Neutral citation number: [2024] EWHC 3207 (Fam)

Case No: **SA23C50106**

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
Sitting in the Family Court at Port Talbot Justice Centre

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23.04.2024

Before:

MRS JUSTICE MORGAN

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Between:

Powys County Council	**Applicant**
- and –	
AB (1)	**Respondents**
-and-	
BB (2)	
-and-	
CB, DB and EB (3, 4, 5) **(through the Children's Guardian)**	
-and-	
AC (6)	

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Sam King KC and Rhys Evans (instructed by **Powys County Council Legal Department**) for the **Applicant**
James Tillyard KC and Lucy Leader (instructed by **Goldstones Solicitors**) for the **1st Respondent mother**
2nd Respondent father not attending the hearing
Susan Jenkins (instructed by **Legal Services for Children**) for the **3rd, 4th and 5th Respondents**
Joanna Wood (instructed by **Peter Lynn and Partners**) for the **6th Respondent father**

Hearing dates: 19-23 February 2024, 26 February-1 March 2024, 5-8 March 2024

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Approved Judgment

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MRS JUSTICE MORGAN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Mrs Justice Morgan:

1. This judgment is given at the conclusion of a fact-finding hearing. Powys County Council ('the Local Authority') on 9th June 2023 made an application for public law orders in respect of three children pursuant to section 31 of the Children Act 1989. The children in respect of whom that application was made are EB who is now five years three months old; DB who is 12 and a half and CB who is 13 and a half. The allegations on which the Local Authority founds its application for orders, arise out of events and behaviours concerning EB and it is those allegations which have been the focus of this fact-finding hearing.

2. AB ('the mother') is the mother of all three children. It is her behaviour towards, and treatment of, EB on which the Local Authority relies for the allegations it seeks to prove. CB and DB are the children of BB, EB is the child of AC. As far as the threshold criteria is concerned, the Local Authority seeks to prove no allegation in respect of either father.

3. The Local Authority has been represented at this hearing by Ms King KC leading Mr Evans. The mother has been represented by Mr Tillyard KC leading Ms Leader. EB's father has been represented by Ms Wood. Ms Wood and her client have taken an entirely proper approach to attendance at this hearing attending on days when evidence of key importance was to be called but not otherwise. CB and DB's father has been represented during the lifetime of these proceedings and will have the opportunity to participate in any subsequent welfare hearing as may be appropriate but in view of his role in the forensic process and the fact that there was no participation intended by way of either evidence to be given by him or challenge on his behalf to evidence to be given by others at this fact-finding hearing it was neither necessary nor proportionate for him to be represented. It had already been acknowledged that his personal attendance was not required and the responsible approach taken by his counsel to her own attendance is to be commended. The children have been represented by Ms Jenkins, taking her instruction from the Children's guardian. The Guardian and her counsel have participated appropriately in the forensic process and have not sought to sit silently behind a stance of 'neutrality'. I have been very greatly assisted by the very considerable skill and diligence with which all Counsel have approached their respective cases. Each team has presented me with documents of very high quality in advance of the evidence and at the conclusion of the hearing. Each team has approached the task of challenging and testing the evidence with appropriate forensic rigour without straying into the territory of what is sometimes described as exploration. To the extent that there has been exploration, it has been with appropriately charted navigation.

4. The Local Authority in its threshold document dated 7th January 2024 sets out in detailed narrative allegations. That threshold document will appear as an appendix to this judgment. For brevity that which is alleged may conveniently be summarised as follows. EB is a child with a diagnosed condition of epilepsy and associated with it, medical issues. Within that context of a diagnosed and genuine condition, the Local Authority asserts and seeks to prove that the mother i) has presented her, to medical professionals and others as a child with problems more significant problems than she has in reality ii) has medicalised EB and has actively promoted for and ascribed to her what the Local Authority terms the "sick role" by exaggeration, non-treatment of real problems, fabrication or illness induction iii) has reported additional/different

symptoms to encourage further medical attention for EB iv) has shown disappointment at negative findings including by request for further tests or opinions v) has avoided assessment in an effort to avoid negative findings by treating doctors vi) has challenged clinicians and made complaints about how she has been treated to create a defensive medical approach and elicit sympathy.

5. In broad terms the mother denies the allegations made. What has been helpful however is that rather than a flat denial the narrative threshold had been responded to in like narrative form expanding on the denials.

Evidence

6. There is an enormous amount of written evidence. The trial bundle exceeds 6000 pages. There are additionally 3 bundles of extracts of relevant e mail correspondence which the mother has had with medical professionals and others which runs to more than 350 pages. I have read a good deal of the written evidence within that material. I have not found it necessary for the purposes of the decisions I have to make at this hearing read in detail the contact recordings though I have dipped into them and note the affectionate tone of the interaction between the mother and children discussion of family pet rabbit and the like. It chimes largely with the evidence I have from other sources that there are plentiful observations of the mother being a warm and loving parent to her children. I have also read many of the recordings made within the clinical and nursing notes at the time of the events under consideration. Counsel have taken me to those parts to which my attention is especially invited. I have heard oral evidence from the following:

i) Dr ZA, EB's lead treating consultant
ii) ZB, specialist epilepsy nurse
iii) ZC, specialist epilepsy nurse
iv) ZD, Speech and Language Therapist
v) ZE, senior paediatric nurse
vi) Dr ZF, Consultant paediatric Neurologist
vii) ZG, Social worker
viii) DC ZH, the investigating officer
ix) ZI, social worker
x) ZJ, worker from the school/nursery
xi) Dr Curran consultant Paediatric neurologist
xii) Dr Robinson consultant paediatrician
xiii) ZK, maternal grandmother
xiv) ZL, Epilepsy Wales outreach worker
xv) AB, the mother of the children

7. It is not my intention in this judgment to set out all that I heard from those who attended for cross examination. Rather I will make reference when necessary to that which has been of particular relevance, has influenced my thinking and has assisted me in forming conclusions.

8. Dr ZA was the lead treating clinician for EB. He has been a consultant in paediatric neurology since 2007. Within the trial bundle there were entries reflecting his ward rounds and consultation with EB and her mother. He had provided a detailed

statement setting out the history of his involvement with EB and her mother. I have read it carefully. He did not depart from the contents of it in any meaningful way. It is neither practicable nor necessary to set out the contents in this judgment but in it he charts the progress of treating EB and the difficulty he and his team had in making sense of the reports being made to him of seizures at a time when the epilepsy they thought they had managed to balance the medication so as to control. He was also the author of a number of letters of referral to fellow clinicians; had provided a letter of open access to PAU; had contributed to a multiagency referral form. He had taken part in a professionals meeting in relation to perplexing presentations and suspected FII on 14th December. In evidence he told me that he had not had minutes of the meeting but when asked for any record of meeting he found he had a cached teams meeting transcript – produced I understand automatically rather than by request- on his computer and so exhibited that to his statement. From some of his answers in evidence, I infer that he had not checked or been asked to check the accuracy of that transcript.

9. Dr ZA had first met EB in clinic on 16th March 2021. She had been referred to him after she had been admitted to hospital the previous November after episodes of unsteadiness and an admission to hospital when she had been seen to be limping or dragging her leg in December 2020. It was thought there was a neurological component to her presentation, but she was not diagnosed formally with epilepsy until October 2021. By that time two EEGs performed in August and September had been normal - which Dr ZA explained is not unusual since often they fail to capture seizure activity. In October a sleep deprived EEG showed results consistent with the episodes she had been experiencing and of which her mother had provided video recordings. The diagnosis was one of Left Temporal Lobe Focal Onset Epilepsy with Secondary Generalisation and following Todds Paresis. At the March appointment, Dr ZA had been accompanied by ZB specialist epilepsy nurse.

10. My impression of Dr ZA was that he was focussed and appropriately so on EB's best interests. By about March of 2022 he regarded EB's epilepsy as being controlled. On 16th May 2022, in an e-mailed response to a query from the GP practice he described the epilepsy as ‘fully controlled’. In oral evidence he said that this was on the basis of EEG, of review of EB and her clinical state. Controlled in his experience might mean no seizures at all or it might mean a small but acceptable level of seizures and there are always things that increase risk of a seizure in children such as infection raised temperature or sleep deprivation.

11. Dr ZA had, in the course of his treatment of EB been troubled by her mother’s own presentation to the extent that he contacted her GP in early 2022 to make enquiries about her mental health. It was the number of calls and contacts she was making, and he wondered if there was some danger of anxiety. He was reassured by the GP at the time he did so but as time went on I detect signs that reassurance wore thin.

12. By April of 2022 on the basis of the reports he added Lacosamide to EB's prescription. This was on the basis of the information he was receiving (from the mother) about the number and type of seizures occurring. Since the mother lived in a relatively remote place and ambulance response times were poor, he also prescribed rescue medication to be used if a seizure lasted more than 5 mins. He had detailed discussion with the mother about the different types of seizure. I accept his evidence

that both he and the epilepsy nurses explained multiple times to the mother the different types of seizures.

13. EB's mother had been asking for a reduction in Lacosamide. He agreed that Lacosamide was a strong drug to have had to turn to and one would wish to remove or reduce its prescription for a child, but his evidence was that whilst seizures – and in his evidence he said tonic clonic seizures were still being reported he had to balance the downsides of Lacosamide with the need to address the seizures.

14. Over time EB became more and more perplexing to him he could not understand the reports that on high doses of medication she was still having seizure activity. He was not troubled by the fact that EEG examination was clear as often between seizures nothing would be captured. There came a time when he made a referral for a second opinion from Dr ZF. There were a number of reasons for so doing. The mother's behaviour he and the team were finding harder to manage in terms of contacts and she had been keen to have another opinion; he had begun to doubt what he was seeing in his patient and wanted to have the views of a colleague as to whether this really was drug resistant epilepsy; he also wondered if not possible to control by medication whether the ketogenic diet or even surgery should be considered.

15. Just before the mother saw Dr ZF he said he had decided to try reducing the Lacosamide but Dr ZFs view was continue it. She had taken a history from the mother and also found reports of active continuing epilepsy and thought it unwise to reduce.

16. Dr ZA was, I am sure a caring and dedicated clinician. I formed the view that he had been very worried about EB and her presentation. It was put to him at one point that he has not been sufficiently careful with his detailed recording ' I wish I had done better' he said. Nothing in my assessment of him caused me to think he was or had been motivated by animus against the mother.

17. He was I am satisfied, genuinely shocked by the nature and extent of the e mails sent by the mother to ZB. He was pressed by Mr Tillyard KC about the fact that he had expressed dismay at the language used. Mr Tillyard KC put to him that someone reading that would have thought he meant bad language or swearing. That was not the impression I formed of Dr ZA's remark. I did not understand him to be suggesting profanity. I do however regard examples of the mother's correspondence as expressed in terms that those who are caring for her child – and making themselves available to the mother far beyond that which other parents have access to - would indeed find unacceptable. Even though he had taken the view he did of the e mail correspondence he said in terms that in the early stages until about March 2022 he thought they were not unreasonable in frequency. He had, I note very considerable sympathy for the mother's position.

18. He was pressed hard about the fact that the mother had not had lifesaving training after an episode in which EB had stopped breathing. His evidence on this was less impressive than in other aspects. Having said he would get someone to do it he did not follow up on it. Even allowing for the other demands of his caseload that was regrettable. Whilst he was an otherwise engaged and insightful clinician, I formed the view as Mr Tillyard KC asked him about this that he may not have appreciated how strongly the mother felt the need for it.

19. He was also asked at very considerable length about the fact that there had been a delay in the provision of epilepsy care plans. There was disagreement about the care plan which had been provided for the school – only when it had been provided could EB return. Dr ZA seemed reluctant to agree that it had been a school plan. He said that the template was the same one used for various different things. I think that he was wrong when he suggested that it was not, in this case, a plan for the school. The second epilepsy plan to which he was taken in the bundle was one which he ended up drafting himself on December 23rd 2022. This plan was intended not for the school but to signpost and direct those who might care for or be called on to treat EB though unfamiliar with her. The document was constructed in in terms of continuity of care all in one document. Dr ZA had to accept when pressed that the plan had been late in coming and had been produced only when the mother and ZL on his behalf pressed for it and indeed by the time it was forthcoming the mother had already made a complaint about him.

20. In relation to the delay in providing the epilepsy care plans also, Dr ZA's evidence was less impressive than elsewhere. I was unsure what to make of the delayed provision. Although it occupied a very significant part of the cross examination of him ultimately for me the significance of it was twofold. First what if any effect it had on the working relationship with the mother which I will consider later in the judgment. Second as part of my consideration of whether this witness's evidence or actions were affected by animus to the mother and in particular whether his referral for consideration of FII in respect of the mother was a retaliatory response to her complaint. That latter I will consider later but I was satisfied listening to him that he was not someone who had done anything other than try to find a way to do his best for his patient.

21. Following protocol of perplexing presentations there was a meeting convened to discuss the prospect of FII. To the extent that the transcript of the teams meeting permitted a glimpse of the discission it showed as I see it professionals asking questions '*could it be*'. By way of illustration a part which Dr ZA was pressed hard about was whether there was any evidence to support the notion – i.e. if the mother was keeping the child up at night – came about not because it was said this was happening but because a participant of the meeting (not as it happens Dr ZA) asked could that be an explanation. The tone of the meeting it is fair to say had something of suspicion – it was a meeting convened precisely to discuss what were by then suspicions. That is the way of it in FII/ perplexing presentations discussions.

22. ZB was from September 2021 the specialist epilepsy nurse for EB. Although her allocation to EB ran from September because it was dependent on a diagnosis she had first met EB and her mother in clinic with Dr ZA in March of that year when a problem with an intermittent limp had caused EB to be referred to the neurology discipline. ZB had at an early stage provided the mother with an e- mail address so that she could forward video clips of events which might have a neurological component.

23. My impression of ZB was that she too was a committed and dedicated professional who had had EB and her welfare front and central in her thinking. She told me that she was as she saw it the epilepsy nurse for EB. In this respect she differed from her colleague ZC who saw herself as allocated to the family. ZB's view was that it had been to EB's detriment that the peculiar circumstances of Lockdown meant that

Health visiting services who would otherwise have provided support for the family were deployed elsewhere.

24. She had very significant contact with the mother a good deal of it by e mail. She was appropriately challenged by Mr Tillyard KC that there was no written evidence that she had told the mother to stop e mailing. She said that she had spoken to her and tried to encourage her to use the advice line; that she had proposed twice weekly phone calls to the mother to try to manage what was otherwise an oppressive and extensive level of e mail communication but to no avail. I accept her evidence to that effect. Whilst of course I have considered carefully Mr Tillyard KC's point that there is no documentary evidence before me as to this aspect, cases such as this are not determined on paper but include as appears later in this judgment, the testing of oral evidence and I believe and accept ZB's account of this.

25. It was put to her that the mother had understood their relationship as having developed into a friendship. It may be that the mother thought that. If she did I am satisfied that she was mistaken and that as ZB told me, it was not at the time a perception she shared. I reject the suggestion put to her that she encouraged such a perception by 'sharing' with the mother personal details of her life. Examples of this were – a negative PCR test in circumstances where she had been obliged to self-isolate for prolonged period in the public health conditions of the pandemic. I do not regard either the detail of the test or the circumstances of her isolation as 'personal' information at a time when that sort of information was exchanged very commonly. In like form I do not regard either the empathetic recounting of the experience of a mother of a sick child herself or the explanation for absence of the death of her father as being properly characterised as the offering of personal information. To the extent that what is suggested is that ZB encouraged the mother's misapprehension of their relationship as a friendship by offering personal confidences outwith the professional boundaries of their relationship, I reject that.

26. I do regard ZB as having been unwise not to have insisted the mother did not e mail her directly at the frequency with which she did so but I was struck by the answer that she gave to the effect that she did not think there was any prospect the mother would do so and that her view was that she had to find a way to work with the parents of her patients.

27. I accept ZB's evidence that the mother did not tell her of the close proximity of the maternal grandmother living a matter of doors down. I also accept ZB's evidence that the mother gave her the clear impression that she did not have a supportive family and that she was isolated not just in terms of geography and location but emotionally. I believe ZB's evidence that she did not know that EB's father was also in the vicinity.

28. I conclude from listening to her evidence that ZB in her dedicated attempts to do her best for EB, became overwhelmed by how disproportionately time consuming it had become to deal with EB's mother. She was reliant on the reports from the mother which were lengthy, frequent and indicated seizure activity which was not responding to medication. I will consider elsewhere the issue of the mother's communication with professionals. The extent to which ZB worried about EB's situation and about the mother's isolation as a single parent was for me encapsulated in that part of her evidence where she explained that even though home visits were not part of her role and even at a time when Wales was subject to stringent pandemic lockdown

regulations, she sought and obtained permission from her manager to carry out a home visit.

29. There had been some suggestion in the Local Authority opening, and more than a suggestion in the evidence of Dr ZA, that the mother's behaviour had effectively driven ZB to an early retirement. That is not a finding I am asked to make or bears directly on any decision I make in these care proceedings, but it is right to say that as the evidence developed, I formed the clear impression that the circumstances were far more nuanced than that. Mr Tillyard KC with some delicacy explored this aspect with her and the position which emerged was that she had found working this case and the proceedings flowing from it stressful. She said frankly that she was at the stage in her career where the NHS sent out communications to employees nudging them to think about when they might retire, and this had made her do so. She did not think she had it in her to take on another similar case should one come along, and she thought someone younger and with a resilience she felt she lacked would be needed. She does intend now to retire but has not yet done so. At other points in this hearing, I was asked to remember the effect on the mother of living within the requirements of lockdown. It seemed to me that this witness had also been affected by working, and specifically by working this case within the requirements of lockdown.

30. ZC who took over from ZB was I find a straightforward witness who did her best to assist the court. She had seen EB twice and regarded herself as allocated to the family rather than the child. I have later found it helpful to consider the evidence she was able to give about the reporting of seizures when I look at the allegation of exaggeration.

31. In like manner ZD who is an experienced speech and language gave helpful evidence which I have considered as I determine whether the Local Authority has established its case in relation to aspects of swallowing and choking and arising within her discipline.

32. Dr ZF to whom a referral was made for a second opinion saw the mother in September 2022. An arrangement for an appointment had had to be cancelled and before it was rescheduled the mother had taken the unusual step of finding her e mail address and contacting her directly. That step she described as very unusual. It resulted however in a consultation being arranged by remote link.

33. Dr ZF whose statement and letters appear in the bundle did not depart from the views she had expressed. She confirmed the accuracy also of the notes she took during consultation with the mother explaining which parts were direct history or verbatim from the mother and which were her own thoughts and annotations along the way. I found her a very impressive and most helpful witness and will consider later some of the detail of the evidence she added to her written views. From her oral evidence a much clearer understanding was possible of how very difficult and expert the interpretation of MRI findings is. She was absolutely clear that it requires very specialised and particular expertise and that what the scans in this case showed was the subject of much discussion and debate amongst the professionals. She was explicit that there is a real danger of overinterpretation –i.e. taking them as showing something they may not. I found her explanation useful to hold in my mind as I considered how a lay person or a parent might be expected to understand the import of or react to such MRI scans.

34. ZG was a social worker whose involvement in the case lasted a short time from January 12th to February 14th 2023 and who conducted the s 47 investigation. She appeared at this stage to have little independent recall of the case and was reliant, largely, on her notes. She was in particular involved in the visit to see the children at school on 17th January in company with DC ZH as part of the investigation. She had seen EB (then 4) in the company of someone who knew her well (ZJ) when she visited the school. She was satisfied that EB was comfortable talking to them and did not regard it as unusual to see a child at school as part of a s 47 investigation.

35. She was unable when asked by Mr Tillyard KC to give any details of how she and the officer concerned had planned their conversations with the children or shed any real light on what they were hoping to discover. She had to agree albeit reluctantly that although she said the visit had been to make sure the children were safe they must have hoped to get some sort of evidence in speaking to the children though as Mr Tillyard KC put to her it was hard to see from the planning booklet what it was intended to discover from speaking to EB.

36. After the children had been spoken to the police decided to arrest the mother and so she was involved in identifying the maternal grandmother as someone to whom the children could go in the interim. She had not in her limited engagement with EB seen any of the symptoms reported to her but was clear that her meetings with EB had been confined to the day when she saw her at school and then after her mother's arrest when she was taken to stay with her grandmother.

37. She had not known that EB's father lived in close proximity. She had recorded that EB's father had little or nothing to do with her through his own wishes although her memory was that EB had had some contact with her father. I did not find that her evidence assisted me greatly in reaching decisions in this case. Pressed on behalf of the mother she did not articulate what it had been intended would be discovered by speaking to the children – other than from the older children what they could say of life at home. She could not assist with the planning such as it had been for how she and the officer concerned would talk to the children.

38. She had met the mother once during her involvement in the case but had also had discussions with her in the course of which the mother had said that the epilepsy team were covering each other's backs and had made complaints to her about Dr ZA observing that she had asked for a transfer of care.

39. The mother had discussed seizure activity and said she had refused point blank to video a tonic clonic because if she did not support EB's airways she would choke. ZG did not recall if the mother said to her why it was she had been asked to provide a video of EB having a tonic clonic seizure.

40. She could not assist with what the mother had said about frequency of seizures at the time of removal save to confirm the accuracy of a recording she made of a conversation she had with the mother on 19th January

> *AB said that EB's seizures are not her biggest concerns as that is under control. She said she is concerns about her stopping breathing and SUDEP. She said that they reduced her medication in the summer and that's when the sleepy episodes started and they thought it was the epilepsy making her sleepy. Since she started*

> *having the sleepy episodes, she began to get apnoea and choking episodes. There is no pattern to the sleepy episodes.*

41. ZG had had conversations with the mother about the fathers of the children with whom the Local Authority wished to make contact. Once again she could add little beyond confirming the contends of her own note:

> *I explained to AB that I needed to inform both the fathers and AB asked why. I explained that if they have parental responsibility, I have a legal duty to inform them. AB said that EB's father isn't on the birth certificate and CB and DB's dad, BB, doesn't have PR because they went to Court and it was diminished in Court. I explained that we would have to see the order.*

42. DC ZH who had accompanied ZG also gave oral evidence. She has been a police officer for 11 years and has apparently undertaken ABE training. Despite which she was able to give no better account than ZG of the planning purpose and putting into effect of discussion with the children. Nothing meaningful appears to have come from their conversation with EB.

43. Very many of Mr Tillyard KC's criticisms of failure to have proper or any real regard to ABE guidance are very well made. Though I do not agree with him that there was the need for an appropriate adult given the fact that this was a conversation in a s 47 context. I bear those criticisms in mind, to the limited extent that which emerges from the conversations with the older 2 children has relevance. They confirmed it seems what the mother and the maternal grandmother have also said – that EB did not wear a helmet at home. Neither described seeing her choking on food. CB reportedly said that EB had small fits at night and other sorts of seizures but had never seen EB have a seizure, though had seen her in what appeared to be a post ictal state. DB is recorded as having said that the mother had told DB that EB had epilepsy but DB had not seen a seizure. Both knew their sister wore a helmet at school.

44. I did not find either ZG or DC ZH to be impressive witnesses or their evidence insofar as it related to the discussions they had with the children especially helpful. I have been cautious, because of the failures in relation to ABE compliance and the absence of verbatim question and answer, in taking very much account of what the CB and DB are reported to have said. I do not however wholly disregard it and there are two aspects of it to which I attach some weight when I place it in the context of the overall picture. First the fact that the children were spoken to without their mother being alerted (or permission asked) in advance means that there is no suggestion that she can have influenced them as to what they might be asked about or say. Second, given what is recorded elsewhere as to the mother reporting of seizures, it is noteworthy that the 2 childrenliving in the same house did not report having seen seizures.

45. ZJ worked at the school of which EB attended the nursery class. She was sympathetic to the mother and had known her a long time. The older children had been through the nursery also. She readily agreed with Mr Tillyard KC that the mother seemed to be a good and attentive parent to her children. She spoke warmly of EB and was clearly concerned for her. She had been the person who sat in when EB had spoken to the police officer and the social worker who attended the school. ZJ was aware of EB's diagnosis with Epilepsy. She agreed that the nursery had declined to have EB back until there was an epilepsy care plan and the staff had the training to deal with any

seizures EB might have at school. In due course, in March there was such a care plan but there was a time lag until June when the training was given to administer Buccal, the recovery medication. In the interim it was agreed at the mother's suggestion that she would remain close by during nursery hours so that should EB need the recovery medication it could be given. The mother had described to the sort of different things to look for in relation to EB's epilepsy: absences, tonic clonic, focal seizures and drop seizures.

46. The impression that ZJ had had from the mother was that she was lacking in support. The mother told her in September 2022 that EB's health was deteriorating and that her brain was shrinking. As ZJ recalled that episode and how upsetting she had found it she said that she had felt for the mother '*as one mother to anothe*r' and it was this that prompted her to ring ZB to see if there might be some support that the mother could be given. She was surprised to hear from ZB of the high level of professional input which she had not been aware of.

47. She said in her evidence that it had been agreed at the mother's request that should EB fall asleep the mother would be contacted to take her home. This was not something instigated or required by the nursery. ZJ also explained that the Seizure Incident record which formed part of the evidence was a document she had devised following the phased return and was a document completed at the mother's request so that she could use it to show at her appointments with Doctors. ZJ explained that it was to be used to make a note of any seizures or anything that might be a seizure. Those episodes which I have seen in the log within the court bundle and to which Ms ZJ was taken in the course of her evidence have entries which are consistent with the diagnosis EB has. That is to say there are entries of twitching and jerking from time to time. ZJ also spoke of an occasion when she had seen EB take herself off and lie down for what she described (and the mother told her sometimes happened) as a lying down seizure. What was striking in its absence from ZJ's evidence at a similar time the mother was telling Dr ZF that EB was having tonic clonic seizures every couple of days along with drop seizures 5 -6 times a day, was that she had not ever seen such in the Nursery. That might have been surprising in and of itself given her involvement in and around the setting when EB was day to day. It is the more so taken together with her evidence which I also accept that she never had reported to her by anyone else - and nor do I see in the records – drop seizures or generalised tonic clonic seizures.

48. ZJ in my assessment was someone who was trying to help the court and was a fair person. Taken to the records of stumbling and clumsiness, she readily accepted that it was at a level which was more than she had thought and described in her police statement. She readily gave credit also to the mother for the way she had tried to get EB back into nursery pending training for the staff. She was however mystified by the suggestion that EB might need Additional learning need support and had no idea – until she found out at the strategy meeting - that the mother intended withdrawing her from nursey and moving to a different school which could offer that support.

49. The maternal grandmother was someone doing her best to help the court whilst finding herself in the unenviable position of knowing that her evidence was to be relied upon by in part by those who brought the allegations 'against' her daughter and in part by her daughter in refuting them. It was therefore, I find, all the more impressive that running through her evidence was a clear thread of concern for the welfare of her grandchildren, a desire to do her best for them and an effort not to

mislead or jump to conclusions, still less to step outside what she knew or remembered herself and so felt able confidently to say. She and her husband had taken the children in without hesitation when they were removed from the mother's care. They had no notice of the intended removal. I found her account of managing the distress of the older two – which showed itself in different ways in each child and of looking after EB striking and affecting. She described how she took EB into her bed because, knowing her to be a child with the diagnosis of epilepsy, and having herself no experience of looking after such a child she was worried that after such an upsetting day, EB might have a seizure, so she held her close. As it happens, she did not have one. She described her being very jerky at night – now of course she knows much more about myoclonic jerks and seizures. Everything she knew until that point about EB and her epilepsy came from the mother, no one else.

50. Her evidence was that she is close to both her children and has always believed she was supportive to them. There was a time in 2019 when the mother and children were living with her at her home – another occasion when she had taken them in unhesitatingly when the mother's own home became uninhabitable - but even when they were not she saw her grandchildren pretty much daily. She would go to her daughter's home and see them there. EB she told me was running around played in the garden when on the swing (with child seat) slide and trampoline all without wearing or, so I infer, needing a helmet.

51. Whilst heavily involved in the lives of her grandchildren it was not until about the last couple of months before removal that she would take EB out as well as the other two. This was because she was nervous about the epilepsy and knowing what to do if EB had a seizure. It changed about a couple of months before removal for a combination of reasons: the mother was reporting to her that things were improved with EB's epilepsy and she was not having as many seizures, EB was a bit older and it seemed to the maternal grandmother that it was not fair that EB was missing out. She described EB as being '*ecstatic*' when she too was allowed to come on the outings.

52. Since elsewhere the mother had given descriptions of her relationship with the maternal grandmother as being bad and one which did not provide her with support, some of those descriptions were put to the maternal grandmother. I found her response to them – which was a lack of recognition tinged with shock – wholly convincing. The more so as she sought to explain or justify what the mother had said. '*Well all grandparents can be a bit critical sometimes*' she said when it was put to het that the mother reported her critical of her; *'We're both fiery temperaments'* she said when it was put that the mother reported terrible rows in which there had been terrible things said by the grandmother. The mother had said that she and EB had been locked out - this was not accepted though she agreed that because her husband was on nights they did have to be out during the day when he needed to sleep. My impression was that she was hurt by hearing the things her daughter had said to others. As well she might be.

53. Her attempts to explain away what the mother had said foundered at the point when it was put to her that she had thrown out the mother and EB when they were living with her – in the sense of giving her and ultimatum and requiring them to leave. Having said that she might well say 'get out' in the course of a disagreement she balked at the idea that she would throw her granddaughter and daughter out.

54. The significance of what mother had reported of her relationship with the maternal grandmother is that it is said by the Local Authority that she sought to portray herself as without family support. It is my view that the mother did do something of that. I have the impression, and the more so from hearing her evidence, that she sought to present herself to the health professionals as alone against the world, a single mother bringing up her children without friends or support. I accept that the recordings put to the grandmother of what the mother had said about her accurately reflected what had been said by the mother but I find what she said about her mother being unsupportive to be largely untrue and said to attract sympathy.

55. The suggestion that the maternal grandmother had in effect thrown her out on the streets however seemed to me to be so improbable having heard the mother and the maternal grandmother that although I had not heard it suggested by any party , I felt it right to ask the mother about something I thought might go some way to giving it context. The e mail which the mother was asked about which contains the allegation of an ultimatum was sent from the CPN to a third party. I heard no challenge to the fact that what had been intended to be a stay of a fortnight or so with the maternal grandmother in an emergency had dragged on when the Council did not sort out the alternative housing. I am satisfied having asked the mother about her recollection and heard the maternal grandmother's evidence that it is more likely than not that the e mail in which reference is made to the maternal grandmother giving the mother an ultimatum to leave her home by a given date was sent at a time when unless the council understood her to be becoming homeless, it would not as a priority take the steps to rehouse her. I make it clear that to the extent that I have reached conclusions about the way in which the mother described the shortcomings in her relationship with the maternal grandmother and why she gave such descriptions I have disregarded the suggestion that the grandmother would have seen her daughter and grandchildren on the streets or that the mother suggested that she would do so.

56. She was aware of the involvement BB had latterly had in the sense of sending gifts to his child and was astute to the fact that in doing so he gave DB in particular a sense of no longer missing out on what EB was seen to be getting from her father. She was clear that EB's father had been involved (save for the lockdown restrictions which affected everyone) during EB's life. I did not regard her evidence about giving a misleading explanation as to why the children moved to live with her following removal as sinister. She lives in a small community where everyone not only knows each other but as she put it 'knows each other's business'. It was notable that when Mr Tillyard KC asked her whether she was worried that an allegation of child abuse would reflect badly on the family, she said it was not that but answered in terms of what it would mean to the older 2 children who were of an age to know people were talking about them and who would be asked questions if it were known social services had removed them.

57. Once EB came into her care, she had seen some of the symptoms that the mother had reported to her. These she had set out in her statement. She had also documented them in a careful and detailed way in her diary. She agreed with the mother that EB was excessively sleepy and that the Lacosamide was the likely cause. This was borne out when it was reduced and then discontinued when EB was as she put it 'a different child'. She had not seen drop seizures in her care besides the one on holiday in July.

There had been 2 episodes of seizure or fit - one 2nd February and in August though the August one was more doubtful. The myoclonic jerks very noticeable when falling asleep at the start of EB's placement with her had diminished over time. The description she gave of EB was of a child with a diagnosis of epilepsy living with the condition controlled.

58. I found the maternal grandmother to be a straightforward and honest child-focussed witness. It is much to be regretted that she had to be required to give oral evidence.

59. Dr Curran the Paediatric neurologist jointly instructed expert remained of the opinion he had expressed in his report. I had read carefully his report before hearing his oral evidence and whilst he expanded on some aspects, he did not change his views. He had agreed with the original diagnosis of epilepsy and still did, regarding the combination of EEG result observed (by independent parties) seizures and sequelae – Todd's Pareisis, video evidence of seizure as establishing the diagnosis.

60. I found him an impressive, knowledgeable, balanced and fair witness. Nothing of his approach smacked of the dogmatic. He had expressed the view in writing that it was possible that EB had grown out of her epilepsy. Children do. There is no particular age at which they might be expected to do it. He was helpful as I consider elsewhere in this judgment, in his reflections on how one might approach reducing medication. He also gave a clear picture of how terrifying it can be for parents especially in the early days of diagnosis to see their children having seizures. There is much that is unpredictable about the condition and the medication used to treat it. Although as a child came off Lacosamide it would be expected to show in diminishing effects such as sleepiness, it could not be predicted how long that might take and it could vary yet again from one child to another. Given that it was Dr Curran who had thought it possible EB might have grown out of her epilepsy I was surprised slightly to hear him say in the course of his evidence – volunteering it rather than directly asked – that he entirely agreed with an observation made by Dr Robinson the paediatric expert in his report i.e.

> *'the possibility that after 24.01.23 EB grew out of her epilepsy is … unlikely. The severity of symptoms described but not corroborated prior to this included complex generalised seizures, falls, tremors, lethargy and choking. It is unlikely that all these naturally resolved'*

61. Dr Currran drew attention also to the fact that epilepsy is paroxysmal in nature so recovery even after a serious seizure (though serious was not a word he would use) might mean a child seemed fine. This has of course relevance in assessing reports of seizures in the context of seeing a child perfectly well a while later. He also noted that epilepsy very often was not captured on EEG. As with all other clinicians in this case he was explicit that those who treat children are reliant on the accuracy of the history given to them. More than once in describing a step one might take he began with '*if you are sure the history is good...'* With young children is will almost always be a parent giving the history.

62. He was asked a good deal about the change seen in EB in her grandmother's care. She is now a different child in many ways. The reported frequency of seizures before removal from her mother's care contrasted starkly with what has been seen afterwards it was suggested to him even before the removal of Lacosamide. In a child with

epilepsy his evidence was, the expectation would be the seizure frequency would not change because of environment change. Asked to expand on this, his view was that EB's seizures (at the level reported before placement with her grandmother) would not have abated in the way that they did.

63. Dr Robinson is the jointly instructed Paediatrician in the case. He had prepared a report and 2 addendum reports. He was astute to point out that, in keeping with his role in the case, he had not met the mother (or indeed anyone else in the family) and to the extent that he commented on her, he did so on the basis of all he had read and seen. Cases which involve allegations of FII – as here are by their nature complex. Sometimes that complexity stems from the fact that the child concerned had a diagnosed and real health condition, and then part of the examination of the situation involves seeking to disentangle that which is genuine illness or symptom from that which is false, exaggerated or fabricated. He was explicit that he does not take any issue with the fact that EB has epilepsy and is correctly diagnosed with the condition. By the time he embarked properly on his oral evidence he had also seen the video clips and photographs exhibited to the mother's statement. They did not cause him to change his opinion evidence to the court.

64. As with others he did not depart from the views he expressed and the conclusions he had reached. In his oral evidence he recognised again as he had in writing that the mother had demonstrated in relation to her three children some good parenting qualities. He also was at pains to identify that it was his view that the mother was extremely anxious. His overarching view of the situation expressed in his report was that it was one of complexity containing as it did elements of true diagnoses, accurate parental reports, exaggeration and fabrication. Although he was cross examined with great skill for the mother, he had not at the conclusion of his evidence moved from his view that there were elements of exaggeration and fabrication in this case. He reiterated his view that the mother was, as he saw it, an extremely anxious sort of person and sometimes an anxious parent behaves in ways that fit within FII. That does not of course excuse the behaviour or alter the effect for the child, but he regarded it as relevant. He was asked to consider a paper authored by Luke Clements. The subject matter was the effect on parents of being suspected or facing allegations of PII. Reading it and the questions he was then asked about it did not cause him to amend his view. He did not regard the criticisms the paper purported to make of the Royal College Guidance as helpful given that it was from the perspective of a legal academic.

65. I found his oral evidence where he expanded on what is meant by placing a child in the 'sick role' very helpful. Of that he said:

> *'The child has gone to the hospital and M has been given a diagnosis. The doctor tries and explain to child what is wrong, You try to reassure the child that everything is alright, that the epilepsy is well controlled, at least reassuring the child to the best of your ability.*
>
> *My experience and common thinking is that to place child in sick role is different. The child comes to believe that they are unwell. It is to do that but to then constantly reaffirm you are unwell, constantly go on about the fits you are having.*

> *Harm is done if it is unnecessary, even if child is v ill, we always reassure a child in clinic, would be very wrong to tell child you are very sick you may need more treatment*.'

66. Dr Robinson regarded the diminution and reversal of symptoms on placement with a different carer as of significant use in determining whether there has previously been exaggeration or fabrication in play. His evidence was that he regarded there as having been a significant reversal of previously reported symptoms apart from myoclonic jerks in EB since she went to live with her grandmother. He did not discount Dr Curran's possibility that a child might grow out of epilepsy and observed that it often resolves but that a sudden reversal of reported seizures coinciding with a change of residence would be highly unusual.

67. For reasons I am not clear about but no doubt lie at least in part in a change in judicial continuity there was no experts meeting in this case. As I listened to the evidence of Drs Robinson, Curran and also (though not a part 25 expert) Dr ZF I regretted that oversight since it seemed to me very likely that a large measure of agreement might well have been achieved. I accept the analysis and opinion evidence of each of the two instructed experts in this case. For completeness the evidence of the other instructed expert Dr Ellis who was not required for cross examination permits me to find, and I do, that there is no genetic cause which accounts for EB's perplexing presentation.

68. In the discussion section which follows it will be necessary to consider aspects of the mother's evidence in detail in a way which is more convenient than setting it out here and so at this point I intend only to record my impressions. The mother attended each day of the hearing despite the fact that as I was aware there were some serious health issues with a close family member and I had made clear that in those circumstances she would have been permitted to join remotely for some of the time had she wished. She followed closely the detail of the evidence listening carefully, taking notes and drawing her counsel assiduously to matters which (I assume) she regarded as being important. She engaged very fully in the process. When she entered the witness box it was clear from some of her answers that she had a very detailed knowledge of the papers.

69. I had already seen from the papers that it has been recognised by a great many people that she dearly loves all three children. I could see for myself that being kept away from EB because of the allegations she faces is a source of very real pain to her. She was able to give me a short pen portrait description of each child highlighting the differences in their personalities. There are some very positive aspects of her parenting emerging from the report of ISW whose report I had read. Those positive aspects had been commented on favourably by Dr Robinson despite the conclusions he had formed adverse to her in relation to EB. Her well documented interest in academia was reflected in her obvious intelligence and ability. She gave answers which were long and detailed. Sometimes these became verbose, and on occasion did not address precisely the question which had been asked. She was obviously nervous which is unsurprising given the stakes at issue. I noticed that she struggled to answer questions which required her to think about and reflect on what she was being asked. I also sometimes had the impression that she was trying to think through the consequences of an answer before she gave it or trying to think what the next question

might be. She was frank and open about her past struggles in relation to her mental health and she did not say as I know she has suggested to others that it is something which is being in a sense used unfairly against her in these proceedings.

Discussion and Conclusions

70. Having listened carefully to the witness evidence and submissions at this hearing and taking that together with the voluminous written evidence I move now to consider the conclusions I reach. In doing so I have had regard to the relevant and applicable legal framework which is uncontroversial and will appear as an appendix to this document. As is often the case there remains at the end of the evidence much that is in dispute between the parties. It is neither proportionate nor purposive to determine every last disputed point in exhaustive detail even were it possible to do so. It is also the case that for reasons I perfectly well understand and about which I make no complaint the document setting out the allegations made, and findings sought by the Local Authority (and therefore also the response) is more narrative and discursive than in a case which more readily lends itself to a Scott schedule. It is likely therefore that there will be conclusions I reach which are relevant to more than one aspect of that which is alleged.

The Helmet

71. The fact that EB wore a helmet at school is an aspect of the case which has assumed a greater prominence as the hearing continued. The mother time and again in her oral evidence and in her responses has relied on the fact that it was a requirement of the plan and indeed the only way in which the school would allow EB back into nursery and that it was not something she had wanted. To a superficial extent that provides an explanation, but I find that the fact that it came to be in the plan at all is as a result of the mother's reporting of drop seizures and so the reliability of that reporting falls to be considered.

72. The helmet is specifically related to the risk of drop seizures. A drop seizure is not a subtle manifestation of epilepsy which is hard to spot or requires expertise to interpret. Dr Robinson in both his written and oral evidence made the point that the wearing of a helmet, is something which would be reliant on drop seizure reporting. He had noted in his report that the helmet was not needed at home and that EB's siblings when spoken to did not say she fell at home.

73. As with so many aspects of this case, it is important not to lose sight of the fact that EB does have a properly founded diagnosis of epilepsy. It is not the case that she had *never* had drop seizures. They had been observed by people other than her mother. Her grandmother had seen three. Most recently whilst EB was on holiday and in her care. Before formal diagnosis the mother says that there had been a drop seizure at nursery in September 2021. There are no recordings of drop falls at nursery. Mr Tillyard KC submits that although ZJ from the school could not remember it, and there were no notes of any, she accepted it was possible there were other drop seizures. I do not regard that passage of cross examination as one on which I can rely to find that it was more likely than not that there were drop seizures at nursery and I reject the submission that there were drop seizures there, but they went unrecorded. In about September of 2022, when the seizure record began to be kept at the school, no drop seizures were included amongst the recordings of observations that were or

might be seizures. I hold in mind the evidence I heard from ZC when asked the level at which she would expect a child to be experiencing drop seizures before prescribing helmet – that it would be very often, *'daily'*. I am satisfied on balance of probability that it was nowhere near this level. I do not accept that, were it happening as frequently as the mother says, it would be the case that her siblings did not see it at home or that the nursery did not see falls there (as I accept on the evidence and consider elsewhere). Nor do I think it more likely than not that the maternal grandmother would have seen only 3 occasions as she told me had been the case.

74. I am satisfied that the Local Authority has established that the mother caused EB to wear a helmet unnecessarily in school. The fact that, as the mother points out as part of her denial, it continued to worn at school until September 2023 whilst EB was in the maternal grandmother's care is reflective of the requirement remaining in place until the plan was changed rather than an indication that EB needed it.

Exaggeration of seizures

75. Although they come after the plan for the helmet was in place, I have reflected on the most useful and detailed notes of the history taken by Dr ZF from her consultation with the mother on 13th September 2022, where she records contemporaneously the mother telling her that EB had '5 – 6' 'drops' per day. I find that was exaggeration. I find it was a lie. When I survey the totality of the evidence, I find that in relation specifically to drop seizures the mother has exaggerated to so great an extent that it goes beyond exaggeration and is more properly characterised as fabrication.

76. I have reflected on Dr ZF's evidence in relation to the finding I make in respect of the helmet but it is important evidence also as to whether, and if so in what respects, the mother exaggerated reports of EB's other seizures and the consequences if she did. At the same consultation at which the mother was reporting to Dr ZF that there were 5-6 drop seizures each day she also told her that EB was having generalised tonic clonic seizures (GTCS) every couple of days.

77. Similarly I find that the frequency of the GTCS she reported to Dr ZF was exaggerated. At about the time the mother was reporting to Dr ZF a very worrying level of seizure activity which would place EB on the spectrum of concern at the more worrying end - 5 –6 drop seizures a day; every second day GTCS - the log at her school was reporting nothing of the sort. It is noteworthy, against the backdrop of ZJ's evidence which I accept, that the seizure incident log was something the mother asked the school to keep so she could produce it to the treating doctors, she did not in fact do so. Had she produced the seizure incident log to the doctors what that would have demonstrated was a child with controlled epilepsy and not a child with the seizure activity the mother reported. The mother had been asked to provide video footage. Some she did provide, and Dr Curran notably regarded the 3 or so recordings she did as being quite a high level of recordings in comparison with many parents. What was captured however was the not GTCS which the mother reported happening so frequently. I do regard that as surprising. At this hearing I heard that although in the early days when parents are frightened and as both Dr Curran and Dr Robinson acknowledged it looks like their child is dying, as they get used to the fact that the GTCS are something the child comes out of, parents are able to record them as they last long enough to capture them. The more so now almost everyone has a smartphone to hand. Although I find the dissonance with that which was not seen at school more

helpful evidence as I assess this aspect, I do also regard it as telling also, when added to that, that the mother did not record the GTCS she was reporting.

78. I find that on the balance of probabilities EB was not experiencing seizures at the level the mother was reporting. Had she been, it defies reason they would not have been seen at least some of the time at school. I have examined carefully the recordings in the log kept by the school. It follows and I so find that the mother was over reporting the seizures. The over reporting represents at least exaggeration. The contrast between what was reported to Dr ZF and what was seen and recorded at school at the same time raises my suspicion that, as with the drop seizures, it may be likely that it contains elements of fabrication. I am however less certain of this than I am in relation to the drop seizures reported at the time and so whilst I find she exaggerated the GTCS I do not make a positive finding that it was more likely than not that the mother fabricated in this respect. Nor do I think it is necessary to strain to reach a firm conclusion as between exaggeration and fabrication. For those in the field of the paediatric diagnosis of the child and or the psychiatric diagnosis of the adult, where one blends into the other is likely meaningful. For the purposes of this Court, whether the mother exaggerates or fabricates, the real significance lies in what that means for EB's welfare.

79. The prescription of medication to control the epilepsy is in very large part dependent on an honest account from a parent or carer. Put simply doctors rely on parents to be truthful in the accounts they give. The medication as I heard from Dr Curran, Dr Robinson and Dr ZA is not without risk or side effects. I was very struck by Dr Curran's observation that from his own perspective he would always medicate if there were seizures and wouldn't conduct a cost benefit exercise but some paediatricians would. He thought it such a difficult area that it was hard to say what would be the view of a reasonable body of paediatric neurologists on whether there should or should not be a cost benefit analysis. EB, who did have a proper diagnosis of epilepsy, was on 2, at times as many as 3, anti-epilepsy medications. It was the exaggeration and or fabrication by her mother that led to this. The doctors relied on her to give a true account. She did not.

80. The exaggerated reporting of seizures is reflected elsewhere in the months following the consultation with Dr ZF. At a brief admission to PAU on 24th October 2022, in relation to an infection the background history is given 'Epilepsy seizure every day'. The senior specialist SALT, ZD records on 18th November 2022 (in the context of making arrangements for a SALT assessment) the mother reporting to her that tonic clonic seizures started last year and that there are daily seizures which can come in clusters. I note also that at a neurology review 3 days later on 21st November as to seizures what is reported is *"up to 1 –2 [on] good days then bad days – multiple drops (swift recovery)- brief myclonic jerks last < 1 sec – can be subtle – GTCS in cluster over several days (daily) then up to 2 week between".* As I read that recording recalled the maternal grandmother's evidence that it had been towards the end of the year that she had been willing to take EB out with the otherchildren because of the improvements with EB's epilepsy.

81. I have had to think about the way in which what is said is recorded in the records. In a number of respects submissions are made on the mother's behalf that if something is

not recorded in a note, or a note is not available, then I should not accept a witness's recollection or statement. One such instance comes in relation to the statement of ZC for this hearing. In it she says that the mother reported a previous 24-hour period where EB had a cluster of seizures including 30 drops the previous day. She relates a conversation about asking whether there were injuries since 30 is a lot, and reports an explanation from the mother as to why there were no injuries as mostly the drops were from sitting. The submission is made that it is inconsistent with an e mail to ZB of the same day which reports a cluster of drops, a huge amount of myoclonics and does not include reference to 30 drops. It is said also on behalf of the mother that there is no mention there of a clonic tonic at all. It is notable to me that it refers to the child having had a tonic clonic at 11. I have thought long and hard about whether I should reject Ms ZC's statement about the 30 drops on the basis of there being no record to support the conversation and the fact that, as it is put for the mother, it '*flies in the face of this contemporaneous record from that we do have from [mother]'* I am wary of regarding the mother as a reliable historian such that I may take an e mail from her as a contemporaneous record. This instance is not one where there is a small difference in the account of something: for example ZC recalling the mother saying something happened 6 times and the mother saying she only said 4 and relying on an e mail sent as supportive. There is a reason why cases such as this are not tried by simple reference to the very large number of papers filed. The advantage I have as the trial judge is to see, hear and assess the witnesses as they give oral evidence and are cross-examined. It was my assessment that ZC was an honest witness doing her best to assist the court in her evidence. I have not formed the same view of the mother. It would be quite wrong, because I have disbelieved her and found her to have been unreliable in other respects, including giving an account to Dr ZF that I find to be false about the number of daily drop seizures, to work on the basis that she is therefore unreliable or untruthful wherever her account conflicts with that of another witness. I do not take that blanket approach, but in relation to this aspect of the evidence I do believe, accept and prefer Ms ZC's evidence that she was told there had been 30 drops. I do not think she added the detail of asking about injuries as it seemed like a lot for any reason other than because that is what she was told and that it was indeed a large number and so that is what she asked.

82. I find that the mother had over reported and exaggerated the number of seizures EB was experiencing. I accept the submission of the Local Authority that the mother reported to the epilepsy advice line on 17th January that EB was having tonic clonic seizures every night. I reject the mother's account that references by her to tonic clonic seizures were very often mis-recorded by others. I reject also the mother's explanation coming late in the day from the witness box that when she was talking of seizures she meant myoclonics and that she did not until the day before she was arrested know the difference between Myoclonic jerks and seizures. Whilst reliance is placed on the e mails shortly before her arrest, I do not regard them as undermining the evidence of Dr ZA which I believe of the multiple explanations or the other recordings where this intelligent, well informed and researched the mother is clearly able to distinguish. By way of illustration the neurology review on 21st November. I accept the closing submissions of the Local Authority on this point. Furthermore, I have had and taken the opportunity to assess the mother giving her oral evidence on this point, and I do not believe her.

83. The significance of the mother's misreporting to Dr ZF is underscored by the fact that it was as a second opinion clinician that she was being seen. Part of the reason Dr ZF had been selected (by Dr ZA, not the mother) was her expertise in ketogenic diets. It is recognised that a ketogenic diet is a step to be taken only if it is warranted because the epilepsy is serious and unresponsive to medication. It is a reasonable inference to draw that someone as well informed as the mother would be aware of this this. She had already assiduously sought out information from the Matthew's Friends website and the Daisy Garland website to which Dr ZF had intended to refer her. It was from one of those websites that she obtained Dr ZF's direct (professional) e mail address so as to contact her to remonstrate about the cancellation of an intended consultation. The fact that Dr ZF put EB on the list for ketogenic diet treatment is not as the mother seemed to suggest the same as saying that it was her idea. It was a direct consequence of what the mother reported to her and of what she understood from Dr ZA, EB's consultant. Interestingly, when asked on behalf of the mother about the fact that she had been asked to consider whether EB should be referred for a ketogenic diet Dr ZF responded *'Dr ZA asked me if it was appropriate as the mother has been asking for it'*. Elsewhere I have considered the extent to which Dr ZA explained the reliance that he and EB's epilepsy team had on accurate reporting. Mr Tillyard KC and Ms. Leader were right to remind me in their submissions by reference to *Sunderland CC v AB (Re-hearing: Factfinding : Expert or Professional evidence) 219 EWHC 3887* that the evidence of those involved as instructed experts and those who come to the case as treating clinicians bring somewhat different qualities and one potential 'drawback' of treating clinician is that they may have formed a relationship with and view of the patient and parent. I held that caution in my mind when re-reading the evidence I had from Dr ZF. In a sense she occupies the ground between the instructed expert and the treating clinician contemplated by Williams J in *Sunderland*. There was certainly no back history, disputed or otherwise, between this doctor and the mother.

84. One consequence of what I find was the mother's over reporting and exaggeration of seizure activity was that Dr ZF thought it right to place EB on the list for ketogenic diet. Another was that it meant that Dr ZF, taking the mother's account to her as accurate, formed the understanding that the situation on which she was advising was one of uncontrolled epilepsy (making EB a candidate for the Ketogenic diet) since she was simultaneously hearing that EB was on Lacosamide and sodium valproate but nonetheless experiencing 5-6 drops a day and GTCS every couple of days. Within that context it is unsurprising that Dr ZF was alarmed when the mother expressed concern about the sleepiness which she thought the Lacosamide brought about, and wanted a reduction. Dr ZF was clear that she could not step into prescribing or withdrawing of medication in any event as that was not her role. She also fairly accepted that the impression she had at the time, that the mother might have been thinking to reduce the Lacosamide levels without reference to Dr ZA was misplaced.

85. From other medical professionals I have heard of the way in which medicating - and reducing medication for the management of seizure activity requires most careful consideration. I did not detect any disagreement between Dr Curran and Dr Robinson or for that matter from Dr ZA, that it would be desirable if safe and indicated clinically to reduced dosage or remove a medication. From Dr ZA I heard that it would be preferable to manage epilepsy with as few medications as possible – so to be on 3 was not ideal. I did not regard the evidence I heard from Dr Curran as contrary to that. All doctors from whom I heard recognised the association between

viral illness, temperature spikes and breakthrough seizures even on medication. It is not well understood scientifically why that is so. Reduction in particular is something about which as appears earlier Dr Curran said it would be hard to get a consensus paediatric neurologist view. Elsewhere I have indicated my clear impression that his own position is that he would almost always medicate if there were a risk of seizures. Dr ZA on the other hand spoke of the balance between side effect and seizure control. This he had apparently expressed to the mother as *better sleepy than seizure* something for which he appeared to be criticised somewhat in cross examination. It was not my impression that he had intended it flippantly in expressing it in that way. There was a seeming consensus that the most important sign that reducing/withdrawing anti-epilepsy medication was clinically indicated was that a child had become seizure-free or seizure-controlled. By way of illustration Dr Curran spoke of it being appropriate to seek to reduce or withdraw where no seizures had been seen for 12 perhaps 18 months. What emerged from all those medical professionals qualified to express a view, was that it would be against a backdrop of controlled or diminished seizures that reducing medication would be contemplated. So it is that when the mother has said several times at this hearing that she was repeatedly asking for the Lacosamide to be reduced, that must be seen in the context of her exaggeration of the seizures which it is being prescribed to address and which on her reports are not well controlled. This part of the evidence has echoes of the way in which the mother characterised the helmet as not being at her request but because it was a requirement of the safety plan, without acknowledging that others relied on her reporting.

Communications with professionals

86. There is a good deal of evidence about the mother's unboundaried approach to contacting professionals. Mr Tillyard KC has most effectively cross-examined ZB to the effect that (though he did not put it as crudely as this) she in a way brought it on herself by not rebuffing the mother when she overstepped the mark. There is some force in that. It was suggested that she had never for example told the mother not to contact her so frequently or to make use of the helpline and that although she had said this in her statement, one could see this did not feature in the run of e mails. She was clear that she had on occasion spoken to the mother over the telephone. Inevitably (and properly) she was challenged on this and asked if there were any notes of such conversations. Inevitably (and properly) a complaint was made that none had been produced. ZB did produce her own notes which included such a conversation on 28 July 2022. It is submitted on behalf of the mother that it is an important omission that in the note (as distinct from the statement) there is no mention of the advice line being the '*appropriate*' way for the mother to contact ZB rather than to e mail. I agree that for this mother, the fact that ZB suggesting (as the note records) that she ring the advice line rather than e mailing is unlikely to have had the same impact as being told that to do otherwise was not '*appropriate*'. It is likely, I think, that ZB was doing her best to deal kindly with the mother when she reasoned with her that were she for example on leave then e mailing her would not work. Reading this note, I do not think a reasonably insightful person could have failed to see what ZB was saying was that she did not want the mother to keep e mailing her. I have not formed the impression that the mother was such a person and it is also my impression (shared I note by Dr Robinson when he gave evidence but not by the mother in hers) that she is someone with high levels of anxiety. I therefore agree with Mr Tillyard KC that the note does

not say quite what ZB's statement does and also that for this mother, that made a difference to what she took from the conversation. Whilst elsewhere in this judgment, I have not found the approach taken on behalf of the mother that if something is not in a record or a note I should not accept the evidence of a witness in this instance the submission is well pitched.

87. I see also that the note, which Mr Tillyard KC suggests is the better and more reliable account of ZB's conversation contains the suggestion to the mother immediately before that ZB would ring at the beginning and end of the week for updates. To me, the mother said that no such thing had ever been suggested and that had it been she would have welcomed it. I reject her evidence on both those points. The note also records the mother responding to the suggestion that she should ring the advice line, that she had deleted the advice line number - I regard that, if true, as an extraordinary thing for a mother in her position to have done. It records also that she deleted it as she does not feel able to leave a message. It is hard to see why that was so, but it inclines me to the view that at this time, for this mother, the focus was on her own preference and convenience. In her oral evidence, as part of explaining why she had not taken a firmer line, ZB had said that she had a memory of the mother in this conversation saying something to the effect that she had her own ways. That too I see reflected in this note.

88. ZB was an empathetic and concerned professional. She almost certainly should have been firmer with the mother at an earlier stage. Hindsight is however quite different. ZB believed the mother on her own account to be isolated and alone (she was not). Without family support (she was not). It is also the case that ZB's role involved her building a relationship with the parents of her patients. I bear in mind also that since much of the mother's dealings with her were during the pandemic that was something that skewed boundaries on both sides as work and home distinctions were less keenly apparent. Nevertheless and allowing for all that I regard the mother as having taken advantage of ZB's openness to her. She certainly I find was resistant to taking the route of ringing the helpline and waiting for a call back. I accept that Mr Tillyard KC is probably right when, as he put to more than one witness, the mother regarded the relationship as having developed into a friendship. Having heard ZB's evidence I am satisfied that that was not her perception of it. I accept Dr Robinson's evidence that the volume of the communication and the reporting of the symptoms was excessive. I have thought carefully about Mr Tillyard KC's well pitched point put fairly to more than one witness that the e mail traffic with ZB was not all one way. ZB would respond – which given her role is not perhaps surprising but she would also as Mr Tillyard KC points out sometimes initiate contact with mother asking how EB was. She did so within the context of understanding from the mother's reporting to her EB's epilepsy to be unresponsive to medication and high level of seizures to be continuing notwithstanding that.

89. I am cautious about trying to identify what would be a reasonable level of correspondence for a parent of a child in such a relationship with a professional for no two children's epilepsy will be identical and no more will any given parent's responses be the same. I also hold in my mind Dr ZA's oral evidence that in the early time following EB's presentation and then diagnosis it was not unreasonable for the mother to be in contact frequently with the specialist epilepsy nurse. The order of magnitude between the level at which this parent e-mailed and made contact as

compared with the next most frequently corresponding parent is however telling. I am satisfied also that ZB came to find it oppressive and overwhelming. I do not find that the mother intended the effect it had on ZB, nor do I think it is even likely that she was aware of it. She appears to me to lack the insight into how the way she behaves affects others. I have in reflecting on this aspect wondered if it is fair to draw firm conclusions from the different approach the maternal grandmother took to communications with the epilepsy services when she assumed care of EB. Her communication was far more limited even although she was very nervous taking charge of a child who she understood to have a serious health condition which she was not used to managing. I have stepped back from relying on that contrast, essentially for two reasons. The first is that the grandmother was entirely candid that the fact that she was as she put it 'petrified' that the children might be removed from her and placed with strangers meant that she did was afraid to make frequent contact with medical professionals for help when she was worried about whether something might be wrong with EB. There is evidence that she needed and was given reassurance by the social worker about this. The second reason is that the maternal grandmother is somewhat different in character and personality. Even when given reassurance by the social worker she instinctively 'saved up' observations to ask about in one session rather than calling daily because she said she didn't want to be 'a nuisance' and she was, she explained, also someone who felt that you had to trust what the doctors said. For those reasons whilst I have found the comparison with the level at which other parents whose children were part of the caseload of the professional concerned helpful and illustrative, I have not found the comparison with the maternal grandmother to be so.

90. I was struck also by the fact that Dr ZF characterised it as very unusual for the mother to have made contact directly with her by e mail in the way that she did. There was similarly an initially high level of e mail traffic sent to ZI who described the constant 'pinging' of her laptop as unexpected e mails came in in large numbers from the mother over and over again as she was in a meeting. Her evidence was that it started the day before she was allocated formally once the mother had been told. She told the mother to stop and it seems that largely thereafter she did.

91. The e mails to which Dr Robinson was referred in evidence which came at a time when the relationship between the mother and the treating clinicians was breaking down were in character hostile and destructive. When the FII meeting was convened on 14 December, Dr ZA complained about the language the mother used. He was challenged in cross-examination about this aspect of his contribution to that meeting and much of the challenge was rooted in the assertion that the mother had not used profanity or bad language at any point. I had not read Dr ZA's remark, recorded on the Teams transcript about the language as meaning that. I do regard the language of 'gaslighting' likening situation to domestically abusive relationships, saying to ZB that she was 'done with' her as unacceptable. I observed the effect that it had had on ZB. I note elsewhere that the mother is recorded in hospital notes of an attendance at PAU saying to those medical and nursing professionals dealing with EB, that she would rather work as a prostitute than work in the NHS, that animals are treated better than children , that they can all sleep at night whilst she is left to pick up the pieces, that EB lost her skills and she is left to pick up the shit. As it happens I agree with Mr Tillyard KC's overarching point on this, that what language the mother may have used does not really bear on the decisions I have to make at this hearing but since it

was put so strongly to Dr ZA that he was wrong to comment on it, I make it clear that I disagree.

92. What then to make of this aspect of the case? Part of the reason why the communications matter is their content. The symptoms she was reporting and the picture of EB she was presenting knowing the reliance to be placed on them. She was reporting multiple symptoms over multiple e mails. Some repeats of the same, some new. Whether they were happening or not is, as Dr Robinson observed, another thing. I have elsewhere made findings as to exaggeration of seizures. The excessive and unboundaried quality of them is something other and even the mother acknowledges that aspect is striking looking at them as she does now from the end point of the witness box. I have not found it helpful to take a mathematical approach to adding up the number of e mails and symptoms in the way that the Local Authority does, or to add up the number of responses as Mr Tillyard KC in the course of the hearing invited various witnesses to. To the extent that it is necessary to determine for the decisions I must make in this case, why it was that the mother communicated in this excessive and unboundaried way with professionals, I think it is likely that the roots lie in anxiety. Whilst the mother told me that she did not think her anxiety had been affected by the pandemic and living under lockdown conditions, it may be that it was. I acknowledge that I am in danger of straying too far into speculation and go no further than to observe that the period of the pandemic was one which is widely regarded as re-igniting difficulties for many whose past mental health profiles included elements of anxiety. It may be that the behaviour is a manifestation of anxiety. I am wary of coming to a firm view on that when, first of all the expertise to do so almost certainly lies in another field and second, it is does not much matter in terms of the effect on EB and her treating clinicians. The effect I find it had was to jeopardise EB's stable continuity of care by e.g. having to have the specialist epilepsy nurse changed. I do not find that it was the mother's intention to bring that about by the correspondence. There is in fact clear indication in the e mails that she was displeased and vexed by the change of specialist epilepsy nurse. She did, however later request a change from Dr ZA and his team.

93. The allegations that the mother has exaggerated or fabricated accounts of EB choking and having an unsafe swallow calls for careful examination. Coughing and spluttering is a common observation in small children, and it is very often not a symptom of a medical condition but a symptom of being a small child. I was impressed by ZD the speech and language therapist who by way of update told me that she has closed her file to EB, since April 2023 so far as eating issues are concerned and to the extent that colleagues in SALT are to see EB it is for slightly delayed speech. She has seen her only once and fleetingly in passing since April 2023.

94. On 14 September 2022, EB was brought to a West Wales Hospital. The history given by her mother was that she had choked after a seizure earlier in the day and was said to be spluttering when drinking. I accept that there was no observed difficulty during her admission. ZD agreed when asked that very often admissions show only a snapshot of difficulties. Having heard and reviewed the available evidence of this admission I find that the Local Authority has not established that the mother was exaggerating or fabricating the account of a choke at home. To be clear, whilst I have already made findings that the mother was exaggerating the seizure activities at this

time, it does not follow that everything else she was reporting in all domains of health therefore was or must be exaggeration or fabrication.

95. On 21 November 2022 at review where varying seizure activity was reported, the mother gave an account of episodes of choking on liquids. A note was made that there would be a SALT review on 7th December 2022. Whilst the Local Authority contends the account given is exaggeration, I don't, on my review of the evidence see that the description is inconsistent with what ZD told me was mild mistiming on swallowing. It follows that I do not find that to be an instance of exaggeration or fabrication.

96. The SALT review on 7th December 2022 which was undertaken at home showed that she has a slow and minimal intake with some mistiming of swallow. This, ZD contrasted with the reported information from the mother which was that she was presenting with fluctuating oropharyngeal dysphagia and a significant risk of choking. In her oral evidence ZD said that because very often when SALT clinicians see children to assess eating and drinking the problems aren't evident, the professionals are reliant on the reporting of the parents. The reports count for a good deal in any SALT assessment and diagnosis.

97. What the mother said to her of the presentation that day was that it was EB at her best. Within that context it has been suggested that this is an example of the mother being disappointed by a more positive outcome than she hoped for. I see why in the landscape of this case the Local Authority suggests that but in my judgment it reads too much into what the mother said. I take however a very different view of examining what the mother said to ZB the following day in her e-mail reporting this review.

98. I am satisfied having heard ZD's evidence she did not say EB had lost her safe swallow. She had had a conversation with the mother which included reports of daily seizures and following on a deterioration in swallowing and difficulty eating. ZD had said she would speak with a dietician about the best plan. She was a careful and fair witness. She did not think she had mentioned a nasogastric tube but when asked if it had been *possible* that she did mention it she agreed that she might have said hypothetically in a worst-case scenario on EB's worst days a nasogastric tube might be needed if for example a child was in paralysis. She was however completely clear and immovable that she had not mentioned the possibility of a PEG. I accept that she did not.

99. What the mother reported to ZB of this meeting included that

> *It looks like EB has lost her safe swallow and is aspirating* and that
>
> *Salt has said she may need NG/PEG moving forward as doesn't feel safe diet alone is going to work*

100. I accept ZD's evidence and I find that what the mother reported to ZB does not accurately reflect what was said to her. I accept the Local Authority submission that set against the evidence at the time from those who were seeing EB eating and drinking at nursery (obtained by ZB as soon as she received the mother's account of the SALT review) the reference to the loss of a safe swallow did not fit with that.

More troubling however is the misreporting and exaggerating of what ZD said. I reject the mother's explanation from the witness box that ZD used interchangeably the terms nasogastric tube and PEG. I reject also the mother's oral evidence that it would make no sense for her to give a misleading report when she knew that in due course a report would come. I see the objective sense of that now as may the mother but rather as with the way in which the mother now sees the volume of her e mail correspondence, time and distance may give a different perspective.

101. I find that on this occasion that the mother exaggerated and misreported both in relation to EB and in relation to relaying what one medical professional had said to her of EB's condition and likely medical needs to another. I regard this as a potentially dangerous escalation. It is unsurprising to see that ZB was alarmed by the mention of the NG and PEG and forwarded the communication to safeguarding (as I accept she did) because she was troubled by the escalation of reported symptoms (as I accept she was).

102. On 20th December 2022, the mother rang for an appointment to her GP practice reporting that there were *swallowing issues* which so the record relates she said had been *ongoing last few weeks.* At the appointment timed about 30 mins later, she is reported to her GP that the SALT assessment of dysphagia left her struggling to get hold of a consultant and she felt she was being left alone in and unsafe position. She reported also that there were *severe apnoeas.* On the evidence I have heard and read I am satisfied that the reference to severe apnoeas in December 2022 is on the balance of probability exaggeration as is the reporting of the swallowing issues set in the context of the SALT review and what had been learned from the school.

103. The effect of the exaggeration to the GP on this point was to generate a letter to Dr ZA seeking 'closer monitoring due to her significant problems of apnoea and dysphagia' and reporting the mother's feeling that the health system had abandoned her.

104. I am satisfied that on the balance of probabilities the Local Authority overarching submission expressed in terms that '*the mother had exaggerated the level of difficulty and misreported what she had been told by SALT prior to EB being placed with her grandmother'* and I so find.

105. There have been suggestions – reflected for example in 2 d iii) of the threshold – that the mother withheld or moved out of reach food and drink which EB wanted and/or was reaching for at a time when she was reporting that her daughter was unwilling to eat or drink. I have examined carefully the evidence said to support this contention. I am not satisfied that the Local Authority has established it on the balance of probabilities.

Sick role and Medicalised

106. In the document filed on behalf of the mother at the outset of the hearing it was suggested that she did not understand what was meant by putting EB in the sick role or medicalising her. Even if that were so at the outset of the hearing, I am satisfied that having heard the clear evidence of Dr Robinson on the point she understood by the time she came to give evidence herself. Ms King KC asked the mother a perfectly straightforward question about how, if it were the case that EB had been placed in the

sick role, EB herself might have felt about it and been affected by it. The extent to which the mother struggled with the question was very striking. She was not dissembling when she said that she was confused and could not think straight; she was completely flummoxed. I thought it appropriate to give her a short break, stepping out of the witness box to calm herself, think about the question and gather her thoughts. The question laid bare her lack of empathy. Her difficulty in even beginning to answer it – requiring her to think about it and reflect, rather than to look for an answer in the documents or cross reference was such that even after the break to collect her thoughts and reflect she could manage only formulaic words of response *emotionally damaging and harmful to her*.

107. I am satisfied that the Local Authority has established on the balance of probabilities that EB was put in the sick role. The fact that at school EB wore a helmet marked her out. The mother in evidence spoke of decorating the helmet because EB did not like having to wear it. She was for some considerable time treated differently from her siblings in relation to days out with or sleepovers with her grandmother – because of her grandmother's understanding of her epilepsy. Epilepsy her treating clinicians regarded as controlled. The Grandmother was explicit that her only source of information about EB and her epilepsy (before she assumed care) was the mother. I regard those aspects of her life as having been emotionally harmful to EB. I am not persuaded it had reached the point that the harm she had suffered reached the threshold of '*significant*' harm. In respect of this finding whilst I accept the Local Authority has established that EB was placed in the sick role I conclude that in so being placed EB was *at risk of suffering* significant harm.

108. I furthermore accept the evidence of Dr Robinson on the seriousness of this finding as he articulated it, not only in terms of the understanding others have of her - health professionals, other children at school, those teaching her, her own grandmother - but critically the understanding the child has of herself. The prospect of a child coming to believe something that is not true of herself carries with it serious emotional and psychological risk. To illustrate by way of an example at the far end of the spectrum of harm and removed from the factual circumstances here: a child repeatedly characterised as one who cannot walk or eat may needlessly find themselves PEG fed and wheelchair reliant because they too come to believe it to be so. I accept Dr Robinson's evidence that medicalising – that is bringing children for medical attention to professionals is harmful. Doctors will try, he said to say to a child who comes to a hospital for diagnosis something like *well yes you have epilepsy but its well-controlled and everything from here on will be ok* .If there are repeatedly presentations, reassessments investigations, parents constantly on the phone about it then the child becomes medicalised. An older child may worry about losing a medical support system. A younger child who is medicalised can be highly anxious and believe they are unwell when they are nor, or more unwell than they are. That is why this is not a makeweight finding sought by the Local Authority but a serious aspect of the case brought. I find it established.

109. The assertion that the mother fabricated or exaggerated symptoms that EB's shoulder was catching and clicking in May 2022 and made additional claims including spasticity and stiffness in August of the same year has been little explored at this hearing. The Local Authority contends that the mother sought unnecessary medical intervention for EB by this route. Viewed through the lens of FII it has aroused

suspicion. The mother said that she was given advice about physiotherapy and followed it and denies exaggeration. I have examined carefully the written evidence in respect of this aspect. I am not satisfied that the Local Authority has discharged the burden of proof in respect of this allegation and accordingly I make no finding.

110. The allegation that the mother sought to evade assessment of EB when she knew that the results would cast doubt on her reports has been the subject of detailed examination of the evidence and submissions at this hearing. There has been a particular focus on the planned VEEG in the latter part of 2022. I have read carefully the e mail correspondence to which Dr Robinson was referred in relation to the VEEG which the mother wanted done at home and the professionals in hospital. It was notable that none of the clinicians and experts who gave evidence and were asked, regarded it as a procedure that should be undertaken at home. Dr Robinson volunteered that he had never heard of it being done outside hospital.

111. There was, it is true, a degree of prevaricating by the mother over the issue, but the starting point of the cancellation is not one that can fairly be laid at her door. It has its roots in EB coming down with a virus and therefore not being a candidate to be taken onto a ward. I did not understand why the mother said (in an e mail) that she had cancelled an in-patient telemetry on 10th November 2022 when she had not. Nor did I think at all convincing her sudden suggestion that it was an autocorrect in her e mail for 'confirmed' although of course, parents in her position do volunteer possible explanations and the Court is rightly cautioned in the authorities not to hold against them a suggestion that may not explain. She had been insistent that it should be done at home. I found myself as I re-read the correspondence and listened to the evidence suspicious that the mother might indeed be seeking to avoid admission for the VEEG to be undertaken in a hospital setting. I have however reminded myself that suspicion must be kept in its proper place. Mr Tillyard KC illustrated by visiting the relevant hospital notes that the appointment which had been cancelled, and not by the mother, had been promptly rebooked. It did thereafter take place. I am not satisfied that the Local Authority has made out its case as to this aspect. In respect of this allegation, I make no finding.

112. I turn now to the allegation that the mother showed disappointment at negative outcomes. By that what I understand is meant is that when tests were objectively speaking 'good news' for EB rather than be pleased by and accepting of it, she was not. I have thought carefully about this. I am not satisfied that the Local Authority has discharged the burden of proof in this respect. I accept the submission made on behalf of the mother that there are a number of occasions when she expresses delight and relief at a positive outcome. Accordingly, I do not find that the Local Authority has established that the mother has shown disappointment on such occasions. It has been especially important not to conflate for example with what the mother understands or questions with disappointment.

113. In relation to, for example the outcome of the discussions about the MRI scans, I have listened to the account from in particular Drs ZA and ZF. It could not be clearer that for even very highly qualified and expert professionals a clear understanding of what the MRI scans mean or even show is a very challenging prospect. To the extent that even now there is not, as I understand it, full agreement to date. For this reason I have been disinclined to read anything adverse into any question or challenge she has raised in relation to the MRI. Nor do I make any finding that she was unwilling to

accept that following the discussions between the neurologist and neuroradiology colleagues in Cardiff there was broadly a position that, to paraphrase, it was nothing really to worry about. I anticipate that, in the context of having been told the scan showed atrophy, most parents would find that difficult. For similar reasons although in contemplating matters about which the mother has given catastrophising or exaggerated accounts, I have seen it has relevance it has seemed to me that evidence about for example reference to shrinking of EB's brain is not sufficiently safe foundation for such findings. There is in any event ample other evidence on which I have made other findings of exaggeration.

114. I have reviewed the evidence in respect of those matters contended for by the Local Authority in respect of this part of its contention at 4 a) - g) of its threshold. Whilst I agree that the evidence in respect of several of them raises suspicion, that evidence has not, when I review it in its totality established the matters contended for by the Local Authority on the balance of probabilities.

115. I take a different view of the allegation which although arising out of the admission to hospital on 1st January 2023, is of a rather different character. The Local Authority contends that the mother inaccurately reported that EB was so distressed that she hurt herself on the cot side of the bed and had a nosebleed and complained that notwithstanding this no nurse came to her assistance. My reading of the records from this period do not support the mother's account of injury. I find that she did in this instance on the balance of probability give an inaccurate account of injury to EB. Since the records do make reference to EB rolling about with the risk she *might* hurt herself, this finding which I would otherwise regard as too trivial to warrant separate consideration warrants it in a case where the issue of exaggeration has been central.

116. I do not regard it as part of my task at this fact-finding hearing to determine the extent to which the clinicians in calling their multidisciplinary meeting on 14 January did or did not depart from the guidance of the RCPH in not involving the child's family in a meeting. Dr Robinson was asked about that and I could see for myself from the mother's apparent distress at this point of the evidence in the court room that it is still an aspect of the case about which she feels keenly. The tenor of those e mails she was sending to which Dr Robinson had been referred may I accept go some way towards why a more collaborative meeting as commended by the guidance may not have been thought a productive course of action though I accept also that there does not appear to be evidence that it was considered. It is plain that the relationship between the mother and professionals had become strained. I accept that the up to date comprehensive care plan set out in the NICE Guidance to which Counsel for both the Guardian and the mother have referred me was something that took far longer to produce than should have been the case. In my judgment that delay heightened the mother's anxiety, contributed to (though does not excuse or fully explain) some of the excessive communications to which I have made reference elsewhere and damaged the working relationship. From ZL, whose evidence I did not otherwise find helpful, I heard how she had become involved to assist with the plan and with CPR training. As to CPR training there was also delay in providing the mother with what might be characterised as 'hands on' training rather than providing her with information via literature. Dr ZA in evidence was cross examined at very great length and to good effect about these deficits. I conclude that the delays in provision contributed to the breakdown of the relationship and formed part of what Mr Tillyard KC called in his

submissions 'Health not communicating with mother'. I reach that conclusion notwithstanding the fact that the mother in her approach to communication and EB's presentation which for the medics working on the mother's report was complex and demanding, placed a burden on an already stretched epilepsy service in meeting the needs of all of the families on its caseload.

117. The criticism made of Dr ZA in relation to his decision not to take forward the Ketogenic diet for which Dr ZF had placed her on the waiting list is not well founded. For the mother it is submitted that it is *understandable* that the mother was frustrated and disappointed that he had cancelled this (and the genetic testing) without telling her or discussing it with her first. In the light of the serious findings I have made about the account the mother gave to Dr ZF on the basis of which she made the referral it is not understandable – at least not in the sense of being justified. It was notable that Dr ZF when she gave evidence did not appear to be troubled by the fact that the ketogenic diet had at Dr ZA's instigation not been proceeded with. I find that but for Dr ZA's decision EB would have been exposed to unnecessary course of treatment. I am not certain he was wise to take the course he did but his response as to the ethical conviction with which he did so in evidence was striking. I agree with Ms King's characterisation in her submissions of him 'putting his career on the line' in so doing.

118. Whilst I accept some of the submissions made on behalf of the mother, about the way in which evolving concerns about perplexing medical presentations and suspected FII were managed, I do not in the circumstances of this case make any further observations still less any finding on the fact the lead clinician for EB took the view that the concerns should not be discussed with the mother who was at the centre of the evolving concerns or that on this occasion there was not a collaborative meeting with her. It was a fact, as is submitted on her behalf that the mother was unaware she was under suspicion and the subject of discussion by medical professionals. Often those whose behaviour towards their children is troubling to professionals in medical settings are unaware. The meetings of colleagues from different disciplines to discuss emerging concerns is an appropriate step to take. To the extent that the Teams transcript shows a free and frank discussion between medical colleagues I do not regard it as improper. It has as I see it the character of a discussion to try to understand what is going on and that encompasses speculation about worst case scenarios of behaviours that I fully accept have not formed part of the allegations before me. I reject the submission for the mother that comments made by Dr ZA were intended to or had the effect of unfairly influencing other professionals at the meeting to a view that this was a case of FII. I am satisfied that the concerns about perplexing medical presentations were discussed both at this meeting and on referral at the multi-agency strategy meeting on 11th January as a result of evolving worries amongst those treating of possible FII.

119. I do not regard it as improper that the referral was made when it was. Nor having clarified with Mr Tillyard KC during submissions is it submitted that it was. During the lifetime of this hearing the mother has from time to time asserted that the question of FII and the referral was made by Dr ZA in response or retaliation to the complaint she had made against him. I do not read the detailed closing submissions as maintaining such an assertion on her behalf and nor did it feature prominently in her oral evidence. It is right also that there has never been a time when the mother as part

of this hearing or the structuring of it contented for a finding to that effect. Lest there be scope for any doubt however, I explicitly reject the suggestion that the FII referral was so caused or motivated and I accept that it emerged from the clinicians concerns as to the evolving picture.

120. From the findings I have made, it follows that the Local Authority has established also that CB and DB were being brought up in a household in which their younger sister - was characterised as more unwell than was reflected by her genuine diagnosis of epilepsy.

121. I am satisfied on the evidence that the mother obstructed the Local Authority in ascertaining the whereabouts of the children's fathers when the children were first removed and once the proceedings were initiated. Although I make that finding, I hold in my mind the grandmother's evidence of her anxiety that living in a small community everyone would know and it would be difficult for the older children who were of an age to be affected by gossip and were already distressed by the removal. There was some component of this in the mother's thinking as well when she was asked about it. In her case however it was not just about the children but about her. She was accused of child abuse and did not want that to get out. I have read in the papers of her distress at being labelled a child abuser. It was her belief that the proceedings would come to nothing and it would all be over in 12 weeks. I think it is more likely than not that she hoped in that case that the fathers would not have to know.

122. The findings I have made in respect of the mother's behaviour in respect of EB are ones which taken together sit, as the Local Authority contends, easily within the context of the Royal College of Paediatricians Guidance on FII.

123. Identifying the findings as to what the mother has done or not done is one thing, forming conclusions as to her motivation is quite another. I have in the course of this judgment and indeed in other similar cases expressed reservations as to whether the appropriate expertise to define and identify the mother's motivations for her behaviour lies within the court room. It most likely does not. I have some similar reservations about attaching to the findings I have made the label of FII which it seems to me is more properly a diagnosis than a legal finding even and although the components of such a diagnosis might be reflected in the findings.

124. I was interested in the view of Dr Robinson, when asked, that the label of FII is meaningful. Perhaps the more so in this case because of the findings I have made as to medicalisation and the sick role, the seriousness of which may be too easily overlooked. Whether the findings carry the label of FII or not what matters for the purposes of any welfare decisions for EB and her siblings is that they establish the threshold and that the mother poses a risk of significant harm.

125. I will list the matter for consideration of such further and consequential directions as may be required in the light of the findings made.