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

Neutral Citation Number: [2021] EWFC 46

IN THE FAMILY COURT

Date: 11 May 2021

Before :

MR JUSTICE PEEL

- -

Between :

The Local Authority	**Applicant**
- and -	
Mother	**1st Respondent**
- and -	
Father	**2nd Respondent**
- and -	
X	**3rd Respondent**

- -

- -

Penny Howe QC and **Harvey Murray** (instructed by **The Local Authority)** for the **Applicant**
Barbara Connolly QC and **Nafeesa Choudhury** (instructed by **Kay Boswell Solicitors**) for the **1st Respondent**
John O'Sullivan (on 20 April 2021 only) (instructed by **Richard Reed Solicitors**) for the **2nd Respondent**
Kate Branigan QC and **Elizabeth Lugg (**instructed by **Aileen Tallintire Solicitors**) for the **3rd Respondent**

Hearing dates: 19 -30 April 2021

- -

Approved Judgment

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

.....

Mr Justice Peel :

Note

For the purposes of this judgment, I shall use the following medical acronyms:

FII Fabricated or Induced Illness (by which a parent falsifies symptoms of illness in a child, or deliberately induces symptoms of illness in a child)

SSD Somatic Symptom Disorder (where an individual genuinely experiences symptoms of illness, which have no organic or medical cause, but are brought on psychosomatically by mental health illness)

FD Factitious Disorder (where an individual deliberately fabricates or exaggerates their own symptoms of illness)

Introduction

1. These public law proceedings were issued on 12 June 2019. They concern X who was born on [a date in] 2019, and is now just under 2 years old. Since birth, she has been separated from her mother ("M"); for a few weeks, under a s20 voluntary placement with maternal relatives, and from 16 July 2019 in foster care. It is unconscionable that it has taken the best part of 2 years, the whole of this young girl's life, to bring this matter to court for a final decision as to her future.

The position of the parties

2. The LA seeks (i) threshold findings and (ii) approval of a Care Plan for permanence of placement outside the birth family. The Guardian supports the LA's position.

3. M accepts that the threshold is met, but disputes some of the findings sought which are relevant to the welfare stage and have therefore formed part of my inquiry. She seeks reunification with X on a staged return basis or, alternatively, she would submit to a s38(6) residential placement for further assessment with a view to consideration of reunification thereafter.

4. The father ("F") does not have parental responsibility. He has played no part in X 's life, nor does he intend to do so in the future. He actively supports the plan for adoption. He indicated at the IRH that he did not intend to attend the hearing, and would prefer not to give oral evidence, although he has filed written evidence. No party sought to compel him to do so.

The Mother's health issues

5. M has been profoundly deaf since birth. In 2006 she had a right ear cochlear implant which is powered by rechargeable batteries. She cannot necessarily hear and understand

all noises and voices, and if a battery is low on charge, she cannot hear at all. Her principal method of receiving communication is via lip-reading, although she can and does use sign language.

6. She has a number of long-standing physical and mental health conditions:

   i) Pendred syndrome, a rare inherited genetic disorder leading to thyroid disorder and sensorineural hearing loss. She was diagnosed in about 2000. Her thyroid has been surgically removed, and she is required to take thyroxine every day.
   ii) Asthma, for which she uses an inhaler.
   iii) Gestational diabetes mellitus.
   iv) Urinary incontinence, as a result of which she is prone to bed wetting. On 9 November 2020 she had surgery for an ileal diversion, and now has a permanent stoma outlet and urine bag.
   v) Recurring anxiety, depression and impulsive and aggressive behaviours, suicidal ideation, and actions consistent with Emotionally Unstable Personality Disorder.

7. In addition, in about 2007 (as M says, and the medical records confirm), she started presenting with light headedness, headaches, nausea and vomiting. In 2011, she was admitted to NN Hospital with symptoms of vomiting and dizziness. Testing established an issue around cortisol levels and suspected adrenal insufficiency. According to M, she was told that she was suffering from Addison's disease, and believed that she was formally diagnosed with Addison's. She cannot recall exactly who told her so, although she was being treated at the time by Dr G and Dr H. As a result, she was prescribed with medication and trained in injection of hydrocortisone. She was told to look out for signs of Addison's crisis including light-headedness, dizziness, fatigue, reduced consciousness, headaches, and nausea (which I shall refer to hereafter as "Addisonian symptoms"). Thereafter, M told A&E, treating clinicians and GPs that she had been diagnosed with Addison's, and she received treatment accordingly. Medical records show multiple crises and admissions to hospital at which M complained of Addisonian symptoms.

8. It is clear from the extensive medical records that treating clinicians (whether specialists in the field or not) told M repeatedly that she had Addison's. I was told by Dr I (a SJE consultant endocrinologist) that the term "Addison's" appears to have been used as shorthand for adrenal insufficiency. Dr I told me that in fact there was never a formal Addison's diagnosis and described the references in the records to Addison's as a process by which a word or phrase from the early days came to be misinterpreted to provide what appeared to be an accepted diagnosis. I am satisfied that from about 2011 to early 2021, M authentically believed that she had Addison's. She was told as much by clinicians. Her medical records suggested she had Addison's, or at the very least indicated partial adrenal insufficiency, which was loosely, and inaccurately, described as Addison's; inaccurately because Addison's is a condition where the adrenal glands are damaged and unable to produce the necessary cortisol, whereas adrenal insufficiency more commonly involves under-stimulation of the adrenal glands.

9. Until further tests carried out by Dr I in January 2021, it was accordingly understood by M, clinicians, the court, legal professionals, instructed experts, the LA, and the Guardian that M had had Addison's disease for many years. In fact, it has become clear

since January of this year that she does not, and never has had, Addison's or even partial adrenal insufficiency. Over a number of years, she had been wrongly told by treating clinicians that she had Addison's. It was, so Dr I told me, reasonable for her to have accepted what she was told, and I am satisfied that she genuinely believed she had this condition. One of the consequences of this development is that it is now clear M presented with Addisonian symptoms over many years, including during multiple crisis admissions to A&E, when she in fact did not have Addison's, or any adrenal insufficiency, and there was no other organic explanation for such symptoms. I will need to consider this aspect of the case in more detail.

The hearing

10. The LA, M and the child were all represented by leading and junior counsel. F was represented by junior counsel on the first day of the hearing. Given his support of the LA's position, F sought to be excused from attending the duration of the hearing or being represented throughout. This had been flagged up at the IRH and was not opposed by the other parties. Accordingly, he played no part in the trial.

11. An Intermediary report dated 5 April 2021 recommended a BSL interpreter for M, but she preferred to use the services of lip speakers, who also acted as Intermediaries, to assist her. In total, five lip speakers performed these roles in relay during the two weeks because of the exhausting nature of the process. Regular breaks were taken. M had access to a dedicated computer in court which allowed her to see the lip speakers at all times

12. The hearing took place on a hybrid basis. M, and most counsel, attended in person. The majority of the evidence was given remotely; only M and one social worker gave evidence in the courtroom. The hearing proceeded relatively smoothly, with occasional frustrating technical hitches; I am very grateful to the almost herculean efforts of the staff at the local Family Court who managed, and resolved, all technical issues. The bundles totalled about 15,000 pages, which included voluminous medical records. Counsel were of invaluable assistance and no stone was left unturned. Helpfully, they prepared an agreed Note on the law, which is well-established and uncontroversial, and which I have largely replicated in this judgment.

Recent development

13. Shortly before the IRH, which took place one week prior to the final hearing, the parties became aware of an allegation of an indecent nature by one of M's older children, A (aged 16) against another of her children B (aged 19). Although neither A nor B is a subject of these proceedings, the information was of potential relevance given that it was understood A intends shortly to move in and live with M, although M in her evidence said that A was in two minds about this. That in turn raised concerns on the part of the LA about the consequences for X were she to be returned to the care of M, and possibly find herself in the same household as an alleged abuser from her own family. Given that the incident purportedly took place while both older children were living with M, it also raised question marks about M's ability to protect X. At the IRH, there was no documentation in relation to the allegation and I made directions for further disclosure including against the police. The possibility of having to adjourn the trial was mentioned, in order to allow for a proper investigation of the allegation.

14. Upon receipt of the relevant disclosure, it became apparent that the allegation is historic and tied in with previous allegations that A had been involved in acts of abuse perpetrated by his father (M's former husband and not the father of X). B is ambivalent about pursuing it. The police intend to take no further action and are treating A as a victim, not a perpetrator. The LA expressly disavows any reliance upon this matter, seeking no findings, nor inviting me to take it into account. All parties agreed that there should be no adjournment for further investigation.

The background and earlier proceedings in 2013/2014

15. M is 37 years old. She was born in NN to parents who separated when she was 18 months old. She moved with her mother and sister to MM when she was about 8 years old. She explains in her written evidence that she had a very difficult relationship with her mother, who found it difficult to manage her. For 2 or 3 years she was placed in a children's home, after which she moved to live with her father in OO.

16. M has a history of criminal activity and involvement with the police. Between 1999 and 2018 she received multiple convictions for property related offences, public order offences, police/courts/prison offences and miscellaneous matters.

17. In 2000 M met Mr R. M became pregnant with their son A. Before his birth in September 2001, M separated from Mr R and moved back to MM to be near her mother. Mr R did not maintain contact. M had other relationships and B was born in March 2005 as a result of a fleeting liaison with another man, Mr Q. M and Mr R resumed a relationship after B's birth and the family settled in MM before moving back to LL in 2009. B was treated as a child of the family by Mr R. They married in 2009 and had C (born in April 2010), D (born in October 2011) and E (born in October 2013).

18. Children's services in LL initially became involved due to M's frequent attendances at hospital, serious welfare issues about the children (for example, A had been seeing eating from a rubbish bin), alleged domestic abuse between the parents witnessed by the children, and violence allegedly perpetrated by Mr R on A.

19. D was born 3 weeks premature in NN General Hospital. He had a number of significant and complex medical problems. He had frequent desaturations in oxygen and feeding difficulties. He required mechanical support for his breathing. He remained in hospital for about 9 months, during which period he was moved between hospitals (including to PP Children's Hospital and QQ Children's Hospital). While in hospital he was almost wholly cared for by M. He was finally discharged home on 30 July 2012 with a high level of support from care workers.

20. D, according to M, deteriorated shortly after his discharge, and was readmitted to LL hospital on 2 August 2012. The LA in LL, increasingly concerned about M's behaviour while D was being treated, issued care proceedings on 3 August 2012.

21. On 26 July 2013 HHJ Richardson QC, who dealt with all substantive hearings, handed down judgment after a 12-day court fixture, which included 3 ½ days of oral evidence from M. It needs to be read in full. It contains a series of damning findings against M in terms of her conduct, and her veracity as a witness. I propose to summarise some of the core findings, conscious that in so doing I cannot do justice to the highly critical tenor of the judgment;

i) The LA's evidence was accepted without hesitation.
ii) The judge found M's evidence to be "far-fetched; disingenuous; lacking any insight; or a downright lie" and "As the evidence unfolded the mother became increasingly unbelievable". At paragraph 128 he described her as "essentially dishonest".
iii) M had been guilty of FII by interfering with the medical care of D including:

a) Interfering with oxygen supply;
b) Excessive suctioning to clear the airways, which the judge described as "bordering on the cruel";
c) Wilfully reporting wrong saturation levels;
d) Interfering with hospital charts;
e) Obstructing staff and being rude, challenging and occasionally manipulative towards them as well as making false allegations against medical professionals about their conduct;
f) Giving exaggerated, misleading, or contradictory accounts to medical professionals;
g) Causing D to be subjected to unnecessary investigations;
h) Failing to follow medical advice.

iv) As a result of prolonging his time in hospital, M caused D developmental delay.
v) D's feeding was not properly handled by M. On regular occasions she was indifferent to him and failed to interact. On occasions, she handled D roughly.
vi) Mr R at that stage was "unwarrantably disengaged; resulting in virtual invisibility".
vii) The judge made no findings about whether M had fabricated or exaggerated her own medical background, although he expressed suspicions.
viii) As a consequence of the above, M had failed to provide safe and optimal care of D's needs
ix) In a later judgment he characterised M's parenting of D as "appalling parenting to a very marked degree".

22. For some time, the LA considered placement of A and B with the maternal grandmother in MM and a regime of trial weekend contact with her was put in place. The plan was suspended due to the LA's concerns that the maternal grandmother was not being open and honest with them. A number of fact-finding allegations by the LA against the maternal grandmother were determined by HHJ Richardson QC on 28 January 2014. Again, and by way of summary only:

i) He was unimpressed by the grandmother's evidence, finding that she was dishonest to him.
ii) The grandmother had disregarded the LA's directions about contact with M and other welfare matters. She was not open with the LA, and had succumbed to pressure from M.

The judge authorised termination of the assessment of the grandmother in respect of A and B.

23. On 6 March 2014, as proceedings continued in respect of the other children, the judge made further significant findings:

i) "The history does not make happy reading. It is a story of a manifestly inadequate family where the mother and father are really wholly unsuited to each other with all the attendant neglect and poor parenting consequences for their children….The children suffered-I have not a shadow of doubt about that".

ii) Mr R had been physically abusive to the children.

iii) Referring to M's lies and a comprehensive lack of insight, the judge found that her apparent and expressed willingness to change was a "thin veneer of pretence".

iv) M did little to protect the children from violence by Mr R and had minimised Mr R's poor treatment of them. She had expressed disbelief of their accounts; "Her response [to Leading Counsel] that she did not believe the children was indicative of complete abdication of responsibility".

v) M and Mr R argued in front of the children and exposed them to a volatile relationship.

vi) M exaggerated her own ill health. "There were several presentations for conditions where no abnormalities were found. Additionally, there were repeated requests for inappropriate drugs and poor compliance with taking prescribed drugs. She has also had a high number of medical investigations that have been unnecessary. Dr L considered the pattern revealed in the mother's medical history to be a form of abnormal illness behaviour and associated with patients who have factitious illness disorder. This in turn may be connected with a diagnosis of FII in their children". "None of this was known when I decided the case in relation to D. It is plain to me the mother has a tendency to exaggerate her own health in the way described by Dr L-".

vii) In respect of B the judge accepted the expert evidence of Dr L that "there were many attendances at doctors (in the first 5 years of her life there were 50 medical attendances of which 30 were at hospital when a GP attendance was all that was needed). There were excessive appointments and on occasion there was no objective evidence seen by medical staff to confirm the mother's reports. The excessive attendances [were] for minor problems. There was one example of exaggeration or falsification on 1 September 2007" and "I accept the analysis of Mrs K– that if another challenging situation arises for the mother there is a likelihood of repetition of FII".

viii) There was no evidence that M had reformed or shifted her basic attitudes or understanding. All the children had been emotionally harmed.

ix) "The history is malign and, absent reform, will continue to be malign" and her "fluctuating parenting…was deleterious for the children to a high degree".

24. Other judgments were given during the proceedings on discrete matters including interim care orders. The common theme throughout is findings strongly adverse to M. Ultimately, and without hesitation, the judge concluded that the threshold criteria were met and separation of the children from their parents was necessary and proportionate. The children were separately placed, and their current status is as follows:

i) A (7/9/2001). He was in foster care, and now, as an adult, lives with his maternal grandfather although he and M spend a considerable amount of time together at M's home.

ii) B (26/3/2005) is in long term foster care.

iii) C (30/4/2010) is placed with her paternal aunt and uncle under a Special Guardianship Order.
iv) D (15/10/2011) is in an adoptive placement.
v) E (21/10/2013) is in an adoptive placement (separate from D).

25. I pause to take stock and note that this catalogue of findings against M were of the utmost gravity, concluding that she was guilty of a very high degree of harmful, cruel, and neglectful parenting. Although they were made 7 years ago, I must take them fully into account and consider, within the context of all the circumstances, whether M has demonstrated change in her behaviour in the intervening period and, if so, to what degree.

Events from late 2014 until early 2019

26. After the case finished, M spent time with her father and then resumed living with Mr R between May and August 2014. In September 2014 she left NN and moved back to the MM area. Her relationship with Mr R ended. She drank to excess. She had relationships with abusive partners, including Mr P and then F. Between 2014 and 2019 there were 26 domestic abuse police referrals, including 13 as between M and F. She continued to engage in criminal activity, including being convicted on 30 May 2016 of harassment of Mr P, and on 7 June 2016 for assaults on a constable for which she received an 18-week suspended imprisonment sentence. She and Mr P attempted reconciliation before final separation in 2017.

27. In 2016, M alleged that she was raped in Turkey by a Turkish man. She reported this allegation to police in England who took no action due to (i) lack of evidence and (ii) the alleged offence having taken place abroad. During this period, she also alleged rape by Mr P; again, the police took no action.

28. In October 2017, M and X started a relationship which was, as they both accept, turbulent and volatile. As I have already mentioned, there were 13 domestic violence referrals during the period of their relationship; the records indicated that both parties behaved violently. Police reports refer to the parents being heavily intoxicated at call-outs. M in evidence told me that she used to binge drink. In October 2018, M became pregnant with X and the relationship between M and F came to an end. M obtained a non-molestation order against X in November 2018, although the allegations made in those proceedings were disputed in court and never made the subject of findings; the order appears to have been made consensually after an initial without notice hearing. The evidence suggests that M and X have not resumed their relationship, although they have occasionally stayed in contact, and M has been single since.

29. In the same period, that is to say from the end of 2014 until the end of 2018, M overdosed on about 12 occasions and there was poor compliance with medication. Her chronic behavioural patterns continued. She told her treating mental health team that her symptoms of PTSD and frustration caused her to feel anger and contribute to volatility and turbulence in her relationships. She was offered therapy but between 2015 and early 2019 her engagement with such support was limited and irregular; in reality, she did not commit, and no progress was made as a result. M also failed to be fully open and honest with her mental health treating team:

i) From September 2015 to 2018, on at least 7 occasions, M did not inform her mental health treating team of the findings made by HHJ Richardson QC.
ii) M told her mental health treating team that she was not in a sexual relationship with F on 6 February 2018 and 9 May 2018, yet on 13 May 2018 self-presented as having had a miscarriage of a baby by F. In fact, she had not had a miscarriage, but she was clearly giving out mixed messages.
iii) She gave an account of what she termed an accident on 16 June 2018, claiming that a laceration to her head was caused by falling downstairs, whereas it is now clear that it was caused by F assaulting her.
iv) M did not openly explore with her treating mental health team or other professionals the abusive nature of her relationship with F.

30. In this same period M attended at A and E on repeated emergency call-outs presenting with Addisonian symptoms. The records suggest at least 27 such instances; 13 occasions with vomiting, nausea, and headaches, and 14 with unconsciousness or reduced consciousness. This was a continuation of some 22 such Addisonian presentations which had taken place between 2009 and 2014.

31. In respect of unconsciousness, or unresponsiveness, the records paint a picture of clinical doubt about whether the presentation was genuine. To pick out a handful of examples, which are echoed many times elsewhere:

i) On 18 September 2015 the notes record a "bizarre presentation with hyperventilation on being woken up; neurologically – keeping eyes shut most of day". M's mother told clinicians that M "has a long history of behaviour seeking medical attention…".
ii) On 13 May 2018 the notes record: "Medical staff report that while she appeared unresponsive, when observed, there were times when M thought she was alone that she appeared alert".
iii) On 16 June 2018 the notes record: "Second attendance with reduced GCS and no identifiable physical cause – medical staff documented that M was observed opening eyes spontaneously when staff stood quietly in the room and queried whether M was intentionally presenting as though her conscious level was reduced".
iv) On 15 February 2019 (the last such entry in this period and typical of the various episodes which had occurred previously and which, as matters transpired, resumed in 2020), M called the emergency services, saying that (to quote the records) "she was having an Addison's crisis". On arrival at hospital, she was noted to be a patient well known with multiple similar presentations of unconsciousness, and the history suggested "No previous organic cause, always resolved without treatment". The note states "Unconsciousness felt to be non-organic in nature and possibly due to personality disorder/behavioural….No evidence of Addisonian crisis…unconsciousness/neurology inconsistent and variable…likely behavioural rather than organic". On review at 02.10am "Shortly after arriving in high acuity from resus [sic], M awoke, took out NPA and took all monitoring off and asked to leave…M states this has happened before and she is always fine, wants to leave".

32. It is clear to me from all I have read and heard, and not substantially disputed by M, that her lifestyle and relationships continued to be chaotic, abusive, and marked by

abnormal behaviour from 2014 until late 2018 or early 2019. She continued to be unable to cope and function appropriately, and her maladaptive behavioural patterns were, as Ms K (the SJE consultant psychologist) explained to me, dysfunctional coping mechanisms triggered by extreme anxiety and stress.

Early 2019 to early 2020

33. Given the history, it is unsurprising that on 4 April 2019 a pre-birth parenting assessment by the relevant LA expressed concern about M's mental health, her relationships characterised by domestic violence, and the findings from previous proceedings. Her capacity to change remained in doubt, as was her ability to understand and appreciate the wider impact of her mental health, domestic violence, and exaggerated illness. The assessment did not recommend X remaining in the care of M following birth.

34. Fairly swiftly, the LA started to form a brighter picture of M's abilities. The first social work statement dated 21 May 2019 (2 days after birth) said "M has some significant health issues including Addison's disease" and that "she accepts the majority of the concerns that were raised regarding her parenting by children's services". M seemed reflective, acknowledging past mistakes, and believed that her young age when having children had been a negative factor, as had been the abusive relationship with her husband. 5 years had passed. She had separated from F, her home conditions were well maintained, and she felt able to cope. This improving picture set the tone for a number of months.

35. From, I judge, late 2018 until early 2020 it is clear from the evidence, and was readily accepted by the LA in its opening written presentation, that M made concerted efforts to effect and demonstrate change in her functioning. This process started during pregnancy. She showed signs of progress. I consider that was partly because of having exited a string of abusive relationships, partly because of the sheer joy of having a new baby and partly because of a real desire to try and find a way to keep her baby. In addition, she obtained a job at a pub which clearly increased her sense of worth and self-esteem. There is no doubt in my mind that M's intentions were genuine. Upon birth, the hospital praised her care of X. She underwent therapy and completed parenting and domestic violence programmes. I note that on 23 October 2019 a hair strand test showed no excessive levels of alcohol between April 2019 and October 2019. She was far more open with social services and other professionals. I was told by the Health Visitor, Ms U, that both before and after birth M was positive about the birth, eager to learn, and engaged with X's needs. Ms U observed M with X in a supervised context on 9 occasions between birth and March 2020 and found the interaction to be good. In February 2020, a referral was made to Ms V, an Early Years Practitioner, particularly in respect of feeding. She told me that M engaged with her and was eager to learn, albeit such learning had to take place online because of the pandemic. The then social worker, Ms W, praised M's attitude, willingness to cooperate, receptiveness to advice and generally open demeanour. The current social worker, Ms Y, spoke in similar terms. It was clear to me that the LA formed a more favourable impression of M during the year than perhaps anybody had expected, although it has to be recalled that all M's undoubtedly warm and loving interaction with X took place with a high degree of support and assistance. The fact that, as Dr I reported, her thyroid tests stabilised toward the end of 2018 demonstrating, for the first time,

regular adherence to Thyroxine medication, is another tangible example of M's renewed outlook.

36. The picture, it should be said, was not perfect. We now know from the evidence that M was continuing to experience flashbacks and nightmares at this time, which in turn indicated a continuation of her PTSD, yet she did not share this relevant information with mental health services.

37. After birth, X was initially accommodated with the maternal aunt and her husband under a s20 agreement with M. Sadly the aunt's husband suffered a stroke and they were no longer able to care for X. As a result, she moved into foster care in July 2019 and has remained with the same foster carer ever since. She is unquestionably happy and settled, and her principal secure attachment is with the foster carer. As another example of M's changed approach, she established a good relationship with the foster carer.

38. Supervised contact with M was initially set at 5 times per week for several hours while X was placed with the maternal aunt. That reduced in duration to 2-hour sessions (still supervised) after the move into foster care, a function of resources rather than any particular concern about M's behaviour. As a result of the onset of the Covid pandemic, and consequent lockdowns and tier restrictions, it altered to remote contact only from March 2020 to July 2020, during which time M was able to connect only by mobile phone; it seems to me that, for reasons beyond anyone's control, this must have been unsatisfactory and greatly dispiriting for M, as well as stressful. In July 2020, restrictions were eased sufficiently to permit supervised face to face contact once more, albeit for short periods of time (about 1 ½ hours) and only once per week. I have great sympathy for M, whose contact is now a pale imitation of how it started through no fault of her own. Notwithstanding all these challenges, M has been fully committed to contact throughout, never missing a session.

39. In general, the observations of contact have been reasonably positive. I was shown some touching and happy videos and photographs of M and X together, and heard evidence about warm interaction. The aspect to which I will return is the need, commented on by the LA's witnesses, for M to be advised repeatedly about basic care elements such as feeding, playing, and sleeping. M, I was told, was receptive to advice and wanted to engage with it, but she was unable to implement it, or to appreciate X's cues, and as a result she would have to be prompted time and time again with the same advice. Ms K told me that M would have genuinely wanted to act on the advice, but her deep-rooted anxiety disorder "gets in the way".

40. A parenting assessment by Ms W dated 10 September 2019 identified the good progress since the previous proceedings, including better interaction with medical professionals, positive reports from hospital staff, engagement with the LA, and pleasing interaction with X during contact. M appeared to have accepted the previous findings, had attended 6 sessions of CBT and 6 sessions of Integrative Psychological Therapy, and had completed the freedom programme and Safe 4 Life Programme. Nevertheless, M continued to require ongoing support. It was noted that there was evidence in the past of M not coping when under stress and experiencing "profound issues within her life which have impacted upon her emotional state and her ability to meet the needs of her older children….At times of stress and crisis within her life her parenting capacity has

been significantly impacted upon, and her ability to meet the emotional needs of her children…..It is impossible to predict any future stressors that may occur particularly as a parent and how M may respond*"*. The conclusion was that "there needs to be ongoing assessment of the depth in the changes that M has made…..and a continued level of professional curiosity applied to the change that M has been able to evidence given the history of the case". Nevertheless, her apparent ability to cope with the care proceedings was a positive starting point for evidencing change. So too was the fact that she was not in a relationship. There were grounds for belief that the changes were capable of being sustained.

41. Accordingly, the LA considered that M and X should be placed for 6 weeks in a mother and baby unit. That contemplated residential assessment was opposed by the then Guardian, given the strong findings made in the previous set of proceedings. The Guardian considered the proposal to be premature and over optimistic, and that updated expert evidence from Ms K, who had reported in the first set of proceedings, should be sought. It also seems that not all the previous papers were available. At a case management hearing on 30 September 2019, the court agreed, noting the complexities of the case. The Recorder refused to sanction a plan involving a residential assessment at that stage, and approved the Guardian's Part 25 application. As time passed, and the scope of expert evidence (initially positive about a residential unit) broadened, the recommendation of the LA for a residential assessment was put on ice, until unfolding events in 2020 meant that it was abandoned altogether. M herself did not make a s38(6) application after the September 2019 hearing, and no such residential assessment has ever taken place. On M's behalf it is said that there was a missed opportunity at the end of 2019, a window within which round the clock supervision and assessment might have provided the necessary level of observation and support enabling the court to identify needs and contemplate a bespoke rehabilitation plan. I understand M's frustration, but I am not at all surprised by the Recorder's decision given the very high level of poor, even cruel, conduct perpetrated by M as found by HHJ Richardson QC previously; an assessment of the sort contemplated needed the firm foundations of expert evidence. As it happens, and with hindsight, a residential assessment would have proceeded on a false basis, namely that M had Addison's, and would therefore not have explored all the issues which have been canvassed before me arising out of the non-diagnosis and consequential impact on an analysis of her mental health.

42. It is, at this point, right to record from M's perspective how initial optimism gradually declined. She had done much right, working meaningfully to re-establish her parenting abilities with X. But events thwarted her. The initial placement of X with her sister changed, through force of circumstances, to foster care. Contact reduced. The LA's plan for a residential assessment was rejected by the court. Further expert evidence was commissioned. The onset of the pandemic brought a total cessation of face-to-face contact which impacted M's ability to nurture her bonds with X, and her attempts to prove her parenting skills. Work with professionals did not cease but was conducted largely remotely which no doubt diminished its scope and effectiveness. M herself was required to shield. As I will refer to below, her contact with her older daughter, B, was suspended, again for reasons outside her control. I consider that these misfortunes, not of her doing, will undoubtedly have generated great anxiety and uncertainty in her, and it seems to me that they must have contributed to the re-emergence of M's previous chaotic behavioural patterns from early 2020 onwards.

43. It is unnecessary to chart the glacially slow progress of the legal proceedings, largely caused by what appears to have been a piecemeal, and sequential, approach to obtaining expert evidence, and disclosure of medical records. I do not doubt the complexity of the issues involved, but nobody could seriously dispute that this prolonged litigation runs contrary to good practice, mandated time limits, and the best interests of a child who needs finalisation so that her future path is clearly set forth. Even by the time of my first involvement in the case, one week before the final hearing, it was touch and go whether it would be ready for trial. Fortunately, and in no small part due to the considerable efforts of all counsel in the case, the case was ready to, and did, proceed.

Events from late 2019-2021

44. Until late 2019 M was having 4 times a year contact with her older daughter B. On or about 16 November 2019, M posted on B's Facebook page a message (which she swiftly removed) that she (M) was not in a good place and nobody cared for her, which must have been deeply upsetting for B. From 18 November 2019, it was intended that B should receive therapeutic trauma intervention from Barnardo's. The view of Barnardo's, supported by social services, was that contact between M and B should cease so as to allow therapy the best possible chance of success. I heard from B's social worker, Ms Z, and, although the chronology was a little confused, it became clear that on a number of occasions between late 2019 and June 2020 (but not thereafter), and contrary to express advice from social services, M regularly contacted B directly or via her father, MGF. I acknowledge (i) that for M suspension of contact with B was distressing and (ii) since June 2020 she has not contacted B, but by ignoring social work advice she did not act in an appropriately child centred way, particularly given the gravity of the findings made in 2013/2014.

45. On 25 February 2020 in the early hours M called 999, complaining of shortness of breath, headache and feeling "spaced out". On an ambulance attending at M's property, she was unconscious. M remained in hospital until 28 February 2020. Dr N (M's treating endocrinologist) confirmed that M's admission was a result of having an Addison's crisis (blood tests did not show the admission as alcohol related, although the paramedics had suggested this as a possibility and M herself said she had drunk 2-3 pints of lager at a pub that evening). This was the first such episode since February 2019 and heralded a reversion to the patterns previously apparent.

46. A number of further such incidents have taken place (I note that sometimes M called 111 and the nature of the call led to an upgrade to 999):

    i) On 12 March 2020 M called 999, and the call log records "Patient is in Adrenal Crisis with Addison's Disease". The Fire Service assisted paramedics to gain entrance. M was found lying on her sofa. Hydrocortisone was administered. On the way to hospital in the ambulance she collapsed again, and a further dose of hydrocortisone was administered.
    ii) On 25 April 2020, M called 111 and then 999, saying she suffered from Addison's and that she was feeling sleepy. An ambulance attended and she was unresponsive. She was transferred to A and E.

iii) On 8 May M called 111, saying she felt fatigued. The Fire Service were called to assist paramedic access to M's house where she was found unconscious but breathing before being transferred to A and E.

iv) On 15 May 2020 M called 999, saying she had Addison's and was experiencing cough and a fever. The ambulance crew found M initially unresponsive on arrival and transferred her to A and E after administering hydrocortisone.

v) On 6 July 2020 the Fire Service attended in response to an oil pan fire and M inhaling smoke. She was admitted to hospital where there was no evidence of inhalation injury, but M presented with reduced consciousness and responsiveness, confused and disoriented.

vi) On 15 August 2020 M called 111 complaining of feeling nauseous, short of breath, vomiting, headache, and diarrhoea. The ambulance crew described it as a "Possible Adrenal Crisis" and transferred her to hospital.

vii) On the night of 18 August 2020, and into the morning of 19 August 2020 the police were called to M's property for what was described by M's neighbour, as a "mental health crisis". M had sent text messages to the Crisis Team on and off for 2 hours stating that she was sitting on the window ledge and had suicidal thoughts; she said she was alone and experiencing nightmares. One text message read "Goodbye if no help". She suggested to the Crisis team that she had taken 8 paracetamol. Although in evidence she told me she had not done so, the fact of having relayed this information is indicative of her turmoil. On attendance by emergency services, she refused to travel to hospital.

viii) On 6th September 2020 M called the police because A (then staying with her) had returned home from the pub angry and agitated because a female had "led him on". M reported that she thought alcohol may have mixed badly with his anti-anxiety medication. A calmed down on police attending.

ix) On 10 September 2020 M telephoned again about jumping out of the window. The records relate a "…historic crime which has led to her threatening to jump out of her window, officers attended, and M confirmed she was not going to hurt herself. Street triage were called and stated that M was a regular caller, she sits at her window to smoke cigarettes and she was alcohol dependant. M often calls the crisis team and it was common for her to go to bed after sitting at the window…..she [would speak with the police the following day] once she was …. rested and sober". M then gave detail of an alleged significant assault by F in June 2018, which she had hitherto claimed was the result of falling down the stairs (including in assessments and statements in these proceedings).

x) On 14 September 2020 M had a fall and was attended by ambulance services after calling 111. She reported that her leg injury was stressing her and triggering an Addisonian crisis, and that she was soiling herself because she was unable to mobilise to the bathroom.

xi) On 26 September 2020, after a 111 call, M was admitted to hospital after reporting vomiting and headache, having taken a rescue dose of hydrocortisone.

xii) On 3 October 2020, after a 111 call, emergency services transferred M to hospital for a possible adrenal crisis, feeling lethargic, dizzy, and nauseous, during which she stabilised en route. M reported that she often had these symptoms.

xiii) On 20 October 2020 M rang 111 reporting headaches and feeling unwell.

xiv) On 1 March 2021 M called 111 experiencing chest pain. The record of the attending ambulance crew indicates she had "been drinking then had a Chinese takeaway, heartburn/indigestion; does not want to go to hospital".

47. M, as she accepted in evidence, has a history of addiction to medication and the medical records show dependency dating back to 2009. A graphic medical note dated 9 August 2016 records M "on occasion kicking off in custody" as her zopiclone was withdrawn. That addiction, or at the very least high dependency, has continued to the present day. GP records show that M from October 2020 onwards sought, against GP advice, on at least 8 occasions, additional, and stronger dosages of anti-depressant, painkilling and sleeping pill medication, in particular zopiclone. M accepted this history, but told me that she is now weaning herself off it; her next review is in 2 weeks.

48. In part because of these events, the LA's position evolved. By September 2020 they had abandoned all notion of a residential assessment and had moved towards a plan for adoption.

49. Finally, and for completeness, a further toxicology report established no evidence of either cannabis use or excessive alcohol use by M between September 2020 and March 2021.

Expert evidence

50. Because of the evolving circumstances, I propose to record the written expert evidence in chronological order, thus dovetailing it with the chronology of events set out above

51. Professor J, consultant psychiatrist, prepared a psychiatric assessment dated 12 December 2019; he was instructed in place of the expert from the previous proceedings who was no longer available. His assessment was largely based on M's self-reporting; he had limited access to medical records. He concluded:

    i) She has a significant previous psychiatric history of depressive disorders with anxiety features, emotionally unstable personality traits, PTSD, behaviour disturbances and poor communication, self-harm, criminal activity and displays of aggression. In previous proceedings she showed aspects of FII in children (albeit not diagnosed).
    ii) Her medical conditions include Pendred syndrome, Addison's Disease, deafness, urinary incontinence, and hypothyroidism.
    iii) There was no recent evidence of alcohol dependence, depression, paranoia, unusual ideas re health, PTSD, or FII, provided M's self-report is accepted by the court.
    iv) M said that the "court's decision was in the children's best interests" and that she had struggled in the past. She was in a much better place, not in an abusive relationship, settled and stable. She agreed with previous findings that her care of the children had been poor and unsafe. She accepted she had been manipulative in the past.
    v) She appeared to have been mentally well for 6 months.
    vi) Her attendance at A and E in February 2019 could be evidence of unusual illness behaviour, but it is not possible to confirm this. It "..could be argued this is evidence of unusual illness behaviour or factitious illness but it is not possible to confirm or refute on the evidence available"….I note this is an isolated episode and her explanation appears logical from a clinical perspective…..In my opinion therefore on the balance of probabilities this episode is not clinically

significant evidence of unusual illness behaviour or factitious illness, based on the evidence available."

vii) There was no evidence of current mental disorder or impairment in functioning from a psychiatric point of view. If, however, her disorders were to relapse it is likely that her parenting would be affected again. M has mild anxiety regarding these proceedings, which renders her vulnerable to relapse and if supervising X in an unsupervised environment there is a risk of the associated stress leading to relapse.

viii) He stated that "if some form of residential placement were available, with 24-hour support and observations, with appropriate professional support, then in my opinion this would enable the most constructive assessment and further work to be undertaken".

52. Ms K, consultant clinical psychologist, reported on 16 December 2019 that:

i) M's behaviour and presentation had improved. She had made considerable progress in the last 6 years. She was significantly more relaxed, candid, and open than in the previous proceedings.

ii) She had made a decision to separate from F, with whom her relationship was negative and characterised by domestic violence, and focus on X. Her engagement with professionals was vastly improved.

iii) There were residual habits of thought and behaviour that impact at times. She recognised she still has progress to make.

iv) She had learned a great deal about her thought habits and better understood X's needs. She believed she had not been equipped to care for her previous children.

v) She can become deeply anxious and frustrated, on occasions impatient with professionals, particularly with contact arrangements. This is a reflexive response which she has the capacity to master and acquire coping skills.

vi) Her negative behaviours were intensified after the sexual assault.

vii) She remained in essential need of therapeutic input to deal with aggression and frustration. "I believe there are reasonable grounds to be optimistic about [M's] capacity".

viii) Her profound hearing loss had contributed to many psychological and social difficulties, including a sense of isolation, frustration, and impact upon confidence.

ix) She had become more stable psychologically but there needed to be evidence of sustained improvement.

x) In many ways, M was practising new skills and relearning effective and positive coping strategies. The possibility that she might lose her child had triggered in M a much higher level of motivation. "I believe it would be of immense importance that there is the opportunity for [M] to be observed in the residential setting". She recommended (a) counselling focussing on trauma and past difficulties, (b) ongoing support from professionals and (c) a period of time in a mother and baby unit with 24-hour support and observation.

53. It is, in my view, important to record that, notwithstanding the note of optimism in the reports of both Professor J and Ms K as to the progress of M, they each tempered such optimism with caution as to the risk of relapse and the need to treat a residential assessment as very much a first step. Further, neither Professor J nor Ms K had had

sight of the bulk of M's medical records (principally hospital records) which were obtained subsequently.

54. Dr L, consultant paediatrician, in a report dated 30 December 2019 reviewed the medical records of M to consider whether the abnormal illness behaviour had continued. He concluded that:

    i) Between September 2014 and July 2019 there were 9 attendances for reduced consciousness and 4 for reported Addisonian crises, which suggested a pattern of somatisation, i.e. psychological factors producing physical symptoms. It is now clear that because he had limited access to records, these numbers were in fact somewhat higher.
    ii) There were 5 reported overdoses from 2014 to 2017, but none thereafter (these figures were also wrongly understated and for the same reason). M's psychological issues were "severe".
    iii) M had repeatedly presented for headaches, abdominal pain, throat pain, vomiting, ear pain, cheat pain, weakness, and blackouts. "I am not an adult physician and cannot provide an expert opinion on the above issues. However, these suggest to me as a paediatrician experienced in managing young adults a pattern of somatization (psychological factors producing physical symptoms)….Although there are entries for Addisonian crises, for some presentations there were no clear signs for this diagnosis…..".
    iv) This pattern was associated with patients who have factitious illness disorder.
    v) There was a history of poor compliance with medication.

55. It was then discovered that these three experts had only had sight of GP records. An order was made on 4 February 2020 for hospital records to be obtained and disclosed to the experts.

56. The addendum reports of Professor J dated 10 February 2020 and 19 May 2020, after receipt of the further medical records, concluded:

    i) The records indicate previously documented history to 2018 of recurrent crises, episodes of self-harm, alcohol misuse, and domestic violence in personal relationships.
    ii) There were no entries relating to clinically significant psychological symptoms from around the middle of 2019.
    iii) There was no evidence of self-harm, alcohol misuse or psychological distress after September 2018. Overall, there appeared to have been significant improvement in M's engagement with the child during and after pregnancy.
    iv) "My understanding of these reports [by Dr L and Dr K] is either that they confirm a current change in [M's] presentation or that her difficulties do not preclude her ability to parent safely". His previous report was therefore unchanged.

57. The addendum report of Ms K dated 1 June 2020 was rather more cautious than her first report:

    i) M's recurrent patterns of behaviour were apparent in childhood and adolescence, caused by upbringing, conflict within the family and attachment

problems with her mother. Hearing and other difficulties have impacted upon her self-confidence.

ii) M had showed a new capacity to be self-reflective and self-critical since the birth of X. She was willing to engage and was committed to contact. There are some grounds for cautious optimism about ongoing change.

iii) A precursor to any rehabilitation would be a residential placement. A "residential placement [with 24-hour observation of care] would be a very necessary precursor for any further plans. M's history of vulnerability, excesses of behaviour and emotion and a need for support and the consolidation of change, remain vital".

iv) There remained a need for ongoing therapy, ideally in a residential placement.

v) There remained a number of ingrained patterns of behaviour, some chronic vulnerabilities, PTSD, depressions, and poor self-confidence, but these had lessened considerably in 2019 compared to 2013. The long history of mental health issues indicated areas of concern going forward. Without support and the consolidation of coping strategies, M might become increasingly vulnerable.

vi) M was most vulnerable to changing levels of confidence and vulnerability to depression, with a risk of chronic instability; "the very many traumatic and significant negative life events and relationships which have affected M have contributed to a consolidation and repetition of many negative and often maladaptive habits of thought, management and response".

vii) "If M has managed to remain stable in mood and behaviour, has sought or been assisted in seeking therapeutic support and if there has been incremental progress, this would provide some grounds for cautious optimism about ongoing change. In the absence of progress, I would however be deeply concerned that without support and the consolidation of better coping strategies, M may become increasingly vulnerable. This would in turn inevitably have an impact upon her …competence in every area" and …"where there are recurring, acute or unresolved issues however, there would be a real and worrying potential for adverse impact upon the child".

viii) "Of particular significance will be how M has progressed, engaged and consolidated change in the six months since the last report. I have some concerns that if the placement with her child has not taken place, if she has not been monitored and supported and that relationship further enhanced, that progress may have been lost or limited. It is of particular concern that the current pandemic with its accompanying restrictions of movement and opportunity may well have triggered for M many underlying difficulties. Updating information in respect of each of these matters will be of assistance in proving further clarification".

58. Dr I, a consultant endocrinologist, reported on 23 August 2020:

i) M has Pendred syndrome, a rare inherited genetic condition which causes thyroid disorder and sensorineural hearing loss:

a) She is prescribed Thyroxine, but for nearly 2 decades consistently failed to take the medication regularly, at times denying that she had not been compliant.

b) Between September and December 2018, her thyroid tests suddenly normalised, indicating good adherence to prescribed Thyroxine.

c) She was fitted with a right cochlear implant on 8 February 2008, but failed to attend a key appointment on 19 August 2016 so it is unclear whether optimal functionality has been achieved.

ii) M is asthmatic and in Oct 2016 she was recorded as smoking 40 cigarettes a day.

iii) M has gestational diabetes mellitus. By letter dated 21 January 2020 Dr N, her consultant endocrinologist, recorded that she attended all appointments and maintained excellent blood glucose control during pregnancy (another example, in my view, of progress by M at that time).

iv) M has urinary incontinence issues. She underwent a urinary diversion procedure in late 2020.

v) M's mental health issues include recurring anxiety, depression and impulsive and aggressive behaviours, suicidal ideation, and actions consistent with emotionally unstable personality disorder. Further:

a) There was a previous high rate of hospital attendances for recurrent symptoms which were non-organic, possibly arising from somatisation of psychological issues. Medical notes showed multiple attendances at emergency departments, sometimes at 2 hospitals on the same day, with profound symptoms (headache, abdominal pain, nausea and/or vomiting) but no evidence of organic illness;

b) However, there had been no clinically significant mental health issues since mid-2019, and no mental health crises, overdoses since September 2018.

vi) Addison's disease:

a) Adrenal insufficiency was first suspected during a hospital admission in June 2009, presumably because of nausea and vomiting. However, the diagnosis was ruled out by an adrenal stimulation test.

b) Tests carried out in 2011 suggested mild adrenal insufficiency but did not constitute a diagnosis of primary adrenal insufficiency, including Addison's.

c) Addison's is a lifelong condition, and requires permanent dependency on medication

d) In 2014 M reported having been diagnosed with Addison's disease by Dr G at NN General Hospital.

e) There were "serious questions" about the validity of the diagnosis apparently given by Dr G, but for the purposes of his report Dr I proceeded on the basis that the diagnosis was correct.

f) Patients with Addison's disease experience extreme fatigue, nausea, loss of appetite, weight loss, increased skin pigmentation, dizziness from low blood pressure, impaired concentration from low blood glucose or salt, potentially progressing to coma, shock, or death. The mortality rate is approximately doubled. Patients report a significantly lower quality of life.

g) Further tests were required to revisit the diagnosis.

h) Superficially, M had been little affected by Addison's apart from taking corticosteroid medication and seeking medical attention. There were no

definite episodes of adrenal crisis, nor other ill health directly attributable to having adrenal insufficiency.

i) On at least 2 occasions M erroneously claimed she was receiving a particular type of medication prescribed by her GP.

j) Poor adherence to medication would be associated with increased propensity to adrenal crisis.

k) Between January 2014 and September 2018, she attended hospital on 30 separate occasions for a variety of reasons, but on no occasion was there firm evidence of adrenal crisis.

59. Dr I arranged for more tests to be carried out in order to confirm, or otherwise, Addison's disease. By letters dated 13 January 2021 and 29 January 2021, he confirmed that the tests revealed M did not have Addison's disease or any other form of adrenal insufficiency. He then provided answers to two sets of questions put by the parties jointly which concluded, in summary:

i) The tests carried out in 2011 suggested the possibility of mild adrenal insufficiency, but unequivocally ruled out primary adrenal insufficiency, including Addison's disease.

ii) On a number of occasions between 2011 and 2014 hospital notes recorded references to Addison's disease by non-specialists in the field (e.g. an obstetrician). Dr I was not particularly surprised by this as he would expect such persons to use "Addison's disease" in a catch-all sense to refer to all forms of adrenal insufficiency. What may have happened is that an imprecise comment by a member of staff became fixed in medical records by accident or misinterpretation, was repeated and gathered spurious credibility over time.

iii) There was never a firm diagnosis of Addison's except in M's mind and in the minds of various members of staff not fully trained in endocrinology.

iv) The first reference to a <u>diagnosis</u> of Addison's appears when she returned to MM in 2014. It appears that M offered the diagnosis herself and the MM endocrinologists "seem to have simply taken this on trust".

60. Inevitably, a forensic retroscope had to be applied to all the previously obtained evidence in the light of this new finding. Accordingly, Ms K and Professor J were asked to update their reports in the light of the updated Addison's evidence, and all the records which then were available, including historic medical records, police, and ambulance disclosure; essentially the material which was before me at trial

61. On 6 April 2021 Ms K reported:

i) "It is sadly evident that there have continued to be difficulties for and within [M] in relation to her state of mind and some behaviours. These fluctuations clearly do not indicate sustained progress or improvement". "Evidence of significant change…has been minimal."

ii) "A very highly anxious preoccupation with health, events of panic and distress and a need on M's part for reassurance in respect of her health (be that physical or psychosomatic) suggests that she has been triggered into these older and deep-rooted familiar behaviours…To address and reverse these…would likely be a very long and potentially damaging process."

iii) There appears to be a re-emergence of these negative patterns of behaviour over recent months. Negative coping strategies are symptoms of stress and distress. "[M's] progress appears to have been overwhelmed by internal and external events". While there was the possibility of opportunity to make and sustain further progress a year ago "this now seems to have been compromised".

iv) As for therapy, "I would anticipate that input would be very long term, highly focused and with no guarantee of a successful outcome". The therapy to date does not indicate longer term goals and potential for sustained change. Regardless of what work has been undertaken it seems that over the course of the last 15 months there have been reversals for [M]".

v) "The evidence of the last 12-15 months suggests that M has been triggered repeatedly into a high degree of vulnerability, defensive behaviours and less than effective coping strategies. This will very sadly be to her own detriment and that of the child…. ongoing care would be in the first instance unreliable and unpredictable…if these older ways of thinking and behaving have re-emerged in whatever guise and for whatever reasons they would likely require not only ongoing and intensive work but the complete engagement of the mother".

vi) "Whether [M's presentation] over the last 15 months since the earlier report of December 2019 represents a reversion, an emergence or a conflation of these triggers, the very sad fact is that they appear to be active, intrusive and shaping M's state of mind and presentation".

vii) "I cannot see scope for effective and behaviour changing input to be bought about quickly enough to allow for sustainable change which could in turn suggest that [M] may be able to provide X with a continuity of good care". "Evidence of significant change…has been minimal."

viii) As for a residential assessment, "to place X in an unfamiliar environment with an individual who is not one of her main attachment figures would be puzzling, confusing and potentially immensely disrupting to her". The advantages of a placement a year ago would be more difficult to achieve now and "X would be profoundly unsettled". If the outcome is not successful, "the period of disruption would likely be very compromising to this little girl". "X's primary attachments are with her foster family". Her mother is probably perceived as a family stranger. In 2019 this may have been feasible, but now Ms K would be "very pessimistic" about a move from her current placement. "I would be very concerned if at this time…a residential assessment was to be pursued in the absence of compelling and consistent evidence of change on M's part. Indeed, at the present time there are few indications of the likelihood of success".

ix) "The child's sense of self, security, well-being and attachment are firmly rooted within the foster family. Any significant disruption, should it not be guaranteed to be positive in outcome, would be deeply compromising to this little girl".

62. Professor J 's update is dated 14 April 2021. Crucially, he concluded that on balance the mother suffers from the previously identified diagnoses and also with SSD and FD. He reports there is considerable overlap between the two; the primary emphasis with SSD is that the symptoms reported by the sufferer are genuinely experienced even if they have no organic basis, and appear to be derived as a response to stress and as a defence to psychological distress. He said:

i) His previous report was based on M's self-presentation and there being no evidence of any current depression or clinically significant psychiatric symptoms. However, it seemed that since then there had been repeated examples of chaotic and risky behaviour. This was the re-emergence of longstanding behaviours, which re-emerged when she was exposed to even minor stress, and even though she had undergone some therapy. Her underlying motivations and behaviours were therefore so ingrained as to be unlikely to be remedial to further psychotherapy treatment. He would not regard a residential placement as appropriate.

ii) He had not previously seen the medical records, Ms K 's material, and other relevant documentation including call-out logs. He had revised his opinion after receipt of those documents.

iii) The records showed:

a) Multiple contacts with GPs, with apparent overuse of medication.
b) Presentations to various emergency services in crisis where she has inappropriately demanded support, using them for what appeared to be relatively trivial circumstances.
c) A re-emergence of a range of psychological symptoms, including low mood and anxiety.
d) One documented overdose in recent times.
e) She does not have Addison's disease. Yet she had presented multiple times with Addison's symptoms, including apparent loss of consciousness, without an organic cause.

iv) Patients with a range of physical health symptoms without apparent cause may have SSD which is associated with anxiety, depression, past trauma and lower level of education and socio-economic status. It is a defence against psychological distress and an attention seeking defence mechanism.

v) On balance, she also presented with aspects of FD which is characterised by falsification of physical or psychological symptoms.

vi) She had in the past been found to have undertaken FII to her children.

vii) He drew attention to research that draws a link between "SSD and FD in the parent, who was usually the mother… found to be particularly associated with FII in the child…":

"15.48 Other research has shown that SSD and FD are over-represented in caregivers, with possible intergenerational transmission of abnormal illness behaviour from the caregiver to the child (Bass et al 2014).

15.49 It is recognised, however, that such features overlap considerably with those of caregivers who are advocates for their children with genuine illnesses, and some parents who fabricate illness in their children do not show such features….The final decision on this is, of course, a matter for the court to decide.

15.51 Given however, that M has previously undertaken FII, in my opinion, however, this significantly raises the risk that M's child would be exposed to FII if she were returned to her unsupervised care.

15.52 FII is associated with significant risk of morbidity and mortality in the victim child".

viii) "For clarity, provided the court does find that M has SSD and FD, and given the previous findings of FII with a previous child, and the association between these disorders and FII, in my opinion X would be at significant risk of being exposed to FII if in M's unsupervised care."

63. It is notable how the written expert evidence of Professor J and Ms K evolved over time, becoming much more pessimistic and ultimately reaching conclusions which are firmly negative about M's capacity for change, her parenting abilities, and her ability to safeguard X. There are main two reasons for this; first, the receipt of all relevant disclosure, including hospital, police and ambulance service records, and second, the events of 2020 demonstrating a regression by M to familiar and ingrained behaviour patterns.

Oral evidence: the experts

64. I was struck by the warmth expressed by the experts towards M. They were balanced, fair and understanding of M's situation. I detected no animosity; on the contrary, they were empathetic and insightful. Each was very even-handed and I unhesitatingly accept their evidence.

Dr I (Consultant Endocrinologist)

65. Dr I told me that for about 2 decades, until she became pregnant with X, M was not taking her thyroxin medication regularly as prescribed. That is objectively verifiable from the blood tests in the medical records. But failure to take thyroxin, or irregular and chaotic taking of thyroxin, would not have caused any of the Addisonian symptoms with which M has presented over a number of years, such as dizziness, vomiting, headaches and unconsciousness. Poor adherence to thyroxin might lead to gradual, chronic symptoms including weight change, loss of body hair and skin coarsening but would not trigger a crisis such as those apparently experienced by M and which is consistent with Addison's. He told me that since M became pregnant in 2018, she has complied with her thyroxin tablet taking requirements. Accordingly, on any view, irregular or missed thyroxin medication cannot have contributed to any Addisonian symptoms since 2018.

66. He told me that usually a patient who is chaotic with taking one form of medication is chaotic also with another form of medication. In this case, he was asked whether M would have been uncompliant with inhaler use for asthma and agreed that was likely to be the case.

67. The initial investigations into adrenal insufficiency arose due to M presenting with symptoms including dizziness, headaches and collapses from about 2007 onwards. The doctors then did Short Syncathen Tests in 2011 which were "sub-optimal" and produced, to Dr I 's mind, unreliable results. This was possibly because M was pregnant at the time and perhaps also because the use of inhalers is incompatible with a reliable test result.

68. There was never a formal diagnosis of Addison's, but M was repeatedly told by clinicians of various disciplines that she had Addison's, and received advice on hydrocortisone emergency injections. Leading counsel for M referred to a number of medical notes from 2011 onwards referring to Addison's, and a reference to Addison's in the expert psychiatric report of Dr O from the earlier set of proceedings. Dr I felt this was a catch-all phrase used by medical staff to describe adrenal insufficiency which had been partially diagnosed in 2011. It was therefore, according to Dr I, entirely reasonable for M, since 2011, to have believed that she had Addison's and to tell clinicians and other medical staff accordingly.

69. As a result, she has been taking hydrocortisone steroids by injection since about 2011 for a condition which, it now transpires, she never had. However, there were no side effects of the treatment and in particular it would definitely not have contributed to the multiple presentations with dizziness, headaches and unconsciousness or semi-consciousness.

70. He said categorically that there were no organic reasons for the multiple Addisonian presentations over many years. Thus, she did not have Addison's but nevertheless presented frequently with Addison's symptoms, and crisis occurrences. He described M's case as very unusual.

71. He felt that for M to have said she has Addison's would not have been factitious because she genuinely, and reasonably, believed it, having been told repeatedly that she had Addison's. But the symptoms which she presented with were not in fact referable to adrenal crisis because his tests confirm that she never had it. Thus, in the absence of organic explanation, those symptoms are consistent with factitious illness. That said, he fairly pointed out that although he has knowledge and experience of factitious illness, it is not within his area of expertise.

Ms K (Forensic Psychologist)

72. Ms K has a particularly helpful perspective as she saw, and reported on, M in 2012 and can therefore comment on M's trajectory. She told me that in 2019 M was strikingly different, and showed much progress. She was more stable and coherent, showing a genuine willingness to change, and clearly devoted to her child.

73. What matters, however, in this case is not her intentions but how her emotions intervene and compromise those intentions. The crux is that she finds it difficult to manage and contain her stress levels. Since the end of 2019, her underlying maladaptive behaviour patterns have re-emerged. They had never gone away but had been better managed during 2019 for whatever reason. But from early 2020 all the old patterns of behaviour resurfaced as her anxiety was triggered. She felt that a number of factors may have had an impact; X moving into foster care, the fear of losing her, the court's refusal to sanction a residential assessment, the ongoing expert evidence, the onset of the pandemic and the consequential impact on contact with X.

74. She told me that M's deep-rooted behaviour remains. When her intense and acute anxiety is triggered it leads to negative behavioural patterns; she finds herself at the mercy of her emotions. Her Addisonian symptoms are likely to have been genuine but psychosomatic, triggered by ingrained anxiety.

75. She confirmed to me that she had viewed the possibility of a residential assessment in late 2019 as an opportunity for 24-hour observation and supervision to assess M's capacity and her needs. But as time has gone by that opportunity is no longer there. It is too late. X is older and has consolidated her attachments. To remove this child into a residential assessment with M, who she has seen little of since March 2020 would be, she felt, very damaging. M is still struggling, and she cannot recommend it any longer without evidence of real change on M's part. She went so far as to say she is 100% against it.

76. She agreed with the suggestion that there is a real risk that M may form relationships with abusive partners, and not be fully open about the consequences thereof.

77. She felt that the prospects of successful therapy are remote because M has such chronic and deep-seated issues. Therapy itself would be stressful and could trigger maladaptive behaviour. Very deep and wide-ranging therapy would take at least a year to make meaningful progress, perhaps more, which she felt was not within X's timescale and in any event, she thought it would not be likely to be successful.

78. The observations at contact of repetitious advice being given did not surprise Ms K. She was confident that M would try to implement it, but her efforts would be compromised by her behavioural issues.

79. Overall, she has made some progress since the previous proceedings. But the 2020 episodes have demonstrated again how deep-seated and structural her anxiety disorder is. The flurry of incidents show that the pre-existing conditions are still there and the potential hazards for this child are unabated. M remains "all at sea" and has not managed to go further than "not doing more badly".

Professor J (Consultant Psychiatrist)

80. Professor J told me that in 2019 M presented with apparent insight into her behavioural patterns, and for that reason he supported a residential assessment. However, having now seen all the medical records, he said that despite that apparent insight, and despite a considerable amount of therapy, the past behavioural motivations and patterns have re-emerged; put simply, therapy has not worked and the apparent insight is to be regarded as highly questionable. The evidence of multiple admissions to hospital, and attendances at her GP's, is highly significant. To address her deep-rooted issues, and bring about meaningful change, would require highly intensive, one to one bespoke therapy for a minimum of 3 years. There is no guarantee that such deep therapy would be successful; indeed, he felt that to be unlikely. He tended to the view that her unconscious motivations are probably not capable of remedy.

81. He was confident that M did indeed experience, to a degree, Addisonian symptoms which he attributed to SSD. They are somatic in that the symptoms are, in part, genuine, and driven by her underlying motivations and anxiety.

82. He also considered that there is an element of FD in that M exaggerates symptoms as an attention seeking device. He felt that in particular her multiple presentations at hospital with unconsciousness, lacking any organic physical or neurological explanation, were likely to be exaggerated. He was referred, for example, to an attendance at A and E on 2 August 2018 when the hospital note records that she was

"likely not truly unconscious" and simply left hospital without any apparent difficulty, and agreed that to be illustrative of a particular, entrenched behavioural pattern. Additionally, he referred to ongoing overuse of medication as entrenched attention seeking behaviour, and addiction to medication in itself would represent a risk to both mother and child. Now that M knows she does not have Addison's, he considers it likely that her SSD and FD will manifest themselves through other symptoms.

83. The combination of previous FII to the older children, together with M's ongoing and unresolved SSD and FD, makes it more likely (as the research shows) that X would herself be at risk of FII if returned to M's care. He also felt that the fact of a return would in itself be a high stressor for M.

84. Finally, his view was firmly that a residential assessment now would be unlikely to enable M to make sufficient progress to a point where consideration could be given to a return of X to her care.

Local authority oral evidence

85. Miss Z (social worker) explained to me about a number of occasions from late 2019 to June 2020 when, despite advice to the contrary, M contacted B who was then embarking on therapy provided by Barnardo's, in circumstances where Barnardo's considered that such contact should be suspended for the duration of the therapy. She said, and I accept, that although this must have been disappointing for M, she should not have continued to communicate with B.

86. X's health visitor, Ms U , who observed interaction between M and X on 9 occasions up to March 2020, was generally complimentary about M, her willingness to engage and cooperate, her warmth towards X, her interest in X's development and her obvious commitment to her daughter. Of particular note, I felt, was her description of how M would be advised about aspects of basis care (feeding, putting X down to sleep, playing with her), welcome that advice and yet be unable to implement it regularly. Nobody suggests she ignored the advice. It had to be given to her on repeated occasions because she was simply unable to absorb and act on it. Repeated advice was given by way of prompts on the same issues. This particular aspect struck me as a very concrete example of how M's behavioural patterns affect her.

87. Ms V, an Early Years Practitioner to whom M was referred in February 2020, was only able to provide assistance and support to M remotely because of the national lockdown. Her witness statement summed up her evidence in which she said that M attended all sessions (remotely) and "appeared to engage well with me and appeared eager to learn".

88. Ms W was the allocated social worker from April to October 2019 and became team manager in June 2019. She was unstinting in her praise of M at that time. M worked well with her, was reflective and cooperative, even during difficult times which involved X being removed into foster care, changes to contact and an issue about M not being allowed to prepare the feeding bottle because of the findings of the previous proceedings about FII. M, to her credit, has developed a good relationship with the foster carer. The problems started in 2020 with the incidents which I have outlined above. Previous patterns came to the fore once again. During the course of the year, the view of the LA evolved until, by September 2020, adoption was thought to be the preferred option. She told me that she had heard from others about the need for

repetitious advice to be given to M and felt that this caused concerns about whether M can provide even basic care.

89. Ms Y, who took over from Ms W as the allocated social worker, told me that the consideration of family members had been kept under review from the outset. A viability assessment of M's father, MGF, was carried out, not because he formally put himself forward but because of a chance conversation with M in early February. MGF has been present at some team meetings and is well aware of the proceedings. Ms Y felt that MGF lacks proper understanding of M's complex issues. On one occasion at a meeting he said that "M is a very experienced and accomplished mother" which is clearly at odds with the history. He, and indeed other members of M's support network, feel that the social services, Ms Y in particular, are picking on M. He blames Ms Y and is dismissive of the previous proceedings. She thought he was not sufficiently appreciative of the risks and has a disregard for the professionals.

90. Ms Y was cross examined, properly so, at length about contact/family times between M and X. She herself observed 6 sessions between October 2019 and March 2020, and 2 sessions in September 2020. She described M's punctuality, positive interaction and fun with X. Her reservations were that she felt M was not particularly proactive, and required repeated parenting prompts from supervising staff; this echoed what I had been told by others. She said that M was repeatedly given advice, including at regular meetings, and by the foster carer and contact supervisors, but was unable to do so. The repetitious nature of advice, despite all the support, has continued throughout and M has been unable to put it into practice spontaneously. She told me that notwithstanding the LA's adoption plan, M maintains a good working relationship with social services. I asked her about M's support network, which M identifies as principally her sister lor, her neighbour, her mother and her father, and which she felt was inadequate to protect X.

91. I accept all the evidence of these witnesses. They were all fair and thoughtful. They gave credit to M where it was due and were generous to M in the steps she had taken. It is clear that M reacts less well to Ms Y than she did to Ms W, but I reject the suggestion made in cross examination that Ms Y has ever been less than scrupulously fair towards M. There may have been differences of opinion, and occasionally tricky judgment calls surrounding implementation of contact, but I am quite satisfied that Ms Y did her very best to be balanced. She was composed in her evidence, and palpably trying to do her best.

Witness on behalf of the Mother

92. M's neighbour has known M for 4 years. She is a neighbour and good friend. She told me that M had not told her about the previous court proceedings or findings of FII; she had been told by M that the older children were in care because of the abusive relationship perpetrated by Mr R. She said that M has told her she continues to experience flashbacks and nightmares as a result of the sexual assault in Turkey. She was asked about the 18 August 2020 episode which she described as a mental health crisis. She agreed with counsel that such an event would be very upsetting for X if exposed to it, and it would not be right for X to grow up with such crises. I thought she was obviously honest, kind and a great source of support for M who confides in her to an extent.

The Mother

93. M gave evidence for a whole day. I have to say that she created a better impression on me that she did on HHJ Richardson QC in 2013/2014. That is, I believe, because she is in a better place, or at any rate a less bad place, than she was then. She was composed, articulate and polite. She acknowledged much that was put to her about the chaotic events of 2014-2018. I did not get the sense that she was telling me manifest untruths. All that said, I came to the clear view that at times, although not being dishonest, her perception of events was rather different than that portrayed by the evidence; she has persuaded herself of a more positive narrative than the evidence justifies. At times she said "I don't remember" (commented on by HHJ Richardson QC in the previous proceedings) when, I suspect, questions were too difficult to answer. She was very over optimistic about her ability to parent X and leave behind her mental health issues. I felt also that to an extent she had expunged, or put out of her mind, or minimised some of the terrible events in her life which have led her to where she is now. I do not think she did so deliberately, or as a façade, but more as a protective measure for herself. The reality, it seems to me, must be for her very hard to bear.

94. Her love for X was palpable in the way she described her beautiful, intelligent, happy little girl. Her eyes lit up when describing her daughter. I was also struck by how she described the job she has had for 2 years or so as a barmaid/waitress in a pub, albeit interrupted by Covid. It gives her evident delight and self-confidence. With this, as with so many other things in her life, the pandemic was a particularly cruel interruption to the genuine progress which she had tentatively embarked upon.

95. More difficult territory for her was questions about the previous proceedings. She fell back on "I don't remember" on occasion. She said that she accepted the findings of the previous hearings, that she had been guilty of FII and neglect, that she did not put the children's needs first and that she had caused them long-term harm. But I am confident that, although her sentiments were at one level genuine, her insight into the consequences of her behaviour was skin deep. Under cross examination by leading counsel for the Guardian, she told me that her memory was poor and she could remember very little before 2017. She was unable to explain why she behaved the way she did (including causing harm directly and indirectly to her children) beyond saying that she was not in a good place. She could not really articulate the effect upon her children of her own actions. She was unable to say whether A has struggled as a result of her own neglect, simply saying that they get on well now. Her communications with B, in particular posting on B's Facebook page in November 2019 a message that she (i.e M) was not in a good place and nobody cared for her, clearly demonstrate to my mind that she does not truly appreciate the impact of her actions on B. Her acknowledgment of past mistakes was more in form than in substance; a true acceptance that findings were made against her, but a continuing difficultly in accepting how and why those findings have impacted on her children. It is also of note that she has not told members of her support network the full, unvarnished truth about the circumstances of the removal of her older children.

96. In similar vein, she agreed that the experts' conclusions about her ongoing SSD and FD are correct and that she has experienced these conditions for a very long time. She confirmed that she continues to have flashbacks and nightmares, particularly about the sexual assault in 2016. She appeared to agree that she requires a great deal of therapy,

but the fact that she believes she can resume care for X immediately seemed to me to belie that, and indicated that she does not, in her heart, feel it to be absolutely necessary.

97. It seemed to me that she underestimates the scale of the task ahead for her, and X, if reunification takes place. She said that her mental health issues would not affect X, although she did acknowledge that recurrent admissions to hospital would impact upon her daughter. I sensed she viewed that aspect more in terms of keeping X physically safe, e.g by placing her with a neighbour, without fully considering the extent of the emotional impact on X of being exposed to M's mental health crises and battles. She expressed optimism about the future, whilst acknowledging she could not predict how her mental health issues would develop.

98. She was asked about her communications with B at a time when all contact should have ceased to enable B to undergo therapy. It seemed to me that much of what was put to M about these events emanated from B who did not give evidence and, as a troubled young woman, may not be entirely reliable. That said, it was clear from M's evidence that she did contact B on a number of occasions, including occasionally via her father. Even if she did not seek to discourage her from the therapy, as was suggested to her, the very fact of engaging with B must have been confusing and disruptive and, in my judgment, was inappropriate behaviour on her part given that she was under no illusion about the need to cease contact. The most obviously inappropriate action was to share with B screenshots of abusive messages which she had received from A and his then girlfriend.

99. M was asked a number of questions about her past relationships. It was clearly demonstrated, as she readily accepted, that there was a pattern with Mr R, Mr P and F of experiencing an abusive relationship yet continuing or resuming that relationship. Thus, she went to live with Mr R for a while after the original proceedings during which they had separated. She alleged rape against Mr P in July 2017 yet continued to stay in touch with him and was the victim of a vicious assault by him in August 2017. X was, she told me, violent, aggressive, and controlling, yet even after obtaining a non-molestation order she continued to stay in contact with him and she had to accept that she initially concealed subsequent meetings with him (including him attending the pre-birth scan) from social services. I felt that this pattern had the hallmarks of dependency.

100. M accepted that on 16 June 2018 she was pushed down the stairs by F, sustaining a serious head injury, yet described it as an accident to the professionals, including medical staff, social services, and her mental health treating team. It was not until police disclosure for the episode of 10 September 2020 when she revealed the assault; M accepted that she was indeed assaulted and had dishonestly concealed it. Similarly, she had given contradictory accounts about her sexual relationship with F. On 6 February 2018 and 19 May 2018 she told her mental health team that she was in a relationship with him, but not sexually, yet on 13 May 2018 she told the Crisis Centre that she had miscarried F's baby (which was untrue) and on 18 June 2018 told the mental health team that she <u>had</u> had earlier sex. She was unable satisfactorily to explain <u>why</u> she had given different accounts.

101. I am also satisfied, as she acknowledged, that she was not fully open with treating mental health professionals, and others in the period up to the end of 2018/early 2019. She repeatedly told them (and indeed others) that her older children were in care as a

result of Mr R's behaviour, without acknowledging her own part; documents put to her in cross examination clearly established this proposition. M was unable to explain why she had said such things.

102. M told me that she does not believe she needs constant advice on the basic care requirements of X. She said that she did not think it would be stressful to look after her. She believes that her support network would be sufficient to ensure X's safety, although I judge that this was another example of over-optimism. Her father lives 2 hours away. Her mother has a number of very major medical issues, and was found guilty of colluding with M in 2014. Her neighbour, Mrs S is, M told me, well aware of the history including the previous findings of FII although Mrs. S had denied any such knowledge. Her friend T is in OO, some distance away. She accepted that she and her sister have never got on well. She mentioned A as part of her network although it seemed to me that to rely on her son, who has himself experienced many troubled years, would not be a sensible proposition.

103. M was willing to enter a residential placement but believes that X can be reunited with her now, safely and securely, perhaps on a phased basis. She told me that she could undertake therapy at the same time. She was confident that the past episodes will not recur and that, even if they did, X can be protected by the support network.

104. She believes she can cope with her mental health now. I felt that she does not really think that she now has an issue. Curiously, she said that one way for her of mitigating mental health issues would be by relying on X, using her as a distraction which struck me as likely to amount to a burden on X to grow up with the knowledge that she is an emotional crutch for M.

105. Ultimately, I came to the view that her measured performance in the witness box was carried out with courage, fortitude, and a true desire to prove that she is capable of looking after X. But she lacks true insight into her past actions or a realistic appreciation of what her needs are, and accordingly whether she can provide X with safe and stable parenting.

Evidence of the Guardian

106. The Guardian's report is comprehensive. She gave her oral evidence eminently fairly, focussing on matters from the point of view of X. She was thoughtful and clear. She was present throughout the hearing and listened to all the evidence. She said as follows:

i) M dearly loves X and all her children.
ii) M has undergone therapy and counselling, and had a great deal of support from social services over many years. Despite this, her patterns of behaviour have re-emerged during these proceedings.
iii) Given the previous findings, and the expert evidence in these proceedings, the risk that X would be exposed to FII would be significantly raised.
iv) M's support network is not sufficiently robust to provide proper protection for X. They have no, or limited, understanding of the reasons for the removal of the older children and are mistrustful of the professionals.
v) She considers that M does not truly accept the findings of the earlier proceedings and "says what she knows is expected of her". M continues to lack insight and was unable to say why she had behaved towards D as she did; she believes that

doctors and nurses did not explain things properly. She describes M as being "superficial" in her acceptance of previous judgments; she means it but cannot explain it. That was, I have to say, very much my view of M's evidence

vi) She felt that therapy would start from an unpromising position namely that there can be little confidence in a mother who cannot explain her past behaviour and might well not be fully open about past actions and present stresses.

vii) In her view, "we have come full circle and M appears to have reverted to her previous pattern of concerning behaviours." She is not a new mother and has been unable to learn from past ways. She considers that M's mental health is top of her list of concerns.

viii) A residential placement would not be likely to be successful and does not fit within X's timescales.

ix) X would be at risk of significant harm and neglect if returned to M. She described the index of risk as "very high".

x) She is firmly against MGF being reassessed. Although he is well intentioned, he lacks insight into his daughter's difficulties.

xi) The various options of residential assessment, kinship care, fostering, adoption, reunification, and special guardianship are weighed up. In the end, and with little hesitation she considers that nothing less than adoption will do for this child.

Threshold: Law

107. The principles are not in dispute. So far as relevant to the present case, I summarise them as follows:

i) The foundation stone of any fact-finding hearing is Section 31(2) of the Children Act 1989:

> (2) A court may only make a care order or supervision order if it is satisfied—
> (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
> (b) that the harm, or likelihood of harm, is attributable to—
> (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him.

ii) The nature and purpose of a fact-finding hearing has been summarised thus by McFarlane LJ in **Re R (Children) (Import of Criminal Principles in Family Proceedings) [2018] EWCA Civ 198** at paragraph 61**:**

> "In family proceedings, the outcome of a fact-finding hearing will normally be a narrative account of what the court has determined (on the balance of probabilities) has happened in the lives of a number of people and, often, over a significant period of time. The primary purpose of the family process is to determine, as best that may be done, what has gone on in the past, so that that knowledge may inform the ultimate welfare evaluation where the court will choose which option is best for a child with the court's eyes open to such risks as the factual determination may have established."

iii) The burden of proving the facts pleaded rests with the local authority. As Mostyn J said in **Lancashire County Council v R and W [2013] EWHC 3064 (Fam):**

"There is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations".

iv) The standard to which the local authority must satisfy the court is the simple balance of probabilities, neither more nor less: **Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35**.

v) Findings of fact must be based on evidence, not on suspicion or speculation: per Munby LJ at paragraph 26 of **Re A [2011] EWCA Civ 12.**

vi) The LA must prove not just the primary facts, but also the causal link between any facts found and the risks alleged: **Re A [2016] 1 FLR 1** and **Re L-W [2019] 2 FLR 278.** In **Re A** Sir James Munby P said:

> **[12]** The second fundamentally important point is the need to link the facts relied upon by the local authority with their case on threshold, the need to demonstrate *why*, as the local authority assert, facts A + B + C justify the conclusion that the child has suffered, or is at risk of suffering, significant harm of types X , Y or Z. Sometimes the linkage will be obvious, as where the facts proved establish physical harm. But the linkage may be very much less obvious where the allegation is only that the child is at risk of suffering emotional harm or, as in the present case, at risk of suffering neglect. In the present case, as we shall see, an important element of the local authority's case was that the father 'lacks honesty with professionals', 'minimises matters of importance' and 'is immature and lacks insight of issues of importance'. Maybe. But how does this feed through into a conclusion that A is at risk of neglect? The conclusion does not follow naturally from the premise. The local authority's evidence and submissions must set out the argument and explain explicitly why it is said that, in the particular case, the conclusion indeed follows from the facts. Here, as we shall see, the local authority conspicuously failed to do so.

vii) The decision on whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence. The court looks at the broad canvas of the evidence before it in order to make findings on the balance of probabilities accordingly. Each piece of evidence should be considered in the context of all of the other evidence. As Dame Elizabeth Butler-Sloss P observed in **Re T [2004] 2 FLR 838**:

> "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."

viii) Appropriate attention must be paid to the opinion of medical experts, but those opinions need to be considered in the context of all the other evidence. The judge is the decision maker, the expert is not. The roles of the court and the expert are distinct: per Charles J at paragraphs 38-41 of **A Local Authority v K, D and L [2005] EWHC 144 (Fam).** The expert evidence is part of a wider canvas. It must be weighed against the lay factual evidence and the court's conclusions concerning the credibility of the participants. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers where appropriate to the expertise of others." (Baker J **Re AA (A Child) (2012) EWHC 2647 (Fam)).**

ix) The evidence of the parents and carers is of the utmost importance. The court should form a clear assessment of their credibility and reliability. The court is

likely to place considerable reliability and weight on the evidence and impression it forms of them; **Re W and another (Non-accidental injury) [2003] FCR 346**.

x) A witness may tell lies during an investigation and the hearing for many reasons, such as shame, misplaced loyalty, panic, fear and distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything: **R v Lucas [1982] QB 720**, applied in family proceedings in **Re H-C (Children) [2016] EWCA Civ 136**).

xi) The need for care with memory and witness demeanour was highlighted by Leggatt J (as he then was) in **Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor [2013] EWHC 3560** and by the Court of Appeal in **Sri Lanka v the Secretary of State for the Home Department [2018] EWCA Civ 1391:**

a) Macdonald J in **A Local Authority v W & Ors (Finding of Fact Hearing) [2020] EWFC 68** noted that the authors of **Phipson on Evidence** say at 12-36:

> "The credibility of a witness depends on his knowledge of the facts, his intelligence, his disinterestedness, his integrity, his veracity. Proportionate to these is the degree of credit his testimony deserves from the court or jury. Amongst the more obvious matters affecting the weight of a witness's evidence may be classed his means of knowledge, opportunities of observation, reasons for recollection or belief, experience, powers of memory and perception, and any special circumstances affecting his competency to speak to the particular case—all of which may be inquired into either in direct examination to enhance, or in cross-examination to impeach the value of his testimony."

b) Commenting on the assessment of credibility, Mostyn J in **Lancashire County Council v R [2013] EWHC 3064** said:

> "The assessment of credibility generally involves wider problems than mere 'demeanour' which is mostly concerned with whether the witness appears to be telling the truth as he now believes it to be. With every day that passes the memory becomes fainter and the imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited. Therefore contemporary documents are always of the utmost importance".

c) King LJ in **Re A (A Child) [2020] EWCA Civ 1230** referred to the need for a balanced approach to the significance of oral evidence. Having reviewed, among other cases, **R v Lucas** and **Gestmin** she said:

> 41. The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of oral and contemporaneous evidence will vary from case to case. What is important, as was highlighted in *Kogan*, is that the court assesses all the evidence in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another.

d) Jackson J (as he then was), referred in **Lancashire CC v. The Children, M & F [2014] EWHC 3** to 'the impact of 'story creep' ". . . a faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated or there may be inaccuracy or mistake in record-keeping or

> recollection of the person hearing that and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered as should be the effect of one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be an unnatural process – a process which might inelegantly be described as 'story-creep' may occur without any necessary inference of bad faith."

Threshold: analysis

108. The chronology of events, as I have found it to be, largely speaks for itself. The findings made in 2013/2014 were followed by a continuous pattern of maladaptive behaviour until the end of 2018 when under no circumstances could M realistically have been capable of bringing up a child. Her deeply entrenched behaviour, negative and destructive, continued unabated. During 2019 she was clearly much improved before she regressed to depressingly familiar patterns in early 2020. It seems to me, and I so find, that, taking the start of the public law proceedings as the relevant date, the s31 threshold are clearly met.

109. I do not consider it necessary to go through each and every one of the findings sought by the LA, many of which are accepted by M, but I record that I accept all the findings sought in the Local Authority's schedule for threshold purposes save for the following amendments

    i) Paragraph 35 is deleted.
    ii) Paragraph 42: the specific tabulated examples are deleted after the entry dated 16 September 2018.
    iii) Paragraphs 50 to 53 are deleted.

    I propose to summarise my core findings which underpin these conclusions.

110. First, and uncontroversially, the findings made by HHJ Richardson QC bind me and the parties. His judgments must be taken in the round, and I do not intend to incant each and every determination he made, but the main findings were:

    i) M wilfully and deliberately interfered with the medical care of D.
    ii) M fabricated aspects of D's ill health.
    iii) M fabricated aspects of B's ill health and on one occasion falsified it.
    iv) M exaggerated her own ill health.
    v) There was a likelihood of repetition of FII.
    vi) M failed to meet the children's needs, and all the children had been emotionally harmed, to a high degree, in her care.
    vii) M obstructed and was uncooperative with professionals.
    viii) All children were exposed to a volatile and abusive relationship between M and Mr R.
    ix) M failed to protect the children from violence perpetrated by Mr R.
    x) M was dishonest to the court.

111. Second, and linked to those findings, M has experienced, and continues to experience, FD which may have started as long ago as 1999, a date which I take from a medical record of 13 April 1999 which said "she often manipulates the family into taking her to casualty for minor limb injuries….", and certainly since 2007 when she first started presenting with Addisonian symptoms. She has sought attention by fabricating, or exaggerating, medical symptoms.

112. Third, I am satisfied that M did not deliberately falsify a condition of Addison's, but the symptoms of which she complained were a product of SSD (headaches, nausea, vomiting and nausea) and FD (unconsciousness and unresponsiveness):

i) She was repeatedly told that she had Addison's, and thereby adrenal insufficiency requiring emergency treatment if a crisis manifested itself. According to the medical records, it is clear that M experienced these symptoms from 2007 to 2011 when there was no "diagnosis". From 2011 onwards, she has presented herself on multiple occasions with symptoms which, as is now known, cannot have been attributable to Addison's; unconsciousness, semi-consciousness, vomiting, nausea, and headaches being prominently repetitious symptoms. Although there was a period of about a year in 2019 when these episodes ceased, they resumed from early 2020 onwards as the chronology outlined above demonstrates. The clear evidence of Dr I is that, absent Addison's, there is no organic explanation for such symptoms. In my judgment, based on all the evidence and submissions I have read and heard, and in particular the evidence of all three experts:

   a) M, to a degree, genuinely experienced such symptoms which were driven somatically by her underlying anxieties; and
   b) M, to a degree, exaggerated the symptoms. In particular, I am satisfied that her multiple presentations of unconsciousness or unresponsiveness, which had no physical or medical cause, were attention-seeking exaggerations; on all such occasions she was able to leave hospital with no apparent ill-effects.

ii) This represents a pattern, originally found in the first set of proceedings although not fully diagnosed in the way it has been before me at this hearing, of seeking medical attention for symptoms which are genuinely experienced in part, but overlaid to a degree by exaggeration, all of which is caused by the extraordinary intensity and acuity of her personality and emotional disorders, in particular extreme anxiety which, when triggered, generates both SSD and FD. M undoubtedly experiences both SSD and FD, and has done for many years. In my judgment, there is a continuing risk (which I would categorise as a high probability) that M will continue to experience and suffer from SSD and FD, and as a result will experience recurrent crises as a reaction to stress and anxiety.

iii) M believes that she will no longer experience such symptoms because she now knows that she does not have Addison's. It is right to observe that since the non-diagnosis in January 2011 there have been no crises involving Addisonian symptoms. However:

   a) She experienced them between 2007 and 2011 at a time when there was no "diagnosis", official or otherwise, of Addison's.
   b) Professor J told me that SSD and FD are likely to present themselves in different ways, now that Addison's is removed from the picture. I am satisfied that the recent confirmation that M does not have Addison's will not lessen, her mental health disorders; they will simply present themselves differently.

c) The underlying anxiety disorders are so ingrained, and so close to the surface, that there is highly likely to be some form of maladaptive behaviour caused by stress and anxiety.

113. Fourth, I accept the clear expert evidence, particularly of Professor J , that a combination of (i) earlier findings of FII to the children and exaggeration by M of her own medical symptoms (FD) and (ii) M's ongoing SSD and FD, indicates a significant risk that X would be subject to FII if returned to M's care. The research demonstrates that this inter-generational impact is a very real possibility. The consequences would be deeply damaging and harmful. One potential cause of such stress (among many others) would be X returning to her care. In other words, and sadly, the very act of rehabilitation of X with M would likely trigger highly negative responses of FII in M's treatment of X, and FD in herself.

114. Fifth, I accept that for approximately 1 year, from about February 2019 to March 2020, no presentations by M with Addisonian symptoms took place. That was during a time when M showed definite signs of improvement. She had undertaken therapy and domestic abuse programmes. She was single and not in an abusive relationship. She had started a job. She was generally cooperative with the LA, although her conduct in this respect was not faultless as demonstrated by her failure to abide by advice not to contact B. However, and despite the therapy, education, counselling, and very high level of support, from March 2020 she lapsed back into a pattern of presenting with Addisonian symptoms, as well as high levels of emotional and mental health instability, including suicidal ideation and dependency on medication. In short, she had not made sufficient progress to be protected from the re-emergence of her multiple issues. I find it to be likely that such episodes will be regularly repeated in one form or another, and carry a high risk of exposing X to physical and emotional harm.

115. Sixth, M continued to be involved in volatile and abusive relationships from 2014 until late 2018, in particular with Mr P and F. I consider on the basis of all the evidence, including that of Ms K , that there is a real risk of M in the future forming one or more dysfunctional relationships with an abusive partner, thereby placing her under the sort of stresses which in the past have repeatedly triggered her negative behavioural patterns to which X would be exposed. Further, I am satisfied that should M enter into an abusive relationship of this nature, she would be likely to conceal, or minimise, its damaging patterns from professionals, and would be disinclined to seek help.

116. Seventh, M continued to engage in a significant level of criminal activity on numerous occasions until 2018.

117. Eighth, I am satisfied that between 2015 and 2018 M was not open and transparent with her mental health treating team and other professionals, particularly (i) minimising her relationship with F, and its abusive characterisation, and (ii) minimising the findings made in 2013/2014 that she had subjected D and B to FII and had neglected all the children's emotional needs, instead casting herself as a victim of domestic abuse. In addition, in this period she did not engage fully or properly with mental health services, undertaking some work but repeatedly disengaging.

118. Ninth, although M has committed to contact and fully engaged with it, she requires repeated advice prompts for basic caring involving feeding, sleeping, and playing, even

though she is an experienced mother. I accept that this was not compendiously referred to in contact notes, but the evidence of these prompts came from a number of sources: Ms U , Ms W and Ms Y all told me of what they had seen or been told by others during contact and at regular care plan meetings, and I accept the thrust of their evidence. It is, as Ms K explained, a function of M's ingrained anxiety disorders. This aspect postdates the relevant time for establishing threshold, namely the institution of care proceedings, but in my judgment, it is informative of M's deep-seated psychological disorders which disable her from meeting the needs of her children appropriately or adequately and which have been present for many years. Absent support and continuing advice, she would, in my judgment be unable to meet even the basic needs of X adequately.

119. Tenth, M has been diagnosed with various mental health conditions including depression, anxiety, PTSD and Emotionally Unstable Personality Traits. She remains subject to, and in the grip of, these conditions. It clear that her emotional functioning and moods continue to be heavily impacted by her mental health and personality traits. She continues to experience flashbacks and nightmares which have been ongoing since 2016. She has poor distress tolerance and lacks healthy coping mechanisms when faced with stress. She remains addicted to, or at least heavily dependent upon, painkilling medication including zopiclone; such addictions represents, as Professor J said and I accept, a risk factor for both M and X. Exposure to these ongoing conditions would expose X to harm.

120. Eleventh, in my judgment, although M says that she accepts the findings made by HHJ Richardson QC, her comprehension of why she acted as she did, and the far-reaching emotional consequences upon her children as a result, remains superficial at best. On 7 October 2015, 4 November 2015, and 9 May 2018 the records show M struggling to accept why the older children were removed from her care. Her failure to appreciate the consequences of her interaction with B in late 2019/early 2020, and her lack of understanding about the impact on A of her past actions, are further indications of lack of insight, which in turn is a risk to X.

121. Finally, in my judgment and based on all the above, X is likely to suffer significant harm, and such harm is attributable to the care which would be likely to be given to her by M, not being what it would be reasonable to expect a parent to give her.

122. I repeat that M made obvious progress for about a year. But sadly, it did not prove to be enduring, despite all the support and treatment on offer. The very fact that M relapsed or, to put it another way, her harmful behavioural patterns re-emerged, demonstrates why X is incapable of being protected by M. With all the assistance and support of various services from 2014 onwards, M has sadly been unable to demonstrate lasting and permanent capacity for change such as to enable her to care for X both physically and emotionally.

Further kinship assessment: M's father, MGF

123. The duty of the LA to assess family members/connected persons and the legal basis for this was summarised by Cobb J in **Re H (Care and Adoption: Assessment of wider family) [2019] EWFC 10** at paragraphs 1-32. Local Authorities have a duty to undertake assessments in order to ensure that the reasonable placement options are properly before the court, but that duty is not limitless.

124. As to the timing of assessments, and challenges thereto, Mr Justice Keehan said in **L & Ors [2017] EWHC 2081** at paragraph 12:

> "The message has to go out loud and clear that these very late challenges to viability assessments, or the very late identification of family member will only be countenanced by the Family Court if there is exceptionally good reason as to why they have not hitherto come forward, and the assessment of them does not have an adverse effect upon the timetable for determining the future of the children. As it is, these proceedings will not be concluded within twenty-six weeks. That is regrettable. But, it is my duty, and it is the welfare best interests of the children that these proceedings are determined, whatever the outcome, as soon as ever possible.

125. MGF has no meaningful relationship with X, having seen her briefly at hospital after birth, and on a couple of occasions when M involved him in remote contact. I accept the evidence of Ms Y that he and the wider family generally were kept in mind throughout as part of an "ongoing conversation". He attended family network and care planning meetings. He has known of the plan for adoption since at least October 2020. MGF has never formally put himself forward as a potential carer. He emerged late in the day as a result of a conversation between himself and M in February (which M passed on to Ms Y) in which he indicated a wish to be considered as a carer for X. The LA rightly carried out a stage 1 viability assessment which was completed on 8 March 2021, followed by a stage 2 assessment dated 19 March 2021. For some reason MGF was not made aware by the LA of the negative outcome until during the first week of the hearing and did not receive a hard copy of the assessment until 23 April. I was told that he disagreed with the conclusion. I invited him to come to court on 27 April to explain his position. He was initially content to participate, including by giving evidence, that same day, but I suggested he should return to court remotely on 29 April so as to have time to prepare and, if he so wished, to secure legal advice.

126. Although MGF, who did not in fact obtain legal advice or representation, did not formulate it as such, I treat him as having applied for a further assessment to reconsider the existing negative viability assessment. I must consider (i) whether he is a realistic possible carer and (ii) whether it is in X's interests for a further assessment to be carried out.

127. On 29 April MGF attended remotely and expressed a willingness to give evidence and be asked questions by counsel. He told me that hadn't read any of the documents in these proceedings. He had read the judgments from the previous proceedings, but it was clear that he did not accept the conclusion that M had deliberately caused harm to D and B by interfering with their medical care and treatment. He told me that he thought such issues were misunderstood. He also seemed to me to have a jaundiced view of the Local Authority, an outlook which he shares with other family members. He said that they all regard M as having been vilified and victimised by the LA. In particular, he felt that Ms Y had been biased and inaccurate. His belief is that M is an experienced and accomplished mother, and that she does not pose any risk to X. In answer to questions from me, he felt sure that he would be able to prevent M from seeing X if that was required. After he gave his evidence, the following day he asked to attend remotely again for a short time to sum up his position which I readily agreed to.

128. I thought MGF was straightforward, frank, and honest in his evidence and subsequent submissions. He clearly wants the best for M and X. However, in my view he

minimised to a very significant degree the damning findings against M from the previous proceedings and is over optimistic about M's progress since then. He has not seen, and is therefore not aware of, the welter of documents in these proceedings, particularly the expert reports. He cannot, and does not, have a full insight into M's ongoing issues, and X's needs. He was ruled out as being a carer of the older children and age (he is 67) is now somewhat against him. I also felt that, although he is a robust and strong personality, he would have great difficulty in protecting X from M if that is what is required. M is herself a strong personality. He does not think she poses a risk, and I judge that the pressure to allow M into X's life, were she accommodated with him, would be hard to resist.

129. I have come to the clear conclusion that (i) he put himself forward very late in the day and, as a result, if his application is granted there will be additional delay, (ii) further delay would be manifestly contrary to X 's interests and (iii) he does not have a realistic prospect of securing a positive assessment nor is there any realistic prospect of the court, some weeks or months down the line, determining that X should be placed with him. I accordingly reject his application.

Welfare and outcome: Law

130. Once the court is satisfied that the threshold criteria are met, it must then go on to consider whether it is in the child's best interests to be made subject of a care order. When the court is deciding whether to make a care order it is required to consider the permanence provisions of the care plan for the child. In considering the care plan, the court must consider how it deals with the impact on the child of any harm that s/he has suffered or is likely to suffer, the child's current and future needs (including those needs arising out of that impact), and the way in which the long term plan would meet the child's current and future needs.

131. Where the court is considering an application for a care order which involves approval of a care plan of placement for adoption, the court should carry out its balancing exercise by reference to both welfare checklists in s1(3) CA 1989 and s1(4) ACA 2002, always bearing in mind that the child's welfare is the court's paramount consideration; **Re C (Appeal from Care and Placement Orders) [2014] 2 FLR 131**. The court must also consider, as mandated by both Acts, the "no order" principle and the general principle any delay in determining the question about a child's upbringing is likely to prejudice the welfare of the child. The court will only make a placement order if it is justified having given paramount consideration to the child's welfare "throughout his or her life" (section 1(2) of the Children and Adoption Act 2002. The court must have regard to the checklist set out in section 1(4) of the Act.

132. I have well in mind the famous words of Hedley J about standards of parenting in **Re L (Care: Threshold Criteria) [2007] 1 FLR 2050**:

> "Society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent. It follows too that children will inevitably have both very different experiences of parenting and very unequal consequences flowing from it. It means that some children will experience disadvantage and harm, whilst others flourish in atmospheres of loving security and emotional stability. These are the consequences of our fallible humanity and it is not the provenance of the State to spare children all the consequences of defective parenting. In any event, it simply could not be done.'

133. When the court is considering the child's welfare it must carry out a welfare evaluation of which set of arrangements for the child's future care are in his or her best interests; **Re G (A Child) [2013] EWCA Civ 965.** In carrying out that welfare evaluation, the court must consider the Article 6 and Article 8 rights of each of the parties. Where there is a conflict or tension between the Article 6 or 8 rights of a parent or carer on the one hand, and of a child on the other, it is the rights of the child which prevail **Yousef v The Netherlands [2003] 1 FLR 2010.**

134. The court should contemplate separation of a child from its parents only if satisfied that it is necessary and proportionate to do so. Before making an adoption order in such a case, the court must be satisfied that there is no practical way of the authorities (or others) providing the requisite assistance and support.

i) In **YC v United Kingdom (2012) 55 EHRR 33,** at para 134 the principle is stated thus by the Strasbourg court:

> "family ties may only be severed in very exceptional circumstances and … everything must be done to preserve personal relations and, where appropriate, to 'rebuild' the family. It is not enough to show that a child could be placed in a more beneficial environment for his upbringing."

ii) The importance of a child either living with, or maintaining a relationship, with his parents and natural family cannot be underestimated. It is not enough for it to simply be better for a child to be adopted than not; per Baroness Hale in **Re B (A Child) [2013] UKSC 33,** at paragraph 34:

> "the test for severing the relationship between parent and child is very strict: only in exceptional circumstances and where motivated by overriding requirements pertaining to the child's welfare, in short, where nothing else will do."

135. However, there is no presumption that a child will be brought up by his or her natural family. The arrangements for the child fall to be determined by affording paramount consideration to the child's welfare throughout his or her life in a manner which is proportionate and compatible with the need to respect any Article 8 rights engage; **Re W (A Child) [2016] EWCA Civ 793.**

136. The words "nothing else will do" do not represent a short cut. In **Re M-H [2014] EWCA Civ 1396** Macur LJ said:

> 8. I note that the terminology frequently deployed in arguments to this court and, no doubt to those at first instance, omit a significant element of the test as framed by both the Supreme Court and this court, which qualifies the literal interpretation of "nothing else will do". That is, the orders are to be made "only in exceptional circumstances and where motivated by the overriding requirements pertaining to the child's best interests." (See In Re B, paragraph 215). In doing so I make clear that this latter comment is not to seek to undermine the fundamental principle expressed in the judgment, merely to redress the difficulty created by the isolation and oft subsequently suggested interpretation of the words "nothing else will do" to the exclusion of any "overriding" welfare considerations in the particular child's case.
> 9. It stands to reason that in any contested application there will always be another option to that being sought. In some cases the alternative option will be so imperfect as to merit summary dismissal. In others, the options will be more finely balanced and will call for critical and often anxious scrutiny. However, the fact that there is another credible option

worthy of examination will not mean that the test of "nothing else will do" automatically bites.
10. It couldn't possibly. Placement orders are made more often in anticipation of finding adoptive parents than with ones in mind. Plans go awry. Some adoption plans are over ambitious. Inevitably there will be a contingency plan, often for long term fostering. The fact of a contingency plan suggests that 'something else would do at a push', the exact counterpoint of a literal interpretation of "nothing else will do", and it would follow that the application would therefore fail at the outset.
11. The "holistic" balancing exercise of the available options that must be deployed in applications concerning adoption is not so as to undertake a direct comparison of what probably would be best but in order to ascertain whether or not the particular child's welfare demands adoption. In doing so it may well be that some features of one or other option taken in isolation would produce a better outcome in one particular area for the child throughout minority and beyond. It would be intellectually dishonest not to acknowledge the benefits. But this is not to say that finding one or more benefits trumps all and means that it cannot be said that "nothing else will do". All will depend upon the judge's assessment of the whole picture determined by the particular characteristics and needs of the child in question no doubt often informed by the harm which s/he has suffered or been exposed to.

137. When determining the welfare stage of the hearing process, the court must consider the realistic placement options (**Re B-S (Children) [2013] EWCA Civ 1146)** and do so by globally analysing those options in a holistic and rigorous evaluation rather than taking a linear approach.

i) In **Re M (A Child: Long-Term Foster Care) [2014] EWCA Civ 1406** Black LJ (as she then was) considered the process in these terms:

"[32] What is necessary is a complex question requiring an evaluation of all of the circumstances. As Lord Neuberger said at [77] of Re B, speaking of a care order which in that case would be very likely to result in the child being adopted:

> "It seems to me inherent in section 1(1) [Children Act 1989] that a care order should be a last resort, because the interests of the child would self-evidently require her relationship with her natural parents to be maintained unless no other course was possible *in her interests*." (my emphasis)

I emphasise the last phrase of that passage ("in her interests") because it is an important reminder that what has to be determined is not simply whether any other course is possible but whether there is another course which is possible *and* in the child's interests. This will inevitably be a much more sophisticated question and entirely dependent on the facts of the particular case. Certain options will be readily discarded as not realistically possible, others may be just about possible but not in the child's interests, for instance because the chances of them working out are far too remote, others may in fact be possible but it may be contrary to the interests of the child to pursue them."

ii) Lord Justice Ryder provided further guidance in **CM v Blackburn with Darwen Borough Council [2014] EWCA Civ 1479:**

"33. A court making a placement order decision must conduct a five-part exercise. It must undertake a welfare analysis of each of the realistic options for the child having regard among any other relevant issues to the matters set out in section 1(4) of the 2002 Act (the 'welfare checklist'). That involves looking at a balance sheet of benefits and detriments in relation to each option. It must then compare the analysis of each option against the others. It must decide whether an option and if so which option safeguards the child's welfare throughout her life: that is the court's welfare evaluation or value judgment that is mandated by section 1(2) of the Act. It will usually be a choice between one or more long term placement options. That decision then feeds into the statutory test in sections 21(3)(b) and 52 of the 2002 Act, namely whether in the context of what is in the best interests of the child throughout his life the consent of the parent or guardian should be dispensed with. The statutory test as set out above has to

be based in the court's welfare analysis which leads to its value judgment. In considering whether the welfare of the child requires consent to be dispensed with, the court must look at its welfare evaluation and ask itself the question whether that is a proportionate interference in the family life of the child. That is the proportionality evaluation that is an inherent component of the domestic statutory test and a requirement of Strasbourg jurisprudence.
34. That is what `nothing else will do' means. It involves a process of deductive reasoning. It does not require there to be no other realistic option on the table, even less so no other option or that there is only one possible course for the child. It is not a standard of proof. It is a description of the conclusion of a process of deductive reasoning within which there has been a careful consideration of each of the realistic options that are available on the facts so that there is no other comparable option that will meet the best interests of the child. The words of Lord Nicholls in In re B (A Minor) (Adoption: Natural Parent) [2001] UKHL 70, [2001] 1 WLR 258 cited with approval in the Supreme Court in Re B remain apposite:

> "[16] … There is no objectively certain answer on which two or more possible courses is in the best interests of a child. In all save the most straightforward cases, there are competing factors, some pointing one way and some another. There is no means of demonstrating that one answer is clearly right and another clearly wrong. There are too many uncertainties involved in what, after all, is an attempt to peer into the future and assess the advantages and disadvantages which this or that course will or may have for the child."

iii) And in **Re W [2016] EWCA Civ 793** McFarlane LJ (as he then was) at paragraphs 68-70 cautioned against misuse of the phrase "nothing else will do";

> "[68] The phrase is meaningless, and potentially dangerous, if it is applied as some freestanding, shortcut test divorced from, or even in place of, an overall evaluation of the child's welfare. Used properly, as Baroness Hale explained, the phrase "nothing else will do" is no more, nor no less, than a useful distillation of the proportionality and necessity test as embodied in the ECHR and reflected in the need to afford paramount consideration to the welfare of the child throughout her lifetime (ACA 2002 section 1). The phrase "nothing else will do" is not some sort of hyperlink providing a direct route to the outcome of a case so as to bypass the need to undertake a full, comprehensive welfare evaluation of all of the relevant pros and cons (see Re B-S [2013] EWCA Civ 1146 , Re R [2014] EWCA Civ 715 and other cases).
> [69] Once the comprehensive, full welfare analysis has been undertaken of the pros and cons it is then, and only then, that the overall proportionality of any plan for adoption falls to be evaluated and the phrase "nothing else will do" can properly be deployed. If the ultimate outcome of the case is to favour placement for adoption or the making of an adoption order it is that outcome that falls to be evaluated against the yardstick of necessity, proportionality and "nothing else will do."

138. Where a care order is in force, s21(3) ACA 2002 provides that the court may only make a placement order if, in the case of each parent, the court is satisfied that the parent consents to the child being placed for adoption with any prospective adopters who may be chosen by the local authority and has not withdrawn the consent, or that the parent's consent should be dispensed with. The court cannot dispense with the consent of any parent or guardian of a child to the child being placed for adoption or to the making of an adoption order in respect of the child, unless the court is satisfied that the parent or guardian cannot be found or is incapable of giving consent or the welfare of the child requires the consent to be dispensed with; **CM v Blackburn with Darwen Borough Council (supra).**

139. In relation to dispensing with consent, Wall LJ said in **Re P (Placement Orders: Parental Consent) [2008] EWCA Civ 535, [2008] 2 FLR 625** at 126:

> "Section 52(1) is concerned with adoption – the making of either a placement order or an adoption order – and what therefore has to be shown is that the child's welfare "requires" adoption as opposed

to something short of adoption. A child's circumstances may "require" statutory intervention, perhaps may even "require" the indefinite or long-term removal of the child from the family and his or her placement with strangers but that is not to say that the same circumstances will necessarily "require" that the child be adopted. They may or they may not. The question, at the end of the day, is whether what is "required" is adoption."

"Required" in this context means the connotation of the imperative. It is what is demanded rather than what is merely optional or reasonable or desirable. It is a stringent and demanding test. The court should begin with a preference for the less interventionist rather than the more interventionist approach. This should be considered to be in the better interests of children unless there are cogent reasons to the contrary **(Re O (Care or Supervision Order)** [1996] 2 FLR 755 at 760.

140. There are material differences between adoption and long-term fostering in terms of what they offer by way of security; **Re V (Children) [2014] 1 FLR** 1009 at 95-96.

Welfare and outcome: analysis.

141. I acknowledge that M loves X dearly and wants nothing more than to be able to care for her. She undoubtedly made progress in 2019, and despite the setbacks in 2020 she is in a better place than she was in 2018. That said, Ms K describes her as no better than "not doing more badly". Many of the issues and patterns of behaviour demonstrated in the earlier proceedings, and which continued unabated until 2018, have re-emerged in 2020 and led to repeated crises. They are very ingrained. She continues to experience deep-rooted psychological issues which prevent her from functioning to a level which would enable her to care for her child. Her PTSD, characterised by recurring nightmares and flashbacks, is ongoing. She continues to lack insight into past events, and her own behaviour which led to the removal of her older children. Her SSD and FD, coupled with past FII in respect of her older children, present a clear and present risk of FII by M to X if rehabilitated to M. M is unable to provide basic care without very considerable support and prompting, despite extensive oversight and support. A return to M's embedded behavioural patterns would be unthinkable for X and, sadly, that is what has happened over the past year. Medical crises, abusive relationships, impulsive overdoses, chaotic adherence to medication, FII/SSD/FD, drinking and criminality are never far from the surface. M has shown herself unable to find appropriate coping mechanisms to address stress and anxiety and I have no confidence that she will be able to do so in the future. Nor, given the history, do I consider that M would be open, transparent, and honest with professionals about such recurring events; she has consistently shown, when under stress, a capacity to minimise and conceal which in turn would jeopardise X's safety. Absent such meaningful change, X would be placed in an intolerable situation, at risk of grave physical and emotional harm. M would quite simply be overwhelmed. Indeed, a return of X to M would by itself operate as a significant additional stressor in M's life and thereby increase the risks to X. In short, the better presentation in 2019 is not nearly sufficient by itself to offset all the maladaptive behaviour present in M for most of her life until 2018, and repeated throughout 2020.

142. The timetable required for M to overcome her deeply-rooted issues is, in my judgment, more likely to be a minimum of 3 years (as suggested by Professor J) rather than 1 year (as suggested by Ms K); the fact that M's patterns re-emerged notwithstanding a considerable degree of prior therapeutic intervention in my judgment tends towards the more conservative timescale. The scale of such a task would be enormous, requiring

bespoke and intensive one to one therapy. In my judgment, based on the evidence of Professor J and Ms K, it is likely that the outcome would be unsuccessful. I have concluded that M is unable to meet X's physical and emotional needs, and were X to be returned to her care she would be at risk of significant harm.X is 22 months old and urgently needs resolution, clarity, and a settled future. M, sadly, cannot offer the strong, consistent, and protective parenting which she requires.

143. Nor do I consider that M's support network is sufficiently robust to assist M in ensuring X's safety and wellbeing. None of the identified persons has any real insight into the enormity of M's difficulties and the reasons for the removal of her older children, in part because M has not been fully transparent about these matters. The family do not have any particular concerns about M, and do not see her as presenting a risk to X; the likelihood is that they would give way to M's own wishes. Some have issues of their own (M's mother's health, her sister's husband's health for example). M's father lives too far away. M does not get on well with her sister. M's mother was found to have colluded with M in the earlier proceedings. The family have a very negative view of the professionals, with whom they would have to work. It is unrealistic to place upon her friends and family the very considerable burden of protecting X. It also seems to me that the support network is broadly the same as that which she relied upon in 2013/2014, and has turned to since then, without any obvious success in terms of M's own mental health, shielding her from abusive partners, and protecting the children.

144. I have carefully considered the suggestion that M and X should undergo a residential assessment for a period of time, although no such placement is currently available. A residential unit, it is submitted, would operate round the clock supervision and support. Therapy could also be part of the programme. Such an approach would afford the opportunity of observing M's ability to parent X, and provide her with the intense support which she so obviously needs. Essentially, what is suggested is a reprise of the proposal in late 2019. Although I can see the attraction of trying to find a way by which the return of X to her mother's care can be explored, in my judgment there is no real prospect of such a placement being successful. Given M's deep-rooted abnormal behaviour patterns, it is likely to break down. Even if it does not formally break down, the prospect of it leading seamlessly to a phased return of X to M seems to me to be very remote. It would be highly disruptive for X, and probably very distressing. M has not had sole care of X at any time since birth and this would be an untested step. Too much uncertainty would lie ahead. Time is not on the side of M or, particularly, X. X's needs are pressing, and an assessment of this sort, with little prospect of success, would delay yet further a resolution to her future. The expert evidence was clear that it would be highly unlikely to achieve sufficient progress to enable the court to contemplate returning X to her mother. M's mental health issues will require prolonged, and successful progress, far beyond the timescale of a residential assessment. Ms K and Professor J were firmly against a residential assessment, as was the Guardian, and I agree.

145. With regret, and notwithstanding all the obvious advantages ofX being brought up by her mother, I conclude that it is simply not possible for that to be achieved in any realistic timescale, whether with the benefit of a residential placement or not. The risks to X are too great. She would not enjoy the stable, coherent, and nurturing environment that she so urgently requires. She would, instead, be exposed to an ingrained chaotic

lifestyle, inconsistent parenting, inability on M's part to protect her and risk of exposure to factitious disorder behaviour.

146. The possibility of kinship care is not realistic. The LA has considered potential family and friends as carers throughout the proceedings, but none are suitable. The family have been aware in general terms of the progress of the case and there has been plenty of opportunity for possible carers to make themselves available for assessment. M put forward only two options; her sister, who ruled herself out because of her husband's health, and a friend who did not want to be considered. Only M's father has put himself forward, albeit late in the day, and the viability assessment is negative. I have ruled against a further assessment.

147. The preferred course advocated by the LA and the Guardian is adoption; to take such a profound step should only be sanctioned where nothing else will do and it is the best outcome based upon a welfare evaluation of all the circumstances. The obvious disadvantage would be the severing of all ties with M and the biological family, including her half siblings. As against that, it would provide X with certainty, security, and long-term stability in circumstances where a return to M is not realistic or safe. X should be able to achieve a sense of permanence, emotionally and psychologically as well as physically, within an adoptive setting. The Guardian told me that there would be little difficulty in identifying appropriate prospective adoptive parents within a fairly short timeframe, and X would be able to form a secure relationship with them. Further delay in securing a placement would be contrary to her interests. X needs to be able to develop her secure attachments with her long term carer as soon as possible, and in my judgment that can best be achieved within an adoptive setting.

148. Long term foster care was not advocated by any of the parties, not least because of X's age. It seems to me that it would not give this child the sense of permanence which is, in my judgment, essential for her wellbeing. She has an immediate need for long term security and stability which long term fostering would not sufficiently provide. M would be able to apply in the future to discharge a care order, which seems to me to be replete with risk and uncertainty for X, whereas an adoption order would be final. A fostering arrangement would leave open the question of contact, in a way which generally does not apply in an adoptive placement; cessation of contact with M in the event of adoption is not, on the evidence of this case, likely to be distressing or damaging for X. In a fostering context, the Local Authority would continue to have a role in X's life. Fostering does not offer the best all round solution for X, particularly given her age. She needs to develop her attachments and sense of identity. She cries out for a warm, enduring, nurturing attachment with long term permanence and in my view a foster placement would not be the best means of achieving this.

149. I have carefully weighed up all the various options, considering the advantages and disadvantages of each. In so doing, I have considered all matters holistically and in the round. In the end I conclude that placement for adoption is by some distance the preferred, indeed required, outcome for X. Her welfare is my paramount consideration and in my judgment, adoption is in her best interests. It would give her a sense of permanence, allowing her to settle into the adoptive family to which she will fully belong. Given M's obvious, and deep-seated difficulties, F's decision to seek no part in her life, and the lack of a viable alternative family carer, placement within the birth family is sadly not realistic. In particular, M's abnormal behavioural patterns may re-

emerge at any time, and carry a high risk of generating distress, confusion, instability and severe harm for X. The best solution for her is permanence outside the birth family.

150. I therefore make the threshold findings as outlined above, approve the care plan for adoption, make a placement order and dispense with parental consent as appropriate. Both in written opening, and during oral closing submissions, the LA invited me to make an order for parental responsibility in favour of F so that his consent to a placement order could then be formally dispensed with under s21(3) of the ACA 2002. Without parental responsibility, he does not qualify as a parent for the purposes of giving consent, and therefore no order for dispensing with consent is required. Although presented to me as essentially a procedural step, it would of course require proper consideration within the context of the welfare checklist and is therefore much more than a technicality. As F had not attended during the hearing (other than briefly by counsel at the very start), I invited the parties to contact his legal team and inquire whether he sought an order for parental responsibility. He confirmed by written submissions through counsel that he does not seek such an order. Since he makes no application for parental responsibility, has played no part in X's life, and M through counsel indicated that she would oppose a parental responsibility order being made, I shall make no such order.

151. An issue arose about the continuation of contact in the event that I approve the Local Authority's care plan. The Guardian considers that there should be one further, farewell, contact session. Her view is that X needs the emotional space to prepare for a move from foster care to identified adoptive parents. The Guardian has been assiduous throughout in looking at matters from X's point of view, but on this issue, and by a narrow margin, I conclude that the Local Authority's proposal for contact to continue until prospective adopters are identified is to be preferred. It is not clear how long that process will take. There is no evidence that X is being discomfited or disturbed by contact with M. On balance, I consider that it should continue as suggested by leading counsel for the LA in closing.

Final word

152. This will be the bitterest of pills for M to swallow. Nobody can condone or excuse her past actions, but the sad reality of this case is that her behaviour has its origins in mental health problems which can be traced back to her own childhood and have gripped her ever since. I have considerable sympathy for her; mental health illness is a curse. Over time, her behaviour has become ever more ingrained. Stressful events lead to crises which in turn set M back and place her under ever greater stress. It is a vicious circle. Unless and until she fully banishes her mental health demons, or at least finds a way to cope with them, she will be unable to lead a happy and fulfilled life. There are glimmers of hope; a degree of progress for a period in 2019, a job, a life currently without an abusive partner. I sincerely hope that she finds it within herself to embark on the hard journey which she needs to undertake with expert mental health treatment.