Neutral citation: [2022] EWFC 220 (B)

IN THE FAMILY COURT **ZE19C00708**

SITTING REMOTELY AS EAST LONDON FAMILY COURT, AND AS A HYBRID HEARING AS EAST LONDON FAMILY COURT AT THE ROYAL COURTS OF JUSTICE

Before Her Honour Judge Lazarus

B E T W E E N:

LONDON BOROUGH OF BEXLEY

Applicant

- and -

M

1st Respondent

- and -

F

2nd Respondent

- and -

PGM

3rd Respondent

- and -

A, B and C
(through their Children's Guardian, Kathryn Deutz)

4th - 6th Respondents

Representation:
Mark Twomey QC and Dr Bianca Jackson, for the LA.
Susan Campbell QC and Shelly Glaister-Young, instructed by Zena Hill of TG Baynes until 21.10.21, then Damian Stuart and Dylan Evans, instructed by Helen Worden Blackfords LLP on behalf of M.
Darren Howe QC and Susan Pyle, instructed by Keeley Lengthorn of Taylor Rose MW on behalf of F.
Alison Ball QC and Rebecca Mitchell, instructed by Philip Wilkins of Hudgell & Partners on behalf of PGM.
Louise MacLynn and Sophie Prolingheuer, instructed by Penelope Moult of Atkins Hope on behalf of the Children through their Children's Guardian.

J U D G M E N T

1. INTRODUCTION

1.1. This is the final judgment in a long-running and complex case in which I have already given a lengthy fact-finding judgment. Needless to say, this judgment should be read in conjunction with that earlier judgment of February 2021. For ease of reference, however, a summary of the findings of fact is set out at Appendix 1.

1.2. This judgment addresses where and with whom the children should live, and under what orders; arrangements for their contact with family members; and ancillary orders relating to the exercise of parental responsibility and the disclosure of documents.

1.3. A is a little girl now aged 4 who suffered a catastrophic ALTE at six weeks old, resulting in a range of serious disabilities. She has almost no sight, significant physical disability and global developmental delay. She was the subject of earlier care proceedings running from 2018 to mid-2019, which concluded in the agreed position that her ALTE had been caused by an accidental combination of factors. She is the youngest subject of this second set of proceedings. These proceedings were begun in December 2019 following observations of her M's treatment of her in hospital, and which resulted in very significant findings against her M.

1.4. A has remained living with her specialist foster carer and has continued to thrive and develop there, following on from the remarkable and rapid improvements seen on moving there in January 2020. She now attends a school for those with special needs. She has been having regular contact, both face to face and virtual with her F and PGM and sisters, and with her M.

1.5. B and C are now aged respectively 6 and 7. They too were subjects of the earlier proceedings. At the start of these proceedings in December 2019 they moved from their M's care to stay for three months with their maternal step-grandfather and his partner before moving to their PGM's home in March 2020, and where they have remained living with their F and PGM ever since under Child Arrangements Orders and Interim Supervision Orders. They have been having regular contact with their sister A, and frequent contact with their M, both face to face and virtual.

1.6. Both F and PGM have continued to care well for the older children and engage well in contact with A and with all assessments and hearings. They have been positively assessed and commended by experts and professionals. Their positions and understanding have continued to react and adapt over the course of these proceedings. Other than in relation to particular issues of contact, their positions have respectively largely agreed with each other's and those of the experts and professionals.

1.7. The children's M has naturally presented a more complex picture. She has co-operated with all assessments and supervised contact arrangements. Over the course of these proceedings, and the second stage of this final hearing in particular, her position has changed from wanting the older girls to be returned to her care while

A returned to F and PGM, or sharing the older girls' care with F and PGM, to conceding that the older girls should stay with their F and PGM and A with her foster carer. She agrees that the older girls should have the Narrative Letter. She concedes that her contact should be supervised. This has narrowed the contested issues to questions over the frequency of her contact with the children.

1.8. The situation regarding any possible criminal proceedings against M as a result of her behaviour towards A is still unknown. The fact-finding judgment was disclosed to the Police. Despite requests, it has been difficult to learn more than that the original Officer in charge of the investigation was no longer available and that a replacement was having to bring himself up to speed alongside other pressing tasks. A report was being finalised to be sent to the CPS, and nothing further has yet resulted despite the LA's enquiries. There remains the possibility that M may be charged with offences, and that the process of bringing any case to trial is likely to be protracted given the current backlog.

1.9. The positions of the local authority and the CG have largely agreed. Both recommend that A remains in foster care under a care order, and that the older girls remain in the care of their F and PGM under Child Arrangements Orders and a 12 month Supervision Order.

1.10. Despite the largely agreed position, it is necessary to review the evidence and the landscape of the case given the gravity of the findings that have been made, the young ages of the children, the older two being placed with family members, and that changes and challenges to the current arrangements may arise.

2. <u>CASE MANAGEMENT</u>

2.1. Expert assessment was sought on a jointly instructed basis. Initially from a forensic psychiatrist Dr Van Velsen to assess M's risk, and from an independent social worker Gretchen Precey to assess F's and PGM's abilities to manage that risk if they were to care for the children.

2.2. Dr VV provided her opinion in relation to M but deferred to the opinion of a child and adolescent psychiatrist as to the implications of the findings and her formulation of M's vulnerabilities with regard to the risks to the children. This led to the further instruction of Dr B and a deferral of the final hearing from an initial listing in June.

2.3. Ms Precey was the ISW instructed to report on M. It is sufficient here to note that she did not in her report address the terms of her Letter of Instruction, but made a wholly different suggestion in which she recommended that A should be rehabilitated to the care of her F and PGM from foster care, and that it would be safe and appropriate for B and C to return to the care of their M. This inevitably fuelled M's hopes and set the scene for a fully contested hearing.

2.4. These experts were then the first witnesses to give evidence at the adjourned final hearing which began in October. This was significant in that: firstly, Ms Precey withdrew her own recommendations; and secondly, Dr VV and Dr B held firm on their analysis of M, the significance of the findings, her insight, her attitude and her risk, and their recommendations that none of the children should be returned to her care and that her contact should be supervised.

2.5. At the conclusion of that expert evidence, and shortly after the social work evidence had begun, M's representatives understandably requested time to discuss the position with M. Unfortunately, this led to the withdrawal of M's solicitor and both leading and junior counsel due to professional embarrassment. Inevitably, this broke

the final hearing into two stages. The remainder of the final hearing, being the evidence from the Social Workers, the family members and the CG, and closing submissions, had to be adjourned while a new solicitor was found and counsel could be instructed. It was also essential to transcribe the evidence that had been heard to that point.

2.6. Fortunately, adjourned dates and experienced counsel could be found to ensure the case was concluded before the end of the year in December, and with as little disruption as possible. I declined requests for another adjournment to enable a further search for leading counsel to be made. There could be no guarantee that the further loss of time and its ongoing impact on the children would bear fruit in the form of a successful instruction, particularly where the most complex aspects of the case had passed (the fact-finding stage and the challenge to the expert evidence in the light of Ms Precey's recommendation), and where M was now represented by two very experienced and highly competent senior junior counsel. The case then further narrowed, as I shall discuss in more detail, when M recognised her position and no longer sought to persuade the court that any of the children should be returned to her care.

2.7. I also declined requests for Dr B and Dr VV to be recalled. The issues for which their recall was requested had either been canvassed sufficiently during the first stage of the hearing or were challenges relating to social issues and structures, and so could be put to the social workers and the CG. In the subsequent event of M's changed position, those issues anyway became irrelevant.

2.8. M has continued to be assisted by the presence, support and occasional intervention by an intermediary. Given her vulnerabilities and the importance to her of the case, I was concerned that she should both be adequately supported and able to participate. In the first stage of this final hearing, this was facilitated by the generous provision of a large conference room at her former solicitor's office where she could attend with the intermediary and a solicitor's clerk or her solicitor, and where the technical links to the court and her counsel were well provided for. Regular breaks have been taken to assist her.

2.9. Given the ongoing national health emergency and the nature of the expert evidence, it was agreed that the experts' and most of the professionals' evidence could be given remotely at the start of the final hearing in October. Due to subsequent changes in the requirements placed upon court attendance in the following weeks, and due to the more fact-based nature of the evidence from the family members and social work witnesses, it was planned that the second adjourned stage of the final hearing would be conducted as a hybrid hearing. Advocates were due to attend court, with M and intermediary present and each witness attending to give oral evidence in the usual way. This plan was modified due to increasing concerns as to public health in December such that only the LA's and M's counsel would attend with M and her intermediary. This modified attendance plan was further disrupted by a combination of factors: the increasing risk posed by the high transmissibility and unknown impacts of a new variant; M's unvaccinated status and exemption from mask-wearing; and the potential numbers in court despite the use of a particularly large courtroom. It became clear that the safest way forward was for the hearing to proceed remotely, with only my clerk and myself in court in accordance with the expectations placed upon the judiciary. However, given that M could only access the hearing by smart phone from her home, and where the signal was known to be

irregular, both of which factors I considered to be inadequate, I also authorised the use of two conference rooms at the RCJ where M, her intermediary and both her counsel could be safely accommodated using laptops and the court's wifi system to join the hearing adequately and support her participation, her instructions and representation.

2.10. I have had access to both the core bundle and main bundle via Caselines in which I have been able to read the parties' statements and the experts' reports and ancillary documents. I have heard evidence from Ms Precey, Dr VV, Dr B, three social workers, M, F, PGM and the CG. I have also been assisted by position statements, updating documents, closing submissions documents and oral submissions.

2.11. Due to the delayed second stage of this hearing and its proximity to the start of the Christmas and New Year break, I provided a summary of my conclusions and orders on the day following the advocates' submissions and before the preparation of this judgment.

2.12. I am very grateful to all counsel and their instructing solicitors for their help to the court and the undoubted hard work that has been required. In particular in M's case, at each stage of these proceedings, every issue has been thoroughly explored on her behalf. I am particularly grateful to Mr Stuart and Mr Evans for their skilful management of M's change of representation.

3. <u>ISSUES TO BE DETERMINED</u>

3.1. THRESHOLD CRITERIA – All parties agreed that the statutory threshold criteria had been met. For A, the criteria are obviously met in terms of the very significantly harmful behaviours by her M that were the subject of findings in my previous judgment.

3.2. For B and C, for reasons that will be discussed later in this judgment I am entirely satisfied by the expert and professional evidence before me that they suffered and were at risk of suffering significant harm at the relevant date in December 2019. This has not been a fully contested issue, and it is not submitted on M's behalf that the criteria are not met.

3.3. STATUTORY ORDERS – All parties have agreed that A should be the subject of a final care order. This has been a significantly painful but realistic and child-centred decision for the F and PGM to reach. They have each found it a sad and difficult realisation, describing it as '*heart-breaking'*, and about which they inevitably feel some guilt. However, given the demands of her care, in conjunction with their role as joint carers of B and C in the complex circumstances in which this family finds itself, I was unsurprised by and commend them for their conclusions.

3.4. All parties have also agreed that B and C should each be the subject of 12 month final supervision orders.

3.5. PLACEMENTS – It is this issue that has significantly narrowed during the course of this hearing and is no longer contested.

3.6. It is clear to me from the evidence I have read and heard from the F and PGM, that their initial reaction to the findings was to understand that this would effectively preclude M from caring for the children. Their remaining dilemma was whether or not they could take on the care of A alongside that of B and C, and as I have

mentioned they have sadly concluded they should not and that she should remain in her foster placement.

3.7. However, when the ISW Ms P met them to conduct her assessment it appears that she confidently proposed an alternative solution, namely that the older girls be returned to their M's care, thus freeing F and PGM to care for A. As lay people, they were understandably confused and were led to believe that this was a feasible proposal. They no longer do so having seen Dr B's and the CG's reports and heard their evidence, and particularly in the light of Ms P withdrawing that recommendation at the conclusion of her oral evidence.

3.8. Equally, the M's initial position, which she mentioned to the CG shortly after my judgment on the findings was provided, was that she did not consider that she would be able to put herself forward to care for the girls. This, understandably, altered with the provision of Ms P's report and discussions with the family members during her assessment. Thereafter, until the start of the second adjourned stage of this final hearing, M pursued the return of the older girls to her care and much of the expert evidence was taken up with considerations of the relevant risk issues.

3.9. M now agrees that B and C should remain with F and PGM under Child Arrangements Orders, and it is a matter of regret that this position was not maintained from M's initial discussion with the CG. M also, in those circumstances, no longer presses the F and PGM to care for A. I will, however, come on to discuss a particular caveat in relation to M's changed position.

3.10. All the family members have stated their support for A's foster carer and her family, in whose home and with whose care she has thrived. I note at this point that the LA should be commended for the efforts made to find and maintain such an excellent and suitable placement, and that it is particularly fortunate that it is so close to the family's local area.

3.11. These placement arrangements for all three girls are supported by all the experts and professionals involved.

3.12. CONTACT ARRANGEMENTS – It is these arrangements that have become the principal focus of the parties' disagreements and the determinations of this court. The issues are set out below.

3.13. THE FAMILY'S CONTACT WITH A:

3.14. From September 2020 to September 2021 contact was as follows: Each parent saw A for 1 hour supervised at the contact centre. PGM joined F's contact twice per month, once with B and C. Each parent had remote video contact with A four times per week for 10 minutes. B and C joined one of M's virtual contacts with A for 'family contact'. M had a further family contact with all three girls once every 2 months. Extra direct contact was provided at the time of A's birthday. From September 2021 when A began school, direct contact timings changed but were substantively the same. Remote video contact between A and each parent changed to three times per week for 10 minutes, B and C joining one of M's sessions once per week.

3.15. The LA's position: no contact order is sought but approval of the care plan which is for fortnightly direct contact with her M which will be supervised at a contact centre, and fortnightly direct contact with her F, PGM and sisters supervised by F and PGM, with additional informal contacts arranged directly by F and PGM with the foster carer taking place as school ends. No indirect virtual contact – this particularly

follows the lead of the foster carer who considers it is a largely negative experience for A, was only put in place due to Covid restrictions, and finds it significantly intrusive.

3.16. The CG supports this plan, supports the foster carer's analysis and needs, and encourages the 'normalisation' of contact between A and her F, PGM and older sisters.

3.17. The F and PGM's positions have come together also to support this plan. There was some reluctance to give up on indirect contact with A, but they respect the views and needs of the foster carer, and would not wish to put any strain on A's foster placement. They wish to build on their excellent relationship with her to explore normal opportunities for contact including occasional indirect contact when the school gate contacts are not available in the holidays.

3.18. M, by contrast, seeks supervised weekly direct contact and weekly indirect virtual contact. She would also like direct contact to progress to community-based activities, such as at a soft play centre.

3.19. M'S CONTACT WITH B & C:

3.20. The arrangements since the older girls have been in the care of their F and PGM have been as follows: M had direct contact with them, supervised by PGM and F, once a week for 2 hours in the community. M had a further family contact with all three girls once every 2 months. M has been having virtual contact 4 times per week with all three girls, joining them by a video-call, for lengthy periods of over an hour and up to 90 minutes. Additional birthday contacts have been taking place, and the court approved M visiting the family for two discrete holiday activities during a trip last summer in Norfolk. This was on the basis that she did not stay with the family and she was supervised by F and/or PGM during her involvement.

3.21. The LA has proposed that this arrangement continues until the Narrative Letter, explaining in appropriate terms what has happened, is shared with B and C on 11.1.22. This will undoubtedly have an impact, albeit the extent of that impact on the girls and the time it will take for that impact to unfold and the range of questions and feelings that will arise are all unclear at this point. Thereafter, the LA proposes a transition plan of direct and indirect contacts for them with their M, supervised by the SW, which are intended to taper down the frequency of their contact and assist the family in supporting B and C with their feelings and questions during this period.

3.22. This transition plan has been developed collaboratively, bearing in mind the advice and concerns of all the involved professionals, and particularly the PGM's and F's concerns about too abrupt a change for B and C who have been seeing so much of their M until now. All parties agree on this transition plan. I am very grateful to the SW who has been prepared to adapt her obligations under this plan to provide extensive direct support: a further visit to the girls the day after they get the Letter, and supervision of three indirect and three direct contacts with their M until the end of January. The first two direct contacts will be in the community so as to provide a focussed and pleasurable activity rather than at a contact centre.

3.23. Thereafter the LA, CG, F and PGM all propose that direct contact should proceed fortnightly at the weekends, supervised by F and PGM, and taking place in the community and at neither M's home nor the girls' home.

3.24. Additionally, F and PGM consider that the girls are likely to need a further fortnightly indirect virtual contact. This is resisted by the LA and CG.

3.25. F and PGM also are concerned that there be clarity and certainty in any child arrangements order regarding M's contact, while at the same time ensuring there is sufficient flexibility to meet the girls' needs as required.

3.26. M seeks supervised weekly direct and weekly indirect contact with B and C. She has also expressed a preference for contact to take place in the family home.

3.27. ANCILLARY ISSUES –

3.28. M would like to attend school events. As far as recreational activities such as plays, concerts, fairs etc are concerned, this is not resisted by the other parties so long as the school agrees, it is adequately supervised by the presence of either F or PGM, and the older girls wish her to be there.

3.29. M would also like to attend parents' evenings, significant medical appointments (not routine primary care), and other developmental or educational appointments of any significance. This is resisted by the LA and CG, and neither F nor PGM see that it is necessary for the girls' welfare but would facilitate it if necessary by ensuring one of them were also present.

3.30. Prohibited Steps and Specific Issue orders are sought to limit M's exercise of her parental responsibility in relation to giving or withholding consent to medical, educational or other developmental procedures or decisions; to provide F and PGM with the ability to address any issues of decision-making, consent and the exercise of parental responsibility in those respects; and requiring them to inform and consult M and to keep her informed.

3.31. It has been agreed that a document setting out a summary of the court's previous findings which has previously been shared with health and education agencies in order to properly inform them of the position should be updated and disclosed to the girls' schools, GPs, and any other professionals involved in their health, education and development, and should be placed on their respective NHS files. It is attached at Appendix 2.

3.32. An issue of particular significance has been the need to explain to the older girls what has happened that has led to their removal from their M's care two years ago, and why their F and PGM have cared for them since March 2020 and will continue to do so. To that end the Narrative Letter from the SW that I have mentioned above has been drafted, amended with the assistance of Dr B, agreed by the parties and not opposed by M. It is planned that the SW will share it with B and C on 11.1.22 and the contact transition plan will follow thereafter. The Letter is attached at Appendix 3. This Narrative Letter will also be disclosed to the older girls' school and GP, so that appropriate support can be provided to the girls as necessary.

3.33. Publication of appropriately edited versions of this and the fact-finding judgment need to be considered. This will require review once the outcome of any CPS decision is known and any consequent criminal process is completed.

4. <u>EXPERT EVIDENCE</u>

4.1. DR VAN VELSEN

4.2. Dr VV is a highly experienced and respected forensic psychiatrist. She provided her main report in April 2021 and three addendum reports in April, September and October in these proceedings. She was a member of the FII Expert Reference Consulting Group that contributed to the Royal College of Psychiatrist's recently

updated report entitled Assessment and Management of Adults and Children in Cases of Fabricated or Induced Illness.

4.3. Submissions are not now made on M's behalf that comment on or undermine her overall analysis. Throughout extensive and probing cross-examination by leading counsel on M's behalf in the first stage of this final hearing Dr VV was not tempted to comment on areas outside her expertise, and continued to provide a clear and thoughtful explanation of her analysis and formulation relating to M. She was careful and undogmatic in reaching and expressing her opinions. I was entirely persuaded by her evidence and read and heard nothing that undermined it.

4.4. Dr VV was clear that M's presentation is complex. She does not suffer from a major mental illness, but has shown a range of disturbed behaviours and has made claims as to various symptoms and experiences over the years. She concluded that M likely shows traits of Emotionally Unstable Personality Disorder, Somatisation and Factitious Illness. This is particularly well explained in paragraphs 435 to 443 of her April report.

4.5. She had doubts about the proposed diagnoses of ASD and/or ADHD for a number of well-explained reasons set out in her April report, but in any event did not consider that this detracted from her overall analysis of the formulation she reached in her evidence. She stressed the importance of not becoming side-tracked by diagnostic labels and conceded that there may be complex comorbidity. Of note, she observed that the importance of the label of the diagnoses to M was significant, whereas the implications in terms of managing social interactions with her children and in terms of parenting were highly minimised by her.

4.6. She firmly identified that M needed reassessing in these two areas of ASD and ADHD, in the light of her conclusions as to the presence of factitious illness traits, and that the assessment should be with the benefit of all information including her reports. It was therefore particularly unhelpful that only a very limited section of Dr VV's first report was provided to the NHS clinician Dr R who has recently had the task of assessing M for ASD, and who therefore would not have had the benefit in Dr VV's full reports of the comprehensive overview of M's medical history and various presentations, nor of Dr VV's observations and anxieties regarding this diagnosis and the role it may be playing in an individual with traits of factitious illness disorder. The overall impact of this course of events has been, unfortunately, indicative of and consonant with the M's history of partial and manipulative disclosure of information to serve her own needs.

4.7. She also considered M's diagnosis of PTSD, said to be rooted in the experience of A's ALTE, and concluded that there were some traits, but that M may have already benefitted from the recommended therapies EMDR and CBT that M had been accessing to address it. Of note, this diagnosis was at one point in her discussions with Dr B relied upon by M to attempt to explain her inability to remember key details of her behaviour and to excuse her actions based upon 'stress', 'anxiety' and her PTSD. Dr VV did not consider this was a satisfactory explanation for repeated harmful behaviours and dishonesty.

4.8. In reviewing her discussions with M, she noted the following:

'*397. During the final part of the interview there was some evidence of what has been described as M being quite persistent in her questioning of me, particularly with regard to what I might say about risk and the fact that she had completed work that had been suggested. I told her that one of problems was that the work was not based on her as a*

perpetrator of harm and there was still little understanding of what had happened. I also made the point that active induction of medical problems, for example kinking the tubes and flushing out the feeding tube was at the severe end of the spectrum and therefore considered higher risk.'

4.9. With regard to Factitious Induced Illness, Dr VV provided a very fair and careful analysis. She set out her discussions with M as follows:

'360. I asked about her thoughts about the findings, and she replied "I was very upset ... I accept them but it is not something I remember". She talked about an image the Judge had used of a double-edged sword. She does not understand what happened, but she knows "it's horrible".

361. She said the findings were difficult and commented that they were based on the balance of probabilities and are not fully definitive.

362. I said she does not have an obvious memory problem and wondered why she could not remember and whether if it was because it was too painful to consider that she had harmed A. She said she provided her explanations in Court and repeated several times "I would never have wanted deliberately to harm her. I love A. I don't understand it ... it is hard for me to think".

363. I said that what had been described in the findings were deliberate acts, for example, hiding syringes under a jumper, injecting them into the flush system and kinking the tubes. She said that she did not do anything deliberately and did not have an explanation.

364. I said that, when A was not in her care, she quickly got better and M said that there were other explanations for that which she gave in court. She added, "I wanted A to be better ... I know how much I wanted A to get better". She said it was a lot of work looking after A and she does not know why she did what she did.'

4.10. Her conclusions are significant:

'449. It used to be stated that the definition of FII required the presence of conscious deception. However, it is now considered that there is a wider range of motivations and behaviour. What is considered important is that the impact on the children, of the behaviour by the parent, is the same whether motivated by conscious decisions or erroneous health beliefs.

450. Within FII the behaviour takes different forms, ranging from giving false accounts of symptoms, exaggeration and fabricating symptoms, for example, putting substances into a child's urine sample and, at the most severe end, inducing symptoms of illness, which is what happened in this case. M was found to have interfered with hospital equipment, flushing a feed line and kinking the line. This cannot realistically have been unconscious - her behaviour was described in the Judgment as 'intended to deceive'. In my opinion, her assertion that she cannot remember what she did or that it was erased out of anxiety, is not consistent with what has found to be deliberate interference with equipment and an attempt to conceal this. ….

452. It is possible that, with regard to M, the existence of ASD or traits thereof could explain a lack of empathy for what she was doing to A. However, it was not possible to explore this as M does not admit to what happened. ….

456. A particular aspect of FII is the involvement of the medical system; commonly mothers can appear very devoted, spending much time with the child and there can be overreliance on the history given by the parent(s). This appeared to happen to a certain extent in this case. ….

Factors that indicate a poor prognosis include:

464. Induced harm - relevant in this situation.

465. Denial - M does not accept the findings of the court regarding her actions in hospital in a meaningful way.

466. Somatisation - there is some evidence for this.

467. Other poor prognostic factors include a previous history of abnormal illness behaviour in the adult or child.' This is not relevant to A but is possibly relevant to M.
468. Risk is increased if a child has a known medical condition and a history of management concerns, which is the case here.
469. Linked to the above, risk is increased if the child is very unwell and has undergone repeated interventions. This appears to be the case here although It is positive if A has shown a good recovery. ….
475. What happened to A is at the serious end of FII. A already suffers from significant health problems so any carer will have to be intimately involved with her management and care. My concern is M repeating what happened, were she to be the carer. ….
480. M does not have a problem with her memory and her behaviours have been described as clear and deceptive. Without admitting to and describing what happened it is hard to establish risk.
481. The situation in this case is complex because, on the one hand, M states that she accepts the findings but, on the other hand, states that she did not deliberately do anything when she was found to have done so. She also pointed out that the findings are based on the balance of probabilities.
482. In my opinion, if the diagnoses of ASD and ADHD are present, then this would also contribute to her difficulty in taking on board the impact of what she did on her child. Overall, in my opinion M has acknowledged the findings rather than owning them.
483. In my opinion M does not see herself as a risk to her children. …
487. Any possible rehabilitation would require a multidisciplinary team with oversight of A's care by a paediatrician.
488. Parenting interventions in the form of understanding and exploring attachment may be useful.
489. Perpetrating caregivers need therapy to address the harm they have caused, its effect on the child and possibly the effect of the loss of that relationship. It should also address feelings of guilt and shame. If those are missing, then that needs exploration. Successful treatment requires both engagement and commitment.
490. M has shown some capacity for this, although in the context of her presenting as the victim of trauma and suffering from ASD and ADHD, both of which made sense to her.
491. Sanders et al suggest that 'individuals who use denial and cannot admit their behaviours present almost insurmountable obstacles to psychological treatment.'
492. 'Therapy for adults should be based on both a diagnosis and a risk assessment. Full disclosure of behaviour may take some time and requires a trusting, non-judgemental relationship with a therapist. In early sessions it is not necessary for every detail to be disclosed or admitted before therapy can start.' This may be relevant to M. However, in my opinion such therapy is going to be long-term as M has only just begun to acknowledge what occurred.
493. The therapist must be experienced, confident and fully aware of the complexity of M's behaviour and formulation as well as the findings. ….
498. In my opinion there are too many variables at present to foresee how any intervention can create a safe enough situation for A to return to M's care. A child and family assessment may help address whether or not the older children could be safely parented.'

4.11. She further added in her April addendum*: 'In my opinion there is no psychiatric reason for her alleged memory loss regarding the harmful behaviour towards A, when no other memories are affected. In my opinion this is more likely to be denial.'*

4.12. In her September addendum, in response to Ms Precey's then confident assertions of possible reunification despite the FII findings:
'32. In my report I described how gaining insight is a process not an event but, in my opinion, M's acceptance of the findings is significantly partial and static. There is no psychiatric explanation for her specific memory lapses which, in my view, reflects denial of what she did.

She told me that the findings were based on a balance of probabilities which I interpreted to mean that they may not be correct.
33. Devising a risk management plan involves understanding past behaviour. As yet there is no satisfactory explanation/exploration of what M was thinking and feeling at the time she harmed A. These were repetitive actions of a severe kind over time and there is no description of triggers. A psychiatric diagnosis, of whatever type, alone does not explain the actions. Ms Precey asserts that it happened in the context of undiagnosed PTSD with no hypothesis of how such a diagnosis caused the offending behaviour. There is no account in the research literature of an established link between PTSD and FII.
34. In my view the situation is much more complex, as I described in my original report, in particular aspects of her personality which are long standing and chronic.
35. Regarding risk, if M does not have the care of A it is important that neither of her other daughters take her 'place'. What will stop M acting again in a dangerous way that is then not remembered? What will be the warning signs she and others need to watch for?
36. M has not received any treatment/intervention that has had as its focus her dangerous behaviour towards her daughter.'

4.13. In her oral evidence, these analyses were further expanded and gained further traction by that process. In particular, on close examination of M's comments about her behaviour, her alleged inability to remember key actions, her own evidence and explanations in the fact-finding hearing, and her attitude to the findings in the judgment, Dr VV confirmed that not only is there no psychiatric reason for alleged memory loss here, but also that M was not simply claiming memory loss but was referring to having given explanations, and to having doubts as to the validity of the judgment. She also confirmed that M had no explanation for the outright lies and dishonest inconsistencies demonstrated in the fact-finding process, and her alleged lack of memory could not explain that lying and dishonesty. It led her to firmly conclude that this was part of M's ongoing denial while paying lip-service to a form of 'acceptance' of the findings. She was asked to review M's comments to Dr B in his later assessment and concluded that M was presenting very much as she had during Dr VV's earlier assessment, and that she was showing an approach seen frequently in forensic work: '*There is simultaneous avowal and disavowal. … We also call it undoing, when the first statement is undone by the second.*', and that she did not appear to have developed any further real degree of insight.

4.14. She further confirmed: that the risk in relation to A remains high without acknowledgement of what has happened; that this level of denial made the prognosis of intervention poor; that it meant it was not possible to develop any understanding of M's emotional rewards or needs that were being met by this behaviour, nor identify triggers nor drivers; that these were all poor prognostic signs in terms of risk reduction and therapeutic intervention; and that there were too many variables to be able to comment about the possible length or success of any therapeutic intervention.

4.15. While she would not be drawn specifically as to the risks for the older girls she stated '*but I certainly think that a risk is present and it needs addressing. There needs to be a risk formulation that helps with management and without having acknowledgement at a real level of what happened it's not possible to formulate the risk',* and she agreed with the assertion set out in the RCP's FII Report that the research identifies that siblings are known to be at high risk of the same behaviour with increased mortality rates (although it may also remain only towards the single child), albeit that the higher risk could not be quantified but would need to be 'unpicked' and addressed.

4.16. She also confirmed that the 'policing' of the M's care of any of the children, whether living full-time with her or sharing their care, could not be shouldered by the F or PGM as it would be too complex and nuanced a task to expect family members to bear the burden or have sufficient confidence and expertise to know what to be looking for.

4.17. DR BOURNE

4.18. Dr B has 30 years experience in child and adolescent psychiatry and has been a consultant for 24 years and providing medico-legal reports for 20 years. He held the clinical lead roles in East Lancashire Hospital Trust Service for Autistic Spectrum Disorders, Eating Disorders and its Sexual Abuse Clinic. He provided his main report in August 2021 and an additional report in September.

4.19. Although the parties seek to emphasise certain parts of his evidence in relation to contact and the children's needs, again no party submits that his evidence is unreliable or undermined in any way. While there were some discrete areas of his evidence that inevitably lacked clarity and which I shall discuss later, he provided helpful explanation as to the needs of the children and the risks to them in the face of detailed and thorough cross-examination. His oral evidence helpfully expanded upon the detailed recordings and analysis set out in his reports.

4.20. His analysis of the risks posed by M to the children fitted entirely with Dr VV's analysis that she had provided from the adult forensic perspective. He too also noted that M did not appear to present with any signs of ASD or ADHD during the lengthy interview process he conducted. There is a significant section in his report at pages 67-74 in which he set out M's attempts to explain her behaviour and her approach to the findings. It was in considering this section that Dr VV stated that there had been little progress and no apparent development of insight or improved acknowledgement or responsibility, and there are repeated examples of the 'avowal/disavowal' pattern described by Dr VV. A particularly telling example is this:
'*We said, "What are you going to say if one of them asks you why did you do what you did to my baby sister?"*
M said, "I will tell them the truth, I'll say I don't know what's going on or I'll say this is the reason and I've gone and done this therapy and I've learned this."' [my emphasis].

4.21. Dr B went further and noted that some of her responses to the discussion of these issues in his assessment epitomised the difficulty in terms of being able to move forward, and he concurred as to the poor prognostic factors. Additionally, given M's repeated emphasis on the positive parenting she has provided, he concluded that M's level of insight about herself as a parent is poor. His conclusion was that her internal psychology does not appear to have changed and therefore neither has the risk she poses to dependent children.

4.22. He considered that this risk remains very high and dangerous for A such that he could only recommend supervised contact between M and A, and did not consider that F and PGM could prevent M's influence if they were to be caring for A, even though he recognised their appropriately developing insights. He considered that similar risks exist for B and C, despite their ages and lack of overt disabilities. He pointed out that children of all ages can be victims of abuse; their ability to speak up does not necessarily provide any safeguard whatsoever, and he referred to his own experience of children up to middle teenage years being the victims of FII abuse.

4.23. He recommended clear boundaries should be in place that enable F and PGM to 'hold the line' and an appropriate set of orders to underpin this including ensuring that the LA plays a supportive role, and recommended a Supervision Order.

4.24. He emphasised: '*I am clear, though, that whilst I believe these are all necessary and helpful inputs, these would not reduce any direct risk that M poses to her children for some considerable time. The therapeutic process that I believe she would need to go through is long, as it involves a psychotherapeutically-mediated piece of work to address her own 'internal' emotional and attachment issues, then to address the abuse she committed, and then to assess and see whether these aspects of her presentation can change. With respect to contact between M and her children, this is a safeguarding matter - it is not about therapeutic work, it is about ensuring the contact is supervised in a way that makes it safe.'*

4.25. And it was also in that context, of not accepting the findings nor owning responsibility nor having therapy, that he strongly recommended in his second report and reiterated in his oral evidence that M should not be a decision maker about the children's developmental or health needs and medical care.

4.26. I turn now to his analysis of the children. I deal first with a controversy that has arisen in relation to C, and whether she suffers from ASD and/or ADHD. A referral for her to be assessed had been made by her school. It has been alleged that M triggered the referral by pressing this issue with the school, and it transpired that she was also asked to contribute directly to the assessor's understanding of C's early development. However, it has not been possible to explore these matters sufficiently before me to know clearly what has been M's degree of involvement in this and therefore whether any suggestion of unmerited medicalisation or factitious behaviour is involved. I can come to no clear conclusion on that. PGM had noticed some issues with friendships, social comfort, reading and literacy levels, but specifically stopped short of asserting her opinion as to any ASD/ADHD. PGM has specialised in her career in assisting children with dyslexia.

4.27. While accepting that he had not administered any particular diagnostic test nor spent a lengthy period of time with C, Dr B was adamant in his evidence that C does not suffer from ASD, but is more likely to be experiencing the harmful consequences of being parented by her M in a somewhat overly critical, emotionally unavailable manner, and has experienced placement changes and disruptions to her relationships (pages 102-103 and 107-109 August report). Dr B concludes that it is more likely than not that C suffers from an insecure attachment with her M and is showing symptoms of that rather than ASD. He wrote in his report: '*Overall C presented as very much neurotypical. She made good, appropriate eye contact. Her speech was appropriate for her age, as were her non-verbal communications, including gestures and expressions, and her general social interactions. There was no evidence or signs of poor concentration, distractibility, being fidgety or overactive. These features were also all clearly the same when we observed her in her contacts with each of her parents and grandmother, when she also often interacted with us, as described further below.'*

4.28. He further emphasised that C showed adept social skills, completely atypical for a child with ASD, when she silently signalled an appeal and mouthed an apology to his colleague when she was in time-out for some misdemeanour during the observed contact session with M. He noted that his colleague, with whom he had partnered for the assessment process, had been a highly experienced paediatric ASD specialist nurse, and that they both were quite certain that C did not present as would be expected in a child with ASD: *'I do not believe any psychiatric diagnosis is appropriate for C - I believe that no inherent or developmental diagnosis is applicable, and it*

would therefore be emotionally damaging to C to put her through such assessments , and there would be the risk of over-medicalising her. There is certainly no evidence to support a diagnosis of ASD (Autism spectrum disorder) or ADHD (Attention Deficit Hyperactivity Disorder) - C's verbal and non-verbal social skills were good, and she was not overactive, impulsive, distractible or fidgety.'

4.29. As a result, I directed and all parties agreed that a redacted version of Dr B's report and the relevant parts of his oral evidence should be provided urgently to the NHS ASD assessor who had otherwise indicated to the PGM that C had appeared at least in terms of an initial or provisional interpretation of a diagnostic tool and interviews with C, F, PGM and M, to have met the criteria for an ASD diagnosis. While the final conclusion of this referral is unknown, it will be necessary for all those involved with C's welfare to be alert to any mislabelling or casual misunderstanding of her complex background and its implications. A diagnosis of autism can have significant and possibly life-long implications that could be harmful if the diagnosis is unmerited.

4.30. Standing aside from that particular controversy, I accepted his clear analysis of harm to the older girls: '*both [girls] having attachments that have been made insecure through their experiences - C's added to by 'being left out' or the scapegoat dynamic just described, and both of them having had to experience changes of primary carer because of professional concerns and social care and court decisions which in practice are because of abusive/neglectful behaviour by their M',*
and further: 'Indeed, B and C are in themselves at least subject to unnecessary emotional harm because of their mother's behaviour, through the distress caused around their sister's severe illness as well as the disruptions to their care system. There is an additional risk of either or both of them being also subject to some expression of unnecessary medicalization or other factitious process. Again, it was professional concerns as to whether this was happening to B that triggered the first set of hearings…'.

4.31. He identified that all three girls *'need safe, nurturing, consistent care that not only meets their basic needs, but can acknowledge and respond to their extra needs because of their experiences - which will, for the older girls, include how they process their understanding of what has in fact happened',*

4.32. He also highlighted particularly C's emotional needs and difficulties*: 'I do believe that C has significant emotional difficulties, arising out of her experiences in her mother's care which as set out previously, have meant she has had insecure attachment experiences mostly because of her mother's parenting style and unmet needs of her own, which have also left C sometimes feeling and being emotionally left out and stigmatised - and, I think, also being told she has or might have disorders which she does not have.*

So, these are not additional needs because of any inherent medical condition, but because of her emotional response to her circumstances. C is developing a sense of self, learning the rules, concentrating on academic work and other competitive activities, managing feelings, and regulating her behaviour in the context of the social world, which are key tasks of her age group - these are all tasks that can prove challenging to an insecure child; they require C to adapt in ways that strengthen her sense of self, but also facilitate fitting in to the group. I predict this will be more challenging for C given her emotional insecurity, which in turn arises from her attachment experiences, not any diagnosis (such as ASD, which has been spoken about by both parents - interestingly PGM was clear that she did not see any such traits in C).

C would therefore benefit most of all from professionals/the family ensuring the care given to her is nurturing, consistent and child- focussed. B and C both, as noted, also need to know why their lives have changed so much and might well need therapeutic support to help manage that.'

4.33. He described in emphatic terms the urgent need for the girls to have a proper, honest, developmentally appropriate explanation of what happened, why they cannot live with their M and what the plans are in terms of their care and contact. He considered that not knowing was increasing their confusion and distress. In his report and during his oral evidence he provided detailed help upon the principles and key parts of the draft Narrative Letter. He pointed out that the Narrative and explanation becomes part of the supportive work for family members, to assist them with accepting the fact of M's acts, and helps her sisters to understand the reasons for A's previous medical interventions and her new improvement. He emphasised that it needs to be agreed and truthful and avoid denigration. Equally, while he agreed that B and C need to have as positive an experience as possible with their M and so the information should avoid 'demonising' her (a profound fear expressed by M), nonetheless the clear opinion that they are not considered to be safe with her cannot be avoided. He recommended its delivery should be a shared matter, involving the SW, F and PGM, and that M should 'stick to the script'.

4.34. He firmly confirmed *'I have an unambiguous opinion that it is not safe for any of the children to be placed in the care of their mother, for the reasons set out above. Whilst I think the father and, to an extent, grandmother continue to find it difficult to fully accept what M has been found to have done, I believe that they can meet B's and C's needs, but will need ongoing support from the professional network in doing so, particularly managing any 'fallout' from what they will be told, and in resisting M's likely attempts to control things she should not be controlling. I also unambiguously recommend that A should remain in foster care. She has thrived there, in comparison with when in her parents' care, and she also of course has ongoing, significant, high-level needs which will be lifelong. She remains extremely vulnerable, and the most 'at risk' from any further similar abuse.'*

4.35. He reiterated in his oral evidence, notwithstanding their wish to return to their M's care and 'to how it was before', his clear recommendation for the girls to remain with their F and PGM where they have been settled now for some 22 months, and where their needs could be safely met. He made it clear both in his report and oral evidence that both B and C have strong and positive relationships with their F and PGM, that neither F nor PGM were complicit nor pose a risk and they offer a safe placement for B and C.

4.36. He nonetheless sounded a note of caution and urged that family members, education and health-care givers needed to remain vigilant: *'It must also be considered that even once all this is in place, there can be no certainty that difficulties might not recur, for any of the children, particularly whilst M continues to deny what has happened and in general, until her motivations are understood, and her needs are acknowledged - by her - and fulfilled or resolved. It will be necessary to continue to be alert to possible recurrence of FII behaviour by the mother, and expressions of this through the children, from their emotional state and/or any health-care-seeking tendencies.'*

4.37. In terms of contact, certain key principles emerged from his evidence:

- *'However, this is a situation where Findings of abuse have been made. Furthermore, there is a need for B and C to be given an understanding of why their care situation has changed and why A is in foster care. Even in a situation where a child/children remain in the care of the second parent, it has to be remembered, I believe, that the children have*

a 'task' to manage, of settling in and adapting to a new situation. Contact that is too frequent inherently disturbs this process.'

- While he thought B and C will need to be '*getting their heads around their new world'*, he also confirmed that there was no need for any of the children to have a period of reduced contact to manage a settling-in period as they had been in their respective placements for considerable periods already. He also added: *'So at least they're not getting used to that new situation, it's very well-established for them. But there isn't a definitive answer to frequency.'*
- *'The principles of contact frequency/duration are that contact is to maintain the real world relationship between children and non-resident parent (Mother in this instance), without disrupting the placement, as the contact experience for the children is of needing to manage leaving their new 'safe' arrangement back into the previous arrangement, and back again. This is as important for children in a family placement as it would be for children in a foster placement; and the need for there to be the clear boundary as to who are now the primary carers is even greater as this would otherwise be less 'obvious', for the children, then if placed outside the family.'*
- *'I think with balance between frequency of contact being high enough to maintain the relationship and not so frequent as to, I'm using this phrase again, disrupt the placement, but disrupting the placement, it's quite a, it's a bit of a catch-all but it is about getting used to this new living situation and their understanding of what's behind it. And it's, it's, although this phrase is unlikely to be used, it is about saying to them is, normality is changing, reality is changing for you, because your understanding is changing.'*

4.38. I note that the above points must be seen in the context of: the girls having lived with F and PGM for the last 22 months and it is undoubtedly a well-established arrangement, with them referring to it from time to time as '*home*'; they are not having to re-experience any 'previous arrangement' where a child is switching back and forth from the new placement into an old set of carers/exposures/environments, but will be having supervised contact in the community with their F and PGM present with them; their understanding will be changed by the sharing of the Narrative Letter; and there appear to be very clear boundaries as to their primary care and have been for a while.

4.39. In his oral evidence he emphasised the following: it is important that contact between M and the girls does not disturb the primacy of the main carers; the girls will need to manage regular transitions; they would not understand why they might see the same amount of M if people are worried about her; it would be confusing if there was no reduction; it would be a falsehood to aim to have the same relationship; and it should not go back to the way it used to be.

4.40. He was far less clear as to fixing on the frequency of contact, particularly relating to the older girls, but did emphasise that it would need to be adaptable: *'So, whereas it is not possible to know with certainty what the 'best' frequency is, I would recommend this being either once or twice a month to begin with - this could be increased eventually depending on how the adults progress with their increased understanding of the issues, as discussed above, including how they contribute to, conceptualise and respond to the narrative to the children, and indeed how the children manage that.'*

4.41. In terms of frequency and whether or not contact should be monthly or fortnightly. He began nearer monthly, but as his evidence developed he favoured fortnightly *'on instinct'*, but also considered that this frequency reflected the court's decisions and the placement of the girls. Part of his reasoning was also that this would be likely to be practically and emotionally manageable for F and PGM. Overall, he was very

clear that it was not an exact science: *'There isn't a guideline or piece of research that shows us exactly what contact levels are right in a given situation.'*

4.42. One of the principal concerns of the parties, and the F and PGM in particular, is the reactions that the older girls will have to the explanations that will begin with the Narrative Letter. While M holds out a hope that they will not be affected much, all other witnesses including Dr B consider that there will be some form of reaction and probably questions. Dr B was clear that there would be a longer process of absorbing and reacting to the import of what has happened. He did not consider that the delivery of these explanations would destabilise the placement with F and PGM. But it was in that context that he agreed that the frequency of contact would need to be flexible and for F and PGM to interpret and exercise their parental responsibility:
'Q. And this might be an obvious point, but does the need for flexibility also remain for the frequency of contact that B and C have with their mother so that obviously there's the narrative to deal with, there's the difficulties that might bring which you have already explained, but once that point in time, and I appreciate that's not one point in time, there is going to be a continuum about it, that really it's down to Father and grandmother exercising their parental responsibility to really have a view on behalf of the children they care for as to what the frequency should be. Would you firstly agree with that?
A. Yes, I would. That's the real world eventually.'

4.43. In terms of indirect contact, Dr B was concerned about what M might say, her skill at presenting messages with malign intent in a positive way, and how she might use those opportunities to undermine the shared narrative and place pressure on the girls or their carers.

4.44. In relation to A, he stated that more than once per week would be too much for A and for her foster carer, and that even fortnightly might be too much. He emphasised her vulnerability and how demanding it is on her. However, his evidence more generally did not reflect so much on the extremely positive nature of the direct contacts for A, nor on the impact of longer gaps between contacts on the quality of her recall and her relationships. He emphasised that contact between the siblings and between A and her F and PGM should be prioritised over M's contact arrangements, and noted the particularly high quality of PGM's contacts with A. He approved of more natural contact between A and her sisters, F and PGM, and of the ad hoc meetings that have been taking place at school pick-up time.

4.45. ISW MS PRECEY – Due to the withdrawal of her principal recommendations that the older girls could safely be returned to M, and that A could therefore be rehabilitated from foster care to the care of her F and PGM, and the consequent change of M's position, her report has played no real part in the balancing exercises that are dealt with in this judgment.

4.46. She otherwise confirmed in her oral evidence that she had every confidence in F and PGM to manage the risks posed by M in terms of their ability to care for B and C and supervise the older children's contact with M.

4.47. However, it must be noted that Ms Precey's initial recommendations led to M holding a false sense of the strength of her potential case. Those recommendations were made in the context of Ms Precey failing to attend to the requests in her Letter of Instruction, and failing to engage with the relevant critical and historical issues in this case, primarily relating to risk. This in turn led to the case initially being pursued and having to be listed with M's staunch position based on that report.

4.48. Ms Precey then withdrew her recommendations under appropriate questioning during the course of her oral evidence. This was not simply revelatory of Ms Precey's inadequate approach to the issues, but was a significant and avoidable blow to M and her case. This painful experience should not have happened to M, let alone in the middle of evidence at court. Those recommendations which were withdrawn should evidently never have been made in the first place.

4.49. Overall, this court is in the highly regrettable position of having had its time and resources, and the parties' time and public funds, wasted as a result of this jointly instructed court expert's failure to meet the proper expectations upon her. A parent has had her hopes raised unreasonably and the wider family members and professionals have had to grapple with the practical, psychological and legal consequences of those unjustifiable recommendations.

5. <u>PROFESSIONAL EVIDENCE</u>

5.1. All professional witnesses have shared, alongside the experts whose evidence is discussed above, a number of over-arching positions that underpin this final hearing:
- Their concerns relating to the findings; the physical harm to A; the emotional harm to all three children; and the ongoing risks posed by M;
- The positive assessments of F and PGM;
- Placement of A with her foster carer, under a care order;
- Placement of B and C with their F and PGM, under Child Arrangements Orders and Supervision Orders;
- And that ancillary orders should be in place to regulate aspects of parental responsibility and information sharing.

5.2. I do not propose to spend time in this judgment expanding on those agreed and well understood positions that I have expanded more fully in my examination of the expert evidence. I will focus on their evidence covering the remaining issues relating to contact.

5.3. A's Social Worker – Her original final care plan prepared in September proposed weekly direct contact between A and her M and for the rest of the family members, with ongoing brief weekday indirect contact sessions. However, by October, and after the CG's report and the IRO's concerns that this was a significant burden of contact for a long term placement, it had reduced to monthly plus special occasions, and then after the first stage of this final hearing when Dr B had given evidence her recommendation had modified to fortnightly.

5.4. While evidently trying to do her very best, her oral evidence did not provide a great deal of clarification of the rationale behind these changes, and significantly emphasised the point that there is little to reinforce exactitude when it comes to considering frequency of contact.

5.5. What emerged more clearly during the hearing itself was the position of A's foster carer and that this had been a significant influence on the LA's planning. This is an important component given the central significance of this placement to A. The foster carer had made it clear in discussions with the SW and the CG that she would be unhappy with too frequent a level of contact once final orders are made, and would consider the placement to be at risk due to the excessive demands of such frequent contact in the long term. She considered that indirect contact was less positive and was a strain at a difficult time of day when A was tired after school. By

mid-December when the LA had refined its final position, the SW received the following email from the foster carer:

'Firstly, we wholeheartedly believe that it is in A's best interest to maintain direct contact between her mum, dad, Nan and her two sisters. There has never been an issue with direct contacts and definitely have not been detrimental to A's mental health. She gets very excited when she goes to visit them and there are never any issues when she leaves.
Therefore, your plan for fortnightly direct contact between A and her mum at the family centre is acceptable and we will support that. We also support a fortnightly direct contact between A, her dad and her Nan after school alongside another alternate fortnightly direct contact between A, her dad and her Nan on a weekend:-
Week 1 - mum at [centre]
Week 2 - dad and Nan after school
Week 3 - mum at [centre]
Week 4 - dad and Nan at weekend
All for a length of time dictated by you.
With regards to indirect contact, we do not feel that this is in A's best interest. It was only ever temporarily set up as direct contact could not take place due to Covid restrictions. In our opinion, the three girls get more out of a direct contact than an indirect, especially if A is not responding to her sisters singing to her. This appears to be upsetting for them. As A's two sisters will eventually be a part of the direct contact with dad and Nan, indirect appears redundant. We will support a couple of variable indirect contacts with A's sisters during the Christmas holidays but that should cease once they are a part of the direct contact.'

5.6. I did not hear directly from the foster carer, nor read any sworn statement. That was not necessary. Notes were provided of two occasions, in September and October, that described A becoming tired and somewhat distressed and distracted. The SW described accounts given by the foster carer of more difficult occasions of indirect contact when A is too tired and requires prompting to engage or the promise of a treat. This was not observed by Dr B or other professionals. The CG also observed a positive indirect contact.

5.7. The SW gave evidence confirming the foster carer's skilful care of A, the progress made by A in her care, A's bond with her foster carer, the proximity of the placement to the family, and the need for this role to be supported and to avoid being strained. She described the demands on the foster carer with her existing domestic arrangements and another child with special needs. There has been no suggestion of anything other than proper child-centred longer-term thinking by the foster carer.

5.8. The SW stated that it would be disastrous for A to lose this placement. She would then likely also need to change schools and might have difficulty bonding with another carer so well. The SW confirmed that the foster carer is committed to caring for A, but pointed out the foster carer's concerns as to the sustainability of the placement with too many contact appointments taking place. I note that the foster carer is prepared to facilitate contacts that effectively take place weekly for A, plus the ad hoc school gate meetings that are taking place more informally.

5.9. The SW confirmed that A does greatly benefit from direct contact, and that M and the whole family had been co-operative and fully engaged with contact arrangements, with positive contact experiences for the children.

5.10. B & C's Social Worker – I acknowledge that the currently allocated SW has had only a short exposure to this case before the final hearing began. She was allocated in August 2021 following the abrupt departure of the previous SW, from whom she had therefore had no formal handover. She had not observed a direct contact between M and the older girls. She accepted that accounts of their contact with her were

positive. She has met the girls themselves on approximately three or more occasions.

5.11. Her sole filed statement is principally taken up with a suggestion that the court adjourn final orders in relation to the older girls' contact and further evidence be commissioned from Dr B once the Narrative Letter has been shared. This betrays the SW's understandable uncertainty over less well understood issues in the case, in particular the *'huge unknown'* of the girls' reaction to the forthcoming explanations, and possibly also her own unfamiliarity and lack of confidence at the point of writing her statement. I commend her and the LA team from moving away from this proposal which would further delay an end to these lengthy proceedings, and instead developing a sensitive transition plan that is designed to work well with the girls' carers and meet the girls' needs. I am grateful for the SW putting herself forward to take responsibility for the tricky task of closely assisting the family and in particular the girls' questions and reactions in the first month of their contacts with their M after the Narrative is shared.

5.12. The original care plan prepared in October proposed only monthly contact between M and the older girls. Upon hearing Dr B's evidence and reviewing the concerns of F and PGM she modified the LA's position to recommend fortnightly direct contact for the girls but no indirect contact. She confirmed in her oral evidence that the girls enjoyed their indirect contact with M, that it was positive for them and that she trusted F and PGM to supervise it properly. However, she considered that it would be confusing for the girls to have a higher level of contact knowing that they were not to return to their M, and emphasised her preference of reviewing the progress of contact and the children's needs at a later stage.

5.13. Children's Guardian – Ms Deutz is an experienced CG who was also the allocated CG in the previous proceedings. Despite this depth of experience, she too, like all the other professionals involved, has not been immune to the vagaries around contact proposals.

5.14. Regarding contact with A, her recommendation in her Final Analysis is for fortnightly direct contact for M subject to possible reviews if it is considered to be in A's best interests, and unsupervised fortnightly contact for the girls with F and PGM which could then progress to weekly; plus indirect contact would become weekly due to A's fatigue or distress and the difficulty managing it.

5.15. Clearly, this recommendation was then affected by the CG's further discussions with the foster carer which followed similar lines as mentioned above. This led to the CG's current recommendations of a limit of fortnightly contact and no indirect contact.

5.16. She noted the positive experience of A during direct contact, commended the normalisation of A's contact with her sisters, F and PGM, and passed on the foster carer's extremely positive appraisal of the informal school gate contacts that are taking place and with which the foster carer is very comfortable.

5.17. She noted that A had gone long periods without direct contact that were dictated by Covid restrictions and had not lost her sense of relationships with family members, and therefore she considered that A would be very well able to manage fortnightly gaps between contacts.

5.18. In her Final Analysis, the CG recommended that direct contact for the older girls should be weekly if possible and could even take place at the PGM's home. She had observed a contact shortly before her report was prepared where the weather

had deteriorated, and due to her own presence, felt confident she could authorise a move to the PGM's home although contact was otherwise taking place in the community. She witnessed a positive contact and based her recommendations on that among other factors including the fondness of the children for their M, the existing high level of positive contact, the 'importance' of it to the girls, the girls' enjoyment of and apparent benefits from their positive contact, and the F's and PGM's concerns at too abrupt and radical a reduction in contact for the girls.

5.19. Subsequently, she has modified her recommendation to fortnightly direct contact away from the family home, and no indirect contact. That is quite a shift, albeit she has prevailed upon the LA to develop a more tapered transition plan and to confirm that she would support flexibility in the execution of that plan dependent upon the girls' needs.

5.20. The CG based her change of view partly on Dr B's analysis, in that her original recommendations would be too frequent to be in the girls' best interests despite their enjoyment of it, their need for stability and adjustment to the new situation, and partly on her concerns as to the M's position evident from the M's oral evidence. She was prepared to acknowledge the unknowns relating to the girls' reactions to the Narrative Letter. However, she firmly held this line despite detailed cross-examination. She stated that fortnightly should be the maximum, but that it should not drop below monthly at a minimum. Her position mirrored that of the LA.

5.21. Her approach is criticised on F's behalf as inconsistent given her concern that the reduction of contact should not be too sharp for the girls, but then leaving an inflexible reduction to a single fortnightly contact. And also particularly where she explicitly supports and commends the safety and reliability of F and PGM in supervising contact. In her oral evidence the CG said that F and PGM '*work really well with professionals and take advice and invest trust in them'* and that she had a high regard for PGM. The CG also stated that the foster carer had told her that she had a really good relationship with the father and grandmother.

5.22. She is concerned that mixed or misleading and undermining messages may be shared by the M with the children, particularly during indirect contact. She observed that this may not be deliberately done, but that it might arise due to the nature of M's insight and beliefs. She relied on certain comments of the M during her oral evidence to support this concern. She accepted that there appeared to have been no such examples to date and that she had expressed confidence in F's and PGM's abilities to safely supervise M's contact. She gave an example of F's appropriate attention and watchfulness during the contact she observed.

5.23. The CG clearly supported the making of ancillary orders that constrain the M's exercise of parental responsibility relating to educational meetings at school and any health and medical appointments. This is tied to the risks posed by M as were set out in the experts' reports and further expanded upon in their oral evidence, and that it presents no benefit for the children's interests for her to do so where there are two competent carers. She supported the M's need to be kept informed and consulted but not to participate nor make decisions in relation to these areas of the children's welfare.

6. <u>FAMILY MEMBERS</u>

6.1. MOTHER – M's position has undergone significant change during the course of this hearing as I have already outlined. What is more problematic is her approach and

her insight in respect of what has happened and what it means. And I was again struck, throughout her oral evidence, at how intelligent she sounds and how persuasive in her vocabulary, tone and manner. I am sure that M was of course trying to do her best, and in some respects I could detect some real effort to at least put into some words her role in all this, and with some evident emotional struggle, but it inevitably remained guarded and limited, and washed over with a desire to be thought well of despite the findings. For those who know the issues in the case well, this did not prevent them from uncovering the inconsistencies, the denials, the uncomfortably held positions, and the reluctantly admitted problems within her explanations. For those who might not know this history well, nor the difficulties posed by M, there would undoubtedly be the risk that she would indeed be intelligently persuasive.

6.2. She expressed keen regret and accepted that she needs help to understand why and how this all happened. She said that her insight has developed over time, and that things she had not realised at first she had accepted in stages, although the overall impression was of a very generalised acceptance and guarded as to any details.

6.3. She emphasised that she would never deliberately harm her children, but clarified that to mean that she was not denying her actions were deliberate but that she had never intended harm by them. *'I love her [A] – I'm not a horrible person – I just made a mistake – I wish I could explain more but I can't – I'm sorry to say that but it's the truth'.* She added that *'no one apart from me knows why I did these things'*.

6.4. She refuted that the older girls had suffered any emotional harm or that she had behaved in any way that could justify Dr B's analysis of insecure attachment: she had always been there for them; they were unaware of her actions towards A; she offered emotional warmth and cuddles. She did eventually accept that there had been some disruption to their care arrangements, but asserted that most of the harm was due to their being apart from her.

6.5. While saying she accepted the court's findings, she deflected from answering as to whether they represented the truth, or to go into any detail as to what she actually accepted had happened, on the basis that she had not yet been able to receive any legal advice as to her potential criminal liability. At one point she accepted she had lied to the court, but also claimed she had not lied because in fact there was more she could have said but was unable to because of the potential criminal liability.

6.6. She sought to debate some of the aspects of Dr VV's formulation, conceding that she does have some personality traits but not personality disorder as she believes there is some overlap with ASD which she believes is more likely. She accepted Dr VV's opinion that there is no psychiatric explanation for her alleged 'memory loss', and ultimately conceded that her purported explanation of being unable to remember was in fact a device to avoid having to answer the experts' questions about the findings.

6.7. She accepted she can't be trusted to care for A and that her contact should be supervised. However, at a later point in her evidence she said that *'A will need to be cared for throughout her life – it will not always be by the foster carer – it will be important for her to have a bond with everybody'.*

6.8. She said how difficult and painful it was to accept that B and C should be cared for by F and PGM, and added '*although I know I would never do anything like that to them I can understand the anxiety of others*', and '*Once I've done therapy then I will be able to*

provide reassurance to professionals', and that she wants to build trust with professionals, F and PGM. While she did use the phrase '*the situation now'* in the context of there being some prospect of progressing her position regarding the girls, she also clarified that she understood that they should remain living with F and PGM until adulthood, while hoping that she could become more closely involved if her engagement with therapy permitted it. In that context she thought her role as their M meant that it was important that she be permitted to attend school and medical appointments and that it would not be fair on the children if she was not permitted to be there.

6.9. In terms of therapy, M has taken some steps to address her PTSD and to seek diagnoses of ASD/ADHD. She explained that she thought that if she addressed those things it would enable her to move forward regarding the findings. She accepted she may have been wrong in taking this tack.

6.10. She is currently taking a wide range of psychotropic medication; such that it was recommended by Dr B that she have a thorough review of what she is being prescribed and why. She has just recently sought a referral to a forensic psychologist and claimed she had not done so before as she was unaware of the details of what was required, although it was pointed out that enquiries could easily have been directed to Dr VV given that it was raised in her April report. It also emerged that she had not yet provided Dr VV's report to her GP.

6.11. Turning to contact issues: in terms of contact with A she described her weekly direct contacts as successful, '*happy, smiley'* with A asking for kisses and cuddles. She expressed worry at losing the little signals between them if contact was too infrequent. In terms of the indirect contact she confirmed that recently in the last few weeks A had sometimes been '*moany, unhappy'*, and she reported that the foster carer thought she had made a rod for her own back in offering A a treat if she engaged with the virtual contact.

6.12. As far as the older girls were concerned, she described a very strong bond and very positive contacts, and gave touching details of the way the girls run up to her and show her pictures and express their sadness that they can only see her once a week. She thought the video contact was very important to them.

6.13. She said that she knew the children very well and that she would be very surprised if they did not in fact want to see her even after having the Narrative Letter. She said she would stick by the account in the Narrative and would never want to jeopardise contact by saying anything undermining. She felt that they would want to see her more once they knew they would not be returning to live with her. She claimed never to have pressured F for more contact than as arranged, but that it was always the children asking for more.

6.14. She was particularly concerned that they would feel punished by not being allowed to see her, and she considered that it was not in their interests at all for contact to be cut. She felt that their knowledge of what had happened and their need for contact were two very different things. She could not understand the rationale in reducing their contact. Given that they had been with F and PGM for so long she claimed that it was largely clear to the girls that they were not living with her and so there did not need to be much change to reflect the reality of the situation.

6.15. She expressed what appeared to be genuine gratitude and appreciation of the care provided by the foster carer, F and PGM. In particular she confirmed that F and

PGM are very vigilant now, and that PGM is devoted, child-focussed and loving, and that she would trust her to make the right decisions for the girls.

6.16. FATHER – I remain as impressed with F through this hearing and in this judgment as I was through the fact-finding hearing. It is clear that he has listened and read and thought carefully about each issue. He has been affected by the reports and evidence of each expert and professional. I have a clear impression from his evidence of how he has weighed each opinion against his own experiences and his understanding of the girls' needs. As his understanding has developed through the course of the case, some opinions he has agreed with and accepted, others he has moved towards and then away from, and positions of his own he has firmly retained despite the views of others. His evidence was straight-forward and heart-felt. He has been able to provide clear and reasonable child-centred explanations for his positions. He has remained committed both to the girls and to patiently enduring and participating in these proceedings which have no doubt been excruciatingly difficult for him.

6.17. It is with evident sadness that he has decided that A is better off living with her foster carer. He listened to the emerging information about the foster carer's discomfort and anxieties at too high a level of contact and expressed the wish not to risk any disruption of her placement in any way as she has been looked after so well there. I note that he mentioned to Dr B and in his oral evidence that in terms of the indirect virtual contact that *'she did not get a lot out of it',* and it was *'more difficult'*. He welcomed the move towards more natural home-based unsupervised contact that he, the girls and his mother could all enjoy with A.

6.18. He clearly had experienced a degree of confusion at the ISW's suggestion that M could care for the girls, which led him to reconsider his expectations following the findings. However, since then he has reviewed the evidence and firmly put himself forward to care for the older girls jointly with his mother, as they have been doing for almost two years.

6.19. He has expressed his deep disappointment and confusion at M's behaviour. He also firmly debunked the frankly surprising notion, promoted by M in her statement of October, that despite what he was saying that he in fact wanted the girls to live with M. He said '*I want my kids to be safe and so they will be staying with me'*. He has moved on a great deal from the original parenting assessment of July 2020 which was undertaken before the fact-finding hearing, and in which many positive qualities are observed but where caveats were raised given his difficulties at that stage in understanding and accepting what M was subsequently found to have done.

6.20. However, he does not consider that he harbours ill-will towards M and thought he had worked through his issues regarding A, and had a confident working relationship with M that he did not think would change much. He was more concerned as to how the girls might react to the forthcoming explanations and felt sure that they would have many questions. He felt he could not predict how the girls might react to hearing the Narrative. They might want less contact with their M, they might want more. He expressed the wish to be able to manage the situation according to the girls' needs, and that he would consult with the SW if they wanted more. He confirmed that C had once asked him '*has M done something?*', which suggested to him her increasing awareness.

6.21. He confirmed that he had moved on from his previous view that contact between the girls and M should continue as it has done on a weekly basis, because he was very concerned at the impact of the Narrative and that he felt a reduced level of contact allows them '*to get their heads around the new normal', and 'It gives them time to deal with it and us to deal with the aftershock'*. He had clearly been listening to key points in the expert evidence.

6.22. His clear view was that there should be clarity, and that the girls would experience a clear change following sharing the Narrative Letter. There would follow the transition period and he then firmly proposed that there should be fortnightly direct contact and a fortnightly pattern of indirect contact every other week, and that this would both satisfy the need to demarcate the new changed situation, but would also meet the needs of the children.

6.23. He was very clear about there having been no challenges or difficulties during contacts and that he was confident that he and his mother could continue to manage contacts for the girls with M. He wanted '*absolute clarity'* and orders in order to avoid any attempts to blur boundaries and press for shifts, pointing out that M still has a lot of work to do and he would not feel confident dealing with arranging contact on his own without an order behind him. He was confident, in those circumstances, that he and PGM would be able to hold the line and would not be dominated by M, and that he considered close supervision of M's contact to be important.

6.24. He saw no need for M to attend medical appointments and preferred that she should not do so, pointing out that she had not done so now for the past two years. He was content for the M to attend fun school events so long as either he or PGM were there, as the girls would enjoy her attendance, and had no issue with M attending parents' evenings so long as he were also there.

6.25. GRANDMOTHER – Similarly to the F, my positive impression of PGM continues very much as during the previous hearing. She is an experienced parent, and an education professional with specific skills and experience in assisting children with dyslexic learning needs. Every professional has been impressed with her intelligent, thoughtful, child-centred and caring approach. These observations range from the original parenting assessment, through to Dr B's and the CG's observations.

6.26. The CG set out in her report that she has visited PGM at her home on a number of occasions and is full of praise for her:

'PGM has always been open in discussing issues with me, she is an intelligent woman who has clearly found the findings made to be shocking and has spoken to me about how she feels she was deliberately misled by M regarding A's care …

PGM has been the main carer for B and C since March 2020 and they have flourished in her care. She has been encouraging of them educationally and has offered them a high standard of physical and emotional care. The very difficult behaviour that was described from B prior to being placed with her grandmother and father now appears to have completely abated …

In the family home, C's main care is completed by PGM and I have seen them being very physically and emotionally affectionate to each other. PGM offers C lots of praise and tries to manage any challenging behaviour in a relaxed way.'

6.27. She has remained dedicated, supportive and caring to her son and her granddaughters. This is highly apparent during her evidence in which she was able to provide thoughtful comments on all their respective experiences.

6.28. Her kindness and generosity is very evident. It is one of the factors that has led her to be an excellent primary carer to the girls, but also to find it very hard to comprehend the implications of the evidence against M, until she heard all the evidence and saw the judgment in the fact-finding hearing. She described her position had '*obviously changed'* with knowledge of the judgment. She feels '*very let down by M'* and that *'the relationship is strained'* and she *'still can't forgive her*'. At the same time she can generously acknowledge the importance of M to the girls, the good relationships they have with her and how much they love each other.

6.29. She too experienced confusion following the ISW's intervention, and was understandably swayed to consider that by this means A might be able to be cared for within the family. This has been a bitter pill for PGM to swallow, and it is regrettable that she has had to have her hopes raised only to have to make the decision she described as '*heart-breaking'*.

6.30. She too did not want to jeopardise the foster placement and explicitly stated that she placed a great deal of importance on what the foster carer was saying.

6.31. Her evidence confirmed the positive picture that M had painted in terms of the girls' enjoyment when seeing M: they love chatting with her and playing games with her, drawing for and reading to her. She described the detail of the indirect contacts where M is on the phone screen propped in front of the girls who sit next to it at the table and interact with M, and where F and PGM are sat on their settees some six feet away so they can hear everything and would be able to intervene at any time without difficulty. She emphasised how much the girls enjoy this contact and felt that a reduction to fortnightly direct contact with nothing in place to reflect the current enjoyment of indirect contact would be too harsh.

6.32. PGM confirmed that having listened to all the evidence, she had modified her position as to more frequent contact and agreed with the position that F had explained in his evidence. She was more generous than F about visits to her home by M, and she was still concerned at the level of reduction but would support it as she could see that it should match what they are being told, although it might depend on how the girls responded to the Narrative. Notwithstanding careful testing cross-examination on M's behalf, given the recent and gradual nature of her conclusions on contact frequency, she maintained her position and indeed she became firmer. She concluded that it should be the baseline, and even if there is a bad reaction it should still be fortnightly, and that she accepted the consensus of opinion.

6.33. She expressed worry that C has wondered that A is not living with them all because she, C, has somehow been naughty. PGM has reassured her, and recognises how important it is for them to have a full and honest account, but also expressed grave concern about the impact of the explanations on the girls and that it would be helpful to have the SW's support through the difficult period immediately following its delivery. She supported the transition plan as a sensible approach and it is said on her behalf that she was relieved to hear the CG's oral evidence that it should be altered as necessary in response to the children's reactions.

6.34. PGM was more flexible than F in relation to attendance at educational and health appointments by M, but was receptive to the suggestion that instead they could keep M consulted and informed but would not have to manage her presence at those appointments.

7. <u>DISCUSSION & CONCLUSIONS</u>

7.1. LEGAL FRAMEWORK – These applications are governed by the Children Act 1989. I must make my decisions in this case with the welfare of the children as my paramount concern, and only if it is in their best interests to do so, guided by the factors set out in section 1(3) Children Act 1989:

(a) the ascertainable wishes and feelings of the child concerned (considered in the light of her age and understanding);
(b) her physical, emotional and educational needs;
(c) the likely effect on her of any change in her circumstances;
(d) her age, sex, background and any characteristics of hers which the court considers relevant;
(e) any harm which she has suffered or is at risk of suffering;
(f) how capable each of her parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting her needs; and
(g) the range of powers available to the court under this Act in the proceedings in question.

7.2. Each family member's ECHR Article 8 rights to family life are engaged, and any intervention of the court must be to promote those rights, to balance competing rights, and in doing so to give appropriate precedence to the welfare of the children and ensure that any intervention is necessary and proportionate.

7.3. A requirement before any section 31 orders may be made, is that the court must be satisfied that the threshold test set out in section 31(2) Children Act 1989 is met, either by agreement or by findings, namely: at the time protective measures were put in place in December 2019, the child had suffered and/or was likely to suffer significant harm and that harm or likelihood of harm was attributable to the care given to him or likely to be given to him, if an order was not made, not being what it would be reasonable to expect a parent to give him.

7.4. In relation to any findings: the standard of proof is the civil standard i.e. the simple balance of probabilities; and where I describe events or make findings, I have applied the balance of probabilities, the burden of proof being on the party seeking the finding. In making any findings I have considered all the evidence and submissions, even if every potentially relevant factor may not be specifically cited.

7.5. As it is agreed that a final care order is to be made concerning A, the Local Authority will have a duty under section 34 Children Act 1989 to allow her to have ‘reasonable’ contact with her parents. What is reasonable will depend on the facts of the case and the determinations of A’s welfare.

7.6. It is also agreed that I grant supervision orders to the LA for B and C, which will require it to ‘advise, assist and befriend’ them. It does not grant the LA parental responsibility.

7.7. Additionally, it is agreed that child arrangements orders are made that B and C shall live with their F and PGM. That order provides parental responsibility to PGM. So, parental responsibility will be shared between F, M and PGM. However, the exercise of parental responsibility will fall to F and PGM as they have day to day care of B and C.

7.8. M is entitled to advance consultation about any significant decision being made concerning them. However, her holding parental responsibility does not provide her with a veto over F and PGM’s decision-making. Were M to wish to challenge a decision made by F or PGM, she would need to invite the court to interfere by

making an application for an order under section 8 of the Children Act 1989; a provision that provides the court with the jurisdiction to determine how parental responsibility can, and cannot, be exercised. As submitted on F's behalf, the legal and practical reality is that if B and C react badly to the delivery of the narrative or for some other reason do not want to see M in the future, the burden would fall on M to make an application for an enforcement order should she consider that she can establish that F and PGM did not have "reasonable excuse" for non-compliance with the order under section 11(3) Children Act 1989.

7.9. When the court is invited to make an order under section 8 of the Children Act 1989, including Child Arrangements Orders for time spent with a parent (contact) or an order which restricts the ability of a holder of parental responsibility to exercise their parental responsibility, the decision is made with the welfare of the children as the courts paramount consideration, again guided by the matters set out in the section 1(3) welfare checklist.

7.10. Once final Child Arrangements Orders are made to F and PGM, with Supervision Orders that require the LA to assist and befriend the children, the proceedings will come to an end. The LA will have no power to compel F and PGM to comply with its direction concerning arrangements for contact between M and B and C. Decision-making concerning the appropriate arrangements for contact will rest with F and PGM, unless otherwise ordered. What orders for contact should be made are, as with other welfare decisions, to be made by reference to the children's welfare and the factors set out in the welfare checklist.

7.11. THRESHOLD CRITERIA –

7.12. As mentioned above, the threshold criteria in relation to A having suffered significant harm are established by the findings made at the earlier hearing in these proceedings. Those are set out in Appendix 1.

7.13. I have no hesitation whatsoever in accepting the evidence of the experts and the professionals that both B and C have suffered significant harm due to their M's actions. In particular I accept Dr B's analysis in his evidence that I have set out at paragraph 4.30 above.

7.14. I also conclude that M poses an ongoing risk of significant harm. I accept the evidence of Dr VV and Dr B that A is at a more acute and obvious risk than B and C. She has been the victim of a wide range of deliberate and dangerous behaviours by M, laced with dishonest claims and attempts by M to mislead medical and social work professionals, the court, and not least also her F and PGM.

7.15. Additionally, M is yet to express a sufficient acceptance, let alone a frank enough explanation of what occurred and what drove her to behave as she did, to enable preventive or therapeutic work to begin meaningfully.

7.16. Accordingly, and also because of the history of inappropriate anxieties shown around B's care and health needs in the first set of proceedings, I also entirely accept the evidence of Dr B as to the likely ongoing risk of emotional and physical harm to B and C set out above at paragraphs 4.20-4.25. I also note and accept the observations of the CG: firstly, as to the risk to B's physical wellbeing due to the extent of M's concerns explored in the first set of proceedings in relation to alleged health issues that were not well-founded then and have not proved well-founded since, and which also included a concern that B too may have been showing signs of ASD; secondly, she points out that B and C are not without their own health and

developmental issues onto which M could latch additional concerns, such as B's wetting and C's possible ASD; thirdly, she echoes Dr B's conclusions, but details how B and C have expressed worry about A's health and witnessed her extreme levels of ill-health and distress in the family home, how they have struggled to understand her improvements since then, and C thinking that she might be somehow to blame for A's ill health.

7.17. I accept Dr VV's conclusions that I have set out in paragraphs 4.10-4.15 above in relation to risk. On the basis of M's evidence before me, I am also driven to reach the following findings which relate to the ongoing risks she poses, its varied implications and the consequent care that will be required:

- It is clear that M has perpetrated dangerous and dishonest actions and behaviours consistent with Factitious Induced Illness at the higher end of the scale. Dr VV described M as posing a complex picture and proposed a number of potential comorbidities and traits. It is not necessary for me to reach conclusions as to M's exact formulation or diagnoses. However, I accept Dr VV's analysis that neither PTSD nor ASD are diagnoses that could explain M's actions, and that if M does suffer from ASD then this only complicates her difficulties further and might explain the lack of empathy required to behave as she did. I also conclude that M's insistence on these diagnoses and her attempts to exclude Dr VV's analysis and particularly the identification of M's personality traits continues to be significant in terms of M's ongoing denial and resisting responsibility for what she did.
- She lacks insight into and denies the existence of any risk she poses. She tried to claim that she poses no risk to her older children. She is prepared only to accept the risk that relates to the inescapable position regarding A, and even so she sought to place perceptions of risk outside her own actions and instead focussed on how other people would feel anxious about her having unsupervised contact.
- She lacks insight into her own difficulties as a parent and their harmful consequences for the children. For example, while desperately seeking a diagnosis of autism, she nonetheless minimises any likely impact upon her interactions with her children as their autistic parent. And she found it almost impossible to consider the harm that her actions towards A will have had on B and C.
- The prognosis for change is mixed, but mainly very poor. The list of factors are set out in Dr VV's evidence and at paragraph 4.10 above and I accept her analysis. A positive feature is that M claims to be motivated to change and there was some sign of emotional congruity and painful recognition with that motivation in her oral evidence. It is also positive that she has previously successfully engaged with other therapies to address her PTSD. However, that was a self-centred therapeutic effort, with herself as the victim of the trauma. There is no evidence currently to support confidence in her ability to face up to the challenges of owning (taking responsibility for), naming and describing her actions, permitting feelings of shame and guilt, or permitting exploration of what drove her to act and to lie as she did. Her admission that the claim of memory loss was a device to avoid addressing the experts' questions and a type of deflection may be a step forward of a sort. However, it only goes so far in that it simply peels back the most recent set of lies in the form of another layer of defensive fabrication. Additionally, her claim to be unable to talk about what actually happened due to

the potential criminal proceedings is another barrier to speaking openly and enabling herself and professionals to grasp where the risks and triggers lie. I am driven to conclude that while there may be a tiny chink of light emerging, that M still struggles with fundamental denials of any real ownership for her actions and cannot, for a variety of reasons, talk about her actions in sufficient detail. Therefore, the prognosis is currently very poor in that this is likely to prevent onward progress via therapy, or at least probably lengthens it and makes a positive outcome less certain. I hope, of course, that this will change and M will access and commit herself to appropriate therapy and engage with it meaningfully. However, this hope cannot be safely relied upon until there is clear and reliable evidence that substantial and relevant progress and changes have been made.

- Unfortunately, I also conclude that she is still demonstrating efforts to try and manipulate or delude others. I have examined this in relation to her oral evidence at paragraph 6.1 above. I was also struck by the strangely manipulative comments in relation to F that are set out in her October statement, including her assertion that in fact he supported the older girls returning to her care despite his saying the opposite. Another worrying such example is that she has also stepped back from involvement in the girls' medical appointments for two years, but in her oral evidence was trying to make it sound as if it was now somehow damaging to the children and in conflict with their rights and needs if she were to be excluded from such appointments.
- It was also clear from her evidence that M to some extent harbours a notion that was not fully expressed, but emerged via the occasional revealing comment, that this set of arrangements for the girls may be temporary, and that she can step back into the girls' lives and take over their care or become more closely involved in their care once some time has passed and some therapy has been attempted. This notion appeared to extend also to A. This demonstrates an ambition based upon her poor insight, particularly given the gravity of her behaviour, the lack of understanding of its triggers and drivers, and the challenges and uncertainties of therapy. It also highlights the vigilance that must be exercised as to ongoing risk and any changes she may claim to make in the future, or any comments she might make to the children.

7.18. CHILD A - CARE ORDER – I am satisfied that it is in A's best interests, bearing in mind the welfare checklist, and that it is a proportionate and necessary interference with the parties' Article 8 ECHR rights in the light of those interests, for a final care order to be made to the LA.

7.19. All parties are agreed that the LA should share parental responsibility for A, and there is no other method by which this can be achieved. All parties agree with the LA's care plan save that M wants more frequent contact. Under the proposed care plan little will change for A save for the frequency and nature of her contacts with her family. She has settled over the last two years in her foster placement and will remain there. Parental responsibility will now continue to be shared by the LA with the parents into the long term and subject to the usual consultation and review processes.

7.20. A has continued to thrive and make remarkable progress in her development and her relationships ever since she has been in this foster placement:

- She eats regular meals, snacks and a varied diet with her foster family;
- She drinks water from a cup with straw and has no concerns passing urine or opening her bowels;
- She was discharged from the care of the community nursing team September 2021 as she no longer has nursing needs following the removal of her gastronomy at her local hospital as advised by Dr U, her Paediatric Consultant;
- The Dietician's report dated August 2021 stated that A's height has increased significantly in proportion to her weight and there are now no concerns with any of her growth parameters;
- She takes no medications;
- At her annual Looked After Child health assessment in July 2021 there was no concern reported;
- Her mobilisation and strength are all improved, using her walking frame;
- She is almost always observed to be smiling and happy, she laughs, plays, sings, repeats words, uses words meaningfully, can join two words together, recognises her foster carer and foster family, recognises her parents, siblings and PGM, and enjoys school.

This is by contrast with her previous presentation at home where the CG notes having experienced the '*shocking and remarkable'* differences in that she was '*always…distressed, crying and uncomfortable. She had a very grey pallor and was largely unresponsive'*.

7.21. The LA has committed itself to supporting this placement long term and following through the matching process. Her placement has kept and will keep her safe and her needs met. While sad for A's family, who have had to recognise that they cannot meet A's needs in the circumstances of this case, it is in many respects an ideal placement in terms of quality of care, location, relationship with the foster carer, and the family's confidence in her.

7.22. I am sure if she could express her wishes and feelings she would want to continue to be cared for well and safely, and for that to be done by her devoted foster carer, whom she occasionally calls 'Mummy' and in whose care she has settled and thrived and with whom she is seen to 'light up'. I am also sure that she would want to maintain close and loving relationships with all her family, and to see them often. Given both parents' observations in relation to indirect contact, and the foster carer's concerns and reports of tiredness, resistance, not engaging and occasional distress, I am less certain that she would want indirect contact to continue so long as direct contact could be taking place.

7.23. A has all the enhanced medical, physical, educational and developmental needs of a child with her range of disabilities. She also has the need to still belong to her family and for meaningful relationships with each of them. She needs to be protected and safe from the risks posed by her M. I am satisfied that the LA's care plan and additional amended care plan properly sets out how it proposes to meet those needs.

7.24. CHILD A - CONTACT – It is notable that both F and PGM responded thoughtfully to the foster carer's concerns about A and herself being overburdened with too many sessions of contact, and particularly with indirect contact which is less positive and worthwhile for A. They now agree with the proposed routine of fortnightly direct contacts, with the additional ad hoc school gate meetings, and no sessions of

indirect contact save where there might be longer gaps in those ad hoc sessions such as during school holidays. They welcome that it will become more natural, home-based and involving the older girls with F and PGM all seeing A together as a unit, reflecting the reality of their situation.

7.25. M, however, wants her contact with A to remain weekly and for indirect virtual contact to continue. She argues that A enjoys her contact, that fortnightly direct contact is too little and A would have difficulties remembering family in between, that there is no real risk of destabilisation of the placement due to the degree of commitment by the foster carer, that indirect contact has also been positive and was taking place four times per week until November. She would like it to take place in the community but accepts that it should be supervised.

7.26. I note Dr B's concerns that A should not have too much to deal with, and that her vulnerabilities mean that contact is a strain upon her. His evidence was that weekly would be too much and fortnightly should be the limit but may still be too much. I bear in mind that A appears to thoroughly enjoy her direct contact with all her family members, and does not appear to show strain in those direct sessions nor is it reported afterwards.

7.27. Despite some of his evidence that emphasised the lack of certainty around fixing the frequency of contact, I also note that his views chime with those of the foster carer. I consider that her views should be respected. She has cared very well for A and proposes to continue to do so, without any requests for respite. She has also built up an excellent understanding of A's needs, and of her and her family's abilities to meet those needs. She has also done so while developing excellent working relationships with the family members. I therefore consider her views are not due to mere convenience or without regard to A's needs, but are in fact centred upon A's needs and her abilities to fulfil her role as A's carer.

7.28. I also consider that notwithstanding her stated commitment to A, it would be foolish to ignore her worries about the sustainability of long term contact once final orders are made and the impact on the placement of too much being asked of her as a long term carer. While it may be right to assert that the availability of the placement is not in real jeopardy currently, it would certainly appear to be a high risk approach to impose more contact than the foster carer considers she could manage. It could lead, albeit over a little time, to a review by the foster carer and her family as to how long they would be prepared to continue to offer such an excellent placement to A. It may also lead to strains and dissatisfaction that cause deterioration in the working relationships and the overall quality of interaction around A's care and wellbeing. Dr B's principles that contact should reflect the real situation and not pose challenges to the stability of the placement can be seen to apply here.

7.29. I note that the updated plans firmly commit the LA to fortnightly direct contact and that this should address the concerns that had recently been expressed by the IRO. Those concerns appear to have flowed from the comparatively generous and frequent contact given it is a permanent long term alternative placement, and its impact on both A and her carer. Given the observations made here as to the importance of direct contact for A, and in particular the commitment of both the LA and the foster carer to fortnightly contact, such concerns should now be allayed. I also note that the CG had discussed these issues subsequently with the IRO and had been reassured.

7.30. I accept the observations of the CG that A has managed long periods without direct contact due to Covid restrictions and that this has not led to a deterioration in her ability to relate to her M, nor her M's ability to pick up on her signals. Therefore I do not accept M's suggestion that fortnightly contact jeopardises those abilities.

7.31. Given the risk issues that have been discussed above, I accept the LA's position and arguments relating to the venue for contact. Not only should it remain supervised, but they consider it should remain at the contact centre and not in the community. Clearly it is harder to safely supervise a high risk contact in the community. The nature of contact arrangements will, of course, be kept under regular review.

7.32. There are also the key issues of priority and parity to consider. Dr B makes it clear that A's relationships with her siblings, F and PGM should be prioritised, rather than A's energy spent on contacts with her M. They, after all, do not pose a danger to A and were not the perpetrators of significant FII towards her. Equally, it would be absurd and illogical for M to have more contact than the level which F and PGM have recognised and agreed is an appropriate and safe amount for her and her placement.

7.33. For the reasons I have already mentioned above, I have also concluded that indirect contact should not be continued as a regular feature. It was begun as a replacement for direct contacts that were being missed due to Covid restrictions. I accept the observations of the foster carer, given that they do in fact fit with some of the parents' own evidence that indirect contact is less positive and less easy for A. The focus for A should be on direct contacts wherever possible as those are the easiest, happiest and most well-suited to her disabilities. However, if long gaps arise between direct contacts that interrupt the fortnightly routine for whatever reason, it would seem sensible to ensure that A's needs are met by arranging a brief indirect contact to keep her connection with her family regular. I invited the LA to amend its care plan on this point accordingly.

7.34. So while I have borne in mind M's evidence and the submissions made on her behalf in this respect, I cannot conclude that her position reflects A's overall welfare interests. Her proposal would be more frequent than any other party, professional or expert considers to be appropriate and sustainable, and more than A's siblings, F and PGM would be having. I consider the contact arrangements set out in the LA's plans to be reasonable and in A's welfare interests, and I make no order under section 34 Children Act 1989.

7.35. CHILDREN B & C – CHILD ARRANGEMENT & SUPERVISION ORDERS – Again there is now no opposition to B and C remaining in their current home with their F and PGM under Child Arrangements Orders. Both F and PGM have been positively assessed and they and their care of B and C are approved by all professionals and Dr B. An initial concern over the unkempt and cluttered state of PGM's home was rapidly addressed and those improvements have been sustained. In all other respects F and PGM have both been committed, co-operative, open, communicative, consistent, reliable, compliant with expectations, trustworthy, straightforward and child-centred.

7.36. Both girls have settled and thrived with them over the last almost two years. The CG reported that B no longer experiences the 'meltdowns' that troubled her in her M's care. C has strengthened her bonds with F and PGM, with whom she shares her feelings and thoughts, and by whom she can be encouraged and drawn out as I

have seen touchingly described in the parties' evidence, and in Dr B's and the CG's reports. I was impressed at the way both girls are sympathetically understood by F and by PGM in particular.

7.37. I am aware that both girls have regularly expressed their wish to return to live with their M and for things to go back to how they were before. Naturally, while I fully grasp how much they feel love for their M, for all the obvious reasons to do with the facts of this case, their age and their ignorance of those facts, and the risks that arise from those facts, those wishes simply cannot be met. It would not be safe to do so and it is not possible to turn back the clock and undo what M has done. Soon, it will not be possible to go back to a point before which the girls did not know what they will shortly have explained to them. Their wishes and feelings will almost certainly be affected by this knowledge.

7.38. They have also begun to refer to PGM's home as their home, and expressed very positive emotions towards F and PGM when the CG was exploring their wishes and feelings. C has gone so far as to express a degree of ambivalence about a return to her M.

7.39. I accept Dr B's analysis of the girls' needs, in particular as set out in paragraphs 4.30-4.35 above. I note in particular that they '*need safe, nurturing, consistent care that not only meets their basic needs, but can acknowledge and respond to their extra needs because of their experiences - which will, for the older girls, include how they process their understanding of what has in fact happened'.*

7.40. This '*process of understanding'* Dr B also identifies as a very significant need. Both F and PGM consider that B and C feel confused, and they are conscious that they have not been able to speak openly with the children about the situation they all find themselves in. That is an artificial and unhelpful constraint. I have no doubt that both girls need honest information in order to be able to understand and discuss why they have experienced the losses of no longer living with either M or A, and to be able to fully feel and share the feelings, the real implications, of what has happened to them and their family.

7.41. Dr B considers that they both have a degree of insecure attachment. C has further enhanced needs and vulnerabilities. Dr B considers they flow from the emotionally harmful experiences of her earlier childhood leading to her attachment problems, and there is also an ASD assessment taking place. It may be the case that these issues are co-morbid and she experiences a degree of both. Care will no doubt need to be taken to manage these issues and avoid over-medicalisation while at the same time sensitively meeting her needs.

7.42. Having considered the positive assessments of F and PGM and heard their evidence, I am confident that they have shown excellent care of B and C, and will continue to do so. I am also confident that they will remain thoughtful and open to advice and support in understanding and managing B and C's needs.

7.43. I note Dr B's confirmation that he does not consider that they were in any way collusive with M and that he considers them to be safe carers for the girls. I also note his caveats as to their ability (as at the time of his report and subsequent evidence) to fully see and accept M's culpability and risk. Again, having heard directly from them and reviewed the evidence carefully, I am confident that despite PGM's kindness and F's apparent quietness that they are both now fully accepting of what occurred, well aware of the risks and that they fully intend to remain careful and vigilant in managing the children's relationships with M. The CG is also confident of

this and her interactions with F and PGM are more up to date and extensive than the assessment process carried out by Dr B. The SW expressed her own trust and confidence in them. Accordingly, while it will be necessary for F and PGM to remain careful and review every step taken and not relax their vigilance, they appear to be up to the challenge of keeping the children safe from the risks posed by M. I note that Dr B considered that they may need support, alongside the children, to manage their changing feelings and the new challenges.

7.44. In all the circumstances I unhesitatingly conclude that it is in B's and C's best interests, bearing in mind the welfare checklist, for F and PGM to have Child Arrangements Orders that establish that B and C should live with them.

7.45. No party resists the granting of Supervision Orders to the local authority. In the complex and challenging circumstances that I have examined in this judgment, it is a proportionate and necessary measure whereby the family can be properly assisted and supported. I am satisfied that it is a justifiable interference with the parties' Article 8 ECHR rights, bearing in mind that it is in B's and C's welfare interests for them to be advised, assisted and befriended as planned by the LA. A 12 month period is sought and is clearly the right length of time in this case. Any shorter would not cover sufficient time for the girls' needs to be properly reviewed following the Narrative being shared and following the end of these proceedings and any potential fall-out.

7.46. B & C – CONTACT – The girls evidently have a need to maintain a good and as positive as possible relationship with M, balanced against the need to understand what has happened to them and to A and their family.

7.47. Once the Narrative Letter is delivered, all parties agree the structure of tapering supervised contacts as set out in the transition plan. These will be supported by the SW carrying out the supervision as I have already described above in order to assist with any difficulties or questions that may arise over the next few weeks.

7.48. I appreciate the effort that has gone into sensitively working out a plan that attempts to incorporate the initial stages of this process of understanding, the needs of the girls, and the worries of F and PGM. I welcome the CG's suggestion, accepted by the LA, that the programme of the plan can be altered if it is necessary to meet the girls' needs. The agreement to this plan should be clearly set out in the recital to the final order in this case, with the prospect of reviewing its impact and making any necessary changes in accordance with the girls' needs.

7.49. The transition plan also marks a reduction in the girls' contact with M, but conducted in a tapering gradual process. The reasoning behind this was to prevent the girls from experiencing a radical cut in the amount of their contact. Although Dr B expressed the view that contact should start at less so it could be built up to more if appropriate, significant concerns were expressed at a sharp reduction and the impact of that loss on the girls given the high levels of direct and indirect contact currently in place. I approve of the transition plan and I consider that its gradual and supported reduction period is more likely to prevent the girls from feeling loss, abandonment, and a sense of punishment which could arise from a more blunt and radical cut.

7.50. Thereafter, the LA and CG propose solely fortnightly direct contact, whereas F and PGM propose fortnightly direct contact with fortnightly indirect contact in the alternate weeks. M wishes for weekly direct to continue with weekly indirect contact.

7.51. I have carefully considered all the arguments and evidence put forward in support of each of these positions. There are some central points that are particularly influential.

7.52. One of Dr B's principles is that contact should reflect the changes being wrought and also the real situation. Here, there are two significant matters that arise: the explanations being given to the children and their changed state of knowledge with consequent feelings and impacts on their relationships; and the final decision that they cannot return to M's care and will be remaining with F and PGM.

7.53. Another of Dr B's principles is that the girls have a significant task to now perform, which is to get to grips with these changes in their lives, make sense of their feelings and develop their sense of understanding these developments. Frequency of contact should not prevent or derail that process.

7.54. All witnesses have also agreed that they cannot know how the girls will react. As set out in paragraph 4.42 above, Dr B confirmed that in those circumstances he agreed that flexibility and discretion should be granted to the girls' carers in order to permit them to meet their needs as required.

7.55. I am aware that every professional and expert involved in this case on this issue has wavered and shown degrees of uncertainty and variation in their own opinions or positions as to the frequency of contact. As I have mentioned above these recommendations have varied from weekly direct plus additional indirect contact on the one hand, right through to only monthly on the other. I also note Dr B's emphasis on there being no research or clear scientific approach to call upon for an answer as to frequency, and his own reference to plumping for fortnightly 'on instinct'. As a result, I have not found any particular variety of frequency asserted by a professional or expert to be particularly convincing, nor has any apparent certainty as to that frequency been of assistance.

7.56. All parties are encouraging the court to grant private law orders to establish the girls' placement with and care by F and PGM, on the basis that they have been and are being trusted to do so safely and well in the girls' best interests, for all the reasons I have discussed above.

7.57. What would appear to be appropriate, therefore, is to do just that and trust F and PGM with: their understanding of the advice and principles that should be considered; their concerns as to too sharp a reduction in contact; their knowledge of the girls and their understanding of the girls' need for and enjoyment of indirect contact as well as direct contact; their awareness of the girls' habits that have been developed over the last almost two years of regular direct *and* indirect contact; and their being the ones who will be caring for B and C after this Narrative is shared and these proceedings come to an end. What would also appear to be necessary, therefore, is to grant them a degree of discretion in interpreting and managing the girls' contact needs, dependent on how they react following sharing the Narrative and informing them of the final outcomes in this case.

7.58. Accordingly, I consider I must pay close attention to their perceptions of the key issues. The Narrative Letter and transition plan and its impacts worry each of them greatly, but also sets up a very clear shift and change to the new reality, by virtue of exposing the girls to the explanations of what has happened and at the same time changing the rhythm of their contact with M.

7.59. As F pointed out, he and PGM have been the girls' primary carers for many months now and the girls have become used to that arrangement, plus he considers that the

shift to fortnightly direct and fortnightly indirect contact will also mark a distinct change from the previous contact arrangements and so also reflects the reality of the new situation. Their proposal would mean dropping from five contacts per week to a single contact, effectively alternating between direct and indirect. Both F and PGM are very concerned as to the distress the girls may feel at too little contact with M, but consider that this would give them and the girls sufficient time and space to think and to progress with this process of the girls' changed understanding.

7.60. Reducing to strictly fortnightly and barring any indirect contact via an order I find to be a surprising suggestion, given the need for flexibility and sensitivity to the girls' needs. It is only F and PGM who will be in a position to observe those needs and take steps accordingly. In light of all the above, the court cannot be in any clear position to dictate rigidly that there should be no indirect contact.

7.61. M's proposal is also too rigid a structure that lacks flexibility and at two contacts required per week, direct and indirect, does not adequately provide the time and space to the girls to work out their feelings and to experience a real difference that reflects the decisions made in the case.

7.62. Given that the children have been living with F and PGM so long and no 'settling in' period is required, there is also no substantial argument on that basis for starting at a low level before returning to a higher level at a later date.

7.63. I note, and fully accept as very important, the need for clarity so that the baseline of contact is well understood. At the same time, I consider that F and PGM need some degree of leeway and discretion that is solely within their power to exercise, and is not stuck within the rigid confines of an order that either requires or prevents its exercise.

7.64. I also note the concerns expressed as to M making unhelpful and undermining comments to the girls during contact. This is an argument proposed in order to prohibit indirect contact. Clearly such comments can be made also during direct contact. Unlike many cases, this issue has fortunately not been a feature here. While M did reveal that she may think of these arrangements as temporary, and therefore there is a risk that she will speak inappropriately to the girls along those lines, that does not mean she will be bound to sabotage her contacts in this way. Forewarned is forearmed, and the SW, F and PGM will be all the more vigilant in their supervision of her contact. Equally, given the imminent delivery of the Narrative Letter, and the inevitable fear that M cannot be considered as trustworthy in sticking to that narrative given her lack of real insight and acceptance of the findings, there will undoubtedly be a very tight attention being paid to anything that M says or replies to the children. I do not consider that this argument, in itself, justifies the removal of a flexible and familiar form of contact from F's and PGM's discretion.

7.65. Overall, therefore, in order to best meet the girls' needs for positive contact with their M that maintains that relationship but balances that against their need to carry out this task of developing their new understanding, that provides stability and a reflection of their new reality, and provides for flexibility in response to their needs and to their reactions to the Narrative and the new arrangements while also providing certainty and a degree of familiarity, I conclude that there should be a clear baseline order for direct contact on a fortnightly basis. I will not order that there should or should not be indirect contact, but I confirm that F and PGM have sole discretion to consider implementing their proposal of up to fortnightly indirect contact if they see fit.

7.66. This does not give M an enforceable demand for indirect contact, but provides F and PGM with some flexibility that can be exercised in their discretion. During the currency of the Supervision Order it would be expected that F and PGM would discuss this option with the SW, but it remains in their discretion as to the exercise of their parental responsibility in this respect.

7.67. There has also been a discussion as to whether a maximum/minimum order would assist. This is resisted by F as lacking certainty, and leaving open the opportunity for M to press for more contact. Although this has not been a feature of her behaviour within proceedings, I acknowledge that these proceedings will shortly come to an end and so I accept that is a relevant anxiety and such an order is not a helpful nor necessary method here. However, I am mindful of the girls' need for contact and the CG's view that even if contact has to be reduced then it should not fall below monthly, in order to ensure that they have sufficient contact with M. Accordingly, if it becomes necessary to reduce the girls' contact and in the exercise by F and PGM of their discretion, it is unlikely that reducing it to less than monthly will be in the girls' interests.

7.68. Equally, if it is in the girls' interests for other contact to be agreed, then it must be agreed in advance in writing. It must be considered in consultation with the LA during the currency of the Supervision Order. This too respects the flexibility and discretion that the girls' needs may require, and in relation to which this court cannot possibly know or rule in detail given the particular circumstances here.

7.69. For the avoidance of doubt, all M's contact is to be supervised and to take place in the community rather than in the girls' home. This keeps them safe given the risks I have discussed above, but also clearly demarcates the new arrangement, underpins the primary carers' roles in their home with the girls, and prevents any blurring of boundaries. Given the risks set out above in paragraph 7.17 above and in particular those relating to M's wish to re-insert herself into the family home and family life, to attend medical appointments, to see herself in an overly positive light and to manipulate others accordingly, it is important at this stage that any blurring of these boundaries and any creeping of M's ambitions is minimised. Contact taking place in the girls' home will make that harder to avoid and to monitor. By contact remaining away from the girls' home and in the community, contact can take place in more neutral and less emotionally significant environments for both the girls and the adults, and their home remains a space that is safe from exposure to these risks, and (as Dr VV expressed concerns about) removes from F and PGM the harder task of having to monitor for these difficult and nuanced behaviours in their own family home. This aspect of the girls' contact with M may become a suitable topic for review and the exercise of F and PGM's discretion at some future point if it becomes safe enough to do so, if they are both content to permit it (currently the F is not), and if there is a benefit to the children in doing so.

7.70. ANCILLARY ORDERS

7.71. DISCLOSURE – It is obviously in the older girls' interests that their school is aware of the content of the Narrative Letter before it is shared with B and C so that they are in a position to support them if necessary. This is not resisted by any party.

7.72. It is also clearly in all the children's interests that those agencies involved in their health, education, development and any welfare issue should know what has occurred in this case. It will assist in supporting the family, meeting the children's

needs and avoiding risks. Accordingly, I authorise that the LA, M, F and PGM may disclose the Narrative Letter, the Health and Education Narrative, the fact-finding judgment and this judgment, and the final orders to relevant agencies.

7.73. However, the Health and Education Narrative should not be disclosed to the Health Trust involved in the case unless there has been confirmation from the CPS that no criminal charges are being brought against M.

7.74. PROHIBITED STEPS & SPECIFIC ISSUE ORDERS – I shall not repeat the analysis of the issues relating to risk here. In the light of those conclusions, it cannot be right that M should be permitted to attend or become closely involved in meetings or appointments relating to the children's health, development or education.

7.75. If she is required to provide information relating to the children's early years, say, then F or PGM can relay the enquiry to her if necessary and she can provide the information to them for onward transmission. By that means they can monitor and filter any information given by M and can prevent her from becoming entangled or influential in any process.

7.76. This does place upon F and PGM a duty to inform and consult M given that she will not be permitted to attend such appointments directly.

7.77. For the avoidance of doubt, F and PGM must be able to exercise their parental responsibility over hers in these areas, and will be able to override M. They will be in a position to provide consent regarding medical, educational or other developmental decisions without her being required to do so and also without her opinion forming a veto upon theirs.

7.78. M can, however, attend at the children's schools for any recreational activities such as plays, concerts, shows or fairs. This must be agreed to by the school, F and PGM and the children must also want her to be there, and either F or PGM should also be in attendance with her and the children.

HHJ Lazarus

14 January 2022

8. APPENDICES

8.1. APPENDIX 1 – Summary of Findings of Fact

SCHEDULE OF FINDINGS

[Pursuant to the judgment of Her Honour Judge Lazarus dated 5.2.21]

1. The mother, by her actions or omissions in terms of making provision for A's adequate nutrition, has been responsible for A's inadequate weight gain and state of malnourishment by the date of her hospital admission in November 2019. [14.17]

2. A's poor development in 2019 and striking progress since shows that her development was held back by her malnutrition. [14.17]

3. The mother tried to lie and mislead the court in relation to her culpability for the matters set out in paragraph 1 and 2 herein to try to deflect onto other causes and away from matters that she knows would not reflect well on her. [14.16]

4. The mother purposefully and repeatedly interfered with A's feeding tubing with her hands, which included pinching and folding the tubing and also clamping the tubing, primarily while her hands were hidden under the blanket to do so, in such a way as to block the flow of feed and trigger alarms on numerous occasions as recorded from 2-8.12.19. [14.35]

5. The mother was aware that her comments made to the nursing and medical staff, that it was due to dystonia, were false. [14.35]

6. The mother was able to introduce sufficient amounts of fluid to dilute and increase the gastric losses in the pattern seen in the charts [during the admission to the Evelina between 29.11.19 and 11.12.19] [14.49]

7. The mother deliberately manipulated the tubing and PEG-J by introducing fluid and squeezing A's stomach to increase the apparent gastric losses. These were physically abusive acts, and frustrated A's treatment with the following harmful consequences:
    a. Her admission to hospital was prolonged;
    b. Her treatment and medical care was frustrated;
    c. Her true state of health was obscured; and
    d. She was subject to unnecessary and harmful investigations and medical procedures. [14.50]

8. The mother misrepresented the comments of three different clinicians to make it seem as if Total Parenteral Nutrition was being recommended. Even though she was clearly aware of its risks given her discussions with the dietitian DM and PGM, she more than once expressed a preference or positive opinion for it. This was an intervention which she had been made clearly aware would be very serious for A, risky, was currently unwarranted

and a last resort, but which she pursued nonetheless. She did so in the context of apparent but manipulated difficulties with A's PEG-J feeding system [14.64].

9. The mother exaggerated the extent of dystonia suffered by A in a consultation with Dr F and at the start of and during A's hospital admission, each of which resulted in the misleading of medical professionals and the administration of unnecessary medications. [14.75]

8.2. APPENDIX 2 – Documents for Health and Educational Agencies

NARRATIVE FOR EDUCATIONAL AGENCIES DEALING WITH A

[Pursuant to the direction of Her Honour Judge Lazarus dated 7.7.21]

10. A judge of the Family Court heard evidence concerning allegations that A's mother had caused her significant harm and/or had placed her at risk of significant harm. The case was brought to court by social services. The mother and other family members were legally represented. The judge heard from witnesses of fact and expert witnesses and reached a conclusion as to what had happened. She has agreed that you can be told of her findings in the following terms.

11. The family court proceedings have concluded. M is considered to continue to pose a risk and to require therapy. The placement of the children has been agreed as follows: A is in long term foster care under a full care order; B and C live with their father and paternal grandmother and are subject to 12 month supervision orders. Mother's contact with the children is supervised. Orders restricting her exercising certain aspects of her parental responsibility and her access to health, educational and developmental appointments for the children are in place. The position in relation to potential criminal proceedings remains uncertain.

12. The judge found that the mother had been responsible for A's inadequate weight gain and state of malnourishment by the date of her hospital admission in November 2019 and that A's poor development in 2019 was a consequence of her malnutrition.

13. During A's period in the Evelina Hospital, the mother was responsible for the following harmful acts:

    (1) She purposefully and repeatedly interfered with A's feeding tubing with her hands, which included pinching and folding the tubing and also clamping the tubing, primarily while her hands were hidden under the blanket to do so, in such a way as to block the flow of feed and trigger alarms on numerous occasions as recorded from 2-8.12.19;

    (2) The mother commented to the nursing and medical staff, that the alarms were due to A suffering dystonia, when she knew this was false;

    (3) The mother was able to introduce sufficient amounts of fluid to dilute and increase the gastric losses in the pattern seen in the charts [during the admission to the Evelina between 29.11.19 and 11.12.19];

    (4) The mother deliberately manipulated A's tubing and PEG-J by introducing fluid and squeezing A's stomach to increase the apparent gastric losses.

    (5) These acts frustrated A's treatment with the following harmful consequences:
        a. Her admission to hospital was prolonged;
        b. Her treatment and medical care was frustrated;

c. Her true state of health was obscured; and

d. She was subject to unnecessary and harmful investigations and medical procedures.

(6) The mother misrepresented the comments of three different clinicians to make it seem as if Total Parenteral Nutrition was being recommended even though she was clearly aware of its risks. More than once she expressed a preference or positive opinion for it. This was an intervention which she had been made clearly aware would be very serious for A, risky, was currently unwarranted and a last resort, but which she pursued nonetheless. She did so in the context of apparent but manipulated difficulties with A's PEG-J feeding system.

(7) The mother exaggerated the extent of the dystonia suffered by A in a consultation with Dr Fairhurst and at the start of and during A's hospital admission, each of which resulted in the misleading of medical professionals and the administration of unnecessary medications.

14. The mother did not give an accurate account to the court about the matters set out above.

NARRATIVE FOR THE HEALTH TRUST

1. A judge of the Family Court heard evidence concerning allegations that A's mother had caused her significant harm and/or had placed her at risk of significant harm. The case was brought to court by social services. Many of the witnesses of fact were employed by the Trust. The judge reached a conclusion as to what had happened and has agreed that you can be told of her findings in the following terms.

2. The court was greatly assisted by the evidence given by staff from the hospital. In particular, she was helped by the nursing notes, the electronic notes being of help and insight and was particularly impressed by the professionalism, detail and regularity with which these notes were kept. They gave a real insight into the events and practices on the wards in question.

3. Although it was alleged, on behalf of the mother, that (a) nursing staff had a particularly negative attitude towards her leading to an 'evidence gathering' exercise based on confirmation bias and (b) negativity, gossip, lack of empathy and objectivity had led the nursing staff to read too much into what were innocent behaviours, the court rejected those allegations. Rather the court found, for example, that (a) the nursing staff <u>were to</u> carefully observe and record in their e-notes any issues of concern, complete the fluids chart carefully, and fill out the feed pump alarm sheet as necessary and (b) there was no sense whatsoever of loose talk, excited or exaggerated gossiping, inappropriate information sharing, nor any example of building up a case.

4. The judge also rejected another criticism made on behalf of the mother (partly because this would have led the hospital to act in contravention of national guidelines): that hospital's concerns should have been openly put to her so that she could then have readily explained what she was doing.

5. Consequently, the judge was able to conclude that, during A's period in the Evelina Hospital, the mother was responsible for the following harmful acts:

    (1) She purposefully and repeatedly interfered with A's feeding tubing with her hands, which included pinching and folding the tubing and also clamping the tubing, primarily while her hands were hidden under the blanket to do so, in such a way as to block the flow of feed and trigger alarms on numerous occasions as recorded from 2-8.12.19;

    (2) The mother commented to the nursing and medical staff, that the alarms were due to A suffering dystonia, when she knew this was false;

    (3) The mother was able to introduce sufficient amounts of fluid to dilute and increase the gastric losses in the pattern seen in the charts [during the admission to the Evelina between 29.11.19 and 11.12.19];

    (4) The mother deliberately manipulated A's tubing and PEG-J by introducing fluid and squeezing A's stomach to increase the apparent gastric losses.

    (5) These acts frustrated A's treatment with the following harmful consequences:
        a. Her admission to hospital was prolonged;
        b. Her treatment and medical care was frustrated;
        c. Her true state of health was obscured; and
        d. She was subject to unnecessary and harmful investigations and medical procedures.

    (6) The mother misrepresented the comments of three different clinicians to make it seem as if Total Parenteral Nutrition was being recommended even though she was clearly aware of its risks. More than once she expressed a preference or positive opinion for it. This was an intervention which she had been made clearly aware would be very serious for A, risky, was currently unwarranted and a last resort, but which she pursued nonetheless. She did so in the context of apparent but manipulated difficulties with A's PEG-J feeding system.

    (7) The mother exaggerated the extent of dystonia suffered by A in a consultation with Dr Fairhurst and at the start of and during A's hospital admission, each of which resulted in the misleading of medical professionals and the administration of unnecessary medications.

15. The mother did not give an accurate account to the court about the matters set out at paragraph 5 above.

8.3. APPENDIX 3 – Narrative Letter from the Social Worker to B and C (anonymised version)

Narrative for C and B

My name is XY and I am your Social Worker. I have been your Social Worker since 2 August 2021. A social worker is someone who works with children to help make sure that they are safe and happy. I am writing this letter to you to explain some of the things that have happened to you over the past 2 years, why you have social workers in your life and what has been happening in the important meetings Dad's been going to with your Nan, Mum and the Judge.

C and B, you were living at home with your Mum and sister A until December 2019. Your sister A sadly suffered an accident when she was about six weeks old and that caused an injury to her brain. Your Mum felt very worried after A had her accident and Social Services helped your Mum, Dad and Nan to keep you both and A safe at home.

In November 2019, the doctors and social workers were worried that A was not growing in the way that she should and that she seemed to be really ill with lots of health problems. The doctors were worried that your Mum was not looking after A properly.

A was taken to a special hospital in London for children so that the doctors and nurses could find out why she was so ill and why she was not getting bigger and stronger.

When your mum visited the hospital to see A, she was seen by other parents in the hospital doing things to A that she should not have been doing and the nurses were also worried about what they were seeing when your Mum was on the ward with A. A didn't get better in your Mum's care. The doctors were worried that your Mum wasn't helping A to get well and sometimes what she was doing was making A more ill. The doctors became more and more worried that Mum was doing this on purpose.

The Social Worker was worried that you would not be safe living at home because of what your Mum was seen doing to A.

The Social Worker asked a Judge in the Family Court to decide where you should live. When people are worried about children's safety, they can ask a Judge to help them. It is the Judge's job to make decisions about where children should live, who they should live with and who they should spend time with.

You moved to live with your Grandad and his partner in December 2019 and in March 2020 the Judge agreed that it would be safe for you both to go and live with your Dad and Nan.

When A came out of hospital in January 2020, she went to live with a foster carer called K. It was decided that A needed to live with her so that she could be given a lot of attention and special care for her to get better. A is doing really well in foster care. She is healthy and well and has put on weight and is happy and comfortable where she is living.

At the meetings your Dad and Nan have been attending, the Judge has had to decide if your Mum looked after A properly or had done things to her that made her unwell. Because this is a hard thing to think about, the Judge spoke to lots of people to help her to decide. She spoke to the doctors and nurses that were there when A was in hospital and the Judge spoke to other parents that had children at the hospital when A was there and to your Mum, Dad and Nan.

After listening to everyone very carefully, the Judge made the decision that your Mum did not look after A properly and the Judge also decided that your Mum did things on purpose that made A unwell. The Judge decided that your Mum had not told the truth about what she had done.

The Judge decided that Mum did not feed A properly and that Mum did things to stop A's feeding tube working properly. The Judge also decided that Mum lied to the doctors and said A was more ill than she really was and that Mum had also lied to the Judge and everybody about what she had done.

Because of all this, the Judge, the social workers, the doctors, Dad, and Nan were all worried about how you could be safely looked after if you lived with your Mum.

So, the Judge listened carefully to Mum, Dad and Nan, the social workers and other people who work to help children like your guardian and Dr B who you met.

The Judge has decided, and in the end everyone agreed, including Mum, that you will live with your Dad and Nan until you are grown-ups. The Judge also decided, and everyone also agreed, that A will live with K. You will get to see A regularly with your Dad and your Nan. The Judge also decided, and everyone including Mum agreed, that you cannot live with your Mum but you will get to see your Mum regularly and your Dad and Nan or I will be with you when you see your Mum.

The Judge knows that your Mum loves you, and she fed you ok and didn't make you ill. But because of everything else, the Judge and everybody are worried that if you lived with your Mum, because she has problems, you might not be looked after safely and properly.

Dad and Nan didn't know what was happening and want to keep you safe and that is why the Judge thinks (and everyone agrees) that you should live with them.

We don't know why your Mum did what she did to A. She did things that were wrong. The Judge and all the adults think it is important that you are kept safe.
Because of all this you won't be seeing Mum quite so often. It is going to be important that there's a new routine but you will still see her regularly. And you won't see A quite so often, but you will be getting to see her in a better way, with Dad and Nan.

I know that this letter is probably a shock for you and may make you feel upset or confused. Because this was being sorted out we could not explain all this to you before. You may have been told it was about Covid; it wasn't, it was about these things.

You may worry that you are somehow to blame but you aren't. None of this is your fault at all. We know that a lot of things about this may worry and upset you. I'm sure that you will have lots of questions after reading this. Please talk to me or your Dad or your Nan about any questions you have. We will all try to answer them as honestly as possible. You may also want to ask your Mum about these things, so please let us know and we will help you to do that.

You are both lovely children and I love being your social worker. You are both very good at playing your musical instruments and I always look forward to hearing you play for me when I come to visit.

I know you probably feel upset or confused and sad about all these things. You can always talk to us about how you feel. We have tried very hard to make sure you are as safe and happy as possible. I know that your Dad and Nan will be trying their very best to make sure that you go on to have a happy and bright future.

XY, your Social Worker

11 January 2022