided false and exaggerated information about A's presentation and mobility, including that he has always been mute. A has been subjected to unnecessary testing, including admission to hospital and tests under general anaesthetic. As a result of the mother's parenting, A has adopted the sick role."

321. The mother denies this allegation. She disputes that the criteria for FII are met. She denies that A has experienced FII or that the younger siblings are at risk of it. She asserts that she has not reinforced in A a belief that he is ill but has followed medical advice and professional advice appropriately. She also points to her and the maternal grandfather also having had similar experiences of selective mutism which they grew out of and she suggests that genetic testing should have been undertaken to see whether there is a developmental issue.

322. I have reminded myself of the Royal College of Paediatrics and Child Health Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH guidance from February 2021. The definition of FII is:

> "FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s') behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm."

323. The chronology of A's presentation over time is striking. I prefer the accounts from the schools about A's levels of ability before he was removed from school to the accounts given by the mother. I also accept the evidence of A's improvement after he was removed from the mother's care. I have considered carefully the impact of other factors, such as the work that CAMHS had been undertaking and the impact of Q's work, which after over a year had started to bear fruit in the 6 weeks of term prior to A's removal into foster care. However, I am mindful that marked levels of improvement were seen rapidly after removal. There have been some clear incidents that demonstrate A's levels of ability – his walking and then running away in July 2021 is a very clear indicator of his improvement. I also accept the evidence of his increased use of speech, in particular since he has been in the care of his current foster carer.

324. The consultant paediatrician and Dr. Kaliakatsos both considered that A's condition was likely to be as a result of FII. Dr. Magid expressed the view that there is evidence to suggest that there was FII in this case:

> "I. Physical examination and results of investigations don't explain the symptoms: (neurology visit April 2018 and October 2019, paediatrician November 2018).
> II. The child's daily life and activity are limited beyond what is expected: not walking, not attending school for nearly two years and not enjoying a normal childhood activities.
> III. Objective evidence of fabrication: (GP December 2018, paediatrician May 2019) (July 2019) psychologist (March 2020)
> IV. Had frequent invasive investigations and treatments.
> V. He missed some education and social isolation. Limitation of daily life.
> VI. The adoption of the sick role (Paediatrician November 2018)
> VII. Characterisation as being disabled special educational provision and receiving DLA.
> VIII. He became anxious and confused about his health."

325. Dr. Wilkinson also took the view that A had adopted the "sick role".

326. I have considered the possibility that A's presentation could have been caused by something else. The possibility of his mobility issues being as a result of hypermobility does not appear to be realistic in the light of Dr. Magid's evidence about the mildness of that condition. I have also considered the inconsistency in his physical presentation at different appointments with the consultant paediatrician which neither he nor the neurologist could explain. I have borne in mind that medical science has limits and advances in knowledge continue to be made, including marked advances that significantly shift the mainstream beliefs about a particular condition. The potential exists for an innocent explanation for A's presentation to lie in the "dark corners" of medical science. However, while I acknowledge that possibility, I do not think it is likely for two reasons, (i) if it was the case, then A's condition drastically deteriorated then spontaneously improved without treatment which seems even more unlikely; and (ii) while it is not said that the other children have suffered FII, there are clear similarities between A and some of his younger siblings, in particular in relation to mutism. Again, it is possible that this is some form of extremely rare and unknown condition that they share, but also in the case of B, his mutism resolved at the same time as A's when they were removed into foster care. I consider these possibilities to be so remote that I should discount as an explanation the possibility of there being some unknown cause for A's condition.

327. Ms Langdale QC submits that this case does not fit comfortably with the RCPCH definition of FII.

328. In relation to the mother's motivation, paragraph 4.1(i) of the RCPCH guidance applies: I have to consider whether I am satisfied that the mother has experienced a gain from the recognition and treatment of their child as unwell. Ms Langdale submits that there is evidence of the mother taking pride in her children and delighting in their success, which I accept. However, I can identify in this case a number of potential gains that may have been applicable. Firstly, there were a number of financial and practical additional supports that were sought or derived as a result of A's condition – Disability Living Allowance was secured; the provision of the school bus for wheelchair users was obtained; A's attendance at special needs school was secured; a mobility scooter was requested. Secondly, the mother had been subject to criticism from social services about

the care she was providing to the children, this first arose when A was a baby. By identifying disability in A, it also provided a justification for the mother struggling to meet his needs. Thirdly, the mother has significant emotional needs of her own. Her experiences during her childhood have had a profound impact on her functioning to the extent that Dr. Garrett and Dr. Lyall formed the view that she has an Emotionally Unstable Personality Disorder which impacts her parenting. By A adopting the sick role and remaining mute he would have provided an unproblematic means by which the mother's unresolved emotional needs could be better fulfilled.

329. In relation to paragraph 4.1(ii) of the RCPCH guidance: this is a "motivation based on the parent's erroneous beliefs, extreme concern and anxiety about their child's health… This can include a mistaken belief that their child needs additional support at school and an Education Health and Care Plan (EHCP). The parent may be misinterpreting or misconstruing aspects of their child's presentation and behaviour." The evidence in this case suggests aspects of this are also present at times.

330. On the basis of the evidence, I have read and heard, I have little doubt that there is a real potential for the mother to misunderstand or misconstrue information, particularly medical information. There are a number of instances documented where after a medical appointment or investigation, the mother has afterwards recounted a more serious outcome than was actually identified. The mother's cognitive functioning and her personality disorder are likely to have played into these sorts of misunderstandings. In particular, the mother has very high levels of anxiety. This has been seen throughout the proceedings themselves both in her interactions with professionals and the court. The mother's fears and anxieties have a substantial impact on her thinking and her behaviour. An example of this was seen in her reaction to A's drawings when she believed they were evidence of sexual abuse and reported the foster carers to the police.

331. I have considered whether the mother's misleading interactions with professionals can simply be explained in the light of her cognitive functioning and personality disorder and, if so, whether the mother is being discriminated against as a result of her disability. I note that although the mother has cognitive issues, she has not been diagnosed with a learning disability. I note that the cognitive assessment of Dr. Garrett was not received

until a relatively late stage and many of the professionals were unaware of its contents at the time they worked with the mother. However, I was reassured when I heard the evidence of the consultant paediatrician about the way he described working with the mother which appeared to be sensitively done and in a way that would have been appropriate had he known about the mother's cognitive functioning and personality disorder. It is significant that the mother described being able to work with the consultant paediatrician until "he changed" – which was at the point that he raised the alarm about factitious or induced illness.

332. I do accept the point that Ms Langdale QC makes that if the parent's needs are primarily fulfilled by the involvement of doctors and other health professionals, this does not sit easily with the mother missing health appointments for the children. However, in this case I cannot ignore the simple fact that for the mother, as a single carer for 6 children with cognitive issues, the day-to-day tasks of getting the children to school and meeting their needs was a considerable enterprise and the potential for appointments to be missed or forgotten would have been quite high. In the context of the demands on the mother and her own vulnerabilities, I am not persuaded that I should read too much into missed appointments. However, the local authority also seeks to rely on the mother refusing to take A to appointments with the consultant paediatrician and then cancelling the first appointment with his replacement. This approach is of a very different type because it reflects the mother rejecting professionals who she considers are against her and withdrawing her co-operation. In the context of FII, absenting herself from the professionals who are raising FII as an explanation for A's presentation is a factor that is consistent with FII rather than a factor against it.

333. I am satisfied that there has been a high degree of misrepresentation of A's symptoms to medical professionals by the mother. She has repeatedly exaggerated the duration of his condition, presenting to multiple professionals that his mutism and his mobility issues were long-term issues arising in early childhood. The consultant paediatrician was clear that the mother had lied to him. I accept that evidence. I have borne in mind the Lucas direction and guidance in **Re M** (Children) [2013] EWCA Civ 388. I have considered the possibility that there could be any number of reasons why the mother misled professionals. I have thought about whether the mother simply misled the professionals as a result of hazy memory or poor recollection. I have considered whether she

exaggerated A's symptoms to the professionals because that is what at the time she genuinely believed – given her high levels of anxiety, it is not difficult to reach such a conclusion. I have considered whether it was a knowing lie, with the intention of misleading professionals in the hope of garnering medical treatment and attention for her vicariously. On balance, I consider it is likeliest that the mother's main driver when she misled the professionals was her anxiety in the context of her cognitive issues. I do not find that she intended to deceive professionals at the time.

334. On the balance of probabilities, I am satisfied that the mother's personality disorder and her anxiety is likely to have had an impact on the way she interacted with professionals about A's health. In my judgment, there are elements of both motivations present in this case although I consider that the second motivation is likely to have predominated.

335. I have considered Ms Langdale's point that the mother's pride in her children and enthusiasm for them to progress is not consistent with this being a case of FII. I accept that the mother has not actively wanted A to be ill. However, I do not consider that this is sufficient to outweigh all the other evidence. I consider that the mother's anxiety and concern for A to have been the predominant driver for her to exaggerate his symptoms and in my judgment, that is not inconsistent with a wish for him to be well. Indeed, it is that misguided wish that is likely to have motivated her to exaggerate and misrepresent his symptoms.

336. I am satisfied that A has suffered harm as a result on a number of levels. He has undergone a series of medical appointments, investigations and examinations. A has also been removed from mainstream schooling for a period of nearly 2 years, during which time he was socially isolated, his presentation severely deteriorated and he increasingly assumed the sick role – ceasing to speak and losing mobility and self-care skills. In addition, he has developed a false self-view of being sick and vulnerable.

337. The RCPCH guidance mentions that there may be active collusion by the child with the parents' illness deception. I am satisfied that this was seen when A attended at

appointments and his physical symptoms were observed. The consultant paediatrician described it as very surprising that when he saw A in November 2018, A exhibited choreoathetoid "writhing" movements. He explained that they are a very specific neurological symptom in children arising from inadequate treatment of jaundice which is "very, very rare" in the UK and not associated with any other form of movement disorder. Those movements had not been seen before in A and did not fit with any clinical scenario that the consultant paediatrician could understand. They were not seen at his other appointments with the consultant paediatrician. In my judgment this is evidence of A colluding with the mother's exaggeration of his symptoms by adopting the sick role and presenting that role to the consultant paediatrician. I do not consider this was an active conspiracy between them, rather it reflected the way in which A increasingly internalised and adopted the "sick role".

338. I have considered the impact of other factors on A. The mother's case is based on bullying and harmful experiences that A experienced at school. Even if she is right about that, I am not satisfied that it is a satisfactory explanation for A's deterioration in the mother's care. In particular because that deterioration appears to have occurred after A ceased to attend school

339. I have also considered the impact of secondary school transfer on A. I recognise that this is a difficult transition for many children and may have been particularly so for A. The art therapist indicated the CAMHS concerns about this change, that A could have found the scale of the school environment and relationships too overwhelming. The same reasoning applies as to the presentation of A's difficulties. The evidence of his behaviour at T School before he was withdrawn does not support this hypothesis as the cause of A's mutism and mobility issues – he had transitioned to secondary school and was talking, even obtaining detentions as a result, and was interacting with peers and partaking in activities properly. It does not make sense that if the secondary school transition was the cause of his difficulties that the severe symptoms would arise only after he had been removed from school. In my judgment, the crucial factor was A being isolated in the care of his mother in the absence of school interactions.

340. When I consider all the evidence in this complicated and nuanced case, I am satisfied that the mother's behaviour and its impact on A did amount to FII. I accept the evidence

of the consultant paediatrician and Dr. Magid in relation to the factors that lead me to this conclusion.

341. I am not asked to make findings that any of the other children have suffered FII. However, in the light of my finding that A has experienced FII, I am also satisfied that the younger siblings are at risk of FII. I recognise that each of the children has their own personality with different levels of resilience and vulnerability, but the conditions exist in the mother's parenting, her behaviour and her personality that led to A suffering FII and therefore that risk applies to the other children.

342. **Paragraph 13** alleges that the mother sought a melatonin prescription for B which was unnecessary. He has not required this in foster care. The mother denies that she sought a prescription for melatonin, but this was recommended by CAMHS.

343. I do not make this finding. The evidence from CAMHS supports the mother's version of events. Dr. Magid's evidence made it clear that melatonin is an unproblematic substance that is produced naturally by the body and a prescription is easily provided if a child is described as having trouble sleeping. I accept that B has not required melatonin while in foster care, but I do not extrapolate from that that his earlier prescription for melatonin was unnecessary. Nor am I satisfied in any event that this would have been harmful.

344. **Paragraph 14** alleges that the mother neglected the children's health needs by failing to attend appointments and/or engage with support. The mother denies this. She accepts some missed appointments which are historical and one missed appointment noted in Dr. Magid's report.

345. The local authority identifies two missed appointments with the paediatric neurology service in February 2019; that A was discharged from the podiatry service in June 2019 as the mother had not contacted the service; that she had previously missed podiatry appointments in 2017 which was significant as A had outgrown his insoles and needed replacements; that the mother refused to continue taking A to see the consultant

paediatrician and that she cancelled the appointment with his replacement causing a delay of 8 months; and that E missed three ophthalmology/orthotic appointments in 2020 and 2021.

346. On the evidence I have read and heard, I am satisfied that the mother did fail to take the children to the appointments identified. In her oral evidence, the mother explained about E's appointments that she had another appointment and they had moved from the one hospital to another so it was rearranged. She did not know about A being discharged from the podiatry service. She could not remember the neurology appointments. She told me that the consultant paediatrician changed when he made the referral, and she could not remember cancelling the appointment with the replacement paediatrician.

347. It is difficult for anyone to remember dates and whether specific appointments were attended or not. For the mother, it is likely to be particularly difficult to remember those sorts of details. I prefer the evidence borne out in the medical records of non-attendance at appointments to the mother's evidence. I find that the mother did fail to bring the children to those appointments I have listed. However, I should put this finding into context. The children have had a multitude of appointments over the years and the mother has maintained engagement with the vast majority of these appointments. The missing of the podiatry and ophthalmology appointments was problematic but not of sufficient seriousness in the context of how many appointments had been attended overall to meet the threshold criteria test. The missed appointment with the consultant paediatrician and the initial appointment with his replacement is of a different sort because this was driven by the mother's antipathy towards the consultant paediatrician after he had raised the concerns about FII and amounted to an attempt to distance herself and the children from those enquiries being pursued.

348. **Paragraph 15** alleges that the mother has neglected the children's educational needs by failing to ensure and support their attendance at school and/or nursery. She did not support them with learning during lockdown. The mother denies these allegations

349. I have already made findings about non-attendance at school and nursery in respect

of paragraph 4. I do not see any need to repeat them. I do not consider it necessary to consider the allegation of failing to support the children with learning during lockdown. Many parents struggled during that period.

350. **Paragraph 15a** alleges that A and B's difficulties have been exacerbated and/or triggered by their isolation at home. The mother in her response notes that it has not been possible to assess A and B's level of development properly due to their mutism and that it is important that no assumptions are made about their development.

351. I have already commented on A and B's deterioration in their presentation during the period when they were not in mainstream education. I do not consider it is making an assumption to identify that they developed mutism and A developed a significant reduction in his motor skills while isolated at home and then recovered significantly after being separated from the mother. I am satisfied that this allegation is proved.

352. **Paragraph 16** alleges that the mother has failed to engage thereby reducing the professionals' ability to safeguard by:

(i) Not making the children available for social work visits – the mother takes issue about the social work visits, and points to the pandemic restrictions and the vulnerability of the allocated social worker being a factor

(ii) Providing inaccurate or inconsistent information to professionals – the mother points to her cognitive issues and asserts that she has never intentionally misled professionals and her communication may have been misconstrued due to a lack of understanding

(iii) Avoiding intervention and support – the mother asserts she has not intentionally avoided professional intervention or support.

353. In relation to subparagraph (i), there is a factual dispute between the mother and the previous social worker about the access that was made available for him to see the children face-to-face. It is agreed that no social worker saw the children in person between March 2020 and December 2020. The context is the Covid-19 pandemic. In March 2020 the first lockdown commenced. In June and July 2020, schools started to

reopen, and the restrictions were eased. In August 2020, restrictions were further eased with theatres, bowling alleys and soft play centres opening. In September 2020, the "rule of six" was applied to indoor and outdoor gatherings. In October 2020 restrictions were tightened with a three-tier system. In November a second lockdown came into force which remained in place until early December, being replaced by a three-tier system, and later a four-tier system.

354. During that difficult period social worker visits went through a range of changes. Initially face-to-face visits were not feasible and virtual "visits" became the norm. The issue in this case is why face-to-face visits were not taking place for this family when they were being made in other cases.

355. The previous social evidence was that when the restrictions lifted, he made a number of offers about the mechanism of visits to see the children – he explained he would be wearing PPE, he offered to see the children in the garden, he offered to see them in the park or at the front door. The social work chronology supports this – that in May 2020 at a virtual visit he offered to visit with PPE, but the mother declined as she said the children are unable to social distance. In June 2020, the chronology states that the mother again declined a request for a home visit. In June 2020, it states that she again refused a home visit and stated that A, B and she suffer from hay fever. In July 2020, it records a virtual visit but notes that the mother's friend had been allowed to visit the home. In September 2020, it records the mother declined a face-to-face visit, claiming the infection rate was climbing again. In September 2020, the mother is recorded to have declined a social worker visit and states that A has Covid-19 symptoms. In December 2020, a home visit by a duty social worker was successfully completed.

356. The previous social worker's account is further supported by parenting assessor A, who described similar difficulties to persuade the mother to allow in-person visits for the parenting assessment. Parenting assessor A's opinion is that "A pattern of avoidant engagement can be seen throughout the mother's time working with the local authority as can be noted from the Team Around the Family Meeting in November 2018 where the mother wanted it to be completed virtually and did not want a formal Team Around the Family meeting."

357. The previous social worker also told me that it was the entire professional network and not just him that was unable to visit the family at home. Despite the mother's positive engagement with CAMHS, their work was all virtual. The health visitors also reported being unable to make home visits.

358. The previous social worker denied that he ever suggested that he conduct a visit while sitting in his car. He pointed out that the mother lives in a restricted parking area so he would not be able to park in a suitable location in any event. He did accept that one option he proposed involved standing at a distance in front of the door.

359. The mother denies refusing the social worker access and asserts that he was given the access he sought. She was aware of the social worker's vulnerability to Covid-19 and the implication is that he was not keen himself to go into the family home as a result. The previous social worker was up front about his health, but I formed the view that he had told her that as part of his attempt to persuade the mother that he would be taking great care with the steps to minimise infection risk by distancing and using PPE.

360. I prefer the evidence of the previous social worker to the mother's where they disagree. I accept his account and I find that the mother did not make the children available for social work visits.

361. In relation to subparagraph (ii), I have already dealt with the inaccurate or misleading information that the mother gave to the consultant paediatrician, to CAMHS, to Dr. Kaliakatsos, to Dr. Garrett about A's history. The local authority in its written closing describes there being "innumerable examples of the mother providing inaccurate, misleading, inconsistent or simply untruthful information to professionals."

362. I do not need to go through all the examples the local authority relies on. The mother in her response document points to her cognitive issues and asserts she has never intentionally misled professionals. I am not asked in relation to this finding to determine

the mother's motivation or her intention. In my judgment it is the impact on the children that is the significant point in relation to this behaviour. I am not persuaded that misunderstandings or professional failures to adapt their communication appropriately to suit the mother's needs adequately explains the inaccurate or inconsistent information the mother gave to professionals. For example, the consultant paediatrician was able in his initial sessions to build an effective relationship with the mother which only changed after he made a social services referral. He impressed me as an experienced and sympathetic paediatrician who would take appropriate care in his consultations. Notwithstanding that I accept Dr. Garrett's analysis of the mother's communication difficulties, it is difficult for me to see how they caused her to misstate matters or be misunderstood by so many professionals. It is not immaterial that Dr. Garrett, who was fully aware of the mother's limitations and highly skilled in adapting her communication style to meet the mother's needs, also received a similar account about A's limitations – for example she also was told that A has "never attended PE lessons at school, and that he could not run or kick a ball".

363. Dr. Garrett gave a clear opinion about the accuracy of the information the mother provides to professionals:

> "I have very significant concerns regarding the accuracy of information provided by the mother, and hence her honesty and engagement both with this assessment and those conducted by others. These concerns, in my experience, were significantly greater than generally encountered in this context and cast doubt on the extent to which it is possible to gain accurate information regarding the mother. As a consequence, I would suggest that it is essential that professionals ensure that they do not rely on information provided by the mother, but that corroborative/independent information is also sought.
>
> "There are many examples of this; the results of psychometric assessment strongly indicate that the mother did not approach this assessment in an open and honest manner; rather, to a degree rarely seen in this context, she was highly defensive, secretive, reluctant to admit to common, but socially undesirable, weaknesses and feelings, and attempted to create a favourable impression of herself. The mother's

responses were inconsistent during this assessment in relation to whether or not she had any sexual/relationship experiences before meeting X; she indicated both that she did and that she did not. She also stated at one point that she did not know the reason he was arrested, but went on to demonstrate that in fact, she is aware of this."

364. I find that the mother has provided inaccurate or misleading information to professionals.

365. Subparagraph (iii) alleges that the mother avoids intervention and support. The local authority relies on Dr. Garrett's opinion that the mother overexaggerates to get support but then struggles with that support unless it is provided in a way that meets her needs and beliefs as to what is best and does not challenge her.

366. The mother's response is that she is not opposed to help and support. She points out that she has previously worked well with CAMHS and with a Family Support Worker. She asserts that she has not intentionally avoided professional intervention or support.

367. The local authority relies on a non-exhaustive list of examples. I am not going to deal with every one of those. However, I am satisfied that there are a number of circumstances which back up Dr. Garrett's analysis:

(i) In March 2019 when the physiotherapist wanted to have A admitted to hospital due to his "acute deterioration in his functioning", the mother "expressed unhappiness" about A being admitted to a paediatric assessment unit. "She said that all was wrong with him was hypermobility and that he just needed physiotherapy. She did not understand why I was now asking her to take him to hospital. She did not understand why I was now asking her to take him to the hospital. I explained that A was showing signs that he could be seriously unwell and that the doctors who know him at Hospital S need to see him to check what could be wrong. Mum continued to give reasons why he should not go to the hospital stating A was just hypermobile and she had other children to look after."

(ii) In June 2018, when the consultant paediatrician sought to refer the mother to social services to help her get support (as a single carer for six children), she did not want social services to be involved.

(iii) In April 2019, when CAMHS wanted to arrange to observe B at school, the mother agreed but then withdrew consent, before agreeing again. The mother had a very positive relationship with CAMHS but was resistant to their work despite this. Similarly, she rejected the CAMHS advice to obtaining the necessary reports for A through T School to obtain an EHCP. Despite the art therapist seeking to explain and persuade her that this would be the fastest route, the mother could not be persuaded. Eventually CAMHS were only able to overcome the mother's attitude by arranging for A to be assessed at School Q (at a time when he had no involvement with that school).

(iv) The mother's approach to the intermediary assessment was very difficult to understand. Her difficulties had been identified and a mechanism to assist her recommended. However, she was unable to engage sufficiently with the intermediary assessment process so that no recommendation could be made. The impact was that she did not receive that additional layer of support to assist her in these proceedings. I have considered whether she did not appreciate the purpose of the assessment, however when she experienced that sort of problem with other assessments, they were overcome by explanations being given. It is unlikely that three different Communicourt workers would have not been able to explain their role sufficiently. I consider it is more likely that the mother realised that the recommendation came from Dr. Garrett and by the time the intermediary assessment was arranged the mother would have received Dr. Garrett's main report (dated June 2021) which was critical of her on a number of levels. The mother's attitude towards Dr. Garrett is likely to have coloured her view of intermediary support causing her to be resistant to the process.

368. I recognise that there were numerous occasions when the mother did engage with intervention and support. For instance, she did engage with CAMHS, she engaged with the FSWs, she took the children to the vast majority of their health appointments. However, alongside this engagement was a repeated pattern of her being resistant to and avoiding particular types of intervention and support. I accept parenting assessor A's

analysis that the, "concerning situation that appears to be the day to day experience of these children one of their mother deciding which professionals are "good" and which are "bad" and then allowing support based on this." In my judgment the distinguishing factor was the mother's perception of that worker or service – i.e. whether she felt they were on her side or not.

369. **Paragraph 17** alleges that the mother lacks insight into concerns and places blame externally. The mother in her response states that she is capable of learning and working with professionals which is made clear by the evidence of the art therapist. The mother asserts that she feels threatened and stressed by these proceedings and in the absence of threats of removal can and does work with professionals for the benefit of the children.

370. In her parenting assessment, parenting assessor A's opinion was that the mother "unfortunately has very limited insight into [the concerns] and does not accept the concerns raised by the local authority… [she] does not view there to be any issue in her parenting or reason for concerns… the mother is very upset about the involvement of the local authority however has remained of the belief that the issues are almost entirely related to A's school and nothing else."

371. Parenting assessor B in her parenting assessment gave a very similar view, the mother "appears to struggle to understand professional concerns. She is unable to consider that there may be a link between the parenting that she provides resulting in the behaviours exhibited by her six children." Parenting assessor B explained that, "On a good day, she is able to demonstrate insight and proactive parenting, as well as mind-mindedness by putting herself in their shoes and consider the world through their lens… Unfortunately, and like everyone else, it is not possible for a parent to have a good day every day. For the mother, she also has the added complexities of managing her anxieties, (of which I am of the belief impedes her ability to function fully as a responsible competent parent is expected to do), and the impact this has on her ability to meet her children's emotional needs consistently every day, irrespective of having a good or bad day."

372. Dr. Garrett also recorded that the mother, "was unable to identify, when asked, any

concerns or criticisms in respect of her parenting," She also identified the mother's willingness to put blame onto A's school, "the staff there 'want to get me' as she made a complaint to the Governors as she believed that the school was not meeting her son's needs".

373. The mother's oral evidence supported the views of the two parenting assessors and Dr. Garrett. The mother was open to advice and support, but it was noticeable that she was unable to identify any point of improvement that was needed in her parenting.

374. I am satisfied that paragraph 17 is established.

375. On the basis of the findings I have made, I am satisfied that the threshold criteria pursuant to s.31 of the Children Act 1989 are established. I am satisfied that at the relevant all of the children were suffering and were likely to suffer significant emotional harm and that A was suffering significant physical harm and that all of the children were likely to suffer significant physical harm attributable to the care given to each of them or likely to be given to them not being what it would be reasonable to expect a parent to give to them.

Welfare

376. In relation to A, B, D and C, their welfare is my paramount consideration and I have regard to the welfare checklist under s.1 of the Children Act 1989. In relation to E and F, their proposed care plan is for adoption and so their welfare throughout their life is my paramount consideration and I have regard to the welfare checklist under s.1 of the Adoption and Children Act 2002.

Wishes and feelings

377. A's mutism has significantly fettered the ability to ascertain his wishes and feelings. However, A has been able to consistently communicate that he wants to return to his

mother's care and to be reunited with his siblings. If not, he would wish to live with his grandfather and his uncle. He has indicated he fully disagrees with the care plan. Although he has also indicated that if he has to remain in care he wishes to remain with his current carer. He has indicated he would like to see his father who he has not seen since his removal.

378. He has written a number of letters and provided documents that I have considered. A wrote a letter to the Judge setting out, in highly articulate prose, his hopes and his experiences. He is clear that he and B should be at home with the rest of their siblings, family and cats. He criticises the local authority for not providing more support to the mother and refers to his knowledge that the local authority asked for D to be removed and how that would be worse than putting in support, "IF behaviour is such a concern, don't you think actual support should be put in place before banishing him or any child...." A goes on to say that staying at Grandad's and uncle would suffice. Interestingly, when the idea of writing a letter to the Judge was discussed with the Guardian, the issue that A was keenest to raise was the level of proposed contact with his mother, but that issue was not dealt with in the letter.

379. A's letter to the Judge is a persuasive piece of writing, making a case for him and his siblings to return or remain at home.

380. I have considered A's other letters in the bundle as well as his email to his MP dated September 2021. I have also considered the exhibits to the mother's fourth statement. This was a document produced, without leave, during the final hearing. The mother explained that she had been passed three notebooks by A during contact in January 2022 and she exhibited their contents. She explained that she thought that A had been given the notebooks and identified some of the handwriting in the first few pages as the maternal grandfather's. The notebooks continue a similar theme as A's email to the MP – expressing his dissatisfaction with the children's guardian and his solicitor. They also deal with complaints about the social worker and the foster carers. They also contain some pages which appear to log A's responses from the MP as well as conversations with the foster carers. On one page, it sets out that, "You can show all this to your solicitor" and is signed twice, once with "2021 signature (old)" and another with "2022

signature (new)". The notes are mostly dated and a large number of them are dated in August 2021 – around the time when A and B changed foster placements and when A ran away. The handwriting in the notebooks is not consistent, with some pages of very careful, neat handwriting, and others of more loose joined up handwriting. The spelling, grammar, punctuation is all of a very good standard and the contents are articulate. Overall, they are highly critical although I note that the current foster carer receives praise, "This is to certify that [the foster carer] is an honorable lady with a scholar." There are also some poems copied out in praise of mother. There are two letters to the Judge, one appears to be an early draft and stops abruptly. They express clearly A's sense of feeling trapped, or hopelessness and wanting to die as a result of being in foster care. A is praising of his mother and his family and reiterates his wish to return home.

381. The GOSH report deals with A's competency to provide instructions to his solicitor directly. They report that while he shows some ability to have independent views from his mother's, his competence to weigh up and communicate these decisions is doubtful. A separate issue has arisen about A's wishes and feelings. The guardian and the solicitor for the child have indicated that when they have seen A, he has not communicated in the way reflected in the letter to the MP and the documents handed over to his mother. Mr. Woodward-Carlton submitted that it is unclear who the author of all the documents was and points to the handwriting being markedly different in different places. Unfortunately, there is also the fact that A was secretly provided with a mobile phone without the knowledge of the local authority or the foster carer which he later said he had been given by the maternal grandmother in contact. I have no information about the contents of the phone, or how long it was in his possession. The information contained within the bundle of documents provided by A to his mother just before the final hearing raises more issues about its bona fides. It was plainly written with the court in mind.

382. In interview with the guardian, A confirmed that things have changed for him, in that he is now walking and being more active. He was happy about the positive changes and agreed that his foster carers have helped him to achieve this. He said he feels healthier now and he is healthier than his mother thought.

383. The view of the solicitor for the child, who is very experienced in representing

children in care proceedings, and of his guardian is that A is not competent to instruct his solicitor separately. His ability to do so is undermined by his mutism, such that it remains difficult to talk in depth as to his wishes and feelings. A has shown a degree of mistrust and disquiet about the guardian, which appears to have reflected the mother's attitude at the time.

384. Ms Langdale raised the issue of A's representation in the proceedings, but I was not asked to make any determination about this – the view of the children's guardian and of his solicitor being that they did not consider that he was competent to instruct a solicitor directly and in any event his wishes and feelings were being fully and faithfully conveyed to the court. Ms Langdale has requested that I record how this evidence developed and I have done so.

385. I do note however that the parties have put before the court the case law that relates to competence assessments of the child in care proceedings and the participation of a child in proceedings. I note the factors that Williams J identified in **CS v SBH & Ors** and make the following comments in relation to A:

(i) A's intelligence is apparent in the writing he has provided. It is articulate and eloquent. Both its contents and the penmanship are remarkedly advanced in the context of a child who has missed so much school and reportedly could not even hold a pen to write.

(ii) A's emotional maturity is difficult to gauge given his mutism and the limitations that has placed on his engagement with professionals. The guardian's evidence was that what A communicated during visits was very different to the contents of his written documents. In my judgment the contents of his written documents demonstrate a high degree of loyalty to his mother, it is highly praising of her and polemical in her defence. There is a casting of individuals as either good or bad which reflects entirely the mother's approach and attitude to those individuals.

(iii) It is difficult to escape the conclusion that A remains heavily enmeshed with his mother. My findings in relation to his internalisation of the "sick role" are a dramatic example of this.

(iv) I accept that A has been highly critical of his guardian and his solicitor and feels they have not undertaken their roles properly, however, A's wishes and feelings have been made abundantly clear to me through his guardian and his representatives as well as through his various written documents. In her final analysis the guardian wrote, "A has remained unable to accept what my role entails and would prefer that I unquestioningly follow his wishes and feelings. It has been hard for him to also accept that I have always been clear that his firm wish is to return home to his mother and siblings."

(v) As to A's understanding of the issues, it is apparent that he understands the different options that the court is considering and has a good sense of what they will entail for him and his siblings. However, there is almost nothing that reflects that he has any sense of the harm that has been caused to him and his siblings. It is likely that he will need therapeutic support to help him to understand and come to terms with that in due course. It is difficult in these circumstances to accept that he therefore has a good understanding of the issues in place.

(vi) As to A's understanding of the litigation process, the different roles and the law that is applied, he does appear to have some understanding, but it is simplistic and his expectations of his solicitor and guardian appear unrealistic. For example, he complains about a lack of visits, but the Guardian's final analysis identifies a high number of visits have been made to him despite the difficulties of the pandemic.

(vii) As to the risk of harm to A of direct participation in the litigation process, it is difficult to see how A would cope with the process. He is a child who was entirely mute until he was removed from his mother's care during these proceedings. He continues to find talking to be a challenge. In my judgment his direct participation in the proceedings would be likely to be difficult and stressful for A and provides a risk of harm by undermining his ongoing recovery.

386. I am not aware that A has requested to be an active participant in the hearing. Although he indicated to the guardian in January 2022 his desire to meet with the Judge, subsequently the foster carer indicated just over a week later that he had changed his mind and only wished to write a letter to the Judge. In the circumstances, I approve the

approach that the children's guardian and the solicitor for the children have taken in their careful consideration about A and I accept their determination that he is not competent to separately instruct his solicitor.

387. B has expressed his wishes and feelings which are similar to A's – he wants to return home to their mother, or alternatively to their grandfather and uncle's home. B has also expressed that he would like to stay with X.

388. For C, D, E and F, the professionals report that given their ages it has not been possible to ascertain their wishes and feelings. They have remained in their mother's care and it is reasonable to believe that they wish to remain there.

The children's physical, emotional and educational needs/particular needs:

389. The Great Ormond Street team diagnosed A with a dissociative motor disorder and likely depression. He also has selective mutism which does not fall readily into a diagnostic pattern. A suffered a significant regression in his functioning both in terms of speech and movement which showed a significant improvement when he was removed from his mother's care into foster care. A has low self-esteem and a negative self-concept. A has missed a substantial amount of education and has an EHCP and now attended a special school where he is thriving. It may be that he will in due course be able to resume mainstream education.

390. Long-term psychotherapy of at least one to two years is recommended due to the extent and complexity of A's emotional difficulties. He will need help in therapy to develop a narrative account of his mother's concerns about his health and development and how these may have developed and how they impacted on him.

391. B was not diagnosed with any mental health condition. Selective mutism was described by GOSH as the "closest appropriate diagnosis… although his mutism is atypical." Prior to his removal from the mother's care B demonstrated increasing levels of mutism and behavioural difficulties. After he was placed in foster care, B demonstrated a marked level of improvement.

392. B has missed a substantial amount of his education. He did not attend school from October 2018 to March 2019 and during the pandemic he did not attend school between March 2020 and September 2020.

393. GOSH considered C to be showing symptoms of anxiety. They also recommended further exploration of her cognitive abilities. C appears to be a resilient child who has generally been unproblematic. More recently in the mother's care there have been issues arising relating to her behaviour.

394. C's medical records show eczema, gastric reflux, one fainting episode (witnessed by her mother) and speech delay. She was assessed for autism but was not meet the threshold for diagnosis. She experiences nightly nocturnal enuresis.

395. C's school have reported concerns about her academic ability and confidence levels. They have reported that C's behaviour is more challenging when with her mother than is seen in school.

396. C presents as a gentle child, but she is able to assert herself with her siblings.

397. D has a diagnosis of Autism Spectrum Disorder. The GOSH assessment raised serious doubts about the accuracy of that diagnosis as they observed D to demonstrate a number of social communication strengths. There is agreement between the experts from GOSH, Dr. Magid and the community paediatrician that assessed D that D needs to have a further assessment in relation to ASD. GOSH considered that a diagnosis of selective mutism is the closest available description of D's speech difficulties.

398. D has also been diagnosed with gastric reflux, nocturnal enuresis, behavioural difficulty and speech delay. He does not have an EHCP. His behavioural difficulties appear to have significantly increased in the months running up to the final hearing.

399. When D was in reception, he did not communicate with adults at all and was mute. He remains reluctant to speak to adults but is very chatty with friends.

400. D presents with unsettled emotions, behavioural difficulties, attachment difficulties and mutism, all of which affect his day-to-day functioning and long-term development. D needs consistent and regular care to assist him to develop a regular sleep pattern.

401. D has shown slower than expected progress. He needs a cognitive assessment to identify whether he has a specific learning difficulty.

402. D's behaviour has been increasingly problematic with him becoming violent and unmanageable. Professionals have identified a pattern in the way that the behaviour of B and D's behaviour problems manifested at home before later being demonstrated at school experience. Given B's improvement since his removal from the mother's care, there is hope that D may also demonstrate a similar improvement if he were to be placed in foster care. However, the Guardian expresses concern that D has been exposed for a longer period to the home environment with the mother's distress heightened by the proceedings and the removal of A and B. It is difficult to predict how D's behaviour difficulties may continue if a care order is made, but in a worst-case scenario it could destabilise his placement, and potentially that of any sibling placed with him.

403. E was described by GOSH as having some delay in her play skills and struggled to express her feelings in words. There was evidence of insecurity and anxiety, including some insecure attachment behaviour, notably over-familiarity with strangers which was commented on also by the Guardian. E's health and development is normal. She has a squint and astigmatism. Dr Magid's addendum report added developmental delay and symptoms of anxiety.

404. F's development was assessed to be delayed and he showed reduced social interaction. GOSH reported that he likes to be with his mother and seems withdrawn in relation to outsiders. When GOSH first saw F, he appeared completely withdrawn and later he presented as dull and distant to what was happening around him; he shows no pleasure playing by himself and had a flat expression; he communicated solely non-verbally and in a regressed way, akin to a child of 8-12 months old. GOSH's opinion is that the extent to which F's developmental delay and reduced social interaction can be attributed to his environment or to any underlying neurodevelopmental or cognitive needs is unclear and will require monitoring and further assessment.

405. Autism has not been diagnosed for F. The children's guardian's final analysis states, "He will need a formal autism assessment based on the history given from mother. *I as his Guardian remain unconvinced that such an assessment is called for*." Since F has been attending at nursery a significant level of improvement has been seen. The Guardian observed that in April 2021 it was striking how quiet, impassive and unresponsive F was to his mother, A and B; but in October 2021, F presented as lively, animated and vocal. His development will continue to need to be monitored and any investigations undertaken.

Likely effect of any change in circumstance

406. If A and B remain in foster care, they will be in a foster home where their needs are met. Their current foster carer is available for the long term, so they will benefit from continuity of care. The evidence shows they have made marked improvements while in foster care. If they return to their mother's care, they will have the benefit of being reunited with their mother and their siblings, which is very much what they want. However, they will also be exposed to the care from the mother which in my judgment was the crucial factor in both of them missing extensive periods of education, becoming mute and in A's case severely reducing his movement. There is a real risk that if they return to the mother's care, their needs will not be meet and their functioning will once more deteriorate.

407. For C and D, if they remain in their mother's care, they will have the benefit of being in the care of their mother who loves them and with their siblings. If they are removed and placed in foster care, they will suffer the significant upset and disruption of that process. They will be placed with strangers which will be a major change. They will be separated from their younger two siblings and continue to be separated from their older two siblings. There are real concerns that D's behaviour is currently so extreme that it may not be feasible for C and D to be placed together. There is a risk if they are placed together, that they may have to be separated at a later stage. If they were placed separately that would be even more difficult and upsetting for them. However, it would also mean that they are placed in a home where their needs are consistently met. In the case of D, he would be likely to receive the sort of consistent boundaries and the focussed reparative care that he needs to learn to regulate his emotions and his behaviour. In the case of C, she would be likely to receive the consistent and reliable care that she needs.

Likely effect on the child (throughout his life) of having ceased to be a member of the original family and become an adopted person

408. For E and F, they would both suffer from being separated from their mother and their middle siblings. They would find that process difficult and upsetting. They are so young it may be difficult to explain to them what is going on, so they may be bewildered by the experience. They are old enough to have a sense of their place within the family and in particular within their sibling group. If they were to become an adopted person, both E and F would lose direct face-to-face contact with their mother, their father and the extended family. There is the potential for contact to be explored with the older siblings if they are in foster care, but that is very much dependant on the wishes of any adopters. They would legally cease to be a part of their birth family and although their sense of identity could be supported through letterbox contact and life story work, that is a very considerable reduction compared to growing up within their family.

409. There is the potential for an adoptive placement to break down. If that happens it is very damaging for the child concerned because unlikely children in foster care, children who have been adopted are told that this will be their forever family and so they may have a profound sense of rejection which can impact on their ability to form future attachments. Given the ages of E and F, they will be relatively old by the time they are placed with prospective adopters. That increases the potential for placement breakdown. It also increased the potential for the local authority's family finding process to be unsuccessful. There is a risk that they will wait for a year in the hope of finding an adoptive family only to end up in foster care anyway. There is also the real potential that they will be found separate adoptive placements or only one of them will be found an adoptive placement. That will be a further loss as they will be separated and placed apart from all of their siblings.

410. On the other hand, they would be able to grow up in a family where their needs are met. They would benefit from consistent boundaries and high-quality care that meets their needs. In the case of F, that is likely to help him to overcome his developmental delays

and his behavioural issues. In the case of E, that is likely to help her to overcome her difficulties with inappropriate boundaries and overfamiliarity with strangers. It would also mean that they could benefit from a childhood without the inference and ongoing involvement in their lives of social services, with the almost inevitable changes of personnel that is likely to entail.

Age, sex, background and any characteristics which the court considers relevant

411. The children are of mixed heritage.

Harm which the child has suffered or is at risk of suffering

412. I have already outlined my findings and the threshold criteria. On the basis of the findings I have made, I am satisfied that all of the children suffered harm in their mother's care and all the children are likely to suffer harm in the future if they remain in her care.

413. When I consider the care plans for each of the children, I have to recognise that these options do not come without a cost to the children. They will each struggle with the impact of being separated or kept away from their mother and with the impact of not being together as one sibling group. There are risks of placement breakdowns in foster care and in adoptive care which would be harmful for the children.

Relationship which the child has with relatives

414. The children's relationship with their father is a considerable unknown within this case. For reasons that are unclear, the mother initially sought to avoid the father becoming involved in the case. Subsequently, when he was contacted, the father has maintained a high degree of elusiveness with professionals. X has been aware of the proceedings and has chosen not to engage. During the proceedings he has not had contact with A and B and his contact with the younger four children appears to have been very limited.

415. There are some considerable unknowns about X. It is not even clear whether he is the father of A and B – he appeared to deny that was the case and the documents from the early care proceedings relating to A support that. However, it is also apparent that A and B both believe he is their father. The role of X in the children's lives is unclear. The children's accounts suggest he has played a role in their lives. However, the way he

behaved when the family support worker was present in the home raises serious concerns about X's behaviour and the maternal grandfather has alleged that he misuses alcohol.

416. The children know X as their father and have mentioned wanting to see him. If he comes forward, he will need to be risk assessed before contact could take place. Unfortunately, if the children are placed in care it appears unlikely that X will come forward and work with the local authority. The impact is that whatever the nature of the relationship the children have with him, it is likely to cease.

417. In relation to E and F, if they are adopted X is likely to not engage with any form of contact, including wish you well or letterbox contact. The extent to which he can be included in their life story work is likely to be extremely limited. The impact is that the paternal aspect of their identity is likely to the greater extent to be lost to them.

418. The children's guardian has proposed that there should be DNA testing to establish whether the children are full siblings or half-siblings. Given the differing accounts about whether X is or is not the father of A and B, that would be a helpful piece of information and I consider it is likely to be in the best interests of the children to know.

419. The children have an important relationship with their maternal grandfather who plays an active role in supporting the family. The maternal uncle also supports the family although his involvement has been more limited than the grandfather's. The children have other family members within the extended family. The children know their maternal grandmother as well as aunts and cousins. I have no doubt that the children are loved by their maternal relatives.

420. In relation to E and F, if they are adopted, the ability for them to engage with their extended family will be severely limited. They will lose that sense of belonging within their wider family. They will have to cope with the loss of their older siblings, who they know and love and are likely to remember. This is an important loss not only because they will not be exposed to the love and affection of their relatives but also it will impact on their sense of identity. I am not satisfied that the maternal uncle is able to meet the needs of the children. I accept the negative assessment of him. His evidence demonstrated that it was an accurate assessment. The maternal grandfather was not put forward as an option

at the final hearing, he did not make himself available and I am satisfied that his is not a realistic option to care for the children.

421. I do not doubt that the maternal uncle wishes to care for the children, but I am not satisfied that he is able to provide E and F, or any of the children, with a secure environment in which they can develop and otherwise to meet their needs.

How capable each of his parents and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs.

422. I entirely accept that the mother loves her children, and they love her. I realise that the mother has tried her hardest to look after the children. I accept that there are some things that the mother does extremely well, like cooking for the family. I have also taken into account the very positive accounts of mother's involvement with the school when A was very young as contained in the assessment of Ms L February 2011. That assessment considered her to be a "very able and committed parent who is competent to care for her son A now and in the long term". However, that assessment is now very old and since then a lot more information has been revealed. Dr Lyall dealt with that issue head on when he updated his assessment of the mother and considered that she does have personality disorder when previously he had not identified that. The focus at that time was on the mother's depression and agoraphobia as well as the difficulties in the mother's relationships with the maternal relatives. Since then, there has been a considerable number of significant issues that have arisen in the mother's care of the children which Ms L was not and could not have been aware of.

423. The current assessments of the mother are all unanimous that she is unable to meet the needs of the children. I accept those assessments. I have found that the mother has a personality disorder and anxiety issues and the way she behaves as a result is harmful for the children. The mother has worried too much at times which has made the children worry and has caused her to make decisions that were bad for the children. For example, her concern about bullying caused her to keep the A and B away from school for a very long time.

424. While I accept that the mother can work well with some professionals, I am also satisfied that she works very badly with other professionals. When the mother feels a professional is against her, it becomes almost impossible for them to work with her. Sometimes she will completely withdraw, like she did with T School and the consultant paediatrician. Sometimes she will be so upset or angry that nothing can be achieved, like she did in some of the multi-professional meetings. Sometimes she will just avoid meeting so that nothing gets done, like she did with the previous social worker and with the children's guardian.

425. The mother did not tell professionals the truth about the deterioration in A's speaking and his ability to walk, run and hold a pen. She told lots of professionals that this was a life-long problem. That was not true. His condition became a lot worse during the time the mother kept A away from school. A stopped speaking and lost his mobility as a response to the care he was getting at home from his mother. He improved dramatically once he was placed in foster care. It was not because A was bullied, although that could not have helped.

426. It is difficult to understand exactly why A stopped speaking and moving normally. I do not think the mother was trying to make that happen. However, her worries and anxiety as well as the fact that she treated A differently as a sick child caused A to adopt the "sick role". I am satisfied that this fits into the definition of factitious and induced illness. Because this has happened to A, there is a risk it will happen to the other children too.

427. I find that B also became mute, and D showed a degree of mutism. These are a result of the parenting they received. B, D, C and F have at times all shown problems with their behaviour. D's behaviour has been really bad in recent months. Although the mother has shown she has the skills to try to manage this behaviour, the cause of these difficulties lies in the care that the children have received as they have grown up. I accept what the experts say that the children have attachment difficulties. There is a pattern seen with B and D in the way the children's behaviour gets worse at home before transferring over to school. There has been a big improvement with B's behaviour since he was put in foster care. This shows that the cause of his problems arose at home. It also shows that despite her efforts, the mother was not able to help B with his behaviour, but the foster carers could.

428. The mother does not accept or recognise these problems. She puts blame on others and reacts in ways that make it difficult to deal with the problems. Her personality and her cognitive functioning make it hard for her to understand or accept these issues. Therapy and other support to fix the problems at home is likely to be lengthy and outside of the timescales of the children. Unfortunately, while the mother continues to lack insight into the need to change, it is unlikely to succeed.

429. I have considered whether support from the family and from professionals would be sufficient to overcome the difficulties for the mother in caring for the children. I am mindful of her personality disorder and her cognitive issues and the need for the court to carefully enquire as to what support is needed for her to be a good enough parent. In this case, I am satisfied that the mother has had a high degree of support. Prior to proceedings, she was being supported to a considerable degree by the art therapist. In addition, the FSW, Ms N was playing a role in supporting the mother from November 2019 onwards. These were supports that the mother found to be very positive and helpful. In addition, she was receiving family support from the maternal grandfather who was assisting with getting the children to and from school. There were other supports from universal services – the NHS and the schools which were more mixed in the way the mother worked with them. In the course of proceedings there has been social worker involvement as well as increased family support presence from the family support worker. I recognise that during that time, the tension and stress for the mother would have been increased dramatically by the proceedings, although also the demands of meeting the children's needs would have been considerably decreased when A and B were placed into care. Unfortunately, despite that support and assistance, D's behaviour has continued to deteriorate to unmanageable levels. I recognise that since he commenced nursery F's developmental delay has improved considerably, although that may be a reflection on the benefit of nursery attendance rather than the care received from the mother. Ultimately however, the mother's lack of insight and the poor prospects of therapeutic intervention to assist with her personality disorder mean that the environment which has led to the children suffering significant harm is likely to prevail and I am not satisfied that even with the very high levels of support being continued, that would be sufficient to ameliorate the risks to the children. Nor am I satisfied that the children will be able to receive the good quality care that they need and for A, B and D, the reparative care that they need.

430. I have considered the options for each of the children of being at home with their mother with support from family and professionals, of being with their uncle with support or of being in care and for E and F I have also considered the option of them being adopted. The most important part of my thinking has been what is best for each of the children, throughout their lives.

431. The advantages for the children of being with their mother are that they will grow up in their family with their mother who loves them. They will be together. They will have their extended family heavily involved in their loves. They will grow up knowing who they are and where they came from.

432. The disadvantage is that they will continue to suffer harm from the problems with the mother's parenting. In the case of A, he is likely to continue to adopt the "sick role" – not speaking and walking. For the other children, they are at risk of something similar. For B and D not speaking is a serious risk. The problems that have happened in the past are likely to repeat in the future.

433. The mother's lack of insight means that these problems are unlikely to go away by themselves. There has been a lot of support over the years, and during the proceedings there has been very high levels of support from professionals and from family. Despite this, there are ongoing and serious problems and the children have not been safe. For example, D twice put a plastic over F's head. I accept the guardian's opinion that no amount of support would be enough to keep any of the children safe in their mother's care.

434. I have considered the option of placing some or all of the children with their uncle. He clearly loves them. The uncle is genuine in his wish to care for the children. However, he does not accept the problems with the mother's parenting. He does not have insight into the children's needs. His understanding and his solutions are superficial. Placing with the uncle would mean the children could be with a familiar family member. They would be in their wider family and have lots of contact with their mother. However, I am not satisfied that the uncle can meet their needs even with support.

435. I have considered the options of placing the children in care. There are lots of problems with this option. The children will be away from their mother. The children want to be at

home with the mother and together. They will be away from their extended family and will have much less contact. The children will grow up in separate homes. The plans for A and B are clear with their current foster carer. However, for the other children they are much less clear. It is hoped but far from certain that C and D could be placed together. If I make a placement order for E and F, it is not clear whether they will be placed together or if they will be found an adoptive home at all. It is possible that C, D and E could all end up in separate foster homes. This is a huge consideration because sibling relationships are really important.

436. Foster placements break down for lots of reasons. It is really hard for the children if that happens. I am well aware of the research that shows the difficult outcomes for children who grow up in the care system. Lots of children do not like being in care because they feel it makes them different from other children and because they have social workers involved throughout their childhood. It does not feel like a normal childhood and children particularly as they become older can feel stigmatised.

437. However, growing up in foster care will give A and B the means to continue to recover and improve. They are getting better with their health concerns and with behaviour as a result of being in foster care. It is important that they can continue to do so.

438. For C and D, growing up in foster care will mean that they will receive care that meets their needs, so that they can grow up with their needs being met. D also needs excellent care so that he can also recover.

439. For E and F, I have considered the impact on them throughout their lives if they are adopted. They will legally stop being part of their family and will become part of someone else's family. That is a massive change. They are quite old and have a real sense of belonging to their family. This is likely to be something that they find quite difficult. That difficulty may increase the chances of an adoptive placement breaking down which would be really harmful for the children. They will have letterbox contact, so they will continue to remember their family, but it is unlikely they will see anyone else face-to-face. They will grow up without experiencing directly the love that their mother and the extended family have for them. There is a real risk they will not be adopted together, and they may

have separate adoptive homes, or one child may be adopted and the other end up in foster care.

440. On the other hand, being adopted would provide them with safe, consistent care where their needs can be met. It would also free them from the involvement of social services throughout their childhood. They would be able to experience a childhood that is much more like a "normal" childhood, compared with being in foster care.

441. I have considered the advantages and disadvantages of each option. I have decided that for A, B, C and D, it is in their best interests that I make a care order and approve the plans for them to be placed in foster care. I recognise all of the uncertainty and difficulties that this may involve, but I consider it is the only way for these children's needs to be met.

442. I am going to make care orders and approve the plan for adoption for E and F. I realise that there are considerable uncertainties about whether an adoptive family will be found and whether they will be placed together. However, I consider that the advantages of being adopted outweigh the disadvantages of this uncertainty. The care plan for time-limited searches for a placement for children together is sensible so that the balance is struck between searching for a joint placement and not missing out on the chance for a single placement. There is a disagreement between the local authority and the guardian as to how long the search for an adoptive placement should continue for – the guardian proposed 9 months, the local authority proposed a year. At the time the parties were planning for judgment to be given in early February. The children's ages have continued to rise during the intervening period, and I consider their ages to be a key consideration when considering how long a search for an adoptive placement should be undertaken. In the circumstances, I prefer the guardian's approach of a search for 9 months for an adoptive placement and I invite the local authority to amend its care plans accordingly. That time limit strikes the right balance between giving the search a proper chance to succeed while also making sure that the children do not have to wait for too long in the hope of a search may never be successful and recognising that as they get older the prospects of successfully identifying an adoptive family will diminish significantly.

443. In considering the placement order application, I have been mindful that adoption is a "last resort" and is only appropriate when nothing else will do in the interests of the

individual child. I have considered the questions that Peter Jackson LJ set out that the court should ask itself. The type of harm that may arise for E and F is set out already in this judgment. They are at risk of physical and emotional harm arising from their exposure to the mother's parenting, including a risk of FII. In the context of the mother's lack of insight into her own difficulties, notwithstanding her willingness to do whatever she is asked, I am satisfied that there is a very limited prospect of her overcoming the deficits in her parenting and not within the children's timescales. Thus, I am satisfied that there is a high likelihood of harm arising to E and F if they remain in her care, even with support from family and professionals. The consequences of that harm could be profound. There is a pattern of significant behaviour problems with B and D and there are indications that F is already showing some difficulties with his behaviour. There are issues with E's over-familiarity with strangers. There is a risk of physical and emotional harm arising from FII. I am not satisfied that there are steps that could be taken to mitigate sufficiently the effects on the children. Although there has been family support in particular from the maternal grandfather and the uncle and seemingly some support from the father as well, it was insufficient to protect the children from the harm they suffered. In the context of the proceedings, with extremely high levels of professional involvement, initially with CAMHS support, and with a high level of family support worker presence as well as social worker involvement; that has been insufficient to prevent D's behaviour deteriorating significantly. The prospects of therapy being successfully engaged with and bringing about effective and sustained change are limited given the difficulties with obtaining therapy as more importantly the mother's lack of insight and lack of appreciation of what needs to be changed.

444. When I factor in the advantages and disadvantages of all the options, ultimately, I reach the conclusion that for E and F adoption is necessary and proportionate. The risks to them of remaining in their mother's care are so significant and likely to remain so, such that it justifies the draconian remedy of adoption.

445. Pursuant to sections 21 and 52 of the Adoption and Children Act 2002, I consider that a placement order for E and F is justified having given paramount consideration to their welfare throughout their lives and for the same reasons, I dispense with the parent's consent to the making of the placement orders on the basis that E and F's welfare requires it.

446. I have considered the local authority's plans for contact with the mother, for a gradual reduction for A and B and separately for C and D to a level of 6 times per year in the school holiday periods is in the children's best interests (with the extended family included in half the sessions). These will need to be kept under review so that the contact can be changed as and when that is best for the children. The plans for separate contact between the siblings every 8 weeks are also sensible.

447. The plans for E and F are for contact with the mother to be reduced to once per month and for sibling contact every 8 weeks. This will continue until an adoptive family is identified when a wish you well contact will be offered for the mother and for the siblings. The local authority is going to try to find adoptive carers who will allow the children to see each other once a year, if that is in the best interests of the children.

448. I make care orders in favour of the London Borough of Z in for A, B, C, D, E and F and I approve the care plans. I make placement orders for E and F.

449. I am very grateful to the advocates in the case for the care and attention they have given to this extremely demanding and difficult case. In particular, I am very grateful to Ms Langdale QC and Mr. Stevenson as well as their trainee solicitor Ms Love for the care with which they represented the mother and their considerable efforts to ensure that she was able to engage so fully in the final hearing despite her difficulties. May I also express my thanks to the mother for the way in which she engaged with the process despite it obviously being difficult for her and also I thank the uncle for the respectful and helpful way he engaged with the court.

HHJ Oliver Jones

24th March 2022