[2018] EWFC 82

IN THE FAMILY COURT AT NOTTINGHAM

Case No: NN17C00092

Courtroom No. 10

60 Canal Street
Nottingham
Nottinghamshire
NG1 7EJ

Friday, 2 February 2018

Before:
THE HONOURABLE MR JUSTICE KEEHAN

B E T W E E N:

NORTHAMPTONSHIRE COUNTY COUNCIL

Applicant

and

M

1st Respondent

and

N
(A Child, through his Guardian, Suki Gill)

2nd Respondent

MR D SHERIDAN (instructed by Northamptonshire CC) appeared on behalf of the Applicant
MS J PORTER appeared on behalf of the 1st Respondent Mother
MR J SAMPSON appeared on behalf the Child through his Children's Guardian

JUDGMENT
(Approved)

MR JUSTICE KEEHAN:

Introduction

1. I am concerned with one small child, N, who was born on 30 September 2015 and so, is two years of age. His mother is M and his father, T. He has played no role in these proceedings nor in N's life to date.
2. The maternal grandmother is C and the maternal stepfather is T (I shall for the purposes of this judgment refer to them as 'the maternal grandparents'). The Local Authority, Northamptonshire County Council issued an application for a care order on 12 May 2017 and on the same date, N was made the subject of an interim care order. He was initially placed in foster care but, shortly thereafter, he was placed with the maternal grandparents, where he remains to date.
3. The Local Authority alleged that the mother had fabricated and exaggerated medical symptoms in N throughout the whole of his life until he was taken into care. They sought findings of fact against the mother which if made by this court, would lead them to apply for a special guardianship order to be made in favour of the maternal grandparents.
4. The Children's Guardian supported the stance of the Local Authority, namely the findings of facts sought and the order to be made. The mother opposed the findings sought in relation to the allegations that she has exaggerated or fabricated medical symptoms for N, although she does accept that she was an overly anxious mother. She sought the return of N to her care. If this was not possible, she supported the placement with her mother and her stepfather, but under the auspices of a child arrangement order and not a special guardianship order. This matter has been listed before me for a composite fact-find and welfare hearing.

The Law

5. In relation to the findings of fact sought, I remind myself that the burden of proof is on the Local Authority. The standard of proof is the simple balance of probabilities, *Re B (A Child)* [2008] UKHL 35.
6. I remind myself in relation to lies told by a witness that I should take account of a revised Lucas direction. Accordingly, I shall only have regard to a lie told by a witness if I am satisfied there is no innocent explanation for a witness to have lied in his or her evidence.
7. The Court of Appeal considered the approach to be taken in respect of a Lucas direction in *Re H-C (Children)* [2016] EWCH Civ 136. McFarlane LJ emphasised the following at paragraph 100:

> 'One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this. In the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration'. In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of *R v Middleton* [2001] Crim. L.R. 251. In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt'.

8. I entirely accept that the mere fact that a lie has been told does not prove the primary case against the party or witness who has been found to have lied to the court. Findings of fact

are based on the evidence, including inferences that can properly be drawn from the evidence, and not on mere submission, surmise, speculation or assertion: *Re A (a Child) (Fact-finding Hearing: Speculation)* [2011] 1 FLR 1817 and *Re A (Application for Care and Placement Orders: Local Authority Failings)* [2016] 1 FLR 1.

9. There is no obligation on a party to prove the truth or an alternative case put forward by their own defence. A failure by that party to establish the alternative case on the balance of probabilities does not of itself prove the Local Authority's case. *Re X (No. 3)* [2015] EWHC 3651 Fam and *Re Y (No. 3)* [2016] EWHC 503 Fam.
10. When I consider issues of N's welfare, I have well in mind that his welfare best interests are the court's paramount consideration, s.1(1) of Children Act 1989 and when considering what orders I should make in respect of N, I have regard to the welfare checklist:s.1(3) of the 1989 Act.
11. When considering whether the threshold criteria are satisfied, I have regard to the provisions of s.31(2) of the 1989 Act.
12. At all times, I have regard to the Article 6 and Article 8 rights of both N and of his mother but bear in mind that where there is a tension between the Article 8 rights of a child on one hand and the Article 8 rights of the parent on the other, the rights of the child prevail, *Yousef v Netherlands* [2003] 1 FLR 210.

The Background: The Mother

13. The mother is 24 years of age, she had a normal childhood and a normal early development. In 2001, her parents separated and subsequently divorced. At the age of 13, she met a young adult male through the internet. She became infatuated with him and was deeply upset when her father brought the association to an end. She later came to realise and accept that this individual had been grooming her. Around this time, she undertook voluntary work with St John's Ambulance.
14. At the age of 14, the mother showed apparent lapses of consciousness and was assessed by a neurologist. She was later referred to Child and Adolescent Mental Health Services and underwent cognitive behavioural therapy. She had a number of relationships which were characterised by domestic abuse in her late teenage years. At the age of 19, she made a suicide attempt. Thereafter, she commenced a relationship with T and she became pregnant with N, but the relationship ended before his birth. Save for his attendance at an emergency pre-birth scan, the father has played no further part in N's life or that of the mother and the father has not seen his son.
15. In January 2016, the mother formed a new relationship and subsequently became engaged. In early 2017, she discovered she was pregnant but suffered a miscarriage eight weeks gestation. Sometime later, she and her fiancé separated. As I have said, N was removed from his mother's care under the auspices of an interim care order in May 2017. A further pregnancy was terminated by an abortion.
16. The mother later recommenced a relationship with B with whom she had previously been in a relationship. Most if not all the mother's relationships involved elements of abuse. During the parenting assessment undertaken by the social worker, the mother asserted she recalled that many of her previous partners had abused her or various abusive actions, including rape and physical assaults.

The Background: The Child

17. The consensus of the evidence from the medical records of the treating clinicians and from Dr Vaughan is that N was born after a normal pregnancy. He was a healthy baby and developed normally. He had and has no significant or long-term medical conditions or

disabilities. I shall consider his medical history in some detail a little later in this judgment, but the overview may be summarised as follows:

(a) in the first 20 months of his life, N presented to the general practitioner and other healthcare professionals for a variety of medical issues, most commonly apparent seizures on no less than 90 occasions.

(b) in the same period, he was admitted to Accident & Emergency Department at various hospitals on no less than 13 occasions and, as before, always by and with his mother and

(c) he was admitted to hospital for examination at his mother's behest on no less than nine occasions.

18. In very marked contrast, during the last nine months while he has been in the care of his maternal grandparents, he has no presentation to a general practitioner or admissions to Accident and Emergency Departments or Hospitals other than for his normal annual GP check-ups. He has not been observed or reported to have suffered any seizures or epileptic-type fits. The only change in his social and developmental medical condition during this period is that his day-to-day care have been transferred from that of his mother to that of his maternal grandparents.

19. The medical consensus remains that N is a perfectly normal little boy, with no significant, unusual or long-term medical conditions or disabilities. There is no medical explanation for the very marked change in N's presentation for medical treatment when in the care of his mother compared with no presentations for medical treatment when in the care of his grandparents, save for routine medical appointments. The question I have to answer is what is the reason, or what are the reasons, for this complete *volte face*.

The Expert Evidence

20. Mr Furlong, a childhood psychologist prepared a report for the court dated 16 August 2017 on the cognitive functioning of the mother and made various recommendations relevant to those working with the mother. His report was uncontentious, and he was not called to give evidence.

21. Dr Campbell is a consultant neuropsychiatrist. He prepared a report on the mother dated 24 November 2017, followed by an addendum on 29 November 2017. In his substantive report Dr Campbell said as follows:

> 'M has presented with episodic seizure-like activities since the age of 14. Investigations of possible epilepsy have consistently proved negative. Her condition has variously been described as a somatisation disorder or dissociative seizures. More recently, her condition has been described by her treating neurologist Dr S as a non-epileptic attack disorder. All of these diagnoses refer essentially to the same condition. The variation arising principally from the perspective of the treating doctor. For the sake of consistency, I adopt Dr S's diagnosis of non-epileptic attack disorder. N has been described by his mother as exhibiting episodic seizure-like activity since the age of six months. Seizure activity has not been observed by others except perhaps by Ms T, nursery nurse in April 2016. Extensive investigation, including a 24-hour ambulatory electroencephalogram with video monitoring on 9 May 2017 has not revealed evidence of his epilepsy. His condition has been described as factitious or induced illness. This resulting in the safeguarding concerns which have led to N's reception into care. In summary, therefore, based on the available medical information, M exhibits a non-epileptic attack disorder. N exhibits a factitious or induced illness, in this case meaning he does not have epilepsy but his mother is

imputing this condition onto him'.

22. A little later in the report, Dr Campbell asserted as follows

> 'At the time of my own assessment, M was able to provide a very extensive account of both herself and her son. She seemingly accepted her diagnosis of non-epileptic attack disorder but still remained convinced that she had been experiencing epileptic attacks. For example, she reported having a massive seizure during the course of her pregnancy with N. She also appeared convinced that N also suffers from epilepsy and is at risk of serious harm if not properly managed. For example, when N was in hospital during May 2017, she feared he would become dangerously ill if not provided with oxygen. However, in my opinion, M's beliefs do not have the unshakeable and fantastic quality typical of psychotic dilutions so they are better classified as over-valued ideas. M did not report any other inter-current psychological symptoms such as anxiety or depression. On the face of it, M currently presents with a specific overvalued idea concerning her own health and her son's health. In themselves, overvalued ideas are not diagnostic of any psychiatric condition. In view of the absence of intercurrent psychological symptoms or any diagnostic medical state of abnormalities, I consider that M is not suffering from any overt mental illness at the present time. In summary, M presents with an enduring overvalued idea, not amounting to a delusional belief concerning her diagnosis of epilepsy. She seemingly maintains that she is suffering from such a condition even though at an intellectual level, she can identify the diagnosis of non-epileptic attack disorder. She has also become concerned that her son has suffered from epilepsy since the age of six months and remains concerned about his ongoing health, in spite of the absence of a confirmed medical diagnosis. Although not currently mentally ill, she displays a pattern of behaviour which may plausibly arise from an underlying borderline personality disorder. In terms of prognosis, I consider that by their very nature, M's overvalued ideas concerning both her own and her son's health are likely to persist indefinitely'.

23. Then a little later in his report, he observed:

> 'Over-valued ideas can prove debilitating for the person experiencing them, but usually do not become seriously dysfunctional, unless they extend to involve other people such as, for example, in cases of harassment and stalking. Currently, there is no medical treatment which can reliably alter the course of over-valued ideas. Psychological approaches such as cognitive behavioural therapy have been attempted, but the academic literature provides little evidence for sustained benefit. Counselling approaches have also been attempted but this is more supportive in nature, rather than a method for altering the course of a strongly-held idea. Overall, there is currently no clearly beneficial therapeutic approach which can be recommended. In respect of prognosis, over-valued ideas typically persist for years and sometimes for life. In M's case, Dr S's nudge approach to anti-convulsant medication withdrawal seems entirely appropriate, although it appears that little act or progress has been made to date. M's over-valued idea concerning her own epilepsy has resulted in her extensive involvement with medical services, including both emergency services and investigative procedures.

If this pattern were to continue, it would reduce her availability to provide continuity of care for her child. This could have a substantial negative impact in the absence of a supportive partner. In M's case, her over-valued idea has extended to incorporate her son. Consequently, from the age of six months, N has experienced a substantial number of hospital attendances for both emergency and investigative purposes. However, in respect of possible epilepsy, these attendances cannot have been beneficial, except only to exclude the condition. This also reduced N's opportunities for more normal family life and participation and developmental opportunities. The impact is likely to become more significant as N grows older. For example, through failed nursery or school attendance. Overall, M's specific over-valued idea concerning epilepsy is likely to distract her away from her parenting role and cause her to pursue a course of action in respect of N which could not be positively beneficial for him. Inevitably, assessment of future risk is somewhat speculative. The most likely outcome could be N's withdrawal from appropriate, developmental or educational opportunities through unnecessary medical attendances. This could arise particularly if M were to seek a succession of further opinions in support of her own idea. This could also include frequent relocation in her search for support. Somewhat more speculatively, M could seek to treat N for epilepsy by sharing her anti-convulsant medication with him. Furthermore, M's current overvalued idea could plausibly extend to other medical conditions for which she may seek medical attention. For example, she was briefly concerned that N may have a hole in his heart. I emphasis the extent of these possible risks is unquantifiable'.

24. In his oral evidence, Dr Campbell confirmed the opinion set out in his report. He told me the mother is aware of what she is doing and treatment at a pre-contemplation stage is a waste of time. The evidence is not strong enough to make a diagnosis of borderline personality disorder.

25. Dr Vaughan is the consultant paediatrician instructed to provide an expert medical opinion on N. Her report is dated 28 September 2017. In that report she said:

'N has had a high number of contacts with health professionals in his 21-months of life. This is unusual for a child who has no diagnosed long-term disorder and no objective persisting clinical signs. This pattern of contact is also unusual because of the high occurrence of normal physical signs of investigation results, despite being presented frequently as unwell. There are an unusually high number of health contact for which there is no documented corresponding clinical signs identified by the assessing health professional. N has recently been confirmed to have iron deficiency for which he is receiving iron supplements. The cause is usual nutritional in toddlers, N is otherwise in good physical health and is meeting his developmental milestones. There are long-standing concerns by the mother that N has seizures, despite assurances to the contrary by his paediatric medial team. Reported events have not been verified by third party observations and clinical observations. There have been diagnostic challenges as the pattern of description of these movement seizures have not tallied with known medical conditions such as epileptic seizures or epilepsy mimics. Epilepsy is a common neurological disorder characterised by a high incident of inaccurate diagnosis and up to a third of people with a diagnosis of epilepsy have indirect diagnosis. Video

telemetry done in N did not identify any abnormal movement or behaviour and the EEG was reported as normal. In my opinion, there is no evidence to suggest N has epilepsy seizures'.

26. A little later in the report, Dr Vaughan said as follows:

'There are concerns by the mother that N has seizures, reported events such as vacant episodes and responsiveness and abnormal motor movements have not been verified by either third party observations or clinical investigations. There have been diagnostic challenges as the pattern description of these movements or events do not tally with known medical conditions. Clinical and laboratory examination after these events have been normal. The events have not been independently observed and there was a normal EEG. EEG is a test that detects electrical activity in the brain. The EEG during reported events and in between events have been reported as normal. A reported event by the mother during the video telemetry did not reveal any abnormal movements. The view of his local medical team is that the reported events are not epilepsy fits. N is now 24-months-old he has an unusually high number of contact with health professionals, 13 A&E attendances, nine in-patient admissions and 90 communications with health are quite unusual for a child that has no diagnosed long-term disorder and no persisting clinical signs. This is also unusual because the absence of abnormal verified symptoms and normal physical signs investigation results. The challenges of medicine are usually more of interpretation over normal physical times and abnormal laboratory investigation results that do not fit recognised physiological processes. From the medical records made available to me, there is no evidence to suggest that N has any long-term disorder. He has iron deficiency and iron deficiency in a toddler is a time-limited condition and would resolve once his iron stores are replenished with iron supplementation. N's daily life and function must have been confusing and chaotic with frequent contact with multiple stranger professionals. The impact of the frequent health physicians he visits, and physical examinations may be difficult to fully understand because of his very young age. N was reported to be very distressed when an ECG was attempted in April 2017. Whilst this is not unusual in children, it cannot be ignored. The impact on interaction with peers due to frequent clinical appointments may lead to poor stimulation with potential to socialise isolation and poor social communication skills. It is unclear what opportunities N has for regular peer interaction, apart from the play activity he was reported to attend at a play centre in Milton Keynes. There is a very strong danger of perpetuating and medicalising the unknown with further risk of subjecting N to unnecessary anxiety by further investigations. FII is a diagnosis continuing. The factors that cause carers to progress along the continuum are not fully known. N is at risk of induction of symptoms'.

27. In her oral evidence, Dr Vaughan confirmed the opinions set out in her report. She had provided the court with an incredibly helpful coloured chart, setting out the timeline of N's contact with health professionals and his hospital admissions. Of importance were those events marked in green which were legitimate contacts, mostly in the early months after his birth and those marked in red which were contacts where there was no objective medical evidence to support the presentation of N to a health care professional or to a

hospital.

28. From about March 2016, the red markers dominate the timeline. In her exceptionally clear and powerful evidence, Dr Vaughan made the following five principal points:
(a) the video of the EEG on 3 May 2017 showed no signs whatsoever of N suffering any form of seizure;
(b) even where there were legitimate reasons for N's presentation, the mother exaggerated his symptoms;
(c) breath-holding in a baby or young child always has identifiable triggers which, if frequent, a parent can recognise the trigger and avert the breath-holding. She described the mother's accounts of N breath-holding as unlikely;
(d) at no time did N suffer severe reflux or associated back pain, Sandifer Syndrome as asserted by the mother; and,
(e) there is no evidence that N suffers seizures.

The Evidence: Treating Clinicians

29. Dr S is the mother's treating consultant neurologist and has been since 2015. He confirmed the diagnosis of non-epileptic attack disorder ('NEAD') which had first been made by the mother's former treating consultant in 2010. Dr S told me that NEAD is a very difficult condition to manage. Furthermore, if the court found that mother denied or did not accept she had been diagnosed with NEAD, this would demonstrate a real lack of insight into her condition.

30. Dr H was one of the consultant paediatricians responsible for N's medical care. She told me she found it very difficult in her first meeting with the mother on 17 February 2016 to reassure her that N was a well and healthy baby. During her examination of N on 17 February 2016, the mother told her N had had three episodes where he became unresponsive. He had had a further episode the night before when he was struggling to breathe and was then pale and unresponsive. By the time the ambulance had arrived however, N was back to normal. She further told Dr H that she was concerned about the strength and power of his upper limbs and that he was not opening up his fingers, but this had improved recently.

31. Two observations on these concerns:
(a) on physical examination the consultant found no problems with N's upper limbs and fine motor skills. He was developmentally normal and;
(b) the mother never mentioned either of these issues to her health visitor S. Dr H told the mother she did not have any concerns about N's development or the power of his upper limbs.

32. The mother told Dr H she suffered from epilepsy.

33. Dr H reviewed N on the 8 June 2016, she noted the EEG performed on 21 March 2016 was normal, nevertheless, the mother said N was still having vacant episodes three or four times a day, lasting for a few seconds, but there were no tired or sleepy episodes afterwards. Further, she said that every four to six weeks he would have episodes of shaking of his body and limbs, especially after feeding, but there was no history of head-nodding or jerky movements of his arms or legs. Dr H told the mother that N was developing appropriately, he looked very well, he had normal power and tone in all four limbs and the episodes described by the mother were not suggestive of epilepsy: these were short-lasting episodes with no postictal event and they may be normal movements. They did not suggest any significant condition.

34. Dr H reviewed N finally on 14 December 2016, all was well, and he was discharged back to the care of his general practitioner. She did make a referral to a dietician because the mother had said he was a fussy eater. The mother did not keep the appointment with the dietician.

35. Dr HW was the senior consultant paediatrician responsible for N's care. He was a clear and careful witness. His oral evidence may be summarised as follows:
(a) N did not suffer from epilepsy;
(b) the video of 3 May 2017 did not show any of the seizures alleged by the mother or, indeed, any abnormal movements at all. At the material time, N was a quiet baby, seeking to sleep;
(c) the EEG does not show any abnormal brain activity and, in particular, no evidence of a seizure;
(d) the EEG would have detected movement by N if it involved his head and neck. At the material time, no movement was detected.
(e) the mother had been told to press a button on the EEG control panel if there was any sign of abnormal movement. This would place a marker on the trace recording. Although the mother opened the bag containing the control panel immediately after she alleged N had suffered three seizures, she did not press the button;
(f) further, the mother had been instructed to press the call button to summon a member of the nursing staff if N had any abnormal movements. The mother approached the call button after she said there was alleged shaking by N, but she did not press it. Instead, she left N's side room to summon the nursing staff;
(g) without any adverse history, the mother demanded of Dr HW that N undergo an ECG procedure. In doing so, she was very assertive and verging on complaining;
(h) Dr HW, has had very considerable experience of interacting with parents of unwell children. He was of the firm view that the mother enjoyed the situation of N being in hospital. She was preoccupied with medical procedures and she did not come across as concerned or worried about her child; and
(i) he was of the view, especially after the video of 3 May 2017, that the mother was and had been exaggerating and fabricating symptoms in N. They, the clinical staff therefore intervened very quickly because an FII parent who is not believed can very quickly escalate matters and move from exaggerating and fabricating symptoms to inducing symptoms. Dr Vaughan was in complete agreement with this analysis.

36. Dr R, another consultant paediatrician, saw N in May 2017. When he examined N, he found no basis for N undergoing an ECG. It was put to him on behalf of the mother that a nurse had told him she had observed N having a shaking episode. Dr R's reply was a firm 'No'. He confirmed that when he examined N in April 2017 the mother had told him that N would have episodes of shaking, going stiff or limp five or six times per week for the previous year.

Evidence: General

37. S was N's health visitor. She had had regular contact with the mother and N from shortly after his birth until May 2017 when N was removed from his mother's care. S was clear that she did not agree with the Local Authority's decision to close the child in need referrals in 2016 and 2017 because she was of the view that the mother required a high level of support to care for N. She, like other health professionals, had had very real concerns about the mother's ready use of medical terms in relation to N. Further, she

expressed a view that on occasions, the mother's care of N was merely basic. There were times when N and/or the home were dirty. Contrary to the evidence and/or assertions of the mother, S told me that:

(a) so far as she was aware, N had never had a breathing monitor attached to his nappy;

(b) she had never seen N have a seizure or a tremor;

(c) she had never criticised the mother's care of N and never sought to undermine the mother as a parent;

(d) at N's eight-month developmental check-up the mother agreed with her assessment that N was developing well and his limb movements, etc., were satisfactory;

(e) the mother had never reported to her that N could only tolerate certain makes of nappies or that he had a significant problem with developing rashes on his body.

38. Ms T was a nursery nurse who worked alongside the health visitor to provide practical support and advice to the mother, e.g. how and when to prepare his bottles and how best to feed him. The mother did not consistently follow this advice and Ms T found it necessary repeatedly to go over old ground. She visited the mother and N at their home on at least 20 occasions between October 2015 and March 2017 and would typically stay for one to one and a half hours. She never saw N suffer a seizure or a tremor. Her initial view was that the mother was anxious but as time went on, she considered the mother's anxiety had become excessive. It was a cause of real concern for her that the mother was keen to talk in very great detail about N's most recent hospital admissions. The mother appeared to enjoy talking about N's medical conditions and admissions to hospital. Further, rather than telephoning her when she, the mother, was worried about N's health, she would only contact Ms T when she, the mother, was at or shortly after having taken N to hospital. The only occasion when the mother telephoned Ms T prior to taking N to hospital, the mother did not follow the advice Ms T had given to her.

39. Ms C is a paediatric epilepsy nurse. She met the mother and N at the epilepsy clinic at Northampton General Hospital on 21 March 2017. Ms C took contemporaneous notes during her conversation with the mother. She noted that in contrast with most parents who are devastated when their child has a seizure and are distressed by it, the mother was smiling during her account of N's hospital admissions and seizures. The mother appeared to gain enjoyment from talking about the same. At no time did the mother exhibit any upset or distress. Ms C noted the mother as having reported the following:

(a) N had been diagnosed as suffering from palliative breath-holding spells;

(b) she, the mother, had been diagnosed with epilepsy. She made no mention of having in fact been diagnosed with non-epileptic attack disorder;

(c) prior to N's birth, the mother had been told that he had brain and heart defects and may die within six weeks of his birth;

(d) armed police were present on the maternity unit when she gave birth to N for her protection in respect of alleged threats made by Mr T;

(e) she had been advised by a specialist that it was likely N would get epilepsy at six to 12 months; and

(f) she administered physiotherapy to N and limb therapy because of N's difficulties in using his limbs. He would not use both simultaneously.

40. None of the foregoing statements are true.

41. It was put to Ms C that she had pre-conceived ideas about the mother prior to this meeting because she had been alerted by a colleague to concerns about the mother. It is the case

that Ms C discussed the mother and N with safeguarding colleagues before meeting with the mother. Rather than in any sense prejudicing her against the mother, however, I take the view that this meant Ms C was acutely aware of the importance of making an accurate note of her conversation with the mother. I am satisfied this is precisely what she did.

42. The Children's Guardian confirmed the contents of her final analysis. She told me:
(a) the mother has no insight into her behaviour or actions as was demonstrated by her oral evidence;
(b) she has consistently expressed a view to the Guardian that apart from being an overly anxious mother, she has done nothing wrong;
(c) there is no prospect of the mother gaining any insight;
(d) the mother has shown herself to be very manipulative;
(e) there was no safeguard which could be put in place which would enable the mother to resume the care of N. The risks were too great and the risk of the mother moving on to induced symptoms in N was real;
(f) it is essential for N's welfare that his maternal grandparents have a special guardianship order in their favour so that they have the upper hand in exercising parental responsibility; and,
(g) it is necessary that an order is made for contact at a frequency of once per month plus such other occasional holiday periods as the maternal grandparents may agree so that they and the mother are clear about what level of contact has been approved and permitted by the court.

43. The Guardian was content with the revised provisions of the special guardianship support plan, as were the maternal grandparents. Accordingly, she supported the making of a special guardianship order in their favour. I heard evidence from the social worker who gave evidence in line with that received from the Children's Guardian.

44. I deal finally with the evidence of the mother. I regret to find that she was a most unsatisfactory witness. She changed her accounts during her evidence and gave contradictory versions of events. She has repeatedly lied to the clinicians treating N and to other health professionals and she repeatedly lied in her evidence to this court. I have considered whether there are any innocent reasons for her lies. I am completely satisfied there are none. I have come to the above conclusions of repeated lies for no innocent reasons for the following 12 reasons:
(a) at the beginning of her evidence, the mother wished to amend an account in her second statement of N having suffered a collapse on one occasion at home. She told me he had not collapsed but had a shaking episode and became floppy. Why the difference in the mother's account? She could give me no explanation;
(b) the mother told me she was devastated by N's presentations and sometimes cried her eyes out. This account is wholly contrary to the weight of the evidence of the clinicians and healthcare professionals, many of whom described the mother as enjoying talking about N's medical history and not exhibiting any stress about him or concern for him. These observations chime with my own observations of the mother over the course of this hearing and during her time in the witness box. Save for two very brief occasions when she became emotional, she smiled throughout most of the evidence;
(c) in April 2016, the mother made an application for disability living allowance in respect of N. She said she was assisted to complete the form by a voluntary organisation. The mother accepted that she gave the information to a person who completed the form for her. She claimed that she had never previously seen the completed form, although she

accepts that her signature appears twice on it. The alleged symptoms and conditions suffered by N is set out in the application form, there are no relation to accounts given by the mother from time to time to the clinicians;
(d) the maternal grandmother told the Guardian that the mother had said she could not attend the wedding of the maternal grandmother and maternal step grandfather because she had cancer. The mother denied this and told me she had been banned by the maternal grandmother from attending the wedding. No reasons for the ban were given to me. I note, however, on 9 April 2014, Dr M, a consultant oncologist, reassured the mother she had not got breast cancer. Thirteen days later, on 22 April 214, the mother is recorded as telling the doctor at Kettering General Hospital that she had recently been diagnosed with breast cancer. The mother denied saying this. Where there is a conflict between the evidence of the mother and a clinical note, I prefer the latter. Accordingly, I am quite satisfied that the maternal grandmother is telling the truth and the mother is lying;
(e) the mother told me, as she repeatedly told others, that N suffers from palliative breath-holding spells. She said the diagnosis was made by a consultant treating N, but she could not remember the name, other than it was a male doctor. When I asked her how many male consultants had seen N, she gave the utterly absurd and false answer of 10 to 15 consultants. The condition of palliative breath-holding spells is unknown to medical science. The mother was, once again, lying;
(f) the mother has repeatedly told clinicians and health professionals that she has been diagnosed with and/or suffers from epilepsy. The mother has known since 2010 that she does not have epilepsy. She has been diagnosed with non-epileptic attack disorder, as confirmed by her treating neurologist, Dr S. The mother may not like this diagnosis and, indeed, she said she was angry when first told of it, but I do not accept the mother's account that she tells professionals she has epilepsy because they will not or do not understand NEAD. She was deliberately seeking to mislead professionals into believing she had epilepsy;
(g) the mother said in evidence that she accepted the report and opinions of Dr Vaughan. Given that Dr Vaughan is of the opinion that the mother exaggerated and fabricated symptoms in N which the mother adamantly does not accept, the mother plainly does not accept the opinions of Dr Vaughan;
(h) the mother asserted that Dr Hewittson had told her in December 2015 that N had a bacterial infection. First, there is no reference in any of N's medical records of him ever having suffered a bacterial as opposed to a viral infection. Second, this assertion was not put to Dr Hewittson when he gave evidence. It is a lie by the mother;
(i) the mother said in evidence that she was worried that N may have an immunosuppressive disorder because he had suffered, 'So many viral infections'. There is no evidence that N has ever had an immunosuppressive disorder and no clinician has ever suggested the same. Further, at the time the mother raised this issue with the clinicians, N had only suffered two mild viral infections. This is a clear example of the mother exaggerating symptoms and medical conditions;
(j) on 3 May 2017, the mother told the nursing staff that N had just suffered three short episodes of shaking along the whole length of his body. This account was given before the mother had viewed the video recording. In her evidence, after she had viewed the video, she gave a different account. She said his head and one arm, which cannot be seen on the video, was shaking. When asked why she told the staff it was the whole body, she gave the wholly implausible answer that she had told the nursing staff what she thought

she had seen. When asked why she was giving a different account in her oral evidence, which she had never given before, she had no answer. She was lying and giving a false account against overwhelming evidence to the contrary. Not just the video recording, but Dr HW's s evidence that the equipment would have detected N's head and neck shaking or moving, and it did not;

(k) in her oral evidence, the mother asserted she had been told by a doctor in 2015 that she had erroneously been informed at an early scan of N in-utero, had revealed that he had two holes in his heart. A few matters arise. First, the mother has never before said that the information about N's heart was given to her in error. Hitherto, she has always asserted that pre-birth scans had shown he had a hole in his heart. Secondly, previously, the mother has asserted N had a hole in his heart. In her oral evidence for the first and only time, she has referred to being told in error or otherwise of two holes in his heart; and

(l) she had asserted in the disability living allowance application forms that N had eczema over the whole of his body. He has never had such extensive eczema, only small patches in some of the folds of his skin. When challenged about this, the mother sought to explain the contradiction by claiming that the phrase, 'whole body' meant the small patches in some folds of his skin. A quite incredible explanation but the mother was lying.

Analysis

45. I am satisfied on the balance of probabilities; indeed, I am satisfied so that I am sure, that N was and is a perfectly normal baby who has had no significant medical conditions or disabilities and certainly none that are long-term. He has not and does not suffer from epilepsy. He has not and does not suffer from any epileptic, non-epileptic or any other forms of seizures or vacant episodes.

46. I am wholly satisfied that any account to the contrary by the mother is false and fabricated. In other words, I am wholly satisfied that when she said N had suffered a fit or a seizure or an epileptic event, she was lying. I am wholly satisfied and find that these were not the actions of an overly anxious mother. These were the actions of a mother who has, as I have found, lied about her own medical condition and has chosen to lie about her son's medical presentation from time to time.

47. Dr Campbell in his report and in his oral evidence drew the distinction between delusional beliefs which are psychotic in origin and over-valued ideas which are not. The latter is an innate part of an individual's behaviour and functioning. It is not necessarily a life-long affliction but in a person who does not recognise the need to change, it is an immensely difficult condition to treat. Indeed, there is no recognised treatment. More importantly, the individual with over-valued ideas knows what they are doing. They are aware of their actions and the consequences of same. A person with over-valued ideas is more susceptible to be diagnosed as suffering from a borderline personality disorder. Dr Campbell was hesitant about making this diagnosis in respect of the mother and, ultimately, did not do so.

48. The most egregious examples of the mother fabricating symptoms in relation to N are

(a) the video made by the mother with a neurophysiologist which the mother asserted demonstrated N suffering a seizure event but which the doctor recorded as 'N sitting quietly'; and,

(b) during video telemetry on 3 May, when the mother asserted and continued to assert at

this hearing that N had suffered three three-second seizure events.

49. All of the treating clinicians and the medical experts are clear that there are no episodes of usual, still less, seizure activity to be seen in this video telemetry. The agreed medical chronology has many other examples of the mother fabricating and/or exaggerating symptoms in N. In fairness to the mother, it is right to recognise that
(a) a number of N's appointments with medical professionals were quite normal and routine medical appointments; and
(b) a number of hospital admissions in the early months of N's life were the result of feeding problems and of him suffering two bouts of bronchiolitis in December 2015 and January 2016.

50. Thereafter, there is an incremental increase in the mother giving a false history and then of fabricating and/or exaggerating symptoms said to have been suffered by N. On 17 December 2015 at 10.30 in the evening, the mother took N to Northampton General Hospital because he did not rouse easily when awoken for a feed. N was found to be a healthy, well baby and was likely to have just been in a deep sleep. He was discharged without any treatment.

51. On 31 December 2015, N was admitted to Northampton General Hospital, having been brought by ambulance because the mother was said to be concerned about his breathing and was anxious about him getting bronchiolitis again. On examination, the child was noted to be alert and smiling, well perfused with no respiratory distress. He was discharged.

52. On 5 January 2016, N was admitted to Northampton General Hospital and was diagnosed as suffering with bronchiolitis. The following day, the mother telephoned the nursery nurse, L and told her that N was in hospital and had bacterial pneumonia: this was not true.

53. On 7 January 2016, N had been discharged from hospital and was seen at home by the nursery nurse. The mother told her that she was concerned that N would be admitted to hospital again and was angry about the medical staff in the hospital and the way she had been treated.

54. On 28 January 2016, the mother had taken N to his general practitioner because she was worried that he could have sepsis after she had seen a programme on television. The GP reassured the mother there was no factual basis for fearing that N might have sepsis.

55. In the early hours of 31 January 2016, the mother had taken N to Milton Keynes Accident and Emergency Department because he had been, 'unwell for months'. N appeared well to the clinician who examined him, and all observations were within normal limits. The mother said that she was concerned that N had an underlying immunosuppressive disorder. There was no objective basis for this concern. The opinion of the clinician was that it was 'far more likely that he had been exposed to recurrent infections with repeated attendance at medical centres'. The medical notes ended with the entry, 'Have advised that for her own peace of mind she should attend the lobotomy and get the blood tests she requests. It was not necessary to perform urgent bloods'.

56. On 16 February 2016, there is the first reference to N being unresponsive and breath-holding. He was taken by ambulance to Northampton General Hospital. After being told by the triage nurse that the wait was likely to be three and a half hours, the mother left with N because she had an appointment with the consultant paediatrician the following day. At the out-patient's appointment on 17 February, the mother reported that N had had three episodes of not being responsive, lasting a few minutes. The episode

previous night had caused her to phone for an ambulance. When the ambulance arrived, N was responsive and back to normal. The consultant advised that the unresponsive episodes might be related to reflux.

57. The following day, the mother telephoned the nursery nurse and said she was not really happy with the paediatrician that N had seen the day before. She said the paediatrician felt that N may be having epileptic seizures and that is why he struggled to breathe and goes blue. The paediatrician did not record in his notes that N may be having epileptic seizures, nor that N struggled to breathe nor that he had gone blue. The mother is not recorded as having reported any of the above to the treating paediatrician on 18 February 2016. Cyanosis had never been mentioned before in N's medical notes.

58. On 14 March 2016, N was seen at Northampton General Hospital Accident and Emergency Department in the morning. The mother said she had switched care to Milton Keynes General Hospital because she was not happy with Northampton General Hospital. She said she had epilepsy and was seeing a specialist who told her the child was likely to get epilepsy at six to 12 months. There was no clinical note of any such advice ever having been given. She then described for the first time of N allegedly suffering a chronic seizure, which lasted about 20 to 30 seconds. On examination, N was found to be alert and orientated, the mother reported the seizures are exactly the same that she has.

59. Later the same day, the mother reported that these absence episodes or going blank for a few seconds had been experienced by N twice a day since he was two months of age. These incidents at this frequency have never been recorded in N's medical records prior to this date.

60. In April 2016, the mother reported that the maternal grandmother had witnessed a few vacant episodes with N. The maternal grandmother denied any such events occurred. By June 2016, the mother was reporting that N was having three to four vacant episodes a day. Dr H explained to the mother that these episodes were not suggestive of epilepsy as they lasted a very short period and are not associated with postictal periods. Therefore, it may be normal movement and does not suggest any significant condition.

61. As I have mentioned above, Dr H discharged N back to the care of his general practitioner on 14 December 2016 because all was well with N, save the mother asserted he was a fussy eater and therefore, Dr H made a referral to a dietician which the mother did not keep.

62. On 27 March 2017, the mother telephoned 111, the call recorded the mother saying N had been having seizures since he was six months old and she felt they are getting worse. She allegedly told the call handler that she was a nurse.

63. In April 2017, the mother told Dr R that N had been having seizures, going stiff or going limb on five or six occasions per week for the last year. This is in complete contrast to the account given to and the examination undertaken by Dr H in December 2016.

64. We then have the events of 3 May during the 24-hour EEG and video telemetry which I have dealt with above. N was then removed from his mother's care, placed for a short time in foster care and then placed with his maternal grandparents where he remains to date. The events of 3 May 2017 confirmed the treating clinician's growing concerns that this mother was exaggerating and fabricating symptoms in N. Their very real concern for N was that the mother would quickly move to the next stage of FII and would induce symptoms in N.

Findings of Fact

65. On the totality of the evidence, the expert witnesses, the treating clinicians, the healthcare professionals and the mother, I am in no doubt at all that this mother deliberately and consciously exaggerated and fabricated symptoms in N. For the avoidance of any doubt, the evidence in support of this finding is so overwhelming that I am satisfied to the criminal standard of proof and so make the finding. I am satisfied on the balance of probabilities that if the clinicians and Local Authority had not intervened and removed N from the care of the mother, it is likely that she would have progressed in short order to induce symptoms in N.

66. I make this finding principally on the basis of the mother's actions on 3 May 2017, when she alleged he had suffered three seizures when, in fact, he was at all material times a still and sleepy baby. My conclusion is reinforced by the mother maintaining her account in her oral evidence against the overwhelming weight of the evidence and by giving a contradictory account to that which she gave to the nursing staff on 3 May and as was captured on the video recording.

67. I am wholly satisfied to the extent that I am sure, that I should make the other ancillary findings sought by the Local Authority set out in the schedule which may be summarised as follows:
(a) the mother exposed N to unnecessary medical treatment and procedures;
(b) she has fabricated and exaggerated medical symptoms in N;
(c) she has asserted repeatedly and contrary to the unanimous medical opinion that N suffered seizures;
(d) she has an admitted history of violent and abusive relationships;
(e) she has an admitted diagnosis of non-epileptic attack disorder;
(f) she has been diagnosed with suffering from over-valued ideas; and,
(g) she has repeatedly demonstrated volatile behaviour.

Welfare Best Interests of N

68. There are two placement options for N. The mother sought his return to her care. The Local Authority and the Children's Guardian opposed a rehabilitation to the mother. The Local Authority, supported by the Guardian, contended that N's long-term welfare interests will best be met by him remaining placed with his maternal grandparents' subject to a special guardianship order. The latter is necessary to enable the maternal grandparents to exercise their parental responsibility for N without undue influence from or involvement of the mother. It is submitted that it would be contrary to N's welfare for the maternal grandparents simply to share parental responsibility with the mother.

69. In the event this court decides that N should not be re-habituated to the care of his mother, she supported a placement with the maternal grandparents but subject to a child arrangements order and not a special guardianship order.

70. I accept the opinions of Dr Campbell that (i) this mother was not at a stage where any possible treatment of her over-valued ideas would have any prospect of success and (ii) there is, in any event, no recognised treatment for this condition in which it is immensely difficult to effect any meaningful and lasting change in an individual suffering from over-valued ideas.

71. Accordingly, there is a very real risk, if not a likelihood, that if N were to be rehabilitated to the care of his mother, he would be subjected to the same style of parenting as he was before his removal to foster care. On the totality of the evidence, I am satisfied on the balance of probabilities that the mother would fabricate and/or exaggerate symptoms in N

and present him for repeated and frequent appointments for examinations by healthcare professionals and, worse still, would start to induce symptoms in N.

72. I am satisfied that such behaviour would cause N to suffer physical, emotional and psychological harm. He would be at real risk of:
(a) suffering unnecessary painful and/or distressing medical assessments and procedures;
(b) with frequent presentation as to GP surgeries and hospitals where he would be exposed to a wholly unnecessary risk of acquiring illnesses and infections;
(c) would suffer unnecessary disruption to his school and daily life and routines; and
(d) a risk of him coming to believe that he does suffer from epilepsy and/or a range of other medical conditions when he is, in fact, a perfectly normal and healthy child.

73. N has settled extremely well with his maternal grandparents. He is very happy and very secure with and attached to his grandparents. He has not suffered any untoward or unusual illnesses in their care. If he is rehabilitated to the care of his mother, he will suffer harm from being removed from his maternal grandparents and he will be at very real risk of being caused physical, emotional and psychological harm by his mother in her care.

74. The only proportionate course for this court to adopt in the welfare best interest of N is to secure his continued long-term placement with his maternal grandparents. Given the findings of fact I have made and my findings of the risks to which N would be exposed if he was rehabilitated to the care of his mother, I am in no doubt that it would be wholly inimical to his welfare if his carers, the maternal grandparents, simply shared parental responsibility with his mother. They need to have the upper hand and to be able to make all decisions about his future life without any need to consult with or be influenced by or involved with the making of decisions with the mother. This is the only appropriate order in N's welfare.

75. Therefore, in N's welfare best interest, I do not make a child arrangements order but I do make a special guardianship order in favour of the grandparents.

76. The Local Authority had originally considered fortnightly contact with the mother would be in N's best interest. Having taken account of the Guardian's views, the Local Authority amended its plan to one of monthly contact. I agree.

77. The paramount need is to permit N to remain settled and secure in his maternal grandparents' long-term care and to accommodate his and their daily commitments, both in terms of family and the grandparent's working lives. This paramount need leads me to conclude that contact once per month, with additional contact in the school holidays as determined by the maternal grandparents, will meet his welfare interests to maintain a relationship with his mother. This contact must, at all times, be supervised. I emphasise the word, 'all'.

78. More frequent contact may meet the mother's needs but not N's. A very clear message must be sent to and received by this mother about the very limited role she now has and must play in her son's life.

Conclusions

79. For the reasons I have given, I make the findings of fact set out above. I am entirely satisfied that it is in N's welfare best interest that I make a special guardianship order in favour of his maternal grandparents. I wholly accept the advice of the social worker and the advice of the Guardian that in N's interest, the mother's contact should be limited to once per month and shall be supervised by the maternal grandparents, and that there may

be such additional school holiday contact as they may agree.

80. I would wish to offer my grateful thanks to counsel for the very helpful and economic manner in which this case has been conducted.

End of Judgment

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This transcript has been approved by the judge.