Neutral Citation Number: [2024] EWFC 51

IN THE FAMILY COURT

Case No: ZE22C50202

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/07/2023

Before :

MR JUSTICE KEEHAN

- -

Between :

THE LONDON BOROUGH OF NEWHAM	**Applicant**
- and -	
(1) A Mother	**Respondents**
- and -	
(2) A Father	
- and -	
(3)-(4) A and B	
(Through their Children's Guardian)	

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- -

Tina Cook KC & Kiran Channa (instructed by **Legal Services**) for the **Applicant**
Alison Grief KC & Fiona Munro (instructed by **Edwards Duthie Shamash Solicitors**) for the
First Respondent
Mark Twomey KC & Jonathan Adler (instructed by **QualitySolicitors Harris Waters**) for the **Second Respondent**
John Tughan KC & Rebecca Littlewood (instructed by **ITN Solicitors**) for the **Third and Fourth Respondents**

Hearing dates: 19th June – 21st July 2023

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Approved Judgment

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

Mr Justice Keehan:

Introduction

1. I am concerned with two children, A, who was born in 2018, and is four years of age, and B, who was born in 2021, and is one year and nine months of age.

2. The parents had another child, C, who was born in 2017 and sadly died in 2020. No findings of fact have been sought by any party in respect of the circumstances of C's death.

3. These public law proceedings were issued by the local authority in respect of both children after the local authority received an alert from the Royal London Hospital that the mother had been filmed on 23 April 2022 taking B into a bathroom when he was settled and well and returning to the room with him, some three minutes later, in an unconscious state. Concerns were raised about fabricated or induced illness. An Interim Care Order ('ICO') was made in favour of the local authority on 12 July 2022. The children have since been residing with their paternal grandparents under the ICO.

4. The matter was set down for a 25-day fact finding hearing. There are a number of findings sought by the local authority and the Children's Guardian which are:

   i) B and A have suffered significant physical and emotional harm and were at risk of the same harm by reason of the care given to them by their mother and father by:

      a) Causing them to be subjected to unnecessary and repeated medical intervention, examination and investigation and being administered drugs that were not required;

      b) Causing them physiological and emotional discomfort and significant harm by reason of that unnecessary intervention and hospitalisation;

      c) Causing them to be at risk of death or near death and brain damage by reason of the partial suffocation and the hypoxia that that would cause;

      d) Causing A to suffer from primary or psychogenic polydipsia;

      e) By virtue of B being in hospital (without any need to be there) caused him to contract 4 different viruses which may leave him vulnerable to lower respiratory tract infections and/or more vulnerable to asthma and/or the cause of the recurrent cough and symptoms he exhibited when in the care of his grandparents;

      f) Exposing B to unnecessary radiation.

   ii) Neither B nor A have epilepsy.

iii) A did not experience any unprovoked epileptic seizures from April 2020 to July 2021.

iv) B has not suffered any epileptic seizures either when being cared for by his mother and father or subsequently.

v) Neither B nor A has any underlying condition or genetic predisposition to cause them to have seizures or symptoms similar to seizure or epilepsy symptoms or to explain their perplexing presentations.

vi) Since A and B have been out of the care of their parents, either in hospital with the mother excluded or with the grandparents, neither has shown any symptoms of seizure.

vii) The pattern of symptoms and conditions in both A and B fall into a pattern of perplexing illnesses:

Perplexing in A

a) The episodes of altered consciousness and “absences” in A;

b) Recurrent and increasing presentations to and attendance at medical settings, including emergency departments:

i) 10 July 2020 – mother reported a seizure in the bathroom which lasted more than five minutes. She did not summon nursing staff and walked onto the ward with A in her arms ‘with no urgency’. A presented as postictal and asleep but rousable;

ii) 17 July 2020 – concerns at the discharge planning meeting regarding mother’s inability to keep A at home for more than 48 hours and lack of diagnosis. Nursing staff did not witness reported seizures on the ward and did not observe postictal behaviour when checked;

iii) 19 July 2020 – mother requested replacement buccal midazolam as she had dropped the syringe under the sofa. When asked if there was a risk of A reaching the syringe, she said no;

iv) 29 July 2020 – mother informed a staff nurse of a staring episode which had occurred on the ward but did not alert night staff and the episode was not witnessed. The episode was reported later. Mother expressed concern that there may be easy bruising on new medication;

v) 10 August 2020 – ambulance crew raised concerns following a call. A was described as unkempt, lying in a living room with used cereal bowls on the floor. It was reported that A had fallen from a high sided cot (unwitnessed) and found sitting on her bottom awake but nonresponsive. Her mother was reluctant to go to hospital, stating ‘you will contact social services’. She stated that she was struggling with the death of her other child

but had not received bereavement counselling. Later, she informed ED staff that she had found A on the floor in a frog like posture and questioned an unwitnessed seizure;

vi) 2 September 2020 – mother questioning why she needed to be in hospital for so long. Requesting allergy tests for the cat as she questioned that this may be causing seizures. She stated that there was no reason to be in hospital as 'everyone knew she did not have seizures in the hospital';

vii) 24 September 2020 – mother voices to ward that A had had breakfast so was unlikely to have a seizure;

viii) 1 October 2020 – admitted to Koala Ward GOSH. Urine toxicology requested;

ix) 17 October 2020 – mother reported to two staff nurses that she thought that A was having a seizure when asleep with her left arm going up and down. Not witnessed on observation;

x) 20 January 2021 – admitted with a history of poor oral intake and report of vomiting blood. Tissue presented stained with old blood and mucus. Despite reports of not eating, A ate 1.5 digestive biscuits and took 200ml of Vimto and orange juice. Mother reported that she had outgrown her seizures but on 22 January 2021 informed a student nurse that A's seizures had returned;

xi) 13 July 2021 – 999 call following apparent chest pain and reported collapse episode with loss of consciousness, unresponsiveness and blue tinge around mouth. Ambulance control recorded cardiac arrest call. Active, chatty with normal observations on arrival at A&E department. Noted to have pinpoint red papules around the mouth which were attributed to 'dermatitis'. Mother questioned an asthma attack although there were no features to support this.

xii) 3 June 2020 – mother asked if the hospital can arrange home oxygen in case of further seizures;

xiii) 8 July 2020 – blood samples were taken from A, A was very unsettled during the bloods;

xiv) 15 July 2020 – mother raised concerns that A is afraid of the shower and discussions were had about obtaining a shower chair for A;

xv) 7 June 2020 – mother wanted to stay in hospital when it was not warranted;

xvi) 13 October 2020 – mother reports she wants a wheelchair for A.

c) Failure to respond to treatment with the seizures apparently continuing;

d) Episodes not being recorded during video telemetry;

e) The commencement of the episodes only being observed by the mother.

Perplexing in B

f) The episodes of altered consciousness and "absences" in B;

g) Recurring and increasing presentations to and attendance at medical settings, including emergency departments;

h) Failure to respond to treatment with the seizures apparently continuing;

i) Episodes not being recorded during video telemetry;

j) The commencement of the episodes only being observed by the mother.

viii) The mother has induced and fabricated symptoms in A including episodes of stiffness, jerking, cyanosis of the lips, being asleep and being 'absent' and those symptoms usually associated with epilepsy, as well as loss of consciousness and chest pains on 13 July 2021.

ix) The mother, on occasions, did not induce symptoms in A, but she misinterpreted and exaggerated normal behaviours.

x) It is likely that on the majority of the following occasions the mother caused A's symptoms by suffocating or causing obstruction to her upper airways. Alternatively, she has caused such symptoms by administering a substance or drug (buccal midazolam):

a) 27 June 2020

b) 10 July 2020

c) 14 July 2020

d) 20 July 2020

e) 25 July 2020

f) 18 August 2020

g) 13 July 2021

xi) The mother has recorded, by video, events which she reported as seizures or symptoms of seizures or epilepsy. She has either fabricated, induced or exaggerated such symptoms. Of those records, the following do not represent epileptic seizures:

a) 4 September 2020

b) 4 January 2020

c) 2 February 2021

d) 10 May 2021

e) 25 May 2021

f) 13 July 2021

g) 13 July 2021

xii) The mother has induced and/or fabricated symptoms in B, including episodes of stiffness, jerking, cyanosis of the lips, being sleepy, being 'absent', and those symptoms usually associated with epilepsy.

xiii) It is likely that on the following occasions the mother caused B's symptoms by suffocating or causing obstruction to his upper airways. Alternatively, the mother caused such symptoms by administering a substance or drug (buccal midazolam):

a) 13 February 2022

b) 1 April 2022

c) 2 April 2022

d) 9 April 2022

e) 12 April 2022

f) 15 April 2022

g) 16 April 2022 at 9.35

h) 16 April 2022 at 17.30

i) 20 April 2022

j) 23 April 2022

xiv) The father has failed to protect the children from the harm that they have suffered:

a) The father disengaged and/or failed to take an active part in the children's medical care and/or to directly inform himself of their treatment and/or make objective decisions as to their symptoms and treatment from the period of June 2020 to April 2022;

b) The father failed to consider the involvement of the mother in inducing or fabricating the symptoms;

c) The father minimised and/or denies the possibility that the mother induced or fabricated the symptoms, telling the Social Worker that he has seen B having a seizure once in the family home, when they had to call an ambulance. He reported that professionals have got it wrong, due to the fact that there is no way the mother would do anything to harm their child;

d) The father failed to take into account that he had never seen the beginning of the medical episodes in the children.

The Law

5. On behalf of the Children's Guardian, Mr Tughan KC and Ms Littlewood helpfully provided me with a narrative note of the legal principles I must apply in considering the issues in this case. It is agreed by all parties. The note is based on the leading authorities which I set out below and which have assisted me in my analysis of this case.

6. In relation to the findings of fact sought, I remind myself that the burden of proof is on the local authority.

7. The standard of proof is the simple balance of probabilities: *Re B* [2008] UKHL 35.

8. In *Re A (A Child)* [2020] EWCA Civ 1230, King LJ considered legal guidance in relation to issues of credibility, demeanour, and memory in the context of a fact-finding process in private law children's proceedings, and legal guidance from family and wider jurisdictions.

9. In the judgment, King LJ observed:

> "32. I have in mind the guidance given by Baker J (as he then was) in *Gloucestershire CC v RH and others* [2012] EWHC 1370 (Fam) and in particular at [42] his point 7:
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> "Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them (see *Re W and another (Non-accidental injury)* [2003] FCR 346)."
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> 33. The reasoning of Baker J in *Gloucestershire CC v RH and others [*2012] EWHC 1370 (Fam) was approved by the President in *Re M (Fact-Finding Hearing: Injuries to Skull)* [2013] 2 FLR 322, [2012] EWCA Civ 1710 at [30]. More recently, the courts have looked at the issue of what can, in broad terms, be identified as the fallibility of oral evidence. The issue of the extent to which a court should rely on the recollection of witnesses and the fallibility of human memory first arose in a commercial setting through observations made by Leggatt J (as he then was) in *Gestmin SGPS SA v Credit Suisse (UK) Ltd and Another* [2013]

EWHC 3560 (Comm) (‘*Gestmin’*) at [15] – [22], and more recently in *Blue v Ashley* [2017] EWHC 1928 (Comm) at [68] – [69].

34. In the *Gestmin* case, at [22], Leggatt J expressed the view that the best approach for a judge to adopt in a commercial trial was to place little, if any, reliance on a witness’s recollection of what was said in meetings and conversations; rather factual findings were to be based on inferences drawn from documentary evidence and known or probable facts. This was followed in *Blue v Ashley*, where Leggatt J at [70], having rehearsed his own earlier observations in *Gestmin*, approached evidence of a crucial conversation in a way that was “[m]indful of the weaknesses of evidence based on recollection”.

35. The Court of Appeal considered both of these cases in *Kogan v Martin and Others* [2019] EWCA Civ 1645 (‘*Kogan*’). This was a case where the judge at first instance had wrongly regarded Leggatt J’s statements in *Gestmin* and *Blue v Ashley* as an “admonition” against placing any reliance at all on the recollections of witnesses.

36. The Court of Appeal in *Kogan* emphasised the need for a balanced approach to the significance of oral evidence regardless of jurisdiction. Although it was a copyright dispute between former partners, the judgment was a judgment of the court with wider implications.

37. In relation to the treatment of the evidence of the Claimant, the Court in *Kogan* said:

“88…. We start by recalling that the judge read Leggatt J's statements in *Gestmin v Credit Suisse* and *Blue v Ashley* as an "admonition" against placing any reliance at all on the recollections of witnesses. We consider that to have been a serious error in the present case for a number of reasons. First, as has very recently been noted by HHJ Gore QC in *CBX v North West Anglia NHS Trust* [2019] 7 WLUK 57, *Gestmin* is not to be taken as laying down any general principle for the assessment of evidence. It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed. Earlier statements of this kind are discussed by Lord Bingham in his well-known essay *The Judge as Juror: The Judicial Determination of Factual Issues* (from The Business of Judging, Oxford 2000). But a proper awareness of the fallibility of memory does not relieve judges of the task of making findings of fact based upon *all*of the evidence. Heuristics or mental short cuts are no substitute for this essential judicial function. In

> particular, where a party's sworn evidence is disbelieved, the court must say why that is; it cannot simply ignore the evidence.
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> […]
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> 41. The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of oral and contemporaneous evidence will vary from case to case. What is important, as was highlighted in *Kogan*, is that the court Judgment assesses all the evidence in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another."

10. In *Re A (Children)* [2018] EWCA Civ 1718, King LJ made the following observations in respect of the discharge of the burden of proof:

> "57. I accept that there may occasionally be cases where, at the conclusion of the evidence and submissions, the court will ultimately say that the local authority has not discharged the burden of proof to the requisite standard and thus decline to make the findings. That this is the case goes hand in hand with the well-established law that suspicion, or even strong suspicion, is not enough to discharge the burden of proof. The court must look at each possibility, both individually and together, factoring in all the evidence available including the medical evidence before deciding whether the "fact in issue more probably occurred than not" *(Re B: Lord Hoffman).*
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> 58. In my judgment what one draws from *Popi M* and *Nulty Deceased* is that:
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> i) Judges will decide a case on the burden of proof alone only when driven to it and where no other course is open to him given the unsatisfactory state of the evidence.
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> ii) Consideration of such a case necessarily involves looking at the whole picture, including what gaps there are in the evidence, whether the individual factors relied upon are in themselves properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.
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> iii) The court arrives at its conclusion by considering whether on an overall assessment of the evidence (i.e. on a preponderance of the evidence) the case for believing that the suggested event happened is more compelling than the case for not reaching that belief (which is not necessarily the same as believing positively that it did not happen) and not by reference to percentage possibilities or probabilities."

11. In respect of the value of oral testimony and demeanour Peter Jackson LJ in the case of *Re B-M* [2021] EWCA Civ 1371 said the following:

> "28. Of course in the present case, the issue concerned an alleged course of conduct spread across years. I do not accept that the Judge should have been driven by the dicta in the cases cited by the Appellants to exclude the impressions created by the manner in which B and C gave their evidence. In family cases at least, that would not only be unrealistic but, as I have said, may deprive a judge of valuable insights. There will be cases where the manner in which evidence is given about such personal matters will properly assume prominence. As Munby LJ said *in Re A (A Child) (No. 2)* [2011] EWCA Civ. 12 said at [104] in a passage described by the Judge as of considerable assistance in the present case:
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> "Any judge who has had to conduct a fact-finding hearing such as this is likely to have had experience of a witness - as here a woman deposing to serious domestic violence and grave sexual abuse - whose evidence, although shot through with unreliability as to details, with gross exaggeration and even with lies, is nonetheless compelling and convincing as to the central core… Yet through all the lies, as experience teaches, one may nonetheless be left with a powerful conviction that on the essentials the witness is telling the truth, perhaps because of the way in which she gives her evidence, perhaps because of a number of small points which, although trivial in themselves, nonetheless suddenly illuminate the underlying realities."
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> 29. Still further, demeanour is likely to be of real importance when the court is assessing the recorded interviews or live evidence of children. Here, it is not only entitled but expected to consider the child's demeanour as part of the process of assessing credibility, and the accumulated experience of listening to children's accounts sensitises the decision-maker to the many indicators of sound and unsound allegations."

12. I remind myself in relation to lies told by a witness that I should take account of a revised *Lucas* direction. Accordingly I should only have regard to a lie told by a witness if I am satisfied that there is no innocent reason for the witness to have lied in their evidence.

13. The Court of Appeal considered the application of a *Lucas* direction in *Re H-C* [2016] EWCA Civ 136. McFarlane LJ, as he then was, emphasised the following at paragraph 100:

> "One highly important aspect of the *Lucas* decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord

> Lane's judgment in *Lucas*, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of *R v Middleton* [2001] Crim.L.R. 251.
>
> In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt."

14. I entirely accept that the mere fact of a lie being told does not prove the primary case against the party or witness who has been found to have lied to the court.

15. Findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on mere suspicion, surmise, speculation or assertion: *Re A (A Child) (Fact Finding Hearing: Speculation)* [2011] 1 FLR 1817 and *Re A (Application for Care and Placement Orders: Local Authority Failings)* [2016] 1 FLR 1.

16. There is no obligation on a party to prove the truth of an alternative case put forward by way of defence and the failure by that party to establish the alternative case on the balance of probabilities does not of itself prove the local authority's case: *Re X (No.3)* [2015] EWHC 3651 (Fam) and *Re Y (No.3)* [2016] EWHC 503 (Fam).

17. The case presented by the mother and the father is that A's and B's various episodes must be as a result of a cause as yet unknown to medical science (the 'unknown cause'). Ms Grief KC and Ms Munro, on behalf of the mother, invited the court in closing submissions to reflect on a number of well known cases where the court was unable to explain the cause of a child's death and/or injuries. The principal case relied upon was the decision of Sir Mark Hedley in the *London Borough of Southwark v A Family* [2020] EWHC 3117 (Fam). At the conclusion of his judgment Sir Mark observed as follows in paragraphs 182 and 187 to 188:

> "182. If ever there was a case in which the court had to retain the big picture, both for the controversial and the uncontroversial evidence, this was it. Much of my time over the last four weeks in preparing this judgment has been spent not in writing or organising but in careful reflection on that big picture. In the end, I have come to a conclusion that the Local Authority has failed to prove its case to the requisite standard. In reaching that position, I also have to recognise that I have no clear answer to give as to how S died, since, and this is really common ground, none of the canvassed alternative suggestions could be clearly established.
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> …
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> 187. Since this is at least the second time that I have concluded after a long forensic enquiry that I do not know what has

> happened, I need to ask myself one hard question: is this simply a failure of judicial nerve to make a finding against a family such as this, the finding which is nevertheless required by the evidence as a whole? I ask that question not just because it occurred to me but also because I recognise that decisions in cases like this are not driven exclusively by the process of reasoning.
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> 188. There is an element in human judgment that lies beyond cold rationality as every experienced trial judge soon comes to appreciate. In order to test that, I have reflected carefully upon the position as it would be were I to have found that the Local Authority had indeed established their case and this child had been sexually assaulted and killed by one or more members of a family who had then conspired to conceal the truth from all legitimate enquiry. I discovered that such a conclusion would be an affront to my judicial conscience."

18. I respectfully agree with those observations but, of course, much turns on the facts of and the evidence in the individual case.

19. Mr Twomey KC and Mr Adler, on behalf of the father, raised the issue of hindsight or outcome bias. They drew my attention to the case of *Surrey County Council v E* [2013] EWHC 2400 (Fam) where Theis J observed at paragraph 75 that:

> "I should guard against 'Hindsight Bias' and 'Outcome Bias' which is described in The Department of Education's Guidance on 'Improving the Quality of Serious Case Review published in June 2013 as follows:
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> *'Hindsight bias occurs when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident. Outcome bias occurs when the outcome of the incident influences the way it is analysed. For example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. If people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair*.'"

20. I respectfully agree with all of the above authorities and I have taken account of them in my consideration of the evidence and in my analysis of the same.

Background

21. A and B's sister C sadly passed away in April 2020 aged two years and four months. Days before her death, C was diagnosed with Wolf-Hirschhorn Syndrome ('WHS'), a rare genetic condition. The coroner found that C's death was related to seizures.

22. The mother has since expressed to medical professionals that she blames herself for C's death as she knew something was *"not right*" with C since she was born. The mother has indicated that she did not have much support regarding C's death.

23. Both A and B experienced some neonatal difficulties. After A was born, she had a gastro-intestinal haemorrhage. She was on the neonatal unit for five days and required incubator oxygen, though was not intubated or ventilated. B developed respiratory difficulties at birth and required intubation, assisted ventilation, and a chest drain placement. B was also noted to have a 6mm atrial septal defect (hole in his heart) in April 2022 which appeared to have closed by August 2022.

24. It has been confirmed through genetic testing that neither A nor B suffer from WHS.

Reported episodes

25. Both A and B have been reported by their mother to have experienced seizure- like episodes on numerous occasions. No one other than the mother has witnessed the onset of the children's symptoms. A and B have regularly been presented to medical settings and, respectively, have spent 74 days and 33 days in hospital for reported seizures. Of particular relevance are the following incidents.

26. On 18 June 2020, two months after C's death, the mother took A to A&E, stating that she had had a seizure for three minutes. She reported that A had laid down, shaken from side to side, that her eyes had glazed over and rolled backwards, and that she had a floppy episode. A was thoroughly investigated, including by way of an MRI, a 24-hour ECH and an EEG; all results were normal. A was not observed to have any episodes during the seven days for which she was an inpatient. A was prescribed clobazam and midazolam.

27. On 27 June 2020 A was brought to A&E again. The mother reported that she had had a seven-minute seizure during which A's limbs had gone floppy, after which she was unresponsive for 20 to 25 minutes. The mother administered midazolam. Upon initial assessment by paramedics A was scored 3/15 on the Glasgow Coma Score ('GCS'), meaning no eye opening and no verbal or motor response. A was still slightly floppy when she arrived at A&E. The mother expressed a wish for A to be transferred to Great Ormond Street Hospital as she was afraid that what happened to C would happen to A. The mother reported a seizure when A was on the ward, but when the nurses saw A, she was pink and well perfused. Later that day the mother was in the bathroom with A and shouted for help. When nurses entered, A was very pale, floppy and cyanosed around her lips. A began to scream and roll her eyes back. The mother again expressed her desire for a transfer to Great Ormond Street Hospital or Royal London Hospital, and a referral was made to the latter.

28. A underwent scalp video telemetry recording from 30 June 2020 to 3 July 2020. The mother reported an eye rolling episode during this period, although the EEG showed no changes during that period. The video telemetry did not capture any seizure activity.

29. On 10 July 2020 during a stay at hospital, the mother reported that A had a seizure in the bathroom which lasted just over five minutes. The mother was noted to

demonstrate no urgency when conveying this to the nursing staff. A was observed as being post-ictal and asleep but rousable. Her observations were stable.

30. On 14 July 2020 the mother called an ambulance, reporting that A had collapsed and had a seizure lasting 5 minutes and 40 seconds after hitting her head on the sofa during a tantrum. The mother gave A buccal midazolam. In the ambulance, A was floppy and she projectile vomited twice.

31. During A's stay in hospital on 20 July 2020, the mother told professionals that A had a cluster of seven small seizures within five minutes. The mother took a video of one of the episodes, which was noted to show A yawn and then stare to the side for under a minute. Nursing staff did not feel that the video showed any seizure activity. A's observations were stable.

32. On 25 July 2020 the mother called an ambulance, stating that A had cluster seizures and then another seizure lasting seven minutes. The mother gave A buccal midazolam and said that the seizure stopped for around 40 seconds before A had a further three cluster seizures. Upon arrival the ambulance crew noted that A had a GCS of 15/15, meaning she was fully awake and responsive. A was admitted to hospital.

33. On 29 July 2020 the mother informed a staff nurse of A having a staring episode which she stated had occurred on the ward. The mother did not alert night staff at the time of the incident, and the episode was not witnessed by anyone other than the mother.

34. On 10 August 2020 the mother called an ambulance, advising that A appeared to have climbed out of her crib and landed on the floor, and the mother had found her awake but not responsive. Ambulance crew found A lying supine on the sofa, appearing to be asleep. After gentle stimulus A woke up but seemed slightly groggy. The mother was reluctant to go to hospital but eventually agreed. A was taken to A&E and upon examination was observed to be completely well apart from some dental issues.

35. On 18 August 2020 the mother called an ambulance, reporting that A had a 7.5 minute absent seizure with twitching arms and legs. The mother gave A buccal midazolam. A was found by the ambulance crew to have limited verbal communication but appearing calm and not indicating any pain or discomfort. She was conveyed to A&E. Her observations were stable.

36. On 1 October 2020 A was admitted to Great Ormond Street Hospital due to her recurrent episodes. A had a prolonged EEG recording which was within normal elements and did not capture any seizure events. Doctors explained to the mother that as they had been unable to capture any seizures on an EEG, they would need to trial taking A off her medication. The mother was noted to be anxious about this.

37. On 17 October 2020 while A was an inpatient in hospital the mother reported that she believed A was having a seizure when asleep as her left arm went up and down twice. Upon observation, A was noted by nursing staff to be settled in a deep sleep and not displaying any seizure activity.

38. On 13 July 2021 the mother called an ambulance to report that A had experienced apparent chest pain and collapsed, lost consciousness, was unresponsive, and had a blue tinge around her mouth. On arrival at A&E, A was active and chatty with normal observations. She was noted to have pinpoint red papules around her mouth which were attributed to dermatitis.

39. Following B's birth in October 2021, no further events in respect of A were reported by the mother.

40. On 13 February 2022 the mother called an ambulance, reporting that she had noticed B was not moving or breathing, that his lips had turned blue, and that he was floppy. The mother stated that she had done CPR including two breaths and chest compressions. On arrival of the paramedics B was awake and alert and had an increased respiratory rate and heart rate. One of the paramedics made a referral to children's services due to concern about B's presentation and the mother's mental health.

41. On 1 April 2022 B was admitted to A&E after his mother reported that B had been asleep on her lap when he suddenly stopped breathing and turned blue around the face. She reportedly gave him CPR and she says he came round after four minutes. When paramedics arrived, they reported that B was alert but pale and slightly sleepy.

42. While B was an inpatient on 2 April 2022 the mother called nursing staff and reported that his oxygen saturations fell to 88% when he was asleep and that he had gone purple around the lips for two minutes. This was not witnessed by the nursing staff. The mother further said that B had an episode of high-pitched crying immediately followed by sudden jerking of arms and legs. On arrival of a nurse, B was observed to be sweaty and mottled with low oxygen saturations of 85%. No seizure activity was observed, and an EEG showed no evidence of seizure activity. B recovered and had no further episodes that day.

43. On 9 April 2022 B was again presented to A&E after his mother reported that he had two seizure like episodes lasting three minutes and two minutes at home. The mother recorded a video on her phone on this occasion. At hospital B was noted to be alert and well-perfused.

44. Whilst at hospital on 12 April 2022 a cardiac arrest call went out while B was in the room with his mother. The mother reported that he had had an episode. B was found by staff to be unresponsive with oxygen saturations of 80%, though nurses did not witness any seizure activity. Video telemetry was undertaken for two days, and no recorded seizures were documented.

45. On 15 April 2022 B was reported by his mother to have had a blue episode which lasted a few seconds. Staff found B blue around the lips and gave him oxygen. Further similar episodes were reported by the mother on 16 April 2022. B had been found floppy, mottled and drowsy with ineffective breathing by the resuscitation team. He was therefore admitted to the paediatric critical care unit. Seizure activity was not captured on video telemetry.

46. On 20 April 2022 B required advanced paediatric life support following a crash call. His mother reported that he had had twitching and stiffening of the right arm prior to a

cyanotic episode. The nursing team attended and found B floppy, apnoeic, and cyanosed.

Safeguarding concerns

47. On 23 April 2022 there was a further incident involving B which was captured on camera. The footage shows the mother going to the bathroom and returning to pick up B. The mother removed the oxygen saturation cable from B's foot and subsequently carried B around the room. The mother switched off the observation monitor and continued to walk around the room with B. She then took B into the bathroom and closed the door. They were in the bathroom for approximately three and a half minutes. When the mother emerged with B he was floppy and blue. The mother placed B back in the cot, reattached the oxygen saturation probe on his foot and switched on the observation monitor. She waited for the light to turn on and then pressed the emergency buzzer, before loosening the blanket in which B was swaddled.

48. A team of medics reviewed this footage on 25 April 2022 and concerns were raised as to fabricated or induced illness. The police were called, and the mother was arrested shortly afterwards. She was subsequently released with bail conditions not to see her children.

49. A was placed into her paternal grandparent's care upon the mother being arrested. The father later signed a section 20 agreement for B to be discharged from the hospital to his paternal grandparents' address. Both children have been living with their grandparents since this time. Neither A nor B have been observed to have any episodes since being in the care of their grandparents.

The Mother's Vulnerabilities

50. The mother had a psychiatric assessment in 2019, at which time she was noted to be going through bereavement in relation to her father and a possible depressive episode. In November 2021, she received support from Newham Hospital mental health team, which had offered bereavement support and a diagnosis of post-traumatic stress disorder relating to C's death.

51. A cognitive assessment of the mother was undertaken by Dr Dowsett in September 2022. A full-scale IQ test was not completed as there was significant variation in the index scores. The mother was determined to have borderline verbal comprehension, low average perceptual organisation and extremely low working memory and processing speed. The mother scored above the threshold on screening measures for dyslexia, ADHD and autism spectrum disorder. It was recorded that the extent of the mother's reported difficulties indicated that she was likely to have significant difficulties with independent living. Dr Dowsett recommended a specialist assessment for autism spectrum disorder.

52. The mother was diagnosed with autism at level 1 severity in January 2023. Her diagnostic assessment emphasised that her full psychological profile needed to be understood in the context of areas of low cognitive function, specific learning difficulty and impact of traumatic events and adverse childhood experiences. The assessment concluded that the mother will need support because of:

i) Reduced use of non-verbal behaviours (eye contact, facial expression, body posture and gestures) within interactions;

ii) Incongruent facial expression leading to misreading from other people as to how she feels;

iii) Difficulties developing peer relationships;

iv) Reduced interest in connecting and interacting with others;

v) Lack of perspective taking and awareness of how actions or words may impact others emotionally;

vi) Understanding what is appropriate to say and do in different social situations;

vii) Repetitive self-soothing actions;

viii) Eye for small details and changes to the norm/what is expected;

ix) Tendency to be literal in thinking leading to misunderstandings;

x) Reduced turn taking, focusing on own ideas and needs;

xi) Lack of creative thinking leading to difficulty generating ideas and possible options;

xii) Quiet voice with little variation in tone;

xiii) Reduced insight in emotions and relationships; particularly her role in them; and

xiv) Preference for order including compulsive behaviours to create order.

53. Special measures, including the use of an intermediary for the mother, have been in place throughout this hearing.

54. I have taken the mother's vulnerabilities into account when assessing her evidence.

Expert Evidence

55. I gave permission for five expert medical witnesses to be instructed to prepare reports for the purposes of this fact finding hearing. They were:

i) Dr Appleton, a consultant paediatric neurologist, whose report was dated 7 March 2023;

ii) Professor Bu'Lock, a consultant paediatric cardiologist, whose report was dated 10 March 2023;

iii) Dr Palm, a consultant paediatric pathologist, whose report was dated 13 March 2023;

iv) Dr Irving, a consultant geneticist, whose report was dated 23 March 2023; and

v) Dr Ward, a consultant paediatrician, whose report was dated 28 April 2023.

56. Further, in relation to assessments of the mother's functioning, I approved the instruction of two experts. They were Dr Dowsett, a consultant clinical psychologist, whose report was dated 2 September 2022, and Dr Harris, a chartered psychologist with a specialism in autism, whose report was dated to 10 January 2023.

57. In his report Dr Dowsett offered the following conclusions and recommendations:

> "On a general IQ test she scored a rather inconsistent profile with both her working memory and her processing speed lying in the impaired (learning disability) range. Her visual-spatial ability appeared to be a strength and was actually in the low average range. As such it would be misleading to compute an overall (full-scale) IQ and it should be noted that she had both strengths and weaknesses in her cognitive functioning with impairment in the areas described.
>
> …
>
> Clearly these findings in combination indicate that the mother needs a learning environment which is optimised to her reported difficulties.
>
> I have suggested that a specific assessment for autistic spectrum disorder (ASD) would be helpful in this regard. In the interim she is likely to need additional support to function independently with a variety of tasks especially in literacy, memory, organisation and social interaction.
>
> The mother is likely to benefit from one-to-one support from someone who is able to carefully monitor her processing, understanding and retention of any information given. She is likely to benefit from extra learning trials and in an environment which is free from distraction and social complexity. She should have a parenting assessment designed for individuals with a learning disability such as the PAMS.
>
> Care should also be taken not to misinterpret any features of her social and emotional presentation until an autistic spectrum or abnormal personality traits have been clarified.
>
> In my opinion the mother should have an assessment by an intermediary for her attendance at court and should be supported by an advocate at other meetings with professionals in order to assist her understanding and retention of information.
>
> …
>
> I do recommend a psychological assessment is undertaken and in the first instance would suggest that is undertaken by a

> psychologist with specialist experience working with adults with ASD. There are recognised semi-structured protocols and assessment instruments which can assist with this."

His evidence was accepted by the parties and, therefore, he was not called to give evidence.

58. Dr Harris diagnosed the mother with autism at the level one severity. He made recommendations, in particular, about the type and level of support the mother would require to enable her to engage with and participate in this hearing and the proceedings more generally. His principal conclusions and recommendations were:

i) The mother receives a formal autism diagnosis. Her full psychological profile needs to be understood in the context of areas of low cognitive functioning, specific learning difficulty, and impact of traumatic events and adverse childhood events.

The mother's assessment provides clear evidence that she meets the diagnostic criteria for autism at the level one severity. There are three severity levels that increase in support needs with level three reflecting the greatest support needs. Her assessment showed the following areas of difference and/or deficit that will need support:

ii) Being autistic does not automatically mean that the mother cannot parent to a good enough level and have interpersonal relationships that are balanced and mutually rewarding. However, there are elements in daily life that she will need to be mindful of in relation to how her autism shapes her thinking styles and behaviours. The following are more prominent aspects of her autism that will need to be considered by the mother and those involved in her care planning:

iii) The mother will need support from an intermediary to provide her best evidence. Alongside her cognitive, receptive/expressive communication needs, as outlined in the Communicourt report and Cognitive assessment, her autism means that she is prone to literal interpretations; difficulty understanding the intentions of others; and a difficulty managing and expressing her emotional state in adaptive ways. This could manifest as a heightened stress response which will negatively impact on her ability to reason at optimal levels.

Continued use of her advocate to help her prepare and communicate her wishes and feelings will also be needed outside of court hearings.

The mother uses text-to-speech applications on her mobile phone to support her comprehension of written information. She uses this to have emails read aloud. Important letters and reports will need to be provided in a summary form and sent in a format she can then use in her text-to-speech application. She explained her preference is to receive short emails that she can copy and paste the text into the text-to-speech application.

Dr Harris' report was accepted by all parties and, therefore, he was not required to give evidence.

59. In consequence of Dr Dowsett's and Dr Harris' reports I appointed an intermediary to assist the mother during case management hearings, in consultations with her leading counsel and/or junior counsel and her solicitors.

60. The intermediary sat next to the mother throughout this fact finding hearing, including, importantly, when the mother gave her evidence. I am told and accept that as well as assisting the mother during the court hearing, the intermediary spent time with the mother at the conclusion of the court day and/or before the start of the court day to ensure the mother was following the proceedings and the evidence to the very best of her ability.

Dr Palm

61. Dr Palm, the consultant paediatric pathologist was instructed to consider the circumstances of C's death in the light of events relating to A and B. The principal conclusions set out in Dr Palm's report are as follows:

    i) Whether C's death was due to natural causes or a result of a miscalculated attempt at smothering may never be established, especially based on the pathology evidence alone.

    ii) C was a well-grown young child with a genetically confirmed WHS, which manifested clinically as early-onset refractory epilepsy with frequent and atypical seizures, delayed global developmental delay and postnatal growth failure. No other internal developmental malformations (e.g., heart defect) or congenital disorders, unassociated with WHS were detected after death.

    iii) The clinicopathological evidence available in 2020, i.e., the provided medical history, circumstances of death and the post-mortem findings fulfilled the criteria required for a diagnosis of 'definite SUDEP'; hence, a natural cause of death. However, as there are no specific pathology findings specific for SUDEP, the diagnosis remains based mainly on the medical and circumstantial evidence.

    iv) Regarding the concerns about possible symptom fabrication by means of smothering in C's siblings, the initial clinical history has become less reliable for reconfirming the diagnosis of SUDEP.

    v) After reconsidering the new evidence in the light of the post-mortem findings, I cannot exclude a possibility of an unnatural death by means of smothering, which is difficult to prove or disprove after death due to absence of specific physical findings.

    vi) Therefore, my professional opinion with regards to the cause and the manner of C's death has changed and should be reformulated as Unascertained.

    vii) Although certain aspects in C's medical history may suggest a possibility of a fabricated or induced illness, the pathology evidence failed to support this suggestion.

viii) Whether or not C's death was due to natural causes or a result of a miscalculated attempt at smothering cannot be established, especially based on the pathology evidence alone.

No party required Dr Palm to attend to give evidence. On the basis of her report the local authority and the children's guardian, rightly in my view, decided not to pursue any adverse findings of fact in relation to the death of C.

Professor Bu'Lock

62. Professor Bu'Lock, a consultant paediatric cardiologist, broadly concluded in her report that neither A nor B had any cardiac defect or condition which on the balance of probabilities explained or caused their respective 'seizure' episodes.

63. In her oral evidence Professor Bu'Lock made the following principle points:

i) there was nothing in B's presentation which suggested he had any cardiac abnormalities;

ii) there was no evidence from the ECG monitoring that B had any rhythm abnormalities;

iii) if B had myocardial scarring it was highly unlikely that this could be a cause for his 'seizure' episodes;

iv) the professor was surprised that B did not die during the 'seizure' episode which was recorded by the mother on her mobile telephone at home on 9 April 2022;

v) the red markings seen on B's face after the event of 16 April 2022 were highly unusual. When asked if these markings could spontaneously occur, the professor replied that (a) she had never seen it and (b) the markings did not correspond with the sit of the underlying blood vessels on B's face; and

vi) all of the events suffered by B were life threatening.

Dr Irving

64. In her report Dr Irving concluded as follows:

> "Neither A or B has Wolf-Hirschhorn Syndrome. Neither child has had seizures whilst in the interim care arrangement with their paternal grandparents, as far as I am aware. And early concerns about any unusual facial features and mild developmental delay have also dissipated.
>
> Genetic testing in B and A has consisted of chromosomal microarray testing, which returned normal result. A has had additional testing of a panel of genes related to childhood epilepsy, and no significant changes were detected.

> In view of improvement in the children's overall condition and given the results of the previous testing, nothing further is required.
>
> …
>
> However, if any of the other experts determine that there is a definitive epilepsy diagnosis and if there have been new concerns raised over the children's development subsequent to the documentation provided in the court bundle, I would be happy to reconsider whether any further testing would be helpful or not."

65. Neither A nor B has a definitive diagnosis of epilepsy.

66. Dr Irving told me in her oral evidence that genetic testing was used to support a diagnosis. She confirmed her report's conclusion that no further genetic testing was required. She said that if it was excluded that neither A nor B had a diagnosis of epilepsy or apnoea (which neither have) then there was no basis which would warrant or necessitate any further genetic testing of either of them. She concluded her oral evidence by confirming that genetic defects do not resolve spontaneously without medical intervention.

67. During the course of Dr Irving's evidence it became apparent that she had not had the opportunity to read and consider Professor Bu'Lock's report. She was invited to do so and to provide an addendum report. In her addendum she concluded that:

> "B is not reported in the medical documentation to have evidence of developmental delay. He has had a normal chromosomal microarray test result recorded. All of this makes a syndrome unlikely.
>
> A has mild delay, and her mother has 'specific' learning difficulties, perhaps on the autistic spectrum. I believe this is what Prof Bu'Lock refers to as 'syndromic'. I agree there may well be an underlying cause of the mother's LD, possibly multifactorial in nature given the extended family history of attention deficit disorder (ADD), but independent of Wolf-Hirschorn syndrome (WHS), and epilepsy/apnoea, as, if the suggestion is that any syndromic association for the children's presentation has been transmitted directly from the mother, we would expect her to have similar issues. She does not.
>
> Prof Bu'Lock makes mention of extending genetic analysis to whole exome or even whole genome sequencing, which would indeed be warranted if any other factors indicative of a wider syndrome were presented in the children, but there are none."

Dr Ward

68. In her report of 28 April 2023 Dr Ward concluded as follows in respect of A:

i) In relation to A, I agree with the findings made by the other experts. Dr Appleton has provided a detailed account of diagnosis and classification of epilepsy and fabricated and induced illness in relation to epilepsy. I defer to his expert opinion and agree with his appraisal of A's perplexing presentation. I agree that it is unlikely that A has any type of epilepsy. I agree that it is probable that some episodes were not fabricated, or induced, but a misinterpretation of normal behaviours by her mother. I agree that it is possible that events reported by her mother were fabricated and induced and that partial suffocation, causing hypoxia, could account for altered consciousness, blueness of the lips, jerking and increased tone. Use of buccal midazolam could have resulted in altered consciousness, reduced responsiveness and apparent absences;

ii) If the Court accepts that A was exposed to induced illness by partial suffocation, or overdosage/poisoning with drugs, the potential consequences are more severe. Induced illness of this nature is potentially life-threatening, or life- limiting, as a result of hypoxia, or drug toxicity. However, even in the case of exaggeration, or fabrication, of symptoms, the child may be denied everyday experiences as a result of recurrent hospitalisation, with possible impact on physical, emotional and cognitive development.

69. In respect of B, Dr Ward expressed the following opinions:

i) The frequent episodes of apparent life threatening events was concerning; the presence of apnoea, cyanosis with reduced oxygen saturation, unconsciousness and jerking was potentially life threatening or life limiting. Clinicians confirmed the presence of hypoxia, apnoea, pallor and altered consciousness but were unable to witness the commencement of the episodes or to capture the episodes on video telemetry despite careful observation in hospital and for a period in the paediatric intensive care unit. Inability to identify the commencement of the seizure made it difficult to identify the causation. Eventually, events around an episode were captured on video but not full video telemetry. The mother was observed to disconnect the monitoring equipment when B appeared to be well. He was taken by his mother to the toilet and, around 3.5 minutes later, was seen in her arms in an unresponsive state, floppy and blue. The mother had not summoned medical attention which was particularly concerning given his appearance on the video. The cumulation of events, lack of a medical explanation for his presentation and the witnessed event was consistent with induced illness; most likely the result of induced upper airways obstruction causing hypoxia, apnoea, altered consciousness and twitching.

ii) Whilst such behaviour could lead to irreversible hypoxic ischaemic encephalopathy, with risk of death or long term neurological consequences, it is important to consider the impact of such behaviour on a child's emotional wellbeing. B spent prolonged periods in hospital and was the subject of multiple investigations which were painful and distressing. He was exposed to radiation and also exposed to potentially serious infections whilst in hospital.

iii) I have identified clear evidence of underlying medical conditions which are not related to the care that B has received. However, in concluding that the

episodes of apnoea, cyanosis and unconsciousness are induced, this has clear implications for the care that B has received from his mother.

70. In her oral evidence Dr Ward confirmed that the above remained her opinions. She explained that the consequences for a child subjected to fabricated or induced illness were having to undergo multiple unnecessary, and sometimes painful, medical investigations and repeated admissions to hospital. She also described the adverse psychological impact of these events, including the impact on a child's psychological development. In respect of induced illness as a result of attempts to suffocate or obstruct a young child's airway, she explained that these actions are extremely harmful which could result in the child's death or could have life limiting consequences for the child.

71. She told that me that the evidence for the inducement of illness was stronger in the case of B than it was in the case of A. The events of 9 April and 23 April when B had to be resuscitated were life threatening and could have resulted in his death. The response of the mother after B's collapse on 23 April, which was captured on the hospital video camera, was completely inappropriate. B was in extremis and needed immediate medical attention.

72. In her cross-examination of Dr Ward, Ms Grief KC explored a number of possible medical causes for the 'seizure' events suffered by A and B (including mould in the then family accommodation, asthma, epilepsy, food allergy or reflux). Dr Ward was clear that epilepsy and asthma did not spontaneously resolve without medical intervention.

73. Dr Ward advised that the episode suffered by A on 17 October 2020 was innocuous and not suspicious. Nonetheless the actions of the mother led to A undergoing unnecessary medical treatment and investigations. In respect of the episode on 20 January 2021 the history given by the mother did not fit with how A presented to the medical staff. In every other presentation of A or B to paramedics and/or medical staff at various hospitals there was no medical explanation for the presentation of or symptoms exhibited by either A or B. The only possible exceptions in respect of A having a reduced level of consciousness and/or being floppy, were when the mother inappropriately and wrongly administered buccal midazolam to A, as set out on in paragraph 4(x) above.

74. Dr Ward agreed with the proposition put forward by Mr Tughan KC, leading counsel for the children's guardian, that as the episodes relating to A tailed off, so the episodes relating to B commenced and quickly escalated in frequency.

Dr Appleton

75. In his report of 7 March 2023 Dr Appleton reached the following conclusions:

    i) (a) C had global and severe developmental delay and an early-onset, complex and medically refractory epilepsy. Both of these features are well recognised and common features in Wolf-Hirschhorn syndrome.

       (b) On the balance of probabilities, it is my opinion that C's reported seizures were not a manifestation of fabricated or induced illness but epilepsy.

(c) Her most likely cause of death was a 'definite' SUDEP.

ii) A is very unlikely to have had any type of epilepsy. The most likely cause of her reported very frequent paroxysmal events was fabricated or induced illness. It is possible if not probable that a minority were not fabricated or induced but a mis-interpretation of normal behaviours by her mother. On the balance of probabilities, the events reported by her mother were fabricated and also induced, the latter by causing the events. Partial suffocation was the most likely mechanism that caused the reported episodes of stiffness, jerking and cyanosis of her lips. Some of her events may have been induced by the use of buccal midazolam in causing her to be very sleepy and 'absent'.

iii) B is very unlikely to have had any type of epilepsy. It is also unlikely that he had an underlying cardiac arrhythmia (an abnormal heart rate or rhythm, or both) that was responsible for his reported very frequent paroxysmal events. A definitive opinion from a Consultant in Paediatric Cardiology may be required on this specific issue. The most likely cause of his reported very frequent paroxysmal events was fabricated or induced illness. Partial suffocation was the most likely active mechanism that caused some or many of the reported episodes of stiffness, jerking and cyanosis.

76. Dr Appleton confirmed his opinion that neither A nor B, on the balance of probabilities, had experienced any unprovoked epileptic seizures. In respect of A, he set out in his report six clear and comprehensive reasons why he had reached this conclusion and in respect of B he set out five clear and comprehensive reasons.

77. In the course of his cross-examination by Ms Grief KC, Dr Appleton said that he was confident that A did not have self limiting infantile epilepsy and concluded by saying that it was highly unlikely that she suffered from this condition.

78. Ms Cook KC was cross-examining Dr Appleton about the video of 23 April 2022 when the mother was seen taking B to the toilet with her. He referred to B being seen in his cot shortly before this when the mother went to the toilet without B. B is seen following his mother's movements as she left the side of the cot to walk to the ensuite bathroom. Dr Appleton characterised B's actions and presentation as 'frozen watchfulness', namely that the baby was anxious and scared that something was going to happen to him. This opinion was not set out in his report.

79. I asked what was it about B's presentation that had led him to this conclusion. He replied that B's eyes were wide open and fixed on following his mother's movements but, most importantly, B demonstrated no other facial expression and made no sounds at all.

80. Unsurprisingly, Ms Grief KC sought to challenge the doctor on this aspect of his evidence and I permitted her to cross-examine him again on this issue. She asked what qualifications he had to give this opinion to the court. Dr Appleton conceded that he did not have a psychiatric qualification but had studied psychiatry during the course of his training. Further he added that this opinion was based on his clinical experience of treating babies and children over a very long period of time which included treating children who had been or were suspected of having been abused by their parents or carers.

81. I should observe that Dr Appleton had not been provided with the video of 23 April 2022 at the time when he was preparing his report and only viewed it subsequently.

82. In my judgment, Dr Appleton is a hugely experienced consultant paediatric neurologist and he was a very impressive expert witness. He gave his evidence in clear, measured but unambiguous terms. I am in no doubt that he has the appropriate clinical experience and expertise to give this opinion. I accept it.

83. The question of what weight I should give to his opinion of frozen watchfulness or what account I take of it in my overall analysis of the evidence in this case is a different issue. In light of the totality of the evidence in this case, but without doubting for one moment Dr Appleton's description of frozen watchfulness, I propose to put the doctor's evidence to one side and not take it into account in my overall analysis. Furthermore, I am fortified in coming to this view because the mother was not cross-examined about it (for the avoidance of doubt, I make this observation as a simple statement of fact and it should not read as to imply that I am making any criticism of counsel: I am not).

<u>The Clinicians and Medical Staff</u>

84. In total five treating clinicians for A and B were called to give evidence and 3 medical staff were called. None of them had witnessed the onset of a 'seizure' event in either A or B.

85. I note the significant evidence of four of these witnesses:

    i) Dr W, is a consultant paediatric neurologist, who was involved in the treatment of A. He confirmed that it was important to consider inconsistencies in the history given by the mother which he termed as a 'red flag'. He gave the example of the mother describing A suffering a 'large seizure' but followed by a full recovery very quickly. This was, he said, most unusual;

    ii) It was put to Dr W by Ms Grief KC on behalf of the mother, that parents can misinterpret vacant and absent episodes as a seizure. He agreed but said that the mother described very violent events which were not open to a misinterpretation;

    iii) It was put to a staff nurse and ward manager, Nurse D, by Ms Grief KC that she was on hand or close by when B suffered an event on 2 April 2022. The nurse explained that this was not the case. B was in the day care unit of the hospital and she was in the in patient unit when she heard the alarm sound. She then had to use a swipe card to return through a secure door to return to the day unit to check which patient's alarm was sounding before attending upon B;

    iv) Dr X is a senior paediatric registrar who attended upon B on 23 April 2022 when the mother had been filmed detaching leads from B, picking him up, switching off the monitoring machine and a short while taking him into the toilet with her. She emerged three minutes later with B in a collapsed state. She calmly placed B back in his cot, reattached the leads, turned the machine back on and then, but only then, pressed the alarm. Dr X said that:

a) she had seen the video and noted how very calm the mother had appeared which in her experience was very unusual. Her usual experience of parents with a collapsed child is that they are extremely panicked; and

b) she had taken the history from the mother who told her she had fed B 20 minutes before. She was certain this was said by the mother: this video recording does not show B being fed. [I note that during the course of this hearing and after Dr X had given evidence a further video recording of 23 April 2022 was provided to the court and the parties. On this video the mother is seen to be feeding B some 20 minutes before his sudden collapse]. Furthermore she was clear that the mother had not told her about removing the leads, switching off the leads, of a visit with B to the toilet or of her re-applying and switching on the machine all before pressing the alarm.

v) Dr Y, the treating consultant paediatric neurologist, had been involved in the care of C, A and B. He told me that:

a) as time moved there was concern amongst the treating clinicians that A did not have epilepsy. Initially the view was that the mother was overinterpreting symptoms and behaviours reportedly seen in A. The concerns increased to a point when the clinicians considered whether this was a case of fabricated or induced illness but the family was given the benefit of the doubt. However, when B then began to have episodes at an alarming frequency a decision was made to proceed down the child protection route;

b) in contrast to the periods when C and A were in hospital, when B was in hospital the mother was very withdrawn and low in mood. There was not the same level of interaction by the mother with the hospital staff;

c) nevertheless, she had always been a robust advocate for all of her children and was able to question the clinicians' proposed investigations and/or treatment plans for all three children;

d) in respect of the monitoring leads attached to B, these were very long and, insofar as Dr Y was concerned, there was no need to detach the leads from B; and

e) importantly, neither A nor B suffered from epilepsy.

vi) In a child protection medical assessment of B dated 1 May 2023, written jointly with Dr Z, Dr Y concluded as follows:

> "We know that mother has had a previous child who was very unwell with a known genetic condition and passed away and has post-traumatic stress disorder. The most likely explanation based on the evidence that we have gathered is that these apnoeic events are as a result of induced illness by his mother."

The Mother

86. The mother presented herself as an anxious mother who had suffered the tragedy of the loss of her first child, C, during an epileptic seizure. She accepted that from time to time she may have misinterpreted a period of absence in A or shaking/jerks by A or B as an epileptic seizure. Save for this the mother maintained a steadfast denial of fabricating or inducing symptoms in either A or B.

87. The mother emphatically denied that she had ever obstructed A's or B's airways whether with her hand, a piece of cloth, a pillow or by any other means.

88. She insisted she had only ever administered buccal midazolam to A in accordance with the instructions given to her by medical staff, namely only to do so after the child had been suffering a seizure of more than five minutes.

89. The mother had videoed A and B on a number of occasions each when they were suffering 'seizures' or when they were in a state of collapse and unconsciousness. Of particular note is that none of these videos captured the onset of the event in respect of either child.

90. The mother's overall behaviour towards A and B are exemplified by two video recordings both of which feature B. They are the video recording of B on 9 April 2022 and the hospital video recording of the room in which B was being cared for on 23 April 2022.

91. The recording of B on 9 April, which lasts for some 3 minutes, shows B in an apparently lifeless condition and during which agonal (end of life) gasps are heard from him. The mother is not seen to take any steps to assist the recovery of her child who is obviously in extremis. Only after stopping the recording does the mother telephone 999 and attempt to resuscitate B.

92. When Ms Cook KC put this video to the mother she responded that she had been told to video the episodes. When asked if B had needed her to help him, she replied no, that she needed to video him. She did not accept that she had done anything wrong nor did she accept that B had very nearly died as a result of this episode. When asked if she had caused the collapse of B, she said that she had not done anything.

93. The mother said that she did not know the video in B's hospital room was still activated on 23 April 2022. The second recording received during this hearing captured events earlier in the morning of 23 April than the first recording when the mother eventually took B into the bathroom with her. This second recording showed the mother feeding B his bottle whilst B was laying in his cot on his back with the mother holding the bottle on the side of his cot. On two occasions, each lasting several minutes, the mother is seen propping up B's bottle on some blankets and/or bedding and then going into the bathroom alone, closing the door behind her.

94. The first video showed the mother waking up. B is awake and quiet. The mother went to the bathroom twice leaving B in his cot. After the second time she went over to B's cot, removed the leads on him, switched off the monitoring machine and carried B in her arms around the room for a short while. B is awake, alert and seemingly

perfectly well. The mother then went into the toilet with B and closed the door. After three minutes she emerged from the bathroom with B in her arms.

95. B was now in a state of collapse and, as the mother agreed with me, in an apparently lifeless state. Did the mother rush to and pull the emergency alarm to seek immediate emergency help for her baby which it was entirely obvious that he desperately needed? No. Without any seeming panic or speed, the mother slowly placed B in his cot, slowly replaced the leads on B and switched on the monitoring machine. Only then did she pull the emergency alarm which brought nurses and doctors rushing to his room and resuscitation procedures were commenced. The mother was spoken to by Dr X.

96. Dr X explained that she found the mother was calm in her mood and effect. The mother was not very forthcoming in her account of B's collapse and said very little. Dr X has past experience of parents whose child has suddenly collapsed to be extremely panicked. In contrast the mother's presentation she said was very unusual.

97. At a meeting of the treating clinicians on 25 April 2022, they carefully watched the video of two days previously. At the conclusion of this meeting child protection procedures were instituted and the police were notified. The mother's care of B ceased. The mother was arrested by the police.

98. Since that date B has not suffered any episodes of sudden collapse or any collapse at all.

99. When cross-examined by Mr Tughan KC, on behalf of the Children's Guardian, about why she had taken off B's leads, she said they were a trip hazard. When asked why she had taken B into the bathroom on this occasion, she said she did not want to leave him alone in case he had a seizure. She said she was glad she had taken B into the bathroom because if she had not he would have had a seizure and no one would have known. When asked why she had put B back in his cot and re-attached the leads <u>before</u> pulling the emergency alarm, the mother said this was what she had been told to do by the nursing staff. When asked if she had been "setting the scene" unaware, as she was, that the camera in the room was activated, she denied having done so.

100. The mother said she had not done anything to B. She denied suffocating him and she denied that she had been trying to kill B.

101. Throughout her evidence the mother maintained that the expert witnesses and the treating clinicians were wrong. She insisted that A and B must have suffered episodes of sudden collapse as a result of a medical condition as yet unknown.

<u>The Father</u>

102. It was plain and clear from the father's evidence that he:

    i) believed the mother's account of denying she had taken any step or had done any act to harm either A or B;

    ii) would not believe the mother was capable of harming either child unless and until he witnessed such an event with his own eyes;

iii) did not accept that the mother poses any risk of harm to either child, even if adverse findings are made against the mother that on multiple occasions she had deliberately obstructed the airways of A and B;

iv) would not willingly separate from the mother even if adverse findings were made against her in respect of harming A and B;

v) loves the mother and wants the children to be returned to their joint care; and

vi) would only separate from the mother in order to be the sole carer for the children if this was the course recommended by the local authority and children's guardian and approved by the court.

103. The father accepted that the expert witnesses were agreed, as were the treating clinicians who had given evidence, that neither child had or had had a medical condition which would explain the 'seizure' episodes that both of the children suffered. He doggedly maintained the view that some, as yet, unknown medical condition accounted for their respective collapses. In light of the fact that these episodes (i) resolved spontaneously and without medical intervention for A and B and (ii) ceased immediately upon the mother being removed from the care of B, the father had to maintain that the unknown medical condition had spontaneously resolved at the same time.

104. He was asked to confirm that he had viewed the video taken by the mother of B on 9 April 2022. This video lasted some three minutes. It showed B to be collapsed and in extremis. Professor Bu'Lock had described B's respiration in this video as agonal gasps (i.e. close to death). During the video the mother simply filmed B and had made no attempt to assist or resuscitate her baby. When the father was asked what he thought of what he had seen on this video, he first said that he had not thought anything of it and then said the mother was doing what she had been told by the medical professionals.

105. In respect of the sudden collapse of B on 23 April 2022 when he was alone in the bathroom with the mother, the father said that this event and the mother's response to it did not ring alarm bells for him. He then added that the mother had done what she had, purportedly, been told to do by medical staff. He would not accept that the mother, when she emerged with an apparently lifeless B in her arms, should have immediately pulled the emergency alarm.

106. He accepted that in respect of A's and B's admissions to hospital he had very largely been absent. He was involved on three occasions with A's hospitalisation in late 2020 and had occasionally dropped off items for the mother or stayed with A or B whilst the mother briefly left the ward and/or the children's rooms.

107. The father asserted that he had not failed to protect either A or B because he had allowed both of them to be taken to hospital, from time to time, for treatment and investigations.

Analysis

108. I am extremely grateful to leading and junior counsel for their comprehensive and helpful written closing submissions. I have carefully read them and I have taken account of all of them.

109. I make the following preliminary observations.

110. The tragic death of C had a profound adverse impact on the mother and the father. The mother became highly anxious in her care of A and then B. There was a serious decline in the father's mental health. Whilst recognising and accepting these understandable reactions to C's death they do not fully explain nor justify the later actions or behaviours of the parents that I set out below.

111. The following important propositions are advanced on behalf of the local authority:

i) That no person saw the beginning of events and that the member of staff came to an episode already in progress;

ii) The mother was the only person present at the beginning of the episodes; and

iii) The fact that there were no episodes in PICU or whilst the children were undergoing video telemetry.

For the reasons set out below I accept each one as factually correct.

112. The chronology of the events concerning A and B are highly significant. In their closing submissions on behalf of the local authority, Ms Cook KC and Ms Channa summarised the key elements of the chronology as follows:

> The episodes "in A started within weeks of the death of C and just over a week prior to C's funeral. They appeared to stop spontaneously. She has had no more episodes since 13th July 2021. Those in B started for no discernible reason on 13th February 2022. They increased in frequency and magnitude until 23rd April 2022. As soon as B was removed from his mother's care, and the mother subsequently arrested, they stopped. There have been no episodes since then. None of that is consistent with an unknown cause. Something which just stops suddenly and does not endure".

113. Buccal Midazolam is a drug which is used to treat a number of conditions, including seizures. In respect of seizures it is generally prescribed when a child has suffered a prolonged seizure in excess of 5 minutes. Dr Appleton explained an appropriate dose administered to a child might lower the child's consciousness, cause the child to become floppy and/or reduce the child's respiratory rate. It would be extremely rare for it to cause a child to have an acute respiratory arrest and for the child to stop breathing. For reasons I set out below:

i) I accept the evidence of Dr Appleton; and

ii) I am not prepared to accept the mother's account of having administered on occasions buccal midazolam to A when she was alleged by the mother to have had a prolonged seizure. She may have done so and she may not have done so.

In any event, I am satisfied on the balance of probabilities, that if the drug was administered by the mother it would not have caused A to suffer a sudden collapse and/or a seizure.

114. The medical experts are agreed:

i) that neither A nor B had epilepsy;

ii) if either of them had had epilepsy it would not or, at least, is very unlikely to have resolved spontaneously without any active medical intervention;

iii) the fact that B did not have any episodes of sudden collapse after the mother was removed from his care reinforced their conclusions;

iv) on the balance of probabilities, the mother provoked the episodes of collapse in the children by:

a) deliberately and intentionally obstructing A's and B's airways; or

b) in the case of A, given she did not suffer from epilepsy, wrongly and inappropriately administering buccal midazolam to her; and

c) that on multiple occasions the mother fabricated the symptoms allegedly exhibited by the children which led them unnecessarily to be taken to hospital and subjected to potentially painful investigations and treatments.

115. The evidence of the various clinicians who treated A and/or B are at one with the medical experts.

116. In oral evidence and when challenged in cross examination by counsel, none of the expert witnesses and none of the treating clinicians who were called to give evidence deviated from their previously expressed opinions and/or conclusions.

117. I have no hesitation in accepting the opinions and/or conclusions of the expert witnesses and of the treating clinicians. The notion that either A or B both had an unknown medical condition which then resolved spontaneously without any medical intervention is patently absurd. This is an entirely fanciful and false basis for the episodes suffered by both children which is only entertained and repeated by the mother and the father.

118. I have no hesitation in accepting the evidence given by the various members of the nursing staff who were involved with the care and treatment of A and B.

119. When considering the evidence of the mother I have well in mind the opinions and recommendations of Dr Dowsett and Dr Harris in relation to the mother's vulnerabilities and difficulties; most especially her diagnosis of autism.

120. Nevertheless, I found the mother to be a wholly unsatisfactory witness. The majority of her answers were limited to “I don’t know” or “I didn’t do anything”. From time to time during her evidence she mentioned that she had short-term memory problems, only then just minutes later to give a detailed account of an event, such as her account of what she did when she took B into the bathroom on 23 April 2022.

121. At various times she gave answers which were plainly untruthful and/or were inconsistent with the account she had previously given to medical professionals, social workers and/or to the police. I take account of the following matters by way of examples only:

i) In her first police interview the mother said that on the morning of 23 April she tried to put B down but every time she tried, he would wake back up. That is contradicted by the hospital video. In oral evidence, the mother said that she did not say that and she might have got mixed up with another day.

ii) In her second police interview the mother said she heard B crying while she was in the bathroom so she went back to him and picked him up and took him to the bathroom with her. In oral evidence the mother corrected herself, saying that she could not hear B whilst in the bathroom and only heard him when she went back into the room.

iii) In her police interview the mother said she went to wash her underwear while B was recovering. In oral evidence she said that she must have got mixed up as she washed her underwear when she went into the bathroom for the first time in the original hospital video.

iv) The mother maintains that you can hear B whining in the video on 23 April which is why she picked him up. B cannot be heard to whine in the video.

v) The mother denies that she was told that B was not thought to have epilepsy except once at Basildon Hospital. The medical notes indicate that she was also told this at Newham Hospital.

vi) The mother said that she had to go to the toilet so many times on 23 April because she had a ‘belly bug’ and diarrhoea. She only raised this after the second video from Royal London Hospital emerged which showed her going to the toilet on another two occasions that morning.

vii) The mother said that she went as fast as she could when coming out of the bathroom with B on 23 April. The video shows her to walk very slowly.

viii) The mother suggested that she would not leave B unless there were nurses watching him, however Nurse G said that the mother would leave B alone to go to the shops. Further, in the hospital videos of 23 April we can see her leave B alone to go to the toilet.

ix) The mother said she cannot recall keeping a log of A’s seizures, yet this is recorded by numerous professionals.

x) The mother has told professionals on numerous occasions that the father has been abusive or aggressive. In oral evidence she said he was never violent or aggressive to her. She denied saying the things that had been recorded and said the social worker had twisted her words, or that they must have got confused with the mother's father, who was abusive. The mother denied exaggerating things about the relationship.

xi) The mother said that she could not remember whether she had any conversations with the father about the expert evidence (i.e. in the past week). It was put to the mother that she'd had a conversation with the father in which he asked her to be honest and she responded that she had not hurt the children. The mother then seemingly remembered the conversation and said it's likely she would have said that because he asked her to be honest.

xii) In oral evidence the mother initially said she could not remember if the father had been curious about why A was getting sick – she said he did not want to know about his child being sick when he couldn't help. Later, the mother said that the father asked her on numerous occasions about why A was unwell.

122. I am satisfied that the mother did not have an innocent explanation for giving any of her untruthful answers and/or inconsistent accounts.

123. The mother's actions and behaviours in respect of the episodes suffered by A are exemplified by the following two examples:

i) Dr W was one of the treating consultant neurologists for A in 2020. In October 2020 the mother gave him an account of A suffering from 'larger events' every week over the previous 3 to 4 months she had described to him. Dr W's entry in the medical notes is as follows:

> "Described as 'larger events'. These events occur approximately every week for the last 3-4 months.
> Last one was one week ago. There was a maximum of four weeks between events in August.
> 1st episode: She was playing. Stopped playing, 'stopped breathing', lip turned blue. Eyes staring to the left, Rolled up. Left hand twitching and not responsive for 7.5 minutes. 'Groggy' afterwards for 20 minutes.
>
> Latest episode of this type reported as playing on the sofa, staring at the TV. Mum placed into recovery position.
> Lips and finger tips blue. Lasted 5 mins and 15 seconds. Also eyes staring into space and left had twitching"

The doctor said it was possible, but not normal, for a parent to misinterpret vacant or absent episodes as a seizure but not major seizures. The mother had described to him very violent events. The mother had said that A had had an episode including body stiffness the night before. However, no abnormal activity was captured on the EEG. Dr W said the inconsistencies in the mother's reporting of events was a 'red flag' because it is unusual for a child to have suffered a major seizure and then to recover very quickly; and

ii) on 13 July 2021 the mother called 999 because it was alleged that A had been unrousable with blue lips for 40 minutes. Yet when the paramedics arrived A's GCS was 15. She was very active, chatty and normal.

124. The mother's actions and behaviours in respect of the episodes suffered by B are exemplified by the events of 9 April and 23 April 2023 which I have set out in detail in paragraphs 90 to 100 above.

125. Prior to the father giving evidence, I reminded myself of the caution advised by the Court of Appeal of making findings of failure to protect in respect of a non-abusive parent or carer. In the case of *Re L-W (Children)* [2019] EWCA Civ 159. King LJ said at paragraphs 62 to 64 as follows:

> "62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.
>
> 63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.
>
> 64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in *Re J*, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm."

126. In the course of the written submissions on behalf of the father, Mr Twomey KC and Mr Adler, drew my attention to a subsequent decision of the Court of Appeal in *Re G-L-T (Children)* [2019] EWCA Civ 717 where at paragraphs 72 to 74 King LJ said:

> "72. I repeat my exhortation for courts and Local Authorities to approach allegations of 'failure to protect' with assiduous care and to keep to the forefront of their collective minds that this is a threshold finding that may have important consequences for subsequent assessments and decisions.
>
> 73. Unhappily, the courts will inevitably have before them numerous cases where there has undoubtedly been a failure to protect and there will be, as a consequence, complex welfare issues to consider. There is, however, a danger that significant welfare issues, which need to be teased out and analysed by assessment, are inappropriately elevated to findings of failure to protect capable of satisfying the section 31 criteria.
>
> 74. It should not be thought that that the absence of a finding of failure to protect against a non-perpetrating parent creates some sort of a presumption or starting point that the child/children in question can or should be returned to the care of the non-perpetrating parent. At the welfare stage, the court's absolute focus (subject to the Convention rights of the parents) is in relation to the welfare interests of the child or children."

127. I respectfully agree and I have adopted this approach when considering the findings of failure to protect sought against the father.

128. The father's evidence was very deeply concerning. He told me he knew the medical experts had excluded any medical cause or explanation for the episodes and/or collapses suffered by A or B. Yet, like the mother, he clung to the notion that their episodes and collapses were as a result of a cause unknown to medical science in the face of compelling, indeed overwhelming, expert evidence to the contrary.

129. On his evidence, the father did not at any time question whether the mother had any role in the events relating to A or B. He did not take any or any meaningful steps to better understand what was happening to his children. I well understand that some parents struggle to accept that their partner whom they love, has harmed one of their children. There comes a time, however, when a parent must or, at least, should put the interests of their children first. This father did not.

130. As the cross-examination of the father progressed the concerns about his evidence increased to a point where he said in terms that:

    i) even if the court found that the mother had on occasions suffocated A and/or B, he would not consider she posed any risk of harm to the children; and

    ii) he would not believe she posed a risk of harm unless and until he saw the mother abuse one of the children with his own eyes.

131. On the balance of probabilities, indeed I am sure, that the father is wholly enmeshed with the mother and is unable to put the needs of his children ahead of his relationship with and love for the mother.

132. Accordingly, I have no hesitation in concluding that the father failed to protect either A or B.

Findings of Fact

133. I accept that in many respects the parents afforded good and positive care to A and B.

134. However the medical evidence, from the experts and from the treating clinicians is compelling, indeed overwhelming that neither A nor B had any medical condition which would cause them to suddenly collapse or to suffer seizures.

135. The notion that both children suffered from an unknown medical cause which spontaneously resolved without any medical intervention is simply not credible. In April 2022 B suffered 12 episodes of collapse. The moment his mother no longer had care of him they ceased without any medical intervention. The only possible conclusion on the totality of the evidence is that the mother induced all of these events in A and B.

136. The father suffered with poor mental health exacerbated by the death of C. This does not explain nor justify his almost total absence during A's and B's prolonged periods in hospital. He never questioned the mother about these events suffered by both of his children. He rarely, if ever, spoke with the treating clinicians to gain an understanding of his children's respective medical conditions. In short he took no step to protect his children.

137. On the balance of probabilities, indeed I am sure, that the local authority have proved each and every finding of fact sought against the mother and father.

138. Accordingly I make the findings of fact as set out in paragraph 4

above. Conclusion

139. I am in no doubt that the mother fabricated symptoms in both A and B and, on occasions, induced symptoms in A and B by obstructing their airways. The events were particularly marked in the case of B who between 1 April and 23 April 2022 on no less than 12 occasions, suffered a collapse and on 6 of those occasions he had to be medically resuscitated. These events very nearly led to his death.

140. Similarly, I am in no doubt that the father failed to protect both A and B for the reasons I have set out above.

141. Against the background of the findings of fact I have made, this matter will be listed for a welfare hearing to determine with whom A and B should live and, if not with either the mother and/or the father, the nature, duration and frequency with which they should spend time with the children.