[2010] EWHC B12 (Fam)

Case No. EY08CO0116

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
DISTRICT REGISTRY

19th February 2010

B e f o r e :

His Honour Judge Clifford Bellamy
Sitting as a Judge of the High Court

Re X, Y and Z (children)

Mr Anthony Kirk QC and Miss Rosalyn Carter for the Local Authority
Miss Jo Delahunty QC and Miss Elizabeth Isaacs for the mother
Miss Lorna Meyer QC and Mr Richard Hadley for the father
Mr Alistair MacDonald for the children

HTML VERSION OF JUDGMENT

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1. On 20th June 2008 the local authority issued an application for care orders in respect of three children, X now aged 12 (born 1.10.97), Y now aged 9 (born 16.10.2000) and Z now aged 8 (born 5.6.02). The children's parents are TC ('the mother') and DC ('the father').

2. In its final threshold document served on 23rd October 2009 the local authority contends that the parents have subjected all three children to unnecessary hospital admissions, medical examinations and tests and that this has been achieved by them lying about or exaggerating the children's symptoms. In other words, this is a case that falls under the broad categorisation of fabricated or induced illness ('FII'). It is for that reason the proceedings were transferred to the High Court.

3. The case was listed for a finding of fact hearing on 25th January 2010 with a time estimate of 20 days. An agreed witness template provided for the case to be opened by the local authority on 25th January and for the hearing of evidence to begin on Wednesday 27th. In the event, the entirety of the first week was taken up by discussions between counsel for the local authority and senior local authority managers and by discussions between counsel.

4. The outcome of those discussions was that on Friday 29th January I was told by leading counsel for the local authority that the local authority intended to apply to the court pursuant to FPR rule 4.5 for leave to withdraw the proceedings in respect of X and Y but that it intended to continue with the proceedings in respect of Z. I was told that the consequence of these decisions was that of the twenty-eight witnesses named in the witness template only six would be required to attend.

5. On Monday 1st February the local authority filed its application under rule 4.5 in respect of X and Y together with a revised and significantly reduced final threshold document in respect of Z. That same day I heard evidence from just one witness, Mr P, a Consultant Ophthalmologist. At the conclusion of his evidence I was told that the attendance of the witness warned for the next day was no longer required. The hearing was therefore adjourned until 3rd February. By the morning of 3rd February the local authority had come to the decision that it also wished to seek leave to withdraw the proceedings relating to Z. In the light of Mr P's evidence, that decision came as no surprise.

6. At this finding of fact hearing the local authority, the mother and the father have each been represented by leading and junior counsel (Mr Anthony Kirk QC and Miss Rosalyn Carter for the local authority, Miss Jo Delahunty QC and Miss Elizabeth Isaacs for the mother, and Miss Lorna Meyer QC and Mr Richard Hadley for the father). The children and their Children's

Guardian have been represented by very experienced junior counsel, Mr Alistair MacDonald. The respondents are all publicly funded. Their costs will, in due course, be paid by the Legal Services Commission ('LSC'). The respondents each have High Costs Contracts with the LSC. I am told that the mother's costs are likely to amount to around £163,000, the father's to around £158,000 and the children's to around £77,000.

7. The position today is that in a case where within the last six months the local authority has twice sought to persuade the court to authorise the immediate interim removal of the children from the care of their parents, it now seeks leave to withdraw the proceedings in their entirety. It seems likely that the proceedings will cost the LSC somewhere in the region of £398,000. The local authority's own legal costs are no doubt also substantial. Against that background it seemed to me inappropriate for me to consider the local authority's applications under rule 4.5 in isolation without also undertaking a review of the history of this litigation in order to understand how we have arrived at this position.

8. What follows is an abbreviated version of the judgment handed down on 19th February in which I consider three issues:

    (a) whether it is appropriate for me to give leave for the proceedings to be withdrawn;

    (b) whether the local authority's proposals for the provision of ongoing support and services for this family are adequate and, if they are not, whether, and if so how this court should address that issue; and

    (c) whether the local authority should be required to pay, in whole or in part, the costs of any of the other parties.

    Before I consider any of those issues I shall first set out the background history.

    <u>The pre-proceedings history</u>

9. Both parents are 41 years old. They were married in June 1995. They and the children live in a two-bedroom house which they own, subject to a mortgage. The housing conditions are very cramped. Both before and during these proceedings, that has been a significant cause of concern to the local authority. It remains a concern.

10. The mother has two older children, D (now aged 23) and J (now aged 22). The local authority's involvement with the mother's older children began soon after D's birth. D and J were removed from their parents' care on more than one occasion. The final removal was on 26th October 1990 and was effected under a Place of Safety Order. The main cause of local authority involvement appears to have been concerns about neglect. In 1992 D and J were adopted outside their birth family. Both have resumed their relationship with their mother since reaching adulthood.

11. The mother's past history of caring for her older two children was the main reason for local authority interest in her new family. X was born on 1st October 1997. Two weeks later an initial Child Protection Conference was held. X's name was placed on the Child Protection Register under the category of neglect. His name was removed from the Register in June 1998 and the case file closed on 6th August 1998. There does not appear to have been any further active social work involvement with this family until 2002

12. In April 2002 the local authority was informed that the mother, then pregnant, had presented herself at Kings College Hospital, London as she wanted her child to be born there. The local authority wrote to the mother offering her support. There was no response. A case file was opened and closed within a week.

13. Z was born on 5th June 2002. When Z was three months old the local authority received an anonymous referral raising concerns about poor home conditions and about the care of the children. According to the chronology, the parents were resistant to local authority intervention.

14. The case was closed in November 2002. The local authority's Closure Summary is revealing. Under the heading 'Summary of events' it says, 'Anonymous referral expressing concerns of neglect: children not fed, not clean and inappropriately dressed and appalling state of the house'; under the heading 'Aims not achieved' it says, 'Family have refused all involvement from SSD – unless under auspices of a court order (*for which the evidence is not available*)'

[emphasis supplied]; and under the heading 'Reason for closure' it says, 'No opening for SSD – although is a role – because family will not accept SSD involvement.'

15. The next month the local authority received a referral from health services expressing concern about inappropriate use of health services, particularly in relation to Z. This is the first and only occasion upon which any health professional has raised an issue concerning inappropriate use of health services.

16. A Strategy Meeting was held. It recommended that a Child Protection Conference be convened. That Conference was held on 10th January 2003. The minutes of that meeting include a section headed 'Conclusion of Risk Assessment' from which the following passages are of interest:

> 'A range of Health professionals had had considerable contact with Z as a result of concerns expressed by Mrs C since his birth. Those concerns had been followed up by a range of medical services and experts in terms of tests, assessments and examinations, including some hospital admissions for observation. There was a need to understand the impact that might have upon such a small baby's emotional well-being, both in the short and long term.
> 'The main focus of concern in the household appeared to be Z and his state of health. The indication from the various reports and Health professionals seemed to suggest that, taking into account Z's age and prematurity, he was quite a healthy little baby. However, it was clear that that perception did not correspond with the view of his parents.'

17. The Conference decided that Z's name should be placed on the Child Protection Register under the category of emotional abuse. The Conference also made a number of recommendations of which two are of particular relevance to the issue of fabricated illness:

> '2. Dr KB (Consultant paediatrician) will oversee the continuity of Z's care and there will be close liaison between herself, the Keyworker, Dr S (GP), Dr R (SCMO), Ms DB (Health Visitor) and SL (Sensory Support Service).
> '7. All agencies involved with any member of the family must report any concerns or changes promptly to the Keyworker to ensure clarity and consistency in all communication with the family and between services/agencies'.

18. The minutes of a further Child Protection Case Conference on 7th July record that

> 'Conference members agreed that it would be appropriate to remove Z's name from the Child Protection Register provided a contingency plan was in place to cover the eventuality of medical appointments not being kept or Z's needs not being met.'

Although Z's name was removed from the register, the case file remained open.

19. Throughout the remainder of 2003 the local authority continued to be involved though the chronology suggests that workers continued to find it difficult to engage with the family. There continued to be concerns about home conditions which were variously described as being 'untidy', 'chaotic' and 'poor'. This is a theme that runs throughout the remainder of the chronology.

20. In February 2004 the mother said that Y had made a disclosure that she had been touched inappropriately by the husband of her nursery teacher. A Strategy Meeting was convened. It concluded that there was no evidence to suggest that Y had been indecently assaulted. Notwithstanding that conclusion arrangements were made for Y to undertake some self-protection work.

21. Concerns persisted in respect of the parents' failure to engage and co-operate with professionals and in respect of visits being cancelled. Notwithstanding all of these concerns the local authority's case file was closed in November 2004. The reason for closure is stated to be: 'Family have a large professional network of support and S/S no longer have a role'.

22. The case file was re-opened on 19th May 2005 but swiftly closed. A 'Closure Summary' dated 24th May 2005 begins by stating: 'Referral received by the police regarding the unhygienic home conditions. Previous involvement with the family did indicate concerns in respect of the home conditions but also difficulties in rehousing the family as the house is too cramped and cluttered due to lack of space.' Under the heading 'Summary of work done' the form records:

'home conditions [illegible] – children were seen. There are issues of severe overcrowding and clutter *but the cramped conditions are beyond the family's control*.' [emphasis supplied] The reason for closure was stated to be, 'no further action required.'

23. By October 2005 the local authority had again become involved. Once again concerns centred around the state of the family home and the difficulty of engaging with the family. In January 2006 the mother agreed to a child in need plan being drawn up so that progress could be measured. In the following months, local authority involvement was frequent, though at a relatively low-level.

24. On 28th September 2006 the local authority case file was again closed. The Closure Summary states: 'Case transferred from Intake team 11.4.06 to progress CIN plan -: Home conditions to improve, to allow social care staff access to the house + children, children to attend school regularly, Mrs C to access NSPCC for work for Y'. Under the heading 'Summary of work done' the form records 'Worker tried continually to engage with family with no success, therefore little work was done'. The Closure Summary goes on to record 'CIN plan not progressed. Non engagement from family, Mrs C extremely resistant'.

25. Just over a year later, in October 2007, the local authority once again became involved as a result of an anonymous referral expressing concern about home conditions and the state of the children. The local authority has been continuously involved with the family since that time.

26. On 28th January 2008 the local authority held a Child Protection Conference. All three children were made the subject of Child Protection Plans. A Review Child Protection Conference was held on 15th April 2008. It is clear that by this stage the local authority had come to the conclusion that it was time to bring the matter before the court.

27. That same month (April 2008) the local authority drew up a Working Agreement. The agreement began by setting out the local authority's concerns. Those concerns included the history of poor home conditions and the inability of the parents to make any sustained change; the presentation of the children and the impact of poor home conditions; the history of the parents being resistant to working with professionals to make changes to the home conditions; Y continuing to be affected by the alleged abuse experienced at nursery; X's challenging behaviour which the parents found it difficult to deal with; the children's poor school attendance; Z's special needs and the perception that the parents needed a break from caring for him; and the fact that the family was in debt.

The post-proceedings history

28. These proceedings were issued on 20th June 2008. The Form C13 outlines all of the concerns that had been raised in the April 2008 Working Agreement. It makes no reference to any concerns about fabricated or induced illness.

29. On issue, the proceedings were supported by an extremely detailed initial social work statement by Mrs D (62 pages) which she concludes by saying that.

> 'It is the view of the Local Authority that an Interim Care Order is needed for all three children so that the Local Authority can share parental responsibility with Mr and Mrs C. This would enable appropriate assessments to be carried out...'

30. The first interim care plans, dated 6th June 2008, proposed that the children be removed from the care of their parents and placed in foster care and that the parents' contact with them should be supervised. The local authority did not proceed with those plans. Instead, at a hearing on 2nd July 2008 the parents entered into a new Working Agreement. This agreement repeated the concerns set out in the first Agreement. This second attempt to engage the parents by means of a Working Agreement was no more successful than the first.

31. The local authority's first threshold document is dated 19th June 2008. The main allegations against the parents related to their 'marked failure' to engage with professional services, their hostility towards social workers, the fact that their home was said to be 'in an untidy and chaotic state', the hygiene of the children, poor school attendance and the parents inappropriate sharing of information with the children. No concerns were raised about either fabricated illness or excessive presentation of the children to medical professionals.

32. The court made an order for a parenting assessment to be undertaken by an Independent Social Worker, Mrs G. Mrs G's report is dated 30th October 2008. In it she records that she had encountered a 'major difficulty' in completing her assessment as a result of the lack of clarity about the health of the family members. She notes that

> 'there are large gaps in the information available, the most obvious being the absence of medical records and independent Expert opinion in respect of…all family members given that health is considered to be a central issue. Also, detailed statements are not provided from the range of professionals involved with this family.'

33. Mrs G highlights the difficulty she faced as a result of the lack of medical evidence. She says that

> 'On the one hand, the parents could be seen as conscientious, totally committed, well researched, persistent and determined to ensure their children receive the best possible care, that to which they have a right. On the other, and the way in which the social work statement could be interpreted, it might be inferred that they seek medical advice and intervention inappropriately, to excess and to the detriment of the children being overly anxious and even exaggerating or manufacturing medical conditions.'

Mrs G goes on to acknowledge that it is for the court to determine which of those two interpretations is the most accurate.

34. In November 2008 the Children's Guardian, Ms J, filed her first 'Interim Analysis and Recommendations'. She outlines her understanding of the local authority's concerns thus:

> 'The position of the Local Authority is that Mr and Mrs C have failed to maintain their home to an acceptable standard and it has been cluttered and unhygienic. They have failed to ensure a satisfactory level of school attendance for X and Y. The Local Authority states that the parents have shown a lack of cooperation with Social Care and been openly hostile. They have failed to engage with steps taken to assist them, and that the parents have shared inappropriate information with the children. Social Care were also concerned about the children's lack of a relationship with their paternal grandparents who had previously been significant people in their lives.'

35. Picking up on an issue raised by Mrs G, Ms J says

> 'I would agree with the report of the independent Social Worker that the Health and Developmental needs of the children in this case are a significant factor which have (sic) not been given serious consideration by the Local Authority. However this is a recurrent theme in social work files and it is a theme that needs to be resolved…I would support the recommendation of a paediatric review of all three children's medical histories and disclosure to that paediatrician of both parents' medical records. This would deal with what I would describe as the rumbling issue of concern that has threaded through years of professional intervention that there has been a preoccupation of Mrs C with health issues, which may have impacted upon her children.'

36. The local authority's second interim care plans are dated 11th November 2008. The overall aim of the plans was stated to be 'to maximise' each child's 'safety and wellbeing'. The plan was for the children to remain with their parents without any order of the court. With respect to each child the plans indicated that

> 'The local authority wish for [each child's] medical records to be reviewed to ascertain whether [their] parents are over seeking medical attention to an extent that it affects [their] wellbeing.'

37. At a directions hearing on 1st December 2008 the local authority indicated that it wished to obtain expert medical evidence to enable it to consider the issue of fabricated illness. I subsequently gave leave to the parties jointly to obtain a report from Dr M, a Consultant Paediatrician. I shall refer to Dr M's report later in this judgment.

38. In the Spring of 2009 the local authority sought to engage the parents by means of a further Working Agreement. The parents refused to sign it. At a further hearing on 9th July the local authority had intended to seek interim care orders. In the event, the parents belatedly signed the Working Agreement.

39. Shortly before a directions hearing listed for 3rd August 2009 Dr M's report was received. By then the allocated social worker was on annual leave. In his absence senior managers took the decision that in the light of Dr M's report the local authority should seek interim care orders in respect of all three children with a view to their immediate removal and placement in foster care. The local authority also decided not to put the parents on notice of its intention to seek to remove the children.

40. At the hearing on 3rd August, at the request of the local authority, I listed the case for hearing of its application for interim care orders. In readiness for that hearing the local authority filed its third interim care plans for these children. The plans proposed that the children be placed in foster care with supervised contact with their parents. The justification for this approach was stated to be that the children needed 'to be protected from suffering *further* [emphasis supplied] significant harm as a result of unnecessary medical attention' and that the local authority wished to ensure that the children's 'welfare and development is not adversely affected by actions taken as a result of the medical and other assessments undertaken to date.' So far as the use of the word 'further' is concerned, I am not aware of there having then been any evidence available to suggest that any of the children had already suffered significant harm.

41. The family was due to leave on a two-week holiday to Egypt on 6th August. In view of the conclusions arrived at by Dr M the local authority was concerned that the parents may seek medical treatment for the children in Egypt. The local authority wished to prevent that holiday from taking place. The parents were presented with the agonising choice of either facing a contested hearing on 4th August, which they and their advisers considered too soon, or giving up their holiday. They chose the latter course. The holiday was cancelled. The parents deposited the family's passports and travel documents with the court. I do not doubt that the children were extremely disappointed.

42. The contested interim hearing took place before me on 12th to 14th August. Although I was persuaded that it was appropriate for the local authority to share parental responsibility for these children, I was not persuaded that it was in the children's best interests for them to be removed from the care of their parents. In my judgment I was critical of the local authority's decision-making process so far as the application for interim care orders was concerned. Given the high level of medical appointments which these children have had, I also made the point that

> '98. In 2008 the Department for Children, Schools and Families published 'Safeguarding Children in whom illness is fabricated or induced' which is said to be 'Supplementary guidance to Working Together to Safeguard Children'. That guidance updates guidance previously given in 2002 'for professional practice and interagency working in responding to concerns that a child may be having illness feigned or induced by a carer'. Given the frequency with which these children have been seen by their GP, paediatricians and other doctors over a period of several years, and given, too, the concerns now highlighted by Dr M simply on a review of the available documentary evidence, the fact that there is apparently no record of any interagency concern or any interagency consideration of any of any of these issues prior to receipt of Dr M's report is in my judgment quite remarkable.'

43. In accordance with the procedures set out in that guidance a Strategy Meeting was held on 19th August. The minutes note that

> 'There was…a brief discussion around the level and nature of medical input for the children, as the family GP had written a letter at mother's request stating that although the number of appointments for the children was above average for their ages, he was not concerned about their appropriateness. This was, however, prior to his receiving Dr M's report and the judgment of HHJ Bellamy.'

The minutes do not indicate whether an approach was to be made to Dr B to see whether he wished to revise his opinion in the light of Dr M's report. In the event, shortly before this present hearing began Dr B wrote two further letters confirming his original opinion.

44. In the light of my judgment the local authority filed further interim care plans dated 24th August. A Working Agreement was attached to those care plans 'setting out the expectations of parents and of the Local Authority'. The local authority's case is that the parents did not

comply with those Working Agreements and in particular that they still did not co-operate with local authority workers.

45. The trigger which prompted the local authority to renew its attempt to seek the court's consent to the removal of the children from their parents' care was the fact that during the October school half-term holiday the mother took Y on holiday to Blackpool and the father took the boys on a camping trip, both of which holidays, it was said, had been arranged and taken without the local authority's agreement and without providing the local authority with sufficient information to enable them to alert the relevant agencies that the children would be holidaying in their area.

46. The second contested interim care hearing took place over three days from 16th to 18th November 2009. At the conclusion of its evidence the local authority decided not to proceed further with its application. In the light of the evidence I had heard up to that point the local authority was right not to proceed further with its application.

The children's medical histories – Dr M's report

47. Dr M is a Consultant Paediatrician. He was instructed to review all of the GP and hospital records relating to each of these children and then to 'set out an accurate history of the referrals, diagnoses and treatment…in respect of each of the children' and to 'provide an expert opinion in relation to each child upon whether any particular referral or group of referrals represent a fabrication, an exaggeration, a minimisation, an omission or is otherwise induced'. Dr M was subsequently instructed, additionally, to examine each of the children and report on their present state of health.

48. Dr M's main report is dated 24th July 2009. It runs to 243 pages. In section 3 of his report, Dr M sets out a chronology of the children's involvement with health services. For the purpose of this judgment, subject to one exception it is sufficient for me to summarise the number of medical appointments and the range of specialists that have seen the children. The exception relates to an early health difficulty for X.

49. The first significant health problem for X was a right inguinal hernia which had become apparent when he was just two months old. In January 1998 he underwent surgery to correct this problem. Following surgery X developed a haematoma of his right testicle. He was returned to hospital. On 9th February 1998, whilst in hospital, he was given an overdose of morphine (6mg instead of 0.6mg). It was only the immediate recognition of this error by the nurse who had administered the overdose that averted what could have been a catastrophic outcome. Although the medical records confirm the parents' account of this incident, local authority records have for years referred to this as an 'alleged overdose'. I return to this issue later in this judgment.

50. From Dr M's overview of X's medical records it would appear that between October 1997 and June 2009, a period of approaching 12 years, X had at least 90 visits to his GP or to an NHS Walk-In Centre and in excess of 30 visits to the A&E Department. In addition, there have been appointments with a wide range of specialists including ophthalmologists, paediatricians, ENT surgeons, physiotherapists, speech and language therapists. When Dr M examined X for the purpose of these proceedings he concluded that apart from mild asthma X was otherwise physically well.

51. X presents with behaviour problems. His behaviour at school can be challenging. He can be confrontational. He is subject to a statement of Special Educational Needs. A diagnosis of ODD was made in October 2003. X has been receiving services from CAMHS.

52. Like X, Y too has been the subject of numerous medical examinations. It appears from Dr M's report that in the period from October 2000 to January 2009, a period of just over eight years, Y had at least 65 visits to her GP or to an NHS Walk-In Centre and around 15 visits to the A&E Department. In addition, there have been appointments with a range of specialists in respect of a variety of concerns and ailments. Y has been seen by her GP and by CAMHS because her parents consider that she is depressed as a result of these proceedings. The Guardian records that Y told her that she is the only child in the family who does not have special needs. When Dr M examined Y he concluded that apart from suffering from migraine, which is well controlled by medication, Y is otherwise physically well.

53. Like his older siblings, over the years Z, too, has had numerous medical examinations. It appears from Dr M's report that in the period from May 2002 to February 2009, a period of just under seven years, Z had at least 65 visits to his GP or to an NHS Walk-In Centre and around 15 visits to the A&E Department. In addition, there have been numerous appointments with a range of specialists in respect of a variety of concerns.

54. Dr M's assessment of Z is brief and appears to understate the significance and the range of concerns for which Z has been under the care of consultants in a range of specialties throughout the whole of his life. He says that

> '1.38 Z has visual difficulties which have been reported by Mr P, consultant ophthalmologist.
> '1.39 Z has mild motor and coordination difficulties, but based on the observations at his school, he still manages to lead a very active lifestyle. His mother reports he tires easily and requires the use of a wheelchair, however, observations of his stamina and activity levels at school would suggest that with encouragement and positive reinforcement, Z could be weaned off his reliance on a wheelchair…'

55. Aside from Dr M's report, the other evidence before me makes it plain that Z has a significant visual impairment. He also has communication difficulties. Although his parents and siblings are able to understand what he is saying it is more difficult for someone who does not know him well. Z is able to communicate using Makaton language. He has uncoordinated gait. In 2008 he was allocated a wheelchair as it was said by his parents that he was unable to walk long distances. He also has some developmental delay. He attends a special school and is subject to a statement of Special Educational Needs. The most recent statement of Special Educational Needs notes that

> 'Z has special educational needs because he has greater difficulty with his learning, speech and language skills, self help skills, he has a visual impairment and some delays in gross and fine motor skills development. Z is known to Dr E, Consultant Neurodevelopmental Paediatrician and the Child Development Unit. Z has been supported by the Sensory Support Service (visually impaired) since October 2002. He has slightly reduced near and distance vision. He has nystagmus. In September 2005 he began attending an assessment nursery.'

56. In his main report, Dr M expresses a number of concerns. He notes that 'At many of the GP visits, the GP found few positive clinical signs'. He expresses the opinion that the mother has 'perpetuated concerns about many illnesses or allergies suffered by her children for which there is little or no objective evidence'. He also expresses the opinion that the mother 'was keen for further investigations and therapies to be pursued in all three of her children, subjecting them to unnecessary medical investigation and excluding the children from enjoying their daily routines of school and play and activities'. He says that 'it will be a matter for the GP practice to comment whether the three C children were presented too frequently for consultation'.

57. In his letter of instructions, Dr M was specifically asked to 'Set out in detail in relation to each child your reasons for concluding…that a particular referral or group of referrals represents a fabrication, an exaggeration, a minimisation, an omission or is otherwise induced.' Given the length of Dr M's report, and given too that this question was absolutely central to the opinion that was being sought, his response was remarkably brief, comprising just four paragraphs. He said:

> '4.209 As stated earlier in this report, it will be a matter for the GP practice to comment whether the three C children were presented too frequently for consultation.
>
> '4.210 In my opinion, when the three children were presented to the GP practice, they often presented with minor symptoms (sometimes of several days duration) which were not easily verifiable, and which the medical practitioner took at face value. At many of the GP visits, the GP found few positive clinical signs, and there are very few occasions when the GP was sufficiently concerned to summon and (sic) ambulance or make an urgent referral to hospital based on the objective clinical signs.
>
> '4.211 The Cs have purported that each of their three children have suffered seizure like activity at some point in their lives. In my opinion there are inconsistencies and unusual patterns of seeking medical attention for the three children in respect of their

initial reported seizure activity, and on occasion these reports have led to unnecessary and invasive investigations. Both Y and Z have had CT brain scans *and it is possible X has had one too*.

'4.212 In my opinion Mrs C has also perpetuated concerns about many illnesses or allergies suffered by her children for which there is little or no objective evidence.'

58. Given the length of Dr M's report, his conclusions are also relatively brief. His eight concluding paragraphs are as follows:

'5.1 An accurate as possible reporting of symptoms in the home environment allows medical practitioners to conduct their daily business of diagnosing medical conditions and providing the correct treatment course for the patient. If a parent or carer misleads the health practitioner, then this poses the risk of an incorrect diagnosis being arrived at, with the attendant consequences of incorrect and inappropriate investigation and therapy.

'5.2 It is noteworthy that despite the numerous GP consultations enjoyed by the three C children, the GP rarely made any positive clinical findings in light of the range of symptoms as reported by Mrs C in her three children. In fact very few of the GP visits culminated in an urgent transfer to Hospital or a more urgent Hospital based assessment.

'5.3 Mrs C has also reported illness in herself including Factor V Leiden and a low Protein S level, and has reported multiple miscarriages and a complicated obstetric history. It is outside my remit to comment on these reports…

'5.4 Where possible, in the main body of my report, I have considered alternative and differential diagnoses for the children's numerous presentations to the GP and at Hospital. I am satisfied that none of the three C children have suffered any life threatening or life limiting disorder.

'5.5 My immediate main concern is that if the three children continue to be inappropriately presented to medical practitioners, then they are at risk of experiencing repeated and probably unnecessary investigations, procedures and therapies.

'5.6 In the long term, Z, Y and X may become anxious due to a false self belief as to their state of health; and if they continue to present to medical attention they may even collude with their mother in "illness" presentation and thereby become themselves "trapped" in a cycle of falsification of illness.

'5.7 It is also possible that any of the three children may suffer a post traumatic stress disorder and there may come a point where they fear medical intervention when it is absolutely necessary and in their best interest – such as if they suffer an acute traumatic accident or a new and verifiable medical illness or difficulty.

'5.8 In my opinion…Mr and Mrs C have not acted in the best interests of their children even though the numerous consultations with GP and Hospital practitioners would on any superficial analysis lead one to believe that they had…'

<u>The children's GP</u>

59. The children have been registered with Dr B since December 2006. The records suggest that he has seen this family sufficiently over the last three years to be able to express an informed professional opinion. Before these proceedings were issued Dr B had attended two Child Protection Conferences (20th January 2008 and 15th April 2008) and so would have been well aware of the concerns relating to these children.

60. Dr B has written a number of letters for the purpose of these proceedings. On 27th June 2008, at a time when the local authority was proposing to apply for interim care orders, he said:

'This lady has asked me to write. At present I have no reason to doubt her ability to care for her children. To the best of my knowledge they have attended all medical appointments. I feel that putting them into foster care may be detrimental to their mental wellbeing.'

Dr M's review of the children's medical records discloses that all three children had, in fact, missed quite a number of medical appointments over the years.

61. In a letter dated 11th August 2009, Dr B wrote,

> 'Mrs C has asked me to make a comment regarding her childrens (sic) attendance at the surgery. I can confirm that although attendances at surgery is (sic) above average for their age, I would not regard the number of consultations as excessive or inappropriate'.

62. Shortly before this hearing began, on 7th January 2010, Dr B wrote

> '…I can confirm that when Mrs C attends with her children there is nothing unusual in her manner, demeanour or attitude and family relationships appear good. I can also confirm…my original view that her presentations at surgery are not excessive or inappropriate, and this continues to be the case…'

Mr P, Consultant Ophthalmologist

63. It is not disputed that Z has problems with his vision. The way the parents have responded to that problem is one of the issues highlighted in the local authority's final threshold document of October 2009. It is alleged that

> 'The parents have at times exaggerated or lied about Z's problems with his vision to obtain further unnecessary treatment, and have also failed to ensure that he was wearing his glasses when this would have helped his vision.'

There follows a catalogue of concerns about reports from the mother to a variety of professionals that Z is photophobic, that he is completely blind, that she wanted him to learn Braille and 'go to blind school', that his visual performance was deteriorating and that he suffers from retinal dystrophy

64. Mr P is a Consultant Ophthalmologist. Z has been his patient since 2007. Mr P is the only witness from whom I have heard oral evidence at this hearing.

65. In his report Mr P summarises his findings thus:

> 'Z's visual acuity…is reduced compared to norms for his age. He can see at 6 metres what normal individuals can see at 12 metres, with either eye…Z's near vision is affected as well, and similarly reduced so that he cannot see fine print…He is long sighted, and wears appropriate spectacle correction…He has a convergent squint (eye turns in) which is related to his long sightedness, and is controlled effectively by his glasses…Z is excessively light sensitive for which he wears tinted glasses…Z has abnormal to and fro eye movements (nystagmus). He is able to control this to some extent by turning his face in a particular direction, to give him the best possible vision…Z has changes in the central part of the retina, the sensitive layer of the eye… These changes, along with the fine nystagmus and light sensitivity are consistent with the diagnosis of cone dystrophy, a condition affecting visual acuity, and may be progressive. He has previously undergone electrical tests of vision…which supports this diagnosis.

Mr P says that the prognosis for this condition is uncertain.

66. In an addendum report Mr P addresses the issue of photophobia. He says that Z 'was markedly photophobic when examined with varying intensities of lights and clearly preferred a darker environment. This finding has been consistent across several examinations.'

67. The mother was able to obtain a prescription for tinted glasses for Z because of her belief (a correct belief as it now transpires) that Z suffers from photophobia. Mr P said that he did not believe that the wearing of tinted glasses could have caused or exacerbated either Z's photophobia or his other sight problems. It would be necessary to completely blank out all light over an extended period of time in order to cause damage, the kind of impact that can occur with cataracts but not by wearing reactolite glasses.

The parents

68. Both of these parents have their own health problems. For the purpose of these proceedings, both have been independently assessed. The mother's current diagnoses are stated to be

asthma, hearing loss, sight impairment (she can only see hand movements in left eye and right eye 6/12 vision), Leiden V and Protein S deficiency causing problems with clotting and risk of suffering venous thrombosis, chronic hip and back pain, unexplained weight loss, complex psychiatric/psychological problems including anxiety, depression and conversion reaction. In respect of most of these conditions the prognosis is poor.

69. The report's concluding comments are of concern:

> 'Physical debility does not prevent an individual from being a good parent. The level of debility depicted to me suggests that Mrs C would have major problems coping with the physical care demands of being a parent. If Mrs C is in receipt of DLA this reflects her lack of capacity. If she is struggling to cope with the activities of daily living herself she clearly cannot provide that function for her children. I have a major concern about the psychological issues and fear for the children in terms of learned behaviour and being exposed to the constant mental health problems of Mrs C. I can do not more than raise concerns as this is outside my area of expertise.'

70. The assessment of the father summarises his health difficulties as Chronic Fatigue Syndrome (modestly at present), hypercholesterolaemia, migraine, obesity and anxiety/stress. The report says that the current diagnoses of relevance are stress and anxiety and attacks of M.E. Of the impact of the father's health problems on his ability to care for the children, the report states that

> 'Mr Cs (sic) ability to care for the children is clearly impaired when he is virtually bedbound by the M.E. or migraine, though these events are limited now. I have concerns about the effect of the stress problem. It is particularly concerning that Mr C relates getting angry as precipitating the M.E. There are also relatively recent anger problems (2008) which were attributed to his weight reducing medication.'

The parents' evidence

71. Although neither parent has given oral evidence their most recent statements have influenced the local authority's decision to seek leave to withdraw its applications. It is appropriate, therefore, that I should make some mention of those statements. Before doing so I want to acknowledge the magnitude of the task for the parents and their legal advisers in preparing these statements. The task required consideration of somewhere in excess of 4,500 pages of medical and social work records for this family going back more than a decade.

72. The mother has filed two statements in response to the allegations of FII contained in the final threshold document. The first of these, dated 7th January 2010, was available at the time of the Advocate's Meeting on 12th January. In this statement the mother acknowledges that the children have probably had a higher than average number of medical appointments compared with most children, which she attributes to the fact that X and Z both have multiple medical problems. However, she goes on to concede that

> 'at times I may have taken the children to see doctors, when with hindsight this may not have been necessary. I accept that I have at times, with hindsight, overreacted when the children have been ill and have been more worried than perhaps I ought to have been…I accept that I have worried more than I ought about things which turned out to be of minimal significance'

The mother refuted any suggestion that she had ever fabricated any illness or symptoms in her children or deliberately exaggerated their symptoms to gain attention or to influence their treatment.

73. By way of contextualising her over-anxious responses to her children's illnesses the mother highlights the fact that in between the birth of her older two children, D and J, and the birth of X, she had suffered the tragedy of two infant deaths and several miscarriages. X and Y were conceived as a result of fertility treatment.

74. In the mother's third statement, filed on the third day of this hearing, she refers to the incident in 1998 when X was given an overdose of morphine. During the course of this hearing Mr Kirk gave a full and unconditional apology to the parents for the local authority's past references to an 'alleged overdose' and confirmed that the local authority accepts that this incident did happen as the mother has always described it.

75. The final threshold document makes reference to, and implies criticism of the fact that, on three occasions the mother took Z to be examined by Dr L, a Consultant Paediatric Neurologist in Dublin. The mother makes the point that the referral to Dr L was made by Z's GP, Dr B.

76. With respect to the strained relationship between the parents and the local authority the mother acknowledges this but again seeks to contextualise it by making the point that the model of partnership the parents have enjoyed with Z's school has never been enjoyed with the local authority. She says

> 'I feel undermined and disempowered by the local authority's approach to me. The recommendations of Mrs G have not been followed so far as the LA and I are concerned. I take some responsibility for being angry and defiant. But I'm a mother fighting to keep my children against the threat of removal. The LA doesn't have that personal stress to carry. They don't live with the worry as I have to do. They don't have to deal with a cramped home on a low income with three children two of whom have very real, (not imagined) special needs.'

77. After giving an account (at the same time both moving and dispiriting) of parenting these three children in these conditions, the mother goes on to say that

> 'Only parents who love their children could cope with the life we have to lead. Support rather than relentless criticism from the LA would be helpful. Mrs G had unlimited access to our time and home and she, for the first time, saw us for the family that we are. She saw the positives that we have as parents. It is a real shame that these positives have not been recognized in any significant way (if at all) by the LA since she first highlighted them. She also identified an alternative to the relentless task of clutter/de clutter: that has to be done at times but it cant (sic) expand the walls. Mrs G suggested that section 17 financial support might be considered if the La were minded to ameliorate the consequences of our cramped conditions. That hasn't been offered.'

78. The father's final statement, like the mother's, was also filed on the third day of this hearing. He supported the mother's explanation for the frequency of presentation of the children to health professionals.

National guidance relating to cases of fabricated and induced illness

79. In February 2002 the Royal College of Paediatrics and Child Health published the report of a Working Party under the title 'Fabricated or Induced Illness by Carers' ('the RCPCH guidance').[1] The Foreword to this report refers to forthcoming guidance from the Department of Health and states that 'The Department of Health document sets out policy and guidelines for all professionals, whereas the College document discusses clinical issues in more detail and provides practical advice for paediatricians.'

80. The report makes the point that

> 'The initial role for the Paediatrician is to find out whether a child's illness and individual symptoms and signs have an unequivocal explanation as a natural illness. If this is not clear the possibility of fabricated or illness induction and the effect of this on the child has to be considered as part of the range of possibilities'.

The report also makes the point that

> 'In comparison with other forms of child abuse, Fabricated or Induced Illness is unique in that health professionals have key involvement from the early stages of emerging concerns through to the completion of enquiries and investigations.'

81. The report provides practical guidance for paediatricians on evaluating signs and symptoms. It advises that

> 'If there is actual evidence that symptoms are being fabricated or induced child protection agencies should be informed immediately. More often medical evaluation takes time before it is clear that there are factors operating other than natural disorders…At some point in the process it will be clear to the paediatrician that the concerns are not being allayed. When there are PERSISTING CONCERNS there should be a wider assessment by social services department. The criterion for referral

is that the paediatrician has continuing concerns about the child's welfare and not that fabrication or illness induction or harm has been proved.'

82. In 2002 the Department of Health published 'Safeguarding Children in Whom Illness is Fabricated or Induced' ('the 2002 guidance'). This guidance, which is supplementary to the guidance given in 'Working Together', was issued under Section 7 of the Local Authority Social Services Act 1970 and as such it 'should be complied with unless local circumstances indicate exceptional reasons which justify a variation'. In 2008 that guidance was updated by the publication by the Department for Children, Schools and Families ('DCSF') of 'Safeguarding Children in whom illness is fabricated or induced – Supplementary guidance to Working Together to Safeguard Children.' ('the 2008 guidance)

83. Like the RCPCH guidance, the 2008 guidance emphasises the point that 'Good practice calls for effective co-operation between different agencies and professionals…and the careful exercise of professional judgement, based on thorough assessment and critical analysis of the available information.' It goes on to say that 'Safeguarding and promoting the welfare of children depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals.'

84. The 2008 guidance states that 'A key professional task is to distinguish between the very anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour.'

85. In the context of the three children with whom I am concerned, it is interesting to note that the 2008 guidance states that

> 'A significant number of children in whom illness is fabricated or induced will have been well known to health professionals from birth…The medical histories of this group of children are likely to have started early and in many instances will have become extensive by the time the suspected abuse is identified. Some children may have been referred to a tertiary paediatric centre because they were thought to have a serious or rare illness requiring expert diagnosis and treatment. They may have been seen at many hospitals in different geographical areas and by a number of professionals. They may also have been seen in centres for alternative medicine or by private practitioners.'

86. Like the RCPCH guidance, the 2008 guidance states that when FII is suspected there should be a referral to Children's Social Care. It says:

> 'Children's social care should decide and record, within one working day what response is necessary. From the point of referral, all professionals involved with the child and children's social care should work together. Lead responsibility for action to safeguard and promote the child's welfare lies with [children's social care]
> 'Referrals…may lead to no further action or to an initial assessment of the needs and circumstances of the child, and the provision of services or other help. If children's social care decides to take no further action at this stage, feedback should be provided to the referrer.'

87. The 2008 guidance gives advice on the action children's social care should take if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm. It says

> 'If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare…'

88. The 2008 guidance also notes that

> 'The GP and all members of the Primary Health Care Team (PHCT), particularly midwives, health visitors and practice nurses, are all well placed to recognise the early signs and symptoms of fabricated or induced illness in a child….Professionals in PHCTs may have unique knowledge of uncorroborated, odd or unusual presentations.'

89. With respect to the particular duties of Children's Social Care, the 2008 guidance goes on to say that

'Children's social care also has lead responsibility for any core assessment and will co-ordinate the process of systematic information gathering to build up a medical, psychiatric and social history and an understanding of the child's needs and the parents' capacities to meet the child's developmental needs. Children's social care should ensure that a comprehensive chronology of the child's history is compiled.
'Children's social care should work collaboratively with all other agencies currently involved with the child and family. In addition, it is likely to be necessary to contact agencies with past involvement in order to prepare a full history of the child's health and family situation.'

90. The importance of this guidance was underlined by McFarlane J in Re X: Emergency Protection Orders [2006] EWHC 510 (Fam). His Lordship said:

> '67. I have found that the social work team had for some weeks considered that this was probably a case of induced or fabricated illness. The need for particular care and caution in approaching such cases is well known. Extensive guidance has been issued by central government (*Safeguarding children in whom illness is fabricated or induced* – Department of Health 2002) explaining the particular approach that is required in such cases. A key message to social workers from this guidance is that any concerns about a child's health must be discussed with the GP or a paediatrician. Whether or not a child may be at risk of induced or fabricated illness must of necessity involve a medical assessment of his past health and parental care. It is not a diagnosis that can be made by social workers acting alone, it is a matter that requires skilled medical appraisal.'

91. I have referred to all of this guidance at some length because it is relevant in the context of the third of the issues I have to resolve, in respect of the costs of these proceedings. It is also relevant in assessing the criticisms that have been made of the independent expert medical opinion of Dr M, an issue addressed later in this judgment.

The local authority's application under rule 4.5

92. The local authority has filed two documents setting out its reasons for seeking leave to withdraw these proceedings. The first document (dated 30th January – hereafter 'WD1') relates to the applications in respect of X and Y. The second (dated 3rd February – hereafter 'WD2') relates to Z.

93. WD1 makes the point that 'There is a world of difference between seeking to withdraw proceedings where there remains material which is capable of satisfying the threshold criteria, and seeking to withdraw proceedings where there is, on the final analysis, either none or very little'. Mr Kirk then very candidly proceeds to acknowledge that so far as X and Y are concerned 'This application falls into the latter category'.

94. The local authority arrived at that assessment – that there is no or very little evidence capable of satisfying the threshold criteria – without the evidence of any witness being tested in court. The decision has been made exclusively upon consideration of the vast amount of written evidence (twenty level arch files containing almost 5,000 pages of medical and social work records) that has been presented to the court.

95. It appears to be implied in WD1 that an investigation of the issue of fabricated illness arose directly and inevitably from the reports of Mrs G and the first Interim Analysis and Recommendations of the Children's Guardian. That investigation began with the report prepared by Dr M. That report was not available until 24th July 2009. In effect, it is said that the ability to prepare and assess the local authority's case on FII could not begin until then. The wealth of material in Dr M's report and the sheer volume of the medical records meant that the process of preparing and assessing the local authority's case on FII was extremely arduous and time-consuming. Dr M's report led to a re-drafting of the local authority's threshold document. Inevitably, that document is itself a very lengthy document. The parents did not respond to it until the first week in January. On day 3 of this hearing – the day upon which oral evidence was due to begin – the mother filed a very full statement responding to the final threshold document. The local authority had to reassess its case in the light of that statement. WD1 goes on to say

> 'By way of summary, some concessions made dealt with previous concerns; certain allegations originally made were withdrawn by the local authority in the light of the

explanations given, and all other allegations which remained disputed were critically analysed (again) to determine whether or not the threshold criteria could be satisfied as at the date of institution of protective arrangements…'

96. WD1 goes on to set out those areas of concern which remain and the local authority's evaluation of their evidential significance. It then says that

> 'Against each, viewed both in isolation as well as collectively, we have reminded ourselves at all times of the fundamental question: "Will this material satisfy the court on the balance of probabilities that, as of 2008, these children were either suffering, or were likely in the future to suffer, significant harm in the care of their parents, such care not being what it would be reasonable to expect the reasonable carer to give?"'

97. WD1 refers to the original threshold document dated June 2008 and says that

> 'As noted above, the original threshold document survives only in respect of paragraphs 7 and 8. We have taken the view that the concerns therein raised have been sufficiently dealt with by parental concessions. Taken alone (and absent a solid foundation of other urgent concerns, into which Dr M was inquiring) they would never have been sufficient to establish the threshold criteria, let alone the making of care orders.'

98. It is unnecessary for me to go through the areas of concern which, in the local authority's mind, still remain in respect of X and Y. The key point is that in respect of those areas of concern, whether taken individually or collectively, the local authority now accepts that even if the court made the findings sought in respect of those areas of concern, that would not be sufficient to satisfy the s.31(2) threshold.

99. WD2 is described as a supplement to the written reasons set out in WD1. It is appropriate to note the following short passages from WD2:

> 'Undoubtedly the mother was at times making exaggerated, grandiose claims about the extent of Z's visual difficulties as is plain from paragraphs 1, 3 and 4 of the Final Threshold document. But the wisdom of the prescription of Plano reactolite glasses must at the end of the day be a matter for the treating clinicians…The central issue that concerned the local authority was confined to writing and we have Mr P's evidence on the point. We do not pursue the matter any further.
>
> 'Although the local authority has long remained concerned about the fact that an application for a wheelchair was ever made or granted in June 2008…the evidence does not go beyond that. We can trace nothing in the material filed to indicate that the wheelchair should never have been provided or that its occasional use at home was detrimental to Z's welfare…
>
> 'In the light of the above, we apply to the court for permission to withdraw the proceedings in respect of Z.'

100. Not surprisingly, both parents consent to the local authority's application for leave to withdraw the proceedings. The position of the Children's Guardian is less straightforward. Ms J has prepared a further Interim Analysis and Recommendations document in which she sets out her views both with respect to the application for leave to withdraw and with respect to the services and support required by these children in the event that the proceedings are withdrawn.

101. In essence, Ms J makes three key points. The first is a complaint that the local authority did not consult with her before indicating its intention to seek leave to withdraw these proceedings. Given the local authority's acknowledgment that it was partially in response to concerns expressed by Ms J that permission had been sought to obtain the report from Dr M, I am surprised that it did not involve the Children's Guardian in its deliberations concerning the application for leave to withdraw. In light of the observations made by the court in Re N (Leave to Withdraw Care Proceedings) [2000] 1 FLR 134 (see below) I regard this as a significant complaint.

102. Secondly, and notwithstanding that last point, Ms J makes it clear that she does not intend to oppose the application and sets out her reasons thus:

'2.6 The Local Authority must of course be able to carry out an ongoing review of its case and I would not in anyway wish to suggest that the Local Authority should pursue matters which it considers it cannot sustain on the evidence before the Court…'

103. Thirdly, Ms J expresses a concern to which I have already adverted and one that has caused me to reflect very hard indeed on the shape and content of this judgment and on the orders I should make. Ms J says

> '…given the nature and extent of the evidence before the Court I am afraid I do struggle to understand the Local Authority's decision to move from a position of seeking on the evidence before the Court to remove the children from the care of the parents on the basis that the evidence demonstrated that the children's safety demanded their immediate removal to a position of seeking to withdraw the proceedings in their entirety without testing (beyond the evidence of Mr P) *any* of that same evidence which appeared to justify an entirely different stance on the part of the Local Authority only a short time ago.'

'The local authority's offer of support for the family

104. Knowing of the local authority's intention to seek leave to withdraw these proceedings and knowing, too, of the local authority's responsibilities under s.17, counsel for the parents prepared a 'wish list' of the services and support the parents would like.

105. In her most recent Interim Analysis and Recommendations the Children's Guardian says that she is 'of the view that each child in this family has needs which would benefit from continued outside assistance being provided to the family through appropriate agencies'. She identifies a number of needs which must be addressed. The family home is the top of her list. She says that

> '3.3 Whilst the children have not complained to me about the conditions in the family home and the conditions were satisfactory when I last visited, it is plain that the current housing situation is overcrowded. Each child would benefit significantly from an easing of the current crowded circumstances of the family home. This benefit would increase greatly as the children get older and privacy and personal space becomes ever more important to them.'

106. Ms J identifies the need for the children to be given the opportunity to work through the emotional impact upon them of their experience of these proceedings. She recommends the 'Time for You' programme run by Relate.

107. On the key issue of medical care, Ms J notes that

> 'Mrs C has candidly conceded that, in relation to medical care of the children, she has on occasion been over anxious or developed unfounded fears in relation to the health to [the children] and has as a consequence, on occasion, exaggerated their presentation to medical professionals.'

In light of this, she recommends that it would be prudent for there to be

> 'a central point of contact on the children's medical files who is aware of these past difficulties and can ensure that any similar difficulties in the future are picked up and addressed in a timely fashion…'

She recommends that this role be fulfilled by the children's GP, Dr B.

108. So far as the children's individual needs are concerned, Ms J underlines the importance of trying to maintain X at his present school, notwithstanding recent difficulties. To that end, and to ensure that he is able to fulfil his full educational potential, she recommends that he should have access to a mentor or advocate at school to assist him to articulate any concerns at school and avoid difficulties threatening the stability and security of his placement.

109. During the course of these proceedings the local authority has been meeting the cost of Y attending a gymnastics class, something which she has very much enjoyed. Ms J notes the local authority's initial indication that it would not continue with this provision and

expresses the opinion that this is 'unfortunate', making the point that it is important for Y to continue her extra-curricula activities.

110. Of all of these three children, Z's health needs are the greatest. Ms J recommends that Z needs

> 'to have the treatment of his medical needs centralised, coordinated and regularly reviewed to ensure that his medical needs are being fully and appropriately met'.

She says that this

> 'will best be achieved by the identification of one medical professional responsible for co-ordinating his healthcare and medical needs...'

111. The local authority's response to this outline of the services and support required can best be described as evolving. In a response dated 3rd February the local authority said that it had made representations 'at a very senior level' but had been unable to persuade the local Transport Bureau (a separate organisation) to agree to reinstate the transport service for Z. In a further response dated 9th February the local authority now says that 'this has been discussed at the highest possible level and agreement is given to provide this transport'.

112. As for replacement carpets, in its response of 3rd February, beyond identifying one or two possible sources of grant aid and offering to write letters in support of any grant applications the parents may make, the local authority offered no support. In its further response of 9th February the local authority now says that it is willing to pay for new carpets to be fitted 'in the communal areas, and children's bedrooms'.

113. So far as concerns the request for assistance in enabling X to meet his educational potential, the local authority makes the point that the parents are entitled to attend the annual review of X's Special Educational Needs Certificate.

114. As for Y's gymnastics class, in its response of 3rd February the local authority stated that

> 'Social Care have funded a Gym class for Y whilst she was a looked after child. Whilst the funding for this cannot continue if she is no longer a looked after child there may be some receipts that have not yet been presented to Social Care for these classes. If these receipts for past classes are presented then they will still be paid.'

In its further response of 9th February, the local authority now says that 'as long as the case is open to them, Social Care will…continue to pay for Y to attend Gym class.'

115. The most pressing concern, and a matter about which the local authority has itself been significantly troubled over a period of several years, is this family's housing position and in particular the overcrowding. The property is owned by the parents, subject to a mortgage. They don't want to move to rented accommodation. However, a move to rented accommodation is the only solution the local authority has to offer. It says that

> 'Social Care accept that the home is overcrowded. They have no ability to pay for any extension to the house, nor any department to which they could even apply. In the past it is true that some Councils have paid for example for extensions to Foster Carer's houses, but this does not happen now. Social Care do not have the ability to grant this request.'

116. The local authority is similarly unmoved by the parents' request for aids and adaptations in order better to accommodate Z's disabilities, saying that

> 'It does not appear to Social Care from their observations, and reports of Dr M, Dr S, and Mr P that Z needs any particular adaptations to the home.'

117. So far as these last two issues are concerned, in its further response of 9th February, the local authority makes some concessions towards addressing this family's housing difficulties. Its position now is as follows:

> 'One of the two rooms on the ground floor is currently not used for living accommodation, but is simply used as a storage facility. The Local Authority would propose that they will pay for an outside agency to attend Mr and Mrs C's property and assist them to clear this room, and help them turn it into a bedroom. The Local

Authority will also pay for some agreed shelving units, and storage units to be brought (sic) for the property, and if so wished, a bed for that room for Mr and Mrs C. Social Care will also pay for the outside agency to assist Mr and Mrs C in clearing any other parts of the property that they wish to have help with.' The local authority has said that it will also pay for fire doors to be fitted.'

118. The final issue relates to the cost of the lost holiday to Egypt. In its response of 3rd February the local authority displays a distinct lack of sympathy for the family's predicament. I set out the local authority's response in full:

> 'Social care are not clear under what circumstances this holiday was booked or paid for, or what arrangements there were for holiday insurance. Whilst they do not wish to be unsympathetic, the family were not able to go on holiday due to an escalation of child protection concerns which the court shared. There was an order made on the 3rd August 2009 at which the parents undertook to surrender their passports, and an order made that the children would not be removed from the jurisdiction. This was therefore an order made by the court whilst Mr and Mrs C were represented, and all advocates had access to the available reports and evidence at that time.'

So far as this issue is concerned, there was no change in the local authority's further response of 9th February.

The law

119. FPR rule 4.5 provides that an application for a care or supervision order may be withdrawn only with the leave of the court. An application for leave to withdraw should normally be made in writing and should set out the reasons for the request.

120. There is surprisingly little authority on the approach to be taken to such an application. On its facts, London Borough of Southwark v B [1993] 2 FLR 559 was very different from the case with which I am concerned. However, the observations made by Waite LJ concerning the approach to applications for leave to withdraw seem to me to be of general application and therefore relevant to the decision I have to make in this case. His Lordship said that

> 'The paramount consideration for any court dealing with a r 4.5 application is…the question whether the withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned. It is not to be assumed, when determining that question, that every child who is made the subject of care proceedings derives an automatic advantage from having them continued. There is no advantage to any child in being maintained as the subject of proceedings that have become redundant in purpose or ineffective in result. It is a matter of looking at each case to see whether there is some solid advantage to the child to be derived from continuing the proceedings.'

121. Re N (Leave to Withdraw Care Proceedings) [2000] 1 FLR 134 was a decision of Bracewell J. in which Her Ladyship gave additional guidance. She said that

> 'In considering the…application the guardian's duty is to safeguard the interests of L and she has a duty to put before the court her view as to whether L's welfare would be promoted or harmed by the withdrawal of proceedings. I agree that guardians should think long and hard before opposing an agreement between the local authority and the parents if it appears to be sensible and if it appears to protect the child…
> 'I recognise that courts should be slow to differ from careful decision-making of a local authority and should take into account the reluctance of a local authority to continue with proceedings when they do not wish to have an order. However, once the application has been made the decision whether to proceed is that of the court and not that of the local authority, guardian or any other party. I accept that any party opposing (which in this case is the guardian) must advance solid cogent reasons…'

122. Her Ladyship also made the point that before pursuing an application for leave to withdraw an application for a care or supervision order a local authority should consult with the guardian and consider her views before arriving at a decision to seek leave to withdraw.

123. Section 17: A local authority has responsibilities and duties towards children in need within their area. That duty is set out in s.17(1) in these terms:

'It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) –

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families.'

124. The meaning of 'child in need' is explained in s.17(10). In the case with which I am concerned it is accepted that X, Y and Z are all children in need for the purposes of s.17. There is rather less agreement about the extent of the local authority's obligations towards these three children given their agreed status as children in need.

125. A failure to comply with the duties imposed by, or to exercise the powers arising under, s.17 may be dealt with by an aggrieved person either by way of complaint under a procedure established by that local authority pursuant to s.26(3) or by means of judicial review.

126. There is now an increasing body of jurisprudence on the extent of a local authority's responsibilities under s.17. The leading authority is the decision of the House of Lords in R (G) v Barnet London Borough Council, R(W) v Lambeth London Borough Council, R (A) v Lambeth London Borough Council (Conjoined Appeals) [2003] UKHL 57. In each of the cases that were the subject of that appeal it was the claimant's case that section 17(1) requires a local authority to assess the needs of a child who is in need and to meet his needs when they have been assessed. By a majority of three to two, their Lordships did not accept that proposition.

127. It is an open question whether, when considering an application by a local authority under rule 4.5 for leave to withdraw an application for a care order, it would be a proper exercise of a court's discretion to indicate that it was unwilling to give leave unless the local authority were willing to provide particular services or support for the child to whom the application relates. That is an issue to which I shall return later in this judgment

128. Costs: Rule 10.27(1) FPR provides that subject to certain exceptions CPR rules 43 and 44 shall apply to costs in family proceedings. CPR rule 44.3(2) provides that where, in civil proceedings, the court decides to make an order for costs the general rule is that the unsuccessful party shall pay the costs of the successful party. FPR rule 10.27(1)(b) specifically disapplies that rule so far as family proceedings are concerned.

129. In the context of public law Children Act proceedings it is unusual for one party to be ordered to pay another party's costs. That point has been made repeatedly in a number of cases. In Re M (Local Authority's Costs) [1995] 1 FLR 533, Cazalet J said

'I have been urged by Miss Parker to…hold that there is a presumption of no order as to costs in child cases. I do not think that it is necessary to fetter a court's discretion as to costs in this way, by applying presumptions or indeed more specific guide-lines. It seems to me that…it would be unusual for a court to make an order for costs in a child case where the conduct of a party has not been reprehensible or the party's stance has not been beyond the band of what is reasonable. Accordingly, any court in deciding the question of costs in child cases should, in my view, approach the question against that general proposition, and it would be a matter for the discretion of the court in the light of those criteria as to what order for costs should be made. In considering these questions the court will always look in particular at whether it was reasonable for one of the parties to have brought or to have maintained the proceedings...'

His Lordship went on to express the opinion that

'As a matter of public policy…where there is the exercise of nicely balanced judgment to be made by a local authority carrying out its statutory duties, the local authority should not feel than it is liable to be condemned in costs if, despite acting within the band of reasonableness…it may form a different view to that which a court may ultimately adopt.'

130. That case pre-dates the coming into force of the Civil Procedure Rules 1998. CPR rule 44.3(4) and (5) set out a list of factors which must be taken into account in determining

what order for costs (if any) should be made. Some of that guidance is not apt for family proceedings. In M v M (Costs in Children Proceedings) [2000] Fam Law 877, Singer J made the point that the broad discretionary approach to costs in proceedings relating to children may be influenced by and have regard to the considerations set out in the Civil Procedure Rules 1998 r 44.3(4) and (5), but that an item by item evaluation of those considerations is inappropriate. However, it is appropriate to note that one of the factors which the court is obliged to take into account under rule 44.3(4) is the conduct of the parties, a factor which resonates with the guidance given by Cazalet J in Re M (Local Authority's Costs).

131. Re R (Care: Disclosure: Nature of Proceedings) [2002] 1 FLR was a case in which a local authority sought findings of sexual abuse in addition to findings of neglect and emotional abuse. The allegations of sexual abuse were fiercely contested and were the main focus of the final hearing. On the thirteenth day of the hearing the local authority abandoned its pursuit of findings of sexual abuse. The judge ordered the local authority to pay 25% of the costs of three of the respondents and 15% of the costs of a fourth respondent. The judgment gives no new guidance on the approach to be taken in determining whether to make an order for costs against a local authority and is, therefore, merely an illustration of how the discretion was exercised in that particular case. The judge, Charles J, said

> 'But the underlying reality at this stage is that allegations of sexual abuse have been abandoned and, to my mind, as I said in my judgment, the primary responsibility for that abandonment and therefore the waste of time lies with the local authority…I have had regard to the fact that the issue arises between two sets of public funding, admittedly from different budgets. But it seems to me that I should reflect what I regard as the primary duty and thus the primary failing in an order for costs.'

132. Re X: Emergency Protection Orders, to which I referred earlier, provides another recent illustration of a case in which an order for costs was made against a local authority. McFarlane J investigated the circumstances in which a local authority had obtained an emergency protection order, an order which led to a nine year old girl being removed from the care of her parents and placed in foster care where she remained for some fourteen months. She was returned to the care of her parents after the court found that the local authority had failed to establish that the threshold criteria were satisfied. His Lordship said that the facts of the case had led him 'to produce a judgment which is highly critical of the social workers and the social services department who became involved with this family'. He marked his criticism by ordering the local authority to pay some of the parents' costs.

DISCUSSION

133. At the beginning of this judgment I indicated that I proposed to undertake a review of the history of this litigation in order to understand how we have arrived in a position where the local authority now seeks leave to withdraw proceedings in circumstances where as recently as three months ago it sought to persuade the court that the children's safety required their immediate removal from the care of their parents and in order to assist me in determining the three issues set out at paragraph 8 above.

134. In Re X: Emergency Protection Orders, McFarlane J made this observation:

> '20. The child protection system depends upon the skill, insight and sheer hard work of front line social workers. Underlying those key features, there is a need for social workers to feel supported and valued by the courts, the state and the general populace to a far greater degree than is normally the case. Working in overstretched teams with limited resources, social workers frequently have to make crucial decisions, with important implications, on issues of child protection; often of necessity these decisions must be based upon the available information which may be inchoate or partial. There are often risks to a child flowing from every available option (risk of harm if the child stays at home, risk of emotional harm at least if the child is removed). It is said that in these situations, social workers are 'damned if they do, and damned if they don't take action. Despite these difficulties, it is my experience that very frequently social workers 'get it right' and take the right action, for the right reasons, based upon a professional and wise evaluation of the available information. Such cases sadly do not hit the headlines, or warrant lengthy scrutiny in a High Court judgment. I say 'sadly' because there is a need for successful social work, of which

there are many daily examples, to be applauded and made known to the public at large.'

135. I am in complete agreement with those sentiments both generally and specifically so far as concerns this local authority. However, although those sentiments reflect what I have no doubt is a widely held judicial perspective on the work undertaken by hard-pressed and dedicated social workers, there are cases, of which Re X was one and this case another, where something goes badly wrong. Mr Kirk recognises that some may perceive the application for leave to withdraw to be 'an astonishing *"volte-face"* on the part of the local authority'. I would be failing in my duty if I were to avoid the hard questions about what has gone wrong in this case.

The original threshold document

136. The decision to issue these proceedings was taken at a Review Child Protection Conference on 15th April 2008. That was more than a decade after this local authority first became involved in the life of this family. Over the course of those years the local authority had opened a case file on eight occasions and closed it on seven; had placed X's name on the Child Protection Register for ten months on the grounds of neglect and Z's name for six months on the grounds of emotional abuse; had in January 2008 made all three children the subject of Child Protection Plans; and had throughout experienced an extremely difficult relationship with the parents.

137. The original threshold document relied on six areas of concern. On 23rd October 2009, sixteen months after issuing these proceedings, the local authority revisited that document. In addition to adding allegations of FII the revised threshold document no longer sought to rely on four of the six areas of concern relied upon originally. With respect to the two surviving allegations it is stated in the local authority's application for leave to withdraw that 'Taken alone…they would never have been sufficient to establish the threshold criteria, let alone the subsequent making of care orders'. I also note that in its Closing Summary the local authority states that

> 'The revised threshold document abandoned concerns previously raised in respect of poor conditions at home and unsatisfactory school attendance. The former had improved in great measure and the latter was no longer of any concern as of the date of the commencement of the proceedings.'

138. It must be borne in mind that the local authority's decision to withdraw the allegations contained in its first threshold document, achieved in two stages (October 2009 and February 2010), was arrived at without any of the evidence being tested in court and by the local authority simply re-evaluating the strength of its case in the light of the available evidence. With respect to the removal of the first tranche of allegations, the local authority did not even have the benefit of written statements from the parents acknowledging some of their shortcomings. It is difficult to resist the conclusion that the local authority has belatedly accepted, with the benefit of hindsight, that its decision to issue these proceedings in June 2008 was the wrong decision.

Collating of health records.

139. The health and social work records in this case run to in excess of 4,500 pages. For the purpose of this hearing that material has been arranged in 20 lever arch files. The burden of responsibility on the legal teams to read, mark and inwardly digest that material is immense. The burden on the parents' legal teams is particularly great given the obvious need for them to go through much of that material with the parents in order to take their instructions on it – a difficulty compounded for them by the fact that the material spans a period of more than a decade.

140. Since December 2008 the only hearing I have not conducted was a hearing on 20th January 2009. That hearing was conducted by His Honour Judge Cleary. His order contained this direction:

> 'The Solicitor for the child shall send a further agreed letter of instruction to Dr M by 27th January 2009. This shall ask Dr M whether it would be appropriate for the Court to direct that a suitably qualified Paediatrician could produce a chronology and carry out some organisation of the medical records to reduce costs.'

141. Dr M was approached but declined the invitation. In my judgment he was wrong to do so. In a case such as this, where GP, hospital and other health records are voluminous, I have no hesitation in saying that the parties and their legal teams, any expert witness instructed and the trial judge would be greatly assisted by having such records collated, paginated and indexed. I am aware that this is quite often done in heavy clinical negligence cases. In terms of the overall management of a case such as this, I am in no doubt that the expense involved would be a proportionate expense and one which could well lead to a reduction of costs in other areas (for example, in the fees of a medical expert).

The report of Dr M

142. Dr M was the jointly instructed expert. He was instructed by letter dated 17th December 2008. The children's solicitor was the lead solicitor. The agreed joint letter of instructions was full and detailed. The letter of instructions contained this paragraph:

> '…in confirming that you are able to deal with the instructions outlined herein we should be obliged if you would outline to us the methodology you would intend to follow in carrying out the assessment including details of whether you would wish to examine the children and whether there would be any further enquiries you would either wish to make yourself or your (sic) would wish the parties to undertake to inform your assessment.'

I asked to see Dr M's written response to that request. I was told that none had been received but that in a telephone conversation Dr M had said that his methodology would be to consider all the papers and form an opinion. He did not indicate whether he wished to see the children. For the purpose of preparing his main report he did not see either the children or the parents. His response to this part of his instructions was wholly inadequate.

143. Dr M's report runs to 243 pages. The report is divided into five sections. Section 1 (one page) is a brief introduction. Section 2 (one page) sets out the five specific questions he was asked to address. Section 3 is a chronological narrative of the health records of the mother (3 pages), Z (71 pages), Y (32 pages) and X (50 pages). Section 4 (76 pages) is headed 'My opinions and answers to schedule of issues' and Section 5 (2 pages) is headed 'Conclusions'.

144. Section 4 is clearly a critical section of the report in that it purports to respond to the five specific issues that he was asked to address. Firstly, he was asked to

> '(a) Set out an accurate history of the referrals, diagnoses and treatment in this matter in respect of each of the children in chronological order, identifying if possible in respect of each referral the identity of the person or organisation by whom that referral was made.'

Dr M's response (1 page) was to direct readers to Section 3 of his report.

145. Secondly, Dr M was asked to

> '(b) Provide an expert opinion in relation to each child upon whether any particular referral or group of referrals represents a fabrication, an exaggeration, a minimisation, an omission or is otherwise induced.'

Dr M's response to this issue (71 pages) is not easy to follow. Although he refers again to large parts of the chronology set out in Section 3, this time with his own added commentary, he does not clearly address the issue.

146. Thirdly, Dr M was asked to

> '(c) Set out in detail in relation to each child your reasons for concluding (if you are so opine) (sic) that a particular referral or group of referrals represents a fabrication, an exaggeration, a minimisation, an omission or is otherwise induced.'

I have already noted that Dr M's response to this issue runs to a mere 1 page. Issues (b) and (c) are fundamental to his entire report. I have described Dr M's response to issue (b) as unclear. I regret to say that in my judgment his response to issue (c) is unacceptably brief and completely fails to address the issue in any meaningful way.

147. Fourthly, Dr M was asked

'(d) In the absence of any particular referral or group of referrals representing a fabrication, an exaggeration, a minimisation, an omission or is otherwise induced, whether any other matters of significance arise from your paediatric overview in respect of each child.'

Dr M's response (1 page) is once again brief. Of the three paragraph response, it is appropriate to set out two

'4.214 In my opinion, where most parents are keen to exclude the diagnosis of a chronic debilitating condition such as blindness, drug allergy, or disability, the chronology of this case suggests that the Cs failed to keep pre-arranged appointments with specialists in order that those conditions could be confidently eliminated, and the children could go on to lead their lives with little intrusion or medical intervention.

'4.215 In my opinion, Ms C was keen for further investigations and therapies to be pursued in all three of her children, subjecting them to unnecessary medical investigation and excluding the children from enjoying their daily routines of school and play and activities.'

148. I find it surprising that nowhere in his very lengthy report does Dr M make any reference to the guidance published by the Royal College of Paediatrics and Child Health or to the guidance published by the Department of Health or to the most recent guidance published by the Department for Children, Schools and Families. It must have been clear to Dr M from the letter of instructions and, more importantly, from his consideration of the medical records, that apart from the referral in respect of Z in December 2002, no health professional involved with these children has at any time expressed a concern about fabricated or induced illness. I would have expected him to have noted that point and, in the light of the national guidance to which I have referred, made comment on it.

149. I would have expected that in an expert report such as this the expert would have defined terms and referred to relevant literature on the topic – for example by explaining what fabricated illness is and what he had been looking for as he trawled through these medical records. All of this is completely absent from the report.

150. I would also have expected an expert to have due regard to the provisions of the 'Practice Direction: Experts in Family Proceedings Relating to Children'. Though a hard copy of that report was not enclosed with the letter of instructions, the letter did refer to it and provided a link to a web-based version of the Practice Direction. Paragraph 3.3 of the Practice Direction is headed 'contents of the Expert's Report' and sets out very clear guidance on the content and structure of an expert's report. In this case I regret to say that there is little evidence of that guidance having informed the preparation of Dr M's report.

151. Mr Kirk has made the point that the length of this report is such that reading it and digesting it takes several hours. It is, in truth, indigestible. In her written submissions, on behalf of the mother, Miss Delahunty submits that the report 'does not fulfil the task required of it'. She goes on to make the point that 'Fabricated illness is a serious diagnosis. Its investigation requires a clinical examination of the issues. Dr M's report did not assist: instead it led to further disquiet.' I agree with those submissions. The £35,000 that has been spent on this report has, I regret to say, not been money that has been well-spent.

152. As a result of the local authority's decision to seek leave to withdraw these proceedings Dr M was not called to give evidence at this hearing. The consequence of that is that these and other concerns have not been put to him. He is therefore unaware of the concerns and has had no opportunity to respond to them. As a matter of fairness to him, it is appropriate that I should make that point.

<u>The response to Dr M's report</u>

153. Though I am critical of Dr M's report, the parties' legal teams do not escape criticism for some of the report's shortcomings. I have already referred to the decision of Charles J. in Re R (Care: Disclosure: Nature of Proceedings). In a section of his judgment headed 'Lessons to be learned', Charles J gave guidance on instructing experts. The first three points he makes are apposite to the problems that have arisen in this case. He says

'(a) All involved should consider with care the instructions to be given to an expert.

'(b) The expert should check that he or she can carry out and is carrying out those instructions and should confirm this.
'(c) All involved should consider and review the report of an expert when it is received and, where relevant, raise points with the expert and other parties relating to the performance of the expert's instructions, his or her reasoning, the factual basis of his or her views and the relevance of his or her views to the proceedings.'

154. Dr M was asked in his letter of instructions to confirm that he was able to deal with the instructions, to outline his methodology, to indicate whether he wished to see the children and to advise whether there were any further inquiries he wished the parties to make. The parties should have ensured that a written response was received to these points. In the event, there was no written response and if the gist I have been given of Dr M's telephone response is accurate, his response (such as it was) was wholly unsatisfactory.

155. More seriously, none of the advocates before me has suggested that Dr M's report is satisfactory. All have been critical of it. The third of the guidance points made by Charles J is particularly relevant in this case. Such were the glaring inadequacies of this report that there was a duty on the lawyers to draw those inadequacies to Dr M's attention and invite him to address them. Although in their position statements for the contested hearing in August 2008 counsel for the parents identified many of the concerns about Dr M's report that have been raised in this judgment, and that should have been sufficient to put the local authority on notice of the problems with the report, none of the parties raised those concerns directly with Dr M.

The local authority's response to concerns about fabricated illness

156. Upon receipt of Dr M's report the local authority arranged a Strategy Meeting which was attended by, amongst others, the police, the Children's Guardian and a consultant paediatrician, Dr KM. The local authority contends that in doing so it was complying with the 2008 DCSF guidance to which I referred earlier. Paragraph 4.29 of that guidance provides that

> 'If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare.'

157. The question in this case is at what point the local authority should have had 'reasonable cause to suspect…' By its actions I infer that the local authority's answer to that question is 'at the time it received Dr M's report'. I disagree.

158. As a result of the local authority's involvement with this family over a period of more than a decade, it has been well aware of the health problems of these children, of the range of health services that have been accessed and of the frequency of presentation to health professionals. In one of its written responses, counsel for the local authority notes that 'Occasionally in the papers there are concerns expressed about Mrs C attention seeking, and there being a lot of hospital referrals…' Although it had concerns, the local authority also knew that since December 2002 there had been no concerns expressed by, and no referral from, any of the health professionals involved with the family concerning the family's use of health services. I am satisfied that up to November 2008 there can be no criticism that the local authority had failed to follow the relevant national guidance.

159. In her report of 30th October 2008, the independent social worker, Mrs G, acknowledged that on one interpretation of the evidence then available 'it might be inferred that [the parents] seek medical advice and intervention inappropriately, to excess and to the detriment of the children being overly anxious and even exaggerating or manufacturing medical conditions.' That observation was swiftly followed by the Children's Guardian's first Interim Analysis and Recommendations in which she noted the 'rumbling issue of concern that has threaded through years of professional intervention that there has been a preoccupation of Mrs C with health issues, which may have impacted upon her children.'

160. The concerns expressed by Mrs G and Ms J, both of them professional witnesses, should have led not only to the application to the court for a paediatric overview of the children's medical records but, more importantly, to the convening of a Strategy Discussion. As well as being concerned about gathering the evidence required to support its application for care orders, the local authority was also under a duty to safeguard the welfare of these

children. Given the concerns then being expressed by Mrs G and Ms J, urgent dialogue with those health professionals who knew this family so well was, in my judgment, essential.

161. The 2008 guidance states that a strategy discussion 'will be used to undertake the tasks set out in paragraph 5.55 of *Working Together*.' Paragraph 5.55 provides that a strategy discussion should be used to 'share available information'. The calling of a strategy discussion in late 2008 would, or should, have led to the collating of information relating to the children's medical histories. The 2008 guidance states that 'It is vital that all available information is carefully presented *and evaluated* [emphasis supplied]…' This work should have been well-advanced by the time Dr M's report was received. In the event, a strategy discussion was not even called until his report had been delivered.

162. Had the guidance been followed, it would not have been left to the parents, to produce a letter from Dr B in August 2009 confirming that as far as he was concerned he did 'not regard the number of consultations as excessive or inappropriate', a point which he subsequently repeated in letters dated 7th January 2010 and 20th January 2010.

163. The result of all of this is that on 23rd October 2009 the local authority filed and served its final threshold document in which it abandoned almost all of the concerns expressed in its original threshold document but added, at great length, allegations of FII and that it did so without making any enquiry of those health professionals who were involved with the children (none of whom had been in contact with the local authority to express concerns about FII) and in absolute reliance upon a report from Dr M which it now accepts (and should then have appreciated) is deeply flawed. In one of its closing responses the local authority conceded that

> 'Upon considering this chronology, and reviewing the files, the LA do identify that they perhaps should have involved a little more forensic analysis of the evidence.'

This, in turn, leads to Mr Kirk making the concession in his 'Closing Summary' that

> 'This was ultimately <u>not</u> a case of FII, despite the expert report of Dr M, and we wish to emphasise that. Our greatest source of regret has been that we felt unable to identify it as such earlier in the day.'

For the reasons I have set out, I am in no doubt that this could and should have been identified at an earlier stage.

<u>Costs</u>

164. I have already indicated my intention to consider whether it may be appropriate for me to make an order for costs against the local authority. Apart from that question there is a wider costs issue that has caused me some concern. In the foreword to its October 2009 'Family Legal Aid Funding from 2010' Consultation Response the LSC's Chief Executive noted that 'Since 2002, expenditure on family legal aid has grown from £399million in 2001/2 to £582 million in 2007/8, a real terms increase of 24%.' In recent times the cost of family legal aid funding has been a matter of governmental concern and public debate.

165. I have already noted that the estimated total public funding costs of the parents and the children is approaching £400,000. That that should be so in a case for which at the eleventh hour the local authority seeks leave to withdraw is, in my judgment, a matter for concern.

166. The Practice Direction: Guide to Case Management in Public Law Proceedings ('The Public Law Outline') came into force on 1st April 2008, just two months before the local authority issued these proceedings. Paragraph 2 is headed 'The overriding objective' and provides as follows:

> '2.1 This Practice Direction has the overriding objective of enabling the court to deal with cases justly, having regard to the welfare issues involved.
>
> Dealing with cases justly includes, so far as is practicable –
>
> (1) ensuring that it is dealt with expeditiously and fairly;
> (2) dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues;
> (3) ensuring that the parties are on an equally footing;

(4) saving expense; and
(5) allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases.

167. Apart from the references to proportionality and saving expense, nowhere in The Public Law Outline does the word 'costs' appear.

168. In civil proceedings it is a requirement of the Civil Procedure Rules 1998 that at various stages of the proceedings (when filing an Allocation Questionnaire and when filing a Pre-trial Checklist) the parties must file costs estimates. The filing of these costs estimates not only enables each party to appreciate how much her own costs and her opponent's costs are at that stage of the proceedings and how much they are expected to be by the end of the proceedings, it also enables the court to have proper and informed regard to the requirement for proportionality in making case management decisions. In my judgment there is a strong case for saying that the requirement to file costs estimates should be extended to The Public Law Outline and, when introduced in 2011, to the proposed new Family Procedure Rules.

169. Although some may say that when it comes to issues relating to the welfare of a child the question of how much the proceedings cost should be secondary to the overriding requirement to achieve an outcome that is in the best interest of the child, this must be tempered by an acceptance that the availability of resources to fund public law Children Act proceedings is not limitless. Ultimately, responsibility for ensuring that a proper balance is struck between achieving the best outcome for the child whilst at the same time not incurring disproportionate expense rests on the judge. In the absence of an adequate costs estimate it is difficult to see how this responsibility can effectively be discharged.

Lessons to be learned

170. The following points seem to me to be of particular importance for the future:

(a) An allegation of FII is a very serious allegation to make against a parent and one that should not be made lightly. Before making an allegation of FII a local authority should be rigorous in satisfying itself that the evidence available, if accepted by the court, is capable of establishing to the requisite standard that there has in fact been fabricated or induced illness.
(b) In reaching the decision to allege FII in circumstances where the allegation is of fabrication of signs and symptoms, it will rarely be appropriate for a local authority to rely exclusively upon the report of an independent expert. The local authority should normally also seek the views of health professionals involved in the care of the children. This should be achieved by convening a strategy discussion as recommended by the 2008 DCSF Guidance.
(c) When instructing an expert to prepare a report in a case of suspected FII the letter of instructions should make it clear that the expert is expected to have regard to 'Fabricated or induced illness by Carers (FII): A Practical Guide for Paediatricians' published by the Royal College of Paediatricians and Child Health in October 2009 and should also draw the expert's attention specifically to the guidance on 'Content of the Expert's Report' set out at paragraph 3.3 of the Practice Direction: Experts in Family proceedings Relating to Children.
(d) As stated by Charles J in Re R (Care: Disclosure: Nature of Proceedings), all those involved should consider and review the report of an expert when it is received and, where relevant, raise points with the expert and other parties relating to the performance of the expert's instructions, his or her reasoning, the factual basis of his or her views and the relevance of his or her views to the proceedings.
(e) In any case in which a local authority applies under FPR rule 4.5 to withdraw proceedings it should state whether or not it accepts that the child is a child in need for the purposes of s.17 Children Act 1989. If it does accept that the child is a child in need the application should be accompanied by a schedule outlining the needs that have been identified and detailing the support and services it proposes to make available to that child to meet those identified needs once the proceedings have been concluded.

CONCLUSIONS

The application for leave to withdraw

171. After re-evaluating the evidence the local authority has come to the conclusion that there is no, or very little, material which is capable of satisfying the threshold criteria set by s.31(2). In its final threshold document the local authority abandoned all but two of the allegations set out in the original threshold document. It later conceded that those two issues 'would never have been sufficient to establish the threshold criteria, let alone the subsequent making of care orders'. In the local authority's Closing Summary it is conceded that 'this was ultimately not a case of FII.'

172. In his closing submissions on behalf of the local authority, Mr Kirk asked, rhetorically, what benefit there had been for these children as a result of the local authority having shared parental responsibility for them since August 2009. The answer, he suggested, is none. He went on to submit that that would continue to be the position in the future if the local authority continued to share parental responsibility.

173. The local authority acknowledges that these children are children in need for the purpose of s.17 and in consequence also acknowledges that before the court agrees to the proceedings being withdrawn the local authority must satisfy the court that it intends to provide appropriate support and services for this family. This it believes it has now done.

174. As I noted earlier, the parents support the application for leave to withdraw and the Children's Guardian 'does not actively oppose the…application to withdraw'.

175. Although rule 4.5 does not itself set out any particular test which must be satisfied before leave to withdraw may be granted, the two authorities to which I referred earlier do give guidance on the approach the court should take. The court should consider whether there is some solid advantage to these children to be derived from continuing the proceedings.

176. These children have lived with their parents for the whole of their lives. Despite the overwhelming negativity of the initial social work statement of Mrs D, it is clear from the independent social work assessment of Mrs G that there are many positives to be found in the parenting provided by these parents. The evidence before me is to the effect that the children are happy, settled and, within the bounds of what is possible in the confines of their overcrowded home, well cared for. Against that backdrop I am satisfied that, subject to one issue, there is no solid advantage to these children to be derived from continuing the proceedings.

177. The one issue that concerns me relates to the adequacy of the support and services proposed by the local authority and the question of whether I should adjourn its application for leave to withdraw these proceedings to enable the local authority to give further consideration to my concerns.

The provision of services and support

178. In indicating to the court on 29th January that the local authority intended to seek leave to withdraw the proceedings in respect of X and Y, Mr Kirk assured me that this did not mean that the local authority wished to wash its hands of responsibility for this family. Although the extent of the local authority's offer of support for this family has been evolving, I accept that it is now offering to provide much of that which was asked for by the parents in their 'wish list' and recommended by the Children's Guardian in her most recent Interim Analysis and Recommendations.

179. I am in no doubt that these children have been 'children in need' for a very long time, long before these proceedings began. Given the problems of this family, as described at length in this judgment, that is not likely to change during the remaining years of these children's minority. This last point is an important point because in indicating its belated willingness to continue to pay for Y to attend Gym class, the local authority's commitment to make this provision is qualified by the words 'as long as the case is open to them'. It is important that the local authority understands clearly that this family will need support and services for a very long time to come. The support and services required are likely to change as time passes by and will, therefore, need to be reassessed periodically. It is important that that reassessment is undertaken sensitively and with due regard to the changing individual needs of each child.

180. So far as the provision of support and services is concerned, the change in the local authority's position between 3rd February and 9th February is very much to be welcomed. However, despite the improvement in the level of support and services offered, there are two areas in respect of which I remain deeply concerned about the local authority's unwillingness to change its position. The first of these I regard as an issue of fundamental importance.

181. The local authority's concern about poor home conditions has been a theme that has run throughout the entirety of its involvement with this family. It is a concern that goes back years. Although the concern has often been about the state of the home – variously described as 'untidy', 'chaotic' and 'poor' – there has for a very long time been a clear acknowledgement by the local authority that the underlying problem is that this house is simply too small for a family of five with the particular range of needs that this family has. As I noted earlier, a Closure Summary dated 24th May 2005 noted that 'the house is too cramped and cluttered due to lack of space' and that 'there are issues of severe overcrowding and clutter' but conceded that '*the cramped conditions are beyond the family's control*' [emphasis supplied].

182. The point made by the Children's Guardian at paragraph 3.3 of her most recent Interim Analysis and Recommendations is, in my judgment, a point well-made. As the children get older privacy and personal space will become ever more important to them. Removing clutter and providing storage units, fire doors, carpets and a new bed will not address the underlying problem: this house is far too small for *this* family. It is overcrowded. It is not conducive to the health and development of these children. Something must be done about that.

183. As I noted earlier, the local authority's position is that it accepts that the home is overcrowded but says that it has no ability to pay for any extension to the house, nor any department to which they could even apply. In her report Mrs G, an independent social worker with a vast amount of experience of social work practice, makes the point that in similar circumstances some local authorities would see expenditure on an extension to an owner-occupied home such as this to be a reasonable and proportionate alternative to the cost of placing children in foster care.

184. It is in my judgment deeply unattractive that a local authority which has been so concerned and so critical for so long about the housing conditions of children in its area whom it accepts to be children in need should be so unimaginative in its approach to helping the family to overcome the problem.

185. The second of the issues upon which I remain concerned relates to the cost of the cancelled holiday to Egypt. The parents say they have lost £6,500. Let me say at the outset that I accept completely that before there could be any question of the local authority making any contribution to that loss the parents must first satisfy the local authority that that sum of money was indeed expended upon that holiday and that either they had no travel insurance or that their insurers are, for some reason, unwilling to accept a claim or that there is some shortfall between the cost of the holiday and the amount which the insurers are willing to pay out.

186. If, having explored those issues, it is clear that the family has suffered a financial loss then, in my judgment, there is a strong case for saying that the local authority should meet that loss. In its written response on this issue the local authority appears to shrug its shoulders and say that the reason why the holiday did not take place was a combination of increased child protection concerns backed by an order of the court requiring the parents to lodge their passports and travel documents at court. That analysis overlooks the fact that, firstly, its contention that the children's safety required their immediate removal into foster care was not upheld by the court and, secondly, that the court expressed significant criticisms of it's decision-making processes leading up to that hearing.

187. The question for the court is how it should deal with those two issues. I have considered whether there is an analogy to be drawn between the requirement for the court rigorously to scrutinise a care plan (see, for example, the comments of Wall LJ in Re S (children) and Re W (child) [2007] EWCA Civ 232 at para 27) and the requirement, when determining an application under rule 4.5, that the court should consider whether there is some solid advantage to the child to be derived from continuing the proceedings. In other

words, should I adjourn the local authority's application under rule 4.5 with a request that the local authority reconsider its decisions on these two issues?

188. The notion that these two situations are analogous may perhaps be said to break down when one compares the options open to the court if the local authority declines an invitation to reconsider its care plan (in the one case) or declines an invitation to reconsider its offer of support and services (in the other). In the former situation the court has no ultimate sanction save that of refusing to make the care order. In the latter, if the local authority is unwilling to make available to the children the support and services which the court considers appropriate, the parents and the children have the right to seek a judicial review of that decision.

189. In this case, Miss Meyer, on behalf of the father, submits that it is not an appropriate use of the court's case management powers to endeavour to continue these proceedings in order to identify or resolve any disputed issues between the parties on matters falling outside the Court's own statutory remit, for example the provision of services for children in need, or to force a local authority to carry out statutory duties.

190. With some regret, I have come to the conclusion that that submission is correct. Though concerned and disappointed by the local authority's approach to these two issues, and particularly the housing issue, I accept that I do not have the power, within these proceeding, to judicially review those decisions or otherwise to compel the local authority to make available the support and services which I consider appropriate. Such an application must be made to the Administrative Court. I also accept that these proceedings have been going on for so long and have been so upsetting not only for the parents but also for the children, that it would not be appropriate for me to extend the life of these proceedings simply in the hope of being able to extract some further concessions from the local authority.

191. I shall therefore give leave to the local authority to withdraw these proceedings in respect of all three children.

Costs

192. The guidance on the approach to costs orders against a local authority in public law Children Act proceedings is limited. However, the approach of Cazalet J in Re M (Local Authority's Costs) is consistent with the reference to 'conduct' in CPR rule 44.3(4) and therefore seems to me still to be an appropriate test to apply: is the conduct of the local authority reprehensible or beyond the band of what is reasonable?

193. I asked that the LSC be informed of the level of the respondents' costs in these proceedings and of the fact that I am considering whether it may be appropriate for me to make a costs order against the local authority. I also extended an invitation to the LSC to appear at this hearing to make representations. The LSC has indicated that it does not wish to appear and that it is content for counsel for the publicly funded parties to address this issue as they consider appropriate. The position taken by counsel for each of the respondents has been one of studied neutrality, saying that the issue of costs it is a matter between the court and the local authority.

194. The local authority has filed detailed submissions on the costs issue. As for the withdrawal of the concerns expressed in its original threshold document the local authority does not accept that it was abandoning its case as such. It says that home conditions had improved quite substantially and that school attendance was no longer a worry. Against that, it could properly be said that, for example, the social work records show that, historically, concerns about home conditions have ebbed and flowed over the years.

195. So far as the issue of FII is concerned, the local authority makes the point that in my judgment of 17th August 2009, at which Dr M's report was available and he gave oral evidence, in evaluating whether the children's safety demanded their immediate removal into foster care, I said:

> '101. I do not doubt the significance of the concerns about fabricated illness in this case. So far as these parents are concerned, Dr M's report makes it very clear that they have a case to answer. If there is substance in the concerns about fabricated illness then I also accept that to leave these children in the care of their parents even

until the fact-finding hearing next January may be to leave the children at risk of harm.

'102. Set against that, despite the children's medical history as set out in Dr M's report, it has not been until very recently that there has been any concern by this local authority about the possibility of fabricated illness. Hitherto, the focus of the local authority's concerns has been altogether different.'

196. The point is made on behalf of the local authority that at the time these proceedings were issued it 'had not collected material that was likely to satisfy the court that this was a true case of FII, still less any cogent or compelling evidence to support this serious allegation'. I have already indicated that I do not criticise the local authority for its approach to the FII issue prior to the issuing of these proceedings. The real issue, as it seems to me, is to consider at what point the local authority should have begun to investigate the FII issue and how it should have done so. I have already expressed the view that the local authority should have begun to investigate once it had received Mrs G's report and the Children's Guardian's Interim Analysis and Recommendations and that at that point it should have convened a Strategy Meeting involving relevant professionals including a paediatrician and Dr B.

197. As I have acknowledged, costs orders against local authorities are infrequently made, and for good reason. However, in this case I am satisfied that it is appropriate for me to order the local authority to make a contribution towards the parents' public funding costs. In arriving at that decision I have in mind all of the analysis set out above but in particular that the local authority:

(a) has abandoned all of the matters relied upon in its original threshold document on the basis of a belated acknowledgment that there is little or no material which is capable of satisfying the threshold criteria.

(b) upon receipt of the reports of Mrs G K and Ms J, failed to convene a strategy discussion or otherwise take steps to obtain and evaluate information relating to the children's extensive involvement with health services in order to determine whether there is evidence that this is a case of FII and, if so, whether steps needed to be taken to safeguard the children.

(c) in seeking to remove the children into foster care, fell below accepted standards of best practice in the decision-making process which led to its application to the court for interim care orders in August 2009; and

(d) failed to raise with Dr M the shortcomings in his report, instead relying upon that report completely and uncritically in deciding to amend its threshold document to raise allegations of FII, in drafting those amendments and in proceeding with those allegations up to the fifth day of this fact-finding hearing.

In my judgment, the local authority's conduct of this case falls outside the band of what is reasonable. I shall order that the local authority shall pay the sum of £50,000 towards the costs of each parent (i.e. £100,000 in total).

198. I note that in Re R (Care: Disclosure: Nature of Proceedings), to which I referred earlier, having made an order for costs against the local authority Charles J. went on to say

'I would also express the view, which can be conveyed, for what it is worth, to the Legal Services Commission that this is an issue between publicly funded bodies. They may, as a matter of discretion, wish to take that into account in deciding whether or not they enforce this order having regard to the circumstances of the case and the way in which legal aid is granted in family proceedings.'

I echo those views.

Note 1 This report has recently been superseded by 'Fabricated or Induced illness by Carers (FII): A Practical Guide for Paediatricians' published by the RCPCH in October 2009. [Back]