Important Notice
This decision was delivered in private to the parties and their lawyers. They may not show or otherwise communicate this decision or its contents to any other person. Any party or their lawyers wishing to show or inform any other person about the decision or any other person wishing to see the decision must first come back to court and obtain the permission of His Honour Judge Richard Clarke.

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

Case No: WD21C00424

IN THE FAMILY COURT SITTING AT WATFORD

Date: 18 March 2022

Before:

HIS HONOUR JUDGE RICHARD CLARKE

- -

Between:

HERTFORDSHIRE COUNTY COUNCIL	**Applicant**
- and -	
(1) MOTHER	**Respondents**
(2) FATHER	
(3) THE INTERVENOR	
(4) THE CHILD (acting through her children's guardian, Jessie Rowlands)	

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DECISION

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Contents

His Honour Judge Richard Clarke :

INTRODUCTION

1. This is the decision of the Court, following a fact-finding hearing, on an application by Hertfordshire County Council (referred to as the Local Authority) for a Care Order issued on 1 April 2021.

2. The trial of this matter has taken place over 10 days, namely on 7, 8, 9, 10, 11, 14, 16, 17, 18, 25 February 2022, with judgment being handed down on 18 March 2022.

REPRESENTATION AND PARTIES

3. The Local Authority was represented by Miss Diaz of counsel.

4. The first respondent is the Mother, who was represented by Miss Harrill of counsel.

5. The second respondent is the Father, who was represented by Miss Spratling of counsel.

6. The third respondent is the Mother's new partner (referred to as the Intervenor), who was represented by Miss Burgess of counsel.

7. The children's guardian is Jessie Rowlands (referred to as Guardian), who was represented by Mr Amos, solicitor.

8. Given the potential for wider distribution of this decision, I have anonymised the names of the children and family members. I have already provided a schedule of anonymised names so that anyone working with this family can readily identify the people referred to it in the decision.

9. I have also decided to anonymise any reference to the professionals due to the risks of jigsaw identification.

ESSENTIAL BACKGROUND

10. This is a case involving allegations of fabricated or induced illness. The Local Authority alleges Mother has fabricated, induced and/or exaggerated medical conditions, symptoms of illness and/or presentations in the Child. They say this has led to the Child receiving and/or being exposed to unnecessary medical procedures, investigations, examinations, medication and treatment. They also say Mother has administered medication to the Child when it was not necessary or medically warranted and when it was not prescribed to her. They allege the Intervenor allowed Mother to give the Child medication prescribed to the Intervenor, assisted Mother in administering medication to the Child and failed to take protective action to safeguard the Child. As a result of this they say the Child has suffered significant emotional and physical harm and neglect whilst in the care of Mother and the Intervenor.

11. There is a long and involved history to this matter. Attached at Schedule B of the full version of this judgment, but not for publication due to risk of jigsaw identification, is a chronology relevant to the Child. In addition, there is a full medical chronology that the Court has considered as part of this decision.

12. Of most relevant note are the following:
    12.1. The parents are not married. The Father does have parental responsibility.
    12.2. The parents were in a relationship for around 6 years, lived together for around 2.5 years and had separated by April 2016.
    12.3. Father entered into a new relationship and he and his new partner had another child who was born around the end of 2016/start of 2017.
    12.4. Mother entered into a new relationship with the Intervenor in around October 2016. She moved in with the Intervenor, along with the Child, on Boxing Day 2016.
    12.5. Within 3 months of the Child's birth Mother was presenting the Child at the Accident and Emergency Department (A&E) of her local hospital. There is a report that the baby had a floppy episode at the GP practice. There is no corresponding GP record.
    12.6. There were multiple A&E attendances around this time. A week later Mother is recorded as informing the Health Visitor the Child had become floppy when being examined by the GP, who advised Mother to take the Child to hospital. There is no corresponding GP record.
    12.7. The first report of the Child developing a rash came at around 9 months of age. Mother was questioning whether the Child had an allergic problem. The same month Mother is recorded as complaining about a diagnosis of upper respiratory tract infection and wanting something done immediately. There is a record of the GP questioning whether Mother was suffering from post-natal depression.
    12.8. At around 11 months of age there is a record of the parents stating they will not go to the GP surgery due to a bad experience.
    12.9. A developmental review was undertaken when the Child was aged 11 months. The Child was assessed as developing within normal limits. Mother was recorded as concerned animals in their previous home may have contributed to several ear, throat and chest infections requiring antibiotics.
    12.10. By the Child's first birthday she had been to A&E on 6 occasions.
    12.11. At 15 months of age there was a report to the GP of a 3-day spreading rash all over the Child's body. The following month there was a report of the Child being blotchy around the mouth after a cheese straw and onion and garlic dip.
    12.12. The 2-year developmental review recorded the Child as developing within normal limits. Mother was concerned about the Child's speech.
    12.13. At 2 years 6 months the Health Visitor was raising concerns about the relationship between Mother and Child, Mother was being referred for cognitive behavioural therapy, and the Health Visitor was recommending Mother take the Child to the GP for a review of the hearing in the Child's left ear. Mother was recorded as failing to attend the GP to have this checked.
    12.14. By 2 years 8 months the Child had been referred to the Child Development Clinic. Development was recorded at the lower end of the normal range and Mother was reported as raising a question of possible autism. The Doctor advised Mother the Child's presentation was not suggestive of autism. Following information from the nursery, the Dr later annotated the report to confirm there were no concerns regarding autism and further follow-up was not indicated.
    12.15. A hearing assessment took place at 3 years 1 month, with hearing found in the normal range. 2 months later there is a report of middle ear fluid in

the right ear. The Child was examined again the following month, when she was found to have normal hearing and no sign of glue ear. It appears questions were asked about grommet insertion and the parents were advised this was not required.

12.16. A referral was made back to the paediatrics due to parental concern about speech delay and behaviour at 3 years 5 months.

12.17. At 3 years 5 months Mother informed the Intervenor the Child was being tested for autism and ADHD.

12.18. The Child was assessed in the Child Development Clinic at 3 years 6 months. A diagnosis of Global Developmental Delay was made, with further assessment for autism planned.

12.19. Mother is recorded as informing the Special Needs Health Visitor, at 3 years 7 months, that she had experience working with older children and adults on the autism spectrum and the Child may have autism spectrum disorder.

12.20. When the Child was just under 4 years old at a review appointment, it was concluded there was mixed information about whether the Child had autism.

12.21. At 4 years and 5 months, Mother completed an asthma history questionnaire advising the Child had mild asthma. A full autism assessment took place and the Child was found not to have autism. Mother was recorded as storming out of the clinic when informed a diagnosis of autism was not being made.

12.22. The following month Mother is recorded as informing a Registrar in the ENT clinic that the Child was suspected of having autism and ADHD. Mother was reporting quite a few infections in the Child's ear over the past year and a very bad spell of glue ear. On examination no evidence of glue was noted and the ears appeared normal.

12.23. The Child was assessed for a squint the next month, but no problems found.

12.24. By 4 years and 8 months Mother was reporting the Child had developed an allergic skin rash. No skin rash was noted on examination.

12.25. The Child's hearing was assessed as normal again aged 4 years 9 months, due to Mother reporting recurrent ear infections and hearing problems. The Child was placed on a waiting list for grommets and they were inserted the following month.

12.26. When the Child was 5 years and 1 month old she was the subject of a school behaviour plan. The plan identified the Child as "still in nappies at this point; she had made progress but still has frequent accidents". The frequent accidents were repeated in further behaviour plans 8 months later and 12 months later.

12.27. At 5 years 1 month Mother was seeking a further assessment for possible autism. A review appointment took place the following month, where it was recorded Mother was asking about whether the Child had Pathological Demand Avoidance syndrome. Mother was also concerned the Child may be hypermobile, stating her shoulders would pop out when she raised her arms, stated the Child had no pain register, spoke about the Child possibly needing a special school and raised concerns about possible allergies. The Child was examined and found to be healthy and well, with no signs of allergy or hypermobility.

12.28. The following day the child was seen by a paediatrician regarding the concerns about the Child developing a red blotchy rash on her face and mild

swelling on the lower area of her face. A diagnosis of spontaneous urticaria, presenting with random hives and rashes which come and go, was made. In the letter following the appointment the Doctor confirmed Mother had informed him that both she and her mother had suffered from penicillin allergy and were prescribed Epipens.

12.29. 6 days later Mother raised concerns with the same paediatrician that the Child may have a penicillin allergy and said there was a need for an Epipen in light of a reported request from school and GP about this. She was advised an Epipen was not required.

12.30. A referral had been made to PALMS for support, but they discharged the Child at age 5 years and 2 months recording Mother had not responded.

12.31. The Child was assessed by the allergy clinic. She was discharged at 5 years and 4 months of age without any diagnosis of an allergy.

12.32. At 6 years and 3 months of age the Child was presented at hospital with Mother reporting frequent nosebleeds. Cautery of the nose took place the following month.

12.33. The Child's eyesight was assessed again at age 6 years and 5 months. Her eyesight found to be normal. The same month Mother notified the Child's school that she was allergic to paracetamol and adhesive dressings. The Child was also examined due to Mother's reports of continued nosebleeds, but no evidence of bleeding was found.

12.34. At age 6 years and 6 months an individual healthcare plan was put in place for the Child at school. It identified spontaneous urticaria plus allergy to all adhesive dressings/tape and paracetamol. On adhesive dressings/tape it stated "severe reaction causes swelling of the whole body", but also "does not go into anaphylactic shock with her allergy so her reaction will not constitute an emergency"

12.35. Mother completed a Data Collection Sheet for the Child's school at age 6 years 7 months where she stated the Child was allergic to paracetamol, all adhesive plasters/tape and tomatoes.

12.36. A review allergy clinic appointment took place at age 6 years 8 months. Various allergy tests were conducted, all of which were negative. Antihistamine medication was changed as Mother was concerned the existing medication may be causing diarrhoea. Mother was reported to have asked if an Epipen was needed and she was informed not.

12.37. Mother subsequently confirmed to the school that the Child could have tomato, but it may cause her to come up blotchy in the face. She also informed the school the Child was under a paediatrician for toileting issues.

12.38. A further hearing assessment took place when the child was just under 7 years old. It found mild hearing loss in the right ear and borderline hearing loss in the left ear, described elsewhere as satisfactory hearing with no more than a mild loss to one side. Grommet removal was planned. Mother contacted the Speech and Language Therapist the same day advising there was hearing loss in both ears, which Mother thought was affecting the Child's behaviour.

12.39. A review took place at the Community Paediatric Clinic just before the child was 7 years old, on Mother's request citing concerns the Child may have autism or ADHD. Mother was reported as stating the child has asthma, seasonal allergic rhinitis, rashes with generic brands of paracetamol and suspected allergic reactions to plaster and micropore. In addition, Mother reportedly stated the Child had hearing loss in both ears because of the grommets not being removed.

12.40. A pre-operative assessment for grommet removal took place when the Child was 7 years and 2 months old. Mother apparently reported the Child had autism, multiple allergies and ADHD. Having asked for the operation to be expedited, Mother was recorded as not wanting it done at the planned hospital. The following month Mother was recorded as not trusting the local hospital.

12.41. Mother sought a further autism and ADHD assessment when the Child was aged 7 years and 3 months.

12.42. The Child was seen due to ongoing nosebleeds aged 7 years and 5 months. It was documented that Mother reported allergies to nuts, paracetamol, penicillin and antihistamines (intolerance, behavioural effects). Further cautery was planned.

12.43. The same month the Child was diagnosed with ADHD and the diagnosis of Global Developmental Delay was updated to Learning Disability. Mother was reported to be unhappy the diagnosis of ADHD had not been made before. A referral was also made to the Local Authority by the hospital due to concerns Mother was struggling to cope. Mother was reported to state she was receiving no support with the Child's behaviour issues. The school was contacted, who reported Mother had received a lot of input regarding parenting but had walked out of courses and was not engaging very well with her positive parenting therapist.

12.44. The Child's school was provided with inhalers by Mother due to Mother's reports of the Child having seasonal asthma. The school asked Mother to complete forms relating to this, but this was not done.

12.45. When the Child was 7 years and 6 months old Mother contacted the Child's GP seeking an Epipen for the Child. The following month Mother was recorded as insisting she speak to a GP that day and asking for 2 Epipens.

12.46. At age 7 years and 6 months Mother provided antibiotics to the school for the Child stating the Child's doctor had said the Child's eardrum was on the verge of perforating.

12.47. When the child was nearly 7 years and 7 months old Mother gave the child oramorph (belonging to the Intervenor), ibuprofen and cough syrup (the "oramorph incident"). Mother called 111 and is heard advising them the Child was having some form of allergic reaction all over her face and her neck. She also stated the Child had previously had a life-threatening allergic reaction. The call handler was informed the Child had spontaneous urticaria and a "fair few allergies", including paracetamol, nuts and penicillin. Mother also stated "they're contemplating that she's allergic to morphine as well", that they had "sent me home with morphine" but that she had not given the Child morphine. Later in the same call Mother stated she had given the Child 2 mils of oramorph. Mother put any breathlessness down to asthma and said the Child would not tell her of problems because of global speech, global development, autism and ADHD. Mother also stated the Child had sleep apnoea and that she had been told to watch out for anaphylaxis. Within 6 minutes of ending her call to 111 Mother escalated the call to 999. An ambulance was sent out and the Child was taken to A&E. The ambulance record shows they were informed the Child had 2 allergies. They considered adrenaline and hydrocortisone, but they were judged not to be required. Breathing was noted as normal. They appear to have been informed the Child was waiting for an Epipen and, due to reported allergies to multiple medications, they decided to transport her to hospital.

12.48. The following day Mother called 111 again, because she was struggling to find liquid antihistamine for the Child, stating the Child had an anaphylaxis shock the previous day, was Category 1 with the ambulance service and received an adrenaline injection. Mother stated the Child's GP was more than happy to prescribe the Child an Epipen but needed confirmation. Mother was reporting the Child as allergic to virtually anything and everything. Mother was also stating she had assisted with dialysing her father and inserting his catheter and that she was quite fully trained and knows what she is doing. A Nurse Clinical Adviser called Mother back, at which point Mother confirmed the anaphylaxis the previous day, had required oxygen in the ambulance, was given an adrenaline injection and had been discharged home because Mother is quite medically trained. Mother also stated the Child had traits of autism. Mother again asserted the Child had previously been on the verge of a perforated eardrum. Mother told the Nurse her father and grandmother had Epipens, so she knew how to administer these. The Nurse referred Mother back to the GP.

12.49. 2 days later Mother spoke to a paediatrician's secretary stating the Child had a severe allergic reaction 2 days ago with swelling of the face and neck with redness, along with difficulty in breathing. Mother was seeking a prescription for an Epipen and, due to concerns of severe allergic reaction, they were prescribed. Due to Mother's reports of severe drug allergy the Child was referred to the paediatric allergy team.

12.50. Within 2 days Mother had been trained to use an Epipen and she had received 2 Epipens. She then rang the GP the following day seeking more.

12.51. 8 days after the oramorph incident Mother informed the school she was seeking ADHD medication for the Child. The following day Mother spoke to the Child's paediatrician, stating the Child was about to be permanently excluded from school and requesting ADHD medication was prescribed to prevent this. The paediatrician spoke to the school, who said there was no plan to exclude the child, and did not prescribe ADHD medication.

12.52. Mother obtained further Epipens. She stated one had been lost at her parents and she had given Epipens to the school and Father.

12.53. Mother contacted the secretary of the paediatrician who had refused ADHD medication seeking a change in paediatrician.

12.54. 1 month and 5 days after the oramorph incident, Mother contacted 111 stating the child was coming up in random red hot blotchy rashes and Mother had an Epipen. She described the Child as being like a 2 to 3 year old with her speech, despite being 7. When asked if the Child had previously had a life threatening allergic reaction Mother said she had had one, an anaphylactic shock on the date of the oramorph incident. Mother was instructed to use the Epipen and an Epipen was duly administered. An ambulance attended and their records indicate a history including autism and allergic reactions was given. The following day the school were informed by Mother that the Child had had anaphylaxis the previous day.

12.55. 1 month 7 days after the oramorph incident the ambulance was called out again. Mother was reporting an allergic reaction 2 days previously, for which an Epipen was administered, and that the Child has multiple reactions to medication, with reactions to an unknown source. The 111 service were stated to have advised Mother to administer the Epipen again due to Mother's report of hives and itchy skin, but Mother did not give this because it did not match with the training she had received.

12.56. A consultation took place at the Paediatric Allergy Clinic 1 month and 11 days after the oramorph incident. Mother was noted to have stated she had had to use the Epipen several times. 2 days later Mother was recorded as asking for Epipens on repeat because she was having to use them every few days.

12.57. At one month and 15 days after the oramorph incident there is a record of Mother taking the Child to A&E and stating she usually gives the Child an Epipen if the rash spreads.

12.58. 2 months and 3 days after the oramorph incident Mother was reported to have stated she had used 5 Epipens in recent weeks.

12.59. 2 months and 17 days after the oramorph incident the Child developed red blotches about an hour after having eaten lunch. Antihistamine medication was given, but the school asked Mother to attend to collect the Child. There is a record that Mother asked for the Epipen to be administered, but the school refused. Mother attended the school to collect the child. She then headed to hospital. On arrival at the hospital Mother was recorded as stating there had been facial and lips swelling with no breathing difficulties so an Epipen was given during the journey. No history of fainting or collapse was recorded.

12.60. The following day Mother informed the school an Epipen was given on the way to hospital, stating the Child had lost consciousness for a couple of minutes. Mother was also reported as stating she had only administered the Epipen once before on the day of the oramorph incident, and that the Child had been given a second one by the paramedics on the way to hospital.

12.61. The Child's teacher spoke to the Child 2 days later, when she stated the Intervenor had held her arms and demonstrated Mother administering the Epipen.

12.62. At 2 months and 20 days from the oramorph incident Mother was recorded as informing a paediatrician that she had administered the Epipen 5 or 6 times.

12.63. Mother and the Intervenor were subsequently arrested for child cruelty. No prosecution has taken place.

12.64. The Local Authority issued these proceedings and the Child has been staying with relatives.

THE LAW AND LEGAL PRINCIPLES

13. The law is well known in this field, uncontroversial and need not be recited at length but the Court needs to remind itself of it both personally and so the parties are aware of the context of the decision it makes. The following legal summary is agreed by all of the advocates and can be summarised as follows:

13.1. The questions for every fact-finder are What, When, Where, Who, How and Why?

13.2. There is only one standard of proof in these proceedings, namely the simple balance of probabilities.[1] Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts.

13.3. If a fact is to be proved the law operates a binary system in which the only values are 0 and 1 therefore it is open to the Court to make the following findings on the balance of probabilities:

13.3.1. that the allegation is true

[1] Re B [2008] UKHL 35

13.3.2. that the allegation is false

and once an allegation has been proven on the balance of probabilities it will be treated as a fact and all future decisions will be based on that finding. Equally if a party fails to prove an allegation the Court will disregard the allegation completely.

13.4. The burden of proof is on the party who makes the allegation(s). It is not reversible, and it is not for the other party to establish that the allegation(s) are not made out. The burden of proof falls always on the local authority. It is the local authority that brings these proceeding and identifies the findings they invite the Court to make. Therefore, the burden of proving the allegations that they make rests with them.[2]

13.5. The fact that a party fails to prove, on a balance of probabilities an affirmative case that he / she has chosen to set up as a defence, does not of itself establish the local authority's case. It is not for a party against whom allegations are made to prove a negative case. Such a party is not required to provide any satisfactory or benign explanation as to why allegations have been made about their conduct[3]. Put another way, there is no pseudo-burden or obligation cast on parents to come up with alternative explanations[4].

13.6. The court is not bound by the cases put forward by the parties, but may adopt an alternative solution of its own[5]. However, the judge should be cautious when considering doing so and if the judge is, as it were, to go "off-piste", and to make findings of fact which are not sought by the local authority or not contained in its Schedule, then he or she must be astute to ensure:

13.6.1. That any additional or different findings made are securely founded in the evidence: and

13.6.2. That the fairness of the fact-finding process is not compromised.[6]

13.7. There has been a significant passage of time since the events in question. As Jackson J (as he then was) stated[7]: To these matters I would only add that in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith."

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[2] Re A (Care Proceedings: Learning Disabled Parent) [2014] 2 FLR 591
[3] Re M (Fact-Finding Hearing: Burden Of Proof) [2012] EWCA Civ 1580
[4] Lancashire CC v R [2013] EWHC 3064 (Fam) at [8(vi)].
[5] Re S (A Child) [2015] UKSC 20
[6] Re G and B (Fact-finding Hearing) [2009] EWCA Civ 10
[7] Lancashire County Council v C, M and F [2014] EWHC 3 (Fam)

13.8. Findings of fact must be based on evidence (including inferences that can properly be drawn from the evidence) and not on suspicion or speculation.[8] If the local authority case is challenged on some factual point they must adduce proper evidence to establish what it seeks to prove. There is also the need to link the fact relied upon by the local authority with its case on threshold, the need to demonstrate why, as the local authority asserts, facts A + B + C justify the conclusion that the child or children has/have suffered, or is/are at risk of suffering, significant harm of types X, Y or Z.[9] The Court's findings must identify what significant harm the Court found the child to have suffered and/or the type of significant harm the child was/were likely to suffer.

13.9. Where the evidence stands only as hearsay, the Court weighing up that evidence has to take into account the fact that it was not subject to cross examination.[10]

13.10. The inherent probability or improbability of an event remains a matter to be considered when weighing the probabilities and deciding whether, on balance, the event occurred. "Common sense, not law, requires that in deciding whether the fact in issue is more probable than not regard should be had to whatever extent appropriate to inherent probabilities[11]" The fact an event is common or frequent does not lower the standard of probability to which it must be proved, nor does the fact it is very uncommon or infrequent raise the standard of proof.

13.11. When carrying out the assessment of evidence, the Court must pay attention to the fact "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof"[12] First, the Court must take into account all the evidence and, furthermore, consider each piece of evidence in the context of all the other evidence. The Court must survey a wide canvas. Secondly, the evidence of the parents and other carers is of the utmost importance. It is essential that the Court forms a clear assessment of their credibility and reliability.

13.12. The Court must weigh up all the evidence, whether given by expert or lay witnesses.

13.13. Any judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so.[13]

13.14. The evidence of the parents and any other carers is of the utmost importance. It is essential that the Court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part

[8] Re A (A Child) (No 2) [2011] EWCA Civ 12 para 26
[9] Re A (A Child) [2015] EWFC 11 paras 9 and 12
[10] Re W [2010] UKSC 12
[11] Lord Hoffmann in Re B at para 15
[12] Re T [2004] 2 FLR 838 at para 33, affirmed in Devon County Council v EB & Ors (Minors) [2013] EWHC 968 (Fam), paras 56, 59
[13] Re M (Children) [2013] EWCA Civ 1147 (paras 11 and 12)

in the hearing and the Court is likely to place considerable weight on the evidence and the impression it forms of them.[14]

13.15. The assessment of credibility generally involves wider problems than mere 'demeanour' which is mostly concerned with whether the witness appears to be telling the truth as he now believes it to be. With every day that passes the memory becomes fainter and the imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited. Therefore, contemporary documents are always of the utmost importance.[15]

13.16. The medical and expert evidence is but one part of the evidence available to the court at the fact-finding stage and must not take undue prominence. As Ryder J observed[16]: 'A factual decision must be based on all available materials, i.e. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be. Just as best interests are not defined only by medical or scientific best interests…likewise investigations of fact should have regard to the wide context of social, emotional, ethical and moral factors… I venture to suggest that if a court considers the broader context of expert evidence, that is the social, educational and healthcare history, with the rigour described above, there must surely be less likelihood of inappropriate reliance on what may transpire to be insufficiently cogent and sometimes frankly incorrect expert evidence even where it is uncontradicted"

13.17. As is highlighted in the 2012 guidance Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians, the key task for paediatricians is to distinguish between anxious carers whose children are genuinely sick and responding in a reasonable way and the 'rare cases' of a carer causing harm to a child by confusing and possibly fabricating presentation.

14. **All parties have been given the opportunity to be represented** within these proceedings. They have been able to put their case. Article 6 of the European Convention of Human Rights has been fully engaged.

15. Any person who might be adversely affected by my judgment, for example by being someone against whom allegations are made, has had the opportunity to be represented within the proceedings and been able to put their case.

THE TRIAL

16. The trial of this matter has taken place as a hybrid hearing, with Mother, the Intervenor, their respective counsel and the Intervenor's intermediary attending in person each day. All the witnesses attended remotely, as did the other parties and their legal representatives save counsel for the Local Authority, who attended in person to cross examine Mother and the Intervenor.

17. This case has been carefully case managed over a period of 10 months. The purpose of those directions is to enable a fair trial to take place between these

[14] Re W and another (Non accidental injury) [2003] FCR 346

[15] Onassis and Calogeropoulos v Vergottis [1968] 2 Lloyd's Rep 403, per Lord Pearce; A County Council v M and F [2011] EWHC 1804 (Fam) [2012] 2 FLR 939 (paras 29 and 30): see Mostyn J in Lancashire CC v R [2013] EWHC 3064 (Fam) (paras 8 and 51).

[16] A County Council v A Mother, A Father and X, Y and Z (by their Guardian) [2005] 2 FLR 129

parties. Each party has a right to a fair trial. That includes the child, as well as the parents.

18. Throughout the trial the court has sought to ensure the parties' Article 6 rights to a fair hearing have been met. Part of the right to a fair hearing involves the parties setting out their case in advance of the trial. The directions preparing the case for trial included directions for a schedule of allegations and responses from Mother and the Intervenor, as well as service of the Local Authority evidence and the Mother and the Intervenor having the opportunity to serve their evidence in response.

19. The Intervenor is a vulnerable witness. A cognitive assessment of the Intervenor confirmed that the Intervenor's overall scores were just above the threshold for Learning Disabilities, with poor verbal memory and a reading age of 6 years. Ground Rules were set at the pre-trial review, which included provision for breaks and questions for the intervenor being sent to the intermediary for advice on appropriate language. She has been attended in court throughout the fact-finding hearing by an intermediary as well as counsel. The report recommended clear and concrete language be used and to avoid figurative language and idioms. Simple, everyday words and phrases were recommended.

20. In addition to expert evidence from Dr Rahman, consultant paediatrician, the court has benefitted from the evidence of a number of professionals involved in the education of the Child, as well as treating consultants.

21. On Day 2 of the trial a treating consultant was asked about a distinction between allergies and intolerances, as set out on the NHS website. At the time the importance of this was not apparent.

22. On Day 3 the expert consultant paediatrician appointed to report to the court was again asked about information on the NHS website. It was only when the court queried the relevance of this that it was explained it was Mother's case that she had researched matters on the internet and had placed some reliance upon the information she had found there. This was not something which had appeared in any of the 5 witness statements served by Mother or in her response to the Local Authority Schedule of Findings.

23. Discussions took place about whether Mother intended to provide a further statement setting out the additional information she wished to put before the court. This option was not accepted by Mother.

24. The schedule of proposed findings was updated by the Local Authority before the start of the hearing on Day 5. Mother asked that the start of her evidence be put back to Day 6 so she could give instructions on this.

25. Unfortunately the intermediary was involved in an accident in the intervening weekend, meaning no progress could be made on Day 6. The intermediary was sufficiently recovered to attend from Day 7 onwards.

26. Mother's evidence finally commenced on Day 7 and concluded on Day 8. By the time Mother gave evidence she had been asked twice whether she wished to

have the opportunity of providing a further witness statement and had declined on both occasions.

27. The Intervenor gave evidence on Day 9. She was assisted in the witness box by the intermediary, who had already provided feedback on proposed questions. There was insufficient time on Day 9 to hear submissions or give judgment.

28. The Court provided a summary of the Law for agreement by the parties on the basis the Court would receive written closing submissions and hand down the decision on 18 March 2022, but providing a written decision, if possible, in advance.

29. The Court was provided with 3 bundles for the hearing, a core bundle, a police bundle and a medical bundle. None of the bundles was properly searchable, despite a clear direction from the court. Just before close of business on 3 February 2022, 2 working days before the hearing was due to commence, the court was informed some of the documents from the other parties "cannot be converted into the right format to make them searchable, and as such only those documents in the correct format will be searchable within the bundle."

30. As a consequence of the failure by the Local Authority to provide a searchable bundle a number of the advocates and the court had to waste their time making parts of the bundles searchable. It should be observed that whilst the guidance in respect of digital bundles has not yet been incorporated into the Family Procedure Rules, directions of the Court for formatting of the bundle are not optional. They also go to the heart of Article 6 rights, because it is not appropriate for the Local Authority to provide a bundle which only provides, in answer to any search, the evidence of the Local Authority and excludes the evidence of the other parties. The following evidence served by the parents/intervenor were not searchable:

    30.1. Mother's first witness statement; and
    30.2. Mother's response to the medical chronology.

THE EVIDENCE AND WITNESSES

31. The Court has read and heard a considerable amount of evidence. The fact that it does not mention something in this decision does not mean that it has not fully considered it. It is impossible to set out in this decision everything that has been heard and read. The decision must be based on proper evidence addressing all the realistic options for the child and containing an analysis of the arguments for and against each option. There must be an adequately reasoned decision which grapples with those factors and which gives a proper and focussed attention to those factors.[17] The basic principle is that the parties need to understand why the Court makes the findings and orders it does.

32. Within its analysis the Court has had the benefit of hearing evidence from the following witnesses:
    32.1. Miss K;
    32.2. Miss B;

[17] Re B-S (Children) [2013] EWCA Civ 1146

32.3. Miss NA;
32.4. Miss S;
32.5. Miss NB;
32.6. Mr M;
32.7. Mr Q;
32.8. Dr S;
32.9. Dr Sl;
32.10. Dr T;
32.11. Dr C;
32.12. Dr Rahman, expert consultant paediatrician;
32.13. Mother; and
32.14. The Intervenor.

33. It has also had the benefit of extensive written evidence, including evidence from the social worker, the police and the Child's medical records.

School information

34. Miss K the Assistant Head Teacher at School A, where the Child attended for just over 3 years. The Child originally attended the nursery attached to the school. Miss K provided a witness statement based on school records, having only joined the school after the Child left. She confirmed a number of concerns had been recorded regarding the Child wetting and soiling herself in school between September 2016 and November 2017. She also reported the Child's attendance as:

First year	89.7% - 5 days family holiday and 7 days illness
Second year	87.8%, with 22 sessions missed due to illness, 14 for medical/dental appointments, 5 for other authorised circumstances and 3 sessions unauthorised absence
Third year	87.5%, with 6 sessions missed due to unauthorised family holiday, 10 sessions missed due to illness, 4 for medical/dental appointments, 5 for other authorised circumstances and 22 sessions where the Child attended late after registers closed
Fourth year	88.6%, with 8 sessions missed due to illness, 1 for medical appointment, 1 for other authorised absence and 3 sessions late after register closed (up to time of transfer to another school)

35. Miss B was the SENCO at School A when the Child was there. She did not regard her interactions with Mother as anything out of the ordinary. She confirmed she had attended the autism assessment appointment with the Child's teacher at the time, to support the family. At the time she was of the view that with the Child's age and the behaviours that she was displaying, some could be attributed to autism or Global Development Delay or speech and language difficulties and the school supported the assessment.

36. Miss B was asked about Mother's reaction to Dr S being unable to make a diagnosis of autism. She said she thought Mother was disappointed. She described Mother as looking for an explanation for the Child's behaviour issues and still believing the Child had autism despite the lack of diagnosis. She also

believed Mother was seeking one to one support for the Child in school which Mother thought a diagnosis of autism would give access to.

37. On being asked about the relationship between the Child and Mother, Miss B described the relationship as good, expressed that Mother was loving towards the Child and confirmed she did not have any concerns witnessing the relationship between them.

38. Miss NA is the designated safeguarding lead at School B. She confirmed Mother had reported the Child to be allergic, initially to a list of food types including tomatoes, chocolate, milk and ketchup, but numerous medications were later added to the list, including Nurofen, Paracetamol and Elastoplast. Despite requests, no written evidence in support had been produced by Mother. Based on Mother's reporting, the school provided the Child with an allergy lanyard to wear. While she provided 2 witness statements, she did not have direct knowledge of events on 18 January 2021 and accepted she had used unhelpful language in her witness statement in describing the events. Her witness statements about those events were based on information provided by other staff members on the school reporting system.

39. Miss NA confirmed records of the Child's allergies were based on reports from Mother. She produced a Data Collection Sheet where Mother identified the Child as suffering from allergies to paracetamol and all adhesive plasters/tape. She also produced a Permissions Form from the same date, where Mother stated the Child was allergic to "tomatoes (as in bases of pizza)", and an Annual Parental Consent Form where Mother drew the schools attention to the Child's toileting needs, double grommets, double nose cauterisation, Global Development Delay and Global Speech Delay. The Child was provided with an allergy lanyard to wear at school.

40. When the Child was nearly 7 years old Mother was reported to have told the school of a diagnosis by the hospital of hearing loss in both ears which would require an operation and subsequent hearing aids.

41. At 7 years and 1 month of age the Child was reported to have suffered an ear infection and attended Hospital B's ENT department. Mother was recorded as informing the school that the Child had been given an appointment to have her grommets removed. She later informed the school the operation was put back and the Child was absent from school with a further ear infection for which she was prescribed antibiotics. Mother allegedly reported that the doctor stated that the Child's eardrum was 'on the verge of perforating'.

42. When the Child was 7 years and 6 months old (the date of the oramorph incident) Mother advised the school that the Child had undergone a tonsillectomy and her grommets had been removed, which was followed by a period of absence.

43. On the following day, Miss N said, Mother emailed the school to advise the Child had suffered anaphylaxis shock 2 days before, which was attributed to the Child having Nurofen following her ear operation.

44. According to school records, Mother provided the school with an epipen and an allergy action plan provided by the Hospital A, citing allergies to tomato, spontaneous urticaria, allergic rhinitis, plaster and micropore and a history of allergic reactions to drugs (ibuprofen, paracetamol and cough syrup).

45. 1 month and 6 days after the oramorph incident it was recorded that Mother had advised the school the Child would be absent having suffered a further anaphylaxis the previous day for which an epipen had been administered.

46. Mother was reported as advising the school, 2 months 11 days after the oramorph incident, that if pain medication was needed it would have to be administered by way of enema. The school were not prepared to administer medication intimately.

47. Miss N confirmed that she had spoken to Mother at the school gate the day after Mother accepts using the Epipen the second time. Mother apparently informed her the Child had lost consciousness on the trip to Hospital B and Mother had to administer the epipen.

48. On the question of toileting, she confirmed there had been 3 incidents shortly after the start of that school year, which could have been related to changes in the Child's routine. However, the concern about toileting was not apparently seen by the school as a huge medical problem or something which caused alarm and concern with the Child's teacher. They did not observe the Child having accidents as often as Mother was apparently reporting them, but while it was unusual when compared to other children it was not seen as unusual given the Child's needs.

49. Miss S was the Child's Year 3 class teacher at School B, although she remains one of the Child's "trusted people" at the school. She was asked about the Child wetting herself and confirmed it would happen occasionally, usually when she was outside playing or if totally engaged with something in the classroom.

50. On the afternoon of the day when Mother accepts using the Epipen a second time, at about 2pm, Miss S walked past the Child and noticed marks to her face. She stopped to speak to the Child and described seeing a red mark moving up the side of her face which was quite noticeable to her and, because the school were aware of possible allergic reactions, was something she had stopped to check. Upon checking the Child's stomach and back she saw further red marks around her chest area. She described those marks as like a heat rash, not blotchy like the marks on the Child's face.

51. The Child was taken to another staff member, who provided the Child with an antihistamine tablet. Mother was notified and it was agreed the Child would be observed for 30 minutes. The redness started to subside and the Child confirmed the marks were not itchy anymore, but said her legs were now itchy. Miss S explained that the Child had a tendency to fixate on something once it had been pointed out to her, and that may explain the itchiness. After 15 minutes the Head teacher decided it would be best for the Child to go home regardless. The Mother was called again, at which point Miss S understands Mother asked that the epipen be administered. The staff member discussed it with Miss S, who did not

believe an epipen was indicated. They then referred it to the Head Teacher, who agreed with Miss S's assessment.

52. Mother duly attended to collect the Child. Miss S confirmed the decision not to administer the epipen and said that Mother appeared to agree with the school's actions, but said she would be taking the Child to Hospital B so she could be checked over.

53. By the time the Child left with Mother, Miss S described her as back to normal. Miss S was subsequently asked to speak to the Child about the fact the epipen had been administered to her on the journey to Hospital B. She said she did so as someone experienced in the field who had received safeguarding training and knew not to ask leading questions. She also spoke to the Child with another staff member present, both taking notes to ensure the accuracy of their record. The Child was reported to state, "Mummy [Intervenor] holded my arms (she patted her shoulders at this point) then Mummy did this (she had her hand in a fist and hit her where she had previously pointed to) Mummy then holded my legs and I cried."

54. Miss S was specifically asked if she was ever concerned that Mother had mis-treated the Child in any way. She spoke about another parent of a child in the Child's year querying why the Child had needed an ear operation, but confirmed she had no concerns herself.

55. Miss N is the Deputy Head of School B. She observed the Child skipping and running out of school when she was collected by Mother, but did not see her close up and could not comment on whether she was symptom-free. She was asked about the school's disciplinary policy. The Child had received Level 3 internal exclusions for behaviour on 7 occasions as set out in the chronology, 4 of which were pre-proceedings. It was her evidence the Child was not at risk of a Level 4 fixed-term or permanent exclusion. She was asked about the fact Level 4 exclusions did not appear on the school's published policy on their website and how a parent may perceive the risk of exclusion. She was clear when speaking to parents about Level 3 exclusions the parent would have it explained to them what this meant.

ENT Evidence

56. The Child was originally referred to the ENT Department around her 3rd birthday. An audio test at age 3 years 1 month found the Child's hearing was normal and a consultation the following month made a diagnosis of mild glue ear.

57. A GP referral for the Child was received electronically in the ENT Department of Hospital A when the Child was 4 years and 6 months old. It stated, "She is struggling with glue ear which may be contributing to her difficulties of global development. Her school is also very concerned regarding her reduced hearing." The referral included no past medical history. This was the referral which led to an appointment with Mr M.

58. There is a Locum ENT letter when the Child was 4 years and 6 months old, having seen the Child with Mother that day, stating the Child was "seen today with mum who mentions that the child has a global developmental delay as well as speech delay and suspected autism and ADHD. They were seen by us last

year and had complaints of glue ear for which grommets were advised but unfortunately they were discharged as the hearing test appeared to be normal. Today, mum mentioned that the child has had quite a few infections over the last year and has recently had a very bad spell of glue ear, and they have to repeat themselves constantly. She also struggles at school due to the same reason. She also snores. On examination, both her eardrums today appeared to be intact and normal. There was no evidence of glue behind the eardrum."

59. Over the course of 4 appointments it was identified there had been fluid in the middle ear with minimal hearing loss which cleared up over the space of 2 months. At the third appointment the consultant advised grommet insertion was not clinically indicated. The fourth appointment recorded the parents' frustration, but identified repeat hearing tests had been normal. It was the opinion of the Specialist Registrar in ENT that any speech delay was not secondary to any hearing impairment.

60. Mr M, ENT Consultant, saw the Child for a consultation 3 months before the Child's 5th birthday. The Child was then admitted as a day case on a month before her 5th birthday where grommets were inserted in both ears.

61. Mr M provided a witness statement dated 6 December 2021 stating "it had been reported by (the Child)'s GP that (the Child) had been suffering from several recurrent ear infections and hearing problems as well as speech and language delay. At the examination there was no evidence of glue ear or hearing loss. He stated that, based on the history of recurrent ear infections documented by the GP and Mother he discussed the options of treatment and suggested (the Child) will benefit from grommet insertion with the aim of stopping the current infections."

62. In oral evidence Mr M accepted the GP had not stated there were recurrent ear infections, that by the time of the examination no medical professional had seen the Child at the time of an ear infection and there was no evidence of the existence of ear infections or glue ear when he conducted his examination. He accepted it appeared that the source of information about recurrent ear infections was Mother. He also accepted that the main, if not the sole, source of the reason for insertion of grommets was Mother.

63. The Child was referred to the ENT Department again aged 6, based on Mother's report of recurrent nosebleeds. The Speciality Doctor in ENT who examined the Child found a congested nose, but no prominent blood vessels were reported. She was subsequently examined under general anaesthetic and the nose cauterised.

64. Within 2 months the Child was seen in the ENT Department again, when Mother was again reporting nosebleeds. No evidence of a bleeding point was found and no further intervention took place. It was noted, however, that if the grommets had not come out in nine months' time they could be removed.

65. An appointment took place with an ENT Nurse a month before the Child's 7th birthday. Hearing testing showed satisfactory hearing with no more than a mild hearing loss on one side. Mother was recorded as keen to have the grommet removed (only one remaining in place).

66. The court also had the benefit of the evidence of Mr Q, consultant ENT surgeon. He provided an overview of the medical records in the ENT Department in relation to the Child in his witness statement dated 6 December 2021.

67. Mr Q saw the Child aged 7 years and 1 month. He recorded Mother telling him the Child had recently had a left ear infection, requiring 2 courses of oral antibiotics and a course of topical ear drops. Mother was apparently stating the grommets were causing some hearing loss. He examined the Child, but could find no evidence of infection apart from a small amount of dried discharge. He was satisfied the hearing was satisfactory from an educational perspective and would not have required intervention. He discussed treatment options and Mother elected to have the grommets removed, wishing the surgery to be expedited. The surgery could not take place at Hospital C because it was felt the reported conditions of autism, behaviour issues, global developmental delay, borderline asthma, allergy to plaster and paracetamol and suspected absent seizures, all reported by Mother, meant the operation should take place at a centre with better paediatric back-up. It was proposed to take place at Hospital A, but Mother declined the treatment there and a referral was made to Hospital B for a second opinion.

68. Mr Q and Mr M agreed that indicators for grommet insertion were glue ear over a period of time with associated hearing loss (which did not apply here) or recurrent ear infections. On reviewing the Child's medical records Mr Q could find no evidence the ENT operations had been definitely medically necessary. He was concerned decisions seemed to have been made on the basis of Mother's reports of infection of the ears. On the nose cauterisation, he identified that it was unusual not to find prominent blood vessels. He explained normally a nosebleed is caused by a prominent blood vessel in the nose, which is normally at the front of the nose and visible. He felt this treatment was also based on Mother's reports of nosebleeds. He stated grommet removal after 2 years was not unreasonable, but not his usual practice

69. Mr M was asked about Mr Q's view that there was no evidence the ENT operations had been definitely medically necessary. He declined to comment on that view.

70. In oral evidence Mr Q was clear that there was no evidence to suggest hearing aids were indicated, unless GP records bore out the suggestion of recurrent ear infections he questioned the need for grommets in the first place, he questioned the examination of the nose under general anaesthetic and had advised against grommet removal, stating it was not medically necessary. He did not say the treatments were unnecessary, but that there was limited information they were necessary. On balance he believed grommet insertion was probably not indicated. He did not think any ENT professional would ever claim grommets caused any measurable hearing loss. He also said that if Mother had not reported a complex history, including allergies, autism, a need for a play specialist, asthma and suspected absent seizures, he presumed Hospital C would have undertaken the grommet removal.

71. The Court was provided with a statement from a Senior ENT Clinical Nurse, who reviewed the Child a month before the Child's 7th birthday. She reported Mother

had informed her that the child's hearing had deteriorated and there was no recent history of ear infections ear discharge or ear pain. A hearing test showed very mild hearing loss in the right ear and borderline hearing loss in the left ear.

72. Miss L, consultant ENT surgeon, provided a letter dated 29 November 2021 confirming grommets were inserted by her in view of the history of recurrent infections. She also confirmed on examination of the ears there was minimal wax in the ear canal and no glue in the middle ear.

Paediatric evidence

73. Dr S is a consultant community paediatrician based at the Hospital A. The Child was referred to her at the Child Development Clinic aged 3 years and 4 months, seeking assessment of Global Developmental Needs. The Child was seen at age 3 years and 6 months, when Mother was stating she was concerned about the Child's speech and language being delayed, leading to tantrums out of frustration, wetting herself frequently and being slow to recognise danger. The Child was found to be delayed with most of her skills, suggesting a diagnosis of Global Development Delay. Dr S also agreed to undertake an assessment for possible autism spectrum disorder.

74. The assessment of Global Development Delay was confirmed at an appointment just before the Child's 4th birthday. At a further appointment 5 months later, the Child was assessed for autism and found not to have an autism spectrum disorder. Different approaches to behaviour management between the parents, along with the Global Development Delay and significant speech and language delay, were felt to account for the Child's presentation. Mother was noted to express disappointment that the Child was not diagnosed with autism and left before the end of the discussion.

75. Dr S was concerned that the focus following the diagnosis of Global Development Delay should have been on management of that, and not on seeking further diagnoses. She outlined that a detailed and lengthy assessment had been undertaken for autism and she would not have expected Mother to continue to seek that diagnosis.

76. Following a further referral shortly after the Child's 5th birthday, the Child was seen again around 5 years and 2 months of age. Mother was apparently asking if the Child might have Pathological Demand Avoidance Syndrome, which is thought to represent part of the autism spectrum. When advised it was not a diagnosis Dr S could make Mother was recorded as again asking if the Child had autism. She expressed a concern that the Child was not getting the support she needed in school and was asking if the Child should go to a special school. Dr S said Mother also queried if the Child was hypermobile, saying her shoulders would "pop out" when she raised her arms, but Dr S could find no evidence of this on examination.

77. When asked whether Mother was reassured by the assessment of possible hypermobility, Dr S says she thought Mother was satisfied with the examination. She also confirmed Mother did not raise the issue again.

78. Dr S recalled speaking to Mother about why she was seeking a diagnosis of autism and Mother apparently stated she thought more support would be

available, although an exact date was not provided. Dr S said she took Mother through the specialised services available with Global Development Delay, which were the same as for autism. She regarded Mother as anxious the Child received all the support needed.

79. Dr S was next involved shortly before her 7th birthday when Mother contacted the Child Development Service. When they spoke Mother was reported as stating staff at the Child's new school, School B, had raised concerns the Child may have autism or Attention Deficit Hyperactivity Disorder (ADHD). Questionnaires were sent to the school, which reported concerns about attention control, difficulty remaining focussed on a task, hyperactivity and impulsivity. When the Child was 7 years and 3 months old, Dr S was informed Mother had contacted the paediatric secretaries seeking further assessment for autism and ADHD.

80. A review appointment took place 2 months later, when a diagnosis of Attention Deficit Hyperactivity Disorder was made and the Child's Global Developmental Delay diagnosis was updated to Learning Disability. Mother was apparently unhappy this had not been diagnosed earlier. It was explained to her that such a diagnosis could only be made when a child had reached sufficient developmental maturity, so it could not have been made sooner.

81. Mother was reported to have contacted Dr S again exactly 2 months later, claiming the Child was about to be excluded from school due to her ADHD and seeking she be medicated. It was explained to Mother that the initial treatment following a diagnosis was implementation of behaviour strategies and psychoeducation of the parents in the first instance and it had not yet been adequately tried. Dr S spoke to the Child's SENCO, Miss T, the same day and was informed the Child was not at risk of exclusion. This was relayed to Mother.

82. Within 10 days Mother requested a change of paediatrician. Dr S understood this to be because Mother said she did not feel Dr S was listening adequately to her concerns.

83. Over her 4 years of involvement with the Child, Dr S agreed Mother was very concerned about the Child's development and behaviour. She stated she did have some concern about Mother's emotional attachment to the Child and about Mother using dramatic words about the Child in front of her, but she did not have any other concerns about Mother's approach.

84. Dr S confirmed Global Developmental Delay has an increased risk of Autism Spectrum Disorder and ADHD and she felt Mother's questions were reasonable questions to ask. She also felt it was reasonable to ask about medication for the ADHD. She said she was more concerned when Mother requested a change in paediatrician when she told Mother medication was not indicated

85. Dr Rahman is the expert paediatrician instructed in the case, who subsequently questioned the diagnosis of ADHD. Dr S was asked about this. She was clear it had been robustly made and there was no indication the diagnosis needed to be reviewed.

86. Dr Sl provided a witness statement, dated 23 November 2021, and attended court to give evidence. He worked as a locum consultant paediatrician with special interest in allergy at Hospital A from September 2019 to December 2020.

87. Dr Sl first met the Child and Mother at an allergy outpatient clinic in December 2019. Mother apparently reported allergies to tomato, spontaneous urticaria (rash), hayfever and a reaction to paracetamol, adhesive plaster and micropore. She was also stating an adverse reaction to medication prescribed for the rash, and Dr Sl changed the prescription to Fexofenadine. Allergy testing was undertaken, all of which was negative. Mother was reported to question whether the Child needed an epipen. Dr Sl informed Mother it was not indicated.

88. 2 days after the oramorph incident Mother contacted Dr Sl's secretary, reporting a severe allergic reaction 2 days prior and seeking a prescription for epipen. Mother was reporting the Child had been given Oramorph (morphine), Ibuprofen and Cough Syrup altogether and had developed swelling of the face with redness, as well as difficulty breathing. An ambulance was apparently called and Mother stated the Child was taken to Accident and Emergency.

89. Based on the history provided by Mother, Dr Sl believed the reactions were suggestive of severe reaction (anaphylaxis). He prescribed 2 epipens for the Child, wrote out an allergy action plan and arranged for Mother to attend for epipen training. Mother was advised she would be contacted with confirmation when the training would take place and that she was only to use the epipen for severe allergic reaction (anaphylaxis) and to give Fexofenadine if the reaction is not severe.

90. In oral evidence Dr Sl was asked about the ambulance records for oramorph attendance, which reported no breathing issues and a normal temperature for the Child. Dr Sl stated the information given by Mother to him was different and did not accord with the ambulance records. While it was possible to have an allergic reaction without breathing problems, he said most of the time there would be a breathing problem. He also stated that with a history as presented in the ambulance record an epipen would not be indicated.

91. Dr T is a consultant paediatrician and the named doctor for safeguarding at the Trust he works for. He was involved in discussions about the Child as the named doctor for safeguarding. He attended a strategy discussion which was also attended by Miss T and Miss N from School B. He provided a witness statement dated 23 November 2021, at which time he had not yet met the Child. The witness statement was based on discussions with colleagues and going through the Child's medical notes.

92. In oral evidence, Dr T confirmed the Child had been referred to him by Dr S. He had met her once, at a video consultation on 18 December 2021. The consultation had technical difficulties and was part-conducted by telephone. He had not seen the report of Dr Rahman by the time he gave oral evidence to the court.

93. He accepted Mother had only sought ADHD medication for the Child on one occasion, roughly a month after the oramorph incident. He had made reference to daytime incontinence not having been observed at school and confirmed this

had been stated by the school, but could not remember the name of the person who said it. He was concerned, based on his understanding of the case, that Mother's continued quest of seeking medical diagnosis and treatment is putting the Child at the risk of iatrogenic harm (i.e. over investigation and overtreatment).

94. Dr T was asked if he was able to say, from the medical notes, how many epipens had been given to Mother and he could not. He was only able to say that for spontaneous urticaria she was given too many. He also accepted there may have been occasions when Mother was given an epipen and it would not have been recorded in the medical notes.

95. Dr C is a consultant paediatrician at Hospital B. He provided a witness statement dated 16 November 2021 and attended to give oral evidence. He confirmed he had met Mother and the Child 8 days after the oramorph incident in the specialised drug and allergy testing unit. A clinical history relating to the Child had been taken previously, which also reported some blistering around the lips by the Child having taken penicillin, and he said he had checked this with Mother. He said Mother was reporting the school was concerned the Child's stools were quite loose and Mother was blaming this on the prescription of Cetirizine as an antihistamine. He confirmed Mother was the source of the information stating the school was concerned and he had not seen any other information from any other source than Mother confirming this. He said it was unlikely this had been caused by the Cetirizine and that it was not a sign of an allergy.

96. An allergy to ibuprofen was ruled out. He also confirmed that skin tests had previously been administered to rule out allergies to various foods.

97. He reported discussing use of the Epipen with Mother. He said Mother had told him she had administered this on 5 or 6 times, and on each occasion it was administered for only mild symptoms. He had not included this in his notes of the appointment, but said he clearly remembered this because it was quite an unusual conversation which had stuck in his mind. He said that in the discussion there were no life-threatening features such as wheezing or difficulty breathing and he had counselled Mother that it was not an appropriate use of the epipen. He believed they had come to an understanding, in his mind, that moving forward the epipen would only be used for significant life-threatening situations.

98. He wrote to Dr Sl promptly following the appointment. His letter included the fact he had been told by Mother that she had administered the epipen on 5 or 6 occasions for only mild symptoms.

99. Dr C stated there should be no reason to use morphine except in the context of post-op recovery.

Expert paediatric evidence

100. Dr Rahman's report is dated 9 August 2021. In preparing the report he conducted an in-person assessment of the Child.

101. The report states a history from the maternal grandparents (who were not called to give evidence) of (a) the Child wetting herself during the day, but being dry at night; and (b) being taken to school in a pram because "she runs off".

There was also a report that "academics have improved significantly now". Examination was normal, with no evidence of hypermobility.

102. He regarded the Child as being in good health and not showing any signs of intolerances or allergies since placed outside of Mother's care. He identified only 2 follow-up appointments having taken place since that time and noted reports of improved behaviour at home and school.

103. Dr Rahman had considered the 43 pages of chronology detailing the contacts with medical professionals. While he accepted many of the contacts may have been necessary and relevant, he stated there was no doubt in his mind that the Child's symptoms were exaggerated by Mother and gave the following examples:
    103.1. Excessive use of Epipen for minimal symptoms especially when clear instructions were provided by health professionals about not using it for minor symptoms.
    103.2. The incident where the child is said to have become "unconscious" and Epipen was administered despite having recovered from a rash with antihistamine
    103.3. Insisting on specific brands of medication quoting allergy to the same drug but from a different company
    103.4. Coming up with a long list of "allergies" despite the fact that the child is able to tolerate these foods
    103.5. Not accepting reassurances from medical professionals and requesting further referrals (allergies, ADHD, Autism etc.)
    103.6. Reporting symptoms that are very unlikely to have been present in a normal child (hypermobility, shoulder "popping out on a daily basis")
    103.7. Using a "buggy" to transport a child of this age quoting behavioural problems
    103.8. Misleading health professionals (about to be permanently excluded from school.)
    103.9. Requesting hearing aids for a child with normal hearing

104. Dr Rahman made specific reference to the RCPCH guidance on FII and felt the following was also relevant:
    104.1. Parents' insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child
    104.2. Parents' insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs
    104.3. Repeated reporting of new symptoms
    104.4. Repeated presentations to and attendance at medical settings including Emergency Departments
    104.5. Inappropriately seeking multiple medical opinions
    104.6. Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments
    104.7. Frequent vexatious complaints about professionals
    104.8. Factual discrepancies in statements that the parent makes to professionals or others about their child's illness
    104.9. Parents pressing for irreversible or drastic treatment options where the clinical need for this is in doubt or based solely on parental reporting

105. On the question of anaphylaxis, Dr Rahman confirmed a person who is having an allergic reaction should use their EpiPen immediately if they experience ANY of the following serious symptoms of anaphylaxis following contact with their allergen:
    105.1. Feeling light-headed or faint
    105.2. Breathing difficulties, such as fast, shallow breathing
    105.3. Wheezing
    105.4. A fast heartbeat
    105.5. Clammy skin
    105.6. Confusion and anxiety
    105.7. Collapsing or losing consciousness
    105.8. Other allergy symptoms may include an itchy, raised rash (hives), feeling or
    105.9. being sick, swelling (angioedema) or stomach pain

106. Given the Child was being reported as consuming all of the foods she was supposed to be allergic to, he believed it highly unlikely the Child has a food intolerance or allergy. He also referred to the fact allergy testing did not support a diagnosis of allergies, but Mother continued to quote this to the school.

107. He identified 3 potential forms of harm to the Child, namely the Child's health and experience of healthcare, effects on the Child's development and daily life and the Child's psychological and health related wellbeing. Dr Rahman also thought it very likely she had suffered physical harm, due to inappropriate injections, and emotional harm, as she had to "play" the role of a child with problems to support Mother while knowing it was incorrect. He also felt it likely that emotional trauma may have caused the behaviours at school which led to the diagnosis of ADHD.

108. In oral evidence he confirmed spontaneous urticaria was referred to as hives or red blotches to the skin. It was a common condition where the frequency of symptoms was very difficult to predict. He described urticaria as a mild form of allergy with no relationship to anaphylaxis itself. A lot of how it is dealt with is based on the history given by the parents. When asked about the fact there had been no further episodes he stated it may have only been a mild condition or the symptoms may have resolved.

109. The 111 recording on the date the Epipen was first used was discussed. Mother is heard to state the Child had had anaphylaxis before. Dr Rahman was of the view it did not sound as though the Child was suffering anaphylaxis on that date. When asked about the call handler advising to administer the Epipen he identified the call handler hearing the Child had anaphylaxis before and having to build in safety in what they were advising.

110. Dr Rahman was specifically asked about events on the second occasion the Epipen was administered. He regarded the likelihood of anaphylaxis on that day as remote to non-existent, because it is a very quick reaction. He spoke about anaphylaxis starting within seconds, involving multiple systems of the body. He had also considered the ambulance records from the date of the oramorph incident and felt they did not suggest anaphylaxis at all.

111. On Mother's behalf, it was put to Dr Rahman that he should be looking at the detail of the referrals and appointments, but he believed the important thing to look at is the overall impression you get from the whole case. Everything has to be considered to reach a conclusion, and that is what he had done.

112. A month after the Epipen was used a second time, two representatives of the Local Authority attended at Mother's address to collect the Epipens remaining in her custody. The Court had a statement stating they took possession of 4 Epipens. Mother and the Intervenor both say there were 6.

Parents/intervenor evidence

113. Father only gave evidence by witness statement, he was not called to give live evidence. His witness evidence confirmed he had never seen the Child have an allergic reaction such as Mother had described. Father is in a new relationship, which includes another child. He stated when the child was with him she would eat the same diet as his family without any concerns. He also discussed the Child wetting herself when engaged in watching Disney programmes, but did not regard her wetting herself as a problem.

114. Mother gave evidence over the course of 2 days. In her written evidence she stated the developmental delay and special needs had been identified by the Child's previous school and not just reported by her. She accepted that by 21 February 2018 she was frustrated because she felt as though she was being dismissed. Her evidence was she "lost faith in Dr S as she was the person who decided [the Child] had no problems whatsoever despite school concerns, behaviour plan, developmental delay, special needs etc…". She maintained she was told that the Child was about to be permanently excluded from school around November 2020. She relied on the advice from 111 when first administering the Epipen. She believed professionals may have misinterpreted what she had said or that she may not have really understood what had been said to her. She also said any comments by the Child following the incident where the Epipen was used the second time may have been the child confusing the use with the first time it was used.

115. Mother stated in the witness box that she understood spontaneous urticaria to be your body believing it has allergies and reacting as though it does, but it does not. She talked about looking on the internet on Google and experimenting with food at home to work out what triggered it. This was not in her witness statements and had not been put to Dr Rahman or any of the treating medics.

116. Mother accepted giving the Child cough syrup, nurofen and then oramorph on the date of the oramorph incident. She stated the paramedics who attended had told her it was the start of anaphylaxis shock, and that is why she passed that information on in the 111 call during the conversation when she was told to administer the Epipen.

117. Mother accepted she told the 111 call handler the Child had sleep apnoea. She accepted there had been no diagnosis of this. She also accepted the Child had never been diagnosed with asthma.

118. On the second occasion the Epipen was used Mother stated she was in the back of the car with the Child, and the Intervenor was driving, as they went to

Hospital B. She said the child had dropped Mother's phone, had looked like she was asleep and Mother was unable to get a response. She therefore administered the Epipen to the Child, in her upper leg.

119. Mother was asked about losing faith in Hospital A, and told the Court about problems with a diagnosis of an aneurysm suffered by her father. She also spoke about losing faith because the Child had to stay in overnight following cauterisation because of a reaction to micropore/Elastoplast tape.

120. In cross-examination, Mother accepted the Child had never had any diagnosed allergies and had never been diagnosed with autism. She pointed out that the Child was not seen as having features of ADHD prior to diagnosis either. While Mother accepted the Child had not been diagnosed with autism, she did not appear to accept the Child did not have autism even now, stating the description of autism is how Mother says the child presents. She accepted the witnesses from the schools had stated they did not think the Child had autism, but she maintained it was what had been communicated to her. She also claimed for the first time in the witness box that she had said autistic traits and not autism. Later she said the reason why her comments that the child had autism was not right was because she did not have the official diagnosis

121. Mother stated the Child had an allergy bracelet from when she had been in hospital and accepted the information on that bracelet had come from Mother. She also stated that whilst there was no diagnosis of an allergy to paracetamol, she had been told by hospital staff that there was an allergy to paracetamol, it had just not been written down.

122. Having questioned the transcript and being asked to listen to the recording, she accepted telling the 111 call handler on the day of the oramorph incident that the Child had allergies to cetirizine, loratadine, paracetamol, piriton, plasters, all forms of adhesives, nuts and penicillin, as well as there being consideration whether the Child may be allergic to morphine. Mother explained that while the Child was not allergic to any of those things she presents with having reactions after these things and, while Mother may say she is allergic to those things, realistically it is intolerances. When challenged that the Child had been tested and found not to have an allergy to piriton and plasters, Mother's response was to question whether the advocate understood spontaneous urticaria. She was asked about never having clarified she was talking about reactions, not allergies, and never stating it in any of her written evidence. Mother said it was because no-one had asked and her oral evidence was her opportunity to say.

123. Mother had not spoken about the spontaneous urticaria in the subsequent call to 999. She said this was because she had taken them as allergic reactions because the body reacts as though it had. She accepted she had not said that and felt she did not need to explain because they should know. She accepted she had said allergies and that she had told the ambulance crew the Child was allergic to multiple medications. She accepted on that date she had not been waiting for an Epipen, but said it was an ongoing discussion and while the allergy specialist had said it was not indicated that because of the reaction that day there was going to be a further discussion about it. She did not accept it was not a life threatening incident because the Child had swelling to her face, but accepted it was not life-threatening at the time and that it had not been an

anaphylactic episode. She accepted the ambulance crew had not given the Child adrenaline. She also accepted that whilst she had told the paediatrician 2 days later there was swelling to the neck and difficulty breathing, there was no swelling to the neck and the ambulance crew had not noted any difficulty in breathing. When asked about stating it was a severe allergic reaction with difficulty breathing she questioned what other explanation there could be for the reaction the Child had, with swelling of the eyes and upper lip and blotchiness.

124. Mother was asked about a call to her GP the following day when it was recorded she had stated there had been swelling of the face, neck, lips and tongue and the Child had been given adrenaline in A&E. Mother denied recalling saying that. She was asked about stating she was going to be prescribed an Epipen and alleged she had spoken to the paediatrician, who she is recorded as speaking to 2 days later, before this. Mother did not recall the 111 call the same day, but accepted the Child had not been given adrenaline and claimed it was a description, not a statement, because they gave the Child antihistamine in a different form, like an adrenaline injection. She accepted it looked like she had lied to the call handler, but disputed the accuracy of the transcript. She also accepted she had said the Child was working at the level of an 18 month old when the paediatrician had stated the Child was 18 months behind. Her view was that the Child acted immature for her age and in Mother's eyes the Child was quite toddler like.

125. On the second occasion the Epipen was used the Child had been reported by the school as having blotches to the face, marks to the chest and itchy legs. By the time the Child arrived at hospital the Mother was reporting swelling and a rash all over the Child's body having had tomatoes that the Child is allergic to. Mother accepted that swelling was not correct. She said in discussion about previous reactions she had said the Child can present with swelling, which had been abbreviated in the notes. On that day the school had raised concerns around 2pm and the Child had been collected around 2:30pm. The Child had been presented at Hospital B at 3:48 pm, with Mother estimating the journey had taken an hour, or an hour and 5 minutes. The hospital notes recorded the Epipen as reportedly administered at 2:25pm. Mother stated all times were estimated and she had been too far through the journey to go to Hospital A, the one she had lost faith in.

126. The hospital record for that date stated no history of fainting or collapse. Mother was clear the Child was unconscious and she had told the hospital this, but also accepted the Child was breathing normally as though she was asleep. She said she administered the Epipen for no other reason than the Child was unconscious. She also confirmed the Child had nothing further to eat or drink in the car after leaving the school.

127. Mother agreed that without recurrent ear infections there was no need for the Child to have grommets. The Child had been seen 10 times at ENT. On only one occasion was there evidence of glue ear with mild hearing loss in one ear. Mother maintained the GP had recurrently seen the Child when the Child had an ear infection and had prescribed antibiotics, but accepted there was no record of this. There was a record, when the Child was 7 years and 5 months, of a telephone consultation where the plan appeared to be for antibiotics, but the child had not been seen. She did not accept the GP had never said the Child was

on the verge of a perforated eardrum, although there was no record of this either.

128. Mother was also asked about stating the Child may need hearing aids. She said she had been told this by an audiogram person at one of the hospitals, but could not say who. Again, this was not covered in her witness statements.

129. At the telephone pre-operative assessment for removal of the grommets, when the Child was 7 years 2 months old, Mother accepted she stated the Child had autism and borderline asthma, with allergies to plaster and paracetamol. She had also stated the Child had suspected absence seizures and Mother explained it had been brought to her attention that the Child had been daydreaming in class. Mother accepted that if you took away all the things that were not accurate the Child had Global Developmental Delay and spontaneous urticaria. The treatment was apparently delayed due to the concerns at the complex medical history Mother had presented, although Mother did not accept this either.

130. Mother was asked about whether she believed the Child's speech and language delay was related to hearing issues. She was evasive in her answers, but then said that generally speech was to do with hearing, that she was entitled to her opinion and that she believed the speech and language issues were down to her hearing.

131. Mother accepted that she did not have a penicillin allergy and had never been prescribed an Epipen. She said her comments about this had been referring to her mother only. However, she then also accepted her mother had never been prescribed an Epipen and stated it was her grandmother. She also stated her father had been prescribed an Epipen. This is consistent with a record elsewhere.

132. Mother accepted the Child was not allergic to chocolate, despite the school stating the Child believed she was. She could not explain why the Child thought this. However, the Mother also later stated the Child had a normal diet in her care and she had only suggested the school avoid certain foods by saying allergy.

133. Mother stated she had not understood that oramorph was liquid morphine. She said the Child had been prescribed this for pain relief in hospital. The Intervenor had a bottle of this and Mother had administered a dose to the Child, stating she thought it was no more than paracetamol. She accepted stating she had been sent home with morphine and that had not been true. Her focus was on making sure her daughter got what she needs. When asked if she gave oramorph knowing it was wrong to do so because it had not been prescribed to the Child or gave an unknown medicine to the Child she opted for unknown medication, but then argued it was not completely unknown because it stated on the bottle what it was. When asked about the Intervenor using oramorph she said she had not asked why as she did not feel the need because the doctor had prescribed it. She was asked about the 111 call on the day of the oramorph incident where Mother stated "she's had er 2 mils of Oramorph like morphine" and said that was what she was told it was, stating her neighbour had told her this by the time of the call. It was put to her the neighbour had not been there on that date, but she maintained he was, despite this not being stated in the neighbour's statement to the police or elsewhere in her own evidence.

134. Mother was taken through the medical records and asked about the number of Epipens issued. She accepted they showed 14. She disputed only giving 4 to the social worker, saying there were 6. Having gone through the number known to have been issued she accepted, even on her own account, there were 4 unaccounted for. She disputed saying she had used an Epipen on more occasions. She also stated she asked for them on repeat because when the Child went to Father's 95% of the time none of it came back, but then accepted she had not stated Father had been given more than 1. Mother also disputed saying she had used the Epipen 5 times at 2 months and 3 days from the oramorph incident, or that she had used it 5 or 6 times at 2 months 20 days from the oramorph incident.

135. Mother was asked about nosebleeds. Father's evidence was that these had not occurred when the Child was in his care. There was evidence from the schools of nosebleeds, but not to a level that they were concerned. The information from the Local Authority was that these had not been noted while the Child had been looked after by the maternal grandparents either, but Mother stated it had and they had just not reported it. Again, there was no evidence to support this. Mother said the nosebleeds had happened millions of times and it had been recurring.

136. A letter from Hospital B when the Child was around 7 years 9 months old stated the Child "frequently traumatises the nasal mucosa with her finger…". Mother was asked about the Child putting her finger up her nose and maintained there were times the Child had a nosebleed without putting her finger up her nose, but accepted there were times when she had caused the nosebleeds.

137. Investigations took place regarding Mother's concerns about the Child's incontinence. An ultrasound of the kidneys was normal. A urology clinic was arranged, but before this could take place, and 2 months after the Child had been removed from Mother's care, Mother had cancelled the appointment stating that, following omission of blackcurrant from the Child's oral fluid intake, the symptoms had resolved. Mother did not accept it had stopped, and said it had only reduced. She accepted she had been advised to avoid blackcurrant around the Child's 7th birthday, a year earlier. The ultrasound took place 7 months later.

138. The Child had been prescribed fexofenadine as an antihistamine because Mother claimed she had a reaction to others. She was unable to explain why she had not used this on the day she first administered the Epipen. Mother had stopped administering the fexofenadine at some stage and claimed this was on the basis of advice from the Allergy Clinic which had not been recorded. She claimed this was because it made the Child aggressive. It was put to her there was no record or any medic or hospital staff noting this caused the Child to become aggressive. She explained that it was the only thing different and that she had started to notice a pattern on days the Child did not take it. While it was administered by School B on the second occasion Mother accepts administering the Epipen, the school had not noted any aggressive reaction. Mother explained the reaction was not instant.

139. Mother disputed a lack of engagement with PALMS and set out a number of courses she said she had been on. None of them were detailed in her witness statements and there was no documentation in support.

140. Mother stated the school had supported her request for medication for ADHD, although there was nothing from the school to support this and what evidence there was stated the Child had not been at risk of permanent exclusion. She put any miscommunication down to the school's inability to communicate. She also stated there was a mis-communication with the paediatrician which had led to her seeking a change.

141. The Child's eyesight was assessed 3 times while in Mother's care. Each time no problems were found.

142. Mother, and the Intervenor, took the Child to hospital with a buggy during the Covid-19 pandemic. This was explained as to prevent the Child from running off, touching surfaces and catching Covid. Father had not agreed with any need for this, saying the Child did not run off in his care. Mother said there was limited communication between them because they were both highly opinionated.

143. Near the end of Mother's evidence she was asked whether, looking back, she may have made the Child's condition seem more serious than it was to make sure she was taken seriously and because she wanted the best for the Child. She was clear she had not. She had not exaggerated matters, and in her own mind the Child's problems were not just Global Developmental Delay and ADHD. While her concern was the Child, she had not considered the impact on the Child of being taken to hospital 3 times in the space of 5 weeks.

144. A number of breaks took place during the course of Mother's evidence. Every time Mother was told not to discuss her evidence with anyone, to the extent it became a running joke because she said she understood. It was somewhat surprising when she then told the Court, during her evidence, that she had spoken to her solicitor about her evidence during the lunch break. When it was put to her that she had been told not to discuss her evidence she explained she had not discussed specifics and had been saying what questions were being asked.

145. The Intervenor suffered a head injury when aged 14. The cognitive assessment of her found her to be on the borderline for full scale IQ (4th percentile), verbal comprehension (5th percentile) and perceptual reasoning (7th percentile). Her verbal memory is poor and she has a reading age of 6 years.

146. Her relationship with Mother began in around October/November 2016. On Boxing Day 2016 Mother and the Child turned up on the Intervenor's doorstep and moved in, due to arguments Mother was having with her own mother.

147. Before they moved in, the Intervenor stated Mother had told her the Child was being investigated for autism and ADHD. While living with the Child the Intervenor's only concern about the Child's health was the rashes. She described these as blotches or red marks which would always be noted on the face first but could go all over the body. She said they could not work out which food was making it happen and so Mother had taken the child to the doctor to be tested for allergies. She had not understood the difference between an allergy and a reaction. Having seen the child's medical records she accepted they presented a picture of an ill child.

148. She described the Child having "accidents" with toileting and the school sometimes sending the Child home with wet clothes. The Intervenor accepted calling 111 about this on one occasion.

149. The Intervenor was not sure why Mother told the school the Child had an allergy to chocolate. At Christmas when the Child was aged 6 she said the Child had shown a reaction to chocolate from an advent calendar, but this was put down to cheap chocolate and she had continued to have chocolate since then. She accepted the Child would have tomatoes in food, but said 9 times out of 10 she would come up in a rash.

150. On the issue of ear infections, the Intervenor stated the Child did have an ear infection once and had glue ear before, but they were both treated. She also said she had seen the Child have nosebleeds on 2 occasions.

151. While the Intervenor may have attended medical appointments, she said she did so to support and distract the Child. She stated she did not pay attention to the discussions and would not have understood what was being discussed. Any decisions about treatment of the Child, including Epipens, was made by Mother.

152. Both Mother and the Intervenor agreed that Mother had not told the Intervenor she was giving the Child the Intervenor's oramorph. The Intervenor was asked what she would have said if told the Child was to be given it and she said she would question it because it was hers and it could be dangerous for anybody else.

153. The Intervenor had believed the Child may be autistic early on because the Child would line cars up in colours and size. However, she said she did not believe the Child was autistic because the Child no longer does the same thing she did. When asked about sleep apnoea she said the Child would snore a lot. When the snoring stopped she would panic and check the Child was still breathing.

154. The Intervenor was present the first time an Epipen was administered to the Child. She had lain down on the floor with the Child to comfort her and said the Child was crying and screaming. She said the Child was already distressed, but screamed and burst out in tears even more when the Epipen was produced. She was unable to say why the Child was so scared of the Epipen as it was the first time it was used. She stated she was shocked that Mother may have stated the Child had an anaphylactic shock the previous month, but did not hear her say this at the time. She also accepted she was present at the oramorph incident when Mother gave the Child a oramorph orally with a syringe, but said she did not know what it was.

155. On the second occasion Mother said the Epipen was used the Intervenor was driving the car. On the way to Hospital B she said Mother said something like "I think she is unconscious". She did not see the Epipen being used, but confirmed Mother had told her it had.

156. The Intervenor had not questioned the number of medical appointments the Child was attending at any stage. She took a simple approach that if that was what the medical professionals were proposing she would accept it.

157. Mother's neighbour was present on the first occasion Mother accepts she administered an Epipen to the Child. He gave a statement to the police in which he stated that as soon as Mother approached the Child with the Epipen she went from calm to being extremely frightened, screaming and crying. He asked Mother about this later. Mother stated the Child had never been given the Epipen before, but he said he found this hard to believe because she was so terrified of it. Mother stated he had withdrawn that statement, but he was not called to give evidence and there was nothing to state the statement had been withdrawn.

158. There is a photo of the child on the evening of the oramorph incident, sent to the neighbour 16 minutes before Mother called 111. The Child is wearing a t-shirt and has long hair in plaits with a long fringe over the forehead and framing the eyes. The Child can be seen to be red in the face, with white outlines to this around the mouth. It is consistent with a rash/blotchiness to the face. It does not extend to the neck. Only a small part of the arms can be seen, but there does not appear to be a rash on the arms.

159. The Child has an Educational Health Care Plan at her current school. There is a suggestion behaviour has improved since leaving Mother's care. However, there have continued to be Level 3 exclusions and the Child has moved between family carers with issues about behaviour.

ANALYSIS

160. This case turns on whether Mother was an anxious parent seeking to obtain the best medical treatment for her child and appropriate support in that child's education, or a parent who was deliberately making things up.

161. Parents are not passive recipients of information. They provide data (a collection of facts) to treating medics and seek feedback. They listen to the information and advice (placing those facts in context) that they are told in return. They may ask questions and/or provide more data. They may receive more information and advice as a result. They then make decisions based on that information and advice. They may also pass that information on to other people, as well as informing them of their decisions. It all forms part of the big picture which the court must assess.

162. It is a well established fact that our memory can play tricks on us. This is also influenced by what is known as confirmation bias. Once we have made a decision on something we will tend to look for or interpret information through the prism of our understanding, focussing on information we perceive as supporting our view and relying on it to show we are/were right without properly engaging with the evidence that may weaken it. We will also tend to describe events with a focus on either matters which we think are important or support our view.

163. As part of the assessment of this case it is necessary for the court to consider the level of knowledge and understanding a relevant person may have. A simple starting point is to consider the level of academic achievement reached by that person, as well as their subsequent career progression. Whilst not an absolute, it

can be a good indication of the person's ability to understand information being given to them, to pass it on and/or to accurately report events that have occurred. In this case the court has a cognitive report on the Intervenor. However, the Mother fails to provide any information about the level of schooling she achieved, any qualifications received or her subsequent career.

164. The court works in bounded rationality. It provides the best decision it can, based upon the data and information provided, in the time available. These are child protection proceedings where the decisions made by the court can be some of the most serious made.

165. The Local Authority pursues these proceedings based on the data and information provided to them. The court then makes decisions based on the data and information received at the hearing. The court is not asked to determine why Mother may have taken the actions she did. The court is asked to decide what happened, the facts.

166. Mother provided 5 statements and responded to the Local Authority's Schedule of Allegations on 3 occasions. She rejected 2 further opportunities to set out her case during the fact-finding hearing. It is wrong for the court and other parties to have to proceed with the hearing in circumstances where a party attends putting forward an explanation which has never been raised before. It is also wrong to discuss your evidence with your solicitor while in the middle of giving that evidence. Here, Mother did both. This affects the weight the court can give to what she says. It also undermines the questions that can be put to the witnesses by other parties and the court. The court has an inquisitorial role with a duty to prioritise the welfare and safety of the Child.

167. Where a treating medic makes a decision it is difficult for another medic to second guess that decision. However, Mr Q identified how reliant medical professionals are on the information provided by parents/carers, as did Dr Rahman.

168. Mother never set out or produced any evidence of the online searches she said she undertook. She did not call any supporting witnesses, such as her neighbour or her parents, to back up what she said. Dr Rahman was never asked if spontaneous urticaria could cause reactions similar to allergies.

169. An Epipen is also described elsewhere in these proceedings as a Jext pen or an adrenaline pen. It is for use in an emergency.

170. It should be noted that on some occasions Mother challenged advice to administer the Epipen and make clear, for example, the Child was not having difficulty breathing. However, this has to be balanced against the numerous instances of Mother allegedly stating, and on occasions accepting stating, the Child had conditions which the Mother now accepts the Child did not have.

171. The chronology of the Child's medical history ran to 43 pages. The medical bundle was some 1,425 pages. While the diagnoses of ADHD, Global Developmental Delay/Learning Disability and spontaneous urticaria are accepted, Dr Rahman was clear that did not explain the extensive medical history. He said

he would expect this with a child with a serious medical condition, such as cerebral palsy.

172. While in the care or Mother and the Intervenor, the Child was under the care of the following departments:
    a. Ear, Nose and Throat (ENT).
    b. Enuresis Clinic.
    c. Child Developmental Clinic.
    d. Urology.
    e. Allergies Clinic.
    f. Ophthalmology.

173. It is the case of the Local authority that, save for the Child Development Clinic, all of the above was unnecessary.

174. The description of the Child's symptoms given to the treating medic who diagnosed spontaneous urticaria was '*red blotchy rash on her face and mild swelling on the lower area of her face*' '*She did not have any cough or difficulty in breathing. There was no other swelling of different parts of the body*'.

175. The advice to the court is that spontaneous urticaria has no known trigger. With this child the evidence is it manifests itself in itchy red blotches.

176. There is a discrepancy between the Child's description of being held down by the Intervenor on the second occasion an Epipen was administered and the fact the Intervenor was driving the car. However, that would be explained if the Child had been given an Epipen injection on more than 2 occasions, and there is the failure by Mother to account for all the Epipens we know she received. At the same time a consequence of the child's Developmental Delay is that memories and events often get very mixed up for the Child.

177. Parents choose which facts they think are relevant to pass on to a treating medic. This may be a conscious decision about what they think is relevant/important, or it may be based on them having an incomplete memory of what occurred. The medic may ask questions to obtain additional data or to test the data they have received. Treating medics have to filter that data to try to provide an accurate diagnosis and advise. They will then seek to explain that diagnosis and advice, but may use jargon or words with specific medical meanings which may be lost to a person who is not medically trained.

178. Mother challenges the accuracy of records. While the court may be prepared to accept there could be some errors, these were numerous and the matters which Mother said were indicated wrongly go to the heart of the treatment decisions, such as whether the Child lost consciousness. They are matters on which the treating medics would have rightly focussed and need to make sure were correct.

179. The challenge to the records included challenging the accuracy of transcripts. Mother was asked to listen to the recordings. When she listened to the recordings she then accepted the transcripts were correct. There is no reason to believe her recollection of other discussions is any more reliable.

180. The court must be careful in its approach to the evidence of the treating consultants in this case. A number of those consultants have been conscious of the reason the Local Authority have been raising issues with them. Some of the consultants have also discussed this matter amongst themselves. There is a risk of 'group think' or confirmation bias in their evidence and/or that some of their expressed opinions are echo chambers of each other. That being said, the evidence of the treating medics and Dr Rahman was clear and reliable.

181. Mother was inconsistent about her understanding of what oramorph is. However, a clear starting point is the approach of the Intervenor who thought the Child should not be given another person's medicine. The Intervenor's evidence stood in stark contrast to that of Mother.

182. Mother's case is not, having had matters explained more fully to her, that she accepts she may have misunderstood anything. In evidence Mother came across as frustrated that people would question her assessment of the Child.

183. There are aspects of Mother's evidence which are clearly wrong, such as her timings on the second occasion the Epipen was administered and her reference to nosebleeds happening millions of times. It is important attempts to give estimated information and use of expressions are considered in context and are not confused for inaccurate information.

184. Mother states that she is highly opinionated. She appeared to consider the questioning and the whole court process as persecutory and wholly unjustified. There was no acceptance whatsoever that her behaviour may have contributed to, let alone caused, excessive or unwarranted medical attention and treatment which the Child has been subjected to for much of her life. It appeared that once she had made up her mind she would not swerve from it and ignored anything to the contrary. Her almost consistent explanation for the fact records did not back up what she said was that the records were wrong. On the other occasions she accepted the information she had given was not correct.

185. There is no clear account of the Child ever suffering an anaphylactic episode, and yet she has had an Epipen administered at least twice. Epipens were prescribed based on Mother stating the Child had suffered an anaphylactic shock. The original occasion it is accepted an Epipen was administered was based on advice from a 111 call handler after Mother had given inaccurate information to the 111 call handler that the child had suffered a previous anaphylactic shock.

186. It is unhelpful that the Local Authority did not ask Mother to sign to confirm how many Epipens were handed to them. They then disposed of them, meaning it is not possible to resolve the dispute of how many were returned. It is also somewhat surprising that there would not, always, be a formal record of how many Epipens had been prescribed.

187. The Mother is recorded as telling multiple professionals on several occasions that she had administered an Epipen on more than 2 occasions and there are a number of Epipens unaccounted for. There is also the clear description from the neighbour of the Child's reaction on the first occasion Mother and the Intervenor state an Epipen was administered.

188. The Child was the subject of a pre-Achieving Best Evidence interview assessment. She was unable to be clear about how many times the Epipen had been used. The best that can be obtained from that discussion is she was definitely injected on 2 occasions.

189. The Intervenor's level of understanding must be considered in the context of the cognitive assessment of her and the fact she is functionally illiterate. She was unable to read any letters received and was reliant on the information Mother gave her. She is unsophisticated. She struggled to recall events or dates, but came across as providing the best information she could. This was despite the fact her evidence questioned Mother's actions and information.

190. The Intervenor does not have parental responsibility for the Child. The school accepted she had limited involvement with the Child. This is not to minimise the relationship and affection which clearly co-existed between the Child and her, but supported the fact Mother was the primary carer and made the decisions.

THE FINDINGS ON THE EVIDENCE

191. Before turning to the findings sought, the court wishes to set out the impressions the court has reached in respect of the evidence.

192. Mother's description that she is highly opinionated is accurate. It came as no real surprise to the court when it was informed Mother had been looking matters up on the internet. Asking if the Child had Pathological Demand Avoidance Syndrome had to come from somewhere.

193. Mother was dealing with being the primary carer of a child with global developmental delay, spontaneous urticaria and ADHD. Having come to her own conclusions about what problems the Child had she then pursued a diagnosis matching her view. When told such a diagnosis was not medically supported, she did not accept that and continued to pursue the diagnosis. This was apparent in relation to her assertion of medical issues relating to the Child's sight, nosebleeds, hearing and allergies. Her focus was on making sure her daughter got what she believed her daughter needs.

194. No substantive medical evidence was found for any issues with the Child's sight, nosebleeds, hearing and allergies. However, the treating medics must take account of the history being presented to them. In isolation, each of the occasions treatment was given is understandable based on the information provided at the time. However, when looked at as a whole a pattern emerges of inaccurate information being provided. This is most starkly demonstrated following the oramorph incident, when Mother obtained an Epipen prescription based on a false assertion that the Child had previously suffered anaphylactic shock.

195. Mother was an unimpressive witness. The failure to set out her case properly did not help. However, while giving evidence Mother clearly came across as feeling everything she had done was justified to obtain the best medical treatment for the Child. When she accepted instances of inaccurate information being provided by her it was because she had no choice based on the evidence. Any acceptance was clearly reluctant at best and often came after the same question had been asked a number of times, with her trying to avoid the obvious

answer, and she then sought to justify it or explain it was true in her eyes. She had clearly failed to consider the impact on the Child of everything the Child had been put through.

196. Mother attributed supporting evidence to the schools and GP which was not there, and was directly contradicted by the records and the witnesses from the schools. She argued the transcripts were not accurate, but then had to accept they were. Those transcripts clearly showed Mother giving inaccurate information. Added to that is the fact Mother also sought to claim a level of knowledge and experience she did not have to add additional weight to her own reports.

197. Mother ringing the solicitor to discuss her case during her evidence is a clear example to the court of her not listening properly to information given. Why she was unable to understand and apply that understanding is a matter for a later stage.

198. It is for the Local Authority to prove its case, not for Mother to disprove it. Mother states there is no evidence sufficient for the court to make the findings sought. The court does not accept that submission. While each allegation must be looked at and the court determine whether that allegation is made out on the evidence, the court is satisfied the Local Authority has made out its primary case of fabricated illness.

199. The consequences of Mother's actions are that the Child has had to wear an allergy lanyard at school when she had no allergies; had nose cauterisation without significant nosebleeds; had grommets inserted without any significant hearing issues, repeat ear infections or glue ear; had Epipens prescribed without any history of anaphylaxis or allergies; had morphine administered without prescription; and had Epipens used on her at least twice when this was not medically required.

200. Father attended some of the medical appointments with Mother. However, Father was equally dependent on accurate information from Mother. While Father was able to report what was happening in his care, primary care of the Child was with Mother.

201. The Intervenor attended some of the medical appointments also. She said she went to support the Child and to keep her occupied. There is no suggestion in any of the records that she took an active role. Her own evidence is not supportive of the significant history of medical issues set out by Mother.

202. The court is asked to determine, and makes findings in respect of the following:

No.	Findings sought	Mother's response	Court finding
1.	The mother has fabricated, induced and/or exaggerated medical conditions, symptoms of illness and/or presentations in the Child. This has resulted in	Not Accepted	The court finds the allegation is made out for the reasons given below, to the extent it is established the

	the Child receiving and/or being exposed to unnecessary medical procedures, investigations, examinations, medication and/or treatment. This has caused the Child to suffer significant emotional and physical harm, abuse and neglect. Further and in particular:		Mother has fabricated and/or exaggerated medical conditions, symptoms of illness and/or presentations in the Child, but not that Mother has induced any conditions or symptoms.
1(a)	**In respect of allergies**: i. The mother has repeatedly stated to educational and medical professionals that the Child has multiple "allergies". This has included allergies to generic brands of paracetamol, to ibuprofen, penicillin, "most antihistamines", Piriton, tomatoes and peanuts. ii. Despite the mother's insistence of an "allergy" to tomatoes and reporting allergic reactions to tomatoes, she has actively chosen tomato-based foods for the Child's school lunches and refused a tomato-free menu. iii. The Child has not been diagnosed with any allergies. Specific IgE measurements for peanuts and tomatoes were negative and an oral challenge for ibuprofen was negative. In view of the allergy assessments undertaken, the Allergy Clinic found the Child to have "only a very mild skin condition" and was not at risk of anaphylaxis. The Child is	(i) Accepted although what I have described as 'allergies' could be 'intolerances' Until I read the report of Dr Rahman, I did not know the difference. My understanding from medical consultations is that the Child has or had spontaneous urticaria. (ii) Not Accepted. As I explained to the school, the Child can tolerate un-concentrated forms of tomato so I did not believe that a completely 'tomato-free' diet was necessary. (iii) I refer to my comments at (i) and (ii) above. (iv) Not Accepted. I did not know why the Child seemed to 'react' to having oral analgesia. She would often complain of headaches or come out in a rash. I sought advice and was told not to give the Child oral analgesia until she had been reviewed at the Allergy Testing Clinic. I accept	(i) Mother accepts no allergies were ever diagnosed. She also accepts saying the Child had allergies to medical, educational and local authority professionals. This was despite attending the Allergy clinic and no allergies having been found shortly before she made some of these assertions. I diagnosis of spontaneous urticaria is not a diagnosis of an allergy and Mother provided no evidence for the source of her belief the condition makes the body act as though it has allergies when it does not. Allegation proven. (ii) Mother clearly completed paperwork for the school identifying the Child had an allergy to tomato, despite this not having been diagnosed and the child being given tomato at home. Allegation proven.

	able to eat a fully inclusive diet, including tomatoes and peanuts, without adverse effect. iv. As a result of the mother falsely reporting that the Child is allergic to oral analgesia, the Child has been given analgesia rectally, which was an unnecessary and intrusive medical intervention. Further, the mother informed the school that the Child was allergic to many painkillers and pain relief would need to be administered by way of an enema. v. Despite not having allergies, the Child had to wear an 'Allergy Lanyard' at school. This would have unnecessarily singled her out amongst her peers causing low self-esteem.	that I told the school about this advice. I explained that she had been given 'enemas' by the hospital. I asked what the school's policy was about this and they told me that they would not normally administer analgesia in this way. I did not ask for pain relief to be administered by 'enema'. (v) I did not request an Allergy Lanyard – this was school policy. I doubt the Child was the only child in the school with allergies or intolerances.	(iii) Mother accepts the Child has been tested for allergies and none have been found. The information relied upon by the Local authority is clearly made out on the evidence and the allegation is proven. (iv) The Mother was not asked about analgesia being administered rectally. While the discussion with the school is proven, the allegation analgesia was administered rectally is not proven. (v) Mother accepts the child was given an allergy lanyard. She also accepts the child was tested for and did not have any allergies. The first testing took place before the lanyard was issued. The lanyard was issued based on Mother's reporting of allergies, which was not true. The fact other children may have also had an allergy lanyard is not relevant. Allegation proven.
1(b)	**In respect of Ear, Nose and Throat (ENT) issues:**		
	i. The mother has repeatedly sought medical intervention in respect of the Child's	(i), (ii) & (iii) Not Accepted. Anything I told the school was in	(i) The child was subjected to 5 audiograms, 3 examinations, grommet

	hearing, including for alleged hearing loss, despite consistent medical advice that the Child's hearing is normal. ii. The mother told the school that the Child had been diagnosed with hearing loss in both ears, which would require an operation and subsequent hearing aids. This was not the diagnosis or medical advice given. iii. The mother told the school an ENT doctor had said the Child's eardrum was 'on the verge of perforating'. This was not the diagnosis or medical advice given. This was repeated to a nurse clinical adviser. iv. The mother has repeatedly exaggerated or fabricated to ENT specialists and/or to her general practitioner that the Child suffered with recurrent ear infections. There is no medical evidence to support the Child having suffered recurrent ear infection. v. The mother exaggerated or fabricated to ENT specialists that the Child suffered with repeated nosebleeds. Blood tests undertaken were all within normal limits. On examination no prominent blood vessels were found.	accordance with what I had been told by medical professionals. Medical notes are not a verbatim account of everything that was said or discussed. The hearing tests as noted below are confusing: the audiogram is noted as "normal" but, "very mild hearing loss in R ear; borderline hearing in left ear" is also reported. The Child did have recurrent ear infections. I did not exaggerate this. the Child also had repeated nosebleeds and again I did not exaggerate this so that she would have unnecessary treatment	insertion and removal and a tonsillectomy over a 5 year period. Each time there were no significant findings, with only mild hearing loss being identified once. Mother was advised the Child's hearing was normal on the first occasion, yet persisted with seeking referrals. Allegation proven. (ii) There is no evidence Mother was ever informed the Child had any significant hearing loss. Any hearing loss identified was mild, as a result of glue ear at the time, in only one ear. An indication that hearing aids may be required is directly contrary to the medical information. Allegation proven. (iii) While Mother disputes the accuracy of the records, 2 independent people reporting the same information from Mother within a month of each other is significant. There is no record supporting Mother's assertion. Allegation proven. (iv) The Child was subjected to 10 medical examinations by ENT specialists. On all but one occasion her hearing was completely

			normal. Mother insisted the GP had diagnosed infections when there was no evidence the GP had seen the Child and any diagnosis appeared to be based on Mother's reporting. The Intervenor's evidence was directly contrary to the Mother's, but was consistent with Dr C. Mother relied on Dr M referring to ear infections reported by the GP, but in evidence he accepted the source of that information was Mother. Allegation proven. (v) The evidence of the school was that while nosebleeds occurred they were not concerning. The Intervenor was only able to identify 2 nosebleeds. It is also accepted the Child would cause nosebleeds by putting her finger up her nose. Mother is the sole source of information justifying this treatment and on examination by ENT specialists supporting evidence was not noted. Allegation proven.
1(c)	**In relation to eyesight:**		
	i. The mother has sought medical intervention for the Child's vision, including for a 'squint'. On examination, the Child's eyes and vision	Not Accepted that this was inappropriate in any way. This was as a result of having taken the Child for a routine eye test. I was	The court accepts Mother's explanation that the first eye test resulted from a comment that the Child

	were normal and no deviation or other significant abnormality or eye pathology was noted[18].	asked at the examination if she had any difficulties and I said that I had seen the Child 'squinting' and screwing up her eyes after using her Tablet or watching the television. The Child had also complained of headaches. This is not uncommon in children and I was in no way asking for medical intervention if it was not needed.	would squint on occasion. However, there were 2 further referrals for the child's eyes to be tested. It is suggested for the first time in Mother's closing submissions they were all routine eye tests. The court accepts the further referrals were not justified and the allegation is proven to that extent.
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1(d)	**In relation to incontinence:**		
	i. The mother has fabricated and/or exaggerated the Child's alleged long history of urinary incontinence. ii. The Child's alleged daily and/or consistent wetting has not been observed at school, by the father or by the maternal grandparents. iii. The mother has unnecessarily sought testing for an underactive/overactive bladder and pharmacological treatment. iv. Urine dips, ultrasound scan of the Child's urinary tract and other tests have not identified any medical issue. v. The mother has related the Child's alleged incontinence to her housing situation by stating that the Child does not wet when she is in her own bedroom. There is no medical basis	(i), (ii), (iii) & (iv) Not Accepted. Mrs M at School B noted and reported the bladder issues and gave me advice. I understand that the local authority/my parents have obtained another ultra sound bladder scan post-dating the time that the Child was in my sole care. (v) Accepted. I only described what had happened. Obviously, I am not a medical expert but perhaps the explanation is psychological rather than physical.	The school evidence was that the Child would wet herself. While this was recorded as happening 3 times in a week on one occasion, it was also accepted this was not always recorded. It was not unreasonable for the mother to seek to identify any possible cause. The court does not make findings on this issue, as sought.

	or explanation as to why the Child would become continent if she had her own room.		
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1(e)	**In relation to behaviour:**		
	i. The mother has unnecessarily used a pushchair when taking the Child to hospital, citing the Child's behaviour as the reason. The father does not use a pushchair for the Child. The mother has placed the Child at risk of significant emotional harm, including poor social development, social isolation and low self-esteem. ii. The mother has described the Child to medical professionals as "toddler-like". This presentation has not been noted by the father or by medical, educational or social services' professionals. iii. The mother has described the Child as presenting like an 18 month-old at the age of 7.	(i) Not Accepted. I have not routinely used a buggy for the Child. I took her to 3 appointments in a buggy during the worst of the Covid situation. This was so that I could ensure that she did not wander off and get too close to others. the Child also uses a proper child's buggy to play and wheel her dolls around. (ii) and (iii) Whilst I cannot remember exactly what I may have said, I accept that I would have described the Child in a similar way. However, I believe that professionals such as have all made independent reference to the Child being immature for her age.	(i) Mother accepts using a pushchair/buggy during lockdown. When this was put to any of the medics they did not challenge this explanation. Allegation not proven. (ii) and (iii) Mother repeated this comment in the witness box. There is a world of difference between being immature for your age and toddler-like. The Child Development evidence was an 18 month delay, yet Mother said like an 18 month old at the age of 7. Allegations proven.
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1(f)	**In relation to other alleged medical conditions:**		
	i. The mother has repeatedly sought medical intervention through the Child's GP in relation to green stools, the Child's shoulder 'popping' out on a daily basis and hypermobility issues, which on medical	(i), (ii) & (iii) I accept that I have raised a number of issues with my GP. I wanted information more than anything because some of the issues I raised with the doctor had been	(i) and (ii) – Mother accepts she has raised these conditions with medical professionals. She asserted School B had also raised concerns, but this does not appear to be

	examination and following blood and stool tests were neither indicated, observed nor of medical concern. ii. The mother again reported to the Consultant Paediatrician in the Child Development Clinic that the Child was presenting with the following symptoms and/or conditions, which, again, on medical examination, were not evident: - Hypermobility. - Pathological Demand Avoidance syndrome. - Green stools and diarrhoea. - Allergies. - No pain threshold. - No danger awareness. iii. On examination by Dr S, the Child was found to be medically fit and healthy and her behaviour found to be normal. iv. Due to the mother not receiving the diagnosis' sought, she subsequently demanded not to see Dr S again and to be referred to GOSH or Hospital B.	brought to my attention in the first instance by School B. (iv) & (v) Not accepted. I did not "demand" to be referred to a paediatric department, I asked.	accurate. the Child was examined and no evidence was found to support Mother's reports. Mother appears to have been unwilling or unable to accept that medical advice. Allegations proven (iii) This is a statement of fact and not challenged by Mother. (iv) The GP record shows Mother both demanded and said she would prefer a different paediatrician. Mother later told Dr S she sought a different paediatrician when Dr S refused to prescribe ADHD medicine. The "demand" is a summary note of the view of the person making the note, who was not called to give evidence, and is not proven. However, the Mother clearly sought referral elsewhere having not received the diagnosis sought, which is consistent with Mother walking out of the meeting with Dr S when autism was not diagnosed. The court finds the Mother sought an alternative referral due to not receiving the diagnosis sought.
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2	As a result of the matters set out in paragraph 1 above:		
	a) The Child has unnecessarily been subjected to high levels of medical intervention and/or extended, ongoing medical intervention from various departments including: - Ear Nose and Throat Department, - Enuresis Clinic, - Child Development Clinic, - Urology Clinic, - Allergies Clinic and - Department of Ophthalmology.	Not Accepted	The Local Authority has accepted the referral to the child Development Clinic was appropriate and the court has not made the findings sought in respect of the urology clinic. While other medical interventions may have been initially warranted, there is clear evidence Mother refused to accept initial assessments and kept seeking further referrals. Referrals took place based upon her reporting, which is found not to be accurate. The finding is made on the other medical interventions to that extent.
	b) The Child suffered and is at risk of suffering a disordered perception of illness and health and confusion over the state of her health.	Not Accepted	Mother stated she was unable to comment on this in the witness box. Dr Rahman gave evidence repeated contacts can leave a child beginning to believe there is something wrong with them and may have a disordered perception. The court accepts the evidence of Dr Rhaman. Allegation proven.
	c) The Child suffered and is at risk of suffering anxiety and low self-esteem due to being deemed constantly ill and having to regularly attend	Not Accepted	Mother stated she was unable to comment on this in the witness box. Dr Rahman liked this with the disordered

	hospital and medical appointments.		perception of illness and health. The court accepts the evidence of Dr Rahman. Allegation proven.
	d) Her routines would have been negatively disrupted.	I accept that her routines would have been disrupted but, for a proper reason.	The court accepts Mother's admission. The court finds proper reason only as set out above. The finding is made in respect of the remainder of the allegation.
	e) The Child had poor school attendance due to the number of medical appointments that she has had to attend. The Child's school attendance in 2020/2021 and whilst in the care of the mother and The Intervenor, was at 87.2%. This would have compounded the Child's global development delay and led her to experience poor peer relationships.	I accept that the Child missed time at school both because of appointments and/or because she was sent home from school. Neither event was within my sole control.	The number of medical appointments has been exacerbated by inaccurate reports from Mother as to the extent of the Child's problems. Allegation proven.
	f) The Child underwent the following medically unnecessary surgical procedures: i. bilateral grommet insertion under general anaesthetic. ii. examination of the nose and nasal cautery under general anaesthetic. iii. as a result of the unnecessary insertion of bilateral grommets, the removal of the bilateral grommets.	It is accepted that these procedures occurred, but I do not accept that I in anyway exaggerated the Child's symptoms or misled the professionals in any way to cause unnecessary surgical procedures	While any treating medical professional at the time must have been satisfied the treatment was appropriate, this was based on Mother's reports which the court finds not to be accurate. The court accepts the evidence of Dr C. Allegations proven.
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No.	Findings sought	Mother's response	Intervener response	Court finding
3	Further to paragraph 1 and 1(a) above, the mother and the Intervenor have caused the Child significant physical and emotional harm by administering an adrenaline autoinjector (an "EpiPen®") contrary to medical advice and when it has not been necessary or medically warranted:	Not Accepted.	Not accepted, whilst The Intervenor accepts assisting when the mother administered an EpiPen® on two occasions she was not aware this was unnecessary or contrary to medical advice.	The court makes this finding as set out below in respect of Mother only. The evidence is that the Intervenor only assisted with administering the Epipen once, at a time when the 111 call handler was advising it should be administered.
	a) The mother has repeatedly requested an EpiPen® prescription for the Child despite being consistently advised by different medical professionals that there was no medical indication for an EpiPen® and the Child's diagnosed spontaneous urticaria was to be managed with antihistamines.	Not Accepted.	This is for the mother to address.	Mother sought the prescription on at least 3 occasions prior to the oramorph incident. The court is asked to and is making further findings in this regard below. Allegation proven.
	b) On the date of the oramorph incident, the mother informed the ambulance crew attending to the Child that the Child was awaiting an EpiPen® when this had not been indicated or prescribed.	Not accepted as such. Because of the immediate event, I explained to the ambulance crew that I would need to speak to The Child's allergy consultant again and they (the paramedics)	Not accepted	The ambulance crew record is clear that the crew were informed of this. There is no suggestion in the record that they

		suggested that an Epi-Pen might be a way forward.		advised an Epipen may be appropriate. The record is consistent with Mother's subsequent report of anaphylaxis. The evidence is also clear no Epipen was awaited at the time. Allegation proven.
	c) On a date between around the oramorph incident the mother together with and/or with the assistance of the Intervenor gave the Child an EpiPen® injection that had not been prescribed to the Child and that was neither necessary nor medically warranted.	Not Accepted. I have been absolutely clear in all my evidence that I have only administered an Epi-Pen on 2 occasions: on 06.12.20 and on 18.01.21.	Not accepted	Not pursued by the Local Authority
	d) On a further date, the mother together with and/or with the assistance of the Intervenor gave the Child an EpiPen® injection in accordance with medical advice that was given based on an inaccurate and/or exaggerated history provided by the mother. The administration of the EpiPen® was, therefore, neither necessary nor medically warranted. Further and in particular: i. The Child did not have an anaphylaxis episode or "life-	(d) generally and (d) (i) & (ii) Not Accepted. It is clear from the recording of the relevant 111 telephone call that I was in fact hesitant about giving the Epi-Pen and that I stated, again quite clearly, on more than one occasion that the Child was NOT struggling to breathe. (iii) Accepted and I made this (that the Child was not having an	Partially accepted, The Intervenor accepts assisting the mother on two occasions so she could administer the EpiPen® but was not aware this had not been prescribed to the Child or that this was unnecessary. It is accepted the Child was upset at the time, she had been crying	The recording is clear that Mother provided an inaccurate history of anaphylaxis which caused the advice to be given. Dr Rahman was equally clear the call handler was reliant on the information provided. Allegation proven against the Mother.

	threatening allergic reaction" on the date of the oramorph incident as stated by the mother to the NHS call handler ii. It was the history provided by the mother in relation to the oramorph incident that led the call handler to advise the EpiPen® be administered to the Child iii. The Child was not having an anaphylaxis episode and nor was she presenting with any reaction that was suggestive of anaphylaxis and/or that warranted the use of the EpiPen®. iv. The Child was extremely distressed and frightened at seeing the EpiPen®.	anaphylaxis episode) clear to the NHS 111 Operator as stated above. (iv) Accepted. I found the whole episode distressing too but I was told to hold the Child down and give her the Epi-Pen.	before she had seen the EpiPen® but it did get worse.	The evidence is that whilst the Intervenor assisted she did so based on the advice given by the call handler. It was reasonable for her to do so in the circumstances. Allegation not proven in respect of the Intervenor.
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4	The mother and the Intervenor have given the Child medication that has not been prescribed to her. Further and in particular:		Not accepted	The court finds the allegation is made out in respect of Mother, but not made out in respect of the Intervenor, for the reasons given below

	a) The mother gave the Child liquid morphine (Oramorph®). The liquid morphine had not been prescribed to the Child but was a prescription belonging to The Intervenor. The oral morphine had been given without medical advice.	Accepted. The Child had been given Oramorph previously at the hospital but I accept that I should not have given her some of the dose that had been prescribed to my partner, the Intervenor.	Accepted	Medication given by a medical professional in a hospital setting is entirely different to a parent administering another adult's medication to a child at home. Morphine is only available on prescription. The Mother appears to have understood it was morphine, given her comments to the call handler on the day of the incident, and that she should not be doing it. There is no evidence the Intervenor was aware at the time or proximate to this. Allegation proven against Mother, but not proven against the Intervenor.
	b) The mother lied to the NHS 111 call handler when she told them that the Child had been sent	Not Accepted. I had no intention to mislead the call handler; I sometimes	This is for the mother to address.	Mother accepts the information was not true in

	home with morphine for her (the mother) to administer to the Child.	struggle to explain things clearly and I may have become confused about the morphine because the Intervenor had been sent home with some the previous year.		any respect. Allegation proven.
	c) The Intervenor was aware that the mother was giving the Child liquid morphine that was prescribed to her (The Intervenor) and not to the Child.		Not accepted, The Intervenor did not become aware it was Oramorph prescribed to her until a later date.	There is an issue as to whether the Intervenor was informed. The Local Authority rely on Mother's initial response under cross-examination. The evidence of the Intervenor was that she had taken her medication that evening and was drowsy and sleepy. Even if informed it is unclear she would have understood. Mother later informed the social worker of her actions but did not say the Intervenor was aware. It is for the Local Authority to prove. Allegation not proven.

	d) The Intervenor did not act or intervene to safeguard or protect the Child from being given medication that was not prescribed to the Child but knowingly allowed this to happen.		Not accepted she was not aware of this at the time it was given.	The Local authority are unable to prove the Intervenor was aware, as set out above. Allegation not proven.
	e) The mother and the Intervenor put the Child at risk of serious ill-health, including that resulting from a potential overdose that could lead to respiratory depression, decreased consciousness and/or death.	a) Not Accepted. Dr Rahman at E107 says that an overdose can lead to respiratory depression and overuse can lead to dependency and other side effects. Whilst I accept that I used the Oramorph and that I am not a medical expert, this was not an 'overdose' or repeated in any way to cause dependency. Even if an adult dose was administered, my understanding is that there is no evidence to establish this was an overdose sufficient to cause the consequences suggested. b)	Not accepted she was not aware of this at the time it was given.	The Mother was not qualified to prescribe or administer oramorph and was not aware of the appropriate dosage for a child. The allegation is not that Mother administered an overdose but that the Child was put at risk. Allegation proven in respect of Mother. The Local Authority have not proven the Intervenor was knowingly complicit and the allegation is not proven.
	f) The mother lied to professionals when she stated that the hospital told her she could give the Child a dose of liquid morphine that had been prescribed to The Intervenor.	Not Accepted. I do not recall ever telling professionals this. I do accept that I told professionals that I had given Oramorph to the Child which		The court accepts the record, that Mother stated this to the hospital.

		had been prescribed to the Intervenor.		Allegation proven.
	g) The mother lied to the NHS call handler when she told them that the hospital agreed to her giving the Child no more than 2 mils of liquid morphine prescribed to her (the mother) following a rugby injury.	Not Accepted.	This is for the mother to address however The Intervenor was not allowed to attend the hospital because of COVID restrictions.	The court accepts the transcript, that Mother stated this to the call handler. Allegation proven.
	h) the mother reported to the Locum Consultant that following the Child being given liquid morphine, along with cough syrup and ibuprofen®, that she had a severe allergic reaction, including swelling of lips and face and difficulty in breathing: i. When speaking with Dr Sl, the mother deliberately did not inform him that the liquid morphine had not been prescribed to the Child and was given without medical advice. ii. **Either** the Child's reactions as described by the mother were caused solely by the Child ingesting the liquid morphine (i.e. not by ingesting the cough syrup and/or ibuprofen®) **OR** iii. The Child's reactions were fabricated and/or exaggerated by the Mother in order to obtain a prescription for an	(i) I accept that this is what I told Dr S. I showed Dr S pictures that I had taken of the Child showing signs of this and other reactions. (ii)This is a possibility but I cannot say for sure. (iii)Not Accepted. I had and produced photographic evidence of the skin reactions suffered by the Child.	This is for the mother to address however The Intervenor was not allowed to attend the hospital because of COVID restrictions.	(i) Admitted (ii) – (iii) the court has considered the photographic evidence. It is not supportive of a severe allergic reaction. The ambulance record identified no issues with breathing. There was not severe allergic reaction. The information was not true and was fabricated and/or exaggerated. Allegation (iii) proven.

	EpiPen®. In either case causing the Child significant harm or putting her at risk of significant harm.			
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5	Despite being given training and clear indications on the use of the EpiPen®, the mother has used the EpiPen® excessively for minimal symptoms and contrary to medical advice. Further, the mother stopped using Fexofenadine for the Child's alleged allergies as medically advised and used an EpiPen® for the Child's rash. Due to the high level of usage, the mother has sought repeated prescriptions for an EpiPen®. At least 12 pre-filled injections having been provided to the mother.	c) Not Accepted. I used the Epi-Pen on 2 occasions only. I am not totally sure how the prescriptions work but I can say for sure I have had a total of 10 Epi-Pens. You should certainly get 2 Epi-Pens each time you get a prescription, although as can be seen below, on one occasion I was given 1 Epi-Pen on one day and 1 on the next and another time I was just handed 2 from the hospital without prescription. It is complicated but I will try and set out details of each time I received an Epi-Pen(s). I received 1 Epi-Pen when I attended my training session on xxxxx (they only had one available at the time). I believe this session was organised by Dr Sl and the training provider who then provided a further pen which I picked up from the Hospital A pharmacy the following day. (I therefore had 2 in my possession at this time). I then gave	This is for the mother to address.	Mother accepted the records showed her receiving 14 epipens. 3 were given to others and Mother says 2 were used. The Local Authority have failed to maintain a forensic record of the number of Epipens returned to them. However, on Mother's account of 6 being handed over there are 3 Epipens unaccounted for. Mother has described administering Epipens every few days, 5 times, and 5 or 6 times. The evidence is that use of the Epipen was not warranted on either occasion that it was admittedly

		one straight to the school bringing me back to 1 Epi-Pen. I was given a further prescription by the Child's GP. I believe I collected a further 2 Epi-Pens on xxxx - (this gave me a total of 3 Epi-Pens). I then gave one of these pens to Father. (This brings me back to 2 Epi-Pens in my possession at this time). On xxxxx I used one of the pens (this brings me back to having 1 pen in my possession). On this date the hospital then handed me two Epi-Pens (I don't think this was by prescription. This brings me back to 3 Epi-Pens). I believe the hospital then must have shared a note from this attendance with the GP as I was given a further 2 Epi-Pens on xxxxx when I collected a routine prescription for Fexofenadine; (this brings me to having 5 Epi-Pens in my possession). I was then given a further 2 Epi-Pens on xxxxxx. I do not remember asking for these, but this then amounted to a total of 7 in my possession at this time. My intention was to give Father and my mother further Epi-Pens so they were		used. Mother accepts stopping the fexofenadine and there is no adequate evidence justifying this. However, the allegation is only that the Epipen was used excessively for minimal symptoms and Mother stopped using fexofenadine. Both allegations are proven.

		covered (you normally have 2 in case the first fails) but we went into to lockdown so I did not end up distributing them. So, overall, I remained having 7 in my possession. Of these 7 Epi-Pens that were now in my possession I used one on xxxxx. I gave the other 6 Epi-Pens back to Children's Services on xxxxx (this was to K the child practitioner and J the social worker who had come round for a visit). Incidentally on the xxxxx, I was also offered an extra 2 Epi-Pens when collecting the Child's routine Fexofenadine from the Boots pharmacy at the xxxxx Retail Park. I declined these.		
6	On xxxxx (the second occasion), the mother and the Intervenor gave the Child an EpiPen® injection contrary to medical advice and that was unnecessary and medically unwarranted. Further and in particular:	Not Accepted.	Not accepted	The court finds the allegation is made out against the Mother only for the reasons given below. The allegation is not proven against the Intervenor.
	a) The Child's rash as noted by the school was minor and had responded well to the antihistamine.	A further and more severe rash occurred after the Intervenor and I collected the Child from school and her condition	The Intervenor was not at the school and so cannot comment but did not notice	Mother appears to accept this is an accurate statement of

		deteriorated quite seriously.	any rash on the Child when she picked her up this day.	the school's position.
	b) Contrary to medical advice and despite being told by the school that the Child's rash was minor, the mother was insistent that the Child be given an EpiPen® injection.	See Above	This is for the mother to address.	The evidence was that Mother asked for the Epipen to be administered, but on attendance seemed to accept the decision not to do so. Not proven.
	c) the Child left school 'skipping' and in good health. There was no indication for the Child to have an EpiPen® injection.	See Above	Accepted	Mother appears to accept this also, which is consistent with the evidence from the school.
	d) The mother reports to have administered the EpiPen® at c.14:20 on the way to Hospital B but did not arrive at Hospital B until 15:48 there by failing to obtain prompt medical attention for the Child. The mother did not call for an ambulance as medically advised.	I did not call an ambulance because we were on the way to Hospital B anyway. I do not remember the exact time that I administered the Epi-Pen but I believed that I was doing the right thing by taking her to Hospital B. Hospital B were charged with looking after the Child in respect of her allergies/intolerances and I believed that they would be able to deal with the situation better than the Hospital A. Dr Sl	This is for the mother to address.	There is a discrepancy in the timings. However, on the timings from the school 14:20 hours was before Mother collected the Child. Mother explained she did not call for an ambulance as it was quicker to just go to the hospital, which does not seem unreasonable in the

		had told me to take the Child to Hospital B when she had reactions so that they could monitor the situation. At the time of using the Epi-Pen, we were closer to Hospital B anyway.		circumstances. The court is unable to make findings about the exact time the Epipen was administered. It is the court's judgment the timing is more significant for the fact that Mother was telling the hospital inaccurate information about how long ago the Epipen had been administered.
	e) The Child has held down by both the mother and by the Intervenor when the EpiPen® was administered in the back of the car.	Not Accepted. The Intervenor was driving the car. I did not have to hold the Child down as she had lost consciousness.	Not accepted, the Intervenor accepts the EpiPen® was administered but she was driving the car at this time so did not hold the Child down and was not involved in administering the EpiPen®	The Child is known to become confused about incidents and the description she provided after this incident is consistent with the first time Mother accepts the epipen was administered. This allegation is not proven.
	f) The Child was distressed at seeing the EpiPen® both in the school office and was scared and distressed when the EpiPen® was	I have no knowledge of how the Child reacted to seeing the Epi-Pen in the school office. I was at home and had not yet been	Not accepted, the Child was not making any sounds in the back of the car	The court accepts the evidence that the child was distressed on seeing the

	administered in the car on the way to hospital.	contacted. The Child does not like 'needles' of any kind so I would not find the reaction described as surprising. As I have said, when I administered the Epi-Pen in the car – the Child was unconscious so there was no reaction as such.		epipen on the occasion Mother accepts it was first administered, and also in the school office. The court is unable to make findings about any distress on the day.
	g) On admission to hospital, neither the mother nor the Intervenor informed medical professionals treating the Child that she had lost consciousness on the way to hospital. The mother reported that there was no history of fainting or collapse. - (i) **Either** the Child did not lose consciousness as was subsequently reported by the mother and the mother lied about this to medical, educational and Children Services' professionals (ii) **OR** the mother failed to report a significant event to medical professionals on the Child's admission to hospital.	Not Accepted. I am sure that I did inform the hospital that the Child has lost consciousness but I accept that there seems to be no written record of this.	Not accepted, the Intervenor was not allowed into the hospital, she dropped the mother and the Child outside the hospital and remained outside due to COVID restrictions.	The Intervenor was unable to say if the Child had lost consciousness, just that Mother had told her this had happened. She said she did not go into the hospital due to Covid restrictions and the hospital record does not identify her presence. There is no medical information supporting any reason for the Child to have lost consciousness. The court has already considered the inconsistency in the child's account following this

				incident. The Mother's evidence that the hospital wrongly recorded such an important fact is not accepted. The court finds the Child did not lose consciousness.
	h) On examination the Child was found to be well, chatty, playing, with normal observations, no skin rash or swelling and no evidence of having recently lost consciousness.	the Child had largely recovered after the Epi-Pen was given.	The Intervenor was not in the hospital so cannot comment.	This is accepted.
	i) Despite the mother's decision on leaving the school that the Child needed emergency medical attention, the mother took the Child to Hospital B a 50-60 minute car journey from the Child's school as opposed to Hospital A, a 10 minute journey from the Child's school, thereby failing to obtain prompt medical attention for the Child.	Not Accepted. When we left the school, the Child did not require "emergency medical attention" at that point. I was taking her to Hospital B for a basic check-up given that they were dealing with her allergies/intolerances. The Child's condition deteriorated whilst we were on the way to Hospital B and at that point, the nearest hospital was Hospital B.	This is for the mother to address. However when collecting the Child from school the Intervenor was not told by the mother there was a need to seek emergency but she should be checked over and this should be at Hospital B because this is where her notes were.	It was not Mother's case that the Child needed emergency medical attention at the time the Child left school and the court has made no finding that an emergency situation had arisen. This finding cannot be made as a result.
7	The mother has lied and/or mislead professionals in relation to the Child's		This is for the mother to address.	The court finds the allegation is made out

	medical conditions. In particular:			for the reasons given below
	d) Previously and during a pre-operative assessment for the Child's grommets removal, the mother informed medical professionals that the Child: - (i) had autism knowing that the outcome of the Autism assessment at the Communications Disorders Clinic was that the Child had mild-to-moderate global developmental delay and not autism, and - (ii) was allergic to paracetamol knowing that this had not been diagnosed. - Due to the medical history as provided by the mother, the Child was considered a child with a 'complex medical history' and could not have the operation for her grommet removal at Hospital C, which delayed the operation taking place.	(i) Not Accepted. I said that the Child may have autistic traits. There was a subsequent diagnosis of ADHD on 10.09.20 (ii) I had been advised previously to 'avoid' paracetamol.	This is for the mother to address.	Autistic traits were irrelevant. If Mother had said this she should have also disclosed the fact the Child had been assessed negatively for autism, otherwise a true picture would not have been given, and this was not her case. There were also repeated reports by Mother of the Child having allergies. There are too many reports from different sources of Mother stating the Child had allergies and autism for her arguments to stand up. Allegation proven.
	e) The mother advised medical professionals that School B were suggesting that the Child had Autism when the school have not made any such suggestions.	Not Accepted. Miss B (SENCO) and the Child's Nursery School Teacher at School A definitely suggested to me that the Child was exhibiting signs of	This is for the mother to address.	Mother does not challenge stating this, she challenges whether her reporting was accurate. The court has

		being on the autistic spectrum. The Child's Year 2 teacher also suspected autism or ADHD (subsequently diagnosed) and this was a large part of the reason that an Educational Health Plan was put in place.		considered the evidence from the school and Mother and finds this allegation is also proven.
	f) The mother advised medical professionals that the Child has Autism knowing that this had not been diagnosed or indicated on assessment.	Not Accepted. I don't recall the conversation in detail but I am sure I would have said 'possible autistic traits'.	This is for the mother to address.	Refer to 7 a) above – allegation proven.
	g) The mother advised medical professionals that the Child had suspected autism and ADHD knowing that this had not been diagnosed or indicated on assessment.	ADHD was indeed diagnosed.	This is for the mother to address.	This was over 2 years before ADHD was diagnosed and after autism had been ruled out. Mother had raised the issue of autism and/or ADHD. The Child was then assessed as having Global Developmental Delay. Autism continued to be assessed, but was then ruled out. There was no ongoing assessment for ADHD at the time. Allegation proven.

	h) The mother advised the NHS 111 call handler that the Child had Autism knowing that this had not been diagnosed or indicted on assessment.	Not Accepted. I told the call handler that the Child had "autistic traits". At this point (and the social worker was well aware of this and involved) I was concerned that the Child should have special educational provision because I did not think her difficulties were solely as a result of global developmental delay. A subsequent diagnosis of ADHD has been recorded.	This is for the mother to address. Whilst the Intervenor was present she was dealing with the Child and so was not aware of conversations the mother was having with 111	Refer to 7 a) above – the recording is clear Mother said autism. Allegation proven.
	-			
8	The mother has lied to medical professionals in order to obtain ADHD medication for the Child:	Not Accepted. I have never lied to professionals. I was told by SENCO that the Child could benefit from ADHD medication whilst in school to help her in class and with her 'behaviour'. I was told that this would be followed up but did not hear anything further.	This is for the mother to address.	The court finds the allegation is made out for the reasons given below
	a) The mother told Dr S, Consultant Paediatrician at the Child Development Clinic, that the Child was about to be permanently excluded from school due to having ADHD and requested ADHD medication be prescribed immediately to prevent school exclusion.	The Child had already been given a number of internal exclusions and I explained my concern that the Child was now at risk of being fully excluded.	This is for the mother to address.	The record is not that Mother was concerned, as she now states. Dr S followed up the discussion in a letter and Mother did not raise an issue at the time

				that the letter was not correct. The court accepts the evidence Mother asserted the Child was about to be permanently excluded as a fact, which she does not appear to challenge in her response in any event. Allegation proven.
	b) There were no plans to exclude the Child from school either permanently or temporarily. The school did not have significant concerns about ADHD symptoms.	SENCO and letters sent home to me from the school suggested otherwise.	This is for the mother to address.	The letters did not state otherwise. At the time it had been 9 months since the last Level 3 exclusion. The consultant checked with the school, it was confirmed this was not the case. The allegation is proven.
	c) As a result of Dr S not providing medication as sought, the mother again sought a change in paediatrician.	I accept that I wanted a change in paediatrician because I felt that Dr S was not listening to me. She told me that SENCO (Miss T) had told her that the Child did not need medication and yet when I asked Miss T about this she told	This is for the mother to address.	This is a clear example of Mother seeking a change in consultant because they would not provide the treatment she believed was appropriate.

		me that Dr S had got this wrong. Miss T told me to leave matters with her and she would speak to Dr S. I was concerned that the issue of medication was not being properly assessed given the apparent confusion.		The closing submission accepts Mother "had to persist to obtain the diagnosis and support (the Child) required". Mother does not dispute the reason she sought a change in consultant. Allegation proven.
9	During the time the Intervenor was living with the mother and the Child, the Intervenor attended numerous medical appointments with the mother and the Child. The Intervenor was aware of the high level of medical intervention being sought for the Child by the mother despite the Child being found to be medically fit and well. The Intervenor took no protective action to safeguard the Child.		Not accepted, the Intervenor accepts she attended some appointments, but her learning needs are such that she does not have any great deal or recollection of what was discussed and the language used may not have been understood. Her primary reason for attending was to pacify the Child.	The court has considered the presentation of the Intervenor overall, while taking into account the medical evidence supports the Intervenor taking no active part in any meetings. The Local Authority allegations require a level of understanding of the situation which appears beyond the Intervenor. The Local Authority no longer pursue this finding,

				but the court has considered the issue in any event as part of the overall picture. Allegation not proven.
10	Despite the mother raising medical and behavioural concerns in respect of the Child, she has not consistently engaged with referrals to services to address concerns raised:	Not Accepted. As far as I am aware, I have engaged with all services.	This is for the mother to address.	The court finds the allegation is made out for the reasons given below
	a) The mother failed to engage with PALMS and was discharged from their service in June 2018.	Not Accepted. We had a 2 hour appointment with PALMS on a Wednesday – I do not recall the exact date. At the end of the appointment they discharged the Child from the service because they said they could not help until she had a formal diagnosis. It was not because I did not engage with them.	This is for the mother to address.	The GP records support PALMS being unable to contact Mother and their being no substantive assessment. Mother has produced no evidence of an appointment or attendance. Allegation proven.
	b) The mother failed to engage with SALT and was removed from their list.	Not Accepted. The Child was discharged from this service too because School A had their own Speech & Language Therapist and we worked with her. There was no need to have SALT in the community as well. We were re-referred to SALT when the	This is for the mother to address.	There was evidence of speech and language therapy at School A. This lends credibility to Mother's evidence such that the court cannot find

		Child moved to School B and fully engaged.		this allegation proven.
	c) The mother failed to consistently engage with Dermatology appointments.	Not Accepted. We were in full 'lockdown' at the relevant time and so the dermatology appointments were cancelled (by the clinic not me). I asked about the proposed appointments and the clinic told me that it was with regard to the mole on the Child's back. This had already been examined and I was told that it was 'normal' and that no further action was required.	This is for the mother to address.	There is inadequate evidence for this court to be satisfied this allegation is made out. Allegation not proven

203. The court shall deal with any consequential directions at the hearing for handing down the decision.