Neutral Citation Number: [2022] EWFC 32

Case No: LV21C00675

IN THE FAMILY COURT
Sitting at Liverpool

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/04/2022

Before:

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between:

Cheshire West and Chester Council

Applicant

- and –

M

First Respondent

- and –

F

Second Respondent

- and –

LM
(a child by Deborah Day, Children's Guardian)

Third Respondent

Shaun Spencer (instructed by **Ms Withers, Local Authority Legal Department**) for the **Applicant**
Daniel Dodd (instructed by **Ms Moss of the Russell and Russell Solicitors**) for the **First Respondent**
Fiona Jamieson (instructed by **Ms Sherrington of GHP Legal**) for the **Second Respondent**
Simon Povoas (instructed by **Ms Hetherington of McAllister Family Law Solicitors**) for the **Third Respondent**

Hearing dates: 28th March – 1st April, and 5th April,

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Approved Judgment

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

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THE HONOURABLE MR JUSTICE HAYDEN

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

MR JUSTICE HAYDEN:

1. I am concerned here with an application made by the Cheshire West and Chester Council (the Applicant) for a care order in respect of LM, who is now two years of age. Her mother (M), who is 22 years of age, opposes the application, contending that the "threshold criteria" pursuant to Section 31(2) of the Children Act 1989 ('the Act') are not met. LM's father (F) does not resist the application and told me, in evidence, that he does not wish to be involved in his daughter's care. He assesses himself, correctly in my view, as not being in a position to provide LM with the care she needs. Further, F opposes the mother's case that she be permitted to care for her daughter. F asserts that M's mental health is too fragile to enable her to meet the full gamut of her daughter's needs. F does not express himself in these terms but this, I believe, accurately reflects his position in this litigation. F attended on the first day of the hearing (by video conferencing platform) to tell me his position personally. He has played no further role.

2. The focus of this case has centred upon M's approach to LM's health and general welfare and, in particular, to her extensive involvement with a variety of medical professionals. The Local Authority, supported by LM's Guardian, submit that LM has been subject to abuse falling within the ambit of Fabricated or Induced Illness (FII).

3. At the pre-hearing review, on 18th March 2022, I asked Mr Spencer, who appears on behalf of the applicant, as to where within the spectrum of this behaviour the Local Authority considered M falls. It is well recognised that these cases cover a broad range of presentation, incorporating exaggerations, fabrication, and sometimes, induction of illnesses. Dr Adeyemi, Consultant Paediatrician, who reviewed LM's medical records and provided an opinion in this case, drew my attention to the *Royal College of Paediatrics & Child Health (RCPCH) guidance, February 2021* which sets out the framework for evaluating the signs of FII. I will turn to Dr Adeyemi's conclusions below, but it is important to signal that she highlighted what is termed "Perplexing Presentation (PP)" as the most common form of FII. It involves presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions, and diagnoses. Dr Adeyemi assessed M's behaviour as incorporating PP and, in particular, *"exaggeration, distortion, and misconstruing of innocent phenomena in the child"*. Mr Spencer has put his case on this basis but also adds an allegation of fabrication. It is not suggested that there was deliberate induction of illness in LM, and it is important that I emphasise there is no evidence of it at all, not even a suspicion.

4. This application was commenced on the 25th February 2021. LM has been in foster care since that date. Manifestly, such delay is inimical to her welfare and requires to be identified as such. There can be no satisfactory explanation for a delay of this kind, even in the challenging circumstances presented by the pandemic. The harm caused by the delay has however, been mitigated by the fact that LM has had the good fortune to be cared for, throughout, by a foster carer who has been vigilant to meet her needs and, in whose care, LM has manifestly flourished. On the 25th November 2021, the Local Authority issued an application for a Placement Order, contemplating adoption.

5. M attended in person to give her evidence, which she gave politely and respectfully. She was plainly emotionally distressed and obviously troubled. I had the impression that though her evidence was widely contradictory, both internally and in the

documented evidence, she was, nonetheless, trying to engage constructively. She was frequently ambushed by her own inconsistency and, at times, irrationality. She plainly loves her daughter. She is aspirational for her daughter's future. The practical care that she has provided is unimpeachable.

6. Dr Fear, Consultant in General Adult Psychiatry, provided a report on M in these proceedings. Though I do not approach his opinion as providing any probative evidence of whether M behaved in the way alleged, it is important to highlight his summary of M's background and personality in order, properly and fairly, to evaluate her presentation in the witness box. Dr Fear succinctly summarises the sad circumstances of M's childhood.

> *"Children who have these experiences show a characteristic range of dysfunctional attitudes and behaviours as adults. [M] exhibits a deeply ingrained pattern of maladaptive behaviour that developed during childhood, became fixed during adolescence, and is likely to persist throughout adult life. These default behaviours represent significant deviations from the way the average person perceives, thinks, feels, and relates to others. The behaviour patterns are stable and encompass multiple domains of behaviour and psychological functioning. They are associated with various degrees of subjective distress and problems in social functioning and performance. These are the criteria for a diagnosis of personality disorder within the meaning of the ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1992)."*

7. Dr Fear analyses this background in the context of M's adult behaviour, which he highlights is his professional territory i.e., not child psychiatry. He makes the following observation in his report, dated 15th September 2021:

> *"[M] is aged 20 and has spent most of her life in psychosocially impoverished and abusive circumstances. She is the product of an abusive early environment, who endured a neglectful relationship with both parents before her challenging behaviour, shaped by a lack of adult attachments and limited parental boundaries, led to her abandonment within the care system. By the time she was in her early teens, she was beyond the capacity of the care system to maintain her safety and appears to have followed an autonomous, semi-feral existence, vulnerable to physical and sexual abuse from boyfriends and casual contacts."*

8. F was assessed by Dr David Allen, Clinical Psychologist. It is, again, important to set out some of Dr Allen's conclusions, in order to give context to F's evidence. The following observations are of particular significance:

> *"[F] is a man of borderline cognitive ability; he is not learning disabled (by any means) however I am of the view that his good social skills may have hitherto masked his low level of cognitive ability. Full-Scale IQ places him at the 4th percentile and below 96% of peers.*

> *[F] has functional literacy and ought to be able to read and comprehend straightforward written materials. He may become overwhelmed by larger text and he may require some assistance to read and understand more complex written material. Reading Comprehension age is around 12 years."*

F, as M is acutely aware, has had a comfortable and secure upbringing which has afforded him a social veneer which masks this low level of function.

9. F displays no evidence of *"frank mental illness"*. His verbal comprehension ability is assessed by Dr Allen as at the third percentile and, as he underscores, *"thereby below 97% of his peers"*. Dr Allen also made suggestions, which I am satisfied all the professionals adhered to, concerning F's effective participation in these proceedings:

> *"It will be necessary for professionals engaging with [F] to be mindful of this and to give him the opportunity to regularly reflect upon information, presenting information in small digestible chunks which [F] is able to understand, retain and weigh. It will be necessary for professionals working with [F] to use straightforward everyday language avoiding complex language structure, idiom and metaphor. It will be appropriate for professionals to keep questions and instructions short in length ensuring a neutral tone is maintained. It will be necessary for those professionals speaking with [F] to avoid moving topics or questions too quickly, giving him the opportunity to consider each "chunk" of information as it is raised.*

I noticed that even with very simple questions, F sometimes struggled, and I have kept in mind Dr Allen's helpful guidance, in particular:

> *"As a result of his below average Verbal Comprehension skills, [F] will find it difficult to concentrate within and 'follow' lengthy meetings. It will assist if those speaking with [F] avoid speaking quickly, allowing him time to absorb information. If technical terminology is unavoidable it will assist him if he is given the opportunity to pre-learn the meaning of words likely to be introduced."*

The Local Authority's Case

10. The Local Authority contend that LM has sustained significant harm in consequence of M's engagement in FII behaviours. Mr Spencer identifies these as follows:

> *"By way of overview the local authority assert that the mother has engaged in the following behaviours, harmful to the child:*
>
> *i. Presenting [LM] to health professionals with exaggerated or fabricated symptoms;*
>
> *ii. Reporting poor responses by [LM] to medication;*

iii. Seeking out clinically unwarranted investigations;

iv. Engaging in a pattern of reporting new or developing symptoms which are either fabricated or exaggerated;

v. Inconsistently reporting symptoms to different health care professionals; and

vi. *Contacting professionals for health advice for the child and thereafter nor following the advice given or responding appropriately."*

11. This structure follows the approach of Dr Adeyemi, which is predicated on identifying signs which are consistent with those recognised in the *RCPHCH Guidance: Perplexing Presentations/Fabricated or Induced Illness in Children*. Dr Adeyemi concluded that LM had been presented on numerous occasions to health professionals in both primary and secondary care and that the medical records identified:

i. "Symptoms not observed independently in their reported context.

ii. Inexplicably poor response to medication or procedures.

iii. Repeated reporting of new symptoms.

iv. Frequent presentations of [LM] with symptoms of illness but paradoxically there was a pattern of lack compliance with medical advice.

v. *Insistence on more, clinically unwarranted, investigations, referrals"*

12. An unusual feature of this case is that the mother candidly accepts that she has fabricated and exaggerated illness in herself since her early teens. It is important to emphasise that this information was volunteered to Dr Fear by M during the course of her assessment. In her oral evidence, M told me that she would present at hospital because she identified it as *"a safe space"* from which to escape her abuse at home, she had foreshadowed this with Dr Fear. In his report, Dr Fear observed:

> *"[M] has made no attempt to deny that she has fabricated and exaggerated illness in herself since her early teens: indeed, this was reported spontaneously during the course of our meeting. The earlier episodes typically occurred late at night, sometimes in association with alcohol, and often in the company of "friends", identified either as fellow residents in the care facility, or an allegedly abusive older boyfriend. She has also admitted fabricating collapses, fits and vomiting with the intention of prolonging admissions to hospital, and this is supported by the timing of those episodes and the reactions of the staff involved. In fabricating episodes, she has doctored*

> *clinical specimens with blood so as to present evidence of haematuria and haemoptysis. [M] has confirmed that there was an intent to deceive staff into diagnosing conditions she does not have and admitting her to hospital unnecessarily."*

13. Both the candour and detail of these recognitions were described by Dr Fear as *"disarming"*. In his experience and, if I may add, in the experience of the Court, such an acknowledgment, particularly proffered spontaneously, is very unusual. There are echoes of this insight in M's early statements relating to LM's presentation to medical services.

14. In M's very first statement, dated 26th April 2021, M expressed:

> *"genuine worries about [LM's] health, which I can now see, looking back, has been exaggerated by my anxiety. I accept that there are occasions when I could have gone to my GP for reassurance but assessment at hospital tends to be quicker and I wanted to be reassured that I had not delayed in making sure [LM] was well"*

15. The following passage from that statement, also requires to be highlighted:

> *"[I] accept that my anxiety has, on occasions, meant that I have exaggerated symptoms (for example the frequency of an event, such as when [LM] had jerky movements) to ensure that [LM] is given a thorough medical examination. I accept that exaggerating symptoms could result in unnecessary tests however on the occasions when [LM] has required tests, such as CT blood tests, these have been based upon legitimate medical concerns and accurate accounts. My exaggeration of symptoms has, on occasion, lead to [LM] spending more time in hospital that might have been necessary".*

16. Mr Spencer told me, in the course of his closing submissions, that the tentative concessions made by M, coupled with the far more detailed acknowledgments relating to M's own health behaviours led, in the early stages of this litigation, to a view amongst the professionals that the threshold criteria might not be in dispute. It was thought that the focus of the litigation would likely centre upon the potential for therapeutic help as a pathway for LM's potential rehabilitation to M's care. In the event, the threshold criteria remained disputed. However, I do not consider that M's evidence, looked at in its totality, veered markedly away from her earlier acknowledgments.

17. In her evidence, both in chief and in cross examination, M was wildly inconsistent, often in consecutive sentences. She accepted with readiness that she may have exaggerated some of LM's symptoms and volunteered that she thought that it was possible that *"my mind plays tricks on me and I see things that are not there".* M specifically identified that she might have, on occasions, interpreted LM's breathing as fast and breathless when it might well have been entirely normal. Though M has been able to understand that she might exaggerate LM's symptoms, this has always been expressed in largely theoretical terms, but never contextualised in the way that she is able to when recognising her FII behaviour in her own presentations. Dr Fear also

highlighted this dichotomy. M's account of LM's breathing (above) is the only concrete example she was able to give and even this did not appear to relate to any particular incident.

The Framework of the Applicable Law

18. The question arises as to how M's similar FII behaviours, surrounding her own health should be evaluated when considering the allegations in respect of LM, which form the basis of the threshold criteria. In ***O'Brien v Chief Constable of South Wales Police [2005] UKHL 26; [2005] 2 AC 534***, the House of Lords considered the issue of similar fact evidence in civil cases, where it is contended that an individual's behaviour in other circumstances makes it more likely that he will have behaved in the manner now alleged because it is evidence of a propensity to behave in that way. Lord Bingham stated the position in this way;

> *"3. Any evidence, to be admissible, must be relevant. Contested trials last long enough as it is without spending time on evidence which is irrelevant and cannot affect the outcome. Relevance must, and can only, be judged by reference to the issue which the court (whether judge or jury) is called upon to decide. As Lord Simon of Glaisdale observed in Director of Public Prosecutions v Kilbourne [1973] AC 729, 756, "Evidence is relevant if it is logically probative or disprobative of some matter which requires proof ..... relevant (ie. logically probative or disprobative) evidence is evidence which makes the matter which requires proof more or less probable".*
>
> *4. That evidence of what happened on an earlier occasion may make the occurrence of what happened on the occasion in question more or less probable can scarcely be denied. ... To regard evidence of such earlier events as potentially probative is a process of thought which an entirely rational, objective and fair-minded person might, depending on the facts, follow. If such a person would, or might, attach importance to evidence such as this, it would require good reasons to deny a judicial decision-maker the opportunity to consider it. For while there is a need for some special rules to protect the integrity of judicial decision-making on matters of fact, such as the burden and standard of proof, it is on the whole undesirable that the process of judicial decision-making on issues of fact should diverge more than it need from the process followed by rational, objective and fair-minded people called upon to decide questions of fact in other contexts where reaching the right answer matters. Thus in a civil case such as this the question of admissibility turns, and turns only, on whether the evidence which it is sought to adduce, assuming it (provisionally) to be true, is in Lord Simon's sense probative. If so, the evidence is legally admissible. That is the first stage of the enquiry.*

> *5. The second stage of the enquiry requires the case management judge or the trial judge to make what will often be a very difficult and sometimes a finely balanced judgment: whether evidence or some of it (and if so which parts of it), which ex hypothesi is legally admissible, should be admitted. For the party seeking admission, the argument will always be that justice requires the evidence to be admitted; if it is excluded, a wrong result may be reached. In some cases, as in the present, the argument will be fortified by reference to wider considerations: the public interest in exposing official misfeasance and protecting the integrity of the criminal trial process; vindication of reputation; the public righting of public wrongs. These are important considerations to which weight must be given. But even without them, the importance of doing justice in the particular case is a factor the judge will always respect. The strength of the argument for admitting the evidence will always depend primarily on the judge's assessment of the potential significance of the evidence, assuming it to be true, in the context of the case as a whole.*
>
> *6. While the argument against admitting evidence found to be legally admissible will necessarily depend on the particular case, some objections are likely to recur. First, it is likely to be said that admission of the evidence will distort the trial and distract the attention of the decision-maker by focusing attention on issues collateral to the issue to be decided. This… is often a potent argument, particularly where trial is by jury. Secondly, and again particularly when the trial is by jury, it will be necessary to weigh the potential probative value of the evidence against its potential for causing unfair prejudice: unless the former is judged to outweigh the latter by a considerable margin, the evidence is likely to be excluded. Thirdly, stress will be laid on the burden which admission would lay on the resisting party: the burden in time, cost and personnel resources, very considerable in a case such as this, of giving disclosure; the lengthening of the trial, with the increased cost and stress inevitably involved; the potential prejudice to witnesses called upon to recall matters long closed, or thought to be closed; the loss of documentation; the fading of recollections. … In deciding whether evidence in a given case should be admitted the judge's overriding purpose will be to promote the ends of justice. But the judge must always bear in mind that justice requires not only that the right answer be given but also that it be achieved by a trial process which is fair to all parties."*

19. In ***R v P (Children: Similar fact evidence) [2020] EWCA Civ 1088,*** Peter Jackson LJ undertook a review of the principles of similar fact and propensity evidence as they relate to the family court. Considering the judgment of Lord Bingham (above), Jackson LJ proffered the following analysis:

[24] This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible.

Secondly, is it in the interests of justice for the evidence to be admitted? This calls for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.

[25] Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established?

That question was considered by the Supreme Court in the criminal case of R v Mitchell [2016] UKSC 55 [2017] AC 571, where it was said that the defendant, who was charged with murder by stabbing, had used knives on a number of other occasions, none of which had led to a conviction but which on the prosecution's case showed propensity. Lord Kerr addressed this issue in the following way:

"Propensity - the correct question/what requires to be proved?

A distinction must be recognised between, on the one hand, proof of a propensity and, on the other, the individual underlying facts said to establish that a propensity exists. In a case where there are several incidents which are relied on by the prosecution to show a propensity on the part of the defendant, is it necessary to prove beyond reasonable doubt that each incident happened in precisely the way that it is alleged to have occurred? Must the facts of each individual incident be considered by the jury in isolation from each other? In my view, the answer to both these questions is "No".

The proper issue for the jury on the question of propensity… is whether they are sure that the propensity has been proved. … That does not mean that in cases where there are several instances of misconduct, all tending to show a propensity, the jury has to be convinced of the truth and accuracy of all aspects of each of those. The jury is entitled to - and should - consider the evidence about propensity in the round. There are two interrelated reasons for this. First the improbability of a number of similar incidents alleged against a defendant being false is a consideration which should naturally inform a jury's deliberations on whether propensity has been proved.

> *Secondly, obvious similarities in various incidents may constitute mutual corroboration of those [24]*
>
> *This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible. Secondly, is it in the interests of justice for the evidence to be admitted? This calls for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.*
>
> *[26] Again, this analysis is applicable to civil and family cases, with appropriate adjustment to the standard of proof. In summary, the court must be satisfied on the basis of proven facts that propensity has been proven, in each case to the civil standard. The proven facts must form a sufficient basis to sustain a finding of propensity but each individual item of evidence does not have to be proved.*
>
> *[27] The issue of similar fact evidence was considered by this court in the family case of Re S (A Child) [2017] EWCA Civ 44. A mother appealed against the dismissal of allegations of domestic abuse, including sexual assaults, by a father. One of the grounds of appeal was that the judge had erred in excluding similar fact evidence in relation to the father's alleged rape of a previous partner. That argument did not succeed for reasons given by Black LJ at [63] and summarised at [58]: the judge had excluded the evidence because the material had only very recently surfaced as part of the mother's case, that the previous partner was not being called, and that it would be unfair to the father to explore the allegation with him on the basis of the paper evidence alone. In other words, the evidence was potentially relevant but it would have been unfair to have allowed the mother to have relied upon the alleged rape of a previous partner.*
>
> *[28] I mention this decision because it touched on the question of similar fact evidence, but there are significant differences between that case and the present one, both as to the underlying facts and the procedural history. In particular, in the present case, the father had been aware of the allegations for well over a year and the allegations were contained in professional reports that the court itself had directed should be gathered."*

20. In ***F v M [2021] EWFC 4,*** I also considered the application of similar fact evidence, in the context of relationships where repeat allegations of coercive and controlling behaviour were made. The essence of the approach is threefold: relevance of the material; admissibility and

fairness. In principle and for obvious reasons, the law should follow a process of thought which an entirely rational, objective, and fair-minded person might follow. The admissibility of evidence will depend on its potential significance, in the context of the wider canvas of the forensic landscape.

21. The application of these principles in a case presenting allegations of this kind, requires subtlety and particular care. To be clear, M has been diagnosed as having an Emotionally Unstable Personality Disorder (EUPD), which likely causes fluctuations in mood. She has also been assessed as having a factitious disorder which has resulted in multiple attendance and admissions into hospital since her early teens. This behaviour continued during her pregnancy with LM.

22. I do not consider M's diagnosis of EUPD to be evidentially supportive or in any way probative of the identified allegations: see ***Re M and R (Child Abuse: Evidence) [1996] 2 FLR 195; Re CB and JB (Care Proceedings: Guidelines) [1998] EWHC Fam 2000***. No party has suggested it should be. Nor do I assess M's FII conduct per se, in the context of her own health, as being so strikingly similar to the general allegations concerning LM that they become probative of them. There are undoubted traces and echoes but, for the most part, perhaps inevitably, they differ in both their nature and degree. However, there is one allegation where the similarity is striking and, in my judgement, legally admissible. The question is therefore whether it would be fair to M to take it into account when considering whether that particular allegation is established. The allegation concerns fabrication of blood in a nappy. I will address it in due course. At this stage, I simply set out what I consider to be the correct approach in law, both to this particular allegation and more generally.

23. The Local Authority has produced a detailed Schedule of Findings. I do not propose to burden this judgment by setting these out. Essentially, they reflect Dr Adeyemi's conclusions; see paragraph 11 above.

The Evidence and Findings

24. LM was born on the 12th March 2020. She was entirely healthy. The birth notes describe her variously as *"pink", "warm",* and *"alert*". She was feeding entirely appropriately. The Newborn Infant Physical Examination procedure revealed no issues of concern. Mother and baby were discharged within 24 hours. The following day, M brought her daughter back to the hospital. She was concerned with what she reported as *"shaky episodes"*. M said she had noticed these movements from LM's birth. She stated that *"they spread across her whole body"*, both *"when she was awake and asleep"*. This is entirely inconsistent with all the medical observations of LM in her first 24 hours of life. M's concerns were, however, taken seriously. She was reassured that she was seeing entirely normal neonatal movements. A senior review was arranged which concluded that her movements were normal. It was suggested, sensitively and in a way that was intended to reassure M, that if there were any further episodes that she might like to film them. LM was discharged. No film has been presented.

25. Seven days later, her parents presented LM at the Accident & Emergency department. M reported that LM had been lethargic and there was a small lump, said to have been at the back of the head following birth, which had increased in size. LM was not at all lethargic on examination. On the contrary, she was alert and well throughout the course of the examination. She did not require admission. In this period, M was having contact with Ms Sarah Hull, Family Nurse Partnership, on a regular basis. The two spoke on the 23rd March and there was a text exchange, on the 25th March. The family nurse noted:

> *"Mum reported that [LM] has a cyst on the back of her head which has been seen by medics in A&E. An appointment with*

> *paediatrician has been made for 01/04/2020 – cyst not seen by family nurse over video call."*

The records reveal no mention of a cyst. There was not a cyst nor was there an appointment with a paediatrician on the 1st April. I have little difficulty in concluding that all this is an example of M's exaggeration/fabrication of her daughter's health.

26. On the 3rd April, M had a telephone consultation with her GP. He diagnosed *"white coating tongue and buccal mucosa of mouth, not unwell".* The GP suggested *"possible thrush"*. The following day, M contacted the out of hours GP service, reporting that LM had a temperature of 39.2 degrees and was *"white inside the mouth"*. M said, that had been the case for two days. The records do not record M informing the out of hours service that she had already spoken to the GP, who had attempted to reassure her. Unsurprisingly, given the reported temperature, LM was referred immediately to hospital. At the hospital, the following history is recorded, as having been given by M:

> *"Under arm thermometer reading 39.7, then retook and 33ºC. Bit more unsettled taking -50-75% feeds, still waking for some feeds. Mum noticed lots of white coating in mouth"*

27. Dr Milner, who was the treating clinician at the Emergency Department, told me in her evidence, that the temperatures given by the mother were not, in effect, a recognisable clinical scenario. A temperature of 39.7 could only indicate a child who was very seriously ill. M's suggestion that the temperature dropped dramatically to 33, in a very short period, was also not a medically credible account. With fidelity to his instructions, it was suggested by Mr Dodd, on behalf of M, that the administering of Calpol might have remedied this *"temperature spike"*. This was discounted by the doctors.

28. In a particularly confused patch of her evidence, M told me that the underarm thermometer she was using was broken. She told me that she knew it was broken. She did not mention this on admission, and I pause to reflect that the primary driver for the emergency admission, was the account of LM's temperature. In fact, on examination, LM's temperature was 36.3ºC i.e., entirely normal, and she was described as *"alert and active"*. It is necessary to record that, in the observations of all the medical professionals on every single presentation, LM is observed to be a very alert, healthy baby. She is fortunate enough to enjoy rude good health.

29. Primarily in consequence of the *"reduced feeding"* reported by M, LM was admitted on to the paediatric ward for observations and for screening. The investigations were all negative.

30. Looking at the whole course of this admission, it once again becomes clear that this is an episode of fabricated illness. As Mr Spencer notes, M's account to the family nurse of this incident, 5 days later, takes a yet further twist and bears no relationship to anything recorded at the time or subsequently advanced by the mother. On the 9th April 2020, M's account became *"[LM] was admitted to [hospital] overnight last week following 111, under the query Covid pathway due to raised temperature"*. Again, this is a plain distortion.

31. In May 2020, concerns of a completely different complexion arose, following LM being admitted for medical re-examination and investigation with bruising to her face.

Concerns were such as to trigger a Section 47 safeguarding investigation. It is not necessary to track these through here, other than to say that the concerns were properly identified, and the investigation satisfactorily concluded. What is of note, however, is that during this period M and F and LM were living with the paternal grandparents. I have heard that they take a particularly dim view about M's frequent visits to the hospital, either for herself or for LM. It is a fact that throughout this period, LM was not presented to healthcare professionals.

32. F is a serving soldier and as part of the Child in Need protection plan, it was agreed that there would be some ongoing support from the Army Welfare Service. They concluded their involvement on the 7th August 2020.

33. On the 28th August, M sent an email to the GP Surgery requesting a consultation.

> *"It is for my daughter [LM]…she has these weird red marks all over her body… Arm, Abdomen, Face, chest, leg…Raised like sandpaper…*
>
> *My partner suffered from scolded skin disease as a baby and I had bad meningitis"*
>
> *Photo uploaded*
>
> *"My little girls rash this is what it's like over her body and I think it hurts her as when I put her cream on, she cries"*

The email is peppered with alarming descriptions. It was accompanied by a photograph at the surgery's request. The view was taken that it looked to be fungal, and that she should be examined and perhaps prescribed cream. M was told to call surgery to book in for a GP appointment the same day. She did not. This behaviour resonates with Dr Adeyemi's summary as to the markers of FII. M has stated that she was indeed offered a GP appointment, but that it was two weeks later. She suggested that this was too long and explains that she decided to take LM to the hospital instead. This is flatly contradicted by the evidence of Dr Winning, who is clear that he advised an appointment on the same day. Having regard to the language used by the mother e.g., meningitis, it is easy to see why he would have preferred a speedy appointment. For the avoidance of doubt, where M's evidence contradicts that of Dr Winning on this point, I prefer the evidence of Dr Winning. It is also pertinent to note that, contrary to M's assertion, there is no record of LM having been presented to the hospital in this period either.

34. LM was in fact presented to the hospital on the 13th September 2020. M reported that LM was *"febrile, with a temperature of 39^{o}C, not feeding as well, rash on belly"*. The temperature was normal, and it was noted *"skin-some dry rash blanching to abdomen and left arm. No petechiae."* On the 18th September, M again, emailed the GP surgery seeking a consultation. LM was reported, by M, to have *"rash all over body"* for *"4-5 days"* and that it was *"raised, doesn't disappear with glass, red look like blistering"*. Photos were also uploaded. It is significant, to my mind, that notwithstanding this alarming description, M spoke with the family nurse at 13:00 on the same day and made no reference to the rash at all. On the contrary, she is reported as saying that *"LM was well"*. Dr Winning saw LM that evening. He identified a rash which he considered

"*looked like eczema*". On this occasion, M said it had been present for approximately a month. That was simply irreconcilable with her earlier accounts. The narrative history given by the mother, when considered in its totality, lacks any coherence.

35. In October, M sought further medical attention relating to 'a rash'. On the 13th October she contacted 111, reporting that LM had developed a rash *"one hour ago"*. It would appear therefore, that this was a different rash to the one analysed above. LM was said to be behaving *"normally"*. M was advised to contact the GP immediately. M had a telephone consultation the same day where it is recorded that he is told that the rash appeared to be spreading *"now on back, legs and arms"*.

36. Given these descriptions, it was thought necessary to arrange a face-to-face appointment. On this occasion, the history changed:

> *"rash over abdomen for more than 6 weeks now – not responded to HC 1% and PO Amox. Mum reports worsening of rash and [LM] more unsettled by it". On examination: "gen blanching rash to chest and abdomen. No vesicles. No infective element. Dryness ++"*

The rash was now said to have been present for more than 6 weeks and was said not to have responded to the antibiotics. On the 15th October, M contacted the surgery again and stated that LM *"hadn't stopped screaming all day"*. The Local Authority contend that the mother exaggerated the nature and scale of the rash. I agree that there is a plain disparity between that which has been observed and that which is reported. It is further contended that M has given an inconsistent history which has led to a confused clinical scenario, which creates real potential for errors in medical treatment. Again, I agree. Mr Spencer invites me to say that the reason the rash failed to respond to treatment could only have been because the mother failed to apply the treatments given, in the manner advised. This may be right, but it is essentially speculative, and I draw back from making such a finding.

37. On the 22nd September 2020, M contacted the GP Surgery. On this occasion, she was reporting a distressed child. LM was over 6 months old by this stage. M was concerned by the extent to which LM was coughing and said that she had gone downhill on her antibiotics. Though she had contacted the GP surgery, she indicated that she was going to telephone 999. M did not contact 999, nor did she seek emergency treatment. It is obvious that had LM been as ill as the mother had insinuated, she would have taken her to the hospital. The only logical inference that can be drawn, was that M was exaggerating or fabricating what she described. In her evidence to me, she said that she had no recollection of this incident at all. It is very difficult to evaluate the accuracy or honesty of the mother's evidence, but if it is indeed true that she has no recollection of telephoning the GP and talking to him about an emergency ambulance, and a 999 call, it is a graphic indicator of how medicalised LM's life had become. All this relating to a child who had absolutely no serious health issues.

38. On the 19th October 2020, M contacted the GP complaining that the three courses of antibiotics that had been prescribed for LM, had *"not done anything for her"*. LM is described as *"very whingy"*. M also reported *"chest is rattling when breathing"*. When LM was examined, she was described as looking *"alert and well"*. There was no evidence of chest recession and no evidence of any difficulty in breathing. The GP, in

what I consider is an attempt to reassure or placate M, suggested that the problem might be viral.

39. It is striking that the observations of the GP resonate with what M then told the family nurse the following day. A note of that conversation records that M reported *"LM is doing well"* and that she had *"no current issues of concern regarding her development, health, or behaviour*". This is entirely irreconcilable with the events of the day before. Whilst I am entirely satisfied that M had fabricated the history of coughing and breathing difficulty, I note that the doctor did not discount that she might have a viral illness. I very much doubt he thought this was likely, and as I have said, I think it was intended to reassure M. On this basis alone, it is difficult to understand how M's account to the family nurse could have been so strikingly positive. The only logical conclusion, looking at the breadth of the evidential canvas, is that LM was indeed doing well and that her symptoms were entirely fabricated. When asked about this in cross examination, M struggled, I do not discount genuinely so, to reconcile the contradictory evidence.

40. On the 8th November 2020, M again contacted 111, complaining that LM had a temperature, breathing problems, and was generally unwell. LM was also said not to have been eating or drinking for two days. M was sufficiently descriptive to persuade the call operator to advise that she attend a treatment centre within 1 hour. An appointment was made with the out of hours doctor. M did not attend. M contended in her statement, dated 13th December 2021, and in her evidence, that she had been told that a practitioner would call her back in an hour. On this, I reject her evidence, I consider that the description she provided would have elicited the response described. I also note that M had behaved in a similar way on the occasions analysed above. Thus, the history provides corroborative evidence in support of my finding that M is untruthful in this account. Moreover, despite the worrying presentation she had described, M did not take LM for treatment that day at all. The following day, the 9th November 2020, the family nurse visited and found LM to be "*bright and alert, clean and appropriately dressed, full of smiles and giggled when mum was tickling her and playing with her"*. I conclude that this was once again, a fabricated illness.

41. On the afternoon of the 4th January 2021, M telephoned the family nurse and informed her that LM had fallen down a gap in her friend's sofa. LM could be heard crying in the background. M was not clear where LM had banged herself or where she had landed. The family nurse checked for *"red flag symptoms"* such as loss of consciousness and vomiting. M was advised to take LM to A&E to be checked over.

42. M attended at the hospital, she gave a far more detailed account of the accident and reported that LM had cried immediately, vomited after being fed, and had an episode of unconsciousness that lasted 5 minutes. At some point, after speaking to the family nurse, M telephoned 999 and was taken to the Emergency Department. A further symptom was reported, namely a waxy fluid coming out of the left ear, after the fall. I have been told, in evidence, that this can be associated with cranial injury. What is striking is the detail of the description as well as the absence of any mention of it to the family nurse. M told me, in her evidence, that she sometimes consults *"Dr Google"* when looking for symptoms. Given the very specific nature of this description and its association with a head injury, I consider that it is a carefully crafted fabrication designed to signal that LM was seriously unwell. When LM was examined, nothing of concern was identified.

43. The following day, the family nurse attended the mother's home to check that all was well following the fall. She too found nothing to concern her, but her notes record that M stated that the doctor who saw LM in A&E *"raised with her that [LM] appeared to be jaundiced".* LM is, by this stage, 9-months of age. I have been told that whilst neonatal jaundice is relatively common, jaundice at this age would be a real concern. The family nurse could not see evidence of jaundice. I emphasise that the doctor did not make any record of any concern regarding jaundice. I am satisfied that had he had such concern, he would have recorded it and would not have discharged LM. In any event, M made a GP appointment to discuss what she now believed to be LM's jaundice. This was a telephone consultation. The GP on this occasion, recorded the following:

> *"Maternal concern*
>
> *Seen in A&E yesterday with minor head injury*
>
> *Mum reports that was advised to see GP about possible jaundice (no reference to this in A&E notes)*
>
> *[LM] had neonatal jaundice but normal bili on screening bloods at 8w old. Mum says that in the last month or so [LM] has looked a little orange on cheeks, nose, and hands.*
>
> *Not unwell in herself. Growing along lower centile line. Feeding ok. Poos sticky but normal colour urine strong smelling. Not concerned about general wellbeing. Occasional vomits*
>
> *TCI for face-to-face assessment"*

44. A face-to-face appointment had been arranged for two days later. LM was found to be entirely within normal limits. I reiterate that the descriptions of the medical professionals invariably describe a child who is "*alert, happy, not unwell, interested in her surroundings"*. Again, that was the case here. The GP had arranged for a face-to-face meeting, *"because of the slightly unusual nature of mum's concern"*. It is clear that none of the professionals was concerned that LM might be jaundiced. In the course of efforts to reassure her, M had been told that LM's stools were regular and healthy and that it would be more concerning if they were paler. On the 10th January 2021, M reported that LM had been passing pale stools.

45. The report was made to a paramedic who encountered M taking LM to the A&E. The reason for the visit on this occasion was that M had become distressed and had passed two pale stools the previous day. M alleged that whilst on the way to the hospital, LM had become unresponsive and asked a passing man for help. The ambulance attended and conveyed LM and her mother to the hospital. The paramedics records reveal a further evolution of the history. Namely, *"a lump in the abdomen but… which causes pain… when touched"*. By the time LM is seen by the doctor, M presents a history which is carefully crafted to signal the presence of jaundice. It is important to set them out as recorded in the medical records:

> *"Mother noticed that the sclera of eyes became jaundiced a week ago.*

> *Skin always been slightly orange from birth but did not need phototherapy.*
>
> *Saw GP a week ago who said to observe but no blood test.*
>
> *Light poo and dark urine in the last couple of days.*
>
> *Open her bowels today after lunch which was tarry black.*
>
> *The mother states that [LM] did not respond to he when pushing her in a pram. Tried to wake her up since she was asleep prior to calling her. She shook her to wake up but [LM] did not respond.*
>
> *Standby man saw it and called an ambulance on mother's request…"*

46. I should also had that M described a paternal history of liver problems. Once again, LM's robust appearance confounded the given history. She was described as looking well, *"Very active… can't sit still. Happy child"*. Though she is described as having slightly orangey-pale skin, there was no rash, no bruises, and no indication of jaundice in the sclera of the eyes, as described by mum. Later that evening, M expanded the family history to include a further family member said to have had liver failure. She also described the incident enroute to the hospital as one in which LM went quiet and was unresponsive for 3-4 minutes and disoriented thereafter. The hospital discharged LM but settled on a plan for blood tests and an ultrasound the following day. The tests were normal.

47. On the 11th January, M gives a further history of symptoms overnight and in the morning. The records for this encounter, state as follows:

> *"Previous jaundice - did not require ptx*
>
> *Has been jaundice past 3 months. Sunday white stool 4x, then black in colour, not opened since. …*
>
> *Mother reports only having 1 ounce since yesterday, passing good amounts*
>
> *PU yesterday*
>
> *Eating pasta and tomato or lasagne, no excess of carrots or sweet potato…*
>
> *Vomited x2 this morning.*
>
> *Mother describes lumps to Abdo on/off*
>
> *Some liver problems in both parents' fathers? diagnosis"*

Observation of LM, revealed her to be alert, smiling and playing. Stomach non-distended, no masses. Yellow discolouration to face, sclera white. The blood tests were repeated and a mildly raised urea noted the day before, had been resolved.

48. Later that afternoon, LM was seen by both the Consultant and the Registrar. M reported that LM had vomited that day, but also introduced a further and alarming claim, namely that LM had *"one nappy, today red in colour but now clear"*. M accepts that she reported blood in LM's nappy. When asked by Mr Povoas, M accepted that she had falsified evidence of blood in her own medical history. She told me how she would sometimes prick her finger, on one occasion, with the blade of a pencil sharpener to draw the blood. When she was asked by Mr Spencer what the blood looked like on the nappy, she described it as *"looking as if it had been smeared on by a finger"*. The Consultant reviewed LM an hour after the pink/red stained nappy that had been produced and found a new nappy full of normal urine with no evidence of blood. The Consultant informed M that this was clinically abnormal. It was very unusual to have passed blood and then to immediately afterwards, *"pass a normal urine"*. On being confronted with this, M suggested that the red stain might be a nappy rash. Having regard to the totality of the evidence on this point, I am satisfied that this was blood deliberately introduced by M, wrongly to elevate medical concern. Because it is so strikingly similar to M's behaviour in the context of falsifying her own symptoms, I find that behaviour to be corroborative of my findings in relation to the nappy.

Conclusion

49. The history that I have laboured to set out in some detail, reveals an escalation of behaviours which I find to be, in the manner that I have described, consistent with factitious and induced illness. The artificial introduction of blood represents a significant escalation in the seriousness of that behaviour. The Local Authority have, in Mr Spencer's thorough and detailed written opening, set out a wider raft of incidents which support the finding I make. It is not necessary for me to further burden this judgment by analysing each of them. They add nothing to the findings I have made. In particular, they do not contain allegations of greater gravity than that which I have found.

Therapeutic Assessment

50. Despite the seriousness of the findings I have made, it is impossible not to feel sadness for and sympathy towards this young woman. As the psychiatric evidence establishes, she has had an abusive childhood which has left her with considerable challenges consequent upon her EUPD. As a teenager, she was unable to engage effectively with the therapeutic support offered by Child and Adolescent Mental Health Services (CAMHS).

51. Dr Fear has told me that therapy involves individual psychological therapy for EUPD which, according to current best practice, is likely to take a minimum of 12 months from the commencement of engagement. However, he also identifies a need for additional therapeutic work to address the illness fabrication in herself and, as I find, the child. This is likely to take a further 12-18 months and will require a therapist who has experience of working in such circumstances.

52. Dr Fear does not consider that M has ever engaged with psychiatric assessment or therapy in any meaningful way. While she presents herself, in his assessment, as someone who has the intelligence to understand that she needs therapy, he considers that she lacks the emotional maturity to understand what it entails or to commit to anything other than short term counselling. Her counsel, Mr Dodd, took her through her evidence in chief in which she expressed a willingness to undertake therapy, but did not consider that she needed anything as extensive as Dr Fear suggested. I agree with Dr Fear that M presents as an intelligent woman. I sensed that on some level, she was frightened by therapy and, in particular, what it might open for her. She is a determined personality and, as I have commented already, aspirational. Her marked resistance to engagement in therapy may simply be, as Dr Fear concludes, a consequence of her emotional immaturity. It struck me that she somehow sensed that it might involve a regression for her in her general ability to cope with life.

53. There is no evidence, as Dr Fear highlights, that M has ever recognised or *"acted proactively in respect of deterioration in her mental health and there is no reason to believe that she will be capable of doing so without therapy"*. He is of the opinion that M will continue to respond to stressful life events by acting impulsively without consideration of the consequences, even though this is likely to mean putting her own needs before those of her child. There have been many positive comments by a variety of professionals on the quality of M's interaction with LM. I have no doubt that M greatly loves her daughter. However, it does need to be stated, unambiguously, that LM's many presentations to the doctors and healthcare professionals with exaggerated, falsified or fabricated symptoms represent a consistent inability on M's behalf to put her daughter's needs before her own. The motivation for such behaviour is difficult to fathom. It is clear that in the sphere of her own health, fabricating illness brings the mother a degree of comfort which she finds irresistible. I am driven to conclude that she found similar comfort by presenting LM. It is also manifest that were LM to continue to be exposed to it, it would cause her significant emotional harm.

54. Mr Dodd seeks, in effect, an adjournment to evaluate M's capacity actively and constructively to engage in the therapeutic process. He, correctly to my mind, identifies M's candour in relation to her own FII and her tentative and tenuous insights into her behaviour with LM as signalling fecund territory for positive therapeutic involvement. Such frankness is, he correctly submits, vanishingly rare in allegations of this kind and indeed more generally in contested fact- finding hearings in public law care proceedings. Dr Fear produced his substantive report in August 2021. It may be that there might have been some traction in the argument at that stage. To date, however, the prognosis for engagement remains as it was in August, poor. M is young, emotionally immature and with limited social support. Her understandable focus on having LM returned quickly to her care is impairing her willingness to consider anything but short-term psychological work. It must also be recognised that, even on this basis, her record of successful past engagement is non-existent.

55. Accordingly, though I would wish to pay tribute to M's courage, the argument advanced on her behalf involves delaying a decision for LM for a period in excess of two years, with no positive prognostic indicators. These timescales are irreconcilable with LM's welfare. She has been in the care system for over 12 months, she is now 2 years of age. Further delay would not only be inimical to her welfare, it carries a significant risk of scuppering her opportunity for any stable and loving home in which she may be

afforded the opportunity to reach, what I suspect may be her considerable potential. Her need is immediate one, for a permanent and secure home.

Application for Assessment by Extended Family Members

56. Very late in the day, paternal relatives have come forward. N, is the half sibling of F and K, is his partner. They have never met LM. They have told the social services, and I accept, that they have only known about LM's current situation for the past month. I do not know what this signals in terms of the family's communications with each other, nor do I speculate. It is self-evident that an application made at a final hearing, in a case that has been before the Court for over 12 months, presents real challenges. The pace of proceedings must always be set by the needs of the child and not the exigencies of the litigation. Children's lives cannot be 'freeze framed' or kept in suspended animation whilst the adults organise their options. In this sphere of law, it cannot be repeated too often that the child is the paramount consideration. I touch upon the difficulties that such applications present in: ***Tower Hamlets London Borough Council v (1) D (2) E (3) F [2015] 2 FLR 535*:**

> *"Before turning to the respective arguments, I should observe that, to my mind, even the prescient architects of the Children Act 1989 could not have envisaged the considerable cultural changes that were to take place in the United Kingdom in the 23 years that followed the implementation of that Act. British society is now multicultural. Assessing parents and family members may, quite frequently does, involve considering individuals based anywhere in the world. I do not believe that the obligation to* ***explore*** *the family option for a child is weakened in any way by geography, although it can provide real challenges to already overstretched resources. The viability of these options must, from the outset, be evaluated rigorously and reviewed regularly. The need for such assessments must be addressed at the very beginning of proceedings. Late identification of potential family carers abroad may bring two fundamental principles of the Children Act into conflict, namely the desirability, if possible, of a child being brought up in its extended family (where parents are for some reason unable to care for the child themselves) and the need to avoid delay in planning for a child's future. Neither principle should be regarded as having greater weight. The recent reforms to the family justice system have sought to emphasise why it was that the avoidance of delay was given statutory force by the Children Act and the real and lasting harm delay causes to children, particularly in public law care proceedings. There will, in my judgement, be occasions when the obstacles to assessment of family members abroad create such delays that to pursue the option will be inconsistent with the child's own timescales. These are taxing and exacting decisions but they require to be confronted with integrity and without sentimentality."*

57. It was also clear that the paternal family has conveyed a very negative impression of the mother. To his credit, N told the social worker, Ms Beth Christopher, that LM's

grandfather never had anything positive to say about her mother. Ms Christopher has endeavoured to undertake a preliminary assessment of these extended family members in challenging circumstances and over a very short timescale. I have found Ms Christopher to be impressive, both in her analysis of the evidence generally and in her sensitivity to the parents. Ms Christopher has identified the couple as *"very apprehensive"* about the assessment process and vigilant to protect their own privacy. This is not only in the context of the assessment but reflects a code of behaviour. They have both expressed understandable worries about the intrusive nature of any assessment. The social worker considers it would be challenging to them. There is a real risk that they might withdraw and indeed, a week ago, they sent an email signalling that they wished to disengage with the assessment. However, they recanted in a few days. I set this out as a facet of the chronology, it should not be taken by N and K as a criticism, it is not.

58. It is also clear that N, lacks a degree of subtlety in his use of language, particularly, in respect of M's father whom he considers to be a "sociopath". The couple, as I understand it, is in their forties. They do not have any experience of parenting. LM is a child who has experienced trauma and as Ms Christopher observes, is likely to require from her carers, a high degree of insight, empathy, and patience.

59. N and K live in America, K is a US Citizen and N holds a green card permitting permanent leave to remain in the US. The proposals that they make for care involve some very obvious and considerable challenges:

    i. Their application would be to adopt LM. This would be an international adoption and, accordingly, a lengthier process;

    ii. The couple has never met LM and have therefore, no relationship to build on. Whilst this would undoubtedly be true in the case of a stranger in an adoption, it also has to be recognised that one of the key advantages of a family placement, i.e., an existing relationship, is not a factor here;

    iii. F has evinced a clear intention to take no further part in his daughter's life. He indicated that this would remain the case even if his half-brother were to adopt his daughter. It strikes me that this creates a difficult life story from which LM can construct a positive image of herself;

    iv. By contrast, M actively supports the extended family's application but, she does so only because she sees it as a lifeline to her daughter which holds out for her, both the prospect of contact and reunification. This is not support which promotes the security of the placement. Indeed, it threatens to undermine it;

    v. The Adoption Orders inevitably involve a legal distortion of LM's family relationships. Her uncle, it is proposed, will become her father. Her father may become a peripheral figure on the edge of her family life. Her grandparents have a deep and entrenched hostility to the mother, which is so embedded as to be likely to communicate itself to LM, jeopardising her own sense of self and self-esteem.

60. The local authority submits that the challenges of N and K's proposal and the stage at which it arrives, renders it effectively irreconcilable with LM's pressing need for stability and a loving home. I agree.

61. LM's Guardian, Ms Deborah Day, has speculated whether a very short period of further assessment should be undertaken. As I understand it, she was contemplating something in the region of 7 days. N and K's application had come, as I have said, very late in the day and Ms Day recognised that she had little opportunity to appraise herself of it and think it through. As she did so in the witness box, the force of her own reasoning really caused her to move away from her suggestion, and ultimately, Mr Povoas, who acts on her behalf, told me in his closing submissions that the Guardian would not oppose the Local Authority's position. Ms Day recognises, as do I, the importance wherever possible of a child being able to live within her family. Though this application has been advanced very late in the day, it has been given very careful thought by all the professionals, not least, if I may say so myself. Ultimately though it is a courageous application, it is also an ambitious one which confronts very significant and lifelong challenges. The assessment process would inevitably have to be intrusive, which N and K would instinctively recoil from. It is also likely to involve, as Ms Christopher suggested, some structured preparatory work involving attachment training and safeguarding training. This in itself, is likely to take 10 weeks, perhaps longer if it has to be conducted remotely. If all went well, there would have to be introductions, negotiated with the additional challenges of the distances involved and the disruption to N and K's work pattern.

62. I do not doubt the sincerity of N and K's application. I pay tribute to them, at this stage in their life, for having the courage to ask to be considered as parents for an extended family member whom they have never met and of whose circumstances they inevitably know very little about. The application does them great credit. I have been told that they have some appreciation of the adverse impact on LM of any further delay in planning for her welfare. I hope that when they read this judgment, they will understand why I have found it impossible to reconcile their well-motivated application with LM's own needs and individual timescales.