

THE FAMILY COURT AT WEST LONDON  
IN THE MATTER OF CHILDREN ACT 1989  
IN THE MATTER OF E

Date: 31 May 2018

Before:

HIS HONOUR JUDGE WILLANS

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Between:

LONDON BOROUGH OF HILLINGDON

Applicant

-and-

- (1) A
- (2) B
- (3) C
- (4) D
- (5) E

(BY HIS CHILDREN'S GUARDIAN)

Respondents

Hearing Dates: 9-11 May 2018

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**FACT FINDING DETERMINATION**

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Ms Nylah Abbasi for the Applicant  
 Ms Janet Mitchell for the First Respondent  
 The Second Respondent was not represented and did not attend  
 Ms Yasmin Jamil for the Third Respondent  
 Ms Gemma Neath for the Fourth Respondent  
 Mr Mark Rawcliffe for the Fifth Respondent

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## Introductory Points:

1. This judgment concerns a discrete fact-finding determination following three days of evidence. The question for me to determine is as to which of two adults caused E to ingest harmful medicines in early 2018. The identified potential perpetrators are E's mother and his mother's partner.
2. I have considered the documents within the final hearing bundle<sup>1</sup>. I have considered written and oral submissions from the advocates for each party. E's father did not attend the hearing and his current whereabouts are unknown. This has not hampered this hearing as it is not suggested he was responsible for the ingestion. I heard evidence from the following:

a.	(Toxicologist):	MSH
b.	(Consultant General Paediatrician: Y):	AS
c.	(Consultant Paediatrician: X):	RG
d.	(Consultant Paediatrician: X):	MC
e.	(Nurse: Y):	CM
f.	(Nurse: Y):	CJ
g.	(Nurse: X):	JE
h.	(maternal grandmother):	C
i.	(mother):	A
j.	(mother's partner at the relevant point in time):	D

3. The final hearing was evidence heavy (10 witnesses in 3 days) and it was impossible to complete submissions and judgment within the available time set aside. I directed written submissions from each party by 18 May 2018<sup>2</sup> and indicated I would do my best to provide my judgment within the week (re-timed to 30 May 2018 given delay in submissions). This is my written judgment which I intend to hand down on 6 June 2018 subject to any typographical corrections and / or requests for clarification.

## Legal Principles:

4. I have referred myself to the authority of Re D<sup>3</sup>. It encapsulated the key principles underlying the approach to fact finding:
  - a. The burden of proving matters in dispute falls upon the party making the allegation. For the purposes of this hearing the LA.
  - b. The standard of proof is the balance of probabilities, i.e. more likely than not.
  - c. If this standard is reached then I will treat the fact as established and all future decisions relating to A will proceed on that finding. If the standard is not reached then I will disregard the allegation completely. In doing so I operate a binary approach which cannot accommodate what might have happened.
  - d. My findings are of fact and must be based on evidence or inferences that can be properly drawn from the evidence not suspicion or speculation.
  - e. I must consider all the evidence and each piece of evidence in the context of all the other evidence, I should not compartmentalise the evidence but must carry out an overview of the totality of the evidence to come to a conclusion.
  - f. Medical evidence must be considered in the context of all the other evidence. My role is distinct from that of the expert. I must weigh up that evidence against all the other evidence and I may reach a conclusion at variance with the expert although I should take care to set out clearly why I have departed from such opinion. In considering the expert evidence I should ensure the expert properly confines him/herself to the bounds of their own expertise.
  - g. The evidence of parents (or equivalents adults) is of the upmost importance. I must form a clear assessment of each parent's credibility and reliability given the considerable weight that is likely to be placed upon their respective evidence.

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<sup>1</sup> A bundle woefully compliant with PD 27 in being copied on a double-sided basis and containing approximately 1200 pages in a single lever arch file. I can find no permission for the bundle to exceed 350 pages.

<sup>2</sup> The last submission from the LA was in fact received on 23 May 2018

<sup>3</sup> Per Roberts J. at [2017] EWHC 3075 (Fam)

- h. In assessing any witness who I have found to be untruthful I must be careful to bear in mind that a witness may lie for many reasons and that the fact that a witness has lied about some matters does not mean he or she has lied about everything: *R v Lucas*
- i. In cases where this is a disputed aetiology there must be factored into the case a consideration as to whether there is an unknown cause. The Court must guard against assuming there is always a ready explanation for all circumstances. The Court must also bear in mind that current orthodoxy of thinking can be subsequently shown to be incorrect.
- j. Returning to the question of credibility I remind myself that this demands an assessment beyond simple demeanour. Demeanour may reflect the current state of thinking of the witness as to the truth yet as time passes memories can become fainter and the imagination more active. As a result, contemporaneous documents are always of the utmost importance.
- k. I must consider carefully the significance or otherwise of reported discrepancies. These may arise for many reasons such as faulty recollection or confusion. The effect of delay and repeated questioning upon the memory also must be considered. As memory fades a desire to iron out wrinkles may not be unnatural and may not justify an inference of bad faith.
- l. Finally, when seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators, is whether there is a likelihood or a real possibility that he or she was the perpetrator. To make a finding that a person was the perpetrator of non-accidental injury the court must be satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injuries to be identified both in the public interest and in the interest of B, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to avoid such an outcome.

I have considered the summary of law provided by the advocates and additionally bear this in mind.

#### Short History:

5. The social work evidence gives an unremarkable history save that E has not seen his father, B, since he was a young child. E is now aged 4 years. Up until the events in question he lived with A. A details a personal medical history at paragraphs 2 – 7 of her second statement. I understand her medical notes to be extensive but it suffices to note that she has ongoing abdominal pain resulting from a series of issues. The upshot of this situation is that A complains of significant chronic pain and has been admitted to hospital on multiple occasions. A has a medication regime which included at the relevant time:
  - a. Nortriptyline, and
  - b. Morphine (branded under the title Oramorph) (“globally the Drugs”)
6. Nortriptyline is a drug used in the management of pain relief. A tells me that her pain relief management was changed to Nortriptyline in 2016 by her Pain Management Team. She tells me she received her most recent prescription on about 12 December 2017 in the form of 100 / 10mg tablets. These are taken three at a time as and when required. Morphine is a drug used for pain relief. A tells me she was prescribed this following an admission to the H Hospital on 5 December 2017. This was given in a bottle (liquid) form. It is a clear fluid taken by oral syringe in 5ml dosage. The size of the prescription is unclear but was suggested to be akin to a large bottle of Calpol<sup>4</sup>.
7. A appears to have known D since around 2014. They formed a relationship in either February or October 2016<sup>5</sup>, do not live together but he would regularly stay over.
8. D cites a largely unremarkable background history<sup>6</sup>.
9. A/D agree they had a fractured relationship between at least October 2016 until December 2017. I note the following without comment or analysis:
  - a. They agree they broke up in December 2016. In around December 2016 there was an incident when D took an overdose outside A’s property<sup>7</sup>.

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<sup>4</sup> 200ml?

<sup>5</sup> Nothing turns on this disagreement

<sup>6</sup> C48 §3-7

- b. D claims they recommenced their relationship around April 2017 and broke up in July 2017. A does not accept this period of relationship.
  - c. There was an incident at a nightclub in August 2017<sup>8</sup> in which D and A came into conflict. D claims they went home together that night whereas A disputes this suggestion.
  - d. D claims they got back together in November<sup>9</sup> whereas A dates this reconciliation to September<sup>10</sup>.
  - e. There was some form of incident in December 2017<sup>11</sup>. A argues the relationship cooled thereafter. Both agree the relationship ended in January 2018.
  - f. Separate to the relationship D agrees there was an incident in September 2017 when he consumed drugs when out with friends<sup>12</sup>.
10. D admits to using cannabis at a relatively low level during the relationship but more so towards the end of 2017. His hair strand testing supports this admission<sup>13</sup>. He alleges A was using cannabis at a higher level which she denies. Her hair strand testing indicates low level use more consistent with her case as to non-use and passive consumption at most. At the outset of his evidence D made material modifications in this regard.
11. In early December 2017 E contracted a series of medical complaints. This included a period of tonsillitis and later - I believe - symptoms of gastroenteritis. He was prescribed penicillin and received medicine for dehydration. On 27 December 2017 matters deteriorated and B was transported to the X Hospital by ambulance at around 11.30am. The indication is that he was suffering with a sickness bug with associated vomiting and diarrhoea. During this time, he was seen by MC and RG alongside other medical staff including JE. There may have been some improvement in E's condition as he rehydrated and E was approaching discharge on 1 January 2018. However, matters then further deteriorated and E was transported to the Y Hospital where he was kept under observation and treated. As part of his treatment regime blood tests were taken and on 5 January 2018 the results indicated the presence within his system of the Drugs. This caused obvious concern on the part of the Hospital and a formal investigation commenced.
12. I intend to summarise the investigation as follows:
- a. There was a meeting with A and hospital staff on 5 January 2018 following which she handed her medication to the staff
  - b. A was interviewed by the police on 6, 17 and 24 January 2018<sup>14</sup>
  - c. D was interviewed by the police on 10, 18 and 19 January 2018<sup>15</sup>
  - d. C was interviewed by the police on 16 January 2018<sup>16</sup>
  - e. E was ABE interviewed by the police on 16 March 2018<sup>17</sup>.
13. On 11 January 2018 E was fit to be discharged. A agreed for him to be accommodated<sup>18</sup> by the LA where he remained until about 9 February 2018 when he was placed with C under a child arrangements order. He has remained there since and has contact with his mother. He has no contact with D and none is sought. A and D have permanently separated. The LA made application for a care order on 23 January 2018 and the proceedings were allocated to Her Honour Judge Rowe QC. The Court managed the case on 9 February 2018; 20 and 27 March 2018<sup>19</sup>.

## **The Medical Evidence: Overview**

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<sup>7</sup> C25 §4 / C52 §39

<sup>8</sup> C26 §6 / C52 §40

<sup>9</sup> C51 §31

<sup>10</sup> C26 §8

<sup>11</sup> C53 §41

<sup>12</sup> C48

<sup>13</sup> E92

<sup>14</sup> H30, 113 and 211 respectively

<sup>15</sup> H62, 65, 156, 186, 206

<sup>16</sup> H91

<sup>17</sup> H244

<sup>18</sup> S20 Children Act 1989

<sup>19</sup> B48, B53

14. In large measure the medical evidence in this case has been standard witness testimony under which a series of doctors and nurses gave an account of their engagement with A, D etc rather than expert evidence as to the medical condition of E and the diagnosis of the same.
15. The key expert evidence in the case was from MSH who assisted the Court in understanding the likely timeframe in which the Drugs were likely to have been ingested by E. MSH calculated the timeframe using samples taken from E (urine and serum)<sup>20</sup>. The presence of the Drugs in the sample indicated an end cut-off point by which time the drug must have been ingested. MSH then calculated backwards from that time using principles relating to the half-life of the Drug. In the case of morphine, I was told the half-life was approximately 2-3 hours. This means the quantum of morphine would double as one counted back every 2-3 hours. MSH could calculate a reasonable cut-off starting point before which any ingestion would have had to be at such a level as would have led to obvious symptoms which would have been noted by clinical staff (but were not noted thus suggesting ingestion at a lower level). He used a similar approach in the case of nortriptyline. However, the 'window of opportunity' was greater as the half-life was much longer (15-90 hours).
16. Having carried out this assessment his evidence was as follows:
  - a. There were two likely ingestions of morphine.
  - b. The first ingestion was prior to the serum sample which was itself taken at 14:10 hours on 2 January 2018. This was consistent with ingestion 2-3 hours prior to this time (i.e. 11:10 – 12:10 hours) back to no earlier than 02:10 hours on 2 January 2018 *or just possibly late on 1 January 2018*. As one approaches midnight on 1 January 2018 so the dose would need to start approaching a *high and potentially life-threatening dose with significant respiratory depression* and other signs<sup>21</sup>.
  - c. The second ingestion was prior to the urine sample taken on 6 January 2018. Morphine identified in this sample likely relates to ingestion in the period 2-3 days prior to this sample. It is unlikely this could represent a residual trace from the ingestion identified in 22(b) above. The fact that this is a urine rather than serum sample makes greater clarity problematic with the associated wider window. It is important to note that this sample was taken after a catheter was removed and hence there is no issue of pooling urine or of evidence of a continuing urine retention issue.
  - d. The above conclusions are posited on a normally functioning liver<sup>22</sup>.
  - e. In the case of the Nortriptyline the serum sampling was insufficient to provide confident results with only a possible indicator of presence on 2 January 2018. However, both Nortriptyline and its metabolites were found in the 3 January 2018 urine sample; the metabolite alone was found in the 6 January 2018 urine sample and neither drug nor metabolite were found in the 10 January 2018 urine sample. Overall the results could be explained by a single dose with ingestion on or before 2 January 2018 but does not preclude more than one dose. However, the negative results (and of course the removal of the drugs on 5 January 2018) for 10 January 2018 suggest no further ingestion perhaps for several days before this date<sup>23</sup>. In his oral evidence MSH commented that ingestion was most likely between 31 December 2017 and 2 January 2018.

#### **My impression of the witnesses:**

17. MSH was a clear witness who plainly understood his area of expertise. He was not challenged in any material way – questions were probing as to the confidence that could be had at various points in time and related symptoms. I found him a reliable witness and I accept his evidence including its inbuilt levels of uncertainty. He did not seek to overplay what he could tell the Court.
18. I equally found the three clinicians (AS; RG and MC) to be witnesses upon whom the Court could place reliance. Once again, I note they were not controversial witnesses of fact. Whilst I note there was a degree of concern at X as to whether the symptom reported by A were in line with those noted by the staff and that MC raised as a concern the possibility of exaggeration, I do not find these issues to be such as to undermine the essential impartiality of each witness. Rather, it is plain to me this difference in reporting and concern flow from the complicated relationships existing in a busy hospital between an

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<sup>20</sup> See E70: 170

<sup>21</sup> E79-80

<sup>22</sup> E82:485

<sup>23</sup> E85: 565

ever present, parent and less present staff. The over view of the clinical team is bound to throw up such inconsistencies but this does make the witness unreliable.

19. AS was brought into the case at Y as safeguarding clinician. She was carrying out an overview and met with A at the meeting on 5 January 2018. I found her a reliable witness.
20. The nursing staff were largely called to comment as to the presence of family around E during the period of stay. The purpose of this evidence was to identify which individuals fell into the pool of potential perpetrators and to provide such information as was available for the care of E during the window of opportunity (as identified above). Given it is agreed that A had significant periods of time as the only family member with E (she slept overnight beside him) and that D also had periods alone with E it is questionable how significant the evidence of each nurse was in determining this case. I found each nurse to be doing their best to give honest answers to all questions put. They were plainly doing their best and were wholly independent witnesses with no interest in the outcome.
21. C was the last witness to give evidence but I will deal with her next. It might be thought that she would have a natural inclination to favour her daughter and indeed in evidence she confirmed she found it difficult to believe her daughter would have given E the Drugs. I approach her evidence with caution to guard against the risk of an in-built bias although did not appear in her evidence to take obvious sides between D and A. She was willing to make appropriate concessions and gave the clear impression of a concerned grandmother who wanted to know what had happened to her grandson. I did not have the sense of her as a witness who was filling the gaps in her knowledge to help her daughter or modifying her evidence for such purpose. I don't recall her finding herself in difficulties answering any questions or tripping herself up on the answers she gave. With the reservations noted above I found her a helpful witness.
22. A and D each have an obvious interest in the outcome of this case. On the evidence I have heard it is very likely one or other of them knows exactly what has happened and for reasons of self-protection are choosing not to be open and honest with the Court. It is highly likely that one or other of them is consciously misleading the Court. At the heart of the allegations is conduct which on any view likely crosses the boundaries of criminal misconduct. I must bear this in mind and approach each of their evidence with real care.
23. In his written evidence D confirms he told a series of lies to the police in interview<sup>24</sup>. At the outset of his evidence he made material amendments identifying two areas in which he gave a false impression in his written evidence<sup>25</sup>. I consider these matters to be relevant to the question of his credibility and the reliability of his evidence. There are aspects to his evidence which I will return to in detail below which cause me to believe him to be somewhat self-centred; emotionally immature and impulsive in his decision making<sup>26</sup>. On my consideration of the evidence he has controlling features to his personality and views himself (wrongly) as being the victim of circumstances/the actions of others. On my findings there are features of his evidence in which he has sought to deliberately distance himself from inculpatory features and areas in which he wrongly sought to blacken the character of A for the same purpose<sup>27</sup>. Overall, I formed the view that he was an unsatisfactory witness of fact and that I should approach his evidence with care. I formed the view that he has the capacity to minimise matters which are unhelpful to him and is willing to do so to assist his position.
24. A did not suffer from having to admit to historic lies or to amend her statement in a material manner<sup>28</sup>. Nonetheless, I must bear in mind the significance of this issue for her. In my judgment she has far more to lose than D due to her continuing relationship with E. This does not mean she is likely to lie about what happened. But it does mean I should approach her evidence with care. In comparison to D her evidence was more consistent and I found her reasonably direct in her answers. There were areas in which I was asked to consider the consistency of her evidence and I bear this in mind<sup>29</sup>. It is also right

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<sup>24</sup> C47 §2

<sup>25</sup> Admitting that he had consumed cocaine on more than one occasion and admitting there was a second recent occasion on which he overdosed in response to relationship difficulties

<sup>26</sup> Including the overdoses

<sup>27</sup> See the drugs allegation

<sup>28</sup> I do accept there is evidence of unrelated historic lies about her mother but I consider these to be of limited probative value. I reach this conclusion having regard to the passage of time. I do not think it would be either fair or helpful to determine this case on what either of these comparatively young people may have said when they were children

<sup>29</sup> E.g. the issue of her account of where the medication was kept at home

that her evidence at points conflicted with the evidence of independent witnesses<sup>30</sup>. I also bear this in mind. It was plain to me she has a strong bond to her son and her evidence was at times appropriately emotional. Generally, I was more impressed by her as a witness than I was by D. In my assessment there are a number of circumstances where I found the evidence of A more impressive than D both as to its inherent plausibility and as to its consistency.

### **Findings of Fact:**

25. In is a fact-finding exercise the Court is often confronted by the following categories of evidence:
- Evidence agreed by the parties or inherently likely on the agreed facts
  - Evidence in dispute but of limited probative value in the determination
  - Evidence in dispute and relevant to the determination.

Applying the formulation above I will identify the matters in (a) and resolve the matters in (c) in reaching my decision. For the benefit of the parties I do intend to identify the key matters in (b) and explain in brief terms why I have not ultimately found their determination helpful to my resolution.

#### **(a) Matters not in dispute:**

26. I find that E ingested morphine on two occasions whilst admitted to Y and that on neither occasion was the ingestion part of his prescribed treatment plan. This finding follows the clear uncontested evidence of MSH in concert with the evidence of the treating institution.
27. I find the first ingestion likely occurred in the period between 02:10 and 14:10 hours on 2 January 2018. I accept the evidence of MSH. Importantly I accept that the closer one gets to 02:10 hours the greater would need to have been the dosage. I accept the evidence of MSH that:

*[The ingestion] could have been just before 2 January – if 2.10am then would have been a large dose – very late evening [1 January] is a slight possibility – anything before 8pm [1 January] would have almost certainly have been fatal – anything before 2am [2 January] would have been significant and serious with obvious symptoms – I am not aware of any such observations*

I received no evidence of ‘obvious symptoms’ referred to by the expert despite E being in a small high dependency bay of 4 children with 2 nurses. As E was under significant monitoring I would expect such symptoms to have been observed. The absence of the same is a limiting feature as to the window of opportunity.

28. I find there to have been a second ingestion of morphine in the period between 4 – 6 January 2018. I accept the evidence of MSH in this regard. This evidence was not challenged. I am unable to be more precise as to timing.
29. I find there was an ingestion of Nortriptyline on at least one occasion in the likely period 31 January 2017 – 2 January 2018.
30. I find the ingestion was of drugs prescribed to A. I find it would be almost unimaginable that E ingested a combination of drugs prescribed for A and in physical proximity to E at the relevant times **but** from another source. The medical evidence confirms that he was not prescribed the drugs in question via his treatment plan.
31. I find the ingestion involved adult involvement. I accept the evidence of A that the morphine has a child lock top and that E would not be able to open it. I also accept the evidence of A as to the morphine having a bitter taste. I find it unlikely E would (if given the opportunity) take the liquid a second time. It is likely E would not have been able to moderate the dosage taken and this would have led to a high likelihood of obvious symptoms. It is unlikely this could have been done twice without being noted by family or staff. Finally, I find it would have been obvious to an adult if E had chanced upon the drugs and used them as it most unlikely he would have re-fixed the top and placed it unobtrusively back into the bag.

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<sup>30</sup> For example, where she claims to have reported E suffering with soreness to his penis

32. I find it unlikely the ingestion was the result of two individuals acting independently on separate occasions. This is not suggested by any party and indeed is argued as implausible by all parties. I agree.
33. I find it unlikely both adults were aware of the Drugs being administered. In my assessment whilst it is not inherently implausible that the two could have had knowledge of the ingestion, e.g. A deciding to provide an extra dose of painkiller with the support of D, I find it unlikely this strategy would have survived unscathed to this point. The parties are now each seeking to blame the other. Were D to have been aware of A providing a dose then I strongly suspect he would have come clean in such regard by now rather than leaving himself at risk on the basis that he cannot say what happened. My conclusion may have been different if each was denying knowledge and supporting the other. The same principle applies vis a vis A.
34. I find it unlikely the ingestion was administered by an individual other than A or D. On the evidence it is clear no other family member had the opportunity to administer the Drugs to E as set out above on all three occasions. Whilst C may have had the opportunity in respect of the first morphine dose it is clear she could not have administered the second dose as she was out of the country. I find it highly unlikely a third party or member of staff could be responsible having regards to the lack of motivation for doing so; the lack of opportunity given the working shift pattern and presence of family, and the reduced access to A's medication. It is plain the potential pool of likely perpetrators is restricted to two individuals.
35. I find it likely the drugs were administered when the culpable adult was alone with E (i.e. when the other family were absent). I find it implausible that either of the potential individuals could or would have sought to surreptitiously administer the drug in the presence of others. I have regard to the real potential for E to recoil from the medication. Such a situation would likely only arise where the administration was with the knowledge of the other individual. I am unable to determine the mechanism of administration. Whilst it could have been by use of the syringe it is equally likely that the morphine was diluted in a drink. I was told the Nortriptyline was a small tablet and so it is possible it was ingested without B being particularly conscious of taking the tablet particularly if it were mixed with a separate substance.
36. I find both A and D had a good working knowledge of the drugs and the dosage given to A. Such is clear from the evidence of D as to his involvement in medical appointments and is obvious in the case of A.
37. I find both A and D were alone with E during each of the three windows of opportunity identified above.

**(b) Matters which are raised but do not assist**

38. I do not find anything of significance in E's medical history<sup>31</sup>. I believe there was a suggestion that the records were in some way significant. If this is correct then I disagree. The notes appear to me to be wholly in line with a child of E's age. I have received no medical evidence to suggest otherwise.
39. I do not find the 'snapchat' message probative of guilt. It has superficial attraction as it might appear to suggest a form of admission by D. I accept A's evidence that she viewed it in this way. The difficulty I have relates to a substantial lack of clarity as to the content of the message<sup>32</sup>. Ultimately A appeared to take the position that the likely account of the message was as found in her police interview<sup>33</sup>:

*"I'm sorry it's all my fault...I feel like it's all my fault because of my past"*

Viewed objectively this is some distance from an admission of responsibility. On balance I do not accept the subtle recasting of the message in A's statement<sup>34</sup>. I am more attracted by the more contemporaneous account to the police and I note the police interview fits better in that the second part of the messaging is an answer to the question messaged by A whereas in the statement suggests no answer was given. I do not rule out the full message including about D having "fucked things up" but I

<sup>31</sup> G6

<sup>32</sup> The message disappeared shortly after the receipt and no screenshot was taken

<sup>33</sup> H147: 17 January 2018

<sup>34</sup> C30



consider it was in the context of previous history. A in evidence said the police interview account was likely to be the more correct of the two.

40. I find no probative value in the suggestion A may have in frustration on one occasion said words to the effect that she would put E in care or wished he was in care. I do not consider I need to make a finding in this regard in respect of what is at most a moment of distress. It comes nowhere near explaining the ingestion.
41. I find nothing of benefit in the anger / frustration A exhibited when dealing with MC. The evidence in this regard is all about the stress of not knowing what was happening with E. It is behaviour well within the range of concerned parents and does not assist me in determining the ingestion. At most it might feed the suggestion that A administered a dose as she felt E was not being properly cared for. I do not consider it should bear meaningful weight in my analysis.
42. I am also unimpressed by the suggested relevance of lies said to be told by D to the police at the instigation of A. It is important to note the suggested lies are restricted in content to (a) how long the parties had been in a relationship<sup>35</sup> and; (b) the extent to which D stayed over at A's property<sup>36</sup>. It is not entirely clear the first matter is said to have been a lie at the instigation of D rather than a correction of her portrayal of their relationship. D's ultimate suggestion of having been in a relationship for three years does not fit his evidence of the relationship commencing in February 2016 (i.e. 2 years). The second point is in my judgment more likely explicable by reference to the fear that repercussion might arise in respect of the tenancy agreement if it were known D was staying over regularly. I find it likely that A has told D not to admit to staying over however I am not persuaded this arose particularly in the context of this police investigation. It is a classic situation in which the Lucas direction applies. It is a lie with a motivation which once understood removes any relevance to the issue under analysis.
43. I am unmoved by the debate as to whether A suggested the medication was kept in a 'safe' at home. On balance I consider there has been misunderstanding as to her suggestion that the medication is 'kept safe' at home. The notion of suggesting a safe is somewhat outlandish and does not fit the actual agreed facts of the medication being kept on a high unit. This fact seems agreed by everyone with knowledge of the home life. A contrary finding would not have assisted me to determine who gave the medication to E.
44. I have spent some time considering whether the mismatch between reporting by A as to E's condition and the observations of the staff are relevant. I have reached the conclusion they are not of real import. I have reached this conclusion notwithstanding I accept there is a degree of mismatch. I consider this is by no means an unexpected situation where a caring parent is stationed in the ward and has full time care whilst nursing staff are engaged in a range of duties. It is far from amounting to sinister evidence. A factual dispute arose as to the bathing of E and the suggestion of a sore penis. CM denied being told this and said she would have noted the same. However, CJ (the next nurse on but one) agreed that she was aware of this issue as a result of the handover notes. I am left being unsure as to the timing of the report but confident that such a concern arose. My overall assessment is that A may well have been hyper-sensitive to E's continuing poor health and she might have overstated the reality of his condition but I do not find this is probative as to the issues in dispute.
45. I was not assisted to any extent by the ABE interview of E. His presentation and engagement was such as to make any inference from his account wholly unreliable. I gain no understanding of what has happened here by E's generalised comments as to the medication he has received. I bear in mind that this was a child receiving medication for the best part of December 2017 due to sickness and tonsillitis. There is a high risk of wrongly attributing what he says about medication to the events in dispute when they are more likely to relate to conventional medication taken at home.
46. I have spent time considering the suggested relevance of perceived inconsistencies in the police interviewing of A as to missing drugs. It is correct to note that A's evidence to me was inconsistent with that given to the police regarding the amount of Nortriptyline taken from the new prescription<sup>37</sup>.

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<sup>35</sup> H188: F

<sup>36</sup> H181: H

<sup>37</sup> As I recall A told me she had taken 3 doses of Nortriptyline at 3 tablets per dose thus there should be 1 tablet on the existing strip. She told the police (and it is the case) that she took one dose and there should be 7 on the strip.

However, it appears to me she was consistent as to there being a missing tablet<sup>38</sup>. I also bear in mind her suggestion in interview that her prescription overlaid a previous prescription and that she effectively packed the old drugs into the box with the new<sup>39</sup>. Standing back though I ask myself what does this tell me about likely culpability? It is as likely to amount to after the event attempts to back calculate as something more sinister. As to the morphine contents I can find little of help. The morphine bottle is not said to have been calibrated and is reported as being half empty when handed over to the hospital on 5 January 2018. Given the likely limited dose given to E on what basis can it be confidently suggested that A would have been conscious in a change of volume of content?<sup>40</sup>

(c) **Matters of relevance in my determination**

47. I find D has exhibited a tendency to controlling behaviours allied with emotional immaturity and a tendency to risk-take with drugs when under emotional stress. In this regard I much prefer the evidence of A over D when considering the incident in the nightclub and the paracetamol overdose. In the case of the nightclub incident I find D has underplayed his anger. The staff response to the incident including his having been removed from the nightclub and subsequently barred fits poorly with a simple loss of footing. On balance I do not accept that A subsequently spent the night with D. I prefer her evidence of returning to her family with her friend. As to the paracetamol incident there is little factual dispute.
48. There is a pattern of behaviour on the part of D where he blames his partners for his own emotional fragility. In late 2015 he overdosed on amoxicillin because of his girlfriend “messaging with his head”. In late 2016 he overdosed on paracetamol having already separated from A when he came to pass by her house and see another man’s car outside. In respect of this incident it is clear he consciously travelled to a shop and purchased the drugs before returning and overdosing in front of the house. This association of misuse and attention seeking behaviour is significant.
49. There is also further evidence of control in the finding of the letter to the man in prison; the concerns about A being given a lift home by someone known to her when E was in hospital and taking some time, and; after the event evidence of being upset by seeing a picture of a man on Instagram<sup>41</sup>. My very strong sense is that D was emotionally insecure in the relationship with A.
50. He is also worrying impulsive. See the evidence of the paracetamol overdose. But also see the incident where he got on a bicycle to ride a considerable distance to see A only to be knocked off by a car. Also see the incident in Nightclub where I find he was aggressive towards her for no good reason whatsoever.
51. When feeling insecure his impulsive behaviour includes the misuse of drugs. In my judgment this is a significant factor.
52. I also find D has deliberately sought to minimise his role and consciously sought to blacken A’s character to exculpate himself. A clear example is in relation to the usage of recreational drugs. The hearing started with D alleging that A was the significant cannabis user<sup>42</sup> and that he had only limited history of misuse. This position was undermined by the hair strand testing that indicated A’s ‘usage’ was at a low level<sup>43</sup> and explicable by passive consumption. The disclosure in the case then showed that D had been found in possession of a quantity of cannabis<sup>44</sup> and when interviewed admitted to buying it in bulk previously. Further by the end of the hearing he was admitting broader cocaine use. I found his evidence in this regard unsatisfactory in the extreme. Having considered the evidence I am entirely unpersuaded that there is any greater truth in the allegations made against A re depression and self-harm.
53. I find A was seeking to loosen the ties of the relationship prior to Christmas and that D would have been conscious of this. I accept A’s evidence in this regard. It has the ring of truth about it. I suspect it

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<sup>38</sup> H57

<sup>39</sup> H41

<sup>40</sup> As an example, it is perfectly possible that one is considering a global dose of less than 10ml from a 200ml bottle.

<sup>41</sup> H172: B

<sup>42</sup> C49

<sup>43</sup> E24

<sup>44</sup> His hair strand tests were more significant than those of A albeit low

is associated with her concerns around the telephone call in December in which she believes she heard D discussing drugs. Such a call would certainly fit the surrounding facts of the case. Further there is support for her interpretation in the fact that she called the police raising such an allegation. My sense of the evidence is that the timing of Christmas and E's deterioration in ill health made the finalisation of the relationship a secondary concern. I am not persuaded A is misstating her intentions and my sense of D as emotionally insecure is of someone who would be very alive to changes in the relationship.

54. In reaching my conclusions I have reflected on the quality of relationship existing between A / D and E. I accept the pre-existing evidence is of A being a caring mother who has managed the care of an at times difficult child with the support of her family (and D). However, I also accept D has shown warmth towards E and whilst this may be a function of his feelings for A it does not diminish its significance. On balance this feature tends to suggest A would be less likely of the two to seek to harm the child, however it does not really help distinguish between which of the two would foolishly administer the medication for genuine but poorly thought through reasons. On balance this factor has not helped me determine the factual dispute. I bear in mind that neither of A or D has been observed to mistreat E.
- 55. In considering the evidence there are two issue which go to the heart of responsibility. The first is as to whether D brought the medication into hospital on 2 January 2018 as alleged by A The second is the refinement of the likely time of ingestion.**
56. I introduce each of these points in turn.
57. If D brought the medication into hospital on 2 January 2018 then the morphine could not have been administered until his arrival. I reach this conclusion as I find there to be no evidence to suggest any part of the medication was decanted prior to being sent home (on 1 January 2018). I find it inherently implausible that this was done. No witness suggested this was the case and I cannot conceive of the circumstances in which A did this without the same being noted. Further there is strong evidence suggesting the medication was always kept together. A significant consequence of such finding is that of D and A, only D is said to have been alone with E between the return of the Drugs and E going for the lumbar puncture procedure which terminated any opportunity for the drug to be administered prior to 2.10pm. As I have found above there is a strong likelihood that the medication was administered when E was alone with one of the adults. This finding would point towards D as being the culprit.
58. Is there good evidence that the morphine was administered no later than 12.10pm as per the submissions of D? If this is correct then this would point to A as being the culprit on the basis that D was not alone with E prior to this time and within the original window of opportunity (approximately 2.10am – 2.10pm). This would though require the drugs to have been either retained at the hospital or returned there prior to 2 January 2018 to allow the same to be available to be administered. D relies on evidence from MSH in support of this contention. This finding would point towards A as the culprit.
59. In reaching my conclusions I have rejected the notion of the Drugs being administered by either D or A whilst a third party was immediately present. This is most unlikely for the reasons set out in paragraph 35 above. It is particularly unlikely to have happened in the relatively short window of opportunity arising following D's arrival at hospital on 2 January 2018. Whilst times for this period are not known with exactitude it is clear that for a period of this time (being no more than 2 hours in total) the family were with a physiotherapist; for part of the time D and A left the ward and in doing so left E with C, and; for part of the time A and C left the ward<sup>45</sup>. On the evidence the time that A would have been with E, with the Drugs present, and with no individuals other than family present would have been very short indeed.
60. This is an evidential conflict which must be resolved to fairly resolve this dispute. Its determination is likely to assist in answering the fact-finding question.
61. There is compelling evidence to suggest D brought the drugs into hospital on 2 January 2018. He volunteered to the police detailed evidence confirming the same. When asked in interview about taking the drugs from home to A he replied:

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<sup>45</sup> C57 §68; C76 §27

*Yeah...only the once, on the 2<sup>nd</sup> when we went to...Great Ormond Street...I had to put them in a JD bag...had to put it in there and bring it up the hospital...what did I bring? I think I brought the three [drugs] but I'm not too sure...I brought the bottle of morphine...<sup>46</sup>*

His evidence is clear and unambiguous. It has significant detail giving a sense of an account which is essentially correct. Whilst I appreciate D has later claimed that this was a lie at the instigation of A I have not been supplied with any reasoned basis as to why the lie was told<sup>47</sup>. In police interview when asked to set out any further matters which he wished to correct D did not refer to this subject. Further it seems clear that when D raises the suggestion of this being a lie with the police<sup>48</sup> he is in fact referring to the first occasion on which the drugs were brought into hospital on the 29 December 2017 rather than in clear correction of his interview evidence. In my judgment there is a clear distinction between overstating the length of the relationship (which is itself a matter of factual dispute before me) and being coy about actions which might breach a tenancy agreement and wrongly stating that you have brought drugs into hospital when the police are investigating the care of the child whilst in the hospital. A final issue relates to the quality of D's evidence in this regard. When asked as to when he spoke to A about getting their stories straight he suggested this was around 2/3 January 2018. This simply cannot be correct as at that time there was no story to get straight.

62. There is also significant supporting evidence from C relating to the transfer of the drugs. I found C to be a credible witness. She was clear she was told contemporaneously that D had taken the drugs home on 1 January 2018 and confirmed that A had:

*...asked D specifically to bring her medication back that he had taken home...<sup>49</sup>*

She was not challenged in this regard. Further she denied the drugs were returned in her car at any point and gave significant evidence of D bringing the JD bag into hospital when he attended on 2 January 2018. Again, she was not challenged in such regard.

63. In addition, there is the consistent evidence of A in this regard as to the drugs being taken home on 1 January 2018 and returned the next day. In interview she gives this evidence naturally and without any sense that she is seeking to construct an account. There is an inherent plausibility surrounding some personal effects being taken home in the expectation of E being discharged the next day. In my judgment little turns on the argument as to whether a taxi was booked or not as the distance was comparatively short.
64. The above points are strongly persuasive in favour of the drugs being brought to hospital by D on 2 January 2018.
65. In contrast D relies upon oral testimony of MSH in which he indicated the morphine was administered between 2-3 hours prior to the sample and up to 12 hours prior to the sample. In answer to direct questioning from D he confirmed this equated to a time frame from around 12.10pm into the preceding hours. The logical consequence of this being correct is that either D did not bring the drugs back into hospital on 2 January 2018 or that A in some way managed to administer the same in a very small window of opportunity and with others present around lunch time on that day.
66. The logic of this argument rests on expert evidence and for reasons given earlier in this judgment I should pay proper respect to this fact. Of course, I am the ultimate decision maker on questions of fact but it would be unwise to disregard clear medical evidence that runs contrary to a conclusion I would otherwise favour. If the medical evidence is clear and compelling then it may well be there is an evidential aspect of the case that is unknown to me or runs contrary to my assessment above and which requires further reconsideration.
67. I have therefore considered the evidence with care. Having done so I consider it is not as persuasive as to exact timing as D would argue. In reaching this conclusion I note the following matters:

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<sup>46</sup> H81: C

<sup>47</sup> Whether in his statement; oral evidence or submissions

<sup>48</sup> H7

<sup>49</sup> C63 §4

- a. First, it was clear throughout MSH's evidence that he was providing time estimates which were not intended to be exact. His use of the 2 to 3 hours half-life reflected this point as did his erring on the side of caution by using the upper level of this band to set the window of opportunity. By this way he was able to provide confident outer bands but at no point was he able to indicate that on balance the ingestion was at an exact time or within a band comprising a very short period.
- b. Second, he was clear that there was an inverse relationship between dosage and timing. The greater the dose the earlier the time of ingestion. As such the smaller the dose the later the time of ingestion.
- c. Third, when giving his evidence as to ingestion being before 12.10pm he wished to make clear that he was not giving evidence to the minute and preferred to say around mid-day.
- d. Fourth, moving on it is clear the focus on 12.10pm and the removal of part of the initial window of opportunity (being 12.10pm – 2.10pm on 2 January 2018) is closely related to the absence of 'free morphine' in the serum sample, or more correctly below a clinical level of detection<sup>50</sup>. MSH discusses this point in detail and I quote:

*Dahlstrom et al. studied morphine kinetics in children and found that the concentration of 'free' morphine in plasma from a therapeutic dose of morphine given intravenously (IV) for analgesia at a dose of 0.15mg/kg to children within an age group from 1 – 7 years fell below 10ng/ml...in 2 to 3 hours. According to hospital records B weighed 15.9kg. A typical morphine dose, if given legitimately for pain relief and intravenously, could comprise 0.15mg/kg x 15.9kg, i.e. approximately 2.5mg. Because only about half of morphine is absorbed when given orally, a legitimate dose of morphine given orally could be around 5mg.*

*One teaspoon of either of the liquid morphine formats...which would comprise either 5mg or 10mg of the drug, would therefore constitute a significant dose to a child which is capable of producing analgesia. I am not aware of the size of syringe which may have been used in this case, but clearly that could be relevant.*

*Olkola et al. found that an IV therapeutic dose of 0.15mg/kg given to children aged 2 – 4 years the concentration of 'free' morphine fell below the 10ng/kg LOD within 1-2 hours. Therefore a significant oral dose of morphine, i.e. one capable of causing analgesia, could have fallen below a detectable amount as 'free' morphine within a few hours of ingestion. No 'free' morphine was detected in B's serum sample taken at 14.10 hours on 2<sup>nd</sup> January.*

*In this particular case, the absence of 'free' morphine in B's serum sample, together with the relatively low metabolite levels, would indicate he had not ingested a life-threatening dose of morphine prior to the serum sampling. The results would be consistent with ingestion of morphine 2-3 hours or more before this blood/serum sample was taken.*

It is this concluding point that is relied upon in timing a cut-off point of 12.10pm. this was put to MSH who agreed albeit not wishing to be held to the minute. However, on reading the above section two points arise. First, the report also relates the 'Olkola' study without distinction which evidenced a period of 1-2 hours rather than 2-3 hours. If correct this would suggest a safer cut-off point would be 1.10pm. Second, the conclusions of the reports relied upon are based on a conventional dose of morphine whereas I have absolutely no evidence as to the actual dose administered or the manner in which it was administered. Whilst the expert notes he is unaware of the details of the syringe I have no evidence a syringe was actually used. It is as plausible the dose was diluted in a drink to make it more palatable. This would plainly dilute the dose actually given if the complete drink was not taken. Given the surrounding circumstances of staff presence and the possible difficulty in getting the child to take a less pleasant drug it is likely it was camouflaged by being put in a more palatable drink. Plainly the smaller the dose the more recent the ingestion.

- e. Fifth, it is important to note that the expert after providing this analysis in his report does conclude:

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<sup>50</sup> Being 10ng per ml

*In summary, the serum result indicates morphine ingestion probably within 12 hours before 14.10 hrs on the 2<sup>nd</sup> January...<sup>51</sup> [my emphasis]*

68. Taking these points together I have reached the conclusion it would be unwise to impose a cut-off point at 12.10pm. I have explained why I consider this conclusion consistent with the global evidence of the expert.
69. It is also noteworthy that there is a factual dispute between D and A/C as to the time at which the lumbar puncture procedure was commenced. This is important as after this time the morphine could not have been administered. Whereas A and C argue it was put back to about 1.30pm, D appears to suggest it was maintained at 1.00pm. If this latter time was correct then allowing for D's written evidence of A being away for 45 minutes, this would place D in sole care of E at around 12.10pm in any event. Having heard the evidence whilst I tend to prefer the evidence of A as to timing I bear in mind the hospital records continue to record the procedure as being at 1.00pm and I am conscious that with the passage of time details such as timings may be incorrect.
70. Having reflected on the evidence I have reached the clear conclusion that the drugs were brought into hospital by D on 2 January 2018 at about 11.30am and I find the first morphine dose was likely administered between about 11.30 (when D returned to Y) and about 1.30 (when E was taking for his lumbar puncture).
71. I find the likely dose given was a modest dose of around a teaspoon and unlikely more than about the 5mg. This conclusion follows from the absence of free morphine and the low levels of metabolites found in the sample. On my reading of the expert report a significantly higher level would have led to expected levels of free morphine. My strong suspicion is that whoever administered the dose was doing so not out of a wish to harm E but rather in a foolish and poorly thought through attempt to alleviate pain in E. Such a dose could have caused serious harm as whoever administered the drug was undoubtedly not giving appropriate allowance for the other medication being prescribed to E, quite aside from lacking the qualification to properly dispense such medication.
72. I find only D (of D and A) was alone with E during this available window. The evidence is quite clear of D arriving and spending time away from the ward with A before A and C leave the ward to have a cigarette / lunch. On the evidence I heard I find this was for a period of around 45 minutes (at some point between around 12.15 – 1.25pm). In contrast there is no evidence of A being alone with E during this period and clear evidence of her being elsewhere for most of the period.
73. I have considered the evidence of CJ as to events on the 4 January 2018 when in the sole care of D, E was unusually emotional<sup>52</sup>. It is noteworthy that this point in time was within the window of possibility for the second morphine dose. In my judgment there is a real possibility that E was exhibiting distress at receiving an unpleasant small dose of morphine. No explanation has been offered by D for E's behaviour on this occasion. In my judgment taken alone this would not make out the allegation but it is a feature supporting the other evidence pointing against D.
74. I have also considered the account given by C of what E said to her about D given him medicine. I treat this evidence with real caution. The evidence was obtained without any of the safeguards required for ABE interviewing. It is reasonably clear that C asked leading questions and whilst I do not seek to criticise her it does undermine the probative value of what is reported. In my assessment it fits with my conclusions rather than shaping my conclusions.

## **Conclusions:**

75. Bringing these findings together I have reached the conclusion that on balance D was responsible for E ingesting drugs on the three occasions in question. I find A was neither responsible nor aware of this action. I am not able to determine D's motivation for so doing but record the likely dose was low and likely inconsistent with an attempt to deliberately harm E. It may be the dose was administered in an attempt to relief perceived pain. It might be it was to attempt to bring D and A closer. It may be there was some frustration felt by D at A being absent and that he wanted to take a step that might impact on

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<sup>51</sup> E81

<sup>52</sup> C40: 10

E causing A to be less willing to leave his side (and thus not leave D). Having given D, the chance to come clean (as I did A) I must be left to wonder.

76. I am conscious A has accepted a failure to protect E. I sought submissions in this regard as it was not entirely clear to me on what basis this was established. The LA no longer seeks to establish the same. I consider this is an appropriate response. Whilst the relationship between D and A had warning signs I consider the events in question were not such as to cause A to consider it was likely D would act in the manner he did (or an equivalent manner) towards E. I do not consider a reasonable parent would have identified a risk of sufficient magnitude to cause them to take steps to safeguard E.
77. I do however consider that A would benefit from undertaking a programme to help her identify aspects of controlling behaviour and the manner in which the same can arise. I consider regard should be had to a resource such as the Freedom Programme to place her in a better position for the future.
78. Having reached the conclusions I have it is clear I make no findings against A and I can find no evidential basis upon which the proceedings should continue. Subject to further submissions I would intend to dismiss the application. Whilst there may be sense for a careful transition of E home to A this must be a matter for agreement in the first instance.
79. I have not referred my findings to the relevant scott schedule as that document has a number of numbering issues. However, it should be quite clear as to which matters have been found proven. I can clarify any uncertainty at the next hearing.

His Honour Judge Willans