Case No: RG22C50065

Neutral Citation Number: [2024] EWFC 326

IN THE FAMILY COURT
SITTING AT READING

Before:

HHJ MORADIFAR
(SITTING AS A JUDGE OF THE HIGH COURT)

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In the matter of:

Re N

(Children: Fact Finding – Perplexing Presentation/Fabricated or Induced Illness)

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Mr Nick Goodwin KC and Miss Sian Cox (instructed by the Joint Legal Team) on behalf of the local authority
Miss Penny Howe KC and Miss Jayne Harrill (instructed by Heald Nickinson solicitors) on behalf of the mother
Mr Andrew Bagchi KC and Miss Fareha Choudhury (instructed by Edwards Duthie Shamash solicitors) on behalf of the father
Miss Sally Stone KC and Miss Susan Quinn (instructed by Creighton Solicitors) on behalf of the children through their guardian.

Hearing dates: 23, 24, 25, 26, 27, 30, 31 October, 01, 02, 03 November, 11, 12, 14, 15, 18, 19, 20 December 2023, 29 January, 27, 28 February, 01, 05, 08, 11, 12, 13, 14, 15, 18, 19, 20, 21, 27 March, 09, 15 April, 03 June 2024

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Judgment Approved by the court
for handing down on 11 October 2024

HHJ MORADIFAR:

Introduction

1. This complex and unusual hearing concerns the horrific life experiences of two young children. I will identify them as A and B. They are respectively nine and six years old. They were removed from the care of their parents on 27 May 2022 and after an abbreviated period in foster care, they have since lived with their paternal aunt where they are said to be thriving.
2. Threaded through the detailed tapestry of the local authority's schedule of allegations is the mother's malign influence that has led to the children suffering significant and intolerable harm. Broadly, it is alleged that the mother has caused each of the children to spend the majority of their lives in a highly abusive environment in which they have been medicalised, subjected to a multitude of unnecessary medical investigations, a significant number of unnecessary invasive medical procedures and they have spent most of their lives in hospitals or under the care of home care nurses. Examples of the mother's behaviour include covert administration of potentially lethal medication to B and withdrawing blood from her over a sustained prolonged period causing her to be the subject of further unnecessary investigations and intrusive procedures. The local authority also alleges that the children's lead Consultant Paediatrician Dr K has unintentionally permitted herself to be manipulated by the mother, has failed to observe proper professional boundaries in her relationship with the mother and has unintentionally caused delay in the detection of the true cause of the children's perplexing presentation.
3. The mother denies the allegations and states that she has done no more than be guided by the practitioners in seeking answers to the complex and worrying presentation of her children. After the parents' separation and with the emerging evidence, the father supports the local authority's allegations. Whilst the guardian has not pursued any additional findings on behalf of the children, she has very properly ensured that all of the relevant evidence has been appropriately marshalled and adduced before the court and has made submissions in respect of which of the findings as sought by the local authority she considers can properly be made.

The law

4. The parties have made detailed submissions on the applicable legal principles and each has highlighted what they say are the important aspect of the authorities which I have considered carefully. There is no dispute on the applicable law, and I do not intend to rehearse this in any detail. However, I observe that it is a simple and general principle of law that the party seeking to rely on a relevant disputed fact must prove that fact. In civil and family proceedings such facts must be proven on a balance of probabilities. The guiding principles were most helpfully summarised by Baker J (as he then was) in *Re JS* [2012] EWHC 1370 (Fam). Following this decision, Jackson J (as he then was) in *Lancashire County Council*

v C, M and F (Children: Fact finding Hearing) [2014] EWFC 3 added a further item to this invaluable list of important considerations.

5. More specifically in *Re B (Threshold Criteria; Fabricated Illness*) [2002] EWHC 20, the court provided further guidance by stating that whilst medical evidence is very important, the court is tasked with assessing all of the evidence that includes the evidence and credibility of the carers, contemporaneous notes, the inherent probability or improbability of events and circumstantial evidence that may corroborate the account of witnesses. Later in *Re T* [2004] 2 FLR 838, Dame Elizabeth Butler-Sloss P recognised the importance of considering individual pieces of evidence but warned against 'compartmentalising' the evidence in a case where the judge of the first instance was found on appeal not to have sufficiently scrutinised the evidence of the parents and explanation for one of the injuries. Furthermore, I have considered and applied the observations of the former President of the Family Division in *Re A (A child)* [2016] 1 FLR 1. I am not bound by the local authority's schedule of findings and can make such findings as are relevant and supported by evidence.
6. More recently, in *Re A, B and C (Children)* [2021] EWCA Civ 45, Lady Justice Macur has provided most helpful guidance on the treatment of lies and dishonesty. These may be summarised as follows:
    a. A 'Lucas' direction which is formulaic in nature must not be included in a judgment as a 'tick box exercise.'
    b. Such a direction is not called for in every family case.
    c. Such a self-direction may be called for if there is "*an established propensity to dishonesty as determinative of guilt … Conversely, an established propensity to honesty will not always equate with the witness's reliability of recall on a particular issue."*
    d. If such a self-direction is called for, it is good practice "*to seek Counsel's submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt."*
7. I have also been referred to and have considered the guidance as set out by the Royal College of Paediatrics and Child Health entitled *"Perplexing Presentation (PP/Fabricated or Induced Illness (GII) in Children – guidance"* (2021) which was preceded by the 2009 guidance that was further revised in 2012 and 2013, introducing the term *"perplexing presentation"* and procedures for safeguarding children together with practical advice for paediatricians.

Background

8. The parents are former publicans who met in 2011 when they worked in the same public house. They were married in 2014. Soon after, the mother fell pregnant with A who was born in the following year. Just over 2 years later B was born. Although, the family enjoyed many joyful moments over the years, it is common ground that the parents' relationship was not always a happy one. They separated in or around March 2023. By the mother's account she commenced her relationship with another man in April 2023 having met him in December 2022.

9. Both children were under the care of their local hospital (Hospital A) with Dr K as their lead Consultant Paediatrician. A was about twelve weeks old when she was taken to Hospital A for her first visit and B was five days old when she first visited Hospital A. In the ensuing years, the children had numerous and frequent admissions to Hospital A. At times, their admissions to the hospital lasted for some weeks and at other times some hours or days. The children were well known to the hospital staff.
10. The medical history and the investigation of the children is extensive and I will detail the relevant parts later in this judgment. The children were the subject of a number of medical investigations and procedures. They were referred to a number of tertiary hospitals for specialist assessments and investigations into their apparent presentations which were mostly perplexing and a root cause could not be identified. It is clear that the children spent a significant part of their lives in a clinical setting that, over time, encroached into their home environment.
11. A was admitted to the hospital on numerous occasions for investigations that included blood tests, sleep studies, x-rays and clinical examinations. In March 2016 she was inserted with a Nasal Gastric Tube (NGT) which was followed by her first referral to a tertiary service at Hospital B where an ENT Consultant saw her. The concerns raised by the mother were related to her breathing that included noisy breathing, cyanosis and holding her breath. After an elective admission to Hospital A in July 2016, A was transferred to Hospital B in August and discharged in September of the same year. The staff noted anxiety in the mother around feeding, the parents questioning if Creon should be prescribed and whether A should be referred to a tertiary Hospital (Hospital F). It was considered that A's diarrhoea was secondary to constipation and she was prescribed laxatives. A continued to be under medical care with another referral to a tertiary hospital centre (Hospital D) in August 2017 when she was seen in the gastroenterology department and then subsequently referred to a third tertiary centre (Hospital C). Following an elective admission to Hospital D, she was further investigated for cystic fibrosis and prescribed Creon. Happily, the investigation for cystic fibrosis was negative.
12. Soon after her birth, B also became a regular patient at the Hospital A with many more medical interventions and referrals to tertiary centres that followed. Like her sister, in March 2018, B was referred to Hospital B where she was attended on by an ENT Consultant who found her to present as a healthy child. M continued to raise concerns about B not crying or vocalising leading to a referral to Hospital E for further investigations. B was due to undergo an MRI scan in Hospital B in May 2018 but did not attend. Subsequently, she underwent a micro-laryngoscopy and bronchoscopy (MLB) at Hospital E that found a mild tracheomalacia. She was also seen by a Speech and Language Therapist (SALT) who referred her to the team at Hospital A. In June of the same year she too was fitted with a NGT and was prescribed Creon although her (faecal elastase) results were within the expected range. In July, the family was referred to Homestart who continued to support the family until 2020 and the Hospital A Outreach Team also began to

visit the home to provide further support for the family.

13. The general developing theme concerned issues with breathing leading to a bronchoscopy in August 2018 that found B to be suffering with severe distal tracheomalacia which was corrected by an aortopexy procedure in October of the same year. In the intervening period and continuing into the following year, there was an emerging theme of mother reporting desaturation episodes in B that were not always supported by clinical observations. The mother was discouraged from using a nebuliser or suction to clear B's airways. In November, B was discharged home with a Continuous Positive Airway Pressure Machine (CPAP) together with a care plan for using CPAP during the night and to take B to hospital if she required Oxygen.
14. At around this time, the mother is said to have described A's behaviour as challenging. There also appears to have developed an assertion that the mother was attempting to increase the use of CPAP and to use Oxygen at home, neither of which was supported by Hospital E which was the specialist centre that had provided the CPAP machine and care plan for using this. However, the mother is clear that she was acting on advice from Hospital A. In December, the mother raised concerns about B becoming desaturated whilst in her car seat. This led to further investigations in 2019 by her treating Consultant Dr J and her team at Hospital E.
15. The increasing clinical and professional involvement was a theme that continued through and beyond 2019. The year commenced with a referral to a charity that provides support for families of children with life limiting or life threatening conditions. B was admitted to Hospital E for the insertion of a Percutaneous Endoscopic Gastrostomy (PEG – feeding tube) which became infected requiring a further admission to Hospital A where her first Peripherally Inserted Central Catheter (PICC) line was inserted. The latter was intended to provide long term intravenous access. By now the local authority had been aware of the family and in February 2019 the children were placed on Child In Need plans and Ms X was allocated to be their social worker. Over the following months the relationship between the mother and the social worker became increasingly inappropriate, crossing professional boundaries to an extremely concerning level that ultimately cost the social worker her career as a social worker. I will detail some aspects of this later in this judgment.
16. B's admissions to Hospital A continued and in June 2019 the investigations included those for low blood sugar levels that may have caused her shaking episodes, breathing issues with the insertion of a further PICC lines at Hospital E and ongoing infections. By August, issues around her haemoglobin levels had re-emerged that led to her second blood transfusion and further admission to Hospital E where clinicians posed questions about a psychological cause for her breathing difficulties when no issues were identified with her feeding. A also started to receive some play therapy to assist her to cope with living with a sibling with such profound medical difficulties. In the summer, home care nurses began to provide evening care for B six nights a week.

17. Hospital E identified the causes of B's breathing episodes as 'self-gratification.' The mother disagreed with this opinion and from this point there was a clear breakdown in the relationship with Hospital E which contributed to B not attending a recommended sleep study at Hospital E. At this time Dr J and her colleagues at Hospital E were considering weaning B off CPAP. With the support of the social worker and Dr K, the mother sought a referral to another tertiary centre. The preferred tertiary centre was expressed to be the Hospital F. In December both children were admitted to Hospital A for respiratory infections. B was also seen for the first time by Dr B at the Hospital F.
18. B's low haemoglobin levels re-emerged in early 2020 that necessitated a further blood transfusion. A who had continued to be treated with Creon was reviewed at Hospital C when Dr P advised that she should be weaned off Creon. B failed to attend a planned video-fluoroscopic study at Hospital E. The rate of infections and need for treatment by antibiotic was increasing, with B at times having to attend hospital up to three times a day to receive her intravenous antibiotics, giving rise later in the year to concerns about a considerable risk of B becoming resistant to antibiotics.
19. 2020 saw a marked change in the mother's developing relationship with some of the professionals. Such were the concerns of Nurse B (nurse at Hospital A) about the mother's personal relationship with the social worker that she challenged Ms X about her objectivity and ability to raise safeguarding issues. The mother also became close to Ms C who was an administrative assistant at Hospital A. This relationship soon began to cross professional boundaries. During this period, the mother also became 'friends' with Dr K on a social media platform and was given Dr K's personal mobile telephone that she used to message her. This period was also marked by an apparent growing divide between some of the nursing staff and the treating doctors at Hospital A, with the former becoming concerned about some of the aspects of the children's presentation and the inconsistencies between their presentation at hospital and as reported by the mother.
20. For the children, the medical interventions continued. In March, A was inserted with a PICC line to assist with the delivery of intravenous antibiotics, which was subsequently removed in May of the same year. However, a further PICC line was inserted in the autumn due to ongoing infections when the test results did not note any abnormality or significant immune deficiencies. She continued on Creon despite normal test results and was referred to the Hospital F immunology team.
21. B's presentation was becoming increasingly perplexing and in the search for answers, a rare condition known as Shwachman-Diamond Syndrome (SDS) was considered. There were no physical features of this disease and genetic testing could not confirm the existence of the condition. B's haemoglobin levels began to drop once again in the summer months causing her to have further blood transfusions. However, unlike the previous single episodes of transfusion, this period saw a marked change in her haemoglobin levels necessitating frequent hospital admissions and blood transfusions. This also led to a referral to immunology.

22. B underwent a bone marrow aspirate, abdomen ultrasound, immunology investigations and physiotherapy. Notably she was given a Ferritin infusion in October and monthly GCSF in November. She was also fitted with a continuous glucose monitoring device after she was referred back to the Hospital F in October 2020. The family was due to go on holiday and the mother was trained to provide intravenous antibiotics for A, however they needed to return home as A's line had become blocked and required replacement. B continued to present frequently at Hospital A and Nurse B began to question if B was using the CPAP machine more than required. In her discussions with Hospital E, it became apparent that Hospital E had not been invited to the multi-disciplinary team meetings.
23. The children's presenting difficulties continued in 2021 with a greater focus on B's medical presentation. B continued to receive blood transfusions. Early in the year there was a notable deterioration in the relationship of the professionals who saw the mother, the social worker and Dr K, on one side and a number of the nursing team on the other who had begun to raise concerns about the children's presentation and treatment plans. The mother had begun complaining about the nurses' behaviour and asking that information should not be shared between Hospital A and the Hospital F. B had her PEG line replaced with a PEG button and later was fitted with a Hickman line.
24. Sadly, the theme of frequent admissions to the hospital continued albeit at a lesser frequency for A who was once again fitted with a PICC line leading to Dr K expressing concern in May 2021 that it was not possible to insert any more PICC lines as A's veins had become stenosed. At around this time, there was an altercation between the parents at the family home that caused the police to attend. The mother began to raise more concerns about the nursing staff and the social worker questioned why the nursing staff at Hospital A were raising more safeguarding concerns than any other professionals.
25. B continued to receive blood transfusions, although she was able to go on holiday with her family and enjoy six days without any material medical intervention. The delayed admission to the Hospital F for an MRI and BMA returned normal findings. A also underwent surgery for a adenoidectomy and appeared well in hospital. Around the same time, mother also underwent a bone biopsy and was prescribed morphine. Whilst SDS remained part of the conversation, it was agreed among the medics that B did not present with the clinical features of SDS.
26. In September, B was part of a planned admission to the Hospital F to consider the reported hypoglycaemic episodes with no abnormal findings. Within the multidisciplinary team meetings, concern was raised about the number of blood transfusions that B had undergone and the fact that she had unexpectedly maintained normal ferritin levels. It was agreed that there should be a structured two to three week admission to observe and better investigate B. At around this time there were concerns about A's PICC line which was later changed to a port-catheter. A used to become highly distressed when her Portacath was accessed and at times required to be restrained. In the autumn months the mother raised increasing concerns about the nursing staff at Hospital A. In the same period she

had a termination which was privately funded by the social worker. The year concluded with Dr B delighting in B's progress with respiratory issues and expressing a hope that she could stop using CPAP.

27. 2022 proved to be a significant milestone in the sad history of this case with the appearance of a marked division in the professional view of the children's needs and ultimately the children's removal from the care of their parents in May. Until May, the children continued to present regularly to the hospital. A had an extended period of admission. With knowledge of A's resistance to her port being accessed, Nurse B began to raise concerns about why A was admitted to the hospital at all given that she seemed well. Following an admission with fever and concerns over her port, A was inserted with a new line under general anaesthetic. Later in April she was admitted to Hospital C where her port was changed with a portacath and released to the care of Hospital A. During her stay at Hospital C and for her return home, A was prescribed Oramorph (morphine). In March, B was also admitted to the hospital with intermittent elevated temperature and erratic blood sugar readings.
28. Later in March concerns about the mother's relationship with the social worker and Dr K had also led to an investigation by the Local Authority Designated Officer (LADO). Later, it became apparent that the charity had raised these concerns which in turn may have contributed to a deterioration in the engagement with their services. At the mother's request, their dealings with the family ended in late February. In March, the parents approached a local hospice that provided support for children with life limiting conditions. Later in a meeting with N at Hospital A, the mother raised her concerns about coping with so many hospital admissions and wishing to have more care for the children at home. At around this time Nurse B was raising further concerns about the mother 'dictating' A's care. Concerns about A's emotional wellbeing continued with the mother describing her as self-harming, withdrawn and scared of becoming unwell. In April, during a telephone conversation, Nurse B together with her nursing colleagues Nurse X from Hospital A and Nurse D from Hospital C raised their collective concerns about the children's presentation and issues of Fabricated or Induced Illness and the mother playing professionals off against each other. Later these concerns extended to the mother delaying B's admission to the Hospital F.
29. B was offered an admission to the Hospital F on 26 April and subsequently on 5 May 2022. The mother was resistant to both on the grounds that the children had recently spent a lot of time in hospital. With the agreement of the parents, B was admitted to the Hospital F on 16 May 2022. During this planned admission, B underwent a number of investigations that included blood and stool samples with the latter being photographed, together with sleep and respiratory studies. Due to the elevated concerns about the mother, B remained under close observation when regular urine and blood samples were taken.
30. On 18 May 2022, the mother was informed of a plan to review B's ventilator. In the early hours of 19 May 2022, the mother alerted the staff that the CPAP machine was malfunctioning and making a 'chugging' sound. A large crack was observed

to the side of the machine. B remained under close observation and her urine samples for 18 and 19 May 2022 (received on 23 and 25 May) respectively indicated a positive result for chlorphenamine and trimethoprim, neither of which was prescribed for B. On 20 May there was a plan to assess B without Creon and Dr I discussed the findings of the sleep studies with the mother. In Dr I's view the elevated CO2 levels and low respiratory rates were not entirely consistent with symptoms of airway obstruction and inconsistent with there being no low respiratory rate in the first few nights of admission when B was using CPAP. Contrary to the professional observations, mother raised concerns about B's stools that were observed and photographed at the Hospital F.

31. Further urine test results covering 20 May to 26 May 2022 showed a positive test result for morphine on each day except 23 May 2023 and trimethoprim on 21, 23 and 24 May 2022. The test results were made available shortly after a multidisciplinary meeting at the Hospital F where Dr I raised concerns about Fabricated or Induced Illness, leading to a professional meeting at 17.30 on the same day. After informing the police, the parents were arrested later that evening. The children spent a brief time in foster care before being placed with a family member where they have each made considerable progress and have not required any notable ongoing medical intervention.

Evidence

32. There is a colossal amount of evidence that runs to a little less than ninety thousand pages of documentary evidence, which excluding the father's telephone records would equate to about two hundred and thirty lever arch files. The evidence includes a considerable collection of medical records, statements from treating clinicians, the parents' evidence including their police interviews and a collection of expert reports from nine jointly instructed experts.
33. The case was heard over thirty seven days which was split into three separate sections that allowed for the parties to continue to refine their case, leading to a number of witnesses being stood down and Dr K having a full opportunity to address the allegations that are levied against her. In addition to the considering the case papers, I heard from thirty-three witnesses some of whom spent a significant period in the witness box. The witnesses included four of the nine jointly instructed experts. I have exercised caution when considering the evidence of the treating clinicians, particularly when their observations or records of the same postdate the parents' arrest and the removal of the children. I will summarise the pertinent parts of the evidence below.

Analysis

34. The complexities of this case have demanded a tremendous effort on the part of the parties' respective legal teams and the court to ensure that the masses of evidence have been properly and fairly marshalled. I endorse the submissions of Mr Bagchi KC and Miss Choudhury who describe this hearing as more akin to an enquiry.
35. I am most grateful to Mr Goodwin KC, Miss Cox and their instructing solicitors who have carried a heavy burden in managing the significant and unusual

challenges of the case. Miss Howe KC, Miss Harrill and their instructing solicitors have each worked tirelessly on behalf of the mother to challenge the relevant evidence in a focussed and proportionate fashion whilst guiding and ensuring that the mother has been able to fully engage and participate in these proceedings. Mr Bagchi KC and Miss Choudhury have been instrumental in ensuring that this hearing remined focussed on the pertinent issues. I would like to pay a special tribute to Miss Stone KC and Miss Quinn who have with laser precision navigated the vast evidential landscape and ensured that all of the relevant evidence has been properly adduced before the court.

36. The local authority's schedule of findings against the parents is detailed by reference to the following broad headings and I will address these in the following order:

Re B

I. Covert administration of sedative drugs.
II. Blood siphoning.

Re A & B

III. Respiratory issues.
IV. Gastric symptoms.
V. 'Doctor shopping', disengaging with professionals or playing them against each other and seeking transfers between hospitals.
VI. Pursuit of medical diagnosis and unnecessary medication.
VII. Consequences for the children and the family.

Other

VIII. Miscellaneous.
IX. Findings about Dr K.

At the conclusion of this judgment I will set out my findings by reference to each child individually.

I. Covert administration of sedative drags

37. The discovery of the unprescribed medication in B during her admission to the Hospital F in May 2022 was the last in time of the most significant events that led to the children's removal from the parents' care. During her admission B's urine was regularly tested and the relevant results may be summarised as follows:
    a. 18 May 2022 - positive test for chlorphenamine,
    b. 19 May 2022 - positive test result for trimethoprim,
    c. 20 May 2022 - positive test result for morphine (two samples taken),
    d. 21 May 2022 - positive test results for morphine and trimethoprim,
    e. 22 May 2022 - positive test results for morphine,
    f. 23 May 2022 - positive test results for trimethoprim.
    g. 24 May 2022 - positive test results for morphine and trimethoprim
    h. 25 May 2022 - positive test results for morphine, and

i. 26 May 2022 - positive test result for morphine.

Other samples that were taken on 16, 17, 26, 27, 28 and 29 May 2022 did not remain intact and were not tested.

38. Mr M Scott-Ham is a Forensic Toxicologist and was the lead jointly instructed expert on the interpretation and timing of the above test results. He explained that whilst the presence of many other drugs that were detected in B's samples is explained as drugs that were prescribed to her, the presence of the above three drugs in B's samples cannot be explained. In summary he opined chlorphenamine was administered to B one or more days before 18 May 2022 but unlikely to be before 11 May 2022, trimethoprim on or close to 19 May 2022 and morphine on three occasions between 20 and 26 May 2022. He expressed his opinion to be with a high degree of certainty in respect of there being two occasions of administration of morphine and on a balance of probabilities a third during the same period. In his opinion, the high readings of morphine in the urine samples and taking account of the length of time between the 19 to 22 May, it would be *'extremely unlikely'* that there was a single administration of morphine. Furthermore, the subsequent high reading on 26 May would not have persisted from a single dose that was administered on 20 May. Taking into account the subsequent negative results, he concludes that there were three administrations of morphine during this period.
39. He further explained that morphine is a controlled drug that is prescribed mainly for acute or chronic pain that can be taken orally or intravenously. It can cause drowsiness, lack of concentration and coordination. It has several side effects that in children includes convulsions. Morphine *"is also well known to produce respiratory depression, if sufficient drug is taken, can be serious and ultimately produce death".*
40. He discounted contamination of samples as contributing to the test results for several reasons including the concentrations that were detected, the pattern of the readings, there being no evidence from the laboratory's validation process that would support any samples being contaminated and finally the test result from Demethylchlorpheniramine (Chlorphenamine metabolite). Mr Scott-Ham raised some concerns about the accreditation of the laboratory. He was clear that the process adopted was entirely appropriate for clinical purposes and the purposes of this court, describing the analysis as not being 'good' but 'not bad'. Miss Stone KC and Miss Quinn submit that there is no evidence before the court that would suggest that the process has in any way made the test results unreliable.
41. Although the mother accepted in cross examination that contamination was not an explanation for the test results, for entirely proper reasons, the point is pursued where Miss Howe KC and Miss Harrill submit that the approach to the urine test results must be cautious in circumstances where they have been identified by Mr Scott-Ham as not forensically robust. Having considered his evidence, I am entirely satisfied that the test results are sufficiently reliable to be taken into account as part of the overall evidence. Furthermore, the detailed clinical evidence does not support contamination as a contributing factor. This evidence includes the process by which the urine sample was collected, stored and sent for testing as

well as the lack of any evidence that there were any known sources of morphine on the ward at the relevant time. Furthermore, the pattern of the results in themselves is inconsistent with contamination contributing to the readings. This makes the hypothesis of contamination most unlikely.

42. After the mother was arrested, the police seized a number of items that included a grab bag that was amongst a number of personal items that were in B's room in the Hospital F. Within the grab bag the police found a purple syringe and tube. On instructions from the police, these were subsequently tested by Eurofins Forensic Services and their report dated 17 February 2023 confirms that there were traces of morphine and chlorphenamine in the syringe and morphine in the tube. At the close of evidence, the police provided a statement that attests to the continuity of the chain of custody of these items. This statement has not been challenged. There is no proper foundation for suggesting that these items were not placed in the suitcase before coming to the hospital or that any person other than the mother had placed these items in the grab bag and then in the suitcase.
43. Dr Dan Hawcutt is a Paediatric Pharmacologist who is a jointly instructed expert whose report has not been challenged. After undertaking a comprehensive study, he found there were forty-nine different medications prescribed for A and sixty-nine different medications for B. He could not identify any relevant prescriptions for morphine, trimethoprim or chlorphenamine for B. In his report he opines that the combination of morphine and trimethoprim can lead to an exaggeration in the sedative effects of the two drugs. In all material respect, his evidence does not contradict and supports the evidence of Mr Scott-Ham.
44. Dr Ward is a Consultant Paediatrician and the lead jointly instructed expert. She has undertaken a comprehensive survey of the children's medical history and written detailed reports about each of the children. She also gave oral evidence over three days and was cross-examined for a significant portion of that time. Whilst she deferred to the expertise of Mr Scott-Ham and Dr Hawcutt, she too identified the morphine as an opiate analgesic with common side effects that include small pupils, decreased responsiveness, drowsiness, fever, reduced respiratory rate and heart rate, and increased carbon dioxide retention. Among the several side effects of chlorpheniramine include drowsiness, lack of sweat production, increased heart rate, reduced consciousness and blood pressure as well as reduced respiratory rate that runs the risk of hypoxia. Finally, the side effects of trimethoprim include diarrhoea, difficulties with breathing and shortness of breath. Dr Ives is a Consultant in Paediatric Respiratory Medicine and a jointly instructed expert whose opinion lends further support to the use of sedatives as the cause of the abnormalities in the sleep studies in the Hospital F.
45. Turning to the circumstances of the May 2022 admission to the Hospital F, the evidence is clear that later in 2019 the relationship between the mother and Hospital E had begun to break down. This was finally fractured after Dr J, who was the Respiratory Consultant in charge of B's care at the Hospital E, expressed a view that the reported desaturation events with B were episodes of 'self-gratification'. With the support of Dr K, the mother sought a second opinion and

the Hospital F was mentioned as one of the alternative tertiary centres. I accept Dr J's evidence that at this point there was no transfer of care to Hospital F but merely the commissioning of a second opinion. Indeed there were discussions led by Dr J about weaning B off CPAP. It is noteworthy that the mother was suggesting that Hospital F was a suitable alternative tertiary service and was requesting a transfer of B's care to the Hospital F.

46. In May 2020 after Dr J and Dr B, a Consultant in Paediatric Respiratory Medicine, agreed to a transfer of B's care to Hospital F, they planned a video consultation to inform the family of the same. Subsequently, Dr B referred B to Dr O, a Consultant in Paediatric Gastroenterology at Hospital F, for a further consideration of SDS. Indeed B was under the care of a multidisciplinary team that was looking into a number of perplexing presentations without a unifying diagnosis. With a shared growing concern, the team agreed that B should be admitted for a planned multidisciplinary review. B was offered an admission in December which was refused by the mother on the grounds that it was too close to Christmas. This invitation was repeated again in January 2022 which was not accepted by the mother stating A was too unwell, then again in February, which was not followed up by the Hospital F, then finally there were discussions for admission in June and significantly discussions on the 5 May, the details of which have been the subject of much dispute.
47. The local authority invites the court to reject the mother's account of the events of 5 May 2022 and to find that she has been untruthful by pointing to a combination of the nursing notes that include notes of direct conversations with the mother, clinical notes of when A was first seen at Hospital A and an email from Dr K confirming that A was admitted with a high temperature and shivering whilst a multidisciplinary meeting was taking place in the afternoon of 5 May. It asserts that these contradict the mother's account that A was admitted to Hospital A in the morning of 5 May and further invites the court to find that when considered with other evidence, it illustrates a reluctance by the mother to agree to B's admission to the Hospital F for a planned study.
48. During the winter months of 2021, A spent a prolonged period in hospital and there is no doubt that she was presenting as unwell on 5 May 2022. It is entirely expected that a parent should have some anxiety or reluctance to agree to a long period of study in hospital for their child especially in the challenging circumstances that these parents found themselves. Whilst the mother was keen for B's care to be transferred to the Hospital F, the evidence when considered as a whole, illustrates a growing reluctance on her part for B's admission for a sleep study. This is a small part of the evidence that is understandable and must be assessed as part of the totality of the evidence that includes the fact of B's admission to Hospital F later in May which was agreed to by the parents. However, the mother's account of the events of the 5 May was contradictory and clearly unsustainable in the face of the clinical evidence that was corroborated by the relevant notes of that day.
49. As attested to by Dr I, following B's admission to the Hospital F, she enjoyed a

short period without any significant medical observations until she started her sleep study. On 20 May 2022, Dr I informed the mother of the initial finding of the sleep study that demonstrated low oxygen levels, high carbon dioxide readings and a low respiratory rate despite being on CPAP. These findings together with variations in the readings were perplexing and not explained by any known factors. This was particularly concerning as the addition of oxygen to CPAP seemed not to have any impact on the readings. These observations were also consistent with the previously expressed concerns of Dr B and Dr J about the perplexing presentation of B. It is not disputed that following the mother's arrest, the sleep study continued, returning normal readings. In Dr I's view, there is a corresponding connection between the timing of the administration of the sedative drugs and B's presentation that leads her to conclude that the administration of a sedative, including morphine, is the most probable explanation for the results of B's sleep study. The evidence about B's presentation during the relevant periods is not sufficiently cogent for me to place any weight upon it.

50. The mother's messages on her mobile device and her internet searches have been properly addressed in this hearing. Whilst the messages can be accurately timed, some of the searches cannot. Her messages in 2018 and 2019 concern morphine and illustrate morphine being considered and used recreationally. More notably, in her message to a friend she mentions that A has morphine and that the mother planned to be taking it at the weekend. On 4 May 2022 in two messages to a friend, she complained about toothache and was considering taking morphine which she confirmed to have taken in a subsequent message later that day. This message was accompanied by a picture of a packet of Morphine Sulphate oral solution. Her internet searches which are not marked with a date or time, include the following searches;

    "Can morphine effect breathing?
    How is Morphine detected in urine?
    How long does it take for morphine to work?
    How long does morphine take to get out system?"

    Mr Goodwin KC and Miss Cox make the salient point that although these searches cannot be accurately timed, the court can readily find that they were undertaken close to the time when morphine was administered to B during her admission to the Hospital F in May 2022 as they could not have been undertaken post arrest as the mother's telephone was confiscated and the mother was not aware of the urine testing that was being carried out. Thus, they submit that this negates any suggestion that these were undertaken innocently or curiously post arrest and after the mother became aware of the urine test results.

51. The mother took the lead in dealing with all clinical matters and the father's evidence on this issue was of little assistance due to his obvious lack of knowledge. He confirmed that the family did undertake a 'clear out' of the medical cupboard and the attic in the home before B was admitted to the Hospital F, but he was

tasked with clearing the attic and could not comment on the presence or the clearing out of morphine.

52. The mother was clear in her evidence that there was no morphine in the house or morphine that she could access after the clear out but was unable to adequately explain how she disposed of this controlled drug. She accepted that A was prescribed morphine and prior to the clear-out in May 2022, morphine was in the family home and she had access to it. A was given a fourteen day prescription upon her discharge in April 2022. She was contradicted by Dr K's evidence who denied telling her that she should discard the morphine but to give it to A when she attended hospital for her IV antibiotics. In cross examination she accepted that the prospect of accidental or deliberate contamination of the urine samples was highly unlikely and she was unable to offer any explanation as to how morphine was found in B's test results. She recognised that the 'grab bag' containing the feeding tube and the syringe had come from her home and explained that this was part of the usual collection of items that she would take to the hospital. She denied having any detailed memory of the contents of the grab bag or where it was within the cubicle but accepted the police evidence about its location when seized. She did not disassociate herself from her comments in her police interview that she was *"set up"* and was unable to explain how morphine and chlorphenamine were detected in these items and commented that it was a busy hospital with many nurses and doctors in and out of B's room.
53. The mother denied having any knowledge of the admission process that was attested to by nurse Nurse E where all feeds and medication are required to be administered by the nurses and all medication stored in a locked box which is not in the patient's room. She accepted that Piriton which is the brand name of chlorphenamine was found in B's hospital room. She stated that B was given this as she sometimes needed it for rashes associated with her intravenous treatment. However, this assertion was contradicted by the evidence about the most recent intravenous treatment that she had prior to her admission and as opined by Mr Scott-Ham, it was highly unlikely that this contributed to the test results for 18 May 2022.
54. The mother was questioned about the contents of her text messages and sought to explain the contents of her text messages as *"banter"* with friends and denied having an unhealthy relationship with medication and sedative drugs. She maintained a similar stance in respect of earlier text messages that are clinically not relevant to the 2022 urine test results. The mother was challenged about the result for trimethoprim and was clear that she had little recollection of this being prescribed or within the home. She recalled having it at home when A was a *"baby".* As Miss Stone KC and Miss Quinn point out, this is corroborated by A's medical records showing that A was prescribed trimethoprim in 2018 when she was three years old, co-trimoxazole in 2021 containing trimethoprim when she was five years old and B had a prescription for co-trimoxazole in April 2021. Neither child was prescribed any medication containing trimethoprim in the period immediately preceding 19 May 2022.

II. Blood Siphoning

55. Between 2 August 2019 and 8 March 2022, B received sixty blood transfusions. At times, the transfusions were given in clusters. Miss Stone KC and Miss Quinn have very helpfully set these out in a table that is based on B's medical records and include some of the transfusions that were not picked up by the experts in the case. The general pattern shows that there were two transfusions in 2019, nineteen in 2020 with three over two days in January and the remaining sixteen given between 29 July to 28 December. In 2021 B received six transfusions over three weeks, including three in one week. There were another thirty from 10 February to 28 December 2021. Finally she received a further two transfusions in January 2022, one in February and one in March of the same year. B was given these transfusions as she was presenting with anaemia which appears not to have resolved over the majority of the above stated period despite the ongoing treatment.
56. Dr RD Keenan is a Consultant Paediatric Haematologist and a jointly instructed expert in this case. He has provided a report and gave oral testimony in this hearing when he was extensively challenged in cross-examination. Dr Keenan's opinion is based on there being forty-eight blood transfusions in the above stated period. There is no criticism levied at Dr Keenan given the state and the volume of the medical records. The additional transfusions have further fortified his opinion. In summary, Dr Keenan was unable to identify a clinical reason for B's anaemia and the need for such an extraordinary number of blood transfusions.
57. In his opinion there are two fundamental issues with B's presentation and treatment. The first is the lack of any evidence of post-transfusion iron build up. He explained that the human body cannot actively excrete iron. The blood that is transfused into the body contains iron and with multiple transfusions, there would be a build-up of iron. B also had additional infusions for anaemia. This can only be explained by significant blood loss of which there is no evidence. There was no evidence of material occult gastrointestinal blood loss or any other blood loss. The taking of blood samples is not of sufficient volume that would explain the lack of expected volume of iron build up.
58. The second and connected issue is the significant number of blood transfusions that would be more than he would expect to see even where there has been a bone marrow failure in which event he would also expect to observe a rise in the haemoglobin levels post-transfusion which would then begin to reduce. The number and the cluster of transfusions was not something that Dr Keenan had experienced before and he found it to be highly unusual. In light of these factors, Dr Keenan concludes that the only plausible explanation for B's unexplained presentation is that for several years significant amounts of blood were withdrawn from her.
59. Whilst deferring to Dr Keenan as the specialist expert, Dr Ward also agreed with this conclusion observing that after the last transfusion on 8 March 2022 and

subsequent events, B appears to have made a full recovery which lends further support to the thesis that there are no undiagnosed medical conditions that may explain B's presentation. Blood siphoning by a parent was outside the experience of both experts with Dr Ward observing that such behaviour by a parent would be among the most serious behaviour in FII cases.

60. The opinion of the two experts is further fortified by the unchallenged views of Dr Z who was B's treating Consultant Paediatric Haematologist and is in charge of a highly regarded specialist centre, that is, in Dr Keenan's view, nationally if not internationally recognised for its expertise in complex cases. In his statement (dated 26 May 2022), Dr Z sets out the history of the referral to his team which was made by Dr K in the context of investigation for SDS. The investigations involved two bone marrow aspirates that were undertaken on 2 October 2020 and repeated on 5 August 2021. The results were consistent with anaemia with no abnormality in the bone marrow. In his statement, Dr Z addresses the issue of iron loading and for the same reasons as set out above, he concludes that:

> *"I do not believe that* [B] *has SDS. To date there is no genetic explanation for her condition. It has not been possible to explain the red cell transfusion requirements. I remain concerned that there has been unauthorised withdrawal from the central venous line."*

61. Concerns were also noted by others in the treating team. Ms G is a specialist pharmacist at Hospital A and in her unchallenged statement (dated 16 September 2022) she confirms that she has been involved with the children for the preceding three years and sets out the details of her involvement. In this regard she observes:

> *"It was also odd that [B] always had low haemoglobin as she was not physically losing blood as far as I was aware, but this could have* [been] *due to poor absorption. I was asked monthly for intravenous iron to top up her haemoglobin. I remember thinking why were we giving her all this iron when there was no evidence that she was losing blood. I felt uneasy but the medication was safe to give her and appropriate."*

62. This was also the subject of further comment by the nursing staff. Nurse V (community nurse) observed that B's blood counts would fall very quickly contrary to what she had observed in other children. Nurse R (Hospital A nurse) described *"a very tense few months"* when nurses were required to attend on B in pairs when taking bloods to ensure that the procedure was accurately recorded. She also described how the mother added to the existing tension by noting the names of all nurses that were accessing B's central line.

63. On 7 July 2022, B underwent an ABE interview by the police, the transcript of which is within the court bundle. During the interview B was invited to draw the lines going into her, which is accepted to refer to the central line. After being distracted for a short period, she explained that the line was used to *"... put some blood in it, nurses done that, and then, they take sugars out. That what it's been there".* When asked who takes the blood out of the line, B responded "*My mummy and the nurses".* Considering the interview as whole, it is clear to me that B is speaking from her lived experience that must be considered in the light of her age

and most unusual life events. Furthermore, the important exchanges detailed above illustrate that when giving a free narrative, B only mentions blood being put in the line. The notion of blood being taken out of the line was introduced into the question by the Detective Constable who was conducting the interview. Whilst in my judgment this is not catastrophic to the veracity of B's account, it requires a high degree of caution in the treatment of this statement and if any weight is to be given to it.

64. In her evidence, the mother clearly recognised and understood the views of the experts and maintained her denial of having any involvement with withdrawing blood from B or knowing how to do so. She was also cross examined on the content of her internet searches that were discovered on her mobile phone. These include the following search terms:

    "can a bone marrow aspirate show blood loss", and

    "can losing a lot of blood cause kidney problems"

    She was unable to explain when and why she searched these terms and denied having any knowledge of B having any difficulties with her kidneys. As Miss Stone KC and Miss Quinn submit, on 2 February 2021 the mother signed a consent form for an MRI investigation of B's kidneys that discovered a pole cyst which the mother also searched for in the terms *"what is a pole cyst".* The mother also denied knowing how to withdraw blood from the central line and to flush it with saline. Her important evidence must be assessed in the context of other evidence that was put to her in cross examination including her being trained to administer intravenous antibiotics to A, observing many professionals including Nurse B undertaking the task, having the tools such as syringes and saline in the home and the process being a relatively easy process as described by Dr Keenan. M also denied that her distress as noted by Dr Q in response to a very low blood count reading in March 2021, was in any way connected to her siphoning blood from B and 'going too far' so as to cause such a low reading. The mother also stated that B's account in her police interview may be connected with the mother undertaking finger-prick blood samples, which must be considered in the context in which B was giving her account.

III. Respiratory issues

65. Respiratory concerns have been a significant feature of both children's lives and a common theme within the household for several years. The essence of the local authority's allegations is that the mother has fabricated or exaggerated respiratory issues in the children that have led to each child receiving unnecessary medical intervention over a protracted period. The details of the allegations are different in respect of each child and the medical concerns and interventions with B were far more pronounced. Therefore I will address the evidence in respect of each child separately and will first consider the evidence relating to A before considering those relating to B.

i. Re A respiratory issues

66. As I have noted earlier, A was about twelve weeks old when she first visited Hospital A. The reported concerns by the mother date back to the early periods in A's life and continued throughout the majority of her life. Her first admission in this regard was in January 2016 after reports by the mother that A was floppy and suffering with stridor. This caused her to undergo a sleep EEG with results in the normal range without any identified issues. She underwent a home sleep study in February of the same year with very worrying results including thirty-four episodes of desaturation which was contrary to the subsequent observations on the ward at Hospital A where no abnormalities were observed. A was under the care of a tertiary specialist team (Hospital B) where she underwent further sleep studies in April and May 2016 in which no abnormalities were identified.
67. A was also referred to another tertiary centre where she was under the care of Dr V. He too observed no abnormalities that would explain the reported concerns about A's breathing and episodes of desaturation. There are a number of examples over a significant period where the mother's reported concerns about A's breathing are contradicted by the professional observations. Dr V discontinued the use of Clenil (inhaler) earlier in 2017. However, three months later, based on the mother's report of breathing difficulties, Dr K prescribed its use again. The theme of inconsistency between the maternal report of breathing difficulties and clinical observations continued in 2018 and 2019, with evidence suggesting that the mother was not accurately reporting A's symptoms or the clinical observations from one clinician to another. A's CT scan in June 2018 showed no evidence of abnormalities despite the mother reporting to Dr K that there was evidence of scarring. For example, in December 2019, the mother is recorded as reporting to Dr K that A had required six out of hours consultations with the relevant records showing three consultations and in the subsequent clinical observation of A describing her as normal. In March 2019, the mother wrongly reported to A's health visitor that A's salbutamol dosage had been increased by Dr V.
68. In April 2021, A was on antibiotics and was taken to Hospital A where she was discharged home. The following day the mother contacted Ms D (nurse) at the Hospital C who recorded her stating that A was not improving on antibiotics leading to Dr V advising to take A to Hospital A. She did not mention to Nurse D that A had already been to Hospital A the previous day and discharged home. Therefore, the disconnect between the mother's description of A's symptoms, the profound differences in the results of the home sleep studies and those undertaken in a clinical setting, the lack of any underlying medical condition and the mother's inaccurate sharing of information, inform the core of the local authority's allegations against the mother.
69. The local authority also submits that the mother has sought to manipulate the outcome of the sleep studies. Examples include a study in January 2016 where the mother described A as having a 'big breathing episode' which was not corroborated by any other evidence and contradicted by the normal test results.

Similarly in February of the same year mother is recorded as reporting to different professionals very concerning results from a home sleep study that were contradicted by a sleep study in Hospital A with results within the normal range. Furthermore, during the sleep studies in April and May 2016, the mother reported that A had not slept well, which was contradicted by the outcome of the two sleep studies. The home sleep studies in November 2021 and the clinical sleep study of March 2022 at Hospital A have each returned very concerning results. Mr F who is an ENT Consultant (EPH) observed that the results of the home in November 2021 were *"quite dramatic".* In his evidence, Dr V observed that A had very unusual results in these two sleep studies that could not be explained by any underlying medical condition, any infection or cold. In the period between the two studies, A underwent a tonsillectomy. Given the reported respiratory difficulties, Dr V expected A to have very large tonsils to the extent that they would be touching so as to obstruct the airway. However, this was not the case.

70. The evidence is clear that based on the mother's reported concerns about A's respiratory issues, she was advised to attend a physiotherapy appointment in February 2022 which she failed to attend. Nurse D who is a respiratory nurse (Hospital C) was clear in her evidence that she has spoken to the mother who agreed to attend the urgent appointment. She was surprised that the mother failed to attend as the mother wanted A to be reviewed. Her account is corroborated by the notes that were made at the time and contradict the mother's evidence that she had an expectation to receive a formal confirmation from the physiotherapy department.

ii. **Re B respiratory issues**

71. The general thread of allegations and concerns about the mother's conduct in respect of B follows a similar theme as those concerning A. However, the degree of professional involvement with B has been far greater and the observations about the mother's conduct and B's presentation are more sophisticated. These extend to the use of CPAP and an allegation that in May 2022 the mother damaged the CPAP machine.
72. Within five days of her birth, B was taken to Hospital A where she became a regular patient over the following years. Parental concerns about her respiratory function were raised at an early stage. At less than two months old, the mother was reporting concerns about 'grunting', breathing and oxygen saturation. Following a referral from Dr K to a specialist tertiary centre (Hospital E), B, at ten months old, had her first appointment with Dr J who is a Paediatric Respiratory Consultant.
73. Dr J explained in her evidence that B presented as normal on examination, but with concerns around possible swallow incoordination and malacic airway she recommended an investigated for Cystic Fibrosis. By the time of her first meeting with Dr J, B was already on naso-gastric feeds with the mother reporting that she was choking at night and at times requiring to 'back slap' her. With concern about

her ongoing malacia and its long-term effect, pending the outcome of the investigations for cystic fibrosis, B underwent an aortopexy procedure to address the tracheobronchomalacia following which Dr J recommended that B should use CPAP. The use of the CPAP was then guided by a plan that was to be implemented by the parents. CPAP was initiated in November 2018 and although it was not intended to be a long-term part of her treatment, it remained a dominant feature of B's life until 2022. During this period, there emerged a theme of a perplexing presentation by B which could not be medically explained and a divergence between the mother's reports about her presentation and the clinical observations.

74. Dr Ives (Consultant in Paediatric Respiratory Medicine and a jointly instructed expert in these proceedings) has reported on both children. In his report he summarises the relevant respiratory issues for each of the children and makes the connection with the concerns about Cystic Fibrosis that was discounted as a diagnosis through appropriate testing. Whilst recognising that he is not an expert in paediatric gastro-enterology, he identified the connection between Cystic Fibrosis and pancreatic insufficiency, before observing that even with a positive diagnosis, it would be uncommon to start the child on pancreatic enzyme replacement therapy that was provided as part of the treatment plans in this case despite multiple samples with normal faecal elastase. He agreed with the opinion of the treating respiratory team which could not identify any underlying medical cause for the children's presentation. Although not an expert in SDS, he could not identify any evidence that either child suffered with SDS which has a recognised association with respiratory tract infection.
75. In respect of B, Dr Ives noted that at an early stage she had a *"severe airway Malacia"* that improved in time. He identified that children with Malacia may have an increased propensity to contracting respiratory tract infections but that does not indicate that her Malacia had not resolved within the expected time frame. Both Dr Ives and Dr Ward commented that they would generally expect significant improvement and resolution of the airway Malacia by the time a child is about two years old. Dr J also expected a similar trajectory for recovery. Dr J observed that following the aortopexy, B was progressing well.
76. Furthermore, there was no evidence of any airway obstruction which when considered with the other mentioned factors raises questions about the necessity of the continued use of CPAP by B that Dr Ives found to be *"unusual"*. He also observed that both children's respiratory presentation was perplexing, given the range of enquires that included enquiries into SDS and Cystic Fibrosis, together with procedures and the improvement in presentation when the care of the children was under supervision, which led him to conclude that the most likely explanation for the children's perplexing presentation is *"fabrication, exaggeration and/or manipulation"* of the children's symptoms. This view is supported by Dr Ward. He also opined that the unusual results in the sleep studies undertaken on 19 and 20 May 2022 were consistent with administration of sedatives to B.
77. Dr Ives was quick to recognise the limitations in commenting on still images from the June 2018 and August 2019 bronchoscopies, as supplemented by the August

2019 thorax CT scan. However, he was confident that the combination of these still images illustrated a narrowing of the trachea in 2018 with mild abnormality and most of the airway tree being patent together with normal vascularity that negated Malacia compression. The 2019 images showed a 'classically normal' trachea. Finally, he agreed that the 2022 sleep studies demonstrated that any Malacia was not having any notable impact on her gas exchange or breathing. These factors did not support the continuing use of CPAP. The evidence is clear that there was no underlying medical condition that would explain B's continued respiratory prestation and use of CPAP.

78. Whilst the intermittent use of CPAP was recognised to be appropriate by the treating medics such as Dr B and Dr J, its use was the subject of a plan that became a focus for the mother and subsequently Hospital A. The continuing issues about the use of CPAP is connected with the broader theme of the mother's account of B's symptoms not matching the clinical presentation. Dr J stated that clinically, B was progressing well but there was a disconnect between the reported episodes of tachypnoea, noisy breathing and desaturation. She found B to be well when she saw her. Such were her concerns that she suggested that B be admitted to Hospital A under the care of a multidisciplinary team to undertake a comprehensive investigation. In a telephone conversation with Dr B (Hospital F) in January 2020, for the first time she raised the possibility that there may be an element of *"secondary gain by parents"*.
79. Mr Goodwin KC and Miss Cox properly refer to a number of examples that illustrate a lack of correlation between the symptoms that are reported by the mother and those that are observed by professionals. These range from November 2017 to May 2022. It is unnecessary for me to set these out in detail but record that in the main they are supported by reliable clinical evidence. These examples include unremarkable findings in the November 2017 sleep study despite the mother reporting a 'drop in her stats and grunting', in March 2018 mother reported that B had almost no cry but on examination she was found to be healthy with a good strong cry, in October 2019 professionals did not observe any of the mother's reported difficulties with respiratory secretion and multiple sleep studies that found B to be within the expected range contrary to the mother's reports of B's presentation.
80. Miss Howe KC and Miss Harrill raise concern about the lack of evidence in respect of the allegation that in September 2018 the mother reported that B slept for no more than one hour contrary to the professional observation that she slept for seven hours. I agree that the evidence is far from clear about the frequency and degree of observations during this stated period. Similarly, they submit that whilst the mother negotiated the terms of discharging B home for a period on 8 November 2020, Dr J did not have sufficient concern about this so as to require the mother to sign 'discharge against medical advice form' and he further noted the mother would be cooperative and she returned B to the hospital at 21.50 where she stayed overnight.
81. Mr Goodwin KC and Miss Cox continue by submitting that other examples

illustrate that the mother was aware that B did not need medical intervention. The examples include mother reporting longer desaturation episodes at Hospital E in September 2018 when the staff observed self-resolving fleeting episodes where the mother did not call for assistance despite her assertion in evidence that she would have done so had the episodes lasted for three or more minutes. Furthermore, B's CPAP plan required her to attend hospital if she required oxygen. The mother was dissatisfied with this and sought to manage this at home. At the same time in September 2019 the mother did not call for an ambulance despite reporting that B had desaturated to about 60%, had stopped breathing and was cyanotic. In this regard, Dr Ward makes a general observation that the mother initiated an interaction with the hospital that pushed for more care to be undertaken at home and yet undermined what was being done at home which was in her opinion an emergent pattern.

82. In May 2020 Dr K noted that the mother had reported that B had stopped breathing and went purple whilst off CPAP. She did not take B to the hospital. This was in contradiction to the mother's evidence that she would have called an ambulance if there was a serious incident. In November of the same year mother allowed B to sleep without her CPAP or an oxygen monitor. Thus the local authority submits that the mother must have been aware that B did not require the degree and levels of medical intervention that she has been exposed to.
83. Returning to the issue of the care plan around the use of the CPAP, the care plan from the Hospital E under the supervision of Dr J provided for the use of CPAP overnight and for more limited periods during the day if B was unwell. Importantly, it also provided for oxygen to be administered at the local hospital should she require it. There is no dispute that the terms of the care plan were breached. Indeed Hospital A from time to time authorised and facilitated the use of Oxygen at home. The evidence is also clear that on many occasions the mother requested for oxygen to be administered at home. As she explained in her evidence, the children spent a lot of time in the hospital environment and she wished to reduce traveling to and from the hospital. This is entirely understandable given the experiences of the family but must be balanced against the strict advice from the respiratory team at the Hospital E. This must further be considered against a background of emerging divergence of opinion between the medics at Hospital A and those at Hospital E especially in respect of the diagnosis of self-gratification by Hospital E. In what was at best a confusing picture for the parents, the evidence does not reach the required degree of cogency so as to justify the findings as sought and the local authority did not pursue its findings in that respect in closing.
84. Although she has little recollection of the events, the mother does not dispute that on 18 May 2022 after a study at the Hospital F, she told the staff that she was glad that B's low saturation and high Carbon Dioxide reading were observed and that on 20 May 2022 she stated she was 'pleased' that B had 'performed' for the sleep study and the next day she stated that it was good for Hospital F to have seen a 'tough night on CPAP'. However, it is submitted on behalf of the mother that these

were taken out of context and not connected with any illness that is alleged to be induced by the mother. In my judgment, it is important that these comments are considered within the totality of the evidence that is before the court and not in isolation.

85. Whilst I take into account that B has for many years suffered with recurrent respiratory infections that required medical intervention, the evidence is overwhelmingly clear that both children's medical issues resolved once they were removed from the care of the parents. In B's case, there is some continuing breathlessness that may be connected with asthma, but there is no evidence of any sleep disorder or a need for CPAP. There are no continuing respiratory issues with A, who underwent further sleep studies in May 2022 with normal results. The resolution of the children's conditions on removal is one of the important pillars upon which the local authority's allegations of fabrication and induced illness in the children rest.
86. The use of CPAP and adherence to the Hospital E CPAP plan appear as a separate pleaded set of allegations against the mother. CPAP provides a positive flow of air which can be set to different pressures, with a setting at ten or above being used in the most extreme cases. In this instance the settings were prescribed and set by the Hospital E and required the clinician's permission to be changed. In this context the local authority asserts that the mother did not adhere to the plan and had B on CPAP for longer than was required, necessary or prescribed by the plan. Furthermore, she initiated changes in the settings that ultimately increased the pressure beyond that which was prescribed and did not engage with the assessments to reduce her use of CPAP.
87. It is correctly submitted on behalf of the mother and the children that the CPAP home plan or prescription was not a static document and evolved over the years that it was used. The first prescription was for use during sleep which then extended to use up to four hours during the day if unwell or tired, and finally its use in a push chair and in the car when travelling. Whilst there is a general perception and assertion of 'over use' of the CPAP by the nursing staff, in my judgment such an assertion does not withstand a closer scrutiny of the evolving CPAP plan and the contemporaneous evidence which collectively or individually do not reach the requisite degree of certainty to make such a finding. Furthermore, as I have already observed, there can be little doubt that the mother was requesting the administration of oxygen at home or otherwise outside the CPAP plan, but the evidence in this regards paints a confusing picture that the parents were presented with and does not reach the requisite evidential threshold for the court to make the findings that are sought.
88. The remaining allegations in this regard are in my judgment based on reliable and cogent evidence that would support the findings that are sought. Whilst I have carefully considered the evidence in respect of each example/allegation, it is the collective picture that these speak to and inform the findings about the overall parental behaviour. The evidence is clear that the use of CPAP was prescribed by Dr J and was the subject of continuing reviews that were in turn informed by

clinical findings and the parental report of B's presentation and use of CPAP. At times the mother's reports were inaccurate and this is illustrated in her exchanges with Nurse B in November 2018 when she was wrongly informed that Hospital E had advised to increase B's CPAP settings from six to seven. The evidence is also clear that in the context of a disagreement that was supported by Dr K, with Hospital E about a diagnosis of self-gratification, the mother's relationship with Hospital E became increasingly fractured leading to a referral to the Hospital F for a second opinion. In my assessment of the mother's evidence, she became increasingly invested in the Hospital F referral propelling her to advocating for the Hospital F to take charge of B's care. In this context, she disengaged with the services at Hospital E at a crucial time when Hospital E wanted to explore the possibility of weaning B off CPAP. The mother's conduct in relation to the use of CPAP was clearly worrying Dr J to an extent that she raised safeguarding concerns in January 2020.

89. B's care was transferred to the Hospital F and the mother engaged well with the Hospital F. However, the evidence is also clear that the mother requested that a planned study in October 2020 should be deferred. The clinicians deferred the sleep study to November 2020. The evidence is also clear that B was taken for a scan and despite being told that this was not necessary, returned to the ward with B on CPAP. The expert evidence that I have set out earlier in this part and those of the clinicians, clearly supports a finding that B did not require CPAP to the extent that it was used between 2019 and 2020.
90. The final issue relating to the use of the CPAP ventilator concerns an allegation that on or before 19 May 2020 the mother deliberately damaged B's CPAP ventilator. This is not an event that was witnessed by any other person and the mother denies this allegation. She confirmed in her evidence, there were no previous relevant malfunctions or noises from the machine prior to her reporting a *"chugging sound"* to Nurse F who also observed a crack to the machine in the early hours of 19 May 2022. The local authority makes this allegation against the background of the mother's asserted general behaviour and her conversations with Dr I prior to the ventilator malfunctioning in which she was informed that the ventilator would be reviewed the following day and that Dr I wished to assess B off CPAP.
91. There is no dispute as to the existence of a crack to the casing of the ventilator and that the machine was making a chugging sound. The evidence in respect of the latter makes clear that it first appeared at some time between 11.40 pm and 12.30 am during the evening of 18 and morning of 19 May 2022. As agreed by the mother, there had been no previous chugging sounds during the time that B had used the CPAP ventilator and no other relevant functionality issues at the point of her admission to the Hospital F on 16 May 2022.
92. The evidence of the damage to the casing is less clear. The father agreed with the mother's version that some time, perhaps several months prior to admission to May 2022, the machine was dropped in the car park at Hospital A by one of the night nurses which caused a small crack to the casing which was in the same

vicinity as that which is seen in the photographs of the ventilator. However, he was clear that the crack was very small describing it as a 'hairline crack'. He was also clear that the crack in the photographs is much bigger and that he had not seen that prior to admission to the Hospital F.

93. The mother's evidence in this regard was inconsistent, with her giving some detail of the incident in the car park at Hospital A in her first police interview and failing to mention it at all in her second interview that took place some months later in March 2023 when she referred to the ventilator *"falling off the side"* when B was previously using it at home. In the same interview she described the crack as small and not one that was noticeable by others which lends support to the father's assertion that it was a small crack. Furthermore, she appears to have given an untruthful account about her contact with the Hospital F in 2021.
94. It is therefore clear that there was a previous smaller crack with no evidence of it having any correlation to the functionality of the machine. It is also consistent with Nurse Y's evidence that it is not uncommon that these machines suffer some damage during the term of their use. This also fits in with why the mother did not raise this as an issue previously or indeed at the time of B's admission to the Hospital F in May 2022.
95. I found Dr I, Nurse Y and Nurse E to be reliable witnesses who were careful to give accurate factual evidence in this regard. I do not accept the suggestion that the nursing entry about the observations of the crack that was made retrospectively, has any material bearing on the reliability of their evidence. The downloaded information from the machine may suggest that the malfunction was occurring at some point prior to the mother's conversation with Dr I. Unfortunately there does not appear to be any reliable independent evidence to verify the accuracy of this by reference to the correct settings and as Dr I stated in her evidence, her conversation with the mother may have been some hours before the issues with the machine were first identified.
96. The cubicle in which B was staying had a glass window and was close to the nursing station. It had a door and a separate ensuite bathroom which also separated by its own door. Given the issues in the case, B was under close observation. Therefore the opportunities for the mother to damage the machine without detection, were more limited, but in my judgment not entirely curtailed. I will consider the mother's motivations as part of the overall consideration of the evidence later in this judgment.

IV. Falsified and exaggerated gastric symptoms

97. This heading is broad and includes allegations concerning both children. It includes pancreatic and intestinal issues as well as feeding concerns. These were first apparent in A and then B. I will first consider the allegations concerning A before considering B.

i. Re A – gastric and feeding concerns

98. The allegations concerning A fall into two main categories, gastro-intestinal concerns and feeding issues with both leading to unnecessary treatment. Turning to the first issue, Dr Ward explains in her report that the issues of pancreatic insufficiency arose in the context of faltering growth, suspicion of Cystic Fibrosis in light of the respiratory issues and loose stools at around the time when B was suspected to have SDS which is also associated with pancreatic insufficiency. She further explains that the umbrella diagnosis of Exocrine Pancreatic Insufficiency can be caused by different conditions that include Cystic Fibrosis and SDS. There is no evidence that would support a diagnosis of either of these conditions. Whatever the diagnosis, the symptoms often include loose stools, fatty stools and poor growth. In the instant case the faecal elastase tests were normal indicating no significant Exocrine Pancreatic Insufficiency. However, if a child is found to be suffering with such a condition, the treatment would include PERT prescribed as Creon. Dr Ward opines that there is no evidence of any underlying medical condition to justify the continued use of Creon.
99. The mother accepts and it is submitted on her behalf that she believed that Creon was making a *"real difference to* [A's] *stools".* Further, she accepts that she is likely to have acted against Dr S's advice by stopping A's laxative treatment. Dr S is a Consultant Paediatric Gastroenterologist (Hospital B). In evidence he was very clear that A's faecal elastase test was within the expected normal range and she did not suffer with pancreatic insufficiency. He was also clear that in his opinion, which was made consistently clear to family in writing and verbally since September 2016, that A's diarrhoea was secondary to constipation and 'overflow' which required treatment with laxatives. He stopped A's prescription for Creon during her admission to Hospital B in 2016 three days after Dr Z had prescribed it in Dr S's absence. In his opinion there could be no correlation between the intake of Creon and A's reported improvements, given that she did not require Creon. He raised his concerns about Dr K's decision to prescribe Creon to A after it had been stopped, observing that he did not wish for A to *"become medicalised".*
100. The mother states that she was mistaken in telling Dr P in August 2017 that A had improved on a two week trial on Creon in the previous year. The trial was in fact for three days and Dr K felt that A should have a longer period on Creon which led to a further prescription for Creon. Dr S's evidence as set out in his statement and oral testimony was clear and insightful leaving no doubt that his advice to the family about the causes and treatment of A's digestive issues was clear and the mother chose to ignore this. It is also clear to me that the mother was giving professionals including Dr K inaccurate information that led to unnecessary prescriptions of Creon. The evidence from A, father and nurse Parsons also demonstrated that A was not given Creon consistently when it was prescribed, thus raising the concern that the mother was aware that she did not require it. For reasons that are set out by Miss Howe KC and Miss Harrill and submissions on behalf of the children, I have approached the evidence of each of them cautiously. However, the main thrust of their collective evidence provides additional texture

to the overall evidential landscape. It is not disputed that once A was removed from the parents' care, all issues with diarrhoea ceased.

101. The second main issue concerns A's feeding issues where the local authority alleges that the mother has reported A to suffer with feeding difficulties and has given fabricated accounts of her vomiting that have led to her taking feeds through a nasogastric tube and the mother being reluctant to agree to its removal. At twelve weeks old, A presented to Hospital A at 2300 hours on 30 September 2015. The main complaint was about her breathing and also included reference to poor feeding, lack of weight gain and projectile vomiting. On assessment, she appears to be within normal expected range of presentation. By 5 September 2016 clinicians at Hospital B observed the mother to be feeding her appropriately and A displaying great interest in her food. The evidence is also clear that the mother displayed great anxiety around feeding issues.

102. The main evidence about the allegation that the mother has fabricated A's vomiting episodes comes from the nursing team that includes Nurse R, Nurse P, Nurse B and Nurse X. It is submitted on behalf of the mother that their evidence must be weighed cautiously as their evidence in this regard is in the context of a 'high index of suspicion' generated by the police investigation and not entirely reflected in the medical records. These four nurses were among the very first practitioners to raise concerns about the children's perplexing presentation. I have no doubt that the police investigation and the subsequent emerging evidence has added weight to their long-standing concerns. I found them each to be professional and balanced in their evidence. It was also clear that they each displayed a degree of frustration and regret that appropriate intervention for these did not come sooner.

103. Nurse R accepted that she had not asked the mother to retain the vomit for weighing but was also clear that no vomit was observed by the clinicians despite the mother reporting several episodes of A vomiting. She also described the mother as controlling and exerting influence on clinical decisions. A was suffering with sepsis and was inserted an NG tube whilst at the Hospital C in the winter of 2022. She was then discharged to Hospital A. Nurse B also stated that the mother had inaccurately told the Hospital A team that Hospital C advised that the NG tube was to remain in, which was clearly incorrect. The mother denies these allegations and states that all decisions were made pursuant to clinical observations and by lead clinicians. She accepts that all feeding issues in A were stopped once she was removed from her care but denies that she has ever raised any significant feeding issues other than in her infancy.

ii. Re B Gastric issues and unsafe swallow

104. The allegations relating to B fall into the above two main categories. The former follows a broadly similar path to those in relation to A. It is alleged that B was prescribed Creon with an increased dosage due to the mother's false and or exaggerated account of B's diarrhoea. The local authority further alleges that the

mother has tampered with B's stool samples so as to give them an oily appearance that would be consistent with the need for continued use of Creon. The mother denies that allegation but accepts that once Creon was stopped in May 2022, B's stool had a normal appearance and her diarrhoea resolved once she was in foster care. She further accepts that there was no objective evidence B suffered with Exocrine Pancreatic Insufficiency. She states that she genuinely believed that B was deriving benefit from Creon.

105. With the exception of one recorded example of independently observed diarrhoea, the significant majority of the reported accounts are by the mother. Dr K was clear that but for very few examples of observed diarrhoea, the hospital was reliant on the mother's account of the same. In her view there was objective evidence of B suffering with pancreatic insufficiency. Similarly, her decision to prescribe Creon for B was informed by the mother's report of B's symptoms. However, Dr Ward observed that the continued use of Creon was out of habit and B appeared to be improving on Creon. Clearly this is a view that would have supported the mother in her belief that B was benefiting from taking Creon.

106. L who is an immunologist at Hospital F, confirmed that on 23 March 2022 mother showed her a photograph of what she (the mother) asserted to be an 'oily stool'. Dr. I observed that the photograph was not representative of what she would consider to be an 'oily stool' which appeared darker in colour and had oil drops on top. She opined that it was likely that the sample had been tampered with.

107. The clinical notes of 22 May 2022 include a shift evaluation which observes *"stools all as inputted on media. Grade 4-5. More yellow in colour. Visible signs of oil"*, thus suggesting that here was at least one observation of a possible oily stool, although it is not clear if the description is referring to oil or an oily stool.

108. It is further alleged that as noted by Nurse E's note that on 25 May 2022 the mother showed a photograph of a loose oily stool to the endocrine dietitian at Hospital F. The representation by the mother was contrary to the observations of the nurses who were collecting and photographing B's stools. The mother is also noted on the same day as telling Nurse G that after stopping Creon, B was having oily stools and refusing to eat.

109. The mother's internet searches reveal that on 22 May 2022 she conducted a search for "*pancreatitis oily stool*" and on 22 May 2022 for *"pancreatitis oily stool x 2".* The local authority also relies on a number of undated searches that include the following terms:

"fat malabsorption stool pictures

fatty stool picture

orange oil in stool

Loose greasy stools

what does orange oil i. stools mean

cystic fibrosis oily stools
fat soluible stool test
cystic fibrosis ouly stools

cystic fibrosis oily stools pictures
stool chart nhs
cystic fibrosis oily stools pic"

110. In evidence the mother confirmed that she has had longstanding issues with her weight and that she had tried various remedies to deal with this. This included the use of laxatives for many years and more recently Orlistat or Saxenda which is a drug that reduces or prevents fat absorption through the digestive tract and assists with weight loss and the production of oily stools. The mother also told the police that the pen found in the fridge in cubical 12 was a weight loss pen belonging to her and in her police interview she stated that other items found in the cubical were weight loss products. In evidence the mother was unable to explain why she searched for the following terms:

"Orlstat shows up in stools sample
Fecal elastase test how if on orlistat/orlistat
How long oralstait dtay in system"

Thus the local authority submits that the mother was contemplating giving this weight loss drug to B so as to induce the production of oily stools.

111. The mother strongly denies these allegations and Miss Howe KC and Miss Harrill argue that it is unfair that the local authority is now pursuing this latter finding without it previously featuring in the local authority's case, notwithstanding that the local authority had previously stated that it would explore the implications of the telephone downloads. In my judgment, this is part of the much broader evidential canvas and the mother has had proper opportunity to respond to this allegation in cross examination and in her closing submissions.

112. The local authority's final allegations under this heading concern the mother's alleged false reporting that B had an unsafe swallow and she subsequently avoided B undergoing a video fluoroscopic swallow study. The mother denies the allegations but accepts that when removed to foster care, B did not display any evidence of having an unsafe swallow.

113. The issues concerning B's swallow date back to 2018 when she was about six months old. At that time the mother repeated as being anxious around choking and weaning. She was admitted to Hospital E on 28 August 2018 for a planned procedure which required her to be nil by mouth. She was also attended to by the Speech And Language Therapy service who *"observed an unsafe swallow when tired".* Whether this was the correct use of the term, it appears to have travelled with B and led to other investigations. Thus, Miss Howe KC and Miss Harrill

submit that the mother cannot be criticised in circumstances where this term was introduced by a professional and subsequently created a degree of confusion around B's diagnosis of an unsafe swallow.

114. The connection between the risk of aspiration and eating was made in the context of her respiratory issues and dysphagia. It is also clear that any concerns about her swallow were fast resolving. The mother in her oral testimony confirmed that the issues were confined to when B was a baby, but then stated that there were continuing issues with liquid intake when in cross examination she was taken to Nurse BD evidence that contradicted her earlier assertion. Nurse BD was a home nurse who started working with the family in September 2019 and in her statement she explains that she understood B to have a multiple diagnosis including that ranged from speech delay, mild autism and respiratory issues. She also had a PEG (line) which she used to give her water when unwell, but otherwise she ate well.

115. I entirely accept that the mother cannot be held responsible for professional observations of an unsafe swallow in 2018, however the evidence is also clear that despite the apparent improvement in B, the mother had maintained a narrative that B was suffering with a degree of an unsafe swallow or was at the risk of aspiration. This makes it all the more surprising that B was not taken to the planned video fluoroscopies that would have addressed this issue. As Miss Stone KC and Miss Quinn submit, there appears to be a disconnect between the mother's reported difficulties and the professional observations. They cite ten examples covering the period between 2018 and 2019 which would have put the mother in the knowledge that the video fluoroscopy was being considered and it being an important feature of the investigations into this issue. B was subsequently discharged from the service due to non-attendance. The mother's assertion that B was too unwell to attend the first planned video fluoroscopy is contradicted by the clinical notes. Whilst I accept this was at a time when she was wanting Hospital F to take over B's care from Hospital E, it does not explain why this was not followed up by her or why she had not sought the assistance of Dr K.

V. Disengaging with professionals or playing them against each other and seeking transfers between hospitals

116. The allegation of manipulative behaviour is a thread that runs through all of the local authority's allegations against the mother. The essence of the allegations under this heading is a broader assertion that the mother sought to take charge of the exchanges of information between different hospitals and where she was told not to undertake a task, she would seek a medical professional who would sanction her doing so. The examples of the mother's behaviour are varied and relate to some of the other allegations that are considered in this judgment. She further sought to control the exchanges of information between different hospitals.

117. During B's admission to Hospital E in September 2018, her planned aortopexy was deferred on clinical grounds and the parents were advised that the

use of Creon or Pancrex was no longer indicated. The parents were unhappy with the degree of communication and understandably concerned to be in hospital unnecessarily. The discussions were led by the mother in which she raised her unhappiness about the lack of communication and stated that she would leave the hospital unless she could see a consultant. After the consultant attended on the parents and explained the decisions that were made, the parents are recorded as being amenable. Prior to meeting the Consultant, the parents are recorded as stating they had lost trust in the doctors at the hospital and they felt that they were watched and *"having to prove that she* [B] *is actually ill".*

118. A and B have both had longstanding exposure to intravenous antibiotics (IVABs). These have been different in character with A's receiving prophylactic and B receiving regular IVABs when acutely unwell. In the latter circumstance B would either be an inpatient or would be required to attend hospital every few hours. Indeed, in the opinion of Nurse U it was unusual that in such circumstances the child would not be an inpatient. She was clear that the mother was very keen for her home nurses to administer the IVABs, negating the need to travel to hospital every few hours. I note that the mother was previously trained to administer A's IVABs at home. It is also important to note that her wish to be at home was supported and sanctioned by Dr K. In this context and the overall picture of B's regular visits to the hospital, it is rightly argued on behalf of the mother that it was not unreasonable for her to make such a request.

119. The evidence, particularly from Nurse U and Dr K, makes it clear that the mother was very resistant to the sharing of information between Hospital A and other hospitals. The mother explained this as her preference that information is shared only between Consultants. In my judgment, this is a wholly misguided attempt to explain what was ultimately very controlling and reckless behaviour that has done nothing to assist with finding a solution to B's perplexing and complex presentation. Similarly, whilst the mother may have been very concerned about her medical records being accessed for the purposes of a Strategy Meeting, convened after concerns about a possible domestic abuse incident at the family home, the evidence is clear that she was seeking to gain a degree of control by stating that she was advised to move to another hospital. The information about this meeting was shared with her by either the social worker or Ms C who was Dr Q's assistant, both of whom the mother had befriended and socialised with.

120. On 24 February 2021, contrary to nursing practice, the mother was permitted by Dr K to access B's central line to flush it after it was blocked. This was later challenged by the nurses at Hospital A who were very clear that no one including the home nurses should be accessing B's central line at home. The mother further communicated with Dr K, seeking her permission to do so. Dr K later reported to Dr B that the mother was clear that it was not her role to manage or access the line and *"she has no desire to do so".* The local authority cites this as another example of the mother manipulating professionals despite the mother's assertion that she was reliant on professional advice. A further example is the allegation that on 31 July 2021 the mother was giving B medication that was outside the hospital's

'charting' process. Whilst on its own, this may not amount to a serious charge and might have been explained as a 'mismatch' in approach that required realignment, in the context of the overall evidence, it may serve as another example of the mother seeking to step outside the plans and exert a degree of control.

121. I have already addressed the allegations about the mother's resistance to agree to B's admission to the Hospital F in May 2022 which illustrated a great deal of anxiety on the part of the mother about the admission, the discussions for which commenced in late 2021. Importantly, Dr K was clear that she had no knowledge of any offers of admission to the Hospital F that would have flowed from her initial referral, thus suggesting that the mother had not raised the issue of admission with Dr K nor did she ask her to follow this up, especially after the difficulties and confusion about admission in February of the same year. It is also clear that the medical notes evidence the mother refusing permission for B to be admitted for observations in September 2021. Although this may contribute to the overall picture, there is very little evidence of the context in which this refusal was made and if there were any valid reasons for doing so.

VI. Pursuit of medical diagnosis and unnecessary medication

122. Most of the allegations about the mother's behaviours are closely connected and as with the other allegations, these are more pronounced and detailed in respect of B. Accordingly, I will continue to deal with each of them separately. I will further consider the consequences for each of the children under a separate broad heading.

i. Re A

123. Mr F who is Consultant Paediatric ENT, Head and Neck Surgeon (Hospital E) explains in his statement that he first reviewed A on 12 May 2021 after a referral from Miss H (an ENT colleague). A was already being seen by Dr V. In light of the concerns about A, on 16 August 2021 he arranged a microlaryngoscopy, bronchoscopy and adenoidectomy. He found A to be presenting within the expected normal range. The family continued to report snoring and sleep apnoea leading to a Coblation Intracapsular Tonsillectomy with no complications. On 23 February 2022 mother reported ongoing concerns with chronic cough and snoring with no improvement post-surgery. The clinical findings were once again within the normal range but there was a discussion about managing her with an inhaler and Montelukast.

124. In evidence, Dr V observed that examinations of A in September 2017, February 2018 and March 2019 were normal despite the mother's reports of respiratory difficulties. He also explained that the prescription of Dexamethasone was not appropriate when A was not suffering with recurrent croup. As previously recorded above given the unexpected results of the February 2022 sleep study, he expected A to have very large tonsils which proved not to be the case. Whilst the

decision to perform any surgery is a clinical decision, in the context of A's ongoing perplexing presentation, the mother's reports of ongoing difficulties would have played a significant role in the decision to operate on A and to prescribe her the medication for the management of her reported ongoing respiratory issues.

125. In my judgment the mother misinformed professionals that A had or was awaiting the outcome of a test for Cystic Fibrosis. There is a raft of evidence that the local authority correctly relies on. Most notably, Dr Ward's evidence makes it clear that in a consultation with the NHS 111 services in November 2016, the mother stated that A was awaiting a possible diagnosis of Cystic Fibrosis that was already proved not to be the case through genetic testing. She also stated to the community nurse in December 2017 that A should not attend a Child Health Clinic as she may have Cystic Fibrosis. This was clearly not consistent with the information that the mother was privy to, that showed the opposite.

ii. Re B

126. SDS is a rare and serious condition that has been considered as one of the possible conditions that may explain the children's presentation. There is no diagnosis of SDS and the medical evidence is very clear in this regard. Professor H, who is a highly regarded geneticist , undertook the genetic testing in this regard. None of these conditions have ever existed in B. The height of the evidence of SDS was the identification of one gene that was insufficient to support a diagnosis for SDS in the absence of all other expected presentations that can include dysmorphic facial features. In respect of the latter, there are two relevant observations by Dr K in October 2020 and Dr T in September 2020. All other relevant description of B's asserted dysmorphic features appear to originate from the mother and the two clinical observations above were in the context of these descriptions having already been raised by the mother years earlier.

127. Whilst the evidence is also clear that some clinicians may have considered SDS to be a working diagnosis, the evidence for which is in fact limited to a few digital medical records, there can be no doubt that there was never a diagnosis of SDS for either child. Furthermore, I found Dr O to be an important and reliable witness who refuted any suggestions that she had ever described B as dysmorphic, observing that B was a *"healthy looking pretty girl".* It is also clear to me that the mother was heavily invested in and anxious about identifying a condition that may explain the perception of the children's ill health and whilst SDS was first raised by the physicians, she pursued this diagnosis by unreasonably attempting to convince the professionals that B suffered with SDS.

128. The mother accepts that in January 2021 she requested a prescription for DNAse which is an expensive medication that does not fall within the NHS guidelines. She further submits that the evidence does not illustrate that she was strongly pushing for this. Similarly, she was requesting a prescription for a costly nebuliser that is again used for patients with Cystic Fibrosis. However, this medication is usually used for patients with Cystic Fibrosis which was confirmed

through testing that B was not suffering with. She also accepts requesting the varicella vaccine for B, which she explains was routinely used for patients who are vulnerable to infections and health workers. This she says was reasonable given the amount of time B was spending in the hospital. In my judgment her request would be entirely reasonable if it was reasonable for B to spend so much of her life in the hospital environment.

129. Considering the totality of the evidence in respect of the respiratory issues that I have summarised above; it is clear to me that the mother was very anxious about any attempt at weaning or trialling B off CPAP. As I have already observed, her anxiety must be considered in the context of her loss of trust in the Hospital E but carried over through to the Hospital F. This is also connected to the mother's overall drive and motivations that I will consider later in this judgment.

130. Whilst I found Nurse X to be an entirely reliable witness who was one of the small cohort of professionals who raised concerns about the mother's care of the children, I accept that the assertion that the mother sought to evade nursing attempts to monitor her administration of medicine to B is not supported by any contemporaneous notes or raised as a concern in the written statement of Nurse X. However, this issue must be considered in the light of the mother's overall pattern of behaviour before it can be properly said that the local authority has discharged its burden of proving this allegation. I also accept that the evidence in support of the contention that the mother stated to a friend at boot camp that the children's conditions were so rare that if *"one of the girls passed away that it ... would be named after them",* consists of a hearsay account without any direct evidence to support it.

VII. Consequences for the children and the family

131. Before I consider some of the specific findings that are sought by the local authority, I note the general submissions on behalf of the children. Miss Stone KC and Miss Quinn point to a non-exhaustive list detailing the interventions that the children have been subjected to which may be summarised as follows:

Both children	**Re A**	**Re B**
Numerous blood tests	Adenoidectomy	Central lines (various types)
Numerous general and local anesthetises	Tonsillectomy	Gastronomy
Skeletal surveys	Colonoscopy	Bone marrow aspirate
X-rays	Gastroscopy	CPAP
CT and MRI scans		Blood transfusion
Sleep studies		IVIG infusions
Sweat tests		GCSF infusions and
Feeding tubes		Iron infusions
Biopsies		
Bronchoscopies		

TPN, and
Countless medication that includes intravenous administration.

132. They further submit that each of the procedures carries a risk and the numerous medications have possible side-effects. Whilst, as opined by Dr Ward, it was reasonable to undertake the early years investigations into the respiratory issues, the subsequent repeated tests and intrusive investigations were unnecessary. Furthermore the use of medication such as intravenous prophylactic antibiotics for A and Creon for both children was unreasonable and as Dr S stated, Creon can cause harm that could include scarring of the bowel.

i. Re A

133. Nurse B was among the first professionals to raise concerns about the mother's care of the children and the children's exposure to unnecessary medical intervention. It is submitted on behalf of the mother that her evidence must be considered with a degree of caution and that it has taken a gloss post the arrest of the parents and the events that unfolded in the Hospital F in May 2022. In my judgment these factors do not detract from the powerful and insightful evidence that she gave to the court. Her concerns included the children having too many lines and procedures that were often provided too quickly. Her experience of the mother was contrary to her experience of other families that fight against intrusive procedures. The overall evidence paints a clear picture of A growing up believing herself to be chronically ill, that she had recurrent hospital admissions, suffered pain and discomfort through unnecessary medical treatment, was exposed to the side effects of unnecessary medication and repeated investigations, together with exposure to the risk of medical complications through a high turnover of lines that were displaced and damaged, which led to infection and thrombosis. A was prescribed prophylactic antibiotics that in the unchallenged opinion of Dr Ward placed her at risk of nausea, vomiting, abdominal pain and possible increased resistance to antibiotics. I will deal with the mother's role and the clinical decisions leading to unnecessary procedures later in this judgment.

134. Therefore, it is hardly surprising that A became very distressed with medical procedures, spitting at nurses, requesting to be held down, shouting in distress during interventions requiring restraint when her port was accessed and screaming during the same events. The factual assertions in this regard are not disputed by the mother. When she was challenged about this she was very distressed which is entirely understandable. She also explained that A's distress was at times such that the mother absented herself during the intervention. This makes it all the more concerning if indeed the mother knew at the time that the procedures were unnecessary.

ii. Re B

135. The evidence of the consequences for B follows a similar trajectory to A, albeit she has had a much greater level of intervention than A. It is clear that for a prolonged period SDS was a topic of much discussion and under investigation. It is also clear that Dr K regarded SDS as a working diagnosis which was recorded on the medical records that the mother accessed. However, the evidence is also clear that both through correspondence and discussions with the parents, they were left in no doubt that neither child was ever diagnosed as having SDS or indeed Cystic Fibrosis. This gives a solid foundation to the local authority's assertions that B was brought up wrongly as a child with SDS. The combined evidence of the experts as summarised above and the clinicians clearly points to a number of unnecessary and intrusive treatment that were not required by B.

136. The evidence of Nurses Nurse X, Nurse B and Nurse U, speaks to the barriers that the mother put in place that divided the professionals, between those that she perceived to be supportive of her and in agreement with her and those who were not. As I have already stated, I address the mother's evidence and motivation in more detail later in this judgment. Furthermore there can be no doubt B was exposed to significant unnecessary investigation that, as pleaded by the local authority, included seven hospitals, fifteen special paediatric consultants, one general paediatric consultant and a number of nurses including those on a rota to provide night care at home during the week. Furthermore, with the assistance of Dr K and an enquiry from the social worker, B was referred to Hospice A and the mother further pursued a referral to Hospice B which provided support for terminally ill children. However, I agree with Miss Howe KC and Miss Harrill, that the first referral was by Nurse B after Dr K described B as very unwell, believing that she met their criteria.

137. I have set out above a summary of the procedures that B has undergone. The factual assertion by the local authority that these were consequent on the mother's falsification, exaggeration and inducement of illness will be established if I find that the mother's conduct under the other headings have been as alleged by the local authority.

iii. Generally

138. Whilst the mother denies deriving financial benefit from the support that she had in the community, she accepts that she was in receipt of disability living allowance for both children, food packages, vouchers and funding for a specialist car seat. Similarly she accepts that the community support included visits from outreach workers, home nursing for B six nights each week, breakfast and after school clubs for A, a weekly cleaner, home start support and significant funds through a Go Fund Me group. I entirely accept that the family had to expend significant time and funds for regularly attending hospital and medical appointments.

VIII. Miscellaneous

139. Many of the allegations under this heading are conceded and I need not address these in a great detail. I readily make the finding that the father regularly smoked cannabis whilst the children were in his sole care and also outside of the hospital. As accepted by the mother she has falsely reported to professionals that she had breast cancer. For reasons that I have set out below, I prefer the evidence of Dr Q and I have little doubt that the mother was aware of the relevant personal circumstances of Dr Q at the time of her conversation with her. I also prefer the evidence of Nurse U who I find to be a reliable witness with no motivation to give an untruthful detailed account of the events surrounding this issue. The mother misled the court in her threshold responses in this regard and her explanations in this regard lacked any credibility whatsoever. Finally, I find that the father gave a detailed credible account of the altercation between the parents on 16 May 2021 where the mother was unable to recall much detail about this incident.

IX. Findings about Dr K

140. Dr K is a highly committed Consultant Paediatrician who has been at all material times concerned to act in the best interest of her two young patients A and B. In evidence she was highly reflective on the past events and was quick to acknowledge her shortcomings. At times, she was very distressed which in my judgment reflected the tremendous stress and regret that she was feeling. She was quick to say that she had crossed the professional boundaries that were her responsibility to observe. She failed to do so by giving the mother her personal mobile telephone number. She confirmed that this was the first and only time that she had done this.

141. Dr K's evidence chimed with other professionals and the expert opinion of Dr Ward by confirming that in a clinical setting practitioners treating the children were highly reliant on the parental report of the child's symptoms. There can be no doubt that at times she treated the children contrary to the specialist advice, with examples including the prescription of Creon with a false impression that it was helping, Oxygen used at home contrary to the CPAP Home Ventilation Plan, various infusions and treating B on the basis of a working diagnosis of SDS.

142. Such was her sympathy for the children and deterioration in her objectivity, that she was abrasive and dismissive towards the small cohort of nursing staff who sought to raise concerns about the mother's conduct. Whilst I note her denial, the evidence including that of the mother, clearly demonstrates this and includes her shouting at the nursing staff. Therefore, she contributed to the emerging division between the clinicians at Hospital A and created an atmosphere in which the nurses faced obstacles in raising their concerns.

143. This was particularly concerning as it was not only unjustified and protected the mother in her conduct and emerging attitude towards those who were critical

of her, it also hindered the prospect of early detection and investigation into the mother's conduct. Dr K was not familiar with the RCPCH FII guidance and failed to recognise the pivotal role that she played in the coordination and facilitation of a multidisciplinary approach to the children's perplexing presentation. Thus contributing to the poor communication and lack of sharing of information between the various hospital and agencies.

144. Where there is a difference in account between Dr K and Nurse X, I overwhelmingly prefer Nurse X's evidence whom I found to be an entirely credible balanced witness. I found Dr N's evidence to be contradictory and wrong in his opinion that all clinical decisions were made on objective evidence of the children being clinically unwell. This was a shallow view that ignored the sophisticated detail of the children's perplexing presentation.

Other witnesses

145. The social worker, the children's previously allocated social worker, presented as dejected and resigned to the loss of her career which she must have worked very hard to accomplish. She was among the intimate circle of professionals whom the mother trusted and confided in. The social worker's career came to an end under the heavy cloud of her unprofessional behaviour towards this family. She was ready to accept responsibility for breaking professional boundaries but was avoidant and less than frank in other important respects. It was clear that she and the mother had developed a close friendship and socialised together. This included attending her home in the evening, drinking, attending parties, going out together, attending a running club together and dating one of mother's friends.

146. The social worker and the mother denied any intimate feelings or any intimacy between them. However, the father gave evidence about the close nature of their relationship and how one evening he found them 'cuddling' in the kitchen which raised serious concerns for him causing him to ask the social worker to leave. Both the mother and the social worker were in my judgment untruthful about the social worker telephoning the mother during professional meetings and allowing her to listen in. She readily agreed the inappropriateness of the text exchanges with the mother in which the nurses and Hospital A were referred to in highly disparaging and profane terms. She believed B in particular to be very ill and her motivations to find support for the family soon turned to a highly inappropriate relationship where she became one of the mother's directing arms.

147. Finally, I would like to identify four practitioners, Nurse X, Nurse B, Nurse V and Nurse U by paying them each a tribute for their respective insightful child centred practice. Their evidence, that I found to be fair and reliable, together with their resilient professional approach to the concerns that they have identified, has been instrumental in ensuring that the children have not continued to suffer ongoing harm. Their concern for the children was genuinely held and its toll on these professionals was obvious. Without them, the future prospects for these

children would have been very bleak. They are a credit to their profession.

The parents

148. The parents' evidence is a crucial part of the overall evidential landscape as they can provide important detail about the children's lives that gives texture to the evidence before the court and helps close the distance between the important events that may be the focus of the dispute. In cases such as this, the parents' evidence is all the more important as often this has contributed or informed some of the professional decisions where treating clinicians are reliant on the parental report.

149. It is crucial to recognise that this family have lived with tremendous challenges and the events that unfolded in May 2022 have inevitably had a significant impact on all of them. The impact of the stresses on the parents, delay in the face of separation from their children and the ending of their relationship is immeasurable. The impact of the police investigations and facing the most serious allegations in these proceedings will have created a most stressful set of circumstances to contend with. Notwithstanding the tremendous skill and commitment of her legal team, the colossal amount of evidence and the allegations against her have presented a monumental challenge to the mother.

150. I found the father to be a reliable witness who was careful not to trespass into areas that were outside his knowledge or of which he did not have a clear memory. Where he recalled events, he gave a consistent and detailed account. I have no doubt that he holds no positive views about the mother and yet he was entirely fair and balanced in his observations of her. He faced up to some of the shortcomings in his parenting and in this context I found him to be very reflective, remorseful and child centred. The revelation of the true nature of the children's life has been an awakening for him and his regret at not doing more to prevent this was palpable.

151. The challenges for the parents that I have detailed above are not exhaustive and are particularly pertinent to the mother who has been facing the detailed and very serious allegations for many months. She spent significant time in the witness box that was punctuated with many long breaks that together with other measures have ensured that she was able to properly participate in giving her evidence. In evidence, she appeared to have a notably detailed knowledge of the medical conditions, treatments and the general chronology for each of the children and her interactions with the professional. However, this was in direct contrast to her evidence when she was challenged on the main issues when she displayed a remarkable paucity of knowledge or any detailed recollection of the events and was unwilling to properly address the questions. At times she gave an untruthful or misleading account and other times she professed to have no recollection or knowledge of important events. The mother accepted no responsibility in a meaningful way for any of the important events in the children's lives and in the main sought to hide behind the argument that she was acting on professional advice. Whilst it is entirely correct that the professionals had the ultimate responsibility to maintain professional boundaries or to make appropriate

decisions for the children's treatment, the mother's manifest failure to recognise her contribution to the children's horrific experiences was profound. I found her evidence to be entirely self-serving and unreliable.

152. The description of her relationship with the social worker, Ms C and Dr K, lacked any credibility and contributed to her overall approach of passing the blame to others. Her attempts at explaining the misleading information that she provided to the treating medics for many years was among the most troubling aspects of her evidence. In the face of a catalogue of expert and clinical evidence that lays a clear path to identifying her disturbing role in causing such intolerable harm to the children, she was unable to display any degree of acknowledgement of her contributions to the children's lives. I have no doubt that she understood the evidence, but it may be all too horrific for her to face up to.

Conclusion

153. At first the mother presented as anxious. This soon became focused on A's presentation outside the expected norms which was not supported by independent objective observation. B's arrival was an important milestone that saw an increasing interest by the mother in the children presenting as unwell. Whilst some of these presentations were justified in the early stages and were anxiety provoking, the emerging picture over the ensuing years was not. With the passing months, the mother became increasingly invested in the children presenting as unwell and exploring ever expanding avenues to persuade the professionals to undertake more investigations of the children's health. B was a particular focus for the mother. The mother's increasing confidence and justification in her approach was fuelled by a number of professionals who could not identify a root cause for the children's perplexing presentation.

154. In my judgment the mother found reward in the children's presentation that was soon to be threatened by a handful of insightful professionals who were beginning to sense that the mother's conduct may be contributing to the children's puzzling picture. She collected a small group of trusted professionals through whose agency she began to control the trajectory of the children's treatment. Before long she was a saintly figure who stopped at nothing to fight for her children. She found further reward in the social recognition and the attention that she was gaining from friends, family, professionals and on social media. The mother developed a dangerously casual relationship with medication that included morphine which is a controlled drug and potentially lethal if administered incorrectly. In the meantime the children were living in a highly abusive environment. Their respite from their regular hospital admissions was a return to a highly medicalised home environment. The pictures of the children's bedroom show it more closely resemble a makeshift paediatric bay in a hospital that was supported by cupboards full of medication and medical equipment. The children's home life was under a constant invasion by professionals.

155. The increasing concerns about the mother's conduct did not deter or slow

her, quite the opposite. In 2020 B's life took a sinister turn where the mother's focus turned to her respiratory issues and anaemia. She began to covertly siphon blood from B's central line which caused her anaemia and exposed her to a disturbing number of blood transfusions and treatments. When faced with the prospect of B having less intervention, she began to undermine the medical opinion that informed such decisions and ultimately disengaged with the services that were considering this. Her anxieties around the admission to the Hospital F were rooted in her concern that this may spell the end of the path that she had travelled for some years. When faced with no option but to agree to B's admission to the Hospital F, she consolidated her efforts to present B as unwell and embarked on an extraordinarily dangerous path that may have put B's life in danger and ultimately led to the children's removal from the parents' care.

156. For reasons that I have set out in this judgment, the evidence about the mother's conduct is overwhelmingly clear. I find that:

As of 27 May 2022 when the children were removed from the parents' care A and B were suffering and/or were likely to suffer significant harm attributable to the care being given to them, or likely to be given to them if an order were not made, not being what it would be reasonable to expect a parent to give them.

This general finding is supported by the following specific findings.

Re B

<u>Covert administration of sedative drugs</u>

a. During an inpatient admission to Hospital F, the mother covertly administered unauthorised medication to B in order to sedate her, to reduce her respiratory rate and to complicate her presentation, thereby placing her at grave risk of harm. None of B's prescribed medications could account for the positive readings set out below. Specifically:

    i. Chlorphenamine a day or more before 18 May 2022;
    ii. Trimethoprim on or prior to 19 May 2022;
    iii. Morphine on at least two occasions between 20-26 May 2022.
    iv. Before the morphine was administered, Dr I, respiratory consultant, informed the mother on 20 May 2022 that the sleep studies thus far were not typical of airway obstruction, that it was strange that B's first few nights on CPAP alone did not show a low respiratory rate or desaturation and that she could not think what would have caused this;
    v. Following the mother's arrest on 25 May 2022, the sleep studies on 26/27 May 2022 were normal.

<u>Blood siphoning</u>

b. On multiple occasions between early 2020 and early 2022 the mother covertly siphoned blood from B's central line causing her severe anaemia:

i. The siphoning of blood coincided with the transfusions undertaken by hospital staff – three by 28 April 2020, then 28 Sept 2020, 6 Oct 2020, 28 Oct 2020, 2 December 2020, 13 December 2020, 28 December 2020, 8 January 2021, 14 January 2021, 21 January 2021, 28 January 2021, 2 Feb 2021, 1 March 2021, 15 March 2021, 30 July 2021;
ii. The mother had syringes at home with which she could withdraw blood from the line:
iii. On 02 May 2021 the mother was asked to bring B in for a blood transfusion as her haemoglobin was 72 but refused to do so and did not inform the father of the need to bring her in, instead going out drinking with friends;
iv. The Hospital F gastroenterology team confirmed at an multidisciplinary meeting on 20 September 2021 that they were unable to explain B's haematology;
v. All of B's haematological issues disappeared on removal to foster-care;
vi. In the absence of obvious loss from gastro-intestinal and/or renal tracts, withdrawal from the central line is the likely cause of her perplexing anaemia.

Respiratory issues

c. The diagnosis of tracheal-bronchomalacia was insufficient to explain all of B's respiratory problems. The mother fabricated and/or exaggerated apnoeic incidents in order to convince the doctors that B suffered from a chronic respiratory condition. The following are examples of this:

i. A sleep study in Hospital A on 24 Nov 2017 was unremarkable, despite the mother reporting that she was dropping her sats and grunting;
ii. The mother reported that B had almost no cry but Mrs Y, consultant ENT at Hospital B reported that on examination on 14 March 2018 she was a healthy normal child who had a good strong cry. Despite this, the mother told Dr K on 24 April 2018 that she still had not heard her cry;
iii. On 05 September 2019 the mother reported that B was on nebulised Salbutamol and Budesonide, whereas advice had been given to stop these;
iv. On 18 September 2019 she failed to call an ambulance despite reporting B was cyanotic and on 27 September 2019.
v. On 29 October 2019 the mother reported concerns about respiratory secretions but the nurse could not observe any;

vi. On 11 May 2020 the mother reported B stopped breathing and went purple whilst not on CPAP but failed to go to hospital;

vii. On 27 July 2020 the mother reported to Dr B that B had occasional nights when her respiratory rate dropped very low, yet blood gases showed a high normal CO_2 when checked at Hospital A;

viii. On 21 November 2020 the mother allowed B to sleep off-CPAP without her oxygen monitor on;

ix. Multiple sleep studies were satisfactory, despite the mother reporting ongoing serious difficulties with breathing: e.g. 28 August 2018 Hospital E normal sleep study, 26 June 2019 Hospital E satisfactory, 22 August 2019 Hospital E sleep study acceptable, 11/12 March 2020 Hospital F sleep study satisfactory, 26/27 May 2022 Hospital F;

x. After the 18 May 2022 sleep study the mother told Hospital F staff she was glad that they had got this (low saturations and high CO2 levels) on a sleep study as it showed B needed more help and on 20 May 2022 told Dr I that she was pleased that B had 'performed' for the sleep study and Nurse L on 21 May 2022 that it was good for Hospital F to have recorded B's rough nights on CPAP;

xi. All of B's respiratory issues (save mild breathlessness which may be asthma) disappeared on removal into care, she no longer had reported symptoms of sleep-disordered breathing and CPAP was not required.

d. On or before 19 May 2022 mother deliberately damaged B's CPAP ventilator after being told by medics that they needed to analyse the respiratory data within it.

e. The mother did not comply with the home care ventilation plan put in place by Hospital E and sought to increase the length of usage and the settings, at times falsely representing what she had been told about permitted use:

f. The mother would apply the CPAP ventilator to B when awake during the day even though she supposedly only required it when asleep. On 13 December 2018 Dr M agreed that B could use it 4 hours a day if unwell;

g. The mother pushed to be allowed to administer oxygen through the CPAP in Hospital A and latterly at home, despite this being against the plan. She informed Hospital E on 03 December 2018 that Hospital A had advised her to put oxygen through the CPAP, which was not part of the home ventilation plan. By March 2019, the mother was administering up to 3 litres of oxygen;

h. On 21 November 2018 the mother told Nurse B that Hospital E said that she could increase the CPAP setting from 6-7cm if B wasn't coping. Nurse

Q at Hospital E confirmed that they had not told the mother this and she should not be changing the settings at home. By July 2019, B was at the maximum pressure of 10 cm and remained at this level until her Hospital F admission in May 2022;

i. The mother refused to engage with the Hospital E's plan to reduce B's CPAP usage and she declined a suggested admission in October 2019 for weaning of CPAP. By 22 January 2020 Dr J, respiratory consultant at Hospital E raised a safeguarding concern that mother was using CPAP almost 24 hours a day and would not engage with going back to the nap and sleep plan;
j. The mother subsequently refused to attend an admission with Hospital E in January 2020 for a sleep study off-CPAP, expressed concern on 09 January 2020 that the admission plan was to wean B off ventilation maintained that concern at a CIN meeting on 05 March 2020 and pushed for B's care to be transferred to Hospital F, informing Hospital F that she would bring her social worker Ms X to any clinic appointments. B's respiratory care was transferred from Hospital E to Hospital F in March 2020 citing a breakdown in communication with Hospital E;
k. On 05 November 2020 the mother put B on CPAP without notifying nursing staff and despite B not requiring it earlier that day;
l. CPAP support was in fact not required at all (alternatively, not to the degree sought by the mother) despite her strongly advocating it.

Doctor shopping and manipulation

m. The mother would disengage from professionals and seek transfer to other hospitals if she did not agree with medical opinions and/or play professionals off against each other:
n. During September 2018, the parents were asked by Hospital E staff not to suction B as much, informed that Creon/Pancrex was felt to be unnecessary as the faecal elastase results were normal and that the aortopexy would be deferred as there were no signs of significant airway obstruction. The parents led by the mother then informed staff that they had lost trust in the Hospital E doctors and the mother subsequently threatened to self-discharge as she did not see the need to remain in hospital;
o. In 2020 the mother pushed repeatedly for IVABs to be administered at home and enlisted Ms X, the social worker to lobby Hospital A for this as well. She also sought for blood gas samples to be taken at home, despite concerns of the Hospital A nurses;
p. 09 February 2021 the mother complained about information sharing between Hospital F and Hospital A stating that it should be confidential. On 12 February 2021 she complained again stating that she did not want Hospital A nurses Nurse C and Nurse B contacting Hospital F or reviewing B;

q. The mother threatened to move B's care to another hospital after learning that her medical notes had been accessed for the strategy meeting on 18 May 2021.
r. On 31 July 2021 Hospital F noted that the mother was not giving medication in line with charting;
s. On 01 September 2021 the mother was advised that B should be admitted for observations but she declined;
t. The mother resisted B's May 2022 Hospital F admission, first postponing it then arguing that A was an inpatient at Hospital A and too unwell.
u. The mother sought to convince clinicians that B's facial features, which would support an SDS diagnosis, were becoming more pronounced and that she was not meeting developmental milestones. B's development since placement in foster-care has been within expected limits and her facial features are not considered to be indicative of any underlying medical condition.
v. The mother falsely reported and/or exaggerated diarrhoea in B, leading to concerns that she might suffer from Pancreatic Exocrine Insufficiency and the commencement of a course of Pancreatic Enzyme Replacement Therapy (PERT), specifically Creon, the dosage for which was increased due to the mother's report:
w. On 23 March 2022 the mother showed Dr L a photo of B's stool to which she had added oil, to mimic the appearance of a fatty stool;
x. On 25 May 2022 the mother informed the Hospital F endocrine dietician that B's stools were loose and oily and showed her a picture of a loose oily stool when in fact nursing staff had been collecting and photographing all stool output, which were all formed and non-oily;
y. When Hospital F stopped prescribing Creon in May 2022, B's stools and faecal elastase levels were normal and there were no fat globules identified;
z. M was actively considering administering Orlistat to B in order that B would produce oily stools, in the hope that the doctors would consider she had a pancreatic insufficiency and/or a genetic condition
aa. There is no objective evidence for Pancreatic Exocrine Insufficiency;
bb. All issues with diarrhoea disappeared on removal to foster-care.
cc. The mother falsely reported that B had an unsafe swallow about which the Hospital F speech therapist and other hospital staff had minimal concerns. Furthermore:
dd. The mother did not attend a video fluoroscopy swallow study at Hospital E on 05 February 2020;
ee. The mother asserted that B would not tolerate a video fluoroscopy which would have provided definitive evidence about any swallowing problem;
ff. There has been no evidence that B has an unsafe swallow since her placement in foster-care. She has demonstrated an ability to take a normal diet/fluids and is no longer dependent on gastrostomy feeds.

Medicalisation

gg. The mother pushed for B to be prescribed medicines outside normal guidelines, for example Dnase, which is usually only for patients with cystic fibrosis, the varicella vaccine, for which B did not meet guidelines, and a high cost nebuliser usually reserved for cystic fibrosis patients or those in ITU.

hh. As a result of the mother's portrayal of B as chronically ill and the mother's enjoyment of the drama and attention that generated:

ii. B has been wrongly brought up as a child with Shwachman-Diamond Syndrome despite the absence of a diagnosis, with respiratory issues requiring CPAP ventilation, pancreatic insufficiency, vitamin D deficiency, frequent infections, anaemia and an unsafe swallow. She lacks the clinical features of Shwachman-Diamond Syndrome. The mother has falsely informed professionals that B had a diagnosis of Shwachman-Diamond Syndrome. The mother raised the possibility of a neuro-muscular disease such as cystic fibrosis, which she does not have;

jj. B was exposed to multiple unnecessary medical procedures and investigations over 7 hospitals, 15 specialist paediatric consultants, one general paediatric consultant and had a rota of night nurses throughout the week at home. The mother also sought to divide health professionals and stated that she did not want Hospital A nurses to communicate with the Hospital F nurses and did not want community nurses to review B. She persistently sought to marginalise Nurse B so that the community and Hospital A teams could not employ a unified approach to B's care. Prior to the May 2022 Hospital F admission the mother's conduct fragmented B's health care;

kk. The community nurse Nurse B even progressed a referral to the Hospice A. The mother pursued a referral to Hospice B in March 2022;

ll. B has had, at various times, a central line, a PICC line, an NG feeding tube, a PEG gastrostomy and GCSF treatment for her bone marrow, none of which was necessary and all of which were the consequence of the mother misreporting and/or exaggerating and/or inducing her symptoms. On 21 August 2019 the mother resisted the removal of the PICC line and again on 23 August 2019. No such lines or treatment were required after her removal into foster-care with a transformation in B's presentation since her removal from home.

mm. In November 2020 the mother sought to evade nursing attempts to monitor her administering medicine to B;

nn. Once placed in foster-care B no longer required any ventilator;

oo. The mother derived a financial advantage, having applied for disability living allowance in respect of both girls and received food packages and vouchers (SAT L13) together with funding for a specialist car seat;

pp. The mother received a significant amount of support in the community, including regular visits from a SAT outreach worker from January 2019, at home nursing for B for 6 nights a week from 2019, free breakfast and

after school care from A, a weekly cleaner provided by children's services, Homestart support and received significant funds via a Go fund me group;

qq. The only explanation for the improvement in B's health and presentation post-May 2022 is a change of carer and the cessation of exaggeration, fabrication and induction of illness as pleaded above.

Re A

Overall finding

a. A suffered from a number of minor conditions such as gastroesophageal reflux, non-IgE mediated cow's milk intolerance, sporadic croup, recurrent viral infections, viral induced wheeze, constipation and possible obstructive sleep apnoea. However, these were all mild and would be expected either to resolve spontaneously over a period of months or years (gastroesophageal reflux, non-IgE mediated cow's milk intolerance, sporadic croup) or to be amenable to treatment in a community setting (recurrent viral infections, constipation). In the absence of an overarching serious medical condition, these conditions did not require regular hospitalisation and intensive treatment with intravenous antibiotics, nasogastric feeding, parenteral nutrition and other interventions.

b. It was reasonable to undertake investigations in relation to early gastrointestinal, respiratory symptoms and faltering growth such as a sweat test, genetic testing for cystic fibrosis and blood tests to exclude coeliac disease, biochemical and immunological abnormalities. Initial upper and lower GI endoscopy was also reasonable - but repeated upper and lower GI tract endoscopy and repeat genetic screening for cystic fibrosis in different hospitals were unnecessary. There was no justification for parenteral nutrition, prophylactic antibiotics and recurrent intravenous antibiotics or treatment with Creon.

c. A's symptoms became increasingly perplexing with a poor response to treatment. Referrals were made to multiple health professionals, partly due to fabricated or exaggerated maternal reporting of symptoms and partly on the basis of unreasonable maternal request. Concerns escalated in the face of B presenting with similar and more severe symptoms and the possibility of an underlying genetic disorder. The mother's conduct was part of a pattern of highly serious health-seeking behaviour which caused A significant physical and emotional harm.

Respiratory issues

d. The mother fabricated and/or exaggerated reports of A suffering apnoeic episodes, turning blue or choking when asleep, a persistent wet cough and thick lung secretions. These episodes were not witnessed during inpatient observations. There was no medical cause for them

and clinical examinations by respiratory specialists were normal, including a bronchoscopy. A suffered from mild GORD in early life but this did not explain the respiratory symptoms described by the mother. Furthermore:

e. The mother attempted to manipulate the sleep study conducted on 27-28 January 2016 by reporting that A had a 'big breathing episode' and went blue during the night, despite the study not flagging this and reporting that her sats were above 90% for 99% of the time;
f. The mother manipulated a home sleep study on 08 February 2016 which showed 34 desaturations to a low of 83%. On 25 February 2016 the mother falsely reported to the health visitor that A's sats dropped twice to 74% during a sleep study. During a hospital admission at Hospital A in February 2016 no desats or apnoea were recorded;
g. Further sleep studies at Hospital B on 10 April and 22 May 2016 were reported as normal, despite the mother reporting that A did not sleep well during the latter;
h. On 18 December 2017 Dr K recommenced Clenil inhaler treatment for prevention of cough, wheeze and breathlessness, despite this having been discontinued by Dr V 3 months earlier. This was due to exaggerated or fabricated misreporting by the mother;
i. On 14 February 2018 the mother falsely reported to Dr U (paediatric respiratory registrar) that A had a nocturnal cough and wheeze, none having been previously noted by Dr V;
j. On 17 December 2019 the mother falsely told Dr K that A's respiratory issues that winter had required 6 OOH consultations. On examination she looked well, had a clear chest despite a chesty cough and her microbiology showed only normal respiratory flora;
k. The mother manipulated the home sleep study conducted in November 2021 in order to prompt the conclusion of significant obstructive sleep apnoea which was completely inconsistent with the absence of any anatomical cause for airway obstruction;
l. On 24 February 2022 the mother failed to take A to be reviewed despite reporting serious respiratory symptoms and failed again to attend a physio appointment on 28 February 2022;
m. All respiratory issues disappeared when A was removed into care and sleep studies on 26 May and 24 August 2022 were completely normal.

Feeding issues, diarrhoea and constipation

n. The mother fabricated and/or exaggerated diarrhoea in A leading to concerns that she might suffer from Pancreatic Exocrine Insufficiency and the commencement of a course of Pancreatic Enzyme Replacement Therapy (PERT), specifically Creon, the dosage for which was increased due to the mother's report. She received pancreatic

supplements on a "clinical basis" with no biochemical, or laboratory, evidence of pancreatic insufficiency. Continuation of treatment was based on a perception that she was "thriving" on Creon as reported by the mother's report to Dr K and although weight centiles mirrored those recorded at the time of commencement of treatment and mother's reporting of improved bowel pattern. After Hospital B stopped Creon, the Hospital D re-started it, in part due to the mother's reporting that it had resulted in A's symptoms improving.

o. The mother was reluctant to accept a diagnosis of constipation (which may have contributed to A's loose stools), resulting in ongoing symptoms, including faecal impaction and overflow incontinence.
p. All issues with diarrhoea stopped when A was placed in foster-care.
q. The mother fabricated and/or exaggerated reports that A was a poor feeder leading to the insertion of a nasogastric tube. However, at Hospital B in 2016 A was observed eating well, anticipating every spoon with open mouth, looked hungry like could eat more. The mother had very strong anxiety issues around feeding. Mild GORD, mild symptoms of cow's milk protein intolerance in early life and intermittent constipation did not explain the feeding difficulties described by the mother.
r. The mother fabricated accounts of A vomiting. A nasogastric tube was used to feed A for a long time as the mother asserted that she did not want to eat. In early May 2022 the mother opposed the removal of the feeding tube by Hospital A, asserting falsely that the Hospital C had wanted it to remain in situ.
s. All feeding issues stopped after removal into foster-care and Omeprazole was discontinued without adverse effect in May 2022.

Medicalisation

t. As a result of the mother's false portrayal of A as chronically ill, she has been brought up to believe she has a high level of medical need. Her recurrent hospitalisations and exposure to medical interventions caused her pain and discomfort, exposed her to the side effects of medication and limited her attendance at school. Referrals from one hospital to another, in an attempt to understand A's 'perplexing' presentation, led to unnecessary repeat investigations . She experienced a highly turnover of lines with various problems including displacement, a split line, line infection and thrombophlebitis, all of which exposed her to the risk of serious medical complications.
u. She was repeatedly prescribed the oral steroid Dexamethasone for her cough and had, unnecessarily, an adenoidectomy and tonsillectomy. Her mother's reports or respiratory distress and stridor led to unnecessary prescriptions for preventative and reliever inhalers

(including Seretide and Montelukast) which were discontinued without ill effect in May 2022.

v. On 15 November 2016 the mother reported at an NHS 111 consultation that A was awaiting a possible cystic fibrosis diagnosis, despite genetic tests having recently been normal. On 06 December 2017 the mother informed the community nursery nurse that there were concerns that A might have cystic fibrosis and it was not appropriate for her to attend the Child Health Clinic for fear of infection.

w. The long-term administration of prophylactic antibiotics exposed A to the risk of nausea, vomiting, abdominal pain, increased antibiotic resistance and, more rarely, various severe complications such as Stephens Johnson syndrome.

x. A became very distressed by medical procedures, refusing to have blood samples taken, spitting at a nurse who attempted to administer chloral, requesting to be held down and have paracetamol administered rectally as she would vomit otherwise, shouting in distress during injections, requiring restraint to access her port, screaming in pain when her port was accessed, being emotional when her Hickman line was used and saying the medicine made her feel weird and sad.

Miscellaneous Findings

y. The mother has falsely reported to professionals that she has breast cancer and suffers from other symptoms which she has not been willing to disclose.

z. On 16 May 2021 the father returned home intoxicated and the mother punched him in the face and pushed him. He then punched the bathroom door in anger and headbutted the bedroom wall causing himself a head injury. The mother informed Hospital A that she should probably have brought B into hospital over this weekend but that these events prevented her.

aa. The father regularly smoked cannabis whilst the children were in his sole care and also outside hospital premises.

Findings in respect of Dr K

157. I recognise that there may be serious implications for Dr K, if I make the findings that are sought by the local authority. However, these findings are an important part of this case. After considering the totality of the evidence before me, with a heavy heart I make the following findings in respect of Dr K;

a. At all times, Dr K acted with the intention of addressing the children's health issues and in order to promote their best interests.

b. With the benefit of hindsight, Dr K was one of a number of health professionals across a number of hospitals, who were manipulated by the mother (including by inducing sympathy for her private life and health issues) and to whom the

mother gave false and/or exaggerated information about the children's presentation.

c. As accepted by her, Dr K's relationship with the mother was unusually and inappropriately close. She gave the mother her personal number, shared with her personal details, exchanged personal messages and allowed mother to 'friend' her on Facebook. The children had a degree of special treatment in that they had open access to the ward and did not need to use the normal admission channels. Dr K allowed the mother into her office to help discuss a transfer letter. The mother was permitted to take the children in and out of hospital for intravenous antibiotics, including at night, rather than remaining on the ward. She gave the mother a choice on 26 January 2021 as to whether B should have a blood transfusion.

d. Dr K was substantially reliant on the integrity of the mother's reports regarding the children's presentation. However, blurred professional boundaries affected Dr K's ability to retain an open mind and look objectively at the potential causes of the children's presentation. In particular, at times she preferred the mother's accounts over the diagnoses and recommendations of the tertiary treating hospitals, particularly in relation to:
    i. B's home ventilation plan formulated by Dr J at the Hospital E.
    ii. The Hospital E's diagnosis of self-gratification in B, with which Dr K disagreed.
    iii. Dr S's recommendation that A did not require Creon.
    iv. The mother's assertions that the children had SDS, contrary to the lack of diagnostic corroboration and for a period of time Dr K allowed SDS to be treated as a "working diagnosis".

e. Her communication with tertiary treating hospital was, at times, limited:
    i. Nurse Z (Hospital E) struggled to arrange a respiratory meeting with her.
    ii. Dr K did not copy Dr J into her referral letter to Hospital F.

f. She should have co-ordinated an early multi-disciplinary meeting across all the treating hospitals. This is an important but necessary finding.

g. At times Dr K behaved in an abrasive manner towards those Hospital A nurses who raised concerns about the mother's behaviour. On several occasions she was abrupt or became angry and shouted at the nurses including Nurse X. She failed to ensure that Nurse B (B's key worker) was present at all meetings and review clinics in relation to the children.

h. The conduct as set out in g. above affected the ability of health professionals at Hospital A to work together, created an obstacle to nurses suggesting anything adverse to the mother, and ultimately hindered their ability to uncover the true cause of the children's presentation. In particular Dr K did not give the FII thesis the attention it deserved or apply the RCPCH FII guidelines as she should. She was visibly unhappy, even angry at the Hospital A 05 May 2022 safeguarding meeting and repeatedly said she did not agree to a multi-disciplinary meeting.

Final observations

158. The extraordinary facts of this case illustrate the ease with which well-meaning professionals can fall into pitfalls that hinder the identification of safeguarding issues at an early stage. However, there are points of practice and practical steps that can help reduce these risks. I am grateful for the Guardian's thoughts in this regard and I have adopted some of those in the list that includes:

a. All paediatricians must have a practical and detailed working knowledge of the guidance of the Royal College of Paediatrics and Child Health entitled *"Perplexing Presentation (PP/Fabricated or Induced Illness (GII) in Children – guidance"* (2021) and any amendments thereto. This is particularly important for the Consultant Paediatricians who often are called upon to exercise an overview of the children's presenting compliant, diagnosis and treatment and are tasked with coordinating the same.

b. The child's Consultant Paediatrician plays a pivotal role in the coordination and facility of investigations. The Consultant Paediatrician, must ensure that there are:

    i. regular multidisciplinary meetings to which all relevant practitioners are invited, including nursing staff and specialist tertiary practitioners,

    ii. SPOC - clearly identified individual(s), may be the Consultant Paediatrician, who acts as a single point of contact and coordinate the opinion of different treating clinicians.

    iii. established clear lines of communication between all relevant practitioners that must include nursing staff, specialist tertiary practitioners and safeguarding leads.

    iv. established collaborative boundaries within which all practitioners regardless of their seniority or position are encouraged to contribute to the discussions,

c. Perplexing presentation raises FII as a point for consideration, even if it is to be considered and dismissed.

d. Where FII has been discounted, it should remain under consideration until it can be properly dismissed.

e. Clinical notes, notes of meetings and notes of conversations should be as contemporaneous and as clear as possible.

f. Safeguarding concerns should be clearly recorded in writing that must include an accurate record of any referrals that follow and the outcome.

g. Avoid ambiguous terms such as 'working diagnosis' unless this is agreed by all at a multidisciplinary meeting and the reasoning for doing so is clearly communicated to the parents/carers.

h. Correspondence and notes should be consistent and accurate. The history should be accurately reported.

i. The parents/carers should be kept fully informed about the clinical thinking and treatment decisions. Over medicalised conversations should be

avoided and kept simple and to the point. The conversations should be clearly noted and the reasoning for clinical decisions should also be communicated in writing to the parents and copied to all relevant clinicians including specialist tertiary clinicians.

j. Step back and take an objective view of whether a referral to a tertiary centre should be made. Record the reasoning for the decision accurately.
k. Save for emergencies and unforeseen circumstances, do not step outside any specialist advice until this has been discussed and agreed with the relevant specialist and communicated to all relevant clinicians.
l. Where a second opinion is sought, record the reasoning for this carefully.
m. Everybody involved in treating and caring for the children is likely to make important contributions to the professional discussions. It is essential that those who work in less senior roles feel valued and are able to freely contribute to the discussions. These individuals can have a greater insight in the day to day life of the family and the patient.
n. At all times establish and maintain professional boundaries with the patients and their family. To do otherwise would be a disservice to the patient and their family at a time when they are likely to need the professional around them most.
o. Always keep an open mind.