This judgment must not be disclosed to any person or body who is not a party to these proceedings without first obtaining the court's permission. No information that is capable of or may lead to the identification of the children or the parties to this case may be published.

IN THE FAMILY COURT

Before:

HIS HONOUR JUDGE MORADIFAR

Sitting as a Judge of the High Court of Justice

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.

In the matter of:

Re W (A child: Emotional Harm)

Nick Goodwin QC and Sara Granshaw instructed on behalf of the Local Authority.

Kate Branigan QC and Amanda Meusz instructed by Ridley and Hall Solicitors on behalf of the mother.

Penny Howe QC and Simon Miller instructed by Clifton Ingram LLP on behalf of the father.

Roma Whelan and Previn Jagutpal instructed by the Head Partnership Solicitors on behalf of the child

Date of the hearing:

25 to 29 November,

2 to 6, 9 to13 and 16 to 20 December 2019

HHJ Moradifar

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Judgment

His Honour Judge Moradifar:

Introduction

1. The local authority invites the court to make a care order in respect of H who is sixteen years old. She currently resides in a residential setting and is making plans for her future as a care leaver. Her parents are respondents to the application and join H in supporting the local authority's application and its broad care plan. The parents accept that the threshold criteria pursuant to s31(2) of the Children Act (1989) is satisfied in that at the 'relevant date' H was beyond parental control.

2. The local authority pursues several findings against the parents to support a contention that H has been emotionally harmed by and in the care of her parents. The parents made a joint application to the court to vary or limit the scope of the findings and the remit of the final hearing. I heard the application on 14 November 2019 and this judgment must be read together with that earlier judgment (*Re W (Scope of the Hearing)* [2019] EWFC B75). In summary, I agreed with the parents as supported by H through her guardian that it was not proportionate or necessary that the local authority's allegations should be determined to establish that the threshold criteria are satisfied. However, those allegations that were in dispute which informed the expert

opinion should be adjudicated upon. Those allegations are detailed in my previous judgment and I will not repeat them. The local authority seeks additional findings in respect of the issues of Foetal Alcohol Syndrome Disorder ('FASD') and Alcohol related Neurodevelopmental Disorder ('ARND') in the following terms;

"1. There is no evidence to support a diagnosis of FASD/ARND.

2.Dr. Carlisle did not diagnose FASD/ARND in her initial or amended interim reports.

3.Dr. Mukherjee based his diagnosis of FASD/ARND on the mother's false assertion in an email to his clinic on 21 June 2017 that H*'s former foster-carer knew the birth mother had abused alcohol during her pregnancy.*

4.On 16 October 2017 the FASD clinic administrator, having received the mother's false assertion detailed above, emailed her to inform her it was "sufficient for a confirmation of a diagnosis" despite the apparent absence of any evaluation of its significance.

5.Dr. Mukherjee did not take steps to verify the history of alcohol abuse or require the mother to submit verified information.

6.Dr. Carlisle's and Dr. Mukherjee's assessments in relation to ASD and ADHD were largely reliant on parental report and cannot be relied on as valid diagnoses."

The law

3. As the applicant, the local authority must prove its case on a balance of probabilities. Before I can make a care order, I must be satisfied that the "threshold criteria" pursuant to Section 31(2) of the Children Act (1989) is

satisfied. Only if I am so satisfied, can I consider whether making a care order would be in H's best interest. My decision in respect of any welfare considerations must be based on relevant findings. Such findings on disputed facts that inform the expert opinion are crucial to assessing the reliability of the relevant expert opinion.

4. The fundamental legal principles that I must apply when considering the disputed relevant facts are very helpfully summarised by Baker J (as he then was) in *Re JS [2012] EWHC 1370 (Fam)*. Following this decision, Jackson J (as he then was) in *Lancashire County Council v C, M and F (Children: Fact finding Hearing) [2014] EWFC 3* added a further item to this invaluable list of important considerations. Furthermore, I have considered and applied the observations of the former President of the Family Division in *Re A (A child) [2016] 1 FLR 1*. I am not bound by the schedule of findings that the local authority seeks and can make such relevant findings as are appropriate based on the evidence.
5. Finally, each of the respondents has a right to a private and family life together with a right to a fair trial pursuant to Articles 8 and 6 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950). These rights cannot be interfered with unless such an interference is pursuant to a legitimate aim, necessary, proportionate and in accordance with the law. I have had particular regard to the father's needs who is suffering with extreme stress and anxiety. I am most grateful to his legal team who have in discussions with the father made appropriate arrangements that have ensured his effective participation in these proceedings.

Background

6. H spent the early days of her life in the SCBU of her local hospital having been born to a drug dependent mother. Her biological mother used heroin, cocaine and methadone. She suffered with Pierre Robin Syndrome and a cleft palate which was subsequently repaired by surgery. Following her discharge from hospital, she lived with her mother for about twelve weeks before she was placed in foster care. When she was about eleven months old she returned to the care of her mother as part of a residential assessment which lasted three weeks. Thereafter she was placed back with the same foster carer. H experienced a period of stability by remaining in the same placement until she was placed with her adoptive parents (whom I will continue to identify as the parents). H was formally adopted by the parents in 2005 when she was two years old.

7. The parents' older daughter A appeared to have formed a close relationship with H. In the early years following her placement with her family, the mother appears to have struggled with forming and maintaining a bond with H. By 2006 the mother had expressed her concerns about H's delayed speech and a possible need for therapy, perceived issues suggesting a genetic syndrome and her growth. The parents also raised concern about H becoming focused on food and her reluctance to walk. In the same year H was the subject of a battery of tests in respect of her growth. Save for her growth factor being in the 'lower part of the normal range' no abnormalities were found. It was noted that her adoptive placement was at this stage under threat when the parents were noted to be contemplating the discontinuation of H's placement with them.

8. By 2007, H was observed to have made progress with her growth and responding well to structure and boundaries. H was also assessed as presenting with difficulty in socialisation, delayed imaginative play and understanding social boundaries. The professionals were becoming concerned about a lack of emotional warmth from the parents towards H whilst observing that the parents appeared *"emotionally drained"*. The medical investigations that included genetic testing for H continued. H was referred to post adoptive support services who put in place an intensive package of support to 'improve attachments' between H and her parents.

9. H started school in 2008 when she attended 'DSchl'. At school she was observed to struggle with peer relationships and boundaries. The parents sought respite care as they were finding her behaviour challenging. However, they withdrew from this support in 2009. From 2008 the family was given professional support through post adoption services. The mother appears to have gained a great deal of support from Ms J Raymen who continued to work with the family for many years. There were renewed concerns about H's growth in circumstances where Stickler Syndrome had been medically ruled out. In October of the same year, professionals at H's General Practice raised concerns about the mother's observed behaviour and coldness towards H. H's growth issues were investigated with a preliminary finding that she was marginally low in her growth hormones with consideration being given to growth hormone therapy. The mother also raised her concern about possible obesity.

10. In 2009 H was noted to have made excellent progress with her reading and some improvements in her behaviour which appeared to be connected to the advice from CAMHS in setting boundaries. The parents also agreed that H should undergo a period of growth hormone therapy. H was also assessed by CAMHS for Autistic Spectrum Disorder (ASD) and found not to meet the diagnostic criteria: who opined that her difficulties should be seen in the context of *"her attachment disorder"*. The concerns about H's attachment appear to be enduring and the subject of further evidence at this hearing. Later in 2009, H left her school for a mainstream school 'WSL' where she remained until 2013.

11. Concerns about H's behaviour with food were also noted at the school together with issues of enuresis during the day that appeared to resolve overnight. Investigations into the latter issue did not identify a medical cause and advice was given that H should be encouraged to ignore the sensation of needing to use the toilet with the aim that this may reduce her anxieties around these issues. By 2013 Dr Jefferson advised that 'regular and time limited voiding' together with observed and controlled fluid intake may be a strategy that would assist with this issue. This routine was put in place by the parents and continued for the years that followed. H's growth hormone therapy was overseen by Dr Yaliwal who is a Consultant Paediatrician and Ms D Barker who is a dietician.

12. In 2012 H was assessed by an educational psychologist who found her scores for vocabulary and comprehension to be two years below her chronological age. However, her scores for picture concepts and matrix reasoning were about

one to two years above her chronological age. This assessment was repeated in 2014 which identified some improvement.

13. H moved to a specialist school ('MSchl.') in August 2013 where she remained until summer of 2014. Concerns about H's toileting issues continued and the parents continued with professional advice as detailed above. H was assessed by an occupational therapist who identified difficulties in vestibular-proprioceptive processing, some oversensitivity in tactile, auditory and vestibular systems, difficulties in screening out extraneous background visual input and sounds together with some bilateral integration difficulties. The said assessment described H as *"sociable and affectionate in the school setting"*. Before leaving MSchl, H was assessed by Community Health at her local NHS trust and found that she did meet the diagnostic criteria for ASD and that her difficulties were to be observed in the context of her 'Attachment Disorder'.

14. In September 2014 H joined 'BH' which is a day specialist school. She remained there until June 2015. H's regime for toileting had by now been firmly established. Her time at BH was rather unsettled and she presented with concerning behaviour that included aggression towards adults, 'running away' and difficulties in forming peer relationships. Her behaviour continued to deteriorate leading to her departure from BH in June 2015. Her behaviour was not observed at home. Furthermore, in 2015 the results of genetic testing did not reveal any chromosome imbalance.

15. Thereafter H received fifteen hours of home tutoring from a tutor and Ms Raymen continued to support the family. Some of her lessons were held at a local school although she was not integrated into that school. This was

intended to be a short-term measure which continued for longer than intended until August 2016. During this period H's toileting and food regime continued. By the time she joined CH School ('CHS') her food and toileting regime had been firmly in place.

16. On 9 February 2016, H's then General Practitioner referred her for an assessment to a specialist FASD Clinic. On 4 April 2016 the FASD clinic produced a speech and language report (after two days of assessments that took place on 23 March and 27 April 2017). In April 2016 Dr J Harrison-Wells (Clinical Psychologist) and M. Timlin (Educational Psychologist) having assessed H, raised concerns about the lack of progress in H's emotional and attachment relationship. They were concerned about the mother and her relationship with H. They jointly observed that H required ongoing psychological therapy to assist her emotional development and relationship. They recognised the benefits of a residential setting but raised concerns about H's childhood experiences and that it *"may need to consider recommending an alternative and reparative parenting experience if* the mother *is unable to address the issues raised in this assessment"*. In August 2016, H suffered a fracture to her arm after jumping out of her first-floor bedroom window. This required surgical intervention that successfully treated her injury.

17. On 25 August 2016 H joined CHS and moved to live in the associated residential home 'KH'. H's first term at CHS was to be an unsettled and difficult period that was punctuated by her challenging behaviour and short but frequent periods of absconding. By the end of the first term, H began to settle into her placement and formed a close relationship with some the staff

at the unit. H appears to have settled into her school and placement by the beginning of the second term. The parents remained concerned about her 'food seeking behaviour' and toileting. KH and CHS appear to have struggled with H's regime that was put in place at the request of the parents.

18. In May 2017 Dr Carlisle wrote to H's General Practitioner and observed that H did not meet the diagnostic criteria of FASD or ARND. She found her to meet the criteria for an ASD diagnosis. She further observed that in her opinion H was *"extremely vulnerable as she has absconded from her current residential placement approximately twelve times in the past six months…".* H was also attended by Ms M Cooper (Educational Psychologist) on 31 May 2017. H remained subject to a regime that sought to control her food and liquid intake together with her toileting. At her parents' instructions her misdemeanours resulted in what came to be known as *"lock down"* which when implemented restricted H's access to activities within and outside of the school and her residential home. By 2017, CHS and KH had made clear their discomfort with the level of restrictions and their ability to continue to implement the same. H was the subject of weekly weighing that could be reduced to a lesser frequency of once every three to four weeks on the advice of Dr Yaliwal.

19. During this period the parents continued to raise their concerns about H's food seeking behaviour. In June 2017 Dr Baker (paediatric Dietician) suggested increasing H's meal portions to reduce her food craving. In the same month the Disabled Children's Team of the local authority undertook an assessment of H that resulted in more support being put in place both with CHS and up to

35 hours per week when at home. In August 2017 the mother is noted as reporting H having a settled period during the summer holidays. Although she is a dietician herself, she was advised by Dr Needham (Consultant Paediatrician) that it would be inappropriate for her to act as H's dietician. It appears that H was also involved in '1000 genomes project'.

20. In December 2017 and January 2018 H underwent further examination and testing in Dr Mukherjee's clinic to compete the investigations into a possible diagnosis of FASD. Dr Mukherjee produced a report in January 2018 that was subsequently amended on 20 February 2018 and 9 April 2018. His ultimate diagnosis of FASD has proven to be controversial within these proceedings and is discussed in greater detail below.

21. By 2017 the family faced further increased challenges when the mother was diagnosed with cancer and was undergoing treatment and therapy for the same. Happily, her treatment has proved to be successful. In January 2018 the mother contacted C Smith who is a dietician and a specialist in Prader Willi Syndrome ('PWS') leading to a face to face meeting with H and a subsequent report in May 2018. In February 2018 the family suffered the greatest tragedy when A took her life. The family faced unimaginable pain. The parents decided not to share with H the circumstances of A's death. Unfortunately, later H found some of those details through searching the internet.

22. In June 2018 H alleged that she had been physically assaulted by her mother. H stated that she wished to stay at KH and not return home. She repeated this in July and wrote to her social worker stating that she was scared to go home. H's allegations included 'strange', controlling behaviour by her mother. This

led to a s 47 investigation. The parents denied the allegations. Later CHS and KH served notice on the parents that H's placement will be terminated at the end of the summer term. It is common ground that this caused great disappointment in H. The parents successfully challenged this decision through a tribunal hearing. H returned to CHS in September 2018. However, she did not stay at KH and when at home during the week, she was supported or cared for by agency support workers. By July 2018 H's weight appeared to have stabilised and the dietary regime continued that placed a calorific and a fluid intake restriction upon her.

23. There were two incidents of concern in October 2018. On 11 October H absconded from school with concerns that she was placing herself at risk. Concern was expressed by the school who report that the parents refused to collect H after her return to school. On 16 October H refused to go home and threatened to abscond once again. The professionals were not able to agree with the parents as to H's accommodation that evening and she was made the subject of a Police Protection Order. H made allegations of further physical assaults against her mother. The details of these two incidents are considered later in this judgment.

24. On 19 October 2018 the local authority applied for public law orders in respect of H. She was made the subject of an Interim Care Order that has continued to this final hearing. H was placed in foster care and later assessed as being at the risk of child sexual exploitation after it was discovered that she had posted inappropriate picture(s) of herself on social media. H did not wish to see her parents but was encouraged to do so. She saw them in December but this

coincided with her finding out about the true circumstances of A's death. The local authority identified a residential placement ('CS'). She moved there in March 2019 but after an initial period of stability, her behaviour deteriorated with reported episodes of physical violence directed at others and herself together with general disengagement with the professionals leading to CS serving notice of termination of her placement on 29 March 2019. Whilst at CS, H had two sessions of telephone contact with her parents.

25. H moved to her previous foster carer and after absconding on 23 and 24 April 2019, she moved to an alternative foster placement. Initially, she started to attend CH as a day pupil and subsequently on 24 May 2019 she resided at KH. The placement ended on 21 June 2019 due to H's violence towards staff. She moved to a foster placement before moving to a residential placement on 5 July 2019. This was to be yet another short placement after it was terminated in August and H moved to her current placement ('SF') on 30 August 2019 where she appears to have settled and made good progress. H began to have some supervised contact with her parents that ceased at her request in May 2019 after she found out that her parents were expecting a child. R was born to the parents in the summer of 2019. The parents have also moved to a different part of the country. Since being placed at SF, H has had more regular supervised contact that has been led by her wishes.

Evidence

26. There are over ten thousand pages of evidence that are contained within the court bundles. Additionally, I have heard the oral evidence of many witnesses during this hearing. Broadly the witnesses may be categorised as the jointly

instructed experts in the case, treating medics, education, local authority and social work professionals, parents and the guardian. Accordingly, I will set out a summary of the oral evidence by reference to those broadly identified groups.

Jointly instructed experts

27. Dr Knight-Jones is a Consultant Paediatrician and a specialist in neurodevelopment who was jointly instructed by the parties to undertake an assessment of H, to comment on her medical diagnosis and identify the need for any other expertise or assessments in the case. She confirmed the contents of her report dated 10 October 2018 to be true and accurate. She observed that it was not unusual for there to be a divergence of opinion in diagnosis and for the professionals to disagree. In her opinion the diagnostic label was less important and it is more important to look at patterns of behaviour. She agreed that H would benefit from clarity about her medical diagnosis and that this was a *"desirable aim"* but that different people may see issues differently.

28. Dr Knight-Jones was asked further about the diagnosis of FASD. She agreed with the diagnostic criteria set out in Dr Carlisle's report. She observed that H's moderate growth hormone deficiency did not point to such a diagnosis whilst noting the lack of any facial features that may point to the same. She further observed that it would be arguable that Central Nervous System ('CNS') deficits are an indicator of possible FASD; H was assessed at low average ability and not as learning disabled. In the documents that she has seen, there is no evidence of alcohol misuse by the biological mother. Indeed,

a note in H's records states *"no alcohol"*. Without evidence of alcohol misuse, a diagnosis of FASD is not sustainable.

29. Dr Knight-Jones questioned the methodology in the reports of Dr Mukherjee that has led him to his diagnosis. She observed that there were at least three versions of the final report. She could not see any analysis of the information that has led to his diagnosis. She stated that the report of Dr Carlisle was narrower in scope and based on her assessment which was more reserved in its conclusion. She stated that it is difficult to see how Dr Mukherjee reaches a conclusion that the diagnostic criteria of FASD is met. She observed that H is a girl with low/average abilities who has behavioural difficulties and in the absence of any other evidence she questioned how this would *"add up to FASD?"*. She further commented that in the absence of confirmed alcohol use by the birth mother, a diagnosis of FASD cannot be made. Dr Knight-Jones expressed concern that there appeared to be heavy reliance on the parental report where there are disputes of fact. She expressed further concern about the "*surprising lack of detail"* of information that has led Dr Mukherjee to his diagnoses. She observed that Dr Mukherjee is a Psychiatrist and a specialist in Learning Disabilities. H is not learning disabled and she questioned whether H's case appropriately fell within his remit. She was sympathetic to the parents' search for answers. In her opinion any neurodevelopmental difficulties would worsen in adolescence. H's issues with weight gain were in her opinion connected to her emotional and attachment difficulties. She did not seek to criticise the parents for the attachment difficulties that have been documented from an early age. She did however

observe that a suboptimal environment and punitive measures would not have helped H.

30. Dr Knight-Jones commented that it was appropriate to restrict H's visits to the toilet to break times, but she could not find any justification for restriction of her water intake. She could not justify treating H as a child who suffered with PWS or 'PWS Like' when she was not diagnosed with this syndrome. She sought not to be critical of the parents and accepted that a daily intake of 1500 millilitres of water seemed appropriate. She observed that she is not a dietician and was careful about how much evidence she could give on this issue. Dr Knight-Jones further commented that the diagnosis of ASD is not a precise diagnosis and it was not unusual for children have different outcomes at different stages. However, in her opinion H did not meet the diagnosis of ASD. She described H as having an *"odd personality ... her interactions are odd"* and her behaviours predicated on the setting that she is in.

31. She further commented that paediatricians are besieged by parents who seek diagnostic labels for their children's difficulties as this can sometimes open the door to services that they may not otherwise receive. Ultimately, she was clear that a diagnosis of ASD was not justified in H's case. She readily accepted that the referral which led to the diagnosis in 2014 was made by the school and made no criticism of the methodology that led to that diagnosis. Furthermore, she was not critical of the parents relying on this diagnosis. She questioned how much of what is observed in H is *"intrinsic and how much of it emotional".*

32. She was taken to task about her use of the phrase *"punitive measures"* when describing the behavioural strategies that were previously described as "lockdown". She stated that she had gained her information from CHS and BH and that the strategies that were put in place *"struck her as punitive"* which did not work. Her primary concern was the reported length of time that these measures were put in place after misdemeanours by H. After concluding her evidence, Dr Knight-Jones wrote an email to the parties in which she stated as follows:

> *"I wish to explain to the court that I am not in general reluctant to diagnose Foetal Alcohol Syndrome or Alcohol Related Neurodevelopmental Disorder/Foetal Alcohol Effects.*
>
> *In 3 cases on which I have done paediatric reports for Care Proceedings over the past year I have suspected that maternal alcohol might have been involved, definitely in one of them.*
>
> *I diagnosed previously unsuspected foetal alcohol syndrome in a child who did have the physical stigmata, including microcephaly; she had severe behaviour problems and moderate learning difficulty. Her mother was known to binge drink. In another case, I noted that maternal alcohol was a possible cause of the child's unexplained moderate learning difficulties; physical signs were lacking but mother was known to be intoxicated on occasion, though there was no definite information about this during pregnancy. In another case I have requested a referral to genetics for further assessment of possible physical features of Foetal Alcohol; the*

> *mother has been known to be in a state of intoxication on occasion though alcohol in the pregnancy."*

33.The next expert witnesses were part of the multidisciplinary team at GOSH. The first of those witnesses to give evidence was Dr H Ritzema (ACP registered Consultant Child and Adolescent Psychoanalytic Psychotherapist). She co-authored two reports with Dr J Neale (Specialist Registrar in Child and Adolescent Psychiatry) and confirmed the contents of her reports to be accurate. Dr Ritzema confirmed that her opinion remained as expressed in her two reports save that, having read the updating document, she was aware that H was settled in her current placement and saw no reason that it should be changed.

34.Dr Ritzema explained that in her opinion H should not be treated as a child suffering with 'unconfirmed' medical diagnosis. She explained that H has undergone many assessments over many years and she is confused about the different diagnoses. Dr Ritzema advised that there should be *"a move away from diagnosis and to identify needs and strengths"* which will assist with getting H the appropriate help in the future. She explained that H has been the subject of many unnecessary assessments which have led to harm, low self-esteem and confusion. She agreed that it would benefit H if these diagnoses do not 'follow' H into adulthood. She observed that the pursuit of an ASD diagnosis fitted with a pattern of the mother wishing to understand her daughter through medical diagnoses. The GOSH assessment did not support a diagnosis of FASD and that it would be inappropriate for her to have such a diagnosis. She further stated that FASD is not a *"diagnosis in itself"* and is an umbrella diagnosis that does not really assist with identifying H's specific needs. The danger is that a focus on this diagnosis may lead to missing what *"*H *is like now"* and what her needs are.

35. She observed that the mother is concerned about H's care but *"gets pulled into understanding this through medical issues and diagnosis rather than what the professionals are saying".* At her meeting with the parents, she found *"inflexibility in the mother's capacity in considering what else is going on for H ... and was wedded to her views about H".* She gave the Sticklers issue as one example where professionals had stated that there was no evidence of this condition and the mother had pursued an assessment of the same. The mother has a much more limiting view of H's abilities which was not consistent with Dr Ritzema's opinion who found H to have definite potential to develop further. She further observed that the father was more able to recognise H's abilities and potential. However, she later added that the father saw H differently to the mother but was unable to mitigate against the mother's views. Whilst recognising a positive relationship between H and her father, she expressed her concerns that the father parented as a couple with his wife and their decisions had been negative for H's care. She further stated that the father does have a role to play in H's life but this must be directed by H. The parents should also be supported in nurturing their ongoing relationship with H.

36. More generally she stated that the parents appeared to lack insight into H's needs and unable to reflect on their own parenting style which can become

'limiting' and harmful if a parent cannot consider different way of parenting. Dr Ritzema recognised that H had a period of stability at home and the move to a residential placement would have been difficult for her. She further recognised that A's death was a very significant psychological trauma for her and her family. She readily accepted that the parents would have been emotionally less available for H and observed that the mother's views of H as a much younger child impacted upon the information that was imparted to her about her sister's death. She recognised that H leaving CHS and KH in the summer and returning in September would have introduced further instability into her life. Whilst having great sympathy for the parents' circumstances, she observed that after A's passing, the parents put their needs above those of H's and her parenting was not 'optimal'.

37. Dr Ritzema found the restrictive regime for H and the 'seven-day lock down' *"striking"* and unnecessary. She found it difficult to understand why H required this where this led to singling her out among her peers which would lead to confusion. She stated that at her age, H needed support to be more independent and to manage herself rather than the restrictions that were put in place. She stated that H needs *"kind, caring and firm boundaries"* and that her carers must be attuned to her needs. If there is no emotional attachment or kindness attached to the firm boundaries, this can lead to a child feeling rejected and may impact on her capacity to form healthy relationships. Dr Ritzema further stated that the combination of her experiences beginning with those in utero, her birth to parents who were drug users and subsequently parenting by the parents will have impacted upon her emotional regulation and capacity to form relationships. She also observed that H had a period of

stability in foster care and that there are no reports of attachment issues prior to being adopted. The parents' concerns about medical issues and investigation of the same began early on. They were also questioning if H was the 'right adoption' for them.

38. In Dr Ritzema's opinion H needs therapeutic intervention to address her emotional dysregulation. DBT may provide an avenue to engage her in therapy and this may lead to other forms of identified therapies. Priority for H is her placement and this must be addressed before her educational needs. She observed that H was unlikely to engage well with education if her placement needs are not addressed. H needs to feel that she is listened to and be supported in making appropriate decisions. She agreed that H may have certain vulnerabilities, particularly about her abilities to form appropriate relationships and she will require support to gain a better understanding of how to safely use social media. H was told not to trust people and this has impacted on her capacity to form relationships with others.

39. Dr L Sawyer (Principal Clinical Psychologist) and Dr S Wilkinson (Consultant in Child and Adolescent Psychiatry) were part of the assessing and reporting team at the GOSH. They gave their evidence together, a practice that was developed in the civil jurisdiction and has come to be known as 'hot tubbing'. They each confirmed the relevant parts of the report to be true and accurate and that their opinion as expressed in the report had not changed. Dr Wilkinson was also responsible for supervising Dr Neale. H was anxious about the GOSH assessment and it was reported that there had been arguments about H's attendance. However, she engaged with the assessment and she

wanted to do her best. After the first test she had a break and felt that she had had enough. She was at times self-deprecating such as stating, *"I am rubbish at this".* The assessment of H included a socialisation subscale; an area that she has difficulty in. Whilst H's scores were younger in certain areas, her overall score indicated that she will need additional support and pastoral support. The ADOS II part of the tests was based on intensive work with H and other sources of information. This is a *"face to face gold standard assessment".* Her scores were significantly below any threshold that would raise concerns. By contrast the DISCO assessment tool is reliant exclusively on parental reporting and not clinical observations.

40. H displayed spontaneous appropriate gestures to support her language. There were no observed stereotypical behaviours such as repetitive behaviour or a need for a high level of routine. The team were aware that in 2009 a CAMHS assessment did not diagnose H with ASD. In 2014 such diagnosis was made although the ADOS assessment was below the requisite threshold, ASD was diagnosed based on the parental report. The latter may be inaccurate or a matter of parental perception of the child's abilities that would lead to distraction and inaccuracy. Dr Wilkinson was clear that he was not suggesting that the mother had wilfully mislead any professionals. However, H's mother had some very strong views about H's difficulties. Despite being heavily challenged, the team maintained their opinion that there was no evidence that supported a diagnosis of ASD, albeit that the difference in opinion was "respectable". The team further observed that 2014 may have been a particular developmental phase for H. Dr Wilkinson was clear that it was reasonable for the school to raise the issue of possible ASD and request that it is investigated.

41. To make a diagnosis of FASD, the team would look for clear evidence of exposure to alcohol and this was lacking in this case. Given that there is an absence of the typical facial features for such a diagnosis, her cognitive assessment does not find her as learning disabled, her overall presentation and behaviour would not lead to a diagnosis of FASD. Furthermore, FASD is an umbrella diagnosis and does not lead to the identification of any specific support.

42. H is now at an age that requires support to prepare for adult life, to develop independence and autonomy, both developmentally and emotionally. H must also be supported in her wish to attend college. H does not need a specialist educational provision but will require therapeutic support. There is agreement with the SENCO observation that H may suffer with sensory overload and that a smaller group and individual attention would be beneficial to her. This may be provided in a college. The witnesses advised that we must always go back to H's wishes and feelings and to support her to make her own decisions.

43. H has significant difficulties with her emotions and forming relationships for which she requires support to address these. She is still developing and there is no single diagnosis that would account for her difficulties. ASD and FASD would not account for her behaviour and high levels of reaction that do not easily fit within a diagnostic category. Going forward the stability of H's placement is *"incredibly important"*. She also requires a *"co-created"* narrative that should be done in a therapeutic setting so that she can gain a better understanding. Subject to her wishes, H should have contact with her

parents of no more than once every two months depending on how supportive the parents are of her placement.

44. The last of the independent expert witnesses to give evidence was Dr J Neale (Specialist Registrar ST6 in Child and Adolescent Psychiatry) who confirmed her contribution to the GOSH report that she co-authored with Dr Ritzema to be true and accurate. She confirmed that she was supervised by Dr Wilkinson. She was privy to the updated case papers including the statements and reports of Dr Mukherjee and Dr Carlisle and her opinion remained unchanged. She did not criticise the methodology of the 2014 ASD assessment and recognised that it relied on the ADOS tool in reaching its conclusions. Dr Neale stated that it was not unusual to have different results in ASD assessments over a period of time and in those circumstances a second opinion may be sought.

45. Dr Neale continued by emphasising the importance of a move away from diagnostic labels and to access the appropriate support for H. It was also important to think about the young person's strengths to be *"future oriented"*. She stated that H can access education with pastoral support. She observed that if H is placed with students who are 'more disabled' it would be limiting for H and make it unlikely that she would reach her full potential. She also emphasised the importance of the 'narrative work' with H who has felt excluded. The pastoral support can help her with forming and maintaining appropriate relationships without which there is a risk that H will be isolated. H has been observed to have had difficulties with peer relationships and some adult relationships. The provision of pastoral support can assist H with these issues.

46. She spoke about her engagement with the parents and found the mother to be lacking insight in her role in H's emotional wellbeing. She acknowledged that the parents were under a great deal of stress and at the time of the assessment the mother was pregnant. She found the mother was very rigid in her thinking. The mother held a view that H had been failed by the professionals in health and education who had, with a couple of exceptions, been substandard. She gave an example where the mother felt that the school had provided poor emotional care for H and that her opinion had not been taken into account. There was no acknowledgement by the mother of her role with no recognition of her contribution to H's emotional care. She felt that all she had done for H was the subject of criticism by the local authority. The father demonstrated a more reflective capacity but had limited insight into his ability to mitigate the actions of the mother. He displayed some insight into how he may have *"done things differently"*. The assessment of the parents' relationship was limited by their keenness to speak about other aspects particularly the SEN tribunal and appear to give it a higher priority.

Treating medics

47. Dr R Jefferson (Consultant Paediatrician) took over H's care in 2007 following complaint by the parents against H's previous Consultant Paediatrician. H remained in her care until January 2014 when Dr Jefferson retired from practice. She confirmed the contents of her statement and the attached medical notes to be true and accurate. She was clear in her statement that during a consultation on 7 October 2018 *"the mother told me categorically that had she known about* H *beforehand she would not have*

adopted her. The family feel let down by the medical professionals who 'deliberately withheld H's *history'."*. Dr Jefferson was reliant on her notes which referred to a consultation in which the mother made H sit alone on a chair and was not allowed to play with any toys. There was a little bargaining and It was agreed that she should sit for five minutes. In her letter addressed to Dr Puddy (General Practitioner) she observed that:

> *"… it is very likely that* H's *emotional environment makes a significant contribution to her growth problem. Over the summer her enuresis improved, but has now worsened again. Her mother perceives toileting as a control issue, used to escape from lessons, and devoid of an emotional precipitant. I have encouraged* H *to continue to drink good quantities at school as this will increase her sensation of a full bladder and assist toilet training."*

She explained that she was describing a lack of feeling for a need to urinate and it was used for escaping going to lessons. She was also clear to state that every child must be allowed adequate levels of liquid during the day. Dr Jefferson further commented that she was satisfied that there was a medical condition that gave rise to H's growth difficulties but she could not exclude the environmental factors. She also accepted that 1500 millilitres of water per day would be an appropriate amount for H at her age.

48.Dr Yaliwal is a Consultant Paediatrician with an interest in Endocrinology. From October 2014 to June 2019, he was the lead clinician treating and monitoring H's growth. He worked closely with his dietetic colleague D Barker. Having confirmed the contents of his statement to be true, Dr Yaliwal explained that he was aware that the mother was a dietician and her depth of knowledge made conversations with her more challenging. He found the mother to have "*a set of beliefs*" and he employed a management strategy of keeping *"it simple"*. In his opinion H was reaching puberty and 'growth spurts' were quite normal. He found the mother wishing to continue with weekly weighing and strict dietary control to maintain H's weight. He did not see this as necessary and expressed some concern that this may be harmful to H as it may be drawing too much attention to her weight. In his view, stability was key and monitoring minor variations from week to week was unnecessary. He was clear that whilst monitoring was important, it was difficult to put a 'time target' on this.

49. He observed that H's weight was an issue for the mother who was concerned about H becoming obese. Dr Yaliwal reviewed this with D Barker every six months. He was aware that in April 2018 H was tested at a specialist centre by Chris Smith. The mother had produced his report in one of the consultations with Dr Yaliwal. Whilst PWS had been ruled out, the mother was keen that the dietary advice was strictly followed by CHS and KH. Dr Yaliwal did not feel that this was necessary. He accepted that the wording of his letter dated 15 June 2018 may appear supportive of the dietary regime that was recommended by Chris Smith. However, he was clear that the parents had insisted on including this in his letter. He refused unless it was agreed to by D Barker. He stated that he also mentioned the importance of physical activity. He further commented that the issue of her growth hormone deficiency had been identified and was being treated. The mother wondered if this was related to FASD and she was genetically tested for this.

50.Dr Yaliwal was clear not to criticise the parents for their actions leading to a referral to his clinic. He was careful not to comment on matters that predated his involvement. He saw H in clinic with her mother and occasionally with the father. He recalled on two occasions both parents may have been present. He was clear that his interactions were mainly with the mother. He did not raise any concerns about H's presentation or interaction during those clinics. He could not recall H's dramatic weight gain in 2017 and 2018. He was clear that there was no identified underlying medical condition to cause this and it had an 'environmental' cause. He did not raise any concerns about stopping H's growth hormone injections in September 2018 or the parents' reaction to the same. He was challenged on his views about H's dietary regime and refuted any suggestion that he was part of the decision-making process. He was clear that such matters would be discussed and reviewed by D Barker as H's dietician. He recalled that there was a consultation booked for H in June 2019 and H was in foster care at that time. She did not attend as the parents were in attendance. He was clear that information about H should be shared with the parents. She continued to recommend DBT as an appropriate form of therapy and observed that it was important for H to form a therapeutic relationship with a therapist which would make it more likely to be successful.

51.Dr H Needham is (Consultant Community Paediatrician) and was involved in H's care from 14 May 2015 to 31 August 2017. After confirming the contents of her statement to be true and accurate she stated that to the best of her recollection H was referred to her as a Consultant Community Paediatrician to attend to her individual needs and her diagnoses. She could not identify where she may have received information that resulted in a reference to H's biological mother using alcohol during her pregnancy, she agreed that the mother requested an FASD referral and support of other professionals. This she thought would be useful and with the support of other colleagues may assist her in gaining a better 'picture' of H. Therefore, she made a referral to a tertiary service. She found it 'unusual' when the mother presented her with a medical report and stated that she had asked for this to be amended.

52. With respect to H's weighing, she observed that it was difficult for the mother to be a professional and a mother. She explained to her that it was important to 'stay away' and allow other professionals to treat H. Dr Needham advised against weekly weighing and encouraged the mother to use a dietician appointed to H (D Baker). She confirmed her doubts about the FASD diagnosis. She also expressed her concern at the inappropriate request by the mother to draft a letter on her behalf and that no other parent had ever requested her to do so. Dr Needham stated that the mother often discussed issues in H's absence. She also had opportunities to see H on her own. The mother was concerned that H's needs were not being met at her school. Dr Needham had no interaction with the father.

53. Dr U Kini (Consultant Clinical Geneticist) undertook an examination of H when she was thirteen years old. She confirmed the contents of her statement and the attached letter to be accurate and true. In her letter dated 28 November 2016 she states;

> *"when I examined her in clinic I was unable to identify any physical features that were in keeping with a diagnosis of fetal alcohol syndrome. However we talked about the possibility of fetal alcohol spectrum disorder*

> *(FASD) in which affected individuals might not have the physical features but may present with behavioural and developmental problems. However, in the absence of a definitive history of alcohol intake by the biological mother during pregnancy, it would be impossible for me to deduce that* H *has FASD."*

54. After referring to her notes, she confirmed that the parents did not mention anything about H's biological mother exposing H to alcohol when pregnant. She was aware there was mention of cocaine and heroin use. She explained that developmental and behavioural issue are 'multi factorial' and complex. These include environmental factors. Without the facial features it would be *"near impossible"* to make such a diagnosis and in the absence of alcohol use FASD cannot be diagnosed. Dr Kini explained that following a referral from Dr Needham, she undertook genetic testing of H and the results were normal.

55. Dr Carlisle (Chartered Senior Clinical Psychologist) works with Dr Mukherjee. She confirmed her statement and the exhibits thereto to be true and accurate. She explained that she saw H once in company of her mother on 23 March 2017 and saw the mother without H on 27 April 2017. She had no other face to face meetings with H. She confirmed that her clinic may see thirty to forty cases but she would see an estimated one case per week. During her assessment, Dr Mukherjee had no face to face interaction with H save that at one point he came into the room to *"update the mother on Deprivation of Liberty"*.

56. She agreed that there are four elements that must be considered before reaching a conclusion on a diagnosis of FASD. These are facial features,

growth deficiencies, deficits in CNS and alcohol exposure in utero. She accepted that there were no observed facial features on H but that this is not needed to diagnose FASD. As for the deficits in the CNS, the threshold is a score of three out of nine. Growth deficit is not diagnostic of FASD and since 2016 it is no longer considered as part of the diagnostic guides. Furthermore, exposure to alcohol in utero is important but no longer necessary to the diagnosis if the other elements such as facial features and CNS deficit are present. She accepted that one cannot infer alcohol exposure but stated that clinicians must look at a *"pattern of information"*. However, Dr Carlisle maintained her views as expressed in page three of her response to questions when she stated *"I discussed the outcome of my assessment in supervision with Dr Mukherjee as well sharing with him the interim report which he checked. No diagnosis was given in my original or updated report as, at the time of writing, even though H met all other criteria for FASD evidence of alcohol in pregnancy had not been established"*. She explained that with CNS deficit and evidence of alcohol exposure the criteria for FASD but not 'full FAS' would be met.

57. By reference to ADHD and ASD, Dr Carlisle accepted that many parts of the information came from the parents but denied that the unreliability of that information would impact on her diagnosis as she had *"comprehensive information that was gathered"*. Some of the information was provided by the school. The information was consistent with her own observations. She remained confident about her diagnosis. Dr Carlisle explained that the Vineland tool provided a day to day presentation and information about H. She considered that 'attachment' was an aetiology and not the outcome and

that she looked at the outcome. To assess the attachment, she would look back at the history but this was not necessary for an ASD assessment. She did not routinely assess the attachment. She explained that ADOS II was an observational model to get to know the child and not using it did not impact on her opinion. She accepted that H's cognitive assessment was at the 'cut off point' although the relevance of this will depend on whether the 2005 or 2016 guide is used.

58. Dr Carlisle was clear that she did not make a FASD or ARND diagnosis and was unable to explain where the information that Ms Oldridge (Clinic secretary) stated in her email 30 January 2017 came from. She accepted that the assessments to her report should have more accurately stated that there was no diagnosis of ARND but that H's behaviour was consistent with ARND. She did not advise as to strategies the parents should employ given the lack of diagnosis. She may have given some advice about behavioural issues, dysregulation and arousal.

59. Dr Carlisle defended the decisions about close supervision of H as she had been absconding at the relevant time. When the mother gave her information about the foster carers' confirmation of the birth mother's alcohol use, Dr Carlisle did not question the validity of this information. In her opinion H's presentation is consistent with FASD and labels can assist with identifying and accessing the correct support.

60. Dr R Mukherjee (Consultant Psychiatrist) confirmed his statement dated 26 November 2019 and the six exhibits to be true and accurate. He explained that he is the lead clinician at the National FASD Diagnostic and Behavioural

Management Team and that Dr Carlisle works in his clinic as part of the assessing team. The clinic was set up in 2009 and Dr Mukherjee is internationally recognised as one of the experts in his field. Dr Mukherjee expressed his regret about the different reports with different conclusions. He stated that he *"would have liked to have got it right the first time"* and stood by his conclusion in his final report. He explained that he had been involved in an accident and was working from home. He *"picked up the wrong file"* which led to incorrect information being included in his report. He accepted that there were 'gaps' between his report and Dr Carlisle's report. He briefly saw the mother when with Dr Carlisle to discuss Guardianship under the Mental Health Act, issues of capacity as an adult and safety. He explained that H's profile suggested that she was more likely to require such considerations.

61. Dr Mukherjee explained that he has now standardised the processes in his clinic and that he should be able to 'pick up' the necessary information to complete his assessments. He considered the four diagnostic criteria. He stated that there were no facial features present in H. He further stated that a recording of between second to tenth centile on the growth chart would 'possibly' not equate to growth deficiency. He commented that H *"had a mild presentation"*. The clinic usually asked for the Red Book to gain a better underrating of the growth and in this case the Red Book was not produced. He further observed that the issue of growth deficiency is becoming increasingly less relevant to the diagnosis, it is not precise and *"less of an issue"*.

62. The characteristics of CNS must be carefully considered as they can be shared with other profiles. In this context the history of maternal alcohol use becomes

more important [that] must be considered with the strong characterises of CNS. He explained that FASD is an *"aetiological syndrome"* and is investigated through cognitive measures and profiles. He mentioned some recent studies (2018) from which he drew certain conclusions about the overlap between FASD and attachment deficits and ultimately concluded that the brain function can impact upon attachment irrespective of 'post-natal neglect'. He went on to observe that parenting can cause an attachment disorder. There needs to be a parenting assessment that takes full account of the underlying issues, otherwise there is a risk of reaching false conclusions. He explained that if a child is not presenting *"typically, we have to ask why? and what impact is the brain having on this"*. Dr Mukherjee was aware that the parents faced allegations of substandard and harmful parenting.

63. By reference to the ADHD and ASD diagnosis, Dr Mukherjee stated that his *"findings are based on meeting the ADHD and ASD criteria that have given a tangible outcome whatever the cause. The post-natal environment was less likely to have caused the ASD presentation but may lead to increased vulnerability ... we identified neurological deficits that are unlikely to be caused by the environment"*. Dr Mukherjee explained that in his clinic they 'triangulate' the information that informed the assessment, in his opinion this ensured that some of the less reliable information did not influence the outcome of the assessment. He was taken to the observation of H's abilities in 2016 by way of challenge to his findings.

64. He stated that behaviours observed (by L Fox) were in fact typical of FASD children. He explained that with increasing complexities in activity, you

would expect H to be able to cope less well. He emphatically agreed that exposure to alcohol in utero was an essential part of the diagnoses of FASD which required a confirmed history. He was strongly challenged about the premise of his opinion that there was confirmation of alcohol use by the birth mother. He explained that this had been confirmed as much as possible. He observed that drinking is common place in Western European countries and it is so in Britain. He also observed that the mother was a known 'polysubstance user' and often alcohol and illicit drug use are connected. He accepted that he was reliant on the information that the mother had provided and considered this to be *"a probable cause"*. He observed that there are no *"absolute safe levels of exposure"* to alcohol. He was challenged about his views as expressed in paragraph 43 of his statement where he states that;

> *"In this case alcohol should still be considered as some risk unless proven otherwise"*

He explained that unless there is evidence that the birth mother was 't-total' or that she had stopped drinking, then his statement would be correct. Dr Mukherjee believed that there had been confirmed use of alcohol by the birth mother but after being taken through several documents including some relating to the birth mother, he accepted that it was no more than a suspicion. He further stated that from the information that they were provided with, there was strong suspicion of alcohol use by the birth mother which was sufficient to justify his conclusion.

65. He accepted that prematurity, hypoxia and genetic causes had been ruled out leaving CNS impairment and a suspicion of alcohol use. This he agreed would

be consistent with a diagnosis of FASD. He further agreed that this was the opinion expressed in Dr Carlisle's report that stopped short of a diagnosis. Dr Mukherjee agreed that the term 'consistent with' should precede the diagnosis of FASD. He also accepted that his assertion in paragraph 35 of his statement was incorrect. He reflected by stating that perhaps he should have checked with Dr Carlisle before sending out the final version of his report. He continued to explain that the differences in the assessment of his clinic and those carried out by the GOSH, may be explained by 'people doing better' in certain settings. The executive functioning element is crucial to the assessment. The IQ is not a 'good indicator' of functioning. He stated that *"unless we look at the higher levels of functioning, we cannot truly measure the daily functioning".* The information gathering and triangulating the same, mitigated against the assessment being influenced by the mother and he was *"pretty confident"* about the diagnosis of ADHD. He also stated that in his clinic they use the DISCO tool which is the 'gold standard' tool for assessing ASD.

66. Dr Mukherjee was less convinced about the appropriateness of DBT for H. He was also concerned that H will require a great deal of support and will remain vulnerable to others exploiting her. He was also clear that H's difficulties are multifactorial. He explained that attachment is evidence of a neurological process that is increasingly recognised in ASD. Whilst this may be caused by parenting, it may also be caused by other factors such as her neurological functioning. He stated that his study suggested that H had already been damaged regardless of the postnatal environment.

67. Mr C Smith is a Senior Paediatric Dietitian who is a specialist in PWS. He has made one statement that has a number of appendices, the contents of all of which he confirmed as accurate and true. He was first approached directly by the mother in January 2018 when she introduced herself as paediatric dietician and working in CAMHS. She sought advice about H who was not diagnosed with PWS but was in her view presenting as a 'PWS Child'. Mr Smith and a telephone discussion with the mother later in the same month when they agreed to conduct further investigations. He saw H on 28 March 2018. He had experience of two children with PWS-like symptoms without a PWS diagnosis. When pressed he stated that H was not one of those two children. Mr Smith further stated that he is sometimes contacted for advice by parents but H was the only child that he had seen face to face after being contacted by her mother.

68. After seeing H, he wrote his report, a draft of which was shared with the mother on 9 April 2018. Mr Smith stated that he viewed the mother as a colleague who shared the same qualifications. He believed the mother as she was a professional. Having seen H on one occasion he was reliant on the information that was provided to him by the mother. He was also better informed by the General Practitioner referral letter which contained important information that was, in this instance more detailed than usual. He did not have any further medical information about H. He accepted that his attempts at contacting D. Baker had been unsuccessful. He saw his role as giving PWS specific advice. At no point was he asked to treat H. He further stated that in his practice he would work with the treating team when giving advice.

69.He explained that if a child rapidly gains or loses weight, strategies will need to be employed to monitor this. He stated that in hindsight the strategies employed for H *"were a more aggressive programme of weight loss and I had concluded from the family that this was acute".* The parents had suggested several amendments to his draft report. On reflection he accepted that some of these amendments were inappropriate. Whilst he did not wish to criticise the parents for the suggested amendments, he stated that he had *"assumed that the professionals would not be relying on it"* when working with a child with *"multiple difficulties".* Having explained his methodology for calculating H's daily calorific requirement, he stood by his advice about the restriction of calories to assist H lose and maintain her weight. He accepted that it would be harmful to a child if she were to become *"over-aware"* of her weight issues. He reminded the court that he was asked to give a 'one-off' advice and was not involved in any ongoing treatment of H. He was never asked to diagnose PWS. He was asked to give advice about H's behaviour that was similar to PWS and her apparent rapid weight gain. Her BMI was in the seventy fifth centile and her height to fat ratio was within the normal range.

70.Dr Vlachos (Consultant Child and Adolescent Psychiatrist) was the visiting schools' psychiatrist attached to CS where H was attending for a three-month assessment. She saw her on 20 March 2019 during one of her regular attendances at CS. She saw H on her own in a meeting that lasted about forty-five minutes. H was guarded and suspicious at first but engaged with Dr Vlachos once she had started to trust her. She explained that she was trying to address specific questions that were asked of her out of concern for H. This was *"an initial holding clinical response".* The plan was for H to be assessed over a three-month period as part of a multidisciplinary assessment. Sadly, her placement was short lived and the assessment could not be completed. At this stage the information that was available to her was limited to that which was in H's file. She recalled reference to Dr Mukherjee's report. Had she continued as part of the planned three-month assessment, she would have interviewed the parents and undertaken a great deal more work.

71. She explained that her email was the initial formulations of her thoughts. The email was intended to be for internal use. As explained in her written statement, when this email was sent out, it had an important passage missing. It was shared without her consent. The email was only intended to offer some advice for H's management whilst at CS. She found H to be appropriate and compliant. She further explained that her observations on H's functioning were observations when she is dysregulated and not as how H continuously presents. She was clear that she was not in disagreement with the GOSH assessment particularly as to how H is to be treated in an age appropriate way. This was a difficult time for H and she was being managed on a one to one basis although at times this had to be increased to a two to one ratio. She was reluctant to make any further recommendations about H's needs beyond what she had stated in her email. She stated that H needs time, support and additional structure around her to form appropriate trusting relationship with adults.

Education

72. Ms J Dunn OBE was the former Principle at MSchl. She confirmed the contents of her statement together with the documents exhibited thereto to be

true and accurate. She explained that the extra training for the staff that the mother insisted upon was undertaken to assist with the transition. She stood by her observations that the school was quite capable with the necessary skills to assist H. This was the only case were a parent had made a request not to praise the child. MSchl. is a specialist school. She raised her concerns about the parents' ability to work cooperatively with the school and she was concerned that H would be removed from the school in the face of disagreement with the parents. The staff sought advice about how to 'deal' with the issues raised by the mother. The school worked hard to minimise the impact of this on H.

73. Ms Dunn further stated that in her experience parents usually presented as grateful for the specialist services that school put in place for their children. She did not observe this in H's parents who appeared to be negative and *"condemnatory"* about H which Ms Dunn found to be *"unusual"*. She recalled H being described as *"constantly lying and being manipulative"*. This view was not shared by the school. The school's assessments prior to H joining the school raised concerns about the mother's relationship with H, *"there was a distance, a coolness"*. Ms Dunn further stated they did not praise or see the positives. In her statement she states that

> *"*H's *self-esteem was very low, the staff would report that she would call herself 'rubbish', 'no good' and say she 'can't do that' …I felt sad for this little girl, who needed love and support around her so badly, but whose mother – from my own experience – didn't seem to like her. She may well*

> *have loved* H *in her own way, but I certainly never got the impression that she liked her…"*

She personally observed H to be despondent and to have a low opinion of herself. She further state that H was a *"project rather than a daughter or a child"*. She also stated that *"often children are bursting to go home where they are loved, cherished ... but didn't see that in* H". H *"desperately wanted approval"*.

74.She recalled the father collecting H from school one day and he presented as much warmer towards H. At the family's direction the school were told not to praise her as it may worsen her behaviour. The school did not see this. It was unusual for her to be praised and *"she really enjoyed it"*. Ms Dunn discussed with the parents the regime with toileting and fluid intake and described this to be like talking to a *"brick wall"*. The minutia was very difficult to deal with, there was no willingness to compromise and the parents adopted a very rigid stance. The staff could not cope with this. Ms Dunn had *"never seen anything quite like it"*.

75.Ms Dunn set about collating information about H as she was concerned that the appropriate information was available for her next placement. She was not aware that the parents had successfully complained against a previous social work team although she knew that there was some friction in their relationship with some professionals. There were many professionals that were invited to a meeting to discuss H, but some were reluctant to become formally involved as they were anxious about challenges by the family. Social workers and Julie Raymen were very mindful of complaints by the family. In her opinion Ms

Rayman was concerned about the placement from the beginning. She observed that *"working with the family was very onerous and demanding of time and energy"*. She had 'first-hand' experience of this. The school raised the possibility of a further ASD assessment as it was concerned about some of H's presentation. Ms Dunn did not see the ASD report in 2014 as H left the school in that year.

76. She also observed that H socialised at school with friends that she chose to be with and progressed well in this respect. The school did not see her as a typical 'PWS child' and it would have been 'significant' if she had such a diagnosis. She was often dysregulated at home and not so at school. She recognised that children may behave differently in different environments but usually they could identify the cause. It was not so in H's case. The school did not see one to one support to be necessary and the parents did. Ms Dunn recognised that the mother was anxious to find the right placement for H. She confirmed that she had little interaction with the father and that almost all the communications were with the mother.

77. LO was the Head of SEN Assessment and Placement Team. She was involved with H in 2014 and attended a meeting on 11 July 2104. She confirmed as she does in her signed statement that the notes of the meeting are accurate to the best of her knowledge and belief. The minutes were taken by H's social worker. Miss Dunn had called the meeting to raise concerns about the restrictions that were placed on H both in school and at home. There were concerns about the parents' emotional warmth to H. She observed that the restrictions were *"unusual and considerable … I have never seen another*

child with this level of restriction". The parents presented the professional opinion that supported the restrictions. There was particular concern about H entering adolescence with her ability to learn and to manage herself being compromised with such restrictions being in place. This also had an impact on the available schools for H.

78. Her involvement was in response to a request for a 'statement' as the school wished to put in place further support for H. Such a statement would draw on several sources of information that included health, educational psychology and the parents. H's case involved two local authorities and there were two educational psychologist reports commissioned. She was clear not to criticise the parents for this. MSch. was a specialist school in speech and language. LO was also involved with the Child In Need ('CIN') process and was invited to the CIN meetings. H was identified as having complex needs with communication difficulties. Her holistic needs were likely to be met by BH which is where she transferred to after MSch. The professionals wished to first support the family before considering a residential placement for H. In her opinion H's dysregulation was the cause of her placement breakdown and not the dietary requirements. The parents had strategies that they said helped with her dysregulation and wanted those to continue into her next school.

79. DG raised concerns about the restrictions in 2017. She was aware of the lockdown regime. Although she did recall the details of it, she felt that it was not punitive. However, the professionals were concerned. H needed to be given opportunities to make mistakes and to learn from those mistakes to develop. She started to have a good working relationship with the mother and

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the parents were *"desperately looking for the right solution".* At that time the plans for H were agreed and she would have raised her concerns if she had any. CH was found by the parents and it was felt that this was appropriate for H. She also observed that H's EHCP was very important as it informed how H was going to developed into a young adult.

80. Ms A Cox-Hynd confirmed the comments of her statement and the exhibits to be true and accurate. She is a private tutor with a degree in psychology and is a qualified psychotherapist. She started tutoring H at home in 2015 understanding from the mother that H had ADD, ASD and complex attachment disorder. There were concerns about 'food obsession' and food hoarding. Her work was commissioned by the relevant local authority and she was contacted through an agency after which she met with the mother for an interview. She was aware that H had been expelled from two schools. She taught H twelve hours each week. This was mainly at home with a weekly visit to a local school where she had her own room for studies. This was not in the main 'teaching part' of the school.

81. When she first met H, she was *"exceptionally withdrawn"* and made no eye contact. She was hyper vigilant and would react to any stimuli such as an opening door. She *"fidgeted and tapped her feet".* She was very anxious and emotional. Stimulus was kept to a minimum, for example the clock on the wall was removed. She was taught on a large landing in the parents' home. After about two or three sessions, H became more trusting of Ms Cox-Hynd. There was no acuity in her behaviour, she was calm and engaged well. She responded well to setting up her desk a particular way that included placing her

completed work in one place. She concentrated on her failures and took time to get her to look at her achievements. A scoring system was introduced but H *"obsessed a little about"* the numbers and the scores. Initially she reacted badly to any negative feedback and with some input she soon distinguished between feedback about her work and feedback about her personally. Despite the distractions in the school setting, she learned to concentrate. Her communications with others at the school also improved. H struggled with anything systematic such as algebra. She was a good writer and liked creative writing.

82. Ms Cox-Hynd was very clear that she was H's tutor and she observed the boundaries in what she could state. There was *"often a lot of anxiety and tension with the mother"*. She recalled a time when H was in the garden and wouldn't come into the house and was *crying and crying"*. On another occasion H was in her room crying and wouldn't come out. Ms Cox-Hynd did not see much interaction between H and the mother other than perhaps handovers. She was very kind and caring towards H. Ms Cox-Hynd recognised the importance for H to socialise with her peers. She knew that she had hobbies such as playing tennis. H did not display any aggressive or absconding behaviour and there was no reason why H should not be part of a peer group at school.

83. She was told by the mother that H does not respond to 'punishment and reward'. However, she observed H to be *"genuinely pleased"* when she scored well. H remained calm, relaxed and engaged when she was praised and there was no sign of dysregulated behaviour. She had no reason to 'punish' H and

was not ever asked to partake in any 'lock down' which she would have found entirely inappropriate. When asked about her knowledge of the restrictions at CHS and KH together with her treatment as a younger child of seven, Ms Cox-Hynd was *"horrified"* that such a regime would be put in place. She was aware that H had an alarm on her bedroom door but not any practice that would equate to a 'lock down'. Ms Cox-Hynd explained that each child is unique and she spent a lot of time working with H. She powerfully displayed her pleasure at learning about H's progress and her plans to attend college. She was *"thrilled for"* H and very happy with her suggestion of attending a mainstream college.

84. She was concerned that H did not fit *"the off the shelf guidelines"* for attachment disorder, ASD or ADHD. She had heard about FASD and wondered if this was applicable to H. She mentioned to the mother and discussed it in a meeting that was attended by BH, parents and J Rayman. She felt that such an investigation or diagnosis may draw more attention and access help for her cognitive difficulties. Ms Cox-Hynd denied having any expertise in FASD. In her opinion, H's was better described as having a cognitive impairment. She was not aware of the multitude of assessments that had been undertaken on H and in hindsight may not have mentioned FASD if she had been aware of these assessments. She was also concerned that H should not be viewed through diagnosis or labels.

85. Dr J Harrison-Wells (educational Psychologist) is the co-author of a psychologist assessment dated 6 April 2016 which was commissioned by the local authority. She confirmed the contents of her statement and the

documents attached thereto as accurate. She had not seen a report about 'attachment disorder' prior to completing her report. In her opinion a better description would be 'developmental trauma'. H was a hypervigilant child that 'fitted' with developmental trauma and autism. She further confirmed that in her opinion there was lack of 'reparative relationship' with her parents that if existed, could have helped H with her developmental trauma. At the time of her assessment she *"felt that* H *appeared to have more capacity than the adults around her seem to think she did".* She did not observe H as a younger child. She further stated that despite a request to see H on her own at her second visit, the mother had said *"it wouldn't be possible".* The mother stated that Ms Cox-Hynd will be present who sat behind H during her visits. *"it was impossible to negotiate ... and the mother had clear ideas about how the assessment should be undertaken".* Dr Harrison-Wells never met the father and did not gain a *"true sense of him".* H was keen to be kept informed and it would have helped to know what to expect. She felt that she wasn't given complete information and her questions were dismissed.

86. She was involved in the professionals' meetings in 2015 and 2016. The parents had requested a meeting to take place in April 2016 but this was brought forward by the professionals. H had a raft of diagnoses and complex needs and there were discussions about therapeutic intervention. She stated that the parents needed to have a report that identified all of H's needs and the mother wanted the best for H and for her to receive the 'right' therapeutic intervention but she struggled to reflect on the impact on H in the future. Within months of meeting the family, she was confronted with *"significant frustration"* and the reports fell short of what was expected by the parents.

The mother felt that she had identified what H will need but it is difficult to know what her future needs will be. There is no doubt that H has complex needs but we must adjust to her ever-changing needs. She agreed with the family that H should be in a residential school.

87. In Dr Harrison-Wells' opinion at the time of her assessment H probably had 'more capacity' than she demonstrated, but this opinion would be mitigated by an up to date assessment of H. She agreed that there is a need to be proactive and not reactive for H. H needs a caring relationship that creates a sense of safety and flexibility. Every child is different and 'anticipatory anxiety' cannot be dealt with uniformly. There was no expectation by the parents that H would change. Mother was clear that she did not want a disabled child. Dr Harrison-Wells was concerned about the mother's emotional reaction to H. The parents *"really wanted to find the perfect place for H".* H may attend college and pastoral support is important. The college should be asked about what support it can offer. H's voice is *"so important even if it is different to the adult view".* H was a child who could cope with 'knowing' information and had far more capacity than the impression that was given.

88. Ms A Salt (Educational Psychologist) was instructed to undertake an assessment of H. Her report is appended to her statement. She confirmed the contents of both documents to be true an accurate. She carefully considered the *"within the child factors"* with H which are separate to environmental factors. The expression *"deficit led"* in her report related to a lack of balance in considering the positive and the negative, rather concentrating on the negative. Such an approach will impact on child's 'self-concept" and self-

esteem which will lead to poor self-image and mental health difficulties. H presented as fearful of being under scrutiny by yet more professionals. The 'punitive' measures such a lockdown will impact upon the young person's self-esteem, security and the child's emotional wellbeing. A child who has been damaged in such a way may recover from it, but the recovery period will depend on how long the young person endured these circumstances and the impact that it had. The information that she had available at the time led her to the conclusion that CHS struggled to implement the parents' demands and this ultimately led to H's placement ending.

89. She did not see importance in any FASD diagnosis and emphasised the importance on focusing on H's actual needs. H's needs support with her emotional needs and she agreed with the conclusions of the GOSH in that they are *"very similar to what"* she has stated. She agreed that it would be appropriate for the GOSH to liaise with a therapist and to undertake a 'handover'. She had read the FASD report and the assessment that informed it. She did not have any interaction with the father and only with the mother. She emphasised that H is now sixteen years old and must be supported in her decisions. If she wants to attend mainstream college, she should be supported to do so. This may include one to one support or smaller groups. H does not need to be controlled. H should be enabled to access education. For this to work, H needs to be invested in it and her voice is most important. Her EHCP will support her wishes and this is very important for her education post sixteen years of age. Socialising is an important part of her needs and this should be stated in her EHCP.

90. H requires counselling and if she doesn't engage, it should be reviewed periodically. H needs to know what her support will look like and if she is willing to engage in with it, she should be supported to access it. H's support should extend to work with her on how to safely access and use social media. The college should have experience of children who have been the subject of care proceedings and have a specified key adult that H can go to. It is important that H has the right adult support and the future will be positive for H.

91. DLW worked as the Special Educational Needs Coordinator ('SENCO') when H first joined CHS in 2016. She remained working there until July 2018. She confirmed her statement and the appendices thereto to be true and accurate. She stated that the parents were sent regular weekly updates by email. There was little from the parents by way of a reply. When there was a reply, it involved reference to medical issues. They were not positive about H's attainments. This was an issue that came up regularly. H was distraught and sobbing when recounting her parents telling her that she could not grieve A's death as she was not her real sister. H kept stating *"why did they adopt me… they don't love me"*.

92. She confirmed her concerns as set out in her statement about the restrictions that H was placed under that extended to not watching films that were certified over twelve years of age, significant consequences of lockdown, not participating in secondary education and therapy. She could not understand why H was to be treated as a child with PWS. She did not observe the parents to be positive about H's potential or to encourage her. She did not agree with H being treated as a six-year-old as suggested by the parents. She was unable

to explain why she had not mentioned being physically assaulted by H. She confirmed that she was assaulted, although could not recall all the details. H pushed, punched her and pulled her hair. She accepted that the first recorded assault by H was in December 2018 (she later agreed that the first physical assault was in October 2018). Although she had mentioned H missing out on the end of year trip, she could not say why H had not joined the trip. She accepted that H could split the adults by stating different things to them. She visited H at her new educational establishment as it was reported that she was struggling with her transition. Although DLW did not recall any direct interaction with the father, she was clear that H spoke very positively about him. H stated they watched films together, he was funny and he made her laugh. She looked forward to seeing her father. When H returned from the summer holidays, she was a different girl. She was very upset and confused. H wanted to know why she had not been given the correct information about A's death.

93. In 2018 CP [name] was the SENCO connected to CHS and the Head of CAMHS education. She has made one statement in these proceedings that she confirmed to be true and accurate. She stated that she worked closely with H and spent some time getting to know her. She worked with her for about two years with almost daily interaction with her. She observed that H had made a connection between her dysregulated behaviour and the level of control in her life. There were discussions and correspondence about this. The parents, particularly the mother, were very insistent on the regime being strictly observed. The correspondence about the regime came from the mother. H felt she had no choice in many aspects of her life that included what and when she

ate, drank, when she woke up and when she went to bed. She derived a lot of pleasure in some of the activities that she was sometimes banned from doing, such as trampolining. In CP's opinion these activities helped with regulating her behaviour. It was noticeable that this regime was unique to H and no other children in CHS or KH were subjected to this level of restrictions who enjoyed going out walking and swimming. The other students had water bottles that they carried with them and H could not do this.

94. H spoke very positively about her relationship with her father and stated that when he was at home *"things were ok"*. However, this appeared to change after returning to school in September 2018. She stated that her father was less engaged with H and *"stuck to what the mother wants all the time"*. H had stated that her father didn't *"seem himself."* H used to speak very warmly about her father and CP felt that she missed her father. CP was clear that they were given no choice about what H was told about the circumstances of A's death. She reflected that this was not appropriate and it could have been explained to her in suitable terms. She recalled that as a result of the information given to her about the circumstances of her sister's death, H was terrified about falling asleep in case she died.

95. By reference to the events of 12 October 2018, CP recalled that the mother was initially agreeable to H staying in foster placement but in her view, such a placement required support. CP agreed with the mother's observations. However, once a temporary foster placement was identified, the mother insisted on a long list of conditions that were impracticable in the circumstances. CP commented about the events of 16 October 2018 and

confirmed that she spoke to the mother on the telephone. She had a clear recollection of the conversation and was alarmed by the mother's lack of care or enquiry about H's welfare and her consideration of taking H to the police station as being an option. In her statement she records the mother responding by stating *"well you've got to do what you've got to do".* This was an option of last resort and this was the only time in her career that CP has had to resort to this option.

96.CP had met the mother on three or four occasions and relied on information that was provided by others at KH and CHS. She explained that H found adults more predictable and easier to form a relationship with. The long periods of restrictions also isolated her from her peers and she was limited to interacting with the staff. She was also aware that H had become close to certain members of staff and this had times become difficult. More generally, she considered that H's behaviour was *"classic attachment difficulty behaviour"* and although some of her behaviour may also fit with Autistic Spectrum, a lot of her behaviour would not. The differences in diagnoses and understanding of her difficulties among the professionals made it difficult to achieve consistency and led to *"conflict in practice skills"*.

97.CP expressed her delight about H's progress. She was concerned that she may not function well in a mainstream setting and required a smaller specialist environment. However, she also observed that she had no recent direct knowledge of H. She felt that H would benefit from support around her attachment issues. H has been denied the experiences that would allow her to *"learn and to manage her world".* She recalled being told that H was not to be praised. She commented that H suffered with *"exceptionally low"* self-esteem and responded, *"really really well"* to *"gentle private praises".*

98. LZ was the registered manager of KH. She has made one statement in these proceedings the contents of which she confirmed as accurate and true. She described H as *"a breath of fresh air"* when she joined KH. She was a lot of fun, giggling and wanting to join in. She developed a close relationship with LZ and would often wait in the morning to have breakfast together. She looked up to her sister and was ambitious. She wanted her parents to be proud of her. She was also very sociable. She arrived with a very strict regime that was set by her parents. The mother was insistent on this. It controlled all aspects of her life including eating and drinking. LZ had *"never seen anything like it".* The frequency of the 'lockdowns' increased over time and LZ estimated that these were at around eighty percent of the time towards the end of her placement. The regime created a lot of tension between the school and the parents. She observed that this made it very difficult to work with H *"in a child centred way and could not put her in the forefront".* She also had a lot of diagnoses which limited the opportunities that was offered to H. She was treated differently to the other children at KH. H didn't ask why and was happy to go to her room to calm down, *"it was quite sad"*. LZ added that she *"really struggled with* H *being treated differently".*

99. She was only allowed to go to the toilet every four hours and *"at one point we had to check her pockets".* She wasn't allowed to come out of her room until 7.30 am despite KH offering '24/7' support to their residents. She had to be in her room at 8.30 each evening and was not allowed to have a television in her

room. The restriction became increasingly rigid. She was not allowed to have the same sandwich on consecutive days, drinking water was limited to one and half litres unless it was hot when she could have an extra sip. There was a water fountain that all children accessed without restrictions. H could not do so. H had a GPS tracker. LZ stated that 'they' had a different perspective to the parents. They felt that H was at times hungry. H wasn't allowed to watch cookery programmes. Whilst not professing any expertise in FASD, she observed that they did not feel that she met the criteria.

100. She did not display any autistic traits and much like other young girls, she needed routine and stability. She was punished by withdrawing her from offsite activities and this could last up to seven days. The restrictions also included her access to the kitchen where she may have undertaken minimal food preparation. She presented as closer to her chronological age than the parents believed. On one occasion the father gave permission for H to watch a twelve-rated film and the mother was very clear that this was not to happen again. The perception of H presenting as a much younger child carried into her education. For example, she was to read texts that were not age appropriate. F communicated mainly by email. Most of the communication came from the mother who was very much the lead.

101. The parents did not wish to tell H about the circumstances of A's death. LZ felt that they needed to respect the parents' wishes and to support them. H found out later and believed that LZ had lied to her. She was in foster care at the time and LZ arranged to see her through CHS. H had also formed the view that it was LZ's fault that CHS and KH had given notice to terminate the

placement. She knew that this could not be correct as LZ was on maternity leave but stated that this was what her mother had told her. LZ was concerned to hear H state that the mother had told her that LZ had ended the placement at KH. LZ was also clear that the mother had stated that she did not care about H. LZ stated that working with the mother could be difficult. She always wanted to add to and amend the notes of meeting and it became so difficult that they started to audio record the meetings. Mother did not want LZ and her colleagues in meetings and did not ask for feedback. She also raised concern that some of the professionals who were viewed as supporting the parents, presented differently in their absence. For example Ms S Armstrong was concerned about the levels of control exerted over H. She felt that they were worried about receiving complaints from the mother. She reflected that her own actions were the subject of *"constant scrutiny"* and meeting with the parents would *"go on and on"*. Often the mother would say that she was *"going to Ofsted"*. The staff were concerned to *"take the mother on"* fearing complaints. LZ estimated that the effort required compared to other parents was about ten times more and it was *"excessive"*. She agreed with the head of CHS (DG) to restrict communication to make this more manageable.

102. LZ agreed that H had several different medical appointments and members of KH could attend with her. The parents were concerned about her 'food seeking' behaviour and there was concern that if she was out, she may steal food from the shops. She had also hidden food although a great deal of these incidents occurred whilst LZ was on maternity leave. She was aware that H had also eaten a frozen pizza but thought that this was an example of dysregulation although they felt that she was at other times hungry. She agreed

that there were concerns about H gaining weight but this had to be balanced with her growth and building muscle. She was also at the early stages of puberty and weight gain was to be expected. LZ was aware that she gained more weight when in foster care. However, she was concerned that the parents scrutinised her weight too closely and each gain led to even more restrictions being put in place which limited her physical activity and made her gain more weight. LZ observed that KH wanted her to socialise with the other children. H liked cycling, archery, trampolining and rock climbing. KH tried to put in measures that complied with the restrictions but helped H to developed. Ultimately, H's socialisation with other children was limited.

103. She was keen to point out the limitations about KH's observations of H. LZ stated that there was a lot that the staff couldn't evidence as they were not given the opportunity to do so. They were given no option but to score H low. H wanted to fit in and needed support to regulate her behaviour. She needed to learn to self-manage this. She wanted to have friends and to socialise. She wanted to please people and make her parents proud. She was given limited opportunities to do this. She only needed about fifteen minutes of 'down time' to start regulating again and thirty minutes was too long. LZ estimated that about eighty percent of the time H was positive. She also mentioned that A always stood up for her. H felt excluded and missed out on some family events. She was quick to recognise that the father was much more positive about H's achievements whereas the mother didn't verbalise this. The mother was more *"clinical"* in her approach and the father more *"parent like"*.

104. DG was the head teacher at CHS. He confirmed the contents of his two statements to be true and accurate. He had good knowledge of H who he taught once a week with more regular interactions outside of class. After a *"rocky start"* and absconding behaviour in the first term, H had a positive start at CHS. She was more able in certain subjects especially language skills. She seemed to get on in class but her statement required her to be separated. H when upset may take a little time to calm but the acuity of her behaviour was not out of the ordinary within CHS. She enjoyed learning and enjoyed physical activity such as swimming. She was a very good swimmer.

105. DG was concerned that the restrictions that were insisted upon by the parents may have contributed to her dysregulated behaviour. He observed that there was no input from H and she wanted to be a part of it. DG was careful not to comment about some of the evidence relating to KH where these were outside of his direct knowledge. However, he observed that the restrictions that were placed on H, particularly 'lock down', a term that he strongly disapproved of, resulted in H spending more time in adult company, missing out on trips outside of the school or KH. He proposed that the seven-day lock down be reduced to four but this was not taken up. In January 2018, during a meeting DG was clear that the seven-day lock down was inappropriate and that to treat her as five or six-year-old would be a 'regression' which he was not prepared to be party to. At one point the mother suggested an even longer period of lockdown to be appropriate. H needed about 30 minutes after school to stay in her room to process the day and to calm down.

106. DG explained that there could be a cumulation of the lock down such that if there was a further misdemeanour during a lock down, then the seven-day period would start afresh. There were onsite activities that H could still access and undertake that were limited to the courtyard. He explained that the parents were given a weekly update unless there was an incident in which event they would be informed on the day of the incident. The school felt that H was progressing well and wanted to support her in preparing for her post sixteen education and gaining independence. The expectation for students was that once they were sixteen years old they would undertake travel to and from associated colleges in the locality. The restrictions placed upon H and requirements of supervision made it difficult to attain these objectives. The mother placed a great deal of emphasis on the FASD diagnosis and other medical issues. H was at par in a number of respects and in some respects about two years below her chronological age. DH disagreed with the parents that H should be treated as five-year-old child. When dysregulated, one could not reason with her and she needed to calm down.

107. The parents were concerned about H's food and fluid intake. No other children were on a restricted diet. DG believed that H's water intake was limited to one cup of water per day. He continued by repeating his concerns that are vividly set out in paragraph 33 of his statement where he addresses the parents' restrictions on the provision of information to H about A's death. He was also concerned about the parents' lack of contribution including any photographs of A to the 'memory book' that the school help H to prepare as a means of digesting and dealing with her sister's death. Whilst recognising the tragic circumstances that the parents were dealing with, he found it very

difficult to reconcile the parents' objection to H having bereavement counselling or therapy. The parents would only agree if they would be informed of exactly what was discussed in those sessions. He *"honestly believed"* that the parents thought that were acting in H's best interests. H's behaviour changed after her sister's death and she was suffering a bereavement that lasted a long time. H was told that A died in her sleep. H was concerned that she may also die in her sleep and struggled to sleep which contributed to the escalations in her behaviour. They received fewer instructions from the father although he agreed with what was stated by the mother. He found the father to be more amenable to reducing the restrictions. The parents were largely cooperative and compromised on some issues such as one to one supervision.

108. DG was aware that there was a formal letter that gave notice of H's placement ending. He believed that this was led by KH. In any event he had little autonomy on these matters and this had to go through 'management'. He struggled to recall much detail about the circumstances that led to H's placement at CHS ending. He was taken through several documents. He recalled being at the tribunal hearing that took place in August 2018 but was unaware that H's placement at the school had ended. He was aware that there were concerns about H's weight and that she was gaining weight. He observed that it *"is not uncommon that food seeking behaviour is associated with attachment disorder"*. He agreed that H's weight was not a concern when educated at home before joining CHS, and added that the EHCP was a guide and it was important to take professional advice. He also agreed that H had limited relationships with her peers and was unable to maintain the same. She

told 'lies' about her friends and played people off against each other. In his opinion H does suffer with delay in 'processing'.

109. DG stated that he was aware of studies with surrogate mothers and children who were adopted who displayed attachment difficulties at the onset of puberty. He accepted that her social skills could be estimated at between eleven to nineteen years old. He disagreed that that her emotional regulation was as low as two years of age and expressed his concern about the parents' view that she should be treated as a five-year-old but accepted that the staff had observed that she struggled with her emotional regulation. He also accepted that the parents were 'entitled' to rely on the medical advice and to follow it. He emphasised the difficulty the school had in maintaining the strict regime that the parents wished to put in place and denied that the ending of H's placement had any connection with CHS' fears of an Ofsted inspection. Looking ahead DG was not surprised that H wants to go to college and that the GOSH report recommends it. He reflected that CHS could send one to one support for their students moving to college and that this can be done in a way that would minimise the impact on that child's independence. It was *"great"* to note that she was managing her work at the garden centre and McDonalds without support.

110. EC was a Teaching assistant at CHS working from September 2016 to May 2019. After confirming her short statement and the notes attached thereto to be true and accurate, she stated that at first, she saw H on average about once each week. Later from September 2018 this was more regular as H was in her tutor group when she saw H in the morning, during lunch and at the end of the

day. H was angry with DG and mentioned that he had done something 'illegal' referring to the ending of her placement and that she hated him.

111. In September 2018 H's behaviour was difficult and it escalated in October of the same year. It appeared to escalate when she went into foster care. EC also stated that H had formed a relationship with a boy that had become *"toxic"* particularly when she 'begged' him to gain access to food. She used him to manipulate and bully her peers. She didn't have a relationship with her peers as the other students didn't wish to engage with H as a consequence of her behaviour. She expressed her concern that *"the child who left in July was very different to the child who returned in September"*. She was aggressive towards EC and called her names. Her account of a member of staff hurting her was not accurate. H responded well to a structure and plan. Without this, she had too much to process. H doesn't know where she requires support and in her experience, she would need specialist support. She was also very positive about her father and was disappointed when she rang home and her mother would speak to her and not the father. H was overwhelmed by the events in 2018 and she was taking out her anger on EC and her colleagues at the school.

112. MS [name?] started work at CHS as a head-teacher in September 2018. She visited the school in July and over the summer became aware that H may not be returning to the school. She was told that it was KH that had given notice to end her placement. H was *"absolutely delighted to be back at school"*. H blamed DG for her placement ending in the summer term. Before returning to school, H didn't know what might happen to her because of what

the parents had told her and this was unsettling for her. She confirmed the contents of her statement to be true and accurate. She stated that in her first meeting with the parents, she was surprised about how little detail the parents gave about H and was told that what she needed was already documented in medical reports. She had hoped to gain a holistic view of H by discussing these matters with the parents. H had multiple medical reports and treatment plans. She was aware that the school had been asked to treat her in line with a child suffering with PWS although she was not diagnosed with this condition.

113. MS confirmed her concern as expressed in her statement that the mother was categorical in her refusal that H should have any bereavement counselling for the loss of her sister and that this was deemed as inappropriate in the FASD report. Having read the report, MS was only able to glean generic observations about this. The mother was resistant to another type of suggested counselling called 'thrive'. MS was very clear in her evidence that the mother stated that A was *"not her real sister anyway",* She was also clear that words recorded by her were *"exactly the words she said".* She was concerned that H did not appear to be part of the family and was not entitled to grieve the loss of her sister as she was not her biological sister. The mother's refusal to allow H to participate in the MacMillan Coffee morning as part of the curriculum was *"not fair on her".* MS was also concerned that the mother's responses were limiting the opportunities for H to develop and in one such conversation the mother stated that she *"doesn't need this as she will be in full time care after she is 25 anyway".*

114. By reference to 11 October 2018 when H refused to get into the taxi to return home, MS confirmed that father was exhausted and she understood why the father may not have been able to collect her. He described the father as *"wearing his heart on his sleeve"* and was easier to talk to. H preferred to call her father instead of her mother. She gave examples of where the father was more relaxed about what H was permitted to do. MS observed not to have any difficulties in her communications with the father. She also confirmed that the staff shared the parents' concern that H can be 'manipulative'. This was observed in the context of her relationship with another child at the unit and how she had manipulated him for her own purposes.

115. At the relevant time RP was the Operations Manager for the group that was responsible to KH and CHS. He has made one statement in these proceedings the contents of which he confirmed as true and accurate. As the Operations Manager he had oversight of the staff. He was aware that H settled well in school and was 'doing well'. After the FASD diagnosis, there were many restrictions put in place. He commented that they have many children with FASD and each have different needs, there is no FASD specific plan or treatment that would be put in place. FASD does not change how we treat the children. Each are looked at and assessed on their individual needs. He had never previously experienced any children with the levels of restriction that were placed upon H. He had little interaction with the parents but was aware that this was at the parents' insistence.

116. He did speak to the father during the incident of 12 October 2018 and the father appeared *"non-committal"*. He said that he couldn't pick H up and kept

saying that we needed to speak to the mother. Normally parents may say they are in a meeting and may be late. He did not react in this way. He was *"evasive and non-committal*". There was no doubt about what he was asking the father to do and that he needed to *"step up*". After H was persuaded to get into the taxi, the driver stopped as he had been speaking to the mother and H had food in the car. H had been given a sandwich. *"I was quite angry and said it is just a sandwich, the important thing is to get* H *home".* He recalled clearly that the mother responded by stating *"no* R*, we mustn't let* H *take control, regardless of what is happening".* Neither parent had a sense of urgency. He agreed that A's death was very difficult for the family.

117. He explained that CHS had become increasingly concerned about the level of restrictions on H and the school's ability to manage this. It was felt that H would benefit from a more specialist setting. The decision to end H's placement was led by CHS and supported by KH. This decision was not taken lightly. He had a limited recollection of the tribunal hearing other than the tribunal judge stating that he had no jurisdiction over KH as this was not an educational establishment. He believed that they agreed that H should return to CHS after an indication from the tribunal judge. He was aware of H's EHCP and felt that the local authority should have sought to amend H's EHCP. RP was clear that CHS was an appropriate placement for H when she joined them and was aware that her behaviour was escalating.

Local authority and social work

118. Mr I Stokoe is an experienced social worker and the assistant Team Manager in a local authority that was involved in the provision of post

adoption support to the family. After confirming the contents of his statement to be true and accurate, he stated that H first came to his attention after receiving a request for a review or increase in the regular payments that were made to the parents through the Children's Disability Team. Most of the discussions were conducted via email. The qualifying children often had 'substantial and significant disabilities' and H did not meet that criteria. He recalled various complaints by the mother over the years. The reassessments of her needs led to a significant increase in the direct payments. The mother was very challenging and would not agree to the proposed professionals to undertake the assessments. Finally, they had to exchange many Curriculum Vitae that eventually led to an agreement. The subsequent paper review raised concerns that the professionals have been unable to see H at home as the mother did not agree to it. Despite many attempts, the professionals could *"not get past the threshold"* of the property.

119. Mr Stokoe qualified his answers by accepting that the complaints against L Haynes were upheld and the assessment had to be restarted. He also accepted that during the PLO process that followed, the local authority funded an assessment by an educational psychologist. He accepted that the local authority continued paying the monthly payments for four years without a review. He further accepted that the first time the parents became aware of the local authority's concerns was through the PLO letter that had a *"profound"* impact on them. He pointed out that they tried to engage with the family, to ensure they met H and to see the mother in a *"non-adversarial way"*. The support provisions are bespoke pacakges based on the individual child's needs. The level of payments for H was in the top ten compared to other

families. This also assisted in providing opportunities for the mother to go out and she used a portion of this to go to the gym. He was clear that he was not criticising the mother for this.

120. CJ [name?] was at the material time the Assistant Team Manager in the Disabled Children and Transitions Team. She has made two statements in these proceedings that she confirmed to be true and accurate. She was allocated to H on 9 July 2018 and first spoke to H after speaking to her mother on 16 July 2018. She had no further involvement with H after June 2019. H was clear that she wanted to return to CHS and KH. She was upset but also prepared to consider another school. A social work colleague dealt with H's education through SEND and CJ was concerned with her social care.

121. She did not lead the s.47 investigation but identified that H needed to be accommodated, have her educational needs appropriately met and to attend to her medical needs. She was not involved with the tribunal hearing in August of that year. She stated that H was reluctant to go home and the parents had employed a carer. They were in receipt of Direct Payments. After returning to school, H was commuting using taxis. She was not involved in the investigations of the allegations that H later made about her mother as she was away from work. She agreed that although H did not present to her in this manner, it was possible that H made the allegations to stay at school. During her involvement, she observed that H was a *"straight talker"* and CJ did not feel that H was manipulating her. H had an unsettled period with changes in her placement. Her behaviour was difficult. CJ was aware that she had made allegations against her foster carer. However, as far as CJ was aware, her

placement in May 2019 remained positive until CJ left. H was engaging with the staff at KH but there was no education provision in place. The staff found ways of engaging well with her. When H felt settled, she could respond *"extremely well and be positive"*. The parents had requested that all communication be undertaken in writing to avoid confusion.

122. Ms. S Armstrong has been a senior social worker since 2012. She has made one statement the contents of which she confirmed as true. She became aware of H when she began working in the Post Adoption Team in 2015. She had little interaction with the family. She attended two meetings and may have had two further telephone calls with the parents. Ms J Raymen was already involved supporting the family. Her involvement came to an end in 2016 or 2017. Ms Armstrong and Ms Raymen jointly delivered some training to the staff at KH. Ms Armstrong left in July 2017. She was aware of the restrictions placed upon H and recalled Ms Raymen having clear views about the restrictions but did not use the term lock down. When referred to a note that records the mother as stating she *"felt like a carer rather than mother"*, Ms Armstrong stated that this was "*incredibly sad"*. In her opinion such a statement indicated that the mother was undertaking the tasks that were necessary without meeting H's emotional needs.

123. She further stated that Ms Raymen had introduced the subject of FASD and she felt that H may have FASD. She understood the impact such a diagnosis may have on the approach taken to H's issues. Ms. Raymen had never said that H had FASD but was very 'pro' H having an assessment. Ms. Armstrong had seen H on one occasion at home and was "*struck by her*

behaviour". She did not feel that she had seen enough of H to have a view about FASD. She commented that there was nothing in the records suggesting that the birth mother used alcohol when pregnant with H. It was *"striking"* that heroin and cocaine were clearly stated and not alcohol use. As such, she questioned if FASD was a 'correct description' for H. She commented that a holistic view was *"vital. As parents we are always the experts in our children … the mother spoke very lovingly about* H *and I gained an impression of* H *through her eyes".* She further commented that the PLO process was damaging to the parents' relationship with the local authority.

124. She recalled that the number of emails from the mother were *"overwhelming".* She had to make specific time to read and respond to the detailed emails. The emails were detailed in their contents and many in numbers. She recalled seven specific responses. Ms Armstrong concluded by stating that in her experience adoptive parents 'go the extra mile' and the early attachment difficulties resolve quickly. She further observed that it would be important to give such children positive messages that are not overwhelming. She stated that these could be specific and may be gentle words such as 'I love the way you did that'. Ms Armstrong was unaware of the detail of the restriction upon H that included when she should be in her room and when she could leave, not being permitted to attend the cake sale at school, not having the same sandwiched on consecutive days and restricted to watching 'Peppa Pig' when she was fifteen years old. She stated that there was a concern that Ms Raymen had lost her objectivity and become too aligned with the parents.

125. FC was H's foster carer before she was adopted. She confirmed the contents of her two statements to be true and accurate. She stated that she has been a foster carer for thirty-three years and has fostered over two hundred children (short term and respite). She clearly remembered H and stated that *"she was very special to"* her, *"she was a lovely girl, so happy and content".* She recalled the parents and remembered meeting them on a few occasions. The mother kept in touch with FC for about two months after H was placed with them. She did not hear from them again until the mother called her with questions about the birth mother. She was asked about whether the birth mother drank alcohol; and FC stated that she did not know. She emphatically denied having any knowledge of H's birth mother drinking. She was equally very clear that she did not say anything about drinking alcohol or taking drugs by the birth mother. FC stated that *"the mother said that she had been to see someone who had asked if the birth mother drank and I said I don't know"* and that she should contact social services. Whilst she could not comment on whether the birth mother did drink, she denied the mother's account of this conversation as it was put to her. She also denied that there were any issues identified about H's eating or early signs of food seeking behaviour.

126. Ms K McCann (Independent Social Worker) employed by the local authority as a Consultant assisting the local authority with the Looked After Child process, these proceedings and the SEN tribunal proceedings. Subject to a minor correction, she confirmed her four statements to be true and accurate. She has met H on five or six occasions and feels that she knows her well. She observed that H's communication style can change depending on the circumstances. For example, she may present differently during an

assessment by the GOSH than when she is talking to her in a more natural setting. She can communicate appropriately and during a meeting lasting for ninety minutes, she conducted a *"perfectly appropriate conversation"*.

127. She noted that H has been more positive about her relationship with her father and it was reasonable for her to have separate contact with her father. However, this must be something that H should oversee and be consulted about. She raised concerns that the father has been unable to mitigate against the mother's views and the restrictions that were put in place. She further highlighted the difficulties in communications with the mother who has insisted that this must be conducted through the team manager. She has not seen any evidence of any acknowledgement by the mother of the harm that she has caused to H. The level of emotional harm that she has caused H is considerable. This includes a harsh and restrictive regime, making professionals believe that H is less capable than she is. This has led to H's 'presenting behaviour' which may be identified as symptoms of emotional harm when she is not acting her age and unable to form relationships.

128. The acceptance by the parents that H is beyond parental control *"does not do her justice"*. In her current placement she is the best-behaved child with many skills. She can be in charge and control her own diet. She shops for her own food, prepares it and cooks it. She goes out weekly unaccompanied. She has friends and has been out shopping with one of them. She was very happy when she did this. She does need to be supported with her relationships. She now works and McDonalds and receives *"fantastic feedback"*. There is no restriction in place and her current placement is well set up to support her. She

further observed that the litigation is really affecting her. She can be full of 'bravado'. She has not had contact with her parents since 16 November 2019. She seeks approval from her parents and this was not forthcoming. Ms McCann was not surprised that H struggles emotionally. H said that she had received a text from her mother stating that the GOSH assessment about her ASD was wrong. This has caused H anxiety about who is telling the truth and she needs to be clear about the decisions that are made about her. She confirmed the changes to the care plan and emphasised that H should be supported to go to college. She found it difficult to predict H's future needs for one to one support and encouraged a sense of flexibility and adaptability to meet H's needs as they arise. She was supportive of H having DBT.

129. Ms McCann stated that H's EHCP needs to be finalised so that she can identify a college to attend. The parents do not believe that she will cope and this has caused delay. The local authority is very clear that H needs an EHCP but is less clear about the parents' position now. She agreed that the mother has tried to persuade the tribunal judge that H's EHCP should be shaped by FASD. She could not see how this would add to the EHCP other than bring with it more control and restrictions. Whilst there were no colleges identified in September 2019, Ms McCann could not see why H couldn't have already started college. Whilst there are no educational establishments identified, there are many local colleges to look at that could meet H's needs. H needs her EHCP and should attend a mainstream college with SEN support. She is capably working at the garden centre and McDonalds without support. H can become quiet or dysregulated but this has not been evidenced in her work environment. H needs to form trusting relationships with those who are

supporting her so that she can engage effectively. Ms McCann was unsure if H was aware that the parents were not seeking her return home. She stated that this information will have to be managed and carefully imparted to her especially considering her emotional difficulties and must avoid her feeling more rejected.

130. H had an understanding that her mother was forcing her to have many assessments and it was explained to her that there were different reasons for having assessments. The number of previous assessments was in part due to the parents' disagreement with the assessments that had been undertaken. She strongly disagrees that the local authority had a closed mind and biased stance towards the parents. However, she accepted that she had not seen H with her parents and had very limited direct interaction with the parents. Miss McCann deferred to the GOSH opinion as experts in the case. She acknowledged that the father's position as expressed in his recent statement was different to that of the mother's. He was supportive of the GOSH recommendation for DBT and in principle supportive of H attending mainstream college with a transition from one to one support to attendance at mainstream college. She also agreed with the possibility of H going through a transition by perhaps attending her chosen college in the summer term as a gradual process to attending mainstream college in September 2020. The details of such transition can be finalised in a LAC meeting in May 2020. She advised against sharing this judgment with H as it would be inappropriate. Ms McCann was entirely positive about H and her father being supported to have separate contact with each other and to develop their relationship. She stated that her placement and therapy must be settled first.

The parents

131. The mother was the first of the parents to give evidence. She confirmed the contents of her five statements to be true. The mother began by giving some evidence about the background that included meeting the father in 1998 and their subsequent marriage. In the early days she worked part time and described a close family who indulged in normal family activities. The girls took an interest in cooking with their mother. They went on holidays to Devon, the Lake District and the Brecons. They returned to the same hotel in Devon for nine years where they took part in many activities and H learned a lot of new skills. H was very good at golf and enjoyed kayaking. They also enjoyed holidays abroad. She gave a little evidence about Jainism, this being her religious persuasion and that she was a vegetarian. She stated that the girls were also brought up as vegetarians. This she said was about respect for all forms of life. She has six siblings and they are generally a close family although some of her family live in the United States of America. They see each other once a month and on special occasions.

132. In December 2016 the mother was diagnosed with cancer. She underwent a surgical procedure which was followed by treatment for the rest of 2017. The first half of 2017 she underwent chemotherapy to which she reacted badly. She lost her hair and was very unwell. H wanted to look after her mother. The mother was signed off work in 2017. The family was struck with the tragic loss of A in February 2018 and she was signed off work again in 2018 but returned to work in 2019.

133. The mother reflected on the events of 2009 and described them as *"absolutely awful".* She was confronted by two social workers who she found to be aggressive. She further reflected that she gained a great deal of support from J Raymen and stated that the term 'lockdown' was a term that was introduced by her. The mother had not heard of this term in this context before. Ms Raymen described the intention behind this was to address H being overwhelmed with 'emotional stimuli' and to involve her in 'low key' activities. She denied ever 'hitting' H. She found it *"frightening"* when H was absconding from CHS during her first term. H had very limited 'stranger danger' and she worried that she may run out in front of cars on roads with sixty miles an hour speed limit. After the first few times, they were told that this is what children who are *"in and out of care do*". She felt that H was not receiving the 'right' support.

134. The events of October 2018 when H refused to leave CHS was very concerning for the mother. Having given the matter further thought, she stated that in hindsight perhaps the parents could have gone to CHS, spoken to H and asked her to come home *"but we were also grieving and it was very difficult for us ... maybe we didn't make the right decision ... but we were grieving, not sleeping and exhausted".* She was very pleased about H's progress in her current placement and how she has settled. She stated that she also worked in McDonalds when she was sixteen years old and fondly found to have this in common with H. She told me that the court has heard a great deal of evidence about H's needs and abilities. She placed great importance on her EHCP as a legal document that can help secure provisions for H until she is twenty-five years old. She further stated that H will require therapeutic support and the

speech and language therapy report in 2018 makes it clear that she may find it difficult to access talking therapies. H will also say things to please people.

135. The mother described a close and loving relationship between H and her sister A. She denied lying to H about the circumstances of H's death. She stated that it was difficult time for all of the family and *"we explained to her that* A *passed away peacefully in her sleep and that is the truth".* When asked if H needed emotional support at this time, she replied by stating *"we all needed emotional support".* She also stated that they were grieving and that is why they didn't see H for a week. They were unable to undertake the journey safely and asked KH to bring H home. She strongly denied telling H that she was not to mention A. The mother could not explain why H would say such a thing and speculated that H's perception can be different to others' perceptions but accepted that this may have been H's perception. She was clear that the parents encouraged H to talk about A. She readily agreed that H should not have found out about the circumstances of A's death through the internet and stated that she should not have had internet access.

136. The parents made a difficult decision after speaking with their GP about not taking H to A's funeral. They felt that it may be overwhelming for H and the parents may not be fully available to her. This was *"about* H *not being able to cope and having a limited understanding of what was happening".* The parents arranged a separate service at home. They had spoken to their grief counsellor and agreed this may be better for H. The mother denied not allowing H to receive support and services for this and had expected a meeting concerning this issue in June but it never took place. She denied *"saying no"* to such services for H. On 18 June 2018 KH recorded an incident in which H

had self-harmed. It included a note stating that H was *"currently not allowed therapy as refused by the parents".* The mother denied any recollection of any such refusal. When pressed about what steps the parents took to facilitate therapy for H, the mother began by stating that they provided her with day to day support and then became highly evasive in her answer. She strongly denied telling H that she could not grieve as A was not her real sister. She could not explain how this had come to be recorded by the educational staff and separately stated by H. However, she was categorical in her denial of making such statement. She agreed that this would be an appalling thing to say even in grief. She accepted that H needed the support of her family at this time but explained that they were grieving and H didn't live with them. She saw H as her daughter, she *"brought her up and always fought her corner".*

137. The mother stated that when the parents were putting themselves forward to adopt a child, they specified that they did not wish to adopt a child with difficulties. She accepted that Dr Jefferson accurately recorded that had the mother known about H's difficulties she would not have adopted her. She also accepted that she was struggling at that time. However, after receiving support with J Raymen, her views about H crystallised and *"I made a vow to myself to fight* H's corner *to the best of my abilities to give her the best chances in life as I would with* A*".* Ms Raymen helped with the attachment issues with H and after eight sessions, she was very pleased with the progress. The mother described the early years with H as "*lovely*", however evidence of her difficulties began to emerge. She was sensitive to touch and was different to other children. She denied 'distancing herself' from H as recorded by Dr Jefferson on 7 October 2008. She did not seek to dispute Ms Raymen's

recorded views about her attachment difficulties and harsh parenting. She stated that the therapy was very helpful. She may have appeared harsh to other people but denied this was experienced as harsh by H.

138. She explained that "H *and I have a lovely relationship and we have a huge attachment but this is different to a neurotypical child".* She denied needing any therapy or counselling for her relationship with H. She accepted the recorded comments that she stated (SEN 11 July 2014) "H *get home at 4 pm and then I have to live with her until 8 pm".* She explained that H was returning from Msch. dysregulated. She reflected on H's early history and opined that this would have been very damaging to H. The mother was reluctant to accept that she had contributed to H's difficulties. She was more definite about not causing emotional harm to her beyond the early years. Whilst qualifying her answer by stating that she disagreed with the GOSH opinion, she accepted that in hindsight the lockdown of seven days could have been for a shorter period. She then blamed the professionals for the lack of services and support for H and causing her harm. She was clear that she disagreed with the GOSH about the level of harm that H has suffered. She denied adopting a negative attitude towards H's achievements and gave a series of examples of physical activities that H undertook whilst in their care. The mother accepted that H and her father had a different relationship but denied that it was more positive than her relationship with H. She explained that individuals with attachment difficulties will have different relationships. The mother accepted that she took the lead on the medical issues, but she did not always agree with the father. For example, the father felt that the seven-day lock down was too long. When asked about the two incidents in October 2018, she could not recall a great

deal of detail and stated that *"she presumably felt rejected and with hindsight she may have been testing me … I don't think that caused her emotional harm …* H *has difficulty in understanding other's perspective".* When asked if H felt abandoned, she replied, *"It is very sad for me".* She stated that it was the taxi company's policy not to have food in the car and not something that she had encouraged on that day. Later in her evidence she added that the father was prepared to go if H would get in the car but the mother was concerned about the father and she *"didn't want to lose him in a car accident".*

139. The mother explained that her instructions to MSch. not to praise H were not about praising her but about how she was praised. When asked about why H was not dysregulated when she was praised at MSch., the mother responded by saying that she did become dysregulated in BH. H needs the praise to be quiet and not 'overt'. She denied that H was not allowed treats at CHS and stated that H was given Amazon vouchers and other treats which was discussed in a multidisciplinary meeting when they also discussed H not becoming fixated. The mother could not recall not coming to see H for her birthday in 2016 and H being upset by this. Similarly, in 2019, the mother denied refusing to see H. She stated that they had R to look after and now living away in another county. She told H to speak to her social worker to arrange it.

140. The mother agreed that lockdown was endorsed and used by her. She agreed to use another term when DG expressed his concerns about the use of this term. He suggested using 'consequence'. It was used when H was dysregulated to help her calm down. She explained that H can take a long time to calm down and in hindsight seven days was *"quite a long time".* She

accepted that the seven-day period may have been longer if there were two episodes of dysregulation with the seven-day period as the second episode restarted the lock down again. She further stated that the staff had difficulty in recognising when H was dysregulated. When asked about how H would feel about the seven-day lock down, the mother stated that *"it was about how the adults presented things to* H". The use of this was agreed in a multi-disciplinary meeting. The idea came from Ms Raymen and the mother suggested this to the meeting. CHS and KH expressed their concern. DG tried to reduce the period of seven days but it was agreed to retain it.

141. The mother accepted that H was to remain in her room from 8 pm to 7.30 am and was not allowed out during those periods. She had an alarm on her bedroom door. She had access to books on the landing at home. H did wear a GPS watch. KH asked about H's routine and the parents explained that she washed on Sundays. The parents were trying to keep life consistent for H which included her washing once per week. The mother continued to speak about the list of restrictions such as supervision of H in the shower as she did not wash properly and had issues with selfcare.

142. She agreed that it was 'terrible' for H to say to CP that *"they want to keep me in a cage".* The mother strongly disagreed with the proposition that she had destroyed H's self-belief. She explained that H is autistic and requires routine and structure. The mother also denied that H was only allowed to watch Peppa Pig. She enjoyed watching other programmes such as Master Chef.

143. The mother stated that H is a very anxious child and does not respond to reassurance, H was reassured but in a different way. She imagined that H would be affected by anxiety although seemed less clear about whether she was affected by her mother's anxiety. She observed that Ms Raymen saw H's heightened anxiety leading to more food seeking behaviour. She stated that when H could eat freely her weight *"shot up"*. Her food seeking behaviour has been present from the start. H had sensory processing difficulties that included feelings of hunger and bladder control. The restrictions around her diet and toileting were in place on advice from professionals. When asked about the impact of this on H, the mother replied that it helped her *"mentally and dietetically"*. The mother accepted that she had influenced Mr Smith but denied that this was to achieve a desired outcome. She accepted that she presented H as a PWS child but denied wanting a PWS child. She stated that H's behaviour may stem from anxiety that leads to dysregulation but denied that this was caused by her parenting and stated that H remains a highly anxious girl. She was unable to explain why H was to be treated as a PWS child and deferred to Mr Smith. She denied causing or lacking insight in the harm caused to H. She stated that there were many professionals involved with H who would have spoken up.

144. The mother agreed that she complained against Dr Needham as she wanted to amend her report on the issue of FASD and Dr Needham did not. She said that she was trying to be helpful. She agreed that she was seeking to amend her recommendations. When asked if this was an attempt to control the professionals, she cited several other doctors who had sought feedback from the parents. She denied directly confronting Dr Harrison-Wells or the team at

the GOSH. She explained that the FASD diagnosis was made by a leading clinician. She denied being manipulative and controlling or that H was 'collateral damage' in this process. When asked about H's comment that *"... you can never win"* with the mother, she explained that this may be the way H spoke. H said things that people wanted to hear and wanted to please them. She accepted that she had requested on a few occasions staff from KH or CHS not to attend H's medical appointments.

145. The mother explained that FASD was *"not on* her *radar"* and Ms Raymen first introduced the subject. She then took this further leading to the investigations that took place. She agreed that there was no evidence of alcohol exposure in utero. If it wasn't for the first report, she would not have contacted the foster mother. The foster mother said that H *"may have"* been exposed to alcohol in utero. She said that FC recalled alcohol being an issue and was subsequently an issue in the mother and baby unit. The mother was taken to the relevant emails and denied being caught out on an 'obvious lie' on this issue. She denied lying about her conversation with the foster mother. She deferred to Dr Mukherjee and recited parts of his evidence about whether confirmation of alcohol use was necessary. However, she agreed that the turning point for the diagnosis by Dr Mukherjee was the evidence of alcohol use. She explained that "*It was helpful for all the adults around her* [H] *to have better understanding of the difficulties that she has".* The mother confirmed that she was in possession of the Red Book in 2017 and could not explain where the Red Book is. She questioned why this was relevant or necessary.

146. She also differed from the professional opinion on the diagnosis of ADHD, ASD and AD. She gave her assurance that she would not be pursuing a diagnosis that is not made out. She denied wishing to present H as less capable than she is or that she is disabled. When taken to entries where the mother is noted as encouraging others to treat H as a two-year-old, she states that H can present as two-year-old when dysregulated. She denied that this was an observation of how H presented always. She disagreed that her parenting and approach restricted H's everyday life. The mother recognised that H has been holding down a job and progressing but was also concerned that she remains vulnerable. She was referred to her email to DG dated 16 November 2017 in which she made statements about the appropriate age H should be treated as. She denied that this was the correct interpretation of what she had stated in that email.

147. She accepted that H may attend college with the support of a key worker but that this needs to be reviewed. She did not wish to see any calorie restrictions in her EHCP and stated that whilst H appears to be managing her own diet, those working closely with her should support her. H was supported with her toileting which has now improved. She did not comment on whether there was any need for such a regime to continue. The mother further stated that H will need one to one support and this may reduce over time. The mother noted that H was working in McDonalds but expressed her concern about whether H will be able to sustain this. When asked about H starting mainstream college, the mother stated that H needs her EHCP plan and that the college need to be aware of her complexities. However, in principle she was not against it.

148. The mother stated that A and the father had a close relationship. He was 'hands on' and tactile. He had a close relationship with H and H has spoken very positively about her father. The father was confident and full of energy and *"a real family man ... Now he is a shell of the man that I knew".* At times the father dissuaded the mother from pursuing certain issues or to voice her views. H did not react well to physical contact. The mother observed that she had *"a young child who was disturbed and not knowing why ... I didn't quite understand and didn't know how to help her... scooping her up in my arms didn't work ... H reacted badly ... she would say ouch that hurt ... felt rejected. I felt rejected and nervous around her and wasn't sure what to do ...".* This was not like being a first-time parent after a pregnancy and *"was not like what I imagined".* The mother found the therapy helpful and could employ certain techniques that she had learnt in therapy. She *"put faith in what Julie Raymen asked us to do ... her advice made a positive difference".*

149. The father didn't like the term lock down and Ms Raymen was clear to use this phrase as a simple term to help the parents understand what it meant. It was intended to lock out the external stimuli. H's behaviour varied and this was an effective method of dealing with her dysregulated behaviour. It was implemented in CHS and KH. During lock down H continued to have access to different parts of the building including the court yard. H had many changes in school and she appeared much happier when she was educated at home. Ms Raymen was managing her food portions and the family worked to address her food seeking behaviour. This was an issue in CHS and KH noted that she had stolen food from the shops. The parents also rewarded her. They worked hard to do what was best for H and *"now it is all chucked back in our face.*

She was my daughter! I made a commitment to her and I was going to do everything I could for her".

150. The mother gave a commitment to supporting H in her therapy whilst expressing her concern that H would 'cope' better with creative therapies. She was happy to be involved in the process of helping H better understand her circumstances if the professionals feel that would be helpful. She was clear that her contact with H should continue to be supervised as it *"would be better for all of us"*.

151. After confirming the contents of his five statements to be true, the father stated that when H first arrived home, she was a smiling happy girl, "a *little bundle, very very cute and we felt privileged".* As time went on, the parents noticed 'little things' that were different about H. She became sensitive to the cold and it was very hard to persuade her to go out in the cold. She became *"fascinated with food"* and if she couldn't get to it, she would become distressed by crying, screaming or sulking. He observed that they were in the process of *"getting to know each other"* and the progress was a 'mixed picture'. She worsened over time and fought off hugs. If she was held tightly, she would fight it off by saying you are hurting me. Ms Raymen's intervention was helpful. The father engaged in one or two sessions but over time observed the mother becoming more confident and H became more comfortable with hugs and kisses.

152. The father reflected that H's first school was picked by the parents as a small independent school. A attended the same school at that time. The school sought to encourage independence and H didn't cope with that. Her next

school was a small village school where H settled well. She had a young gentleman as her teacher. She was taught the times-table and spelling. H was doing very well. The following year, there was a change to her teacher and H started to suffer with "*quiet confusion*"*.* She moved to the back of the class and he felt that H was avoiding exposure to the more challenging teaching. She then started misbehaving. The placement ended on good terms and she moved to MSch. He had little recollection of this period and recalled SEN identifying BH as being the next appropriate school. This was a 'failed placement' with H suffering with low self-esteem and poor behaviour. Some of the other identified school provisions looked like prisons and not right for H. He observed that *"she was violent when she was distraught and it wasn't her fault and that was an absolute no".* On her return form BH, she was *"disturbed, moody, sad, shouting and breaking things".* It took about three months for her to transition to a lovely girl without any need for routines. The father gave evidence in similar terms to the mother about the activities that H enjoyed such as playing golf.

153. He recalled H not feeling full after eating and he believed her to be hungry. On one occasion the parents tested her by offering a one-kilogram bag of vegetables after she had eaten. She ate it and still felt hungry. The father *"hated"* the term lockdown. This was introduced by Ms Raymen and not the family. He could not recall the precise detail of the lock down regime. He recalled withdrawing certain activities such as rock climbing or trampolining. The parents were concerned for H transitioning to a residential school. CHS was chosen with the assistance of SEN and the restrictions were to help with this change. As far as he could recall, the restrictions concerned diet and

toileting. She was distraught in the first term, she was running away, seeking food and forming 'toxic relationships'. He understood that the plan for H was based on building blocks and building on each block to the next stage. The father further stated that he has

> *"…been thinking a lot about this and if the school was reasonable … or if we were asking too much of the school".*

He further reflected that the school wished to loosen up the restrictions and the parental strategy was to tighten them up

> *"and that wasn't the right choice … we got it wrong. This was terrible for* H *who was away from us and her base. We missed her dreadfully. She was probably a bit lost thinking these adults are trying to look after me and doing different things and* H *probably thought that it was an impossible task. When the school did relax the rules, it didn't work either and we should never have sent her away … I regret deeply sending her away."*.

154. The father gave a tragic description of his family following the mother being diagnosed with cancer and then A's death. He vividly described his feelings at the time by stating that after waking up in the morning he would have a cup of tea with the only thing to look forward was going back to sleep so he could feel no pain. He then explained that the two incidents in October 2018 must be seen in this light. On the first occasion he was in a meeting and explained that it may take up to one hour and thirty minutes to get to H. He started to cut the meeting short but was aware that the mother was discussing H's collection with the taxi company. Ultimately the taxi was sent to collect her. On the second occasions, he was under the influence of sleeping tablets

and in bed when the school contacted him. He did not feel it would be safe to drive but was prepared to do so. He reflected further that perhaps H felt that if she didn't cooperate, then she may be placed in KH. He described H's placement in foster care as *"a disaster,* H *would have felt alone and rejected. Looking back this was bound to happen as it was escalating and she was desperately unhappy".* He accepted that the *"issue of medicalisation occurred on his watch".* He stated that there were also good times. As a family they enjoyed some very good times. They were told they were bad parents and some of the medical issues were driven by SEN. This was aimed at accessing more provisions for H. He would help with any narrative work for H. He felt *"desperately sad"* about the two sessions with the GOSH as he felt that they did not listen to him. He said

> *"I want my daughter back and just to be normal. I don't think that's going to happen!"*

155. The father has been suffering with high levels of stress and his memory and concentration have suffered. He has been unable to read much of the case papers that include the expert reports. He has heard some of the oral evidence (including the mother's) and has been updated by his legal team when in court. When asked if he disagreed with any parts of his wife's evidence, he struggled and identified the issue of H's attendance at mainstream college. He stated that his wife had reflected on the evidence and was more supportive of H attending mainstream college. He restated some of his concerns about lock down. He then expressed his difficulties in understanding how H is at present given the limited involvement that he has had in her life. He appeared genuinely delighted at her achievements and ability to work two different jobs

together with her ambitions and plans. He was supportive of H staying in her current placement and felt that any college should be within an hour commuting distance. He thought that H would benefit from some support at the start to become familiar with the route and the new surroundings when she is there. He was keen to point out that she needed one to one support but such a person should be a safe distance away, who can be there when needed but not interfere with her independence, *"*H *needs the space to get on with things"*. He saw it as important to be flexible and *"not dogmatic"* about where H attends college. He too stated that H would benefit from a transition plan to see her start college in September 2020. This needs to be flexible and adapt to her reaction. He confirmed that he was not at odds with the local authority's updated care plan. He expressed his hope that a three-day tribunal hearing may be avoided. He observed that a unified voice by all adults would benefit H.

156. The father continued by stating that H needs to learn coping strategies that are built on. He stated that the mother has devoted her life to helping her children, family and young people. The regimes that were put in place were intended to help H and *"what we got wrong was to try and translate those into an institution. We were desperate for it work for our daughter. It was deeply unsatisfactory for* H *that we got it wrong"*. He reflected further on the events of 2018 by stating that LZ going on maternity leave *"was a huge thing for H"* and A's death was devastating for the family. LO was the glue that was keeping everybody together. The way H was told about A's death *"was a huge rejection for H"*. More generally, he observed that *"*H *didn't settle and got lost in who is wrong and who is right"* and agreed that the mother was the 'prime architect behind' this. He denied that the mother was rigid with H. The

restrictions were not punitive but not always appropriate. He recounted some other appropriate measures that were in place in the home such as if H was in a bad mood she would go to the tree house for thirty minutes to calm down. He thought that the seven-day lock down was in fact from Monday to Friday. Ms Raymen had stated seven days and at first the father did not agree with this. He further reflected that *"*H *was a series of experiments that were suggested by Julie Raymen who had a good track record".* He recalled a period when H was wetting the bed and Ms Raymen had told the parents not to change her or the sheets, *"we did it and* H *stopped wetting the bed. It was a terrible example but it worked".*

157. He was unable to explain why he did not voice his concerns in meetings or stop some of the regimes that H was exposed to. He appeared helpless in the face of the many professionals and his wife. When asked about why he had suggested not to follow one of the mother's proposed amendments to Mr Smith's report, he explained that it was better that Mr Smith remained independent and that the mother was not the expert. He wanted to stop people thinking that Mr Smith was not independent. Part of him wanted to say that H *"has not got ASD but that may have closed the only available option. In my heart I think she is autistic … I stand with Dr Mukherjee and Dr Carlisle as the experts on FASD".* He recalled the mother coming into the lounge after speaking with FC stating that she had confirmed that there were concerns over alcohol with the birth mother. She did not say any more than that. The mother did not say that there were concerns about alcohol use in pregnancy. He denied that his wife would ever lie to him. He agreed that he had failed H in some respects but denied failing her in this respect.

158. He also recalled that the mother used one of A's handbags for comfort and asked H if she wanted something belonging to A for comfort. She asked for her lunch box. He also stated that he oversaw the school uniform and making sure H turned up well to school. He did not receive any emails complaining about how she was presenting after returning to school in 2018. She had new shoes and others that the father had repaired. The father was not involved with the social workers' visits in 2009 but commented that the mother was very upset. The father stated that he was terrified about losing R and spontaneously stated that *"we are grieving losing* H *and I do worry about what that is going to look like*".

The guardian

159. The guardian confirmed her final report and analysis to be true and accurate. She set out her vast experience that included many years as a social worker with experience of working with adopted children and adoptive families. H's case was allocated to a different guardian who had to leave the case to commence maternity leave. The guardian was allocated to H's case on 20 May 2019. She explained that she had become very familiar with the case papers and the updated papers that have been filed and did not change her recommendations. She has experienced some difficulty in seeing H due to a combination of her moves in her placement and the guardian's assessments of H's needs at the relevant time. The guardian was very pleased to note that H has settled well in her current placement and is planning passively for her future. She was clear throughout her evidence that the stability of her placement must take priority to all other matters such as her education or

contact with her parents. In H's own words, she is *"sick of professionals"*. She has been the subject of a great many investigations and professional input. She is currently well supported with key professionals around her.

160. The guardian was very much in favour of a transition plan that sees H entering a mainstream college in September 2020. Such a plan will need to be reviewed and adjusted to meet H's needs. She agreed that H is likely to need one to one support at the start of the process that can be reduced as H settles into her educational establishment. She was reassured to note that her current placement is available until she is eighteen years of age and thereafter ongoing support will be made available to her. She also saw great value in the recommended 'co-narrative' work and was very clear that this work needs to be undertaken by a person that H trusts and who can stay involved with H for a longer period than a single piece of work. The guardian was clear that H must be and feel in charge of the decisions that are made about her that include her contact with her family. She was not against additional separate contact with her father but emphasised that this must be *"led by"* H.

161. The guardian deferred to the GOSH opinion as to whether DBT is the appropriate form of therapy. She stated that this may be the start and may lead to more specific therapeutic services for H. She very properly refused to comment in detail about H's therapeutic needs. However, she observed that H may not engage with therapy and this needs to be reviewed and approached creatively. The key will be involving her in the process. The evidence suggests that despite her initial refusal to engage, she can be supported to do so effectively. The professionals and her family will need to support her. The

guardian had no doubt that the parents love H, however it is the mother's perception that the local authority is set to demonise the mother. She observed that the mother is *"very adept at splitting the professionals"*. The guardian was clear that there needs to be clear and transparent communication and boundaries for H's benefit.

162. She continued her evidence by stating that there is a vast amount of information that is available to those supporting her. She needs a trusting and supportive relationship with the adult supporting her. She agreed that a breakdown in her college placement can be devastating to H. Furthermore, H is very explicit in her views about college. The professionals and her parents must work together to support her in realising her choices and ambitions.

163. The guardian was clear that the parents love H and have followed the professional advice. It was difficult to identify when *"it all went wrong"* but is clear that the parents have a difficult relationship with the local authority. Given H's age, the guardian would be surprised if H has not 'picked up' on this difficulty between her parents and the local authority. She emphasised again the importance that all adults need to work effectively together for H's benefit. She agreed that it was also important to remember that H was an adopted child and that adoptive parents have certain anxieties and in her experience, the early period can be a highly stressful time for the adoptive families. She stated by reference to research that twenty seven percent of adoptive parents felt that they had not been given detailed information about the child but noted that this also depends on how much information the parents are willing to accept.

164. To their credit, the parents have sought support and committed to H. She also agreed that adopted children can be very different to children with secure attachments and this is more difficult for parents with certain expectations who have already had their own biological children. Whilst she did not specifically comment on these parents, she observed more generally that most adoptive parents do experience a 'honeymoon period' before some difficulties are identified. The Guardian recognised that the father deeply loves H and has *"shown a good deal of remorse and reflection on some of his decisions".* She expressed her sincere hope that there will be a positive future for H and her father and advised that the father must now accept that the future progress will be led by H and for him *"not to shy away from his role as* H's *father".*

Analysis

165. H's early life experiences that include exposure to illicit drugs in utero, a period in the SCBU, changes in her placement between her biological mother, foster care and finally to placement with her adoptive parents have had a combined impact and have shaped H as an individual. These experiences have contributed to how H presents and interacts with the world around her. Notwithstanding the detailed evidence in this case, it is impossible to state if one of these factors is more important or relevant than the others. In my judgment, the collective impact of these factors is a significant consideration in understanding H's experiences after she was placed with her parents. I have no doubt that the parents' experience of H was very different to their expectation especially when they had already experienced A's birth and their continued interaction with her as she grew and developed.

166. When considering H's life experiences in the years that followed her placement, it is crucial to consider the evidence in the relevant context. Most obviously the mothers' diagnosis with cancer in December 2016 and the treatment of the same during 2017 had a significant impact on the family. As the green shoots of hope began to emerge in late 2017 and early 2018 after responding well to her treatment, the family suffered the greatest tragedy when they lost A. I have no doubt that this tragedy was further compounded by its circumstances. The devastation that followed this event has without doubt impacted on the parents' choices and their ability to parent H. There can be no doubt that the parents' physical and emotional availability to H was significantly compromised.

167. The mother also gave evidence of the happier times when the family went on many holidays, attended family gatherings, cooked and indulged in pleasurable family activities. To a degree this was supported by the father when giving his evidence. I have no doubt that mother's description of those times is accurate and that the family also enjoyed positive family time together. This is an important factor that must be put into the balance when considering the issues before me.

168. As H has grown up, she has presented with different and complex behaviours and needs. At times, she has divided the professional opinion about the causes and the treatment of her behavioural issues. Her parents have pressed for a better understanding of her needs and for the provision of support and services to meet those needs. As attested to by the mother, she has been

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the main individual and the lead in this pursuit who has been supported by the father.

169. I found the evidence of the parents most illuminating albeit in very different ways. I found each parent to be intelligent and notwithstanding the father's current difficulties, they were both articulate in different ways. The contrast in their presentation and the contents of their evidence was stark. Whilst recognising that giving evidence can be very daunting and a stressful experience, the mother displayed very little emotional content when giving her oral testimony. I was also left in no doubt that the mother loves H and she has been driven by wanting to find the best available options for her daughter. The early years after H was placed with the parents, presented the mother with unexpected challenges. It was clear from her evidence that after the initial settling in period, the mother found it increasingly difficult to form an emotional bond with H. Whilst I recognise that the mother was the main carer, the evidence does not suggest that the father found this with the same degree of difficulty as the mother.

170. To the parents' credit, they sought help to address this issue which was provided to them by engaging the services of Ms J Raymen. I have listened and read a great deal of evidence about Ms Raymen's contributions that span many years. I also note that she has not been available to give evidence. She became close to the family and gained a good deal of influence over the decisions that the family made about H. There is evidence suggesting that there was some professional concern that Ms Raymen had lost her objectivity by becoming too close to the family. There is also clear evidence that she too

had concerns about the parents but feared raising those concerns. The evidence before me is clear that she had a significant role in the restrictions that were placed upon H and the introduction of FASD. Whilst as a trusted professional involved with H, the parents could properly rely on her views, this was taken by the mother, as supported by the father, at the ignorance or rejection of the relevant alternative professional views.

171. In her evidence, the mother was calm, intelligent with a clear knowledge and understanding of the case papers. She was present in court and listened to all of the material witness testimony. In the many hours in which she gave her oral evidence she was offered numerous opportunities to reflect on her parenting of H and her choices in this regard. She displayed a most striking lack of insight or any acceptance that she had any part to play in the harm that H has suffered in her care. Whilst accepting that H had been harmed, she attributed this harm to the conduct of the professionals involved with H. At times when blaming the professionals could not be sustained, she became evasive. When pressed to reflect on the evidence and her parenting of H, she was stunned and paralysed in thought giving no indication of engagement in any insightful processes. In very few instances where she began to show an element of reflection, such as the duration of lockdown, she was quick to defend her primary position and deflect blame onto the professionals.

172. Another striking feature of the mother's evidence was her inability to consider H's life events from H's perspective. The mother was given many opportunities to do so and manifestly failed at this task. On the material issues, the mother's answers shifted the focus on her or her and her husband as the

individuals suffering the difficult circumstances at the relevant time. The mother lacked any meaningful ability to recognise or to consider the impact of those events on H. Her lack of insight and inability to reflect on her parenting of H, chimes very closely with the observations of many professionals that have been involved with this family. Latterly this has been clearly identified and commented upon in the GOSH assessment.

173. The mother's evidence also clearly illustrated a medicalised and a quasi-professional approach towards caring for H. I have no doubt that she was and remains true to her commitment to 'fight H's corner'. However, it was clear to me from the mother's own evidence that such a commitment has come at the expense of a nurturing parental bond. At times, the mother saw herself as H's carer and others have described H as the mother's project. The mother's commitment to H has driven her quest for certainty and a better understanding through medical diagnosis, presenting and believing H to be less capable than she is, putting in place extraordinary and harmful restrictions that have controlled and limited many aspects of H's day to day life.

174. The mother's interaction with the professionals has at times exploited the differences in the professional approach and has created two clear groups of professionals. Those with whom she agrees and regards as supportive of her approach and those who are the opposition. She has exerted influence and control over some of the professionals and their response to this has been determinative of which side of the divide she viewed them as falling. There are several examples of this that are detailed in the evidence. One such example is her interactions with C Smith, where despite a lack of any

diagnosis of H suffering with PWS, she had clearly sought to influence C Smith's views and recommendations. Such was the level of her attempted influence that the father had to interject to maintain a degree of distance with C Smith and to preserve his credibility. The evidence of the mother about what FC told her about H's exposure to alcohol in utero lacked credibility. The mother appeared to look for information that supported her views and goals. Her presentation and account of what FC told her was inaccurate and has shaped the medical opinion about FASD. Consequently, H been exposed to greater levels of restrictions in her daily life. I found the FC's account consistent and entirely credible. On this issue I overwhelmingly prefer her evidence to that of the mother.

175. Where her attempts at such influence have been met with resistance, she has at times confronted those professionals. Whilst in some instances the parents have been justified in raising complaints, in other circumstances this has been deployed as a means of securing professional compliance with the parental view. In my judgment there is clear evidence of this pattern of behaviour with the educational, local authority and medical professionals. This has in turn contributed to H not always receiving appropriate support and being exposed to a number of professional interventions.

176. Notwithstanding a great deal of evidence attesting to H's capabilities and achievements, the mother continues to consider H less able than she is. The mother maintained a concerning negative narrative about H's abilities and vulnerabilities without any balance by recognising and celebrating her achievements. Even when reflecting fondly on her work in McDonalds that

the mother had also experienced as a teenager, she was quick to question if H would be able to sustain this. The mother appeared unable to truly acknowledge H's attainments which must be viewed as more significant by the mother when considering her firm views about H's abilities to be significantly limited.

177. As I have identified earlier in this judgment, the father has suffered with limitations in his participation in these proceedings. Notwithstanding his circumstances, the father was far more focused on H and very reflective on the conduct of the parents together with others involved in her care. He spoke of H with great affection and love. I have no doubt that he dearly loves his daughter and his sorrow at losing H was palpable. He considered some of the important issues from H's perspective and the impact that some of the parental decisions may have had on H.

178. The father appeared to be very pleased and proud to learn about H's achievements. Despite his concerns about some of the expert assessments, he considered the information and accepted those parts that he felt to be appropriate for H. He was also involved in the proposals for a transition plan that would pave the way for H attending college. He was prepared to consider and compromise on the choice of therapy for H which was closer to the opinion of the independent experts in the case.

179. It is clear to me that the father deeply regretted some of his past choices such as H being subjected to lock down. It is also clear to me that the father continues to support the mother in her views albeit there were some examples where he recognised that he could have done more for H or to have insisted

on a different course of action to better serve H. Whilst the father was not the driving force behind the harmful parenting that H has suffered, I agree with him that he should have intervened and could have done a great deal more for H.

180. There is no issue about H's placement. She is settled in her current placement and making plans for her remaining teenage years into adulthood. Having considered all the evidence before me, I have no doubt that she is of sufficient capacity and understanding to make responsible decisions about her future. She will need to be supported in this task and I am confident that the local authority will put in place the necessary support and services that H requires. It is crucial that H is and feels in charge of decisions about her future. There is no material dispute on the detail of the amended care plan and I have no hesitation in approving this as the appropriate care plan for H. Similarly, there is no dispute that H's interests require her to be made the subject of a care order and I agree.

181. The remaining issue is H's diagnoses that may be relevant to planning for her future. It is clear that H does not suffer with PWS and inappropriate that she should be treated as 'PWS child'. As for the issue of FASD, I was alarmed to note the assessment journey that started with no diagnosis to a diagnosis. In my judgment this clearly illustrates the negative impact of the mother's influence on perfectly respectable professionals that has led to a diagnosis that has in turn detracted from H's actual and real needs. I have also heard and read a great deal of evidence about the diagnosis of ASD and ADHD. I note that at different stages H has been assessed as meeting the diagnostic criteria of ASD

and at other times she has not. I accept Dr Knight-Jones' evidence that this is not unusual. The very nature of the diagnoses of ASD and ADHD rely on several sources of information that help the practitioners to triangulate the relevant evidence. I also note that H has complex presentation and in the opinion of many professionals who have been involved with her, she does not easily fit a particular diagnosis. The information that has informed this diagnosis has in part come from the mother and other sources including the school. The reliability of that information is highly questionable given my findings about the mother and the parents generally. Triangulation of information mitigates against some of the other influences. The GOSH assessment was informed by a great deal more information and the assessing team had access to the relevant crucial case papers. This will in my judgment make the process of triangulation much more accurate and reliable. Furthermore, the information that has been available to the GOSH has spanned a greater period and is much more up to date. In the circumstances, I prefer the up to date assessment of the GOSH in this respect. In doing so, I make no criticism of Dr Carlisle's assessment as her work was informed by the information that was available to her. The concerns about the reliability of that information were not known to her when undertaking her assessment.

182. In my judgment Dr Carlisle's conclusions on FASD and ARND as set out in her interim reports are the more accurate and reliable conclusions. Whilst there can be no doubt about the expertise of Dr Mukherjee in his field, I note that he was conducting his assessment in difficult circumstances that have led to three versions of his report. The material change to a firm diagnosis coincided with the assertion that there was confirmation of alcohol exposure

in utero. It may that in in the day to day running of a clinic such information is taken as reliable unless there are good reasons to illustrate the need for verification. It is clear that there was no such attempt at verifying this information. In his evidence Dr Mukherjee sought to justify this by reference to assumptions and likelihood of alcohol exposure in modern western societies and in 'polysubstance users'. These are not assumptions that I can reliably make in the context of this case. To do so would potentially reverse the burden of proof and seriously risk approaching this issue on a false premise. The evidence before me continues to suggest that alcohol exposure is one of the four criteria for such a diagnosis. It may be that there is a developing belief among the FASD experts that this consideration is of less significance, but the evidence before me clearly suggests that alcohol exposure remains an integral part of any FASD diagnosis.

183. My findings on the issue of exposure to alcohol in utero and ASD/ADHD, reliability of the information provided by the parents, together with the lack of any other supporting evidence of the remaining two features of FASD or ARND and the complexities in H's presentation fundamentally undermines the diagnosis in this regard. It may be that as Dr Mukherjee observed, with the greater recognition and understanding of other factors that influence the development of the brain the diagnostic criteria will be further reviewed. It may also be that in time there will be other medical tests available that would better inform the practitioners. Perhaps the need for confirming alcohol exposure will become less relevant as we gain a better understanding of the influences of other substances and environmental factors. Until then, I must

proceed on the basis of the most up to date diagnostic criteria that must be applied to reliable evidence.

Conclusion

184. The parents' evidence has highlighted the significant deficits in the parenting and the substandard emotional environment that H has lived in. This has caused her significant emotional harm. Their evidence is corroborated by the independent expert assessments and other professionals that have been involved with H covering many years and many aspects of her life. The totality of the significant evidence leads me to find that:

   a. The parents love H and have been committed to her. They have sought to access what they believed to be the best services and support for her.

   b. The mother was H's main carer and has struggled to form an appropriately close and reparative emotional bond with H which has exacerbated her difficult early life experiences.

   c. The parents have not provided H with reliable, predictable and secure emotional attachment which has caused H emotional harm.

   d. The mother has with the support of the father taken the lead in seeking intervention and investigations into H's complex needs, to access support and service to meet those needs. In doing so, the mother has:

i. become preoccupied with H's health and has pursued many medical diagnoses to explain her perception of H's presentation which has resulted in H being subjected to numerous assessments and investigations despite medical assessments concluding normal or unremarkable results,

ii. sought to influence the conclusions and outcomes in medical investigations by

  - attempting to contribute to or restrict the provision of information to different professionals, and

  - seeking to amend or contribute to conclusions of medical investigations and opinions which has at times led to conflict with some treating medics and at other times served to confirm her rigidly held views of H and her abilities, and

  - providing inaccurate information to the medical professionals, for example, Dr Mukherjee and Dr Carlisle with inaccurate information about H's exposure to alcohol in utero,

iii. sought to control professionals who presented with a differing view to her and to secure their compliance with her views by creating an atmosphere of confrontation and fear of complaints against those professionals,

        iv. formed a rigidly held view that H is less capable than she is and has selectively relied on the professional opinion that confirms her views whilst ignoring the contrary view or opinions,

        v. used the professional opinion favoured by her to put in place measures that have been highly controlling of H's environment at school, home or residential placement. These measures of control have included seven-day periods of lockdown, confinement to her bedroom each evening between 8 pm and 7.30 am, no access to television whilst in her room, access to offsite activities and her personal care.

e. The father has supported the mother in her conduct as set out in paragraph d above and has been unable to mitigate against the impact of the same upon H.

f. Consequently, H has suffered harmed by:

    i. her mother/parents limiting her opportunities to form appropriate peer relationships, and

    ii. excessive and at times unnecessary assessments that have contributed to her high levels of anxiety and self-worth, and

    iii. her mother/parents believing and presenting H as less able than she is, and
    iv. her mother/parent limiting her opportunities to access education at a level commensurate to her abilities, and
    v. suffering with low self-esteem, and
    vi. H feeling rejected, and
    vii. Her mother/parents limiting her opportunities to developed independence.

g. The diagnosis of ASD and ADHD is no longer sustainable as;
    i. it relies in part on the parental reports that have proven to be unreliable which was not known to Dr Carlisle at the time of her assessment, and
    ii. the evidence informing these diagnoses is more limited in its scope and less reliable than those informing the more up to date assessment.

h. The diagnoses of FASD or ARND are unsustainable as:
    i. the evidence that informs and supports the diagnosis is not reliable, which includes the mother's false assertion in an email to Dr Mukherjee's clinic dated 21 June 2017 asserting that FC knew the birth mother abused alcohol during her pregnancy, and

ii. the reliable evidence fails to reach the relevant diagnostic criteria.