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IN THE FAMILY COURT

Before:

HIS HONOUR JUDGE MORADIFAR

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

In the matter of:

Re C (Children: Fact Find Medical Presentation)

Nick Goodwin QC and Sara Granshaw on behalf of the local authority.

Tina Cook QC and Sharan Bhachu instructed by Wollens on behalf of the mother.

Jacqueline Wehrle instructed by Heald Nickinson on behalf of the father.

Jason Green and Kate Ferguson instructed by Oxford Law Group on behalf of the children through their guardian.

Date of the hearing:

23, 24, 25, 26, 27, 30 September
and
1, 2, 3, 4, 7, 8, 9, 10, 11 October 2019

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HHJ Moradifar

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

His Honour Judge Moradifar:

Introduction

1. There are two children who are at the centre of this case and are the subjects of applications by the local authority for public law orders. I will identify the children as A and B who are respectively twelve and ten years old. The matter comes before me to determine the local authority's allegations against the mother that are set out in the following terms;

> ***"1* Mother's *excessively high level of anxiety about and preoccupation with the children's physical and mental health. Her mental state has compromised her parenting capacity and her ability to meet the children's physical, emotional and educational needs in the following respects:***
>
> *1(a) She has entrenched beliefs about her children's physical and mental health which have adversely impacted on her capacity to report health and welfare concerns reliably*
>
> *1(b) She has falsely reported diagnoses (eg. in relation to* B *on 14.11.18 to Dr Sell – dysautonomia ... a diagnosis of hypermobility syndrome/disorder; restricted/limited movement; in relation to* A -

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dyslexia ... and ADHD) and has often misrepresented the children's mental or psychological conditions or symptoms when describing them to professionals, due to her excessive level of anxiety.

1(c)(i) Mother *administered unprescribed treatments/medication to the children that were not medically indicated or advised.*

1(c)(ii) Her excessive anxiety_has given rise to an unhealthy dynamic in her relationship with A *... As a result of* mother's *behaviour and any difficulties which* A *had (whether arising from a psychological/psychogenic disorder or ASD) were exacerbated. He has internalised his Mother's belief system and adopted the role of a sick child. Mother's behaviour and presentation has had a similarly detrimental effect on* B *in relation to separation anxiety.*

1(d) Mother's *fixed belief that the boys have a number of serious medical conditions (including epilepsy, ADHD, multiple food allergies, dyslexia, hypermobility) has caused her to pursue medical/psychiatric diagnoses relentlessly for each child…*

1(d)(i) The boys being repeatedly subjected unnecessarily to medical and/or psychiatric/psychological assessments, examinations, tests and procedures in a quest to find a medical/psychological/ psychiatric diagnosis. (Repeated unwarranted presentations for medical treatment are evident from the medical records and chronology).

1(d)(ii) Mother *disagreeing with professionals when they have advised that the boys did not have a medical or other condition/illness and either:*

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(a) making complaints about them or

(b)commissioning additional assessments privately … without discussion with the existing NHS treating clinicians or school, thereby undermining a joined-up approach for the boys.

1(d)(iii) The boys suffering emotional and psychological harm, as she has ... on occasions expressed her concern in their presence that they will not get better and she has consistently maintained a negative outlook, focussing on negatives rather than positive aspects of their situation…

1(d)(v) Mother *has constantly sought professional assessment of and support for the children, but has undermined the effectiveness of therapeutic intervention and professional support when it has been offered to the children: for example:*

-Play therapy – she made A watch videos of play therapy sessions before he attended play therapy with CAMHS and declined to take A *to the last 2 sessions of play therapy*

-Following a comprehensive assessment of A*, CAMHS recommended Health Psychology, but* mother *refused this as she felt it was not the right service as she believed he needed medication*

-Inconsistent engagement with professionals (eg. Children's Services, CAMHS) and non-engagement with Health Psychology and in sessions with a child psychologist.

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2. M's failure to meet the boys' emotional needs in the following ways:

2(a) She has failed to promote their relationship with their father:

2(a)(i) She has not abided by court orders in relation to contact, despite professional assessments finding no evidence of emotional abuse by father *as alleged by* mother

2(a)(ii) She has consistently portrayed father and his wife in a negative way, spoken disparagingly about them to professionals in the boys' presence, and has exposed the boys to her negative views and anxieties about contact; in particular:

- *By expressing her view to professionals within earshot of the boys that they have been emotionally abused by their* father *and would continue to suffer abuse if contact resumed;*
- *by attributing A's emotional difficulties, challenging behaviour and FND presentation to his* father*'s (and step-mother's) actions and his relationship with his* father
- *by attributing* B*'s anxiety and school non-attendance to his mistrust of and contact with* father

2(a)(iii) She has inappropriately exposed the boys to adult conversations which were likely to cause them distress, alarm and/or confusion; eg. about the court proceedings in relation to contact with Father.

2(b) as a result of her actions and by exposing the children to her own rigidly held beliefs and anxieties, she has not enabled B to separate from her in a healthy way. She has engendered in B *an emotional dependency on her and an inappropriately high level of*

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concern for her welfare, reinforced his belief that he has separation anxiety and failed to encourage him to spend time away from her in order that he can develop self-identity, resourcefulness, resilience and independence.

2(c) She has been unable to protect B *from suffering emotional and physical harm due to* B *experiencing A's violent and disturbing behaviour, which has caused him to become highly anxious and fearful for his own safety and that of his mother. On occasions, A has physically injured* B *in his mother's presence.*

3.She has failed to provide the boys with a stable routine and home environment: they have been frequently taken to see a GP or A & E hospital she has constantly taken them to medical appointments with numerous healthcare professionals, sometimes on a daily basis and often out of hours.

4.She has failed to meet the boys' educational needs:

4(a) She withdrew A *from school on 22.12.16 on the basis that she wanted to address what she perceived to be bowel difficulties and anxiety, but has subsequently failed to ensure that he has received an adequate level (or any) education at home for a prolonged period.*

4(b) She withdrew B *from school in November 2017 and then failed to ensure that he accessed education appropriately, whether*

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by attending mainstream school or receiving an adequate level of home education and/or tutoring

5.She has prioritised her own needs over the needs of the children:

She has on occasions prioritised her own negative views about father and his wife over the emotional needs of the children to maintain a relationship with father

e.g. she has stated that father and Lucy had emotionally abused the boys and that they had caused the boys' difficulties."

2. The mother states that due to her personality and functioning as an individual who was diagnosed with Autistic Spectrum Disorder (ASD) she has at times searched for certainty in medical diagnosis or investigations, but does not accept that the children have been harmed by this. The father, having experienced a period of stability in contact with his children, has been anxious not to appear critical of the mother but broadly supports the local authority's position. The guardian does not put a positive case forward and has assisted the court by highlighting the relevant evidence before the court.

The law

3. The fundamental legal principles that I must apply are very helpfully summarised by Baker J (as he then was) in *Re JS [2012] EWHC 1370 (Fam)*. Following this decision, Jackson J (as he then was) in *Lancashire County Council v C, M and F (Children: Fact finding Hearing) [2014] EWFC 3* added a further item to this invaluable list of important considerations. Furthermore, I have considered and applied the

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observations of the former President of the Family Division in *Re A (A child) [2016] 1 FLR 1*.

4. Furthermore, I have considered two important cases of *Re X Y X (Minors) [2011] EWHC 402 (Fam)* in which the court stated as follows;

"The last thirty years have seen a radical reappraisal of the way in which people with a learning disability are treated in society. It is now recognised that they need to be supported and enabled to lead their lives as full members of the community, free from discrimination and prejudice. This policy is right, not only for the individual, since it gives due respect to his or her personal autonomy and human rights, but also for society at large, since it is to the benefit of the whole community that all people are included and respected as equal members of society. One consequence of this change in attitudes has been a wider acceptance that people with learning disability may, in many cases, with assistance, be able to bring up children successfully. Another consequence has been the realisation that learning disability often goes undetected, with the result that persons with such disabilities are not afforded the help that they need to meet the challenges that modern life poses, particularly in certain areas of life, notably education, the workplace and the family.

To meet the particular difficulties encountered in identifying and helping those with a learning disability in the family, the government published in 2007 "Good Practice Guidance on Working with Parents with a Learning Disability". In their closing submissions, Miss Ball and Miss Boye

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contended that such good practice guidance is required because there is little evidence of effective joint working between adult and children's services and practitioners in each area rarely have a good working knowledge of the policy and legislative framework within which the other is working. They submitted that local authorities frequently do not take account of the fact that, if children are to be enabled to remain in their own families, a specialist approach to a parent with a learning disability is absolutely central to any work that is done, any protection which is offered and any hope of keeping the family together. The 2007 guidance points out, inter alia, that a specialised response is often required when working with families where the parent has a learning disability; that key features of good practice in working with parents with a learning disability include (a) accessible and clear information, (b) clear and co-ordinated referral and assessment procedures, (c) support designed to meet the parent's needs and strengths, (d) long-term support where necessary, and (e) access to independent advocacy; that people may misunderstand or misinterpret what a professional is telling them so that it is important to check what someone understands, and to avoid blaming them for getting the wrong message; that adult and children's services and health and social care should jointly agree local protocols for referrals, assessments and care pathways in order to respond appropriately and promptly to the needs of both parents and children; and that, if a referral is made to children's services and then it becomes apparent that a parent has a learning disability, a referral should also be made to adult learning disability services. The guidance also stresses that close attention should be paid to the parent's access needs, which may

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include putting written material into an accessible format, avoiding the use of jargon, taking more time to explain things, and being prepared to tell parents things more than once."

and *P v Nottingham City Council and the Official Solicitor [2008] EWCA Civ 462* where the court stated that:

"*It is, I think, inevitable that in its pre-proceedings work with a child's family, the local authority will gain information about the capacity of the child's parents. The critical question is what it does with that information, particularly in a case where the social workers form the view that the parent in question may have learning difficulties.*
At this point, in many cases, the local authority will be working with the child's parents in an attempt to keep the family together. In my judgment, the practical answer in these circumstances is likely to be that the parent in question should be referred to the local authority's adult learning disability team (or its equivalent) for help and advice. If that team thinks that further investigations are required, it can undertake them: it should, moreover, have the necessary contacts and resources to commission a report so that as soon as the pre-proceedings letter is written, and proceedings are issued, the legal advisers for the parent can be in a position, with public funding, to address the question of a litigation friend."

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5. I am not bound by the schedule of findings that the local authority seeks and can make such relevant findings as are appropriate based on the evidence.

6. Finally, each of the respondents has a right to a fair trial pursuant to Article 6 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and this right cannot be interfered with unless it is pursuant to a legitimate aim, necessary, proportionate and in accordance with the law. I am most grateful to the mother's intermediary who has provided an invaluable service for the mother and assisted the court and the advocates to ensure that the mother has been able to fully engage and participate in these proceedings.

Background

7. The parents met in 2000 and married in 2004. A was born in 2007 and B in 2009. The father worked full time and sometimes the mother taught music in the evenings. Whilst the mother was the main carer during the working day, it appears that both parents were involved in caring for their children. Sadly, not long after B was born, the parents' relationship began to suffer and they separated in 2010. At first the father lived close to the mother and continued to be involved in supporting her and looking after the children. The father has since remarried and lives with his wife and her two children. He continued to enjoy seeing the children regularly. However, in January 2015 the weekend overnight contact was stopped leading to the father applying to the court to reinstate the overnight contact. This was resolved by a consent order in July of the same year. The main difficulty surfaced in 2016 when his contact with A ceased.

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8. Following his birth and until 2012, A was presented to the doctors on a significantly above average number of medical admissions with concerns about respiratory difficulties. On three occasions he was seen for concerns about his hip which were quickly resolved. Thereafter the main area of concern was around A's constipation that in 2009 led to A undergoing a Meckel Scan and other investigations before a referral to a specialist who undertook a gastroscopy and colonoscopy. A's issue with constipation continued. Additionally, the mother raised concerns about food allergies and intolerances that were diagnosed as mild with no further action. In 2014 he underwent a further colonoscopy and gastroscopy which did not find any abnormalities. By now the professional view was that A's toileting issues were functional in nature and there were no identified medical conditions that would explain A's presentation. Thereafter he appeared to respond well to the continued use of laxatives and a toileting regime. Although A appeared to have settled in school, by 2014 there were signs of concerning behaviour with some of the professionals observing that the behaviours were less frequent when in the father's home. From January 2016, A began to display symptoms of leg paraesthesia and numbness that could not be explained by an underlying medical condition. He was presented to primary health on occasions using a wheelchair. A wheelchair was also used at home. In February of the same year he was withdrawn from school. In August 2016, he was due to attend a holiday with his father. He refused to attend and this led to a prolonged period when he had no contact with his father.

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9. By 2017 A had begun to suffer with seizures that were subsequently the subject of further investigations that included an EEG and in 2018 a video telemetry that could not exclude epilepsy but the working medical view was that in the main, the seizures were functional and not medical in origin. In the intervening period A had many attendances at the accident and emergency department during some of which he was noted as wanting to be admitted or refusing to go home. In May 2017 he was admitted to a weekly residential home for three weeks to further assess and address his ongoing toileting issues. Subsequently A was diagnosed with ASD but did not meet the criteria for ADHD.

10. B's early life experiences reflected those of his brother's. He too had a significantly above average presentation to his General Practitioner with respiratory difficulties. He successfully underwent a grommet insertion procedure in 2012. The next notable period was 2014 onwards when he was confirmed to be suffering with a mild allergy, although the mother insisted that he should carry an EpiPen. In 2016 the mother had sought advice about B possibly suffering with dysautonomia which was not evidenced or confirmed. In the same year B was investigated for some issues with constipation that resolved far more quickly than those of his brother's. By 2017, mother had raised some concerns about B's anxiety at school. He was withdrawn from mainstream education in November 2017.

11. The concerns of the professionals involved with the family were rapidly increasing in 2016 and 2017. By autumn 2017, the local authority's

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concerns were such that it convened a strategy meeting that was the prelude to the first investigations into the medical presentation of the children. This concluded that in May 2018 that the mother and the children should be provided with a list of identified support. At the same time there was a change of social work team that was deemed appropriate by the local authority. By the autumn of 2018 the previous concerns were once again investigated by the local authority. A was the subject of assessment of Occupational Therapist who observed concern about the home environment. In the relevant period he was observed to be wearing nappies and suffering with double incontinence. On 17 January 2019 the local authority applied for public law orders in respect of the children. On 21 January 2019 A was made the subject of an interim care order and placed in residential placement ("ED") that continues to date. B has remained in the care of his mother and started mainstream school in the summer term of the same year. Both children now have contact with their father.

Evidence

Medical

The independent experts

12. Dr David Robinson, Consultant Paediatrician, was jointly instructed by the parties to consider the medical records of both children and comment on any issues of concern arising from those records or issues that may

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contribute to or otherwise explain their current "condition". Whilst he would have liked to have seen the children, he did not feel that A would *"tolerate"* a meeting with him. However, this did not impact upon his conclusions and opinion. Dr Robinson confirmed that his opinion as set out in his main report and two addenda to be accurate and correct. In summary in respect of A he stated that;

> *"There are elements of illness fabrication with high level of complaint against the professionals and reversal/improvement of reported symptoms in hospital, school and a change of residence. Fabrication of some episodes of abnormal, movement cannot be excluded.*
>
> *Evidence of fabrication also relates to excessive presentation to primary care, considered to be abnormal health seeking behaviour rather than the actions of a highly anxious carer.*
>
> *… there is no medical evidence of falsification or induction.*
>
> *There is evidence of somatisation leading to severe functional (psychogenic) symptoms. These have substantially resolved in care suggesting that the personal crisis faced by* A *has resolved. A child who somatises may or may not have suffered FII.*
>
> *In emotional abuse (psychological maltreatment) the carer fails to provide a nurturing environment for psychological and emotional well-being and is emotionally unavailable for the child. Interactions to include both commission and omission become persistent and harmful. Anxiety, depression, fear, social withdrawal, development and educational delay are observed in such children …*

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> *Consistent support within the family home will be required for* A *to achieve his potential. Some psychological issues may take years to resolve.* ED *29.04.19 reported continued behavioural concerns."*
>
> …

In respect of B, he summarised his opinion (p 106/108) by stating

> *"There is evidence that* B *was highly anxious and presented with some functional symptoms …*
>
> *It may be that he is a naturally anxious child or that he was exposed to psychological maltreatment."*

13. Dr Robinson explained that he was aware of the mother's diagnosis of ASD but was unable to comment about ASD in adults. His expertise included children with ASD and generally observed that ASD must be regarded as a condition in communication and not a learning disability. He further explained that the average number of A's presentation to primary health was sixteen per annum which was much higher than the national average of expected six per annum. In Dr Robinson's opinion this is a complex and unusual case. He explained that most of A's difficulties are psychologically routed. Having considered the investigations into his seizures, he was clear that whilst there was evidence of some epileptic seizures, in the main his seizures where psychogenic. There is clear evidence that A suffers with Functional Neurological Disorder ("FND") which can explain the longstanding issues with soiling and his leg paralysis. A non-epileptic (psychogenic) seizure may feel and look like an epileptic seizure. There are many examples of such seizures recorded throughout the case records.

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However, Dr Robinson believed that there were some examples when A has also fabricated such seizures.

14. In his main report, he referred to the Royal College of Paediatrics and Child Health 2009 Fabricated or Induced Illness by careers (FII) as the starting point before further citing his publication [*D.L Robinson Paediatric Forensic Evidence, Chapter 8 Fabricated and Induced Illness by Carers (FII)]*, where Dr Robinson sets out the main indicators for FII. He further elaborated by reflecting on his clinical experiencing that it is *"crucial"* that such an investigation must be undertaken by a senior lead clinician who can marshal and coordinate the relevant medical history to prepare a detailed accurate chronology. Without such a chronology *"one is lost"*. He warned that great caution must be exercised when relying on hearsay evidence and in relying on generalisations. He further stated that such a chronology will often cover many years. He has undertaken this task when compiling his report. Dr Robinson further observed that the professional concerns where not limited to FII and included the *"child's psychological difficulties"*. Usually the treating physicians do not recognise FII at the time or fear that any criticism of the carer may lead to disruptions in the relationship with the patient or the carers.

15. He was clear that anxiety is not FII. He was referred to the paper by Dr Gullon-Scott entitled *Munchhausen by Proxy: under-recognition of autism in women investigated for fabricated or induced illness* (GAP.19.2.2018) and readily agreed that a person with ASD may speak in a manner that may present professionals with concerns about FII and

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he could not accept a proposition that carers with ASD are more likely to fabricate symptoms. However, Dr Robinson was careful to state that he had no personal experience of this. He further stated that the mother's ASD and A's ASD add a layer of difficulty when interpreting their interactions. Dr Robinson repeated that the *"pivotal"* issue in this case is the psychological state of the children and what has caused it. He further explained that the *"other piece of the jigsaw is how things are now"*. He observed that B is *"doing very well living with his mother but* A *not so well and his psychological issues"* are continuing.

16. Dr Robinson stated that he did not criticise the mother for having an 'encyclopaedic knowledge' or displaying rigidity in her thinking. Nor has he made any criticism of the mother's need for information to be presented to her at a suitable pace. He did not think that there were any criticisms levied at the mother for being rude or blunt. Dr Robinson was quick to recognise that the mother required support that should have been provided to her and agreed with several cited examples where professionals such as Dr Maltby had shared her concerns about other professionals such as lack of progress with referrals to CAMHS. He further stated that investigation into FII can be *"devastating"* for the carers and may cause more harm to the child.

17. He continued to explain that in FII cases the removal of a child from their home environment can lead to improvements or resolutions of the issues that were observed in the home. However, he also accepted that A's removal was to a specialist environment and that is a factor which must

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be taken into account when considering the observed improvement. He agreed that this would not be a *"fair comparison"* to when living at home. Furthermore, he reminded me of the importance of analysing the information before reaching a conclusion. For example, he agreed that if blood in A's stool was observed independently by a medical professional, then the investigations that followed could not lead to a criticism of the mother. A similar observation may be made in respect of the two-week period he spent in a residential setting in May 2017 to deal with his toileting issues. Additionally, A had made good progress with his toileting whilst in the care of the mother between May 2018 and January 2019 before he was placed at ED. Moreover, there are complexities in A's relationship with his father and the impact of this must be further considered in the work that Great Ormond Street Hospital (GOSH) is undertaking.

18. Dr Robinson was concerned that there remains a possibility that A suffers with epileptic seizures that if not attended to can be life threatening. He observed that some of the psychogenic/non-epileptic seizures can at times closely mimic epileptic seizures and great care must be taken before the mother is criticised for her attendance at hospital or seeking assistance for such seizures. He was taken through the 'seizure chart' prepared by ED and agreed that it is important that the entries are accurately recorded as close to the event as possible. When it became apparent that the chart was far from complete and other sources of material from ED revealed a greater number of seizures, Dr Robinson readily accepted that his

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assertion of a significant improvement since being admitted to ED and his conclusion in this premise would have to be reconsidered.

19. He further commented on his reliance on the observations that the issues of paraesthesia had much improved or resolved whilst A had been at ED. If those observations are inaccurate and those issues have remained whilst at ED, Dr Robinson would have to reconsider his views. Dr Robinson was clear that the root of A's difficulties is psychological and it is not within his expertise to comment on this. However, he was clear that A is *"a child in crisis",* his *"...psychological issue run deep and may take many years to resolve"*.
20. Dr Robinson accepted that through most of the medical chronology, the mother's ASD was unknown. He accepted that the mother's characteristics may lead to a greater number of visits to medics to seek clarity of information. However, in his experience children with ASD did not present with an increased number of attendances at medical appointments. whilst the mother's ASD may have led to increased attendances, Dr Robinson was not critical of the mother in this respect. Dr Robinson also confirmed that B had been appropriately presented for investigations into tachypnoea. Finally, Dr Robinson did not seek to disagree with Dr Maltby about the mother's presentation to out of hours emergency services and her observations about the MRIs that were deemed appropriate by her. He agreed that A had two spinal and three cranial MRIs which were *"not excessive*".

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21. Dr Gullon-Scott is a Consultant Chartered Psychologist whose assessment addressed if the mother was on the Autistic Spectrum, her cognitive profile, sensory profile and whether the mother needed the assistance of an intermediary to fully participate in the court process. She confirmed the accuracy of the contents of her email and her main report dated 28 June 2019. Dr Gullon-Scott concurred with the opinion given in a previous NHS assessment of the mother dated January 2019 that she is indeed on the Autistic Spectrum. She further found the mother to experience difficulty with flexible thinking, coping with unexpected changes and difficulties in her attention. She is likely to miss rapidly presented stimuli and become overwhelmed with in an environment with multiple stimuli.

22. In her report, she raised her concerns, citing two research papers (McNicholson et al 2000 and Gullon-Scott & Bass 2018), that there are an 'alarming number' of cases where FII is under investigation when the children and the family may be diagnosed with ASD. She explained that this is mainly due to misinterpretation of these families by professionals. Dr Gullon-Scott developed this further by stating that in her experience there is a *"spike"* in the investigations of cases involving ASD families. She stated that most parents with ASD *"don't fabricate"* illness. Generally, they are honest and the concept of deception is absent. Often, they adopt coping strategies that may be misinterpreted by professionals working with them. This negates any intent to mislead or fabricate. However, she accepted that when both the parents and the child are

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diagnosed with ASD, the child may learn the behaviour from the parents, the risk of which is lesser in a non-ASD parent child relationship.

23. She stated that the mother was diagnosed late when she was forty-four years old. Adults with late diagnosis will have spent their life adopting coping strategies. They can become overwhelmed and exhausted. They can become anxious or suffer with chronic fatigue. She found the mother to honest and 'blunt' who shared a great deal of detail with her. She accepted that some of mother's behaviour may be anxiety driven or 'hypochondria by proxy'. One of the key features of the mother is her intolerance of answers that are not concrete and not expressed in 'black and white' terms. This may also be seen in the reports from the children about the father's alleged behaviour or those of his wife. After concluding her evidence, Dr Gullon-Scott sent an email to the court through the lead solicitor stating;

> *"… yesterday I was unable to state a clear professional opinion regarding anything around the relationship between* Mother *and her children because I was not instructed to undertake any such assessment. However,* I *feel it is imperative that an expert in autism (does not need to be me) undertakes an assessment with her eldest son to give professional opinion on how his autism presents, and why placement in a residential setting for autistic children would change their behaviour for the better. I got the impression that the LA wish to suggest this is evidence that mum 'caused' elements of his presentation. That is the most outrageous and frightening logic if it is*

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the case. All autistic children who move to a specialist environment improve and change their behaviour, because they have the right support and structure. That does not make all parents of those children bad parents or abusive parents. It makes them unsupported parents. If the child has not had an independent assessment by an autism expert to address his presentation, which elements can be explained by his diagnoses, and why he would change in the residential setting, then I strongly suggest this occur before any decision is made about causality.

As I said in court yesterday, not one of the autism-related cases I have been involved in (and typically I do get to see parents and children) was a case of an abusive parent - intentionally or unintentionally. The saddest thing though is that in the cases where a child had already been removed, the incredible damage to the families by that removal had been done, and in some cases the children are still not returned - not because of any parenting problem or risk, but because the child protection system is not geared up to know how to facilitate their return. There remains a significant lack of understanding of autism and support needs across authorities.

The fear that children who may be at risk could be missed, seems to have led to a rise in parents who are 'different' being investigated, and the current assumption that multiple requests to health professionals for investigations equates to abuse has no evidence base. Even the FII and 'perplexing presentations' proponents state in their own literature that there is no knowledge of sensitivity or

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> *specificity for the current descriptions (i.e. no research on whether these are or are not actual abuse cases), no evidence for whether PP ever transitions to FII, no evidence of the efficacy of removing a child, and no evidence that removal is beneficial or protective. In other words, assumptions are being made that a child being taken to the GP or health professionals frequently is 'abusing the child', but no evidence exists to support that assumption.*
>
> *I truly hope that* Mother *and her family will receive the support they need, and that poor understanding of autism (in parent and child) does not lead to a damaging and - in my opinion - unjust outcome in this case."*

The treating clinicians and other medical professionals

24. Dr Philips is an Associate Specialist in paediatrics and Paediatric Gastro-enterology. She confirmed the accuracy of her two statements in each of which she sets out a brief history of her involvement with the children. In respect of A, she explained that he has been suffering with longstanding chronic constipation and overflow soiling. He is currently under the care of Dr Afzal after a referral from Dr Williams, a Consultant Paediatrician, in 2009. Dr Afzal undertook a gastroscopy and limited colonoscopy in 2009 and this was repeated in 2014. He has been treated with laxatives and a toileting routine. Dr Phillips first saw A in 2014 and has been seeing him since. From Monday to Friday of the weeks covering 15 May to 2 June 2017 A was admitted to Bursledon House which is a paediatric inpatient establishment to assist him with his toileting issues. She reported that in a review on 11 January 2019 he was reported to be

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making good progress with continuing issues of 'weak legs/paralysis' and non-epileptic seizures. Shortly after, A was taken 'into care' and placed in a residential unit. She reviewed him again in May 2019 when it was noted that his toileting had regressed and he was 'doing less well'. Dr Philips stated that in March 2016 B was referred to Dr Afzal by Dr Lajeunesse a Consultant Paediatric Immunologist with concerns around abdominal pain and constipation, the latter being confirmed later in 2016 through a bowl transit study. B did not like taking Senna (laxative) and his medication was changed in June 2017 which appears to have helped with his progress. Since 2017 his reviews have been limited to six monthly as he appears to be making good progress. Dr Phillips notes that the mother had questioned if a gastroscopy or colonoscopy were indicated in B's case. Dr Philips did not think that they were and the mother was accepting of this advice.

25. Dr Phillips commented that she was not aware that the mother had a diagnosis of ASD but was aware that there was such a possibility for A. In her experience of more than twenty years, she typically deals with some of the more difficult and challenging cases and in this context, it was not unusual to have a child treated for constipation and soiling for such a long time. She found the mother to be anxious and needed a lot of accurate and detailed information. She did not observe any concerns about the mother and stated that she appeared accepting of her advice. She further explained that mother appeared to accept Dr Phillip's opinion that the root cause of A's difficulties was psychological and not physical. She further explained that the routine of sitting on the toilet at regular set

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intervals during the day complimented by laxatives is the treatment method for A's difficulties. Dr Phillips observed that between May 2018 and January 2019, A had improved in his toileting and at the January meeting it was agreed that the dose of his laxative should be reduced.

26. Whilst accepting that the two procedures in 2009 and 2014 were invasive, she opined that those were justified and clearly authorised by Dr Afzal. She further commented that A had been discharged from Dr Afzal's care and referred to him in 2014. The two procedures are some years apart and given the chronic nature of A's condition, it did not strike her as unusual or concerning for A to have undergone such procedures. Finally, Dr Phillips could not confirm that there was any evidence that the mother was seeking to increase A's dose of laxative and that the most likely explanation in her view was that the mother was seeking a repeat prescription which is normally requested through the General practitioner or the department's nursing staff.

27. Dr Maltby is a Consultant Paediatrician who first became involved with A on 4 October 2016 when he attended the Children's ward. In her statement dated 4 September 2019, Dr Maltby sets out a detailed history of her involvement with A which continues to date. Dr Maltby was at first consulted with A's transient lower limb paraesthesia and paralysis. There were no medical conditions identified that could explain his presentation. Dr Maltby also became involved with A's seizures. The investigations included MRI, nerve conduction studies that were normal and EEG studies over prolonged episodes. By winter of 2017, Dr Maltby had

formed an opinion that A's conditions were manifestations of his FND. Referrals to neurology did not identify any medical conditions that would explain his presentation, particularly his seizures and Paraesthesia.

28. Dr Maltby explained that if a child suffers with genuine epileptic fits over a period that it is not covered by the period of telemetry, for example six times per annum, the absence of observed epileptic fits during the shorter period of telemetry does not exclude epilepsy. Having considered the evidence she was of the opinion that a significant majority of A's seizures are functional and non-epileptic in origin but there is some evidence that he may also have some epileptic fits. She found the mother to be accepting of this opinion following discussion of the telemetry results. Her advice was that non-epileptic fits could settle if ignored and A was distracted. She also felt that A's circumstances have impacted on both children's ability to access education and benefit from peer relationships. She was careful not to criticise mother's choice of home schooling.

29. She expressed some sympathy for the mother in this context. Dr Maltby explained that she did not find criticism in the mother presenting A to the accident and emergency department. She explained that some of the non-epileptic fits can be quite worrying and hardly surprising that the mother would seek help for this. She further stated that during the 'out of hours' periods, parents often have nowhere to go but the accident and emergency department. Usually the treating doctors are junior and dealing with the child in isolation of the history. They can become overwhelmed with such a complex case. The mother was advised that if the seizures last more

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than five minutes, she should seek medical assistance. Dr Maltby did not feel that there were an unreasonable number of paramedic call outs. She felt that B may have been somewhat *"side lined"* and presented as unhappy. This had caused her to raise child protection issues with the local authority.

30. In her opinion, A's behaviour was the manifestation of his *"emotional distress"* that he carried into hospital which at times escalated. At times A requested admission to hospital and on one occasion he refused to leave. His symptoms resolved in hospital. Dr Maltby was clear that in the winter of 2017, the mother had associated A's behaviour to their father's treatment of him. She could not comment further as she had never met the father. She also expressed her surprise that the mother had requested a change of consultant but explained that they were able to resolve the issue in discussions with the mother. She was aware that the mother had made complaints against Dr Aldridge and that for a period she took A to a different hospital as she had *"put in a complaint"* against this hospital.

31. Dr Maltby shared the mother's frustrations with CAMHS not helping A. She explained that the CAMHS criteria can be strict and the feedback she was receiving was that CAMHS could not meet his needs. She thought that it was reasonable for the mother to feel frustrated and exacerbated. Dr Maltby expressed her surprise that in autumn 2018 A was reported to be in pull-ups due to his urinary incontinence. She wondered if this was going to be helped by medication.

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32. Dr Maltby recalled that in the autumn of 2017, she attended a meeting with Dr Mellins and JB. In that meeting there were discussions about FII and she was very clear in her opinion that there was no evidence of FII. She could not recall if she was asked to be the clinical lead in those investigations but explained that, if asked, she would have refused due to her work commitments.

33. Dr Mellins is the children's General Practitioner who joined the practice in November 2016. He confirmed the contents of his two statements to be accurate. He confirmed that he first saw A in early 2017. He was struck by the mother's attention to detail and it was possible that he felt pressured by her approach. He told me that mother would often have several concerns written down when attending an appointment. She talked openly in front of the children about her concerns. Dr Mellins felt that A presented as *"medicalised"* using adult language, medical terminology and very *"grown up"*. A's presentation was variable, at times articulate and other times would not communicate. He was concerned that the mother may have been *"indoctrinating"* A with her views against his father. He was concerned that A appeared isolated and expressing suicidal thoughts.

34. He stated that overall, he could discuss issues with the mother until his view did not agree with hers. At these points she could become challenging. He believed that his unfortunate comments as recorded in the MASH referral are likely to be accurately recorded. He explained that this is likely to have *"sent things off on a wrong trajectory"*. He shared

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the mother's frustrations with the lack of support from CAMHS and in his view the mother was generally in need of much support. Dr Mellins agreed that it was reasonable to describe B as suffering with mild hypermobility, although this was nothing unusual. He had no reason to disagree with or challenge Dr Robinson's opinion in respect of B.

35. Dr Mellins recalled a meeting in October 2017 that involved the team manager in the case JB and Dr Maltby. He recalled Dr Maltby held the view that this was not an FII case but was open minded about this issue. He did not agree with the recording that Dr Maltby *"dominated the meeting"*. He took on the role of preparing the medical chronology for the investigations into FII. He also confirmed that he had not been involved in the FII investigation during 2018. Dr Mellins was clear that he was not asked to be the lead clinician in this investigation and he has no previous experience of assuming this role.

36. Dr McDonald is a Consultant Child and Adolescent Psychiatrist of many years' experience. He previously worked in a Mental Health Trust for twenty-two years before joining the specialist team in Child and Adolescent Mental Health Services (CAMHS) in 2003. His first initial assessment of A took place on 7 November 2018 although he had previously had discussions with Dr Maltby in February 2017. Dr McDonald explained that he prefers to use the term FND with its manifestation being clinically categorised as *"Psychogenic Non-Epileptic Seizures"*. He explained that this is rooted in the fight, flight or freeze response. The brain takes over manifesting symptoms such as twitching

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or seizures. Dr McDonald was clear that the psychogenic seizures can look and feel very similar to epileptic seizures. However, he also pointed to examples when A was clearly 'putting on' a face twitch. In one example this stopped when he was distracted by B. He commented that these look markedly different.

37. At the beginning of his involvement A would be seen with the mother. However, as the sessions progressed the mother was able to persuade A to meet on his own. A held a negative view of his father and during meetings the mother corrected him on negative factual reports that she felt to be inaccurate. This caused A to become angry with his mother. He was aware that the mother was under investigation for ASD and that A was diagnosed with ASD. He observed that as an ASD child, A would have difficulties in communications and tended to see things in rigid 'black and white' terms. He would be particularly sensitive to domestic abuse and anger from the parents. Dr McDonald found the mother to be highly anxious and *"very pedantic"*.

38. During the latter part of 2018, CAMHS had undertaken an assessment that was going to lead into family therapy commencing in early 2019. This never came to fruition as A was moved to a residential setting after the local authority issued these proceedings. Dr McDonald explained that the purpose of the family therapy was to help translate and better deal with issues that A and the mother were finding very difficult to manage as ASD individuals. It was intended that there would be six to eight sessions before reviewing and progressing the therapy. Subsequently, Dr

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McDonald's involvement with A was limited to two further visits in April and August. These were largely to review his medication and used as an opportunity to check on A. In the April meeting A reported that in the previous week he had experienced improvements in his circumstances. He reported that the issues with his toileting and seizures had much improved. Unfortunately, this had deteriorated by the time he visited him in August 2019 when A had experienced self-harm and regression in his toilet functioning.

39. Dr McDonald confirmed his diagnosis of FND and that his concerns in this respect were accurately documented in the notes of the strategy discussions on 21 November 2018. He explained that FND is an umbrella term and he was concerned that the mother was *"latching onto"* this. The meeting considered the issue of FII and there were discussions about the levels of dysfunction and the number of different teams that family had been through. At the meeting, there was a view that the mother was always *"seeking a diagnosis … there was an FII process"* in place.

40. Dr Brown is a Clinical Psychologist and at the relevant time worked with Dr McDonald at the Central Specialist Community CAMHS team. Having confirmed accuracy of her statement and its exhibits, Dr Brown explained that she was the care coordinator. She was aware that A was diagnosed with ASD before coming to her team. Her team was aware that the family may have additional needs and the mother was clear from the outset about some communication difficulties, that she needed to process and digest information that was given to her. She and Dr McDonald

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found A's language to be idiosyncratic. He told Dr Brown in his words of the *"emotional abuse"* that he had suffered at his father's hands. Other examples include the expression such as *"betrayed"*.

41. Dr Brown confirmed that the mother described B as suffering with separation anxiety but this was inconsistent with the observations of the school before he was 'withdrawn' from the school. Whilst understanding that B was increasingly withdrawn from activities due to anxiety, the mother was advised to encourage B to complete anxiety provoking tasks but there was a difficult balance to strike between undertaking this therapeutically and overwhelming B. Dr Brown was not critical of the mother and observed that it was reasonable for her to rely on B's diagnoses of separation anxiety. She also found the mother to comply with the advice that was given to her. She remained concerned that the mother was struggling at home and that there was danger that B would begin to *"pathologise"* his anxieties.

42. Dr Brown stated that the mother was struggling with the behaviour at home and not receiving appropriate professional support. She further commented that the mother would have found the investigation into FII to undermine her confidence. Dr Brown confirmed that she was asked by the local authority to consider safeguarding concerns and was aware that FII was under consideration. She prepared a CAMHS chronology to assist with the investigations. She and Dr McDonald identified safeguarding concerns but not FII. They both agreed that there was evidence of 'complex trauma' but were not clear about the life events.

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43. She commented that the mother was frustrated about the lack of joined up thinking by the professionals and no one seemed to be taking the lead. Dr Brown was very sympathetic towards the mother in this regard by observing that many parents find it difficult to navigate this complex system. She was used to dealing with parents who are not happy but noted that in her experience, the frequency at which the mother was unhappy was higher than others. Dr Brown further commented that the mother did correct A on issues that she knew to be wrong. Furthermore, she observed that both the mother and A think rigidly in 'black and white' terms. This she found to make communications between the two very difficult.

44. Dr Goodall is a specialist Clinical Psychologist who from October 2017 to October 2018 worked at CAMHS Anxiety and Depression Pathway. She currently works is a Specialist Learning Disability and Adult Autism Diagnostic Team. Dr Goodall explained that she undertook assessments of B in September and October 2018. In her evidence she detailed the challenging circumstances that B lived in. She noted that B was experiencing significant anxiety that had progressively worsened over the preceding two and half years. She assessed A to present a medium to high risk to B in circumstances when A *"... struggles with his emotions and will frequently lash out"*. The mother gave examples of A getting hold of a carving knife and other times when B is simply caught in the 'crossfire' between mother and A.

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45. Dr Goodall further noted that the mother was trying to engage support from the professionals. She was overwhelmed by her circumstances and appeared to struggle to make appropriate decisions about the children's contact with their father. Dr Goodall felt that B was at risk of emotional harm through his relationship difficulties with the father and A's behaviour at home where the mother reported that he has adopted a protective role of the mother. She found that B met the criteria of separation anxiety but ultimately CBT was ruled out as a possible course of treatment. He was discharged from Dr Goodall's care after the assessment. She further noted that the mother and the children needed significant support and B was referred to the CAMHS Specialist Community Team.

46. Dr Goodall was clear that B had stated that he was anxious about the mother's safety but had not given any further details. The cause of his anxiety was in her opinion rooted in the home environment that he lived in. She was unable to comment about the mother's insight but elaborated by stating that the mother engaged with the services and was seeking support. She appeared to be accepting of the advice given. She further stated that during her assessment, CBT had been discussed as a possible source of treatment but ultimately deemed not to be appropriate. Her information about the children's feelings towards the father was limited to that which she was told by the mother.

47. Miss D Hunt is an advanced Metal Health Practitioner who undertook six therapy assessment session with A. After confirming her two statements

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to be accurate, she was taken carefully through her notes. She confirmed mother's own account of being unable to protect A from her feelings about their father. The mother was also reluctant to involve the father in the planned sessions and felt that this made her feel *"disloyal"* to A. She felt that A had been *"massively rejected"* by his father and that what the father did *"was emotional abuse"*. She continued to describe the father and his wife to (?) *"this massive toxic point"* and she knows that *"this person sat in front of me is very manipulative …"*.

48. Miss Hunt observed that A's relationship with his father and the difficulties therein were a great source of sadness for A. She concluded that a systemic family therapy would be beneficial and that A did not have any mental health issues that could be assisted by CAMHS. She planned a final session which had therapeutic value to A. A did not attend and the mother told her that A was upset as he wanted the sessions to continue. Miss Hunt wrote A a letter to convey the message that she would have done in the last session. This appeared to have some value to him but was less than ideal. A had stated to her that he found the session beneficial. She did not observe A to have any seizures during her sessions.

49. Dr Wheeler is a clinical psychologist who between October 2017 and August 2018 had the oversight of her team in CAMHS. She did not provide any direct supervision but had the oversight of a multidisciplinary team. Her interactions were limited to telephone calls and correspondence. She confirmed that she was aware that Dr Maltby had made a 'working diagnosis' of FND, but that her referral was made due to

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concerns that A may be depressed. She explained that her CAMHS team were not an FND specialist and the mother was concerned that A should receive FND specialist treatment. She felt that the mother was reasonable to act on Dr Maltby's working diagnosis. She did not have enough information to comment on whether the mother displayed any ASD traits. She accepted that the mother may rightly be frustrated with the lack of services or coordinated services for her children. Her team recommended that A should be offered play therapy.

50. Mr Smith is a Paediatric Mental Health Liaison Nurse who was involved with A between 9 and 17 July 2018 when A was under the care of Dr Thomas, a Paediatric Neurologist, and A underwent a video telemetry. His team is based within the hospital and involved during a patient's admission. His team also communicate with the Community CAMHS. He became involved with A as he had *"voiced thoughts of wanting to die"*. A was also presenting with several symptoms and impaired function.

51. The mother was concerned about manging A at home. There was a multi-disciplinary meeting to ascertain where A would be best placed. At this stage they were not aware that he had already had an admission to Bursledon House. Mr Smith had suggested Bursledon House and the mother had favoured this suggestion. He explained that the mother had recorded most of the telemetry results but this was common practice.

52. He was aware that there was a concern about FII and he accurately recorded what he saw. He recalled that the mother had posted a

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handwritten note to him which was very detailed setting out the required support for A and referring to Bursledon House. She made some observations that Community CAMHS found to be at odds with some of the professional opinion. The mother also referred to a need for structural changes to her home to accommodate A's needs when using the toilet and shower. Mr Smith further confirmed that the nursing staff had reported A to have more symptoms in the presence of his mother. He was clear that the mother made some of her comments in front of A who seemed *"un-phased"*.

Education

53. Miss Bento is an Educational Psychologist who was involved with A from November 2018 until 8 January 2019. She was a member of the local Education Health Care Panel. Having reviewed A's referral dated 5 October 2018, she agreed to undertake an assessment to inform his EHCP. She undertook two home visits, one telephone call with the father and attended EHCP draft planning meeting. During the first visit A was in bed and not very interactive. The mother had warned Miss Bento of this possibility. He wanted the mother to be present during this session and initially spoke through her. He engaged with the tasks set for him. During the second session A was much more engaged and stated that *"he would much rather be at school meeting people"*. During the second session A spent a great deal more time on his own with Miss Bento. She was struck by how differently he presented and when she commented about this to A, he replied stating *"No, I am not better and rather be in bed"*. He appeared fixated on his computer and after the mother turned

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his computer off, A became rude and disrespectful towards his mother and at one point his face started twitching. Miss Bento was clear that the mother dealt with this appropriately and she should have stated this clearly in her statement.

54. Miss Bento raised concerns that the mother appears to have no concerns about the impact on A when discussing him in his presence and was not open to the possibility that at times he may use his symptoms to his advantage. She stated that she felt *"uncomfortable"* about the level of information the mother shared in front of A. However, she did not raise this as an issue with the mother, nor did she give the mother any advice about this. She further commented that the mother is quick to interpret a lot of A's behaviour through the *"filter of his illness"*. For example, the mother tried to explain why A had given a wrong answer by reference to detecting a slight seizure. Miss Bento was also concerned that A appeared to have a similar *"narrative"* to his mother such as describing his last school as *"dreadful"* or when discussing the concept of honesty, he stated that *"I inherited my dad's personality ... passive aggressive ... not a good man"*. Miss Bento was concerned that these were expressions that he could have learned from adults including his mother.

55. Miss Bento could not recall the detail of the conversations she had with other professionals but denied a charge that FII was the main topic of conversation in the local authority offices. She was sure that FII was first raised with her by the mother. The mother made her aware that she was

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being assessed for ASD. She found the mother to work openly and honestly with her.

56. Dr Barrett is an Educational Psychologist employed by the local authority. In the autumn of 2018 she undertook an assessment of B to inform his EHCP due to B's reported anxiety and refusal to attend school. Dr Barret was concerned to note that the mother appeared to exert an *"extreme level of control ... over the boys' experiences as well as the dominant problem narrative that is perpetuated in the home. This language of deficit and need seems to pervade all aspects of life with* mother *continually framing the boys' behaviours through this lens. As such it is these behaviours that* the mother *pays attention to and acts upon. This seems to have reinforced the situation of high dependency between her and the boys and maintains the language of behaviour and illness within the home…It is my opinion that the high anxiety and low resilience that* B *presents with is highly influenced by this rarefied environment that he is in ... becoming more and more socially and educationally isolated…There seems to be no normalisation of any feelings of anxiety empowering* B *to gain strategies to tolerate levels of stress ...* Mother *did not show any awareness that her behaviour may be impacting on the situation and this is despite dad's referral for FII".*

57. Dr Barrett raised further concern that the mother discussed her views in front of B. The mother spoke in medicalised terms and was concerned with 'labels' talking in 'black and white' terms rather than 'shades of grey'. B was denied the opportunities of spontaneous problem solving

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which was necessary for his development and his anxieties had led to his withdrawal for education. She discussed these issues with the mother in the second meeting but she was unsure about what the mother 'took from' these discussions.

58. Dr Barret confirmed that FII was the topic of discussion within the office. She was very uncomfortable about this. She was concerned that her opinion should not be influenced by those discussions. She stated that she took a great deal of time to reflect on her findings before forming an opinion that she hoped was free of such influences. She was clear that she was not criticising the mother for choosing to home tutor the children. She could not recall the detail of any recommendation for CBT for B, but confirmed her agreement that a systematic family work would be beneficial for B and the family.

59. Ms Mowczak is an Occupational Therapist who was involved with A and his family between 1 August and 17 October 2018. At the time of her involvement she had been employed by the local authority for about one year. She shared an office with other local authority employees involved in this case. She noted that A had longstanding difficulty with seizures and leg paralysis. These were closely monitored by the mother. The mother kept a detailed chart of these activities. Ms Mowczak was not critical of the mother in this respect. Ms Mowczak prescribed a commode to promote A's independence and 'avoid' use of pads together with a profile bed, a transfer board and slide sheets.

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60. In her statement she raised her concerns that the observed difficulties were "*cyclical and not moving forward… both children were in a pervasively sick/negative atmosphere,* A *presented as angry … with a worrying emotional presentation and* B *was reported to be becoming more distressed and anxious with a lack of attention to his needs by his mother*". She explained that the mother had reported that B was becoming more tearful, distressed and anxious. She noted that she started her involvement in the school holidays. The mother spent a lot of time attending on A. In her view the observed seizures "*were behavioural in origin*". Ms Mowczak explained that it *"felt like the symptoms were switched on and off"*. She further observed that mother was eager to receive as much help as possible for A but was *"intent on medicalising"* his needs. She gave an example that when she suggested that the issues around the seizures and leg paralysis were temporary, mother was quick to say that they were not. She had a clear memory of this and was confident in her account. She was clear that the observations about B were stated to her by the mother.

61. Ms Stewart is a Link Counsellor with twelve years' experience in counselling young people and adults. She met the mother on 6 November 2018 when she visited the educational establishment with a view for A to attend there. The school caters for variety of children with needs and she estimated that seventy to eighty percent of the children at that school are diagnosed with ASD of varying degrees of severity. During the visit, she found the mother to be defensive and very negative about what the school

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could offer. Ms Stewart observed that the mother appears to present obstacles to A attending school referring to ASD, his leg paralysis that may come on suddenly and his multiple daily fits. She understood from the mother that there were no medical explanations for A's fits and may be psychological. She stated that the mother *"inferred"* that the treating medics may have missed something important when referring to his fits.

62. Ms Stewart was reliant on her notes and had very little dependant recollection of the mother's visit. She made those notes one or two days after the mother's visit. However, she observed that at the conclusion of the mother's visit she was confident that A would not be attending that school. She confirmed that she contributed to the meeting in 21 November 2018. She was aware that FII had been raised as an issue but this was raised after the mother had left the school. She denied having any training or specialism in FII.

63. Ms Day is the Special Educational Needs ("SEN") team manager who was employed by the local authority until August 2019. She has no direct involvement with the mother or the children and it is limited to receiving and reading documents referred to her. She chaired the SEN panel that considered the referrals for the two children. She confirmed that the referral for B was received on 25 September 2018 and for A on 8 October 2018. B's papers included privately commissioned reports from an Occupational Therapist and Educational Psychologist. A's papers included privately commissioned reports by an Educational Psychologist and Dyslexia Specialist. Ms Day commented that whilst it was not the

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norm for parents to commission private reports, this does occur and she was not critical of the mother in this regard.

64. In respect of B there were concerns about the disparity in his needs as stated by his mother and observations by professionals that did not support her view. The panel concluded that B had not attended his registered school since November 2017 and an up-to-date needs assessment should be undertaken. Between November 2017 and November 2018, B was placed in Education Other Than School ("EOTS"). B was seen by Dr Sell on 11 November 2018 and found to be fit and well. In respect of A, the panel was concerned about A considering the mother's report of his condition that included encopresis, hypermobility, sensory needs, double incontinence, Irlen's Syndrome, spinal problems, epilepsy and Grapheme Colour Synaesthesia. He had been home educated sine 2016 with no up-to-date independent assessment of his needs. The panel agreed that there should be an up-to-date needs assessment be undertaken. In respect of A the mother stated that an examination was unnecessary as A was already under the care of Dr Maltby. The panel was concerned to gain a better understanding of A's needs. He was in nappies and unable to attend to his own personal care such as washing or cleaning himself. The reports were largely based on the mother's observations and no direct observations by those who compiled the previous reports. The only professional who saw A at that time was the person who reported on the issue of dyslexia.

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65. Ms Day was clear that the mother had made the 'application' to the panel and was seeking further assessments to see if the children had special education needs. The process in respect of A was interrupted as he was moved to a residential school ("ED") in January 2019. B started in mainstream school in March 2019. She confirms that she was invited to the strategy meeting on 21 November 2018 as this is part of *"the protocol"*. She explained that the panel wanted the NHS to commission its own report but the mother contacted the hospital and asked for Dr Maltby despite it being explained to the mother that the panel would receive information and reports from many professionals. In respect of A being home educated, Ms Day was not critical of the mother.
66. Ms Baker is the Head Teacher at the children's school before the family moved in 2016. She stated that A attended her school between 2 June 2015 and 11 February 2016. B joined the school on 4 September 2015 and left on 29 April 2016 when he joined a new school in the area to which the family had moved. Ms Baker did not have daily personal involvement with the children or the mother. She could not recall ever meeting the mother. She was aware that the mother wrote a great deal to the school and stated that A had a number of needs that required toileting routine otherwise he may soil himself and hide it. The mother had made the school aware that this was on advice from Consultant Paediatrician. She found it "*odd"* that the mother needed to measure the toilet at school. There were a lot of letters that took up a lot of the staff's time. She was not aware that A had been diagnosed with ASD. The school did not experience these difficulties including stomach pains. The mother stated that A needed special coloured lenses and a special shade of lilac paper.

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This lasted for about two months. Again, she commented that the school did not identify any such need. A did find the physical act of writing difficult. The family liaison manager Ms Worth challenged the mother and this led to A being withdrawn from the school. B was much more settled and socialised well at school. He loved drama and acting for his class-mates. Ms Baker was concerned that the mother's reports of the children's needs were *"embellished or exaggerated"*. She remembered the children as *"happy, active boys*" and was unable to reconcile one child being taken out of school and not the other.

67. The mother's reported difficulties for B were far fewer although he had complained of stomach pains at school and was referred to a Doctor. Ms Worth had tried to work with and assist the mother. As part of this she challenged her by stating that the reported symptoms were not observed at school. Ms Baker recalled receiving a letter from the mother stating that she was withdrawing A from school and he did not return to school the next day.

68. Ms Winchcombe is a teacher and SENCO at a school where B attended between May 2016 and November 2018. She confirmed her two statements to be accurate. She stated that B had a poor school attendance at his previous school. She was aware that there was an allergy action plan in place and in the Spring term 2017 B suffered with separation anxiety. She was careful to state that this was not observed at school although there was one example that could be interpreted as such. The mother stated that B's anxiety at home was spilling over into school. The school did not share this view and did not see the need to engage an

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Occupational Therapist. Ms Winchcombe further stated that the school can access many services if the need is identified. She recalled the mother would almost be *"excited"* when discussing the needs of the children. She described B as a happy child with no concerns about special needs. He seemed happy and settled in school. The mother talked positively about getting B into school but *"things like fear and anxiety would get in the way"*. She could only recall one occasion when B wouldn't come to school. He engaged well at school but did not return to school after the summer holidays in September 2018.

69. She was quick to recognise that a great deal of her observations and comments were based on information from other professionals and her discussions with the same. The mother was keen to receive help and assistance and spoke openly about their needs. She commented that the mother was proactive in seeking such support. Ms Winchcombe was concerned that B presented differently to that which was reported by this mother. She rang Dr Mellins to express her concerns, who in turn contacted JB and she understood the discussions to be about FII. She was also careful not to suggest that the issue of separation anxiety was *"made up"* by the mother. She reminded me about another issue concerning his swimming and how this was related to low self-esteem.

70. Ms Boothroyd is the manager of the residential establishment ("ED") where B has been placed since 22 January 2019. Her statement, that she confirmed as true and accurate, was prepared by reviewing the records held at ED. She sees A in passing on a regular basis. A's toileting

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continues to be monitored and he continues to observe the protocols that were set before he attended. His laxative dosage has been reducing in line with the plan that was recommended before his attendance at ED. He attends many activities such as trampolining, kayaking, water rafting and tree climbing. There are no issues with hypermobility although his paraesthesia has been observed on some occasions.

71. A's seizures have continued during his time at ED and can be best described as *"static"*. The staff at ED have been trained to manage his seizures and to keep a record of the same. Once taken through the 'seizures chart' she readily agreed that this was incomplete and there are many more that had not been noted. She commented that there is an element of 'staff turnover' that may contribute to the lack recoding of all the seizures in the same chart. An ambulance has been called out on two occasions as a result of his seizures.

72. Ms Boothroyd stated that A is sociable and engages well with his peer group. He had difficulty with another resident child who has since moved to another establishment, A has kept in touch and visited that child. He responds well to routine and being prepared as to what to expect next. He can be challenging if he is given demands such as taking a shower and some examples of his leg numbness are closely connected to this. He is doing very well at school and has received recognition for thirteen separate achievements that are largely concerned with independence, hygiene, relationship with others and self-awareness/reflection. July was a particularly unsettled difficult time for A and he required the involvement of Dr McDonald. In August 2019, Dr Phillips noted a slight

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improvement in his toileting issues. A does not need spectacles having attended an optician's appointment in February 2019 and by April 2019 he was assessed as not needing inhalers for asthma. A has been having contact with his father since June 2019 and this has been a very positive experience for him. He is close to his brother and misses home.

73. Ms Boothroyd accepted that ED provides a bespoke plan for each child and was very different to being at home. She observed that his ASD is only one part of many factors that they would have to consider and cater for. Initially there was 'spike' in his behaviour and more recently he has been more unsettled which she believed was closely connected to the proceedings and this hearing taking place. She observed that there was a high volume of correspondence with the mother but she was not critical of the mother in her observations. She also commented that the medication therapy as prescribed by Dr MacDonald appears to be working well.

Social work

74. Ms Mackenzie is a social worker employed by the local authority who in 2017 was directed to undertake a s7 enquiry and report to the court in private law proceedings that were issued by the father to spend time with his children. Ms MacKenzie confirmed that the contents of her statement and report to be true and accurate. She explained that she recalled that there had been a breakdown in the relationship between the father and A as result of an incident concerning a holiday in August 2016. This was largely confirmed by A. B was more confused about why contact with the father had stopped. The mother was concerned that the children were

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'emotionally abused' by the father and his wife and treated them like 'second class citizens' compared to his wife's two children. The father reported having regular positive contact and save for some changes, it appeared to be settled until August 2016. In a meeting with A, he described his father's wife as *"wicked", "mean and treating him coldly".* He didn't wish to see his father if his wife was present. She expressed her surprise at B using the term *"separation anxiety".* Her recollection was that the meetings with the mother were lengthy and there was reluctance for A to be seen alone. When she did subsequently see A alone, he engaged well in play and presented as happy. The mother had also advised her of some of the medical issues that A suffered with.

75. Ms Mackenzie thought that A felt rejected by his father but couldn't elaborate as to why. He presented as angry with his father. He seemed very specific about how and when he would see his father. The mother had told them that the parents were going to court over the issue of contact. Ms Mackenzie was clear that this can be done in an appropriate way to prepare the children for her visit but may also be done in a negative and inappropriate manner. They seemed anxious about the court process. They stated that their father was *"taking them all to court".* The mother did not seem very supportive of contact starting. The mother was unable to give a lot of detail of concerns about the father's wife. It was the mother's opinion that the children had been emotionally abused but it was unclear how she had come to that view. The boys gave independent negative and positive views about their father. She was unsure about her knowledge of A's ASD and that the mother may have told her. She was

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not aware of the 'mother's ASD'. At times it was difficult to discern how much of A's views came from the mother and how much was genuinely his.

76. Ms Freshwater is the children's social worker who was allocated to them on 17 September 2018. She has filed three statements in these proceedings the contents of which she confirmed to be true and accurate. She believed that the mother was in *"crisis"* when the children lived with her. They were not receiving adequate education and the mother told her that A had not had any education since March 2018. A was reported by the mother to spend hours in bed and wearing nappies. Ms Freshwater felt that A was using his behaviour to control the home environment. The mother was unable to manage his behaviour. A and his needs dominated the home. B was scared that A might attack him or the mother. The mother was unable to put in place and maintain any boundaries for A. The children were isolated. A told the social worker that living with his mother was *"miserable* "and that it was her job to change that. The mother accepted that B was struggling with A's behaviour but could not recall the mother ever taking any responsibility for the children's circumstances. By reference to an incident in September 2018 when A ran away, Ms Freshwater believed this was an attempt by A to control his environment. She did not believe that his mother had sworn at him as reported by A.

77. Ms Freshwater was aware of A's diagnosis of ASD. She was also aware that the mother had been referred for an assessment of ASD. This normally takes many months but given the needs of the family, they

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could expedite the process. In her first meeting with mother, Ms Freshwater was *"a little overwhelmed by the language and detail"* that the mother presented her with. Subsequently she adopted the guidance set out by Ms A. Wilson and the mother also corrected her when needed.

78. The social worker was taken through the list of support that was identified for the family in May 2018. She was unable to explain why this support had not been put in place. She accepted that the respite care was used on limited occasions that corresponded with the mother's medical appointments despite this being identified as regular source of support. Ms Freshwater accepted that the support should have been put in place and now that it has, she was not surprised that improvements have been noted. Ms Freshwater also accepted that A's placement is highly specialist and any improvements in A will be closely connected with the services he receives in that environment.

79. At the time of the telephone strategy discussions, the social worker was on annual leave. The decision to undertake a s47 enquiry took place in her absence. After returning, she arranged the meeting on 21 November 2018. In her opinion the mother was driven by a need to know if there was something wrong with the children. Reading Dr Gullon-Scott's report has given Ms Freshwater a better understanding of the mother. She believes that on occasions the mother exaggerated the children's symptoms to get answers and obtain referral back to CAMHS. The mother maintains the view that the children were 'emotionally abused' by the father. The first mention of FII was raised by Ms Stewart. This was

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clearly one of the points under discussion in the strategy meeting. She also confirmed that she was involved with the mother's application for educational review and EHCPs for the children. She observed it to be unusual for the children to have private reports commissioned by a parent but was not critical of the mother in this regard.

80. A was clear that he did not want to see his father. He explained this by reference to the father not seeing him when A was prepared to see him and A had since changed his mind. In Ms Freshwater's view, what she observed in December 2018 was positive and contradicted the children's reported stance about their father and a report by their mother that such negativity is *"engraved in their very being"*. The children now see their father regularly on alternate Saturdays and this has been very positive. They would wish to see more of their father but this is not a possibility at present.

81. By way of an update, Ms Freshwater stated that A is settled in his placement at ED. On a day to day basis little has changed, but more recently he has been struggling with the court hearing taking place and wants 'answers'. At the beginning of his placement he refused to go to school but soon settled and now attends school. He does not require any specialist equipment in his accommodation or school. He has also made friendships that he has been able to maintain. B is doing very well in the mother's care. He is attending full time mainstream education. When asked how he felt on a scale of one to ten, he has maintained a score of five or six. He was asked what would increase it to seven or eight, he

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replied chocolate cake for lunch. The mother is working very well with B's school which has made this a positive experience for B. There are no signs of separation anxiety, save that he has said he was worried about leaving his mother. The school and the mother have worked well together to resolve this. B clearly misses his brother.

82. JB was the last of the professionals to give evidence. His involvement with the family was during two separate periods, firstly from October 2017 to the end of May 2018 as an Assistant Team Manager and thereafter from November 2018 to date as the Team Manager. He had little direct involvement with the mother. He explained that the local authority was working with the mother under the Child In Need (CIN) provisions. The mother did not attend a CIN planning meeting held on 30 June 2017 as she disagreed with the proposed plans and didn't see the benefits of the CIN plan. Despite the attempts to engage her, the mother did not feel that the plan reflected the children's needs. The original plan was concerned with supporting contact with their father, provision of family therapy and assisting the father in understanding the children's 'issues'.

83. The team manager explained that there were inconsistent views among the medical professionals and concerns about the mother that led to the issue of FII being raised. This need to be investigated in a transparent manner that made the mother aware of the issues. Ultimately the conclusion of the investigation in May 2018 was that there was no FII. Dr Mellins was concerned about this issue. He assisted in preparing the medical chronology.

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When pressed on this issue, he stated that Dr Mellins was the clinical lead and then stated that there was no clinical lead in those investigations. He accepted that this was not appropriate considering the 2009 guidelines. JB was not aware of the 2009 guidelines but adopted the local authority's own guide on investigating FII. JB was involved in discussions with Dr Mellins, Ms Rippington and Dr Maltby. He stated that Dr Maltby did not agree that there was evidence of FII and that her views were absent in the main meeting in November 2018. He wasn't aware of the psychologist being present at the LINK when mother was visiting, who on limited information expressed concerns about FII. He found this to be very worrying.

84. The children's circumstances were deteriorating with being home schooled, A suffering with multiple seizures and behavioural issues and mother stating at one point that she couldn't manage A and needed someone to look after him. This led to further investigations and the strategy meeting in November 2018. The local authority was concerned about the negative views that the children had about their father and it appeared to be the views of the mother that they had taken on. They were speaking in medicalised language and A was expressing suicidal thoughts at nine years old which was great cause for concern for Dr Mellins. JB did not speak to the mother about this specifically but expressed the opinion that mother did not display insight into the children's difficulties and externalised a lot of behaviour and her views about the father in front of the children.

85. JB expressed his sympathy for the mother feeling under pressure which seemed to be caused by the investigations into FII. He felt that it would

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be 'sensible' to have a change in the allocated local authority personnel. He referred to the mother's complaints, which although may not have been raised as complaints by her, were treated as complaints by JB and he was required to formally respond to the same. JB also confirmed that he agreed with the support that was identified by Ms Rippington in the single assessment in May 2018 and reminded me that he signed off the assessment report. He was unable to explain why that support was not put in place and stated that he was not involved in the case for about six months in 2018. He understood that an adult worker was offered but the mother did not see benefit in her involvement. The respite foster care was offered and the mother used it when she had medical appointments. He was also aware that A was not accepting of the new allocated social worker. As the children's circumstances deteriorated, the local authority was becoming increasingly concerned about the children's home circumstances. B was missing on services at school such as play therapy and professional support, with increasing isolation and the mother was exhibiting little self-reflection and capacity to change. It was not proportionate for the local authority to intervene on a twenty-four seven basis.

The parents

86. The mother confirmed her statements to be accurate and true. She reflected that A is a *"complicated"* child and she could not point to a specific cause for his difficulties. She told me that she has not been *"perfect"* but she has been concerned to get the help he needs. She felt

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that she was much better at self-control than assumed by the local authority and she had learnt a great deal about ASD given A was diagnosed with this. She struggled to think how she could have been a better parent.

87. She stated that when she and the father separated in 2010, it was difficult for her but she has moved on and this has not presented as an issue. The children enjoyed regular time with their father. From July 2015, the children had weekend contact with their father when they stayed with him in his home with his wife and her children. Generally, contact progressed well until August 2016. The mother explained that after a weekend contact, A had expressed concern that the father's partner had been unkind about the father when purchasing ice cream for the children. The mother did not treat this seriously and told A that it was perhaps said in jest. The children were due to go on holiday later in August. A had expressed his reservations about the holiday. She felt that she had worked hard to persuade him to go, but by the time A had decided to go it was too late. The father did not assist and was rigid in his approach to A. She felt that A was very hurt by this and subsequently refused to see his father. The mother persuaded A to make proposals to see his father, but the father did not accept those proposals and was in her opinion unyielding. The mother stated that A was "*heartbroken*" and this was the start of a long period of no contact between A and his father. She denied being unsupportive of the father's contact and cited many examples where she had encouraged and supported contact. She accepted that the contact that both children now have with their father is *"good"*.

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88. The mother reflected on her parenting of the children and could not think how she *"could have done better"*. She did not perceive any difficulties in 'self-control 'or her ability to protect the children from her own views and anxieties. She further reflected that B did not display any anxiety around separation from her until he was about eight years old when A's difficult behaviour had started. She recognised that she and the father had different parenting styles but 2016 was very difficult. She did not at first blame the father but stated that he did not do anything to ease the difficulties. The mother accepted that in her letter to Dr Maltby dated 3 November 2017 she set out a list of abusive behaviour by the father towards the children. She stated that whilst she took a number of matters raised by the children *"with a pinch of salt"*, she was genuinely concerned about the children. She accepted that in this context she may have used the term 'emotional abuse' in front of the children and that this may be why A has used this term. When challenged about the list in the said letter, the mother appeared to try to distance herself from it but later stated that she stood by that list as it had been *"independently verified"*. She did not have any memory of telling the General Practitioner in 2011 that A's father *"fumbles with"* A's penis. She stated that A had a number of 'issues' with his penis at the time and felt it important to mention it. Otherwise, this was an isolated incident and she had no concerns about the father in this regard.

89. From about 2014, A complained about going to his father's home. She described A as impulsive and that he would say things. She knew what he

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was like and would put on an A *"filter"*. The mother stated that she had an 'open' home in which the children were permitted to talk and discuss issues. This, at times, will have involved discussions about the father. She accepted that she had repeated some of those concerns in front of the children but excused this by stating that she was only repeating what A had already stated. She was pressed to comment on the impact of this on the children and the mother was unable to recognise any impact on the children. She was unable to explain where A would have learned the phrase *"master manipulator"* when describing his father, but denied any responsibility for this. When asked about why she did not want the father involved in A's therapy, she explained that A did not want him involved and it would have been "*disloyal"* to A to have done so.

90. The mother considered her communication with A to be 'effective' as they both have ASD. Her communications with B were less effective. She felt that her ASD has led to a lot of detail in conversations that may be *"jarring"* to a non ASD individual such as professionals. She explained that as an ASD individual it is sometimes hard to decide what is important and this may impact on asking and seeking information about the children's health.

91. The mother accepted that A had no history of seizures when he was in the father's care save that on 9 February he had to be carried up the stairs. She reflected that the seizures are more common in the evening and the father now only sees the children during the day. Furthermore, they are busy during those visits and this may distract A. These she offered as

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possible explanations for A not having seizures in the care of his father. When asked if intense parenting can result in more seizures, the mother accepted that A's behavioural and psychogenic seizures are a response to demand and when you place demand on him, he is likely to respond in this manner. She accepted that the 'bowel charts' and other health strategies may have resulted in A suffering more seizures but qualified this by stating that the health strategies where put in place on the advice of the medics. She also accepted that the father's more relaxed parenting style may have contributed to A suffering fewer seizures but observed that there is a difference between caring for children twenty-four hours a day each week, than caring for them during alternate weekends.

92. The mother explained that she had not previously thought that multiple medical appointments may cause harm to the children and first considered it in her discussions with GOSH. She accepted the expert opinion in this regard but then displayed reluctance to accept that her children had been harmed. She did not agree that her children had become 'medicalised'. She challenged Dr Robinson by stating that if each of the medical interventions were appropriate, then the totality could not be said to be inappropriate or harmful. She defended her request for a referral for A to a Paediatric Rheumatologist by stating that sometimes his knee cap would *"pop out"* and was in pain. He was *"usually stoic about it"*. A is a child who may throw up and then *"get on with it"*. The mother did not feel that the use of the wheelchair was damaging to A and explained that it was used to bring him out of his bedroom instead of staying in bed. The mother denied that she may have inadvertently

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promoted a 'sick role' for within her home but accepted that the *"situation"* in her home may have created this.

93. She accepted that at times she would have presented as anxious. Dr Maltby had explained that epileptic seizures can be life threatening and prior to the EEG results in July 2018, it was difficult to distinguish between epileptic and non-epileptic seizures. She accepted that in her interaction with the medical community she searched for certainty and may have gone back to the treating clinicians more regularly if she was not receiving all the information she was searching for. She accepted that uncertainty can make her feel unsettled. She explained that she had acted on medical advice and returned to the treating clinicians when they had said *"come back if it gets worse"*. The mother also explained that there were times that she did not agree with the professional opinion. For example, she did accept CAMHS recommendation that A should be dealt with through 'health psychology'. Whilst she did not reject the CAMHS opinion, she was told different things by CAMHS. The mother explained that at that time A was not suffering with seizures and the concerns were around 'his FND' and suicidal thoughts. She explained that it was A's distress that caused the issue with his legs. The discussions about medication related to the suicidal thoughts and not his legs. She felt that play therapy was helpful.

94. The mother was taken to some examples when A had insisted or requested to remain in hospital. She was unable to explain why this may be but denied that it was due to his home environment. She stated that A

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"says a lot of strange things". The mother stated that she only called the paramedics when necessary but accepted that this may have exacerbated A's difficulties. She also accepted that it was possible that A exaggerated some of his symptoms for his benefit. The mother also accepted that she had given medication to A without consulting with the treating medics. She stated that with the benefit of hindsight she should have consulted with Dr Maltby first, but in any event Dr Maltby subsequently prescribed the same medication. She also accepted that she had administered oxygen to A and gave him a small dose of the daily allowance of dioralyte and potassium that appear to have assisted with his mobility.

95. The mother was pressed about her comments to Ms Mowczak that A would not recover from his conditions. She strongly denied making such comment. If this was said at all, it would have been relating to A's need for psychological support. She denied being negative in front of the boys all the time and she sought to facilitate the children's views to be communicated. She denied being 'obsessed' with the children's health. She further denied that the children's home environment was unhealthy and dysfunctional. She stated that they were in a *"bad situation"* without CAMHS support. When challenged about the medical terminology within the home, she stated that *"the children use a lot of good words"*. She was pressed yet further and asked about why she had sought gastroscopy and colonoscopy for B. She was clear that she had merely asked about this and accepted Dr Afzal's advice on this issue.

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96. In relation to A suffering with Irlen's Syndrome and Grapheme Colour Synaesthesia, she stated that she had raised these issues as she 'suspected it'. She felt that A was happy to wear his coloured lens glasses and did not feel that this had a negative impact upon him. She accepted that in 2016 she had reported A to be hypermobile without any such diagnosis and that he had 'traits' of Asperger's. As to a referral for scoliosis concerning A, she explained that she suffers with scoliosis and felt justified in pursuing this. She explained that she had discussed the use of a brace with Dr Kazaz and the need for a brace was not identified. The mother was taken through seven examples of what she accepted to be complaints. She expressed her frustration that there was no 'joint up thinking' by the medics.

97. The mother continued her evidence by stating that she had mentioned to professionals that A may have had ADHD but was unable to state if this was her opinion or if she was referring to certain traits. She explained that Dr Walsh had mentioned Asperger's and in 2017 was told that A didn't have ADHD and she denied wishing for A to have a diagnosis of ASD. She felt that A's auditory issues where connected with his FND. With respect to B, the mother stated that he had traits of dystonia but that she was never told that he suffered with this condition. She further stated that he is hypermobile and has told other professionals that B suffers with hypermobility.

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98. In cross examination the mother was challenged about the children's schooling. She stated that A didn't go back after half term. She spoke to him about this but could not say if he had the opportunity to say goodbye to anyone. A was struggling at the time and the mother denied that his removal from school was to meet her needs. She also saw the specialist school that was on offer. Given the distances, she explained that the main issue was how she was going to get him to school.

99. The mother explained that in 2017 B was affected by A's behaviour. The mother was *"powerless"* and it was *"hugely harmful"* to B. B was anxious and worried about his mother. She reflected that B had not been schooled for a year and complained that there was no reintegration programme put in place for him. The mother accepted that it was her choice to remove B from school in November 2018. She expressed her concern that B's removal from school in 2017 was due to a lack of support during summer 2017. He was *"too terrified"* to go back. She accepted that B benefited from being in mainstream school and explained that she never professed to have the teaching skills to school him at home.

100. She was taken through several provisions of support that were put in place for her and the children. She spoke positively about some of the support that was put in place for her that included the provision of respite care. she understood that this was limited to times when she needed to attend medical appointments and other professional appointments. She spoke very highly of Ms J Percy by describing her as "*really helpful and … it was a negative that she couldn't carry on"*. She found Ms Mowczak

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to be *"really helpful ... supportive and practical"*. She denied that the mother's insight was a topic of conversation with her. She found the home education officer very helpful who helped her with *"anything that* she *asked for"*. She made a referral to the resources panel and the mother *"felt very supported by her"*.

101.The father was the last witness to give oral testimony. Having confirmed his two statements to be true and accurate, he told me that he worked when he lived with the mother and the children. Some evenings the mother would teach music and he would care for the children. He saw the children regularly after they separated. After their separation and until 2013, the father lived close to the children and saw them very regularly. He supported the mother by looking after the children. Later the children visited his home that he shares with his wife and step-children. He told me that the children got on well, although it took A longer to establish himself in the family unit. He did not observe either to suffer with any significant health issue or anxiety. The children were healthy and ran up and down his three-storey property. They climb trees, cycled and at no time required any contact with the medical profession. He described his relationship with the boys as positive.

102.He stated that he had a different parenting style to the mother. He was concerned about the number of medical appointments that the children had to attend. He denied 'pushing' Dr Afzal to undertake further investigations of A. He said that the test in 2009 had not observed one area and Dr Afzal felt that the only way to exclude any doubts about this was to undertake

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further investigations of A. The father was very frustrated as no organic cause could be identified. He recalled seeing the photograph of the blood in A's stool in 2009 but could not recall seeing the blood first hand. The father described the mother as follows;

"In my experience, if she has an idea, she would investigate it to the nth degree until it complies with her idea"

He went on to explain that a varying view to that of the mother's may prompt attempts at further investigations. He accepted that the strategies adopted by him and his wife failed. He was aware that A would hide his soiled underwear and accepted that his toileting issues were also observed at his home.

103.The father was taken through several items on the list of behaviour in which the mother alleges the children have been abused by him. The father strongly denied any such behaviour or that it was abusive. He had not been aware of these allegations until these proceedings had commenced. He stated that A can be *"idiosyncratic"*, may be *"playing to an audience* "and he was aware that A would present *"situations"* differently to a different *"audience"*. He also wondered if the mother treated what A may have said to her more seriously than merited. He was sure that neither child reacted *"out of the ordinary"* in his presence.

104. He stated that he has experience of working with children diagnosed with ASD and has had some training in safeguarding. He was concerned about the number of medical appointments that the children, particularly A were taken to. He denied being under the control of the mother. When asked about the children's schooling, he stated that he had

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not been consulted about the children schooling and their withdrawal from school, provision of education through Education Other Than School and could not recall being consulted about a specialist educational establishment that was on offer for A. He stated that he was surprised about the children's removal from mainstream education and had no awareness of it.

105. The father stated that his applications to the court were aimed at re-establishing overnight contact with the children. He was very pleased to hear that A wanted to start contact with him in May 2018. He was unaware that he had asked for contact much earlier. The father reflected that the current arrangements for contact work very well and given all that is happening in their lives it should remain at this level. He was delighted about the progress that B has made and he is now attending full time mainstream education. He also accepted that he and the mother have been able to work more collaboratively citing their joint work with GOSH as one such example.

Analysis

106. The local authority has not presented a case nor has it pleaded its case to seek findings of FII. However, given the professional concerns and the investigations into FII, this issue has unsurprisingly occupied a significant part of the evidence before the court. FII has been an important feature of this case and it is argued by the mother that it has shaped and influenced much of the local authority's approach to the mother and to this hearing.

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107. The issue of FII was first raised in 2017 and this led to a detailed investigation by the local authority that commenced in October 2017 and involved the family's General Practitioner Dr Mellins. His evidence together with that of Dr Maltby and JB illustrates a shocking example of an investigation into FII. Dr Maltby was clear from the outset that there was no evidence of FII and her views have since played little part in the investigations that were subsequently conducted. The appointment of a lead clinician is crucial to this process. The evidence in this regard is at best confused and lacking. Whilst noting that Dr Mellins undertook the preparation of a medical chronology, there was no understanding on his part of being the lead clinician. JB who at that time was the Assistant Team Manager, was unable to provide any clarity on this issue. His reference to the local authority's own guide in this investigation has not produced any document that is capable of being noted as a guide to FII investigations and by his own admission, he was at that time ignorant of the 2009 Guide.

108. I accept JB's view that this process must be transparent and open. This brings with it a high level of stress and anxiety for the parent who is under investigation. I also note that by the end of May 2018, the local authority had concluded that there was 'no FII' and proposed a package of support to be put in place for the mother and the children. JB stopped his involvement due to a concern that the mother should have a new team to work with. This I found to be entirely reasonable and considered. The evidence is also clear that the issue of FII had come under renewed consideration by November 2018. By this time JB was the allocated social worker's Team Manager.

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109.It is beyond argument that the issue of FII had by this stage occupied the local authority for a significant period. It is also clear that this was the subject of much discussion within the small local authority office. I note Dr Barrett's discomfort at the discussions that where taking place. Whilst the local authority seeks no findings in respect of FII and indeed its own conclusions, albeit with considerable doubt as to its reliability, this is a significant factor and the context in which the other evidence about the lives of the children must be assessed.

110.Furthermore, in May 2018, the local authority concluded that the mother and the children required support and identified a list of support that was to be put in place. At this stage the children were no longer attending school and A was not receiving any education. The evidence was also clear that A and his needs dominated the family. His behaviour was causing a great deal of stress and concern for B, who had refused to attend school due to concerns for his mother. Save for *ad hoc* respite, the identified support was not put in place. Later in November, the issue of FII was under consideration again and this would have added even more stress to what were already very difficult circumstances for the family. This must also be considered in the context where the mother had already stated that she was not coping with A's behaviour.

111.The mother has two confirmed diagnosis of ASD. This is a significant factor when considering her behaviour before such diagnosis was made as well as assessing her evidence before the court. A has also been diagnosed

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with ASD which is also a significant consideration in this case. The combination of the two diagnoses adds a further layer of complexity that must be central to any consideration of the main issues in this case. The mother is intelligent and articulate. She gave her evidence with great care. Whilst she displayed a high level of attention to detail, this was most obvious when considering the medical issues in the case. In other respects, most profoundly issues concerning the father, this detail was lacking and her recollection was vague.

112. I found the mother's evidence to be very informative. Her search for answers and detail from the treating medics has been a significant feature of her life and those of her children. She gave a reasoned account of the main medical investigations that in some respects were corroborated by the relevant treating doctors. Examples included Dr Phillips making no criticism of the mother in investigating A's toileting issues and the treatment regime that has been put in place. Dr Phillips did not raise any concerns about the 2009 and 2014 investigations that were deemed necessary by Dr Afzal. She also noted that Dr Afzal found the mother to be accepting of his advice when she was questioning the need for a similar investigation for B. Other examples include Dr Maltby authorising the MRI scans, undertaking the telemetry investigation and mother acting on the advice that she had given about when to call an ambulance.

113. Whilst noting the mother's characteristics, particularly as observed by Dr Gullon-Scott, the mother was very rigid in her views about her parenting and unable to reflect on the impact of aspects of it on her children. This

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was particularly surprising given her previously stated inability to cope with A, her concerns about B including his 'separation anxiety', A's behaviour towards B and the mother together with the accepted difference in the children's behaviour when in the care of the father. Furthermore, having accepted that B benefited from being in mainstream school, she was unable to reflect in any meaningful way on how his removal from mainstream school may have impacted on him. Moreover, she was unable to recognise any concern about the impact of removing A from school with one-day notice. This was particularly concerning given mother's own knowledge of ASD and the need for routines, consistency and predictability. Similarly, the impact on A of not attending his last therapy session that was of intended therapeutic value to him. Furthermore, there is no evidence that the mother's one-off administration of over the counter medicine to A has caused him harm.

114. The mother's evidence on the medical issues was rich in detail and in the main spontaneously given. She seemed at ease when answering questions on these issues. She gave cogent and detailed reasons for the many medical appointments and investigations that the children have been exposed to. She was unable to reflect or accept that cumulatively these may have negatively impacted on the children. Her limitation in this regard included the use of wheelchair in and out of the home, discussing her medical concerns in front of the children and the use of medical terminology. I note with concern the mother's response in respect of the latter issue by stating that the children use *"a lot of good words"*.

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115.It was striking that the mother was unable to show any appreciation or concern for A when she was questioned about his requests to be admitted or to remain in hospital. To state that A *"says a lot of strange things"* was dismissive of the underlying reasons why A may wish to be admitted to or stay in hospital with a worrying lack of curiosity by the mother. Ms Mowczak's observation of A's behaviour and his reticence to be observed as recovered or in better health provided an important insight into A's mindset. Similarly, his challenging and rude behaviour towards his mother when challenged by her I found to be informative. Where Ms Mowczak was challenged about her testimony in relation to the mother's assertion that A's condition was permanent, Ms Mowczak was entirely clear in her recollection of the events. In this respect, the mother's evidence was unclear and speculative. I overwhelmingly prefer her evidence to that of the mother on the material differences between them.

116.The mother's evidence as corroborated by other witnesses told a picture of ever increasing pressure and anxiety. It is quite apparent that from about 2016 onwards, A had begun to control his home environment by relying on his medical conditions that had been a significant and prevalent factor in this family's life and otherwise through his aggressive dysregulated behaviour. It is also clear that this marked a start of a period when B had to take second place to A and his needs where not always adequately met. With increasing demands by A in his ever-escalating medical concerns and behavioural issues, this family was fast reaching crisis point. I have no doubt that at times of great stress, the mother's ability to make sound decisions was compromised. This had a significant impact on the children's

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schooling and the benefits that school attendance may bring with it. The presence of both children at home added a further layer of stress and issues that at times were beyond the mother's ability to manage. It is hardly surprising that the mother felt *"powerless"* and stated that this was *"hugely harmful"* to B.

117. The factors that I have stated above covering the period 2017 to 2018 would have added a further layer of stress into what was already a harmful home environment. This was significantly exacerbated by the breakdown of the contact between A and the father and the issues for both children that followed. This also introduced a further level of toxicity into the home environment. I have no doubt that the mother's written list of alleged abusive behaviour by the father towards the children and those of his wife were genuinely believed to be true by her despite the lack of any real evidence to support the same. This may explain why the mother was unable to elaborate on the allegations and equally unable to distance herself from the same. At times of great stress and poor decisions making, I have no doubt that the children were involved and not protected from the mother's views about the father. She appeared incapable of entertaining any thought that this may have been harmful to the children and sought to excuse the same by stating that she was repeating what the children had already told her. The father's conduct in the aftermath of the August 2016 holiday was far from ideal and not child centred. This would have served to further validate the mother's views of him and expose the children to the same.

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118.There is a coincidence in the accumulation of the factors stated above and the increase in A's perceived medical needs and psychogenic rooted behaviour. The evidence about the connection between A's psychogenic seizures, FND and demand is clear. Save for the possible epileptic fits, such behaviour by A is closely connected to *"demands"* or stress that are placed upon him. It is therefore hardly surprising that there should be an observed increase in such behaviour in the circumstances set out above that will add further exacerbation of the stressed home environment. The impact of this on the mother was unsurprisingly profound which included an increase in her quest for certainty and medical diagnosis. This in turn translated into further professional intervention some of which was privately commissioned and mostly was medically related. In my judgment it is significant that this period also marks the first examples of A expressing suicidal ideation that appears to have been first evidenced in January 2017.

119.The period following the children's birth leading to 2016 is also an important period that not only raises other issues of concern but provides the context and the background to the more recent times. As set out in Dr Robinson's report, the evidence of presenting the children to the medical professionals is clear. The numbers are clearly far above the average numbers that are expected for children in the relevant age groups. This raises the concern about mother's 'health seeking' behaviour. However, such behaviour must be carefully considered in the context of the medical opinion and advice that was given to her at the time. The issues concerning A's toileting date back to when he was a very young child. Having regard

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to all the evidence in this connection, including the father's memory of seeing a photograph of the blood in A's stool in 2009, when taken together with the overall treatment opinion of the relevant medics, does not in my judgment lead to a natural conclusion that this was in any material way inappropriate. Indeed, Dr Phillips was clear about this. She was also clear that the procedures in 2009 and 2014, though intrusive, were undertaken with the approval of Dr Afzal. The toileting regime was one that was recommended by Dr Phillips. On balance I agree with Dr Phillip's opinion that the letter in which mother is 'seeking more' laxative for A, is no more than her requesting a repeat prescription and not an increase in dosage. Indeed, the evidence clearly shows that the use of laxative was to be reduced as A's toileting has improved between May 2018 and January 2019.

120. The evidence, not least the mother's own evidence is clear that the mother's personality and quest for certainty has played a significant part in what has been referred to as her 'health seeking behaviour'. When her need for detail and certainty has not been satisfied, it has caused her to seek further information with a consequence of additional consultation with the treating doctors. This clearly corresponds with the above average medical attendances that are observed by Dr Robinson. In my judgment, the mother's motivations were dictated by her personality. I note that long before the local authority sought to investigate these issues, the father had written to the treating doctors raising his concerns about the number of medical appointments that the children were taken to. The evidence is also clear that the medical concerns and the discussions about the same was

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commonplace in the mother's home with no attempt at protecting the children from the same. Indeed, the mother accepted discussing these issues in front of the children as illustrated by children's use of medical and quasi medical terminology. This is further corroborated by the professional assessment of the family living in a culture of deficit without hope of recovery from their medical conditions.

121. The root causes of the children and particularly A's behaviour are complex and multifaceted. This will be the subject of a detailed assessment by the GOSH. The impression or assertion that there has been a significant improvement in A whilst away from his mother has been shown to be wrong. As stated by Dr Robinson, this must lead to reviewing those parts of his opinion that were based on this assertion. Of equal importance is the undisputed fact that B is thriving in his mother's care and regularly attending mainstream school form which he has gained much benefit.

<u>Conclusion</u>

122. Having regard to the totality of the evidence before me and after carefully considering the mother's evidence in light of her reported personality and characteristics, I have no hesitation in finding that;

   A. The mother has failed to maintain and promote a positive relationship between the children and their father by;

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i. Portraying the father and his wife negatively and speaking disparagingly about them in front of or within the earshot of the children, and
ii. Wrongly holding a rigid view that the children have been emotionally abused by the father and his wife. The mother has exposed the children to these views, and
iii. Asserting that the cause of A's FND behaviour and B's 'separation anxiety' related to contact with father in circumstances where such behaviour was much reduced when A was in the care of his father, and
iv. Seeking to explain B's 'separation anxiety' by reference to his contact with the father.

B. The mother removed A from school in December 2016 and B in November 2017 without any good reason for doing so and subsequently failed to ensure that the children received adequate, consistent and appropriate education.

C. The mother was unable to
i. manage A's behaviour, to put in place appropriate boundaries and maintaining the same, and
ii. protect B from A's behaviour that caused B significant anxiety, distress and concern for the mother's safety that in turn created further anxiety about attending school and leaving the mother alone with A, and
iii. appropriately address B's anxieties.

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D. The mother has been anxious and rigid in her quest for certainty and detailed information about any perceived medical condition that the children may have had. This has led to;

   i. Above average presentation of the children to treating medics, and
   ii. Open discussions about medical conditions in front the children, and
   iii. Over anxious attention to the children's medical and health needs within and outside of the home, and
   iv. Over anxious pursuit of medical diagnosis and employing strategies to deal with undiagnosed conditions such as ADHD, Dyslexia, Grapheme Colour Synaesthesia, and
   v. Children's home circumstances being dominated by medical issues and the children living in an environment of deficit and negativity with little hope of recovery from the perceived medical conditions, and
   vi. At times A assuming a 'sick role' to control his home environment and those individuals within the home, and
   vii. The children's home environment and the mother's inability to cope with the same has led to an increase in A's psychogenic and FND behaviour who has since 2017 expressed suicidal ideation, and
   viii. At times B's needs not being met and forgotten, and
   ix. During these periods of significant stress and anxiety, the mother's ability to make appropriate decisions for the children has been significantly compromised.

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E. The mother is unable to reflect or demonstrate any meaningful insight into the impact of her behaviour as found in above paragraphs (save for paragraph C ii.) on the children.

F. The mother clearly loves her children and I do not find that any of her conduct as I have found and set out above was intended to harm her children.