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Neutral citation number: [2023] EWFC 139 (B)

IN THE FAMILY COURT  
SITTING AT MIDDLESBROUGH

Case No. MB22C50597

Before:

HIS HONOUR JUDGE MURRAY  
ON 7<sup>th</sup> JULY 2023  
SITTING IN PRIVATE

B E T W E E N :

REDCAR & CLEVELAND BOROUGH COUNCIL

Applicant

- and -

(1) AB

(2) EF

(3) C & D

(through their Children's Guardian)

Respondents

Ms Jacqueline Thomas KC and Ms G. Kane (instructed by Redcar & Cleveland Borough Council) appeared on behalf of the Applicant.

Ms Louise MacLynn KC and Ms K. Dodds (instructed by FAB Solicitors), appeared on behalf of the First Respondent

Ms J. McKie (instructed by Kathy Webb and Co.), appeared on behalf of the Second Respondent

Ms S. Boothroyd (instructed by Andrew Brook solicitor), appeared on behalf of the Children via their Children's Guardian, Liz Poynter.

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## **JUDGMENT**

1. C ("C") was born in 2017 at James Cook university hospital ("JCUH"). He was born at 34 weeks gestation by Emergency Caesarean section due to problems with the umbilical cord. His mother is "mother" and his father is "father". C was the parents' first child.
2. At 16 weeks into the pregnancy, a scan revealed that C had a cleft lip, alongside heart and kidney abnormalities. When C was born, the following specific issues were noted by the hospital:
  - a) Tetralogy of Fallot<sup>1</sup>
  - b) Cystic kidney disease
  - c) Cleft lip and palate
  - d) Imperforate anus<sup>2</sup>
  - e) Hypospadias<sup>3</sup>
3. Due to C's cleft lip and palate, he was started on naso-gastric tube feeding soon after birth.

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<sup>1</sup> A complex congenital heart disease

<sup>2</sup> an abnormality present at birth, and characterized by the absence of the normal opening of the anus

<sup>3</sup> An abnormality of the penis where the tube draining the bladder opens on the underneath surface of the penis rather than the tip

4. Within a week of being born, he then underwent urgent surgery to address his imperforate anus<sup>4</sup>. Because of his complex needs, he was transferred to the Royal Victoria Infirmary (“RVI”) for further treatment before being transferred to the Freeman Hospital. At 6 weeks of age, C underwent cardiac surgery before being discharged home into the care of his parents.
5. Because of C’s difficulties and complications, his first year of life was not an easy one. It was characterised by a high level of medical interventions and operations:
  - a) 01.02.17: colostomy formation
  - b) 13.03.17: tetralogy of Fallot repair
  - c) 23.06.17: anorectoplasty (PSARP)
  - d) 17.07.17: tetralogy of Fallot repair
  - e) 11.10.17: cleft lip repair and gastrostomy placement<sup>5</sup>.
6. Thereafter, C received additional medical attention to deal with his ongoing birth related issues as well as interventions to address issues raised directly by the parents:
  - a) 26.01.18: Closure of colostomy and gastrostomy change
  - b) 15.05.18: diagnosis of mild overall hearing loss in one ear
  - c) 23.05.18: Cleft Palate repair and dental extraction
  - d) 31.12.18: first stage hypospadias repair
  - e) 11.07.19: jejunostomy<sup>6</sup>
7. Because of the constellation of issues with C’s health, he had been the subject of extensive genetic investigations, which failed to identify a known genetic diagnosis.
8. The mother has a diagnosis of epilepsy. In April 2018 the mother raised concern about C suffering from seizures. The seizure activity has been reported over time to consist of vacant episodes, drops and occasional convulsions. Some of the reported seizure activity has been recorded on video by the mother and shown to medical professionals. As a result, some of that observed footage has been considered to most likely represent seizure activity. Whilst it is difficult to be clear whether the medical records represent incidents of in-person

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<sup>4</sup> Sigmoidostomy and mucous fistula formation (a type of colostomy)

<sup>5</sup> Primary 14fr button

<sup>6</sup> Surgical procedure whereby a feeding tube is placed through the abdomen and into part of the small intestine. From this point (April 2018) until end of 2022, C remained on jejunal feeding and gastric drainage.

independently observed seizure activity, or reporting by the mother, there is reference to a physiotherapist documenting two episodes of witnessed episodes where C has become vacant.

9. The parents second child, D, was born on 08.04.2022. He was delivered by way of emergency caesarean section at 36 weeks gestation. Although there were some initial concerns expressed in respect of hypospadias, D did not suffer from the same complex issues as his brother.
  
10. However, during the first 8 months of his life, whilst in the care of the parents, a Court appointed expert has noted an “excessive number of overall attendances for review, rare and worrying symptoms of disease, unusual response to medication and over interpretation of symptoms “.<sup>7</sup>

#### **Precipitating referral**

11. A referral was received by the Local Authority on 01.12.2022 from Dr W at Great North Children’s Hospital. Dr W is a gastroenterologist who had recent care of C.
  
12. The specific concerns being raised by Dr W will be explored in fuller detail later within this judgment. However, a summary of those concerns can be extracted from page 4 of his report dated 11.12.22:

*“C’s presentation of GI symptoms and signs is perplexing. I am now of the view there is Fabrication of Illness. The reasons from moving from PP to FII has included definite situations where observations are falsified, observations discrepant from the history given by the mother and line tampering (actual harm to C). Symptoms reported are severe and long-standing and investigations and treatments performed (three endoscopies, surgical closure of infected gastrostomy site, surgical insertion of jejunal feeding tube) are likely to not be needed, are at significant risk to C’s health (operative death, bowel perforation or serious bleeding) and follow on from a history given by his mother that looks false”.*

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<sup>7</sup> Dr Mecrow; report dated 04.05.2023, at paragraph 91

13. Those wider concerns appear to have crystallised following an incident on 22.11.2022. On that occasion it is alleged that the mother has engaged in falsification of gastric aspirates:

*“The most stark and inexplicable event of fabrication of symptoms, was presenting to me 2 syringes of feculent material, that was totally different from that draining out of the stomach. I have elaborated on why this observation is important above. I am not legally trained, but I am concerned that this is a probable act of deception that appears brazen”.*

14. Following that referral, a strategy meeting took place on 02.12.2022. At that strategy meeting the following is recorded<sup>8</sup>:

*“Concerns have been reported on 01.12.22 from Dr W (Royal Victoria Infirmary, Newcastle upon Tyne) that during hospital observations of child C that it was identified that his mother had given a sample of fluid which she reported had been taken by her from C’s stomach which was found to contain faeces. Dr W reports that this is clear verifiable evidence of fabrication of illness as this sample of fluid containing faeces was evidenced by him not to be from C’s stomach area. Dr W reports that this faeces appears to have been the same faeces as was identified to be in C’s nappy, so it his conclusion that C’s mother has attempted to fabricate illness by taking the sample from the nappy. Dr W reports that the potential impact of this fabricated illness is that C may receive unneeded medical interventions which could potentially include the risk of him having a perforated bowel from an unneeded operation which could then cause death”.*

15. Dr W was not at that initial strategy meeting; it is clear from the minutes of that meeting that Dr W’s concerns are simply being rehearsed to those present. Nor was Dr V present, C’s lead paediatrician from JCH. However, a second strategy meeting then took place on 07.12.22. Both Dr W and Dr V were in attendance at that meeting. It is clear from those minutes that whilst some wider issues are being raised from professionals about exaggerated symptoms, the focus of the meeting comes from Dr W’s concerns around the presentation of syringes which contained feculent material<sup>9</sup>, two occasions when a feeding tube has been snapped<sup>10</sup>,

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<sup>8</sup> J131

<sup>9</sup> “Dr W is 99.9% - 100% confident that what was in the syringes had not come from his stomach” (J140)

<sup>10</sup> “Mum reported that C has pulled out his line when falling backwards, Dr W stated that it is preposterous to believe that when falling backwards, he has pulled out his own line” (J140)

reported but unobserved excessive vomiting, reported by unobserved diarrhoea and that the mother has “consistently provided false information about various Medical Professionals”.

### **Commencement of proceedings**

16. The local authority issued proceedings on 14.12.2023. The application was made on an urgent basis; the application itself explaining that the precipitating concerns relate to risk of Factitious or Induced Illness, including a recent concern that the concerns have escalated and that the respondent mother has perpetrated an act of deception to amplify the needs of C. The application goes on to explain that the parents are not aware of the child protection enquiries or the intention to issue proceedings and seek to abridge notice to 2 hours before the urgent hearing.
17. The matter came before HHJ Brown on 14.12.2022. Understandably, Judge Brown was concerned about the issue of notice to the parents, indicating that the parents must be served with the application, be given the opportunity to take legal advice and proper notice of the hearing before the matter could be fairly heard. The case was adjourned to 15.12.22 on the basis that the parents would go and stay with maternal grandparents overnight, who would also supervise any parental contact.
18. On 15.12.2022 the matter came before HHJ Cains. It was agreed that the children would go and stay with paternal grandparents, underpinned by an Interim Care Order and subject to a contract of expectations.
19. Following a number of case management hearings, the case came back before HHJ Matthews KC on 10.02.23. At that hearing the Court approved the instruction of the following experts:
  - a) Paediatric Gastroenterologist (Dr Salvestrini)
  - b) Psychiatrist (Dr Quinn)
  - c) Child and Family assessment (Dr Stanley)
  - d) Paediatrician (Dr Hobbs, but subsequently amended to Dr Mecrow)
20. The case was listed for a fact finding before me on 05.06.2023 with a time estimate of 10 days and a final hearing on 08.08.2022, time estimate 4 days.

### **The Fact-Finding Hearing**

21. As is usually the case in complex proceedings such as these, the papers are voluminous.
22. I have read the core bundle and supplementary “Section K” bundle. I have also been referred to various documents within a primary medical bundle and a Newcastle medical bundle. I have been greatly assisted by the advocates taking me to the relevant documents within the medical bundles upon which they seek to rely, as well as a full medical chronology directed to be prepared as part of these proceedings.
23. I have, over the course of 10 days, heard evidence from the following witnesses:
  - a) Dr Y (paediatric ST1 doctor: RVI)
  - b) DN (paediatric dietician: RVI)
  - c) NN (nurse: RVI)
  - d) Dr Mecrow (Part 25 consultant paediatrician)
  - e) Dr Salvestrini (Part 25 paediatric gastroenterologist)
  - f) Dr W (consultant paediatric gastroenterologist: RVI)
  - g) Dr X (Professor of Paediatrics and neonatology: JCUH)
  - h) ZW (Baby Hospice)
  - i) Dr V (Consultant paediatrician: JCUH)
  - j) HW (Health Visitor)
  - k) Mother
  - l) Father
24. In addition, I have seen a further statement prepared by the father during the course of the hearing along with associated questions and responses from Dr Salvestrini.
25. Having heard all of the evidence in the case, I adjourned to allow for written submissions to be prepared. I have received those documents from all of the parties. The case then returned on 27.06.2023 to allow the parties to speak to their submissions, having at that stage had sight of the documents prepared by the other parties.
26. This judgment was then prepared to be formally handed down on 07.07.2023.

### **Findings sought**

27. Following the close of evidence, the LA prepared an amended document setting out the findings sought. I am grateful for them having done so as it has allowed the other parties, in particular those representing the mother, to focus their submissions.
28. I attach to this judgment, as **Annex A**, the findings that the LA invites me to make. The original document included annotations to assist me in identifying how the findings have changed since the close of the evidence. The attached document does not include those annotations.
29. The findings sought against the mother fall into 4 categories, with associated pleadings in respect of harm/risk of harm:
- a) exaggerated, misrepresented, or fabricated C's symptoms when speaking to medical professionals
  - b) tampering with C's gastrojejunal tube ("GJ"), causing it to become dislodged
  - c) contaminating a bag containing gastric aspirate from C's stomach, by adding feculent matter to the fluid
  - d) a repeated pattern of mother's reporting of exaggerated medical needs in respect of D
30. Whilst not minimising any of the concerns raised by the various medical professionals and local authority, a) to c) above are set out on a basis of an ascending degree of seriousness, where allegations of exaggerated/misreported symptoms then escalate to physical interference in medical interventions.

### **Legal principles**

31. I am again grateful to Ms Thomas KC and Ms MacLynn KC for setting out the legal principles which apply specifically to fact finding hearings of this nature. As Ms MacLynn KC notes within her submissions, the relevant law is settled. However, principles and guidance to be applied in respect of allegations which involve Fabricated or Induced Illness,



continue to be finessed. In particular, there have been a number of recent cases heard in the High Court, where I can turn to for particular assistance.

32. It is not my intention to repeat verbatim within the body of this judgment the case law that I have considered and applied. To do so would simply make this judgment unwieldy. However, the principles are important and fundamental to how I approach my consideration of the evidence. To that end, I attach as **Annex B** a document which sets out the legal framework submitted by Ms Thomas KC and Ms MacLynn KC. I should add that Ms MacLynn also refers me to some guidance which has recently been given by Pool J in a recent FII case, in respect of good practice to be followed by Trusts faced with issues such as these.
33. Whilst wanting to avoid repetition, there are some principles that are so fundamental to the Court's decision-making process, that they ought to be explicitly set out within the body of this judgment. They are as follows:
- a) The Local Authority brings these proceedings and invites me to make findings on the evidence I have before me. The burden is therefore on the Local Authority to prove that the findings it seeks are made out.
  - b) There is no burden on a respondent parent to prove an alternative explanation. Parents may provide alternative explanations as part of a hearing. If the Court does not accept an alternative explanation provided by a parent, that rejection of an alternative explanation does not establish the Local Authority's case. I must be alive to the dangers of inadvertently reversing the burden of proof.
  - c) The standard of proof is the balance of probabilities.
  - d) Findings of fact must be based upon evidence, including inferences that can be properly drawn from the evidence. They must not be based upon suspicion or speculation.
  - e) In cases such as this, there will be a wide canvas of evidence, made up from many different sources. The Court must take into account all of the evidence and consider each piece of the evidence in the context of all of the other evidence.

- f) This case involves a large amount of medical evidence, including expert medical opinion. Whilst the Court is entitled to rely upon expert medical opinion, the opinions of medical experts need to be considered in the context of all of the other evidence:

*“It is important to remember that (1) the roles of the Court and the expert are distinct and (2) it is the Court that is in the position to weigh up the expert evidence against its findings on the other evidence. The Judge must always remember that he or she is the person who makes the final decision”<sup>11</sup>*

- g) The Court must be alive to the fact that the extent of medical understanding is constantly evolving and developing. It is not finite and future developments in science and medical knowledge may undermine what was previously regarded as medical fact.
- h) The evidence of the parents in this case, in particular the mother, is of the utmost importance. Whilst the Court should not reach a conclusion on the veracity of a witness based purely upon their performance from the witness box, a parent must have the fullest opportunity to take part in the hearing and the Court must form a clear assessment of their credibility and reliability.
- i) It is not uncommon for people to tell lies in proceedings such as these. People tell lies for a number of different reasons. If the Court finds that someone has told a lie about a matter, that does not mean that they have lied about everything.

### **The evidence**

34. I am very alive to the fact that this judgment will be considered by individuals who have varying cognitive abilities and varying degrees of the understanding of medical jargon and points of reference. The evidence in cases of this type is complex and complicated. I will not be repeating the contents of the written statements, reports, notes, and live evidence that I have considered. To do would be disproportionate. However, I am setting out the parts of the evidence that I consider relevant to my decision-making process. If I do not mention an aspect of the evidence before me, it is not that I have ignored it or failed to consider it.

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<sup>11</sup> A County Council v KD & L [2005] EWHC 144 Fam; para 39

Rather, I have focused instead on those elements of the evidence which has directly assisted me in reaching the decision that I have.

35. There is always a risk that the ability to discern the Courts reasoning for the decisions it is making, is lost behind a lengthy rehearsal of the medical history and medical evidence. To that end, this judgment will consider each of the headings of findings sought by the Local Authority and set out an analysis of the medical evidence that I have heard about each of those findings sought. Although I am setting out the evidence for each finding in a linear manner, I am considering each of the findings alongside the others as part of an analysis of the wider canvass. I am not considering each finding sought in isolation. To do so would risk blinding myself to the broader landscape of evidence that I have heard.

36. I have already indicated the health difficulties which C suffered from birth. They were complex in nature requiring a significant level of medical intervention. As a result, there were a number of treating clinicians who were involved in C's care over the years. Various chronologies have been prepared within these proceedings, including a full medical chronology prepared as a result of a Court direction. However, for the purposes of a chronology of issues identified by the treating clinicians, I am greatly assisted by a detailed but specific chronology prepared by Dr V, consultant paediatrician. That chronology was prepared as part of a report dated 13.12.2022. Dr V has been involved in C's care following a referral letter dated 4<sup>th</sup> May 2018, albeit I was told that it was likely that Dr V had met C on ward at some stage earlier than that. That chronology prepared by Dr V has been an invaluable tool in piecing together the issues raised over a number of years.

**1. Between 2018 and 2022, C's mother has exaggerated, misrepresented, or fabricated his symptoms when speaking to medical professionals as follows:**

**a) Exaggerating and misreporting the frequency of epileptic seizures observed in C**

37. I start by setting out the chronology from Dr V<sup>12</sup>:

*C presented with seizures and was subsequently diagnosed with epilepsy in 2018.*

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<sup>12</sup> E20

*On 26 April 2018 C was admitted to the ward with possible seizures. The mother described an episode 2 weeks ago whilst at The Royal Victoria Infirmary when his limbs were shaking whilst crying and then he held his breath for 30 seconds and this was associated with a temperature of 40 degrees. C was seen by a doctor.*

*During this admission at the Royal Victoria Infirmary C had an episode when he woke up, fists were clenched, his head went from side to side. His mother called a nurse but it had stopped when the nurse arrived.*

*Following this C had started to have staring episodes lasting from seconds to minutes several times a day. His mother said these were observed by his Health Visitor and Visually Impaired Teacher.*

*Clinical impression (seen by Dr V)- the episodes reported at The Royal Victoria Infirmary are not suggestive of seizures but the staring episodes could be seizures. Dr V arranged an EEG and suggested that his mother tried to film any episodes*

*Based on the history provided the possibility of epilepsy was considered.*

*29 April 2018 – C was admitted to the ward as there was ongoing parental concern regarding seizures. He was described by his mother as having a couple of staring episodes on the Admissions unit and one was captured on a mobile phone. The film footage was shown to a doctor. This was described by the doctor as a vacant stare.*

*There are multiple recorded entries whilst C was on the ward of unresponsive episodes. It is difficult to tell from the notes whether these episodes were recorded as parental reporting or nurses/ doctors had witnessed them.*

*A couple of entries documented that C appeared to be staring for 30 seconds but when a nurse/HCA went to him he then responded and smiled. A Physiotherapist documented witnessing two episodes when C became vacant. A Consultant viewed the film footage taken by C's mother on the ward. C appeared vacant for 10 seconds and then recovered.*

*The description provided by the nursing staff was of C having clusters of absences and therefore a plan was made for buccal Midazolam if there were significant clusters given on a couple of occasions. An EEG did not show any evidence of epilepsy but this was a limited study as EEG leads did not stick.*

*C was reviewed by Dr P, Consultant Paediatrician, who has a special interest in epilepsy. His clinical impression was seizures. He planned a further EEG and then after this to commence treatment. The maternal history of epilepsy was noted.*

*3 May 2018 – His mother captured several suspected seizures. He was reviewed by Dr V. C was observed to be unresponsive ‘vacant’ occurring both when he was lying down and sitting, sometimes associated with subtle limb stiffening or shaking. It was concluded from this that C was having atypical absence seizures and Levetiracetam was commenced.*

*Episodes were witnessed by health professionals who thought that these were most likely seizures although on a couple of occasions episodes identified by mother to staff were not convinced they were seizures.*

*A normal EEG does not rule out epilepsy and the diagnosis is usually made based on the history and any observations of events. The EEG can provide supportive information, for example identifies a specific epilepsy syndrome or what kind of seizures are occurring.*

38. There then followed a history of the mother regularly reporting incidents of vacant, falling and convulsive episodes. The mother was being asked to try to record incidents on her phone so that medical professionals could understand what was being reported. On 12<sup>th</sup> August 2019 film footage was reviewed by the paediatric epilepsy nursing team. The footage captured part of the seizure that led to hospital admission on 29<sup>th</sup> July 2019. It was agreed that C still had some awareness and were not typical of generalised tonic clonic seizure, but it was agreed that it appeared to be a seizure, possibly focal, and if prolonged he would need buccal Midazolam. Dr V notes in her chronology:

*“Film footage provided was in keeping with C having an epileptic seizure”<sup>13</sup>*

39. Dr V notes that if C was having frequent seizures, then at least some of the seizure activity would be seen at school. On 20<sup>th</sup> November 2019 epilepsy nurses met with school staff. The school reported that they did not think that C fell more frequently than other children and did

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<sup>13</sup> E24

- not think that they were seeing seizure activity. They described an episode where C seemed to lose concentration and his mother had said that she thought that was a seizure.
40. However, on 26<sup>th</sup> February 2020, school staff did provide a description of behaviour which Dr V believed was in keeping with C having epileptic seizures.
41. The mother continued to report frequent episodes of seizure activity. The concern was growing that, whilst Dr V indicates that there was evidence of some seizure activity, if it had been as frequent as reported by mother, she would have thought there would be wider reporting.
42. On 11<sup>th</sup> November 2021 a professionals meeting was held. The mother was receiving assistance from Baby Hospice at that stage, who did not report seeing any seizure activity. They had raised some concerns which appeared to have then resulted in the professionals meeting taking place<sup>14</sup>. A number of concerns were raised at that stage in respect of the mother's reporting of a number of issues. One of those issues was in respect of seizure activity. However, Dr V and a speciality epilepsy nurse, both described film footage of C that they had seen which was in keeping with epileptic seizures. The concern expressed, was that based on the frequency of reports from the mother, the episodes would be expected to be seen in different locations.
43. It was at that stage that concern was being raised in respect of over-reporting by the mother. It was agreed that epilepsy treatment would not be escalated further unless there was substantive evidence of epilepsy seizure, seen on film footage or witnessed by a professional.
44. A meeting was arranged to be held between Dr V, Dr T (consultant paediatrician) and the parents. The purpose of this meeting was to discuss the concerns being raised by professionals that the mother was not always accurately representing issues to health professionals. By all accounts that meeting appeared to be a positive meeting and, as I will consider later in this judgment, led to the mother telling me that as a result she reflected on what she ought to be informing professionals about.

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<sup>14</sup> Med bundle C1277

45. Dr V's report in respect of epilepsy concludes with the following<sup>15</sup>:

*Based on some of the witnessed events by various professionals both on the ward, in film footage provided by his mother and observations made at school staff I do believe that C has had epileptic seizures...*

*However there appears to be a discrepancy between the types and frequency of seizures reported by his mother and what is observed by professionals working with C. This has become more evident over time as C gets older and spends more time in environments other than the family home.*

*There have been only a few occasions when professionals have seen any episodes that appear to be epilepsy although his mother reports frequent vacant episodes, drops, and at times convulsions. I would expect more of these episodes to have been observed in other environments.*

*It would therefore appear that his mother is over-reporting. It is also possible that his mother is over-interpreting episodes where C loses concentration as seizures, and episodes where he falls down (not uncommon in young children) as seizures.*

*It is not uncommon when a child has epilepsy for parents to interpret any unusual events such as brief staring episodes or falls as seizures. However, it is notable that at school he is not noted to have significant episodes of staring or falls. Therefore, it is puzzling why only his mother appears to have been observing these.*

*There have been frequent requests for film footage, some of which his mother has managed to provide but it is acknowledged that it can be difficult to capture very short seizures such as drops or absences.*

*It is more unusual for any other behaviours to be interpreted as convulsions and it might be expected that more of the described convulsive episodes could have been filmed.*

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<sup>15</sup> E28

*It is recognised that when a child first has a convulsion this can be very stressful for parents and at the time they do not always manage to film but I would expect that with time a parent may be able to film such an episode.*

46. I heard evidence from Dr V as part of the fact-finding hearing. She told me that she thought that she had a good working relationship with the mother. She confirmed her view that she thought the other was a very anxious person, particularly when it came to C's health. She reinforced her view that C had probably previously had seizures indicative of epilepsy. Her concern was around the frequency of the episodes as being reported by the mother. She recognised that there were a number of medical professionals involved with C, which may cause some element of confusion for the mother in terms of information being received from different sources. However, she remained of the view that the mother had over reported incidents of seizure activity. That over reporting, she told me, ran the risk of C receiving medication which he did not need.

47. She told me that the reason the professionals meeting in November 2021 was convened was because of growing concerns that the frequency of reporting by the mother was not being independently verified. As she told me in her oral evidence:

*“At the beginning we thought it was epilepsy, it was only as time went on and we had concerns that we thought that maybe everything reported may not be epilepsy... As time went on, when professionals were not witnessing seizures in these settings, we started to become concerned”.*

48. It was telling for Dr V that, following the meeting between herself, Dr T and the parents in February 2022, the reporting of seizure activity significantly reduced.

49. I found Dr V to be a helpful and measured witness. She was clear in her views in respect of there previously being an accurate diagnosis of epilepsy. She was balanced and fair in so far as her acceptance as to the difficulties for the mother in being provided with complex medical views from a number of different sources. However, she remained clear in her view that episodes of seizure activity had been over reported by the mother and that at times his



medication may have been increased (or trialled) unnecessarily, if his mother's reporting was inaccurate<sup>16</sup>.

**b) Exaggerating and misreporting the extent of C's behavioural difficulties when in the care of others, which was not observed by the relevant professionals**

50. On 25<sup>th</sup> May 2021 C was reviewed by Dr Q, Consultant community paediatrician. The mother was in attendance. The reason for referral to community paediatric clinic was set as being due to:

*Concerns regarding aspects of behaviour and development and in particular difficulties with regulating emotions and modulating behaviour which include aggressive behaviours, struggling to focus on one activity, concerns regarding peer interaction, repetitive language, and repetitive play.*

51. A letter was prepared following that consultation which includes the following:<sup>17</sup>

*He has also been supported by Baby Hospice and the early years SEND team. Mum reports that after a session at Baby Hospice, the staff can be exhausted after caring for C...*

*Whilst mum feels that C is happy to be around other children, he tends to play next to them [sic] rather than interacting directly with them.*

*C seems to be having increasing difficulties regulating his emotions and modulating his behaviour. Whilst C initially could be cooperative at Baby Hospice, he is becoming more challenging with his behaviour and from what mum understands he can be fairly wild at times and aggressive.*

52. It is fair to say that the mother went on to describe her own experiences with C, which included physically aggressive behaviours.

53. Those comments were fed back to Baby Hospice. I have seen a number of emails sent by ZW to Dr V, raising concern in respect of the way that the mother was reporting issues about C. In particular, reference was made to the absence of any seizure activity and that the mother's

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<sup>16</sup> E29, confirmed in oral evidence

<sup>17</sup> Med bundle C1225

descriptions of C's behaviour to Dr Q, were not in accordance with how they would have described him.<sup>18</sup>

54. Within her written evidence, ZW said the following:

*From my own interactions with C, my communication with colleagues, and reviewing the notes, C presented as a happy child who enjoyed singing and playing alongside other children when he attended the hospice. He demonstrated kindness to other children, asked lots of questions and appeared to enjoy attending Baby Hospice. His behaviour was age appropriate when he stayed at the hospice<sup>19</sup>.*

55. I heard from ZW in oral evidence. She maintained those matters set out within her statement. She told me:

*I think Mother and the team got on well. The mother rang frequently and needed lots of reassurance. There was a concern that the mother would say different things to different people... The team were nervous about speaking to mum alone and wanted someone to be there. But on whole, we worked in partnership with mother. She was his main carer and the parent that we had interaction with.*

56. That oral evidence reflected the concerns set out in her witness statement; that there was a concern that information given by workers at Baby Hospice would be misrepresented. As a result, Baby Hospice would try to ensure that more than one member of staff interacted with the mother.

57. ZW described having a conversation with the mother about what had been reported to Dr Q. Although ZW could not say whether a member of staff might have referred to C as "wild" as part of a conversation with the mother, she confirmed that there was certainly no record of such a conversation. She told me that even if there had of been a passing comment about C being "wild", that was not how the mother had conveyed information to Dr Q.

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<sup>18</sup> C178

<sup>19</sup> C175, para 9

58. ZW also told me of her concern that there was a tendency for the mother to portray C in a negative way. Even when C was being described in a positive way, the mother was reported to bring the conversation back to a focus on the negative.
59. It was the ongoing concerns being raised by Baby Hospice which was one of the primary reasons for the professionals meeting convening in November 2021.

**c) Informing professionals that C either has autism or is on the spectrum**

60. On 21<sup>st</sup> December 2021, the mother had a telephone clinic appointment with Dr Q<sup>20</sup>. One of the concerns had been that C had been referred to the community child health clinic because of reports around his development, in particular in respect of regulation of emotions and behaviour modulation and behaviours. The reasons for that referral had been set out more fully in the letter from the appointment with Dr Q on 25<sup>th</sup> May 2021, which had led to concerns being expressed by Baby Hospice and the subsequent professionals meeting in November 2021. The following is recorded within the letter arising from that appointment:

*In terms of the initial referral through to Community Child Health, both mum and professionals do not feel that there is evidence currently to support an autism assessment. Mum was always keen to ensure that all support was in place for C and reiterated today that she is in agreement with this decision... Overall mum feels that there has been some progress with emotional regulation and behaviour and certainly towards her there is less aggressive behaviour.*

61. On 21<sup>st</sup> November 2022, C was at hospital at the RVI. On that day a conversation took place between the mother and DN, following a ward round. DN is a paediatric dietician and her role with C was to assess his nutritional status during admission.
62. DN says that the mother told her multiple times that C had autism<sup>21</sup>. When pressed as to whether he had an official diagnosis, the mother confirmed that he did not, but believed that he is on the spectrum.

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<sup>20</sup> Med bundle A522

<sup>21</sup>C50 and Newc Med G396

63. In her oral evidence DN told me:

*At the time mum was talking to me about C's general behaviour. She was saying that he had autism numerous times. She had said that on previous occasions as well. She said that C doesn't respond to emotions in the same way as other children. She had a chart which she brought on to admission and was trying to use on ward as well.*

64. DN was clear in her evidence that the mother had told her that C **had** autism, and that she had said that to her on a number of occasions. It was only when DN challenged the mother as to a formal diagnosis, that the mother told her that there was not a formal diagnosis but that she believed he exhibited symptoms consistent with being on the autistic spectrum.

**d) Exaggerating and misreporting the extent of C's breathlessness and fatigue, leading to cardiological investigations. The mother also reported having obtained a wheelchair which was manifestly unnecessary for C by late 2022.**

65. It is clear from the medical evidence that C has ongoing significant issues in respect of his heart functioning. That is an issue that has been in existence since birth and is ongoing.

66. The evidential basis of the exaggeration and misreporting as pleaded seems to come from the evidence of Dr S and Professor X.

67. Dr S saw C in a cardiac clinic on 4<sup>th</sup> October 2022. His typed note is dated 03.11.2022. It appears that Dr S saw C for an urgent echocardiogram as part of his pre-assessment for his upcoming procedure under gastroenterology at the RVI. It seems that the urgent review was instigated by the mother. Within that note of the clinic, Dr S says the following:

*Mum said that he is feeling more tired and sometimes breathless. She also said that he is really sweaty when he is running around*

68. Following tests, including an echocardiogram, C's cardiac status was considered normal.

69. Professor X is a Professor of Paediatrics and Neonatology. On 15<sup>th</sup> November 2022 the mother had an appointment with Professor X. The letter from that appointment sets out the following:

*His mother tells me that he is not as fast when he is running around and asks to be picked up a lot. Even with his grandparents he does not now walk to the shop with them and asks to be carried. They have a wheelchair at home for him but they do feel this is a problem which is increasing over time*

70. I have not noted any reference to the grandparents being present at that appointment; the reference at the start of the letter is to the mother being in attendance with C and D.

71. Of relevance in respect of my consideration of the broader canvas is this reference:

*This is clearly a very difficult situation for his mum to deal with as she has so many issues with C and he now has a new baby brother as well*

72. On examination by Professor X, C's presentations were no worse than had been seen previously.

73. In respect of the reference by mother to a wheelchair, the evidence is clear that occupational therapy had initially assessed C as benefitting from postural support. However, apart from the reference within Professor X's notes, I have not been taken to any other medical reference which suggests that the mother was routinely, or at all beyond her concession in oral evidence, using the wheelchair as a form of mobility for C.

**e) Exaggerating and misreporting C's vomiting as being frequent during November 2022 which was not then witnessed during the hospital admission from 18 to 23 November 2022**

74. The admission in November 2022 was aimed at trying to understand, through observation, the reports the mother was making in respect of C's ongoing vomiting.

75. From emails contained within the bundle, it is clear that between 7<sup>th</sup> and 9<sup>th</sup> November 2022, there has been a high level of contact between the mother and medical professionals in respect of concerns she has with feeding generally and vomiting specifically.

76. During that correspondence between medical professionals, Dr W says on 07.11.2022<sup>22</sup>:

*I am sufficiently perplexed, to think this may be just that... a perplexing presentation*

77. I was told by Dr W in oral evidence that he had been concerned with the reports provided by the mother previously, in respect of C's intolerances to feeds, which had reportedly resulted in vomiting. Within his report Dr W notes that the mother had previously provided a history whereby the mother was reporting that C was vomiting twice a day, sometimes more, and that the vomiting gets worse when his gastrostomy is clamped<sup>23</sup>.

78. The decision was made on 10.11.2022 for C's admission for observation. As DN noted<sup>24</sup>:

*A lot of emails and contact from mum over the past few weeks to local team here. Has been offered admission for acute issues but declined by mum.*

*Presentation still perplexing- need admission for close observation and nutritional interventions. Dr W requested letter to be sent to him and local teams summarizing events. To arrange admission next few weeks*

79. C was admitted for observation on 18<sup>th</sup> November 2022. The mother was telling medical professionals on admission that C had been suffering from intermittent vomiting over the past few weeks and that he is regularly sick but has days when not vomiting<sup>25</sup>. When a dietetics assessment was undertaken on admission, the mother informed PQ<sup>26</sup> that C tends to vomit 3-4 times per week, more often after 12pm and that there is no pattern to the vomits.

80. C remained on ward until the 23<sup>rd</sup> November 2023. During that time there was no unusual observed vomiting. The mother was clearly aware that there had been no observations of

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<sup>22</sup> Newc Med G401

<sup>23</sup> E3 and in chronology at E11 (23.06.22)

<sup>24</sup> Newc Med G403

<sup>25</sup> Newc Med G496

<sup>26</sup> Newc Med G383

unusual vomiting. Of significance, on 23.11.22 the mother tells DN that she wants her to speak to maternal grandmother. When asked why, the mother says:

*You all think I am a liar. C does vomit at home and school, ask anyone, grandma will tell you<sup>27</sup>*

81. The next day, on the 24<sup>th</sup> November 2023, the mother reports that C had vomited 4 times that night but had kept it in his mouth and swallowed it back down. It was for that reason that there was no evidence of C having vomited. I have been unable to find a reference at any point before that reference whereby it has ever been reported, by mother to professionals or within the family, that C has vomited in his mouth and swallowed it back down.

**f) Exaggerating and misreporting C's diarrhoea as persistent and severe between 18 and 23 November 2022**

82. The mother had historically raised concerns in respect of C suffering from persistent diarrhoea. One of the reasons for C's admission on 18<sup>th</sup> November 2022 was to understand the reports of chronic diarrhoea<sup>28</sup>. Dr W told me in oral evidence that the reason for the admission was to look at the symptoms of diarrhoea and vomiting that had been reported by the mother. From the medical notes it seems clear that there had been an earlier admission on 14<sup>th</sup> October 2022, where diarrhoea had been observed<sup>29</sup>.

83. On admission to hospital on the 18<sup>th</sup> November 2023, the mother reported that stools vary in frequency from 3-10 times a day. Dr W suggested at one point in his evidence that the mother was reporting that C was having stools 10 times a day, *every day*. I cannot see any reference to the mother having said that C has stools 10 times a day, *every day*. Even from Dr W's own chronology, the frequency is set:

*Mum reports 3-10 stools a day, no normal stool.<sup>30</sup>*

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<sup>27</sup> Newc med G389

<sup>28</sup> Newc med G462

<sup>29</sup> Newc Med G473

<sup>30</sup> E12

84. On admission the mother was unable to answer what she would class as “normal” for C. She confirmed that C had multiple stools overnight, usually from 3am and can have 3 stools until waking in the morning.

85. During his admission on the 18<sup>th</sup> November 2023, the medical records indicate that the stools observed were mainly of a “paste” consistency. No diarrhoea was observed on the admission.

**g) Misrepresenting C’s gastrological symptoms to professionals and maintaining that he would become unwell if his gastric aspirates were not drained, and his dressing needed to be changed, on a more frequent basis than suggested by independent observations**

86. There are many references within the medical records of the mother reporting issues in respect of C’s presentation, if his aspirates were not drained. It seems that one of the main reasons why free drainage lasted as long as it did, was because of the mother’s reporting of concerns. In particular, in 2021 the mother reported that C was unable to tolerate clamping of the drainage tube and would “sniff and vomit”. The medical notes also record the mother reporting that when the gastrostomy drainage tubes become blocked (thereby creating a scenario similar to clamping), that C would sniff and vomit. On 21<sup>st</sup> November 2022 the mother tells medical professionals that “*if gastrostomy is clamped, C starts sniffing and then will retch and vomit. Mum reports only vomit if gastrostomy is blocked*”<sup>31</sup>. On that same occasion, the following is noted:

*Dr W asked mum about clamping gastrostomy, mum informed us she has been told by Dr X (cardiologist) not to clamp C as when attended clinic last, his gastrostomy bag wasn’t attached and he was sniffing a lot and retching.*

87. There is no reference within the papers of C attending a clinic with Professor X when he was retching due to not being attached to his gastrostomy bag. There is no reference to Professor X giving any advice on clamping. In his evidence to me, Professor X told me that he would not give advice in respect of clamping as it was outside of his area of expertise. He indicated that, even if he had, then he would have noted that he had given that advice.

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<sup>31</sup> G395



88. It is not clear to me whether the mother was maintaining that C was retching and sniffing at the appointment with Professor X. The focus in her evidence seemed to be on the issue with the bag and what was said by Professor X, rather than the impact on C in terms of retching and sniffing.
89. Whilst admitted between 18<sup>th</sup> November and 23<sup>rd</sup> November 2022, clamping the gastrostomy was tested. There are no observations within the medical notes of any adverse impact upon C. He is described at playing and there being no retching or vomiting<sup>32</sup>.
90. At the professionals meeting on 11<sup>th</sup> November 2021, one of the issues raised was in respect of the mother reporting to Baby Hospice that C's gastrostomy site dressing needed changing 4 times a day. ZW told me in evidence:

*The nursing team queried with mother why we needed to change dressing 4 x a day. Mother had been specific about it. The wound was clean and healthy and C did not like a change of the dressing. The nursing team asked mother what was the reason for 4 x changes. Mother said she could not remember. C then went home. Later that day the mother rang and spoke to deputy manager and asked why we were querying the dressing changes. Mother said that Newcastle hospital had told her to change the dressing 4 x day. I do not believe that one of the nurses from Newcastle would not have recommended it.*

91. The paediatric nurses at the professionals meeting on 11<sup>th</sup> November 2021 confirmed that it is quite common to change dressings on a daily basis, but that none of the team have suggested that it needs to happen 4 times a day. SR, the consultant paediatric surgical registrar, confirmed that she had not advised the mother to change the dressing 4 times a day.

**h) Exaggeration and misreporting of C's pain responses and requesting analgesia as a result, overnight on 22 November 2022**

92. This finding appears to rely on a reference within the medical notes about the mother asking for a further 5mls of melatonin on 22.11.2022 due to C being unsettled. There is no reference to any other analgesic. There is reference to C in fact remaining unsettled for 1 hour and the mother reporting that C was complaining of a "hurt tummy".

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<sup>32</sup> Newc med G556 and G395

93. The other reference within the medical bundle appears to be in respect of a request on 23.11.2022<sup>33</sup> for paracetamol and melatonin. The mother is reporting that C is complaining that his stomach is hurting. Although C was not complaining of any pain, he is described as “clinging to mum, and appeared tired... did appear to be darker under the eyes”.

94. The finding appears to have been sought on the basis of the inclusion within Dr W’s report as one of the identifiable problems being:

*Requesting analgesia when not in pain 22<sup>nd</sup> and 23<sup>rd</sup> November 2022.*

**i) Exaggeration of the number of times that C’s tube had become dislodged or removed, saying that it was on 7 occasions between April and November 2018. The notes show the tube becoming dislodged on 3 occasions in 2018, and one occasion in May 2019.**

95. I heard evidence from DST about what the mother had told her about C’s tube becoming dislodged or removed. DST is the Clinical lead paediatric dietician at South Tees NHS Trust.

96. Although DST had provided a statement to the Court, she was also the author of a letter to C’s GP, dated 29.11.2018<sup>34</sup>. Within that letter, DST describes a review with C and his mother. During that review, DST states that the mother told her that C had pulled out 7 feeding tubes since April 2018 and that Newcastle are thinking about placing a surgical jejunostomy as he will be less likely to pull that out. Whilst there are incidents recorded of C pulling out his feeding tube on 3 occasions, he does not appear to have done so on 7 occasions. The mother did not seek to persuade me that the correct number was 7, rather than 3.

97. In cross examination on behalf of the mother, it was suggested that DST had misheard the mother saying “several” rather than “seven” or that her note was incorrect. Under expert cross examination DST resisted the urge to concede that it might be a mistake. The following exchange took place:

*LMKC: could it have been a mistake?*

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<sup>33</sup> Newc med 3860

<sup>34</sup> Med bundle A541

DST: *I don't think it is, I keep quite accurate records.  
It is likely I would have written the number in the notes I was taking.*

LMKC: *Do you think that misread the number?*

DST: *No I don't think so. I could tell you how many feeding tubes have been sent to the mother because a record is kept.*

LMKC: *You don't think it is possible for a mistake to have been made?*

DST: *Extremely unlikely.*

LMKC: *Is it possible that it was a typing error?*

DST : *No. I type them myself.*

LMKC: *Do you use word? If so, auto correction?*

DST: *No. I write directly into the clinical notes on the system  
I cannot say 100% that it is a mistake, but I think it is very unlikely.*

**2. Despite discussions with the mother and the importance of accurate reporting having been emphasised to her in November 2021, she has continued to over report and misrepresent symptoms.**

98. The professionals meeting, convened to consider concerns being raised about the mother's reporting, took place on 11<sup>th</sup> November 2021. Following that meeting, a meeting was then arranged on 2<sup>nd</sup> February 2022 between the mother, the father, Dr V and Dr T. A letter was produced as a result and sent to the parents<sup>35</sup>. That letter starts out by reiterating that a professionals meeting had taken place and that a number of positives had been identified in respect of C's care. However, it goes on to set out some of the issues that had been discussed at the 2<sup>nd</sup> February meeting. In summary:

- a) There were concerns in respect of information that had been reported to professionals by mum about C's presentations

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<sup>35</sup> Med bundle C1315

b) There were concerns in respect of misrepresentation of information communicated to the mother by professionals when she had relayed that information on to the professionals.

c) That harm can be caused to C by sharing of misinformation.

99. In her oral evidence, Dr V indicated that following that meeting there had been a reduction in the number of reports of seizure activity. Dr V saw that as a real positive coming out of the 2<sup>nd</sup> February 2022 meeting.

100. However, the finding is sought on the basis that I make findings about over reporting and misrepresentation of symptoms following that meeting. For example, whilst the LA accept that there was a subsequent reduction in reports around seizures, they say there remained issues around vomiting and diarrhoea, resulting in the admission on 18<sup>th</sup> November 2022.

**3. The mother has hindered C's feeding development as a result of her over presentation of symptoms, limiting his oral solid food intake,**

101. Within her report, Dr Salvestrini opines the following<sup>36</sup>:

*Feeding difficulties due to cleft lip and palate he could not efficiently and safely orally feed. He was initially dependent on NGT and was appropriately escalated to gastrostomy prior to his cleft repair (ENT surgeons do not want NGT in place at the time of the repair). After the cleft repair, he was diagnosed with unsafe swallow for thin fluids with a videofluoroscopy on 07.09.18. Over time his ability to eat and drink did improve, and he was happy to chew on food. Unfortunately, he was asked by his mother to spit the chewed food out up until November 2022. This is not what usually recommended for patients like C. I could not find evidence of ongoing SLT advice to chew and spit food out. By asking him to spit out the chewed food, **his mother has hindered his progression to effective oral intake...** [my emphasis].*

102. In reference to the suggestion that the mother has hindered his progression for effective oral intake by asking him to spit out his food, I am alive to the advice that the mother was being given. By letter of 13<sup>th</sup> June 2022 Dr V was advising the mother that C should avoid

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<sup>36</sup> E264-E262

swallowing food because it could block his NG drain<sup>37</sup>. Likewise, on 27<sup>th</sup> May 2022 the mother was being told that if he swallows solid food this may block the drainage tube and cause C pain and discomfort. Thin watery foods could be swallowed if supervised but anything else he should be encouraged to spit out<sup>38</sup>.

103. However, whilst there may be an argument around what information the mother was being provided with and whether it was reasonable to act in the way that she did, there is still a need to consider how C found himself in that medical situation in the first place.

104. Dr Salvestrini continues within her report:

*It is my understanding that the decision to progress to a surgical jejunostomy was driven by the vomiting and multiple jejunal tube dislodgments facilitated by recurrent site infections. I suspect that his procedure could have been avoided entirely if C had better gastrostomy site care...*

*The decision to move to jejunal feeding was made in April 2018 following maternal report of persistent vomiting. From this moment to the end of 2022, C remained on jejunal feeding and on gastric drainage...*

*I believe that over time his gastric tolerance did improve but he was started and maintained on jejunal feeding and gastric free drainage for so long due to maternal over-reporting and/or falsified symptom reports...*

*C could have been therefore harmed by delaying his progression to oral intake and therefore making the transition to it more difficult for him”.*

105. The picture in so far as C’s feeding plan is concerned, is not clear. C was a child with a series of complex issues, some of which, at various times, became the priority. When I look at the medical records what is clear is that C’s move to jejunal feeding was influenced by what the mother was reporting to medical professionals in respect of his vomiting. But even that point is not straight forward as Dr Salvestrini also raises an element of concern over the decision making that took place which resulted in the procedure. She says the following in her report:

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<sup>37</sup> Med Bundle C1328.

<sup>38</sup> Med bundle C1335

*I am in the unique position of being able to analyse C's medical history with the advantage of hindsight. This was not available to the clinicians who were looking after him.*

*From the gastro-intestinal perspective, I believe there are [a] few crucial moments in his care where a different approach could have been taken... It is my opinion that the decision to move to jejunal feeding was not taken after having made the appropriate observations and having exhausted all dietetic or medical interventions...*

106. In essence, Dr Salvestrini opines that even if what the mother was reporting was accurate, there were other interventions that could have been trialled before the decision was made to move to jejunal feeding.

107. I pause there to reflect that treating clinicians are in a very difficult position. They are doing their best, in often extreme circumstances, to do what is right for the patient in front of them. To that end, they often rely on information being provided by caregivers because that is where the primary source of information comes from. It is an expectation that the information being provided is accurate and true. I doubt that those in the medical profession start from a position of doubt and/or suspicion.

**4. The mother has tampered with C's gastrojejunal tube causing it to become dislodged:**

**a) Between April and 11 November 2018, C's GJ tube was dislodged on three occasions which are not accepted by the clinical team or expert evidence to have happened accidentally.**

108. In her report Dr Salvestrini notes that C allegedly pulled out his GJET tube on 3 different occasions, in June, October and November. The fact that the GJET tubes were pulled out on those occasions is not disputed by the mother. It is how they were pulled out which is disputed.

109. The GJET is a particular type of port which is designed to mitigate the possibility of it being pulled out accidentally. As well as having two ports for gastric drainage and jejunal feeding, there is also a 3<sup>rd</sup> port. The sole purpose of that third port is for the inflation of a balloon that sits just beyond the tract and acts as an anchor to prevent the tube being pulled out.

110. To inflate the balloon, 5ml of water is syringed into the third port which then inflates the balloon. When inflating the balloon, you are unable to see the inflation because it sits inside the patient's body.

111. I was told that the inflation would have been undertaken by a care giver at home, having been shown how to do it. However, should the GJET be removed, reinsertion would require medical intervention.

112. Within her written report, Dr Salvestrini opines<sup>39</sup>:

*I struggle with the idea that a premature 17-month-old baby with development delay, could be capable of firmly grasping the outside button and pull it out with enough force and co-ordination to remove it... Malicious manipulation of the device should be considered in view of the above consideration and the report that during admissions he was not seen touching his gastrostomy site.*

113. In her oral evidence, Dr Salvestrini maintained that accidental removal, in her clinical experience, was very unlikely. She went so far as to say:

*It is a balloon; you cannot pull it through. That is how difficult it is to pull it out. Cannot pull it through. The balloon keeps it kept in for millions of patients. It is extremely rare to come out fully inflated.*

*If it were to be pulled out it is usually damaging and painful. If the tract is healthy then it could not be pulled out. If the tract is widened because of constant infection, then it could come out. It would certainly be painful.*

*Possible that it could come out if the tract had widened or that balloon is not fully inflated.*

*I have not seen any evidence that the tract was infected at the time. No significant widening is noted in the records.*

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<sup>39</sup> E267

*The inflation of the balloon is impossible to measure as no evidence that anyone measured the balloon.*

114. In cross examination Ms MacLynn KC attempted to persuade Dr Salvestrini that there was a possibility that C could have done it himself, by falling and having the tube caught or some other mechanism. Dr Salvestrini replied:

*I do not think that is accurate. I do not agree with that. The GJET is not easily dislodged. It is a very sturdy device. It is so sturdy that you could probably hang a small child from it, pick up a child with it, without issue.*

115. Dr Salvestrini was clear in her view as to the likelihood of being able to pull out a fully inflated balloon from a healthy tract. She told me:

*Again, it is extremely difficult to pull a tube out. Very hard to pull it out unless tract widened, or balloon not inflated. Would expect colleagues to have noticed if the tract site was in bad shape, or when moved to Newcastle for that to be noticed.*

116. However, given how firm Dr Salvestrini was in her views, I was surprised to note that at no point is there reference within the medical notes to any clinician raising concern or alarm that the GJET had been pulled out accidentally. The only concern was that further intervention was required to prevent any further *accidental* dislodgement. The concern in respect of potential GJET tampering is raised for the first time by Dr W on 7<sup>th</sup> December 2022 (strategy meeting). Nor is there any reference within the medical notes to any clinician contemporary to any of the dislodgements, raising any concern about damage/bleeding to the tract site.

- b) On 20 May 2019, the mother reported that C had fallen backwards and pulled his GJ out. This is not considered to be credible by medical professionals.**

117. As above, Dr Salvestrini's view is that it is unlikely that the GJET could have been pulled out accidentally. However, this finding is slightly different, in that the medical note for the hospital presentation refers to a history given by the mother that C had hold of the tube then



moved backwards, pulling it out<sup>40</sup>. Dr Salvestrini was clear in her evidence that she could not see how the force could be generated by a child moving/falling backwards, so that the balloon could be dislodged.

118. However, as above, the history of the admission from 21.05.2019 does not indicate any concern being raised by any professional in respect of what the mother was describing to them, or any concern in respect of the site itself.

**5. On 22 November 2022 the mother contaminated a bag containing gastric aspirate from C's stomach, by adding feculent matter to the fluid and informing Dr W that she had drawn the contents from the stomach.**

119. As indicated above, it is this incident which led to Dr W making the referral and, seemingly, moving from a position of perplexing presentation to suspected fabricated or induced illness.

120. There are different sources of evidence for the incident, with varying degrees of clarity. The local authority suggest that the Court's clearest evidence comes from the nurse, NN. Her written evidence sets out the following:

- a) On 22<sup>nd</sup> November 2022 NN had taken over C's care from the night shift.
- b) She entered C's cubicle.
- c) She was given a gastrostomy bag with light brown liquid and flecks of black in it.
- d) She emptied the contents into a 60ml bladder syringe and saved it and a dirty nappy from medical review.
- e) She emptied the gastrostomy bag that was still attached to C. It contained a pink tinged fluid. She emptied 80mls and also saved it for medical review.

121. In her oral evidence she provided further detail:

- a) The used gastrostomy bag had been left by the mother on a bin inside C's cubicle.
- b) Having taken the sample from that bag, she then drained some of the aspirates from the bag attached to C.

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<sup>40</sup> Newc Med F1001

- c) The contents from the attached bag were tinged pink. As she drew the aspirate into the syringe, it looked cloudier than it had in the bag.
- d) She then left the two syringes in the sluice for examination.

122. It seems on NN's account, she left a nappy and 2 syringes in the sluice for medical examination. One of those syringes contained the aspirate from the used bag (light brown fluid, flecks of black). The other syringe contained fluid which was tinged pink and cloudier than it had appeared in the bag attached to C.

123. An addendum note by Dr Y on 22.11.22 refers to<sup>41</sup>:

*"Currently has clear gastronomy fluid in bag. Syringed gastrostomy fluids from last drained is brown on rv in sluice"*

124. Dr Y's note from the next day, 23.11.2022, refers to the gastronomy bag on 23<sup>rd</sup> November being *"75mls yellow clear translucent liquid. No bits"*.

125. In his evidence, Dr Y told me that he could remember NN telling him that she had syringed out the contents of the gastronomy bag and had left them in the sluice to review. In his oral evidence he said the following:

*I think there were 2 syringes.*

*They both appeared to be identical in respect of contents. I looked at them both.*

*I don't think I focussed on one in particular.*

*I think the colour of the fluid was clear apart from the matter in it.*

*The two syringes were similar in appearance.*

*I don't remember examining the bag that the contents of the syringe came from*

*From myself there was no discussion about the contents with the mother.*

126. Dr W's written statement dated 19.04.2023 indicates that he recalls only one syringe<sup>42</sup>. He says that he had a conversation with the mother who told him that the content of the syringe was the content of the gastronomy bag. He says at paragraph 10:

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<sup>41</sup> Newc med G471

<sup>42</sup> G61 para 13

*The feculent material in the syringe was clearly different from the fluid we could see in the gastrostomy bag at that point of time.*

127. I take Dr W to be referring to the contents of the bag which is attached to C, and not the used bag from which the gastric sample had been taken.

128. There is no mention in his statement to the two syringes identified by NN by Dr Y or within his own earlier report. In his report dated 11<sup>th</sup> December 2022<sup>43</sup>, Dr W describes the following:

*The most stark and inexplicable event of fabrication of symptoms, was presenting me 2 syringes of feculent material, that was totally different from that draining out of the stomach... I am concerned that this is a probable act of deception that appears brazen*

129. Unfortunately, I found Dr W's oral evidence to be confusing on this issue. He seemed to accept that, contrary to his statement, there were two syringes. It was put to him that NN had identified two syringes and that Dr Y had told me that the contents were identical. He was specifically asked if both syringes had sediment in them to which he replied:

*"Yes, they did"*

130. However, there seemed to be some confusion from Dr W as to when an aspirate sample he observed as pale yellow and clear, had been taken. It seemed that Dr W was confusing a sample taken earlier in the morning from that which had been taken from C's attached bag by NN at the time she had taken the sample from the used bag.

131. A photograph was taken of a syringe, as arranged by Dr W and Dr Y. If there were two syringes, it is unclear which syringe was photographed. There are no tests that can be done to confirm the presence of faeces within the syringe. Dr Mecrow indicated that appearance and smell would be diagnostic. Dr W confirmed that he had not smelt the contents of the syringe/s.

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<sup>43</sup> E7

132. C appears to have been on free drainage until the morning of 22<sup>nd</sup> November 2022. There is reference within the papers to C being given food up to his admission on 18<sup>th</sup> November 2022, albeit the expectation was that he would chew and then spit. It appears that C continued to eat during his admission. There is reference within the nursing observations from 18<sup>th</sup> November 2022 that C was eating toast<sup>44</sup>. In her evidence to me, the mother also indicated that C had continued to be provided with food, albeit she had thought he would be spitting it out. The mother told me that C liked the taste of “pepperami” sticks (a dark meat-based snack) and that he had been chewing on such a snack at a point/s during his admission. There is reference pre-admission to C nibbling on a pepperami<sup>45</sup> previously.

133. Although it was later on 22<sup>nd</sup> November 2022 from the gastric aspirate sample being taken and after the initiation of clamping, there is evidence of C not only eating but also swallowing food<sup>46</sup>. C clearly had the ability to swallow food.

### **Other findings sought**

134. Those findings sought above are the basis upon which the Local Authority invite me to then proceed to consider additional findings which they say then flow as a consequence. I do not intend on setting those additional findings out at this juncture but rather will consider them more widely as I turn to look at the specific findings sought below.

### **Expert evidence**

#### **Dr Mecrow**

135. Dr Mecrow provided an extensive report looking at all of the issues raised by medical professionals since C’s birth.

136. He makes it clear from the outset that there is no test or investigation which, of itself, proves that a child has been a victim of FII. He notes that in his experience very many of the children who fall victim to FII have had a true organic illness or disease to account for at least part of their symptoms:

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<sup>44</sup> E11; 18<sup>th</sup> November 2022, G15 and Newc med G561

<sup>45</sup> H114; 07.11.2022

<sup>46</sup> Newc Med G386

*It can therefore be very difficult to be clear where a child crosses from simply having an anxious parent who frequently seeks out medical opinion, to a parent who seeks medical opinion unreasonably and misleads doctors as to the child's symptomatology<sup>47</sup>.*

137. In respect of C, Dr Mecrow concludes that the abnormalities in symptom reporting have been around the gastrointestinal symptoms of diarrhoea and vomiting. He also raised concerns around the reporting of neurological symptoms of epilepsy but confirmed that he would defer to the opinion of Dr V, who had knowledge of the video recorded incidents said to be seizure activity. In any event, the LA do not seek a finding that C never suffered from epilepsy; preferring instead a finding that the seizures had been exaggerated and misreported in terms of frequency (see above).

138. Dr Mecrow concludes as follows in respect of C<sup>48</sup>:

*I would advise the Court that I have not found evidence of these symptoms being induced in C but believe that they have been exaggerated.*

*The records indicate that the source of the reports of these symptoms have been almost exclusively from his mother.*

*The dramatic improvement in C after only 4 months of alternative accommodation is astounding and of itself points very strongly to a relationship with his mother that was having an adverse effect on his health.*

139. Dr Mecrow's conclusions in respect of D are as follows<sup>49</sup>:

*In summary then, there are a number of concerns about the pattern of his healthcare in the first eight months of life. These include an excessive number of overall attendances for review, rare and worrying symptoms of disease, unusual response to medication and over interpretation of symptoms..*

*I would have strongly advised the Court that the pattern of health care seen in the first 8 months of life is so unusual and striking that careful consideration needs to be given to the possibility that if this had been allowed to continue, D would eventually have been subjected to invasive investigations and harmful treatments. The Court will need to*

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<sup>47</sup> E201

<sup>48</sup> E236

<sup>49</sup> E205

*consider the possibility that this progression has only been halted as a result of the intervention by health care professionals and social care services because of the identified concerns in his older brother C.*

140. In his oral evidence to me, Dr Mecrow stood by the contents of his report. In cross examination on behalf of the mother, he was referred to the evidence that C had continued to suffer from diarrhoea whilst in the care of the paternal grandparents, having been removed from the mother's care. Dr Mecrow acknowledged that issues of diarrhoea had continued and that it may be linked to issues around medication. However, that did not change his overall opinion. He told me that it was the speed at which previous issues had resolved, which indicated that something had been very different from the care he received now and that he received from his mother.

141. Ms MacLynn quite properly cross-examined Dr Mecrow in respect of individual elements of the medical evidence, upon which he had relied when forming his opinion. Dr Mecrow told me that he accepted that there may be some explanations for some the issues that had been reported. But it was the whole picture, rather than individual incidents, which must be considered. His evidence to me was that this case involved true and complicated issues that C suffered from birth, with resulting symptoms from those issues and side effects of medication aimed at dealing with those symptoms. However, there was also evidence of over reporting. This was a case, Dr Mecrow told me, that involved a combination of all of those factors.

142. In respect of D, Dr Mecrow reiterated that he did not think that D had been a victim of FII. His concern was for the future and how presentations might have developed.

### **Dr Salvestrini**

143. I have set out already in my identification of the evidence in support of the findings sought, Dr Salvestrini's primary views. I do not intend on setting out that evidence again.

144. However, there is one additional piece of evidence that Dr Silvestrini gave in her oral evidence that has relevance to a more generalised assessment in respect of the mother's reporting. In connection with gastro issues, Dr Salvestrini was asked about her analysis of the mother's reporting in respect of episodes of vomiting. She was asked about the mother's

reporting of vomiting and whether she is satisfied that it represented over reporting. She answered:

*Yes. I am satisfied that there was over reporting of vomiting on occasions. That view takes into account the outpatient appointments sought, phone calls made and absence of nursing observation. There has been a tendency to see doctors and seek advice which has been led by the mother's reporting.*

### **The mother's evidence**

145. The mother accepts that she is an anxious parent. In my view, given the circumstances around C's birth and the complications that have flowed since then, it is unsurprising that she is an anxious mother to both C and then also D. C's complications have been described within the expert evidence as only being seen in 1/10,000 children.

146. In her oral evidence to me when asked about D she said:

*I was an anxious mum. I never had a mainstream child before. I think everything I took him for, was because I was anxious, an anxious mum.*

147. The mother accepts that she was anxious to get the right help for C but denies intentionally exaggerating, misreporting or over reporting symptoms to get that help. However, in her oral evidence the mother did accept that she does at times struggle to express herself to others and, in her interactions with the father and her own mother, will use figures of speech which could be considered to be exaggeration. Having made that concession, she then denied doing so with professionals.

148. She told me that following on from the meeting with Dr T and Dr V in February 2022, she realised that she should not report absolutely everything to professionals. She told me that she then "paused" before reporting issues around seizure activity. She accepted in her oral evidence that she may have been reporting seizure activity before that meeting when it was just normal daydreaming behaviour.

149. She denied exaggerating issues in respect of diarrhoea or vomiting. However, she told me that there may have been some misreporting because of the way that she describes events. For

example, she told me that C might have an episode when he is being sick. If he is sick and then is sick shortly afterwards, she would describe that as two episodes of sickness, even though others might consider that a continuation of a single event.

150. She denied tampering with C's GJET at all and maintained that it had come out through by accident. She maintained that she had certainly never intentionally pulled a GJET out. She was able to tell me that there had been a dislodgement that had occurred when C had been having a seizure.

151. She denied categorically putting faecal matter into C's gastric aspirate during his admission in November 2022.

152. In respect of the wheelchair, the mother told me that C had been given one, but they had not really used it. He had used it to start with but quickly didn't like to be in it. She had stopped using it except, she told me, when she was required to use it to get on the bus that collected C. She told me that it was not that he needed it at that point, but rather she was told it was a requirement.

153. The mother was unclear in her evidence to me in respect of the gastric aspirate allegation. Her accounts as to the circumstances of the removal of the sample from the gastric bag, were inconsistent as between her oral evidence and written evidence. It was entirely clear to me from her written statements what her evidence was in respect of how and by whom the sample had been collected. However, I have been very cautious in my consideration of a lack of clarity from the mother in respect of that allegation. What is clear from the evidence is that the issue of contamination was not initially disclosed to the mother; she was not asked about it nor made aware of the issue until weeks later when the LA issued proceedings. When she was discharged from the hospital with C in her care on 24<sup>th</sup> November 2022, if she had not intentionally contaminated the gastric aspirate. I very aware that the finding is not for the mother to disprove, it is for the Local Authority to prove on the evidence before me.

### **The father's evidence**

154. During the course of the hearing, the father filed a statement in respect of his own observations of C pulling out tubes. It surprises me, given the issues in this case have been known for some time, that the evidence was not produced earlier.



155. In any event, it was not clear to me what incidents the father was describing when he was referring to having seen C with tubes dislodged and whether those were incidents involving the GJET or not. He was certainly not able to assist in respect of timeframes.

156. In his oral evidence he confirmed what he had said in his written statement dated 10<sup>th</sup> February 2023. Within that statement he had said<sup>50</sup>:

*It's fair to say that mother has some difficulty in expressing herself and sometimes what she tells me is not in keeping with the reality of the situation. For example, there are times when I have returned home from work and mother will tell me that C has vomited everywhere, when in reality it is nothing out of the ordinary.*

157. In his oral evidence the father elaborated on that evidence. He told me that it was the terms of speech that she used which were sometimes not in keeping with reality. He told me that if you knew her, then you would know what she meant.

158. He went on to say to me in oral evidence:

*Q: Must be difficult if cannot tell what might be a genuine concern. Difficult to tell the difference?*

*A: Yes. There were certain things that I would see every day. But the more complex health needs, the seizures, the feeding routines, things I did not have input in, I could not tell if they were being exaggerated or not.*

*Q: Must be worrying if information you were being given was not reliable?*

*A: I had to take what she was saying was the truth. I had no reason to believe that what she was saying was untrue. Looking back now there have probably been appointments which did not need to happen, things said that did not need to have been said.*

159. However, the father remained adamant that the mother would never intentionally cause harm to C. As such, he did not believe that she would have intentionally pulled out a GJET. Nor did he believe that she would have put faecal matter into a gastric sample.

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<sup>50</sup> C55

### **Submissions**

160. I have had the benefit of detailed and well-presented written submissions on behalf of the local authority and the mother. As would be expected in this case, I have also received shorter submissions on behalf of the father and the Children's Guardian. I am grateful for the eloquent and clear way in which each party has set out their case and arguments. Those written submissions were supplemented by brief oral submissions.

161. I do not intend on repeating those submissions within this judgment; to do so would double its length.

### **Local Authority**

162. In summary, the LA invite me to the view that I can rely on the medical evidence as set out above, so that I can make the findings sought to the requisite standard. They remind me that the concerns in respect of the mother are, generally, held by a variety of different professionals from different specialities. I am invited to the view that the evidence I have heard can lead me to the view that this mother is prone to exaggeration. They submit that there are numerous examples of exaggeration within the papers, but that I have also heard the mother exaggerating first hand from the witness box. For example, the mother has during her evidence described C as being "the loudest baby on the neo natal unit", and that D's thrush was "the worst the doctor had seen". It has to be accepted that someone's thrush will be the worst that a particular doctor has seen, but the Local Authority asks me to consider that evidence within the context of the evidence of exaggeration within the papers.

163. In terms of exaggeration and misreporting, the Local authority invites me to look not at single incidents, but rather take a broader view of all of the evidence, to consider the wider canvass.

164. In respect of tampering with the GJET, the local authority invites me to consider the clear evidence from Dr Salvestrini. They remind me that Dr Salvestrini firmly maintained that that a child of C's age could not pull the device out himself. They remind me that Dr Salvestrini does not accept the mechanisms described by the mother. To that end, they invite me to the conclusion that the dislodging of the GJET must have been caused by the mother, presumably intentionally.

165. The local authority reminds me of Dr W's clear evidence in respect of his belief that the contents of the gastric aspirate appeared to be feculent. His position is described as a "strong stance". Whilst it is accepted that Dr W identified 2 syringes, and that they both had sediment in them, they remind me that Dr W's view was that the contents did not have the appearance of food.

**The mother**

166. It is submitted on the mother's behalf that, bluntly, the evidence does not support a finding that the mother deliberately contaminated C's gastric bag on 22<sup>nd</sup> November 2022. I am reminded about the discrepancies within the evidence of Dr W, Dr Y, and NN. I am reminded about the sequence of events that is set out by NN in respect of taking aspirate samples from both the used bag, as well as the bag still attached to C. It is submitted that the evidence suggests that there were two syringes, taken from both bags, which contained similar looking particulate material. It is further submitted that Dr W's comparison of the syringed samples and the bag attached to C at the time of the ward round is flawed, in that there were a number of hours passed between samples being taken and observation of the attached bag.

167. Whilst Ms MacLynn KC acknowledges Dr Salvestrini opinion in respect of it being unlikely that a GJET could accidentally dislodge, she quite properly notes Dr Salvestrini's most recent email evidence that:

*As stated in the evidence given in Court, I can't fully explain a fully inflated balloon coming out from a not dilated gastrostomy site, without trauma.*

168. Ms MacLynn invites me to look to the broader canvass of evidence. In looking at the broader canvass of evidence before me, Ms MacLynn invites me to consider what is missing from that canvass. In particular, there is no concern raised at any point in respect of the dislodgement. The only concern seemingly expressed is not about how the balloon could have been dislodged, but rather what could be done to stop it happening again in the future.

169. Regardless as to my findings in respect of misreporting or exaggeration of gastric symptoms, I am invited to consider what I know about this mother and consider that

alongside the medical evidence when determining whether the Local Authority have proved that this mother has deliberately tampered with the GJET.

170. I am invited to consider the circumstances surrounding mother's reporting of vomiting and diarrhoea in the lead up to his admission on 18<sup>th</sup> November 2022. I am reminded that the term diarrhoea has a specific medical meaning which is not a definition generally understood by a lay person; it is not unusual for a parent to refer to loose stools as diarrhoea. In particular, I am asked to consider that there is evidence of diarrhoea within the care of the grandparents, once removed from the mother. I am also asked to consider whether the cessation of the reported vomiting is as a result of the passage of time between the mother's report and C's admission. I am reminded that Dr V had opined that it was possible that C had in fact been vomiting prior to his admission but that his symptoms were resolving<sup>51</sup>, something which Dr Mecrow seemed to accept as a possibility in his oral evidence.
171. I am asked to consider that the assertion that the mother discouraged or prevented C from eating and swallowing food against advice is incorrect. In a wider sense I am asked to reject the assertion that the mother misrepresented C's gastrological symptoms to professionals.
172. Ms MacLynn submits that whilst the mother may have inadvertently misreported the extent of C's vomiting, the Court cannot say that this in itself led to C suffering significant harm. That point is echoed throughout the submissions; even if I make findings in respect of exaggeration and/or misreporting, how does that equate to C suffering significant harm?
173. I am asked to be careful about placing too much weight on a direct comparison between C's presentation in the mother's care and in the care of the paternal grandparents. Ms MacLynn submits that the comparison would only be fair if the circumstances were the same under both sets of carers. Ms MacLynn submits that they are not. Specifically, there has been a change of plan from gastric to oral feeding with a resolution of the lengthy jejunal feeding that had been taking place in mother's care. Further, there has been a change in medication once in the paternal grandparents care which may have had an impact on any vomiting and/or diarrhoea observed in the mother's care.

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<sup>51</sup> E19

174. Finally, Ms MacLynn asks me to consider the mother's own circumstances and cognitive abilities as I survey the wider canvass of evidence before me. I am reminded of the evidence provided by Dr Ollis in respect of his assessment of the mother and warned against holding the mother to a harsher standard than other parents, in light of her learning difficulties.

175. Ms MacLynn submits that the evidence before the Court falls significantly short of establishing fabricated illness. At worst, she says, the mother has unwittingly exaggerated or misreported some of C's symptoms as a result of her anxiety and cognitive functioning issues.

### **The father**

176. In her short document, Ms McKie notes that no findings are being sought against the father, that he had no concerns in respect of the mother's care of the children and that he was "shell shocked" once he had been made aware of professionals concerns.

### **The Children's Guardian**

177. I am grateful to the Children's Guardian and Ms Boothroyd for making general observations on the evidence that I have heard. Too often Children's Guardian's take a position of neutrality when submissions are appropriate as to the quality or otherwise of the evidence.

178. Ms Boothroyd notes some of the concessions made by the mother in respect of exaggeration to family, in terms of her use of speech. She also notes the mother's acceptance that since the meeting with Dr T and Dr V in February 2022, her approach to reporting seizure activity had changed as she took the time to think carefully about incidents before reporting them.

179. Ms Boothroyd acknowledges the evidence from the experts, in particular from Dr Salvestrini, as to the likelihood of a balloon being dislodged from a healthy tract. She also notes that none of the clinicians involved at the time raised any concern in respect of the dislodgments. Ms Boothroyd also notes the lack of evidence in the contemporaneous notes of any trauma to the tract at the time, and an absence of evidence in respect of the state of balloon inflation.

180. Ms Boothroyd notes some of the difficulties with the evidence in respect of the allegation that the mother intentionally contaminated the gastric aspirate, including the difficulty presented to the Court where there is no forensic test that can be undertaken to ascertain whether the contents were feculent. Ms Boothroyd notes that the contents of the syringe/s were not smelt by any clinician and that the evidence suggested that if C had eaten something then it would be present within the gastric bag if he was on free drainage.

**Conclusions on the specific findings sought**

181. I have taken a considerable amount of time to consider all of the evidence before me. I have analysed the source of the medical opinion upon which the local authority relies, but have then considered that medical opinion having regard to the specific circumstances that the mother found herself in following the birth of C, and subsequently D. In essence, I have not restricted my view to the concerns as expressed by the medical professionals, but have looked at the wider canvas of evidence which has been made available to me.

182. There is clear evidence on the papers, and within the oral evidence provided by the mother and father, that the mother in this case has a tendency to exaggerate. Whilst the mother says that her exaggerated figures of speech are only used with family members, it became clear to me that, even in her evidence to me, she has a tendency to use exaggerated phrases when describing scenarios.

183. I have therefore looked carefully at what evidence there is within the papers that the mother's tendency to exaggerate has filtered into her interactions with professionals. One allegation of exaggeration involves the mother's comments made to DST. DST has recorded the mother as saying that C's tube has been dislodged 7 times. DST rejected the suggestion that she could have misheard "several" times, albeit was willing to concede that she couldn't be 100% sure.

184. I found DST's evidence to be compelling. She told me about the process in which she takes notes and enters them into the system. On balance, I accept DST's evidence that the mother did in fact tell her that the tube had been dislodged 7 times. In accepting DST's evidence, I am left with a question as to whether the mother saying 7 times was an exaggeration or a simple mistake. It is hard to see how such a specific mistake could be made.

There is no suggestion within the note that the mother was making an estimate or guess. There is no suggestion within the note that the mother was suggesting it was *around* 7 times.

185. On balance I am satisfied that not only did the mother say that the tube had been dislodged 7 times, but that in so saying she was exaggerating the frequency of dislodgement.

186. I am satisfied on balance that the exaggeration was not an inadvertent exaggeration, it is an example of the mother's tendency to exaggerate not being confined to conversations with family members but extending to the professionals with whom she was interacting with.

187. That example highlights the difficulty raised by Dr Mecrow in cases where exaggeration is being suggested; there is often a truth at the centre of the assertion and the difficulty is unpicking whether what is said goes beyond that core truth.

188. Another allegation of broader exaggeration is in respect of the mother's reporting of C's behaviours which she said had been observed by Baby Hospice. I have a clear note, as referred to above, as to the what the mother was relaying to Dr Q on 25<sup>th</sup> May 2021. It was not suggested by the mother that the recording was wrong in respect of what she had said. Instead, the mother suggests that she had been told by a worker at Baby Hospice that there were concerns about his behaviour.

189. Having heard evidence directly from ZW I am satisfied that the concerns being raised by the mother, as then reported to Dr Q as having originated from Baby Hospice, were on balance exaggerated by the mother. Even if the mother is right that she had spoken to a worker who had made some comments about C being "wild", that does not tally with the description given by the mother to Dr Q of C displaying challenging behaviour, being fairly wild and aggressive. Again, there may be some truth at the core of what the mother was saying to Dr Q; the mother may well have been told by a worker that C had been wild in a session/s. However, I am satisfied that the mother has taken that core truth and has then exaggerated it to professionals. I am mindful that it was that specific disconnect between what the mother was saying to Dr Q and their own observations of C, that caused Baby Hospice to initiate the raising of concerns which led to the professionals meeting in November 2021.

190. Another example of exaggeration relied upon by the Local Authority is in respect of the mother telling DN on 21<sup>st</sup> November 2022, that C had autism. In her evidence DN was clear that the mother had told her on a number of occasions that C had autism. It was only when DN probed that assertion that the mother then indicated that he did not have a formal diagnosis of autism, but that she believed he presented with traits consistent with being on the autistic spectrum. I accept DN's evidence that the mother told her on numerous occasions that C had autism. He plainly did not have a diagnosis of autism. But more than that, discussions around autism had been had with the mother with Dr Q on 21<sup>st</sup> December 2021 where it was highlighted that both the mother and professionals do not feel that there is evidence currently to support an autism assessment.
191. It may be that the mother was growing increasingly concerned about C's behaviours by November 2022, although the evidence seems to suggest that his behaviours were getting better rather than worse. Even if they were getting worse, the mother had again taken that core truth, and relayed that core truth as an exaggerated fact. On balance, having accepted DN's evidence, I find that the mother has exaggerated issues around C's behaviours resulting in her misreporting to DN that C has autism.
192. Finally, there is an incident whereby the mother is reporting to Baby Hospice that C's dressing needed to be changed 4 X per day. I deal with the evidential basis for that at paragraph 90 and 91 above. The mother told me in evidence that she had simply told Baby Hospice that it needed to be changed if it got wet. The evidence from Baby Hospice is clear and specific. I do not accept the mother's assertion that she was talking about it being wet, rather than a frequency of 4 X a day. It is, in my judgment, another example of the mother exaggerating to professionals in respect of C's needs.
193. Those are a number of clear examples that I am satisfied, on balance, represent situations where the mother has exaggerated C's circumstances/presentations to professionals. I do not accept the mother's suggestion that any exaggerated terms of speech she may use, is confined solely to her interactions with family.
194. Having considered the wide canvass of evidence before me, I am satisfied that the mother has a general tendency to exaggerate, to both family members and professionals.



195. That does not mean, of course, that the mother's tendency to exaggerate including in her interactions with professionals, means she has exaggerated as specifically pleaded by the local authority. Just because I have found that the mother has exaggerated to professionals does not mean that she has exaggerated everything.

196. I turn then to the specific allegations.

*1. Between 2018 and 2022, C's mother has exaggerated, misrepresented, or fabricated his symptoms when speaking to medical professionals as follows;*

*a) Exaggerating and misreporting the frequency of epileptic seizures observed in C,*

197. The mother accepts in hindsight that she may have been misreporting incidents of seizure activity prior to February 2022. Whilst she says that the seizure activity was already reducing at the time of her meeting with Dr T and Dr V, she accepts that following that meeting she took time to properly consider suspected seizure activity before then reporting it. She told me that she realised that some of the incidents were simply occasions of daydreaming.

198. When I consider not only the mother's evidence, but also that from Dr V and Dr Mecrow, I am satisfied that the mother has over reported the frequency of seizure activity, up to February 2022. I am satisfied that on the basis of Dr V's evidence, there was underlying seizure activity which had been independently verified. That was the core of truth. That truth being relayed to the mother, that C had been diagnosed with epilepsy, simply heightened the anxiety that the mother was already experiencing in respect of C's underlying health problems. I am satisfied on the evidence that the mother's anxiety manifested itself into the mother alerting professionals as to any presentations that she thought might be unusual. In doing so she would tell professionals that she thought he was having seizure episodes. In my judgment she was not fabricating symptoms or episodes. Instead, she was exaggerating and misreporting symptoms, without stopping to consider that many of the episodes may simply be normal behaviour. That would result in medical intervention, including hospital visits. Those interventions would occur because clinicians had to rely on what the mother was telling them, especially when he had an underlying diagnosis.

199. I accept the submission made by Ms MacLynn that it is difficult to determine what medication might have changed if the mother had not misreported the instances of seizure activity, especially where there was a genuine diagnosis that had been made on independently verified video footage. Whilst concern is raised by Dr V as to increases of the medication that C has received, I am unable on balance to say that his underlying diagnosis did not require the medication he had received. I have my suspicions that his medication has, at times, been increased inappropriately on the basis of the mother's misreporting. I accept Dr V's suggestion that it could be argued that it has<sup>52</sup>. However, suspicion is not enough.

200. What I am clear about is that the mother's misreporting resulted in C being subjected to frequent medical interventions, which he did not require. He was placed at risk of requiring more significant medication, which may have adversely impacted upon his health.

*b) Exaggerating and misreporting the extent of C's behavioural difficulties when in the care of others, which was not observed by the relevant professionals*

201. I have already dealt with this allegation above. I confirm that I make the finding as pleaded.

*c) Informing professionals that C either has autism or is on the spectrum.*

202. Again, I have already dealt with these finding above. I confirm that I make the finding as pleaded.

*d) Exaggerating and misreporting the extent of C's breathlessness and fatigue, leading to cardiological investigations. The mother also reported having obtained a wheelchair which was manifestly unnecessary for C by late 2022.*

203. The mother told me that she and grandparents had been on holiday and that they noticed some issues with C. Those issues were in respect of C becoming tired easily and wanting to be carried more frequently than he normally would. It is not clear to me when that holiday was, but I note that there was correspondence from C's neurodisability consultant on

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<sup>52</sup> E29

- 22.09.2022 when C was specifically witnessed walking and running around the consultation room, opting to do so most of the time.
204. This came at a stage when C was due to be admitted for a gastroenterology procedure on 10.10.2022<sup>53</sup>. This was no doubt a time of high anxiety for the mother. The appointment with Dr Z on 04.10.2022 had been arranged urgently because of the upcoming gastroenterology procedure.
205. There is nothing within the note, or medical evidence more generally, to suggest that the mother was only talking about a short period of time when on holiday. A period of holiday is not mentioned at all.
206. Again, in my judgment this is likely to be an exaggeration of a core truth. It may be that the mother had noticed an occasion when C had been feeling tired or had been sweaty. However, the way she then conveyed it to the medical professional, in a setting which was specifically looking at whether there might be issues with his heart which may impact upon his upcoming surgery, was exaggerated. I am unable to say whether the mother's reporting resulted in the echocardiogram taking place; it may be that one would have been undertaken regardless of the mother's reporting. However, it certainly **ensured** that an echocardiogram would take place.
207. In his appointment with Dr X on 15.11.2022, the mother again is reporting C to not be as fast when running and asking to be picked up a lot. Again, it is not clear to me whether the mother is still referring to the period of holiday, but no holiday is mentioned. She refers to C not now walking to the shop and asking to be carried. This is at a time when C is fast approaching his admission, arranged by Dr W, to get an understanding of how C is presenting in light of the mother's reporting. Dr X can see no reason for the mother's reported symptom of increased tiredness. In her telephone conversation with Dr V on 10.11.2022, the mother made no mention about concerns she had with C's tiredness and mobility.
208. As above, I find that the mother was exaggerating C's symptoms at a time of acute anxiety.

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<sup>53</sup> G456

209. It was during the conversation that the mother had with Professor X that the issue of the wheelchair was raised. When I go to the notes<sup>54</sup> from Professor X I note:

*Even with his grandparents he does not now walk to the shop with them and asks to be carried. They have a wheelchair at home for him, but they do feel this is a problem that is increasing over time.*

210. The finding sought suggests that the mother was not only reporting that she had a wheelchair, but that it was being used unnecessarily in November 2022. On that note from Professor X alone, the evidence does not support a finding that the mother was using the wheelchair for C in November 2022. She did report that she had a wheelchair, in my view as a way to stress her exaggerated concern. However, I am content that the first part of the finding accurately deals with the mother's exaggeration at that time without the need for reference to the wheelchair.

*e) Exaggerating and misreporting C's vomiting as being frequent during November 2022 which was not then witnessed during the hospital admission from 18 to 23 November 2022,*

211. There are a number of references to the mother reporting frequent vomiting at the beginning of November 2022. The mother accepts that she was reporting frequent vomiting. On 7<sup>th</sup> November 2022, the mother is reporting that C has been vomiting for the last 6 days.

212. The finding is sought on the basis that the frequent vomiting was not observed when C was admitted. However, the admission took place on 18<sup>th</sup> November 2022. On 8<sup>th</sup> November 2022 the mother had attended at the Emergency Department, it seems as advised to do so by Dr V. At that appointment she gives an explanation that C has not vomited since 1pm on 7<sup>th</sup> November 2022<sup>55</sup>. There is then no report of the mother saying that C has vomited from the point of that report to the point of admission; some 10 days later.

213. In his oral evidence, Dr Mecrow accepted that C may have been ill with a virus which caused the vomiting in early November. On 8<sup>th</sup> November 2022 the mother seems to be associating the vomiting with an improper placing of the jejunostomy.

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<sup>54</sup> Newc Med C381

<sup>55</sup> Med bundle A88

214. It seems to be accepted by all that during his admission from 18<sup>th</sup> November to 24<sup>th</sup> November 2022, C was not vomiting frequently. However, that does not prove to the requisite standard that the mother had been exaggerating or misreporting frequent vomiting in early November. Whilst I have already raised my concerns in respect of the mother's tendency to exaggerate to family members and professionals, that does not mean that every report is exaggerated or misreported.
215. I am however concerned with an aspect of the mother's reporting whilst in ward during that admission. On 23<sup>rd</sup> November 2022, the mother was clearly becoming concerned that medical professionals did not believe her and thought that she was lying about C's vomiting. Then, it seems that night (through to the 24<sup>th</sup> November 2022), the mother reports that C had been sick 4 times. However, the evidence of his multiple sickness episodes is not available, because the mother informs the medical staff that he had then swallowed the sick back down<sup>56</sup> on each occasion. When being asked to account for why he would do so in oral evidence, the mother told me that she thinks that C did it because he wanted to go home. She told me that he knew that if he were to vomit then it would mean that he would have to stay in hospital. On that basis, she told me that she thinks C intentionally swallowed the vomit back down.
216. I find that an incredible explanation for C swallowing his own vomit. At the time he was 5-year-old, even if he had been able to keep the vomit in his mouth in the process of being sick, I do not find it credible that he would then have the clarity of mind to analyse the consequences of vomit having been discovered in respect to his current admission. I do not accept the suggestion that C was sick and swallowed his vomit on 4 occasions on the night of 23<sup>rd</sup> November 2022.
217. I have considered very carefully whether, on the evidence, this is an incident of fabrication by the mother. Given the concern that the mother had expressed only the day before about her suspicions that people did not believe her about C's vomiting at home, I can see a situation where the mother might be minded to fabricate the episode. However, on balance, whilst I have my suspicions, the evidence is not before me to prove that this as a complete fabrication. On balance, I am satisfied that C may have retched or coughed that night, which the mother has then exaggerated into 4 separate episodes of being sick.

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<sup>56</sup> Newc Med G388

f) *Exaggerating and misreporting C's diarrhoea as persistent and severe between 18 and 23 November 2022,*

218. C had been admitted to hospital on 11.10.2022 with chronic diarrhoea<sup>57</sup>. Watery, mucously loose stool had been observed on the following days, with the medical notes confirming on 14<sup>th</sup> October 2022, that C was suffering from diarrhoea. That is a clinical note, using the clinical definition of diarrhoea. I must take care not to properly consider whether I should criticise the mother for the use for the word “diarrhoea” when the reality is that different people use that term to define differing looseness of stools.

219. It seems then that diarrhoea had been a problem for C both before his admission on 18<sup>th</sup> November 2022 and following his removal from the mother's care. The medical evidence was unanimous in the acceptance that one of the side effects of C's medication was diarrhoea, or loose stools.

220. There is reference within the medical notes to C having loose stools whilst on admission from 18<sup>th</sup> November 2022. On one occasion, that stool is described as<sup>58</sup>:

*Stool in room from morning. Contained in nappy, not large amount. Soaked into nappy but solid bits left in nappy.*

221. I suspect that many parents would consider themselves reasonable in describing that type of stool as diarrhoea. I further suspect that stool described as a “paste” might also be referred to as diarrhoea by many parents. I remind myself that any description the mother is giving at this stage is on the basis that the medical team is able to fully consider and examine C's stools. This is not an instance where unverifiable reporting is taking place. The mother would know that that her description can be analysed alongside the stool itself.

222. There seemed to be some confusion in Dr W's evidence as to the mothers reporting of frequency of stools. When initially answering questions, Dr W seemed to be under the belief that the mother had been saying that C's stools had been occurring at a frequency of 10 times a day, every day. He had to be taken to his own chronology to clarify the point. Both in that chronology, and within the medical notes, it seems clear that the mother was saying that C's

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<sup>57</sup> Newc Med G476

<sup>58</sup> Newc Med G395

stools varied in frequency from 3-10 times a day. There is no record as to how often the mother would say that the frequency reached 10 times a day. Although the passing of 10 stools in a 24-hour period seems high, I have not heard any evidence to suggest that such a frequency could not be right, on at least a single episode. Nor am I satisfied that any criticism ought to be directed at the mother for using the term diarrhoea when, in my judgment, the description of the loose stools could reasonably be termed “diarrhoea” by an untrained lay person. I am also mindful that C suffering from diarrhoea is an independently verifiable fact, both before his admission and after.

223. I am not satisfied that the Local Authority have proven to the requisite standard that the mother’s descriptions on admission were an exaggeration or misreport.

*g) Misrepresenting C’s gastrological symptoms to professionals and maintaining that he would become unwell if his gastric aspirates were not drained and his dressing needed to be changed, on a more frequent basis than suggested by independent observations.*

224. When I consider the mother’s views to clamping within the medical notes, they are all of a negative nature. It appears that it was the mother who caused the clamping to be stopped in 2021 due to her reporting of sniffing and vomiting. Whilst it is right that the mother engaged with the clamping trial whilst on admission from 18<sup>th</sup> November 2022, it is clear to me that she was not happy about the clamping being tested. In an act, I find of clear misreporting, the mother informed medical staff that Professor X had told her not to clamp the tube on 15<sup>th</sup> November 2022. The context of the mother reporting Professor X telling her that, is important. It comes from a discussion that Dr W was having with the mother on 21.11.2022. Dr W is specifically asking the mother about clamping. It is recorded<sup>59</sup>:

*“Mum informed us she has been told by Dr X (cardiologist) not to clamp C as when attended clinic last, his gastrostomy bag wasn’t attached and he was sniffing a lot and retching”*

225. That report from the mother reads as if Professor X witnessed retching and sniffing and as a result told mother not to clamp because clamping has a negative impact on C.

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<sup>59</sup>Newc Med G395

226. In his evidence Professor X told me that he would not give advice about clamping as it was outside of his specialty. In any event, advice in respect of an issue like that would make its way to his notes. That advice is not in the notes.

227. In her evidence, the mother told me that Professor X had told her not to clamp, unless medical advised to do so. That addition in oral evidence does not sit well with the mother reporting concerns about clamping, to medical professionals, if the advice had been simply to clamp if advised to do so *by* medical professionals. I do not accept the mother's assertion that Professor X told the mother not to clamp, unless medically advised to do so or otherwise. I accept Professor X's evidence to me that he would not give that advice for the reasons set out in his statement. I also accept that such advice, in those circumstances, would form part of the detailed note that he then prepared, if it had been given. In my judgment this is an example of the mother misreporting information to create a negative picture around the issue of clamping.

228. When I consider that misreporting and negativity, alongside the concerns raised by Dr Silvestrani in respect of the clamping in 2021 having ceased as a result of the mother's reporting, and her opinion that there is a history of misreporting from the mother in respect of vomiting, I am persuaded on balance that the mother has either misreported or exaggerated gastrological symptoms in order to paint a negative picture of the impact on C if clamping were tried.

229. In so far as the mother's reporting as to the frequency of the change of dressing, I have already dealt with that above. I confirm that I make the finding as pleaded.

*h) Exaggeration and misreporting of C's pain responses and requesting analgesia as a result, overnight on 22 November 2022*

230. I am able to deal with this finding in brief. I have already set out above the evidential basis upon which I am invited to find this allegation proven to the requisite standard. That evidential basis is lacking. The evidence as set out within the papers does not come close to the Local Authority establishing the exaggeration and/or misreporting as pleaded.



- i) *Exaggeration of the number of times that C's tube had become dislodged or removed, saying that it was on 7 occasions between April and November 2018. The notes show the tube becoming dislodged on 3 occasions in 2018, and one occasion in May 2019.*
231. I have already dealt with this finding above. I confirm that I make the finding as pleaded.
2. *Despite discussions with the mother and the importance of accurate reporting having been emphasised to her in November 2021, she has continued to over report and misrepresent symptoms.*
232. I believe this refers to the point that the mother had the meeting with Dr T and Dr V in February 2022. The fact of that meeting and the discussions that took place are accepted and set out above.
233. The findings I have made so far have referred primarily to incidents prior to February 2022. There are some findings that I have made in respect of exaggeration and/or misreporting since then, in particular in respect of reports of breathlessness and fatigue, ongoing misrepresentation in respect of gastrological symptoms and the reporting of vomiting on ward during his November 2022 admission.
234. On the basis that this finding refers only to those incidents, then it follows that this allegation is made out to the requisite standard.
3. *The mother has hindered C's feeding development as a result of her over presentation of symptoms, limiting his oral solid food intake.*
235. I set out above my reasoning for a finding in relation to the mother misrepresenting C's gastrological symptoms. The consequence of that finding is that the mother's actions have then played a role in hindering C's feeding development. However, as I have already indicated, the situation in respect of C's progress is far from clear. There are concerns expressed within the papers as to whether, in hindsight, alternative medical plans and actions might have been a better plan for C.
236. I am also concerned to note that even at the point of his admission in November 2022, his feeding plan was far from clear. It seems unfair to me that the mother ought to be criticised

specifically for hindering C's oral solid food intake when the evidence suggests that the mother was being provided with ambiguous advice in terms of solid feeding. That is not to lay blame at any professionals door; C's medical picture was unclear. However, equally, the blame should not be laid solely at the mother's door.

237. On the basis of my finding above, it is clear to me that the mother's actions in terms of her misreporting and over presentation of gastrological symptoms have contributed to the lack of progress for C. But there are other factors in this case which, when considered, indicate that other routes were available for C which were not progressed by medical professionals involved in his care.

*4. The mother has tampered with C's gastrojejunal tube causing it to become dislodged:*

*a) Between April and 11 November 2018, C's GJ tube was dislodged on three occasions which are not accepted by the clinical team or expert evidence to have happened accidentally,*

*b) On 20 May 2019, the mother reported that C had fallen backwards and pulled his GJ out. This is not considered to be credible by medical professionals.*

238. If proven, this finding sees a step up from exaggeration, misreporting, over reporting and misrepresentation. This finding would mean an active participation by the mother in not only tampering with C's medical equipment but, on the basis of the pain described by Dr Salvestrini, actually causing C pain and distress.

239. Dr Silvestrini, as indicated above, was adamant in her views in respect of how difficult it would be to accidentally remove a GJET, along with the pain, distress, and physical injury that such a dislodgement would likely cause.

240. Dr Silvestrini is a well-respected expert within her field and was clear in her opinion. I accept her evidence that it would be very unlikely that a properly inflated balloon positioned within a healthy tract, could be dislodged accidentally, let alone on 4 different occasions. There is no evidence before me to suggest that Dr Silvestrini is wrong in that opinion and no research has been provided to me to counter that view.

241. And so, I must consider that opinion against the wider canvass of evidence that I have before me. One of the most striking absences from that wider canvass of evidence is any concern, at all, being expressed by those clinicians who have then dealt with the immediate aftermath of the dislodgement. If Dr Silvestrani is right, then a dislodgement in circumstances where there is no infection of the tract and/or the balloon is fully inflated, should be causing alarm bells to sound. Further, the force that Dr Silvestrani suggests would be needed to dislodge a fully inflated balloon in the absence of infection, is likely not only to cause upset, pain and distress but also actual physical injury around the site. And yet, there is no mention of any concerns being raised about damage to the tract area within any of the medical records.

242. It seems to me, that the only concern being raised at all within the papers is by Dr O whose focus is not on the mechanism of dislodgement, but rather on how dislodgement can be prevented in the future.

243. I consider that evidence alongside:

- a) The fact that the obligation and responsibility to properly inflate the balloon had been given to the parents following a demonstration.
- b) That there is some evidence, albeit not specific to the times of dislodgment, that the site was prone to infection.
- c) The distance in time from the dislodgment episodes.
- d) The absence of evidence from those clinicians directly involved in those incidents
- e) The father's evidence in respect of previous dislodgements, albeit vague in detail.
- f) The mother's evidence and her denial in writing and from the witness box that she would ever take an action to cause her child actual physical harm.
- g) What I know about this mother. This fact-finding hearing is concerned with considering findings, which will then later filter into further assessment. At this stage the purpose of the fact-finding hearing is not to answer "why" things were done, but rather "whether" they were done. But it would be entirely inappropriate not to look at the wider picture in so far as the mother's care of C and D, and the difficult start that she had as a first-time mother. For all the criticism that might be found within this judgment on the basis of the findings I have made in respect of the mother's actions, there is nothing in the history of this case to suggest that this mother has ever taken an action so as to overtly physical

harm either of her children. Rather, the evidence suggests that this mother loves both of her children and her actions, no matter how unreasonable they may seem, are born out the anxiety that she has suffered as a result of her experiences in caring for C in the early days, weeks, and years. That is not evidence that I can simply ignore because determination of the question “why” is yet to be considered.

244. When I look to the wider canvass of evidence before me, alongside the evidence of Dr Silvestrani, I am drawn to the conclusion that there was a combination of factors that made the accidental dislodgement of the GJET probable. I am unable to point to a specific cause, but I consider that material issues include:

- a) Whether the balloon had been properly inflated by the mother prior to those episodes of dislodgement
- b) Whether the size of the tract had been widened at one, some or all of those incidents due to infection
- c) Whether some other cause, such as the balloon not sitting flush and allowing leakage, had caused lubrication to the site<sup>60</sup>

245. On that basis, I do not find that the Local Authority has proved the allegation to the requisite standard.

*5) On 22 November 2022 the mother contaminated a bag containing gastric aspirate from C's stomach, by adding feculent matter to the fluid and informing Dr W that she had drawn the contents from the stomach*

246. I have set out above the confusing picture the evidence paints in respect of this allegation. I have been provided with pictures within the bundle of a syringe which contains matter. I am told by Dr W that the matter contained within the syringe is that which he describes as the feculent material. However, it is not clear which of the two syringes that NN left in the sluice, the picture is of. According to Dr Y, it matters little as he describes the two as being similar in appearance.

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<sup>60</sup> As accepted as a possibility by Dr Silvestrani within her evidence on the basis that at one point the balloon line had to be shortened.

247. But if NN is right that she took two gastric samples, one from the used bag and one from the attached bag, then the similarity of the contents of the syringes becomes highly relevant. Further, when Dr W is making his comparison as between the contents of the syringe/s and the attached gastric bag, there is a significant passage of time; by my calculation some 3 hours.
248. This core of this allegation is based upon Dr W's opinion that the contents of the syringe/s he examined were similar to the contents of a used nappy. It is based on his observation of the syringe and the nappy. There are no forensic tests which can be done to ascertain whether the contents of the syringe contained feculent material. Dr Mecrow suggests that a clinician could smell the contents to assist in identifying whether material is feculent. Dr W did not do so.
249. The evidence is so unsatisfactory that all I am able to say, on balance, is that there were two syringes produced for examination by NN, one from the used bag and one from the attached bag. The contents of those two syringes were similar and contained particulate material. The medical evidence is in agreement that if C had swallowed food, then it would end up accumulating in the gastric bag on free drainage. There is evidence that C had been at least chewing food whilst on ward.
250. The mother has suggested that if the material contained within the syringe was feculent, then it could have been contaminated accidentally by stools covering the port for the gastric bag tubing. It seems to me that the evidence is lacking in terms of that explanation. Although I do not accept that suggestion from the mother, I remind myself that a rejection of her proposition does not add to the strength of the case put by the local authority.
251. When I have looked to the broader canvass of evidence, I have considered whether this incident is an extension to the finding I have already made above in respect of the mother's exaggeration of the 4 x vomiting into the mouth and swallowing. I have considered whether this incident is an example of the mother becoming desperate to show that C is as poorly as she reports him to be at home, and she has then acted to fabricate evidence to support her previous reporting.

252. However, I have returned to the primary evidence produced by the Local Authority and asked myself whether it is of sufficient quality that I can rely upon it. I have reached the conclusion that it is not. It is confusing and at times contradictory. The standard of proof remains the same for each allegation, regardless as to its seriousness. The evidence for this finding is far from cogent.

253. As such, I do not make the finding as sought.

*6. As a result of the above actions:*

*a) Medical professionals have been compromised in their ability to make rational and good medical decisions as to C's health and care needs.*

254. Ms MacLynn makes the point that I must take care when I consider what treatments C has been provided with, given the unclear picture of his health needs and the lack of clarity in respect of how his gastrological issues ought to have been medically managed, There is some strength to that argument, as I have highlighted in respect of the medications that C may or may not have received if the mother had not presented C so frequently in respect of seizure activity.

255. However, I am satisfied that the mother's actions have generally compromised the medical professionals ability to properly treat C, if for no other reason than I have found that the mother's misrepresentation of gastric symptoms has contributed to the lack of progress in respect of C's feeding development.

256. On the basis that I have made the findings I have, I determine that this finding naturally flows. As I have indicated above, clinicians make decisions on treatment, medication, and health plans on the basis of information that they are given by a child's primary carer. If that information is consistently exaggerated, misreported, or misrepresented, then their ability to make good and informed medical decisions is compromised.

*b) C has been subject to investigations and treatments. The treatments*

*performed (endoscopies, surgical closure of infected gastrotomy site, surgical insertion of jejunal feeding tube) are likely not to have been needed.*

257. Again, Ms MacLynn suggests caution ought to be exercised in identifying treatments which have been undertaken, based on the mother's reporting. There is evidence that some of the treatments and plans have taken place as a result of the mother's misreporting or exaggeration. For example, the mother's reporting influenced the treatment for C's gastric issues by way of years of free drainage and repeated endoscopies.

258. I am satisfied on balance that some treatments that were performed were likely not to have been needed. However, I decline to make the specific findings as to the particular treatments sought by the local authority in respect of surgical closure and surgical insertion.

259. In any event, I am satisfied on the evidence as discussed above and upon the findings I have made, that investigations have been undertaken in respect of gastrological and seizure related issues that would not have been required, but for the exaggeration, misreporting and/or misrepresentation by the mother.

*c) C is likely to be subject to medical investigations and treatments which may be unnecessary, harmful, unpleasant and places him at risk of significant physical harm and death through complications (including operative death, infection risk, bowel perforation and serious bleeding).*

260. I accept the Local Authority's submission that, on the basis findings that I make, and have now made, that the mother's history of exaggeration, misrepresentation and misreporting make it probable, **at the time that these proceedings were issued**, that C would have continued to have been made subject to investigations and treatments which may be unnecessary, harmful, unpleasant and places him at risk of physical harm. It is not for me to undertake a welfare assessment at this stage as to the risk that such behaviour will continue into the future.

261. However, on the basis of the findings that I have made (and also refused to make) I take the view that since February 2022 the exaggeration, misrepresentation and misreporting by the mother had lessened. That is not to say that it disappeared altogether. But in my view that

lessening in the mother's reporting has resulted in a lessening in respect of the nature of investigations and treatments that may have been required, at the point that protective measures were put in place.

262. As such, the Local Authority has been unable to show that the mother's reporting at that point was likely to mean that C would be subjected to procedures with a risk of death. That is a step too far on the evidence I have before me.

*d) C is suffering and is likely to suffer further emotional harm through the enforcement of a sick role, interference with normal nutrition, and obstruction to normal socialisation.*

263. On the basis of the findings I have made, this finding naturally flows.

7. *D is likely to suffer significant harm in the form of exaggerated, fabricated and induced illness due to a repeated pattern of parental reporting of exaggerated medical needs,*

*a) D had attended A&E six times in the 34 weeks since he was born and has been subject to 12 consultations at the GP surgery.*

*b) D's symptoms of skin inflammation and reaction to emollients were exaggerated by the mother,*

264. I accept Dr Mecrow's evidence in respect of this finding. Ms MacLynn properly addressed several of D's presentations with Dr Mecrow, making the point that some of those presentations were entirely reasonable. Like Dr Mecrow, I agree with that proposition. Not all of D's presentations to medical professionals are worrying.

265. However, I also agree with Dr Mecrow that a step back must be taken to look at the picture more generally. In doing so, Dr Mecrow looks at a study of paediatric attendances in



primary care<sup>61</sup> and concludes that D had been taken for review on many more occasions than would be usual in the first 8 months of life<sup>62</sup>. He concludes as follows:

*In summary then, there area number of concerns about the pattern of his healthcare in the first eight months of life. These include an excessive number of overall attendances for review, rare and worrying symptoms of disease, unusual response to medication and over interpretation of symptoms<sup>63</sup>*

266. Dr Mecrow is clear in his evidence, both written and oral, that D has not been a victim of FII. For Dr Mecrow, it is the risk that he may in the future become such a victim if the mother's reporting continued:

*I would have strongly advised the Court that the pattern of health care seen in the first 8 months of life is so unusual and striking that careful consideration needs to be given to the possibility that if this had been allowed to continue, D would eventually have been subjected to invasive investigations and harmful treatments. The Court will need to consider the possibility that this progression has only been halted as a result of the intervention by health care professionals and social care services because of the identified concerns in his older brother C.*

267. I have made findings already in respect of specific areas of the mother's exaggeration, as well as more generalised finding in respect of a tendency to exaggerate. The Local Authority seek a finding that the mother's exaggerating of symptoms in respect of C has also manifested in respect of D. To that end they point to a specific example of the mother exaggerating in respect of D's symptoms of skin inflammation.

268. On 7<sup>th</sup> July 2022 the mother is recorded as raising concern that treatment of very inflamed skin with E45 and antifungal creams are making the issue worse. Steroid cream was prescribed, which the mother said had worked well.

269. There is a recording from the Health Visitor, HW, to the effect that the mother was telling her that D was reacting very badly to the application of Epaderm, which had been prescribed

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<sup>61</sup> Al-Saffar M N et al Children as Frequent Attenders in Primary Care: a systematic review BJGP 2020

<sup>62</sup> E204

<sup>63</sup> E205

by the GP. According to that note the mother specifically informed HW that upon application of the cream, D's *skin goes red and he screams*<sup>64</sup>.

270. As a result, the HW sought permission to apply some of the Epaderm to D's forehead and scalp. It is recorded that when she then did so, there was no reddening of the skin and D did not scream.

271. HW gave oral evidence during the fact-finding hearing. It was suggested to her on behalf of the mother, that the reason why there was no reaction was because the steroid cream had already dealt with the issue. It was suggested that when the mother was referring to the reddening and screaming, the mother was referring to the application of the Epaderm to the already inflamed skin. That suggestion was not accepted by HW. She was clear in her evidence to me that the mother was telling her that D would have a reaction generally upon the application of the Epaderm.

272. It seems to me that if the mother is right and HW is wrong, then there would be absolutely no need for the health visitor to apply the Epaderm to the forehead and scalp, as she did. I am satisfied that the mother was telling HW that C would suffer a general reaction to Epaderm, rather than it irritating an already inflamed section of skin. As such, I find that this was an example of the mother exaggerating in respect of D's symptoms.

273. It seems to me that this mother has been significantly impacted by C's early life experiences. The extent of that impact will form the basis for further assessment. On the basis of the findings in respect of exaggeration I have made in respect of C, including around the mother's more general tendency to exaggerate to family member and medical professionals, I am satisfied to the requisite balance that this finding is made out.

*c) The mother has reported perplexing presentations in D, for example blue spells/colour change with cough, and black or tarry (melaena) stool,*

274. Dr Mecrow has raised these reports by the mother as a concern in respect of perplexing presentations. Having heard the evidence about blue spells and tarry stools, I am not satisfied that these are unreasonable reports by the mother. I have heard evidence that a report of a

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<sup>64</sup> Med bundle G12

blue spell is not particularly alarming and that children sometimes do have blue spells. I have also noted above the difficulty with being too critical in respect of descriptions of stools, in terms of frequency and consistency. The mother may have reported tarry stools as a reasonable description of what she saw before her. That may raise a medical alarm bell, but it does not mean that the report itself was unreasonable.

275. Having already made the finding I have about the potential for D to be exposed to increasing reporting by the mother, this additional finding is not necessary, nor is it made out to the requisite standard as a fact in support of the primary allegation.

### **My Findings**

276. On the basis of the above, I am satisfied that the following findings are proved to the requisite standard:

1. The mother has a general tendency to exaggerate, to both family members and professionals.
2. Between 2018 and 2022, C's mother has exaggerated and/or misrepresented his symptoms when speaking to medical professionals as follows;
  - a) Exaggerating and misreporting the frequency of epileptic seizures observed in C.
  - b) Exaggerating and misreporting the extent of C's behavioural difficulties when in the care of others, which was not observed by the relevant professionals
  - c) Reporting to professionals that C either has autism or is on the spectrum
  - d) Exaggerating the extent of C's breathlessness and fatigue, leading to cardiological investigations.
  - e) During his admission from 18<sup>th</sup> November 2022 to 24<sup>th</sup> November 2022, the mother exaggerated an incident when she told medical staff that C had vomited into his mouth 4 times, and then swallowed it.

- f) Misrepresenting C's gastrological symptoms to professionals and maintaining that he would become unwell if his gastric aspirates were not drained, and his dressing needed to be changed, on a more frequent basis than suggested by independent observations.
- g) Exaggeration of the number of times that C's tube had become dislodged or removed, saying that it was on 7 occasions between April and November 2018, when the notes show the tube becoming dislodged on 3 occasions in 2018 and one occasion in May 2019.
- h) Despite discussions with the mother and the importance of accurate reporting having been emphasised to her in February 2022, she has exaggerated, and/or misrepresented as per the findings at 2(c), (d) and (e)
- i) The mother's actions have contributed to the lack of progress in respect of C's feeding development, as a result of her over presentation of his symptoms.

3. As a result of the above actions:

- a) Medical professionals have been compromised in their ability to make rational and good medical decisions as to C's health and care needs.
- b) C has been subject to investigations and treatments. Some of the treatments and investigations performed are likely not to have been needed.
- c) Exposure to unnecessary medical treatments and investigations have placed C at risk of suffering significant harm.
- d) C is likely to be subject to medical investigations and treatments which may be unnecessary, harmful, unpleasant and places him at risk of significant physical and emotional harm.
- e) C is suffering and is likely to suffer further emotional harm through the enforcement of a sick role, interference with normal nutrition, and obstruction to normal socialisation.

4. D is likely to suffer significant harm in the form of exaggerated illness due to a repeated pattern of the mother's reporting of exaggerated medical needs:

- a) D had attended A&E six times in the 34 weeks since he was born and has been subject to 12 consultations at the GP surgery;
- b) D's symptoms of skin inflammation and reaction to emollients were exaggerated by the mother,

277. Having considered those findings, I am satisfied that they satisfy the threshold for the purpose of making public law Orders, pursuant to s.31 Children Act 1989.

278. That ends my judgment

HHJ MURRAY

**POSTSCRIPT**

**08.08.2023**

279. Following the handing down of my written judgment, clarification has been sought in respect of paragraph 81 above. For clarity, that paragraph of my judgment reads as follows:

*81. The next day, on the 24<sup>th</sup> November 2023, the mother reports that C had vomited 4 times that night but had kept it in his mouth and swallowed it back down. It was for that reason that there was no evidence of C having vomited. I have been unable to find a reference at any point before that reference whereby it has ever been reported, by mother to professionals or within the family, that C has vomited in his mouth and swallowed it back down.*

280. Those representing the mother have alerted me to an entry at C169 of the medical bundle. That entry refers to a note made by nursing staff on 05.08.2020. It reads:

*6.23 C has had a relatively settled night.*

*Woke up at around 0200, around the time of his feed finishing. Began to wretch, small vomit in mouth but then appeared to swallow it. Was then unsettled for a little while afterwards. Mum said that he does this 'all the time at home'.*

281. I am grateful to the mother's team for alerting me to the factual inaccuracy within my judgement. I have as a result considered that nurses note as part of the context of the finding that I made in respect of that incident and have considered whether it would have altered the finding that I made at paragraph 276 (2) (e) above. Having done so, I am satisfied that the nursing note from 05.08.2020 would not have altered the conclusions that I ultimately reached.

282. Although it does not impact upon the basis upon which I made the finding, I note in any event that the mother in her response document has accepted the finding that I made.

HHJ MURRAY

#### ANNEX A

It is submitted that at the date that the local authority took protective measures, namely 14<sup>th</sup> December 2022, C had suffered significant emotional and physical harm, and D was likely to suffer significant emotional and physical harm arising from their mother's care not being that which it is reasonable to expect a parent to give.

The following facts are relied upon in support of the threshold criteria;

*(MB = Medical Bundle)*

*(Newc = Newcastle medical bundle, pdf page followed by G ref)*

1. Between 2018 and 2022, C's mother has exaggerated, misrepresented or fabricated his symptoms when speaking to medical professionals as follows;
  - a) Exaggerating and misreporting the frequency of epileptic seizures observed in C.
  - b) Exaggerating and misreporting the extent of C's behavioural difficulties when in the care of others, which was not observed by the relevant professionals.
  - c) Informing professionals that C either has autism or is on the spectrum.
  - d) Exaggerating and misreporting the extent of C's breathlessness and fatigue, leading to cardiological investigations. The mother also reported having obtained a wheelchair which was manifestly unnecessary for C by late 2022,
  - e) Exaggerating and misreporting C's vomiting as being frequent during November 2022 which was not then witnessed during the hospital admission from 18 to 23 November 2022.
  - f) Exaggerating and misreporting C's diarrhoea as persistent and severe between 18 and 23 November 2022.
  - g) Misrepresenting C's gastrological symptoms to professionals and maintaining that he would become unwell if his gastric aspirates were not drained and his dressing needed to be changed, on a more frequent basis than suggested by independent observations.
  - h) Exaggeration and misreporting of C's pain responses and requesting analgesia as a result, overnight on 22 November 2022.
    - c) Exaggeration of the number of times that C's tube had become dislodged or removed, saying that it was on 7 occasions between April and November 2018, [MB A541]. The notes show the tube becoming dislodged on 3 occasions in 2018, and one occasion in May 2019.
2. Despite discussions with the mother and the importance of accurate reporting having been emphasised to her in November 2021, she has continued to over report and misrepresent symptoms.
3. The mother has hindered C's feeding development as a result of her over presentation of symptoms, limiting his oral solid food intake.

4. The mother has tampered with C's gastrojejunal tube causing it to become dislodged:
  - a) Between April and 11 November 2018, C's GJ tube was dislodged on three occasions which are not accepted by the clinical team or expert evidence to have happened accidentally.
  - b) On 20 May 2019, the mother reported that C had fallen backwards and pulled his GJ out. This is not considered to be credible by medical professionals.
5. On 22 November 2022 the mother contaminated a bag containing gastric aspirate from C's stomach, by adding feculent matter to the fluid and informing Dr W that she had drawn the contents from the stomach.
6. As a result of the above actions:
  - a) Medical professionals have been compromised in their ability to make rational and good medical decisions as to C's health and care needs.
  - b) C has been subject to investigations and treatments. The treatments performed (endoscopies, surgical closure of infected gastrotomy site, surgical insertion of jejunal feeding tube) are likely not to have been needed.
  - c) C is likely to be subject to medical investigations and treatments which may be unnecessary, harmful, unpleasant and places him at risk of significant physical harm and death through complications (including operative death, infection risk, bowel perforation and serious bleeding).
  - d) C is suffering and is likely to suffer further emotional harm through the enforcement of a sick role, interference with normal nutrition, and obstruction to normal socialisation.
7. D is likely to suffer significant harm in the form of exaggerated, fabricated and induced illness due to a repeated pattern of parental reporting of exaggerated medical needs.



- a) D had attended A&E six times in the 34 weeks since he was born and has been subject to 12 consultations at the GP surgery;
- b) D's symptoms of skin inflammation and reaction to emollients were exaggerated by the mother,
- c) The mother has reported perplexing presentations in D, for example blue spells/colour change with cough, and black or tarry (melaena) stool,

## ANNEX B

### THE LAW

#### LEGAL FRAMEWORK – FINDING OF FACT

##### *Burden and standard of proof*

1. In any fact-finding exercise the burden of proof of proving any allegation lies on the party seeking to prove the allegations. In the present case the burden remains on the local authority at all times.
2. The burden of proof must not be reversed. It is not for the parents to have to prove any matter. It has repeatedly been made clear that there is no pseudo-burden upon a parent to come up with alternative explanations, Lancashire v R [2013] EWHC 3064 (Fam).
3. The appropriate standard of proof is the civil standard of the simple balance of probability as confirmed by the House of Lords in Re B (Children) [2008] UKHR 35.
4. This means that if the local authority or another party proves an allegation to this standard, that fact must be treated as having been established and will bear on all future decisions concerning the children. Equally, it means that if allegations are not proved to that standard, then they must be disregarded completely. However it does not follow that a rejection of evidence mandates a judge to find that it is false; see Re M (Children) [2013] EWCA Civ 388.
5. The inherent probability of an event remains a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2008] 2 FLR 131 In Lord Hoffman said at paragraph [15] –

*'[15] Common sense, not law, requires that in deciding this question regard should be had, to whatever extent appropriate, to inherent probabilities.'*

Judicial approach to evidence

6. Findings of fact must be based on evidence not speculation; see Re A (Fact Finding: Disputed findings) [2011] 1 FLR 1817 Munby LJ (as he then was)

*'It is an elementary position that findings of fact must be based on evidence, including inferences that can be properly drawn from evidence and not suspicion or speculation.'*

7. The judge must decide if the facts in issue have happened or not applying the binary system made plain by Lord Hoffman in Re B (Children) [2008] UKHR 35 at paragraph [2]. This applies to the conclusion as to the fact in issue, not the value of individual pieces of evidence (which fall to be assessed in combination with each other).
8. The court must take into account all of the evidence and consider each piece of evidence in the context of all the other evidence and look at the overall canvas. Evidence should not be assessed in separate compartments. The judge must assess and evaluate the evidence in its totality; see Re T [2004] 2 FLR 838 Butler-Sloss P
9. The evidence of the parents and of 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.
10. However, in assessing and weighing the impression which the court forms of the parents, the court must also keep in mind the observations of Macur LJ in Re M (Children) [2013] EWCA Civ 1147 at [12], that –

*'Any judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so.'*

11. When considering the 'wide canvas' of evidence the following section of the speech of Lord Nicholls in Re H and R (Child Sexual Abuse: Standard of Proof) [1996] 1 FLR 80 remains relevant –

*'[101B] I must now put this into perspective by noting, and emphasising, the width of the range of facts which may be relevant when the court is considering the threshold conditions. The range of facts which may properly be taken into account is infinite. Facts including the history of members of the family, the state of relationships within a family, proposed changes within the membership family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child, and unsatisfactory parental responses to complaints or allegations. And facts, which are minor or even trivial if considered in isolation, taken together may suffice to satisfy the court of the likelihood of future harm. The court will attach to all the relevant facts the appropriate weight when coming to an overall conclusion on the crucial issue.'*

#### Credibility, memory, recall and reconstruction

12. The evidence of witnesses and the explanations given by them are of the utmost importance and a clear assessment of their credibility and reliability must be made by the court. In the context of the consideration of a wide canvas of material in reaching the factual decisions in the case, investigations of fact should have regard to the wider context of social, emotional, ethical and moral factors. The assessment of credibility generally involves wider difficulties than mere 'demeanour', which is mostly concerned with whether the witness appears to be telling the truth as he or she now believes it to be. With every day that passes the memory becomes fainter and the imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited. Therefore, contemporary documents are always of the utmost importance.
13. A (A Child) [2020] EWCA Civ 1230 in the Court of Appeal concluded that the Court must be mindful of the fallibility of memory and the pressures of giving evidence. Lady Justice King observed that –

*[30] Inevitably in such cases, the oral evidence of the key protagonists, most often the mother and her partner, is highly significant. The case law has developed in a way designed to ensure that, whilst there is recognition of the fact that the oral evidence of lay parties is often critical, it also has its limitations; there are dangers in an over reliance by the judge on either demeanour, or upon the fact that a witness has told demonstrable lies.*

*[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 assesses all the evidence*

*in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another.*

### Expert evidence

14. In considering the evidence of an expert witness, the court must not confuse the functions of the expert and the judge whose roles are distinct. It is for the court to make the factual decisions based on all the available evidential material in the case, not just the scientific or medical evidence; and all that evidence must be considered in the wider social and emotional context; see A County Council v X, Y and Z (by their Guardian) [2005] 2 FLR 129.
15. If the court disagrees with an expert's conclusions or recommendations an explanation is required; see Re B (Care: Expert Witnesses) [1996] 1 FLR 667 and Re D (A Child) [2010] EWCA 1000.
16. In Re B (Care: Expert Witnesses) [1996] 1 FLR 667 Ward LJ gave the following guidance as regards the evidence of expert witnesses –

*'The expert advises but the Judge decides. The Judge decides on the evidence. If there is nothing before the court, no facts or no circumstances shown to the court which throw doubt on the expert evidence, then, if that is all with which the court is left, the court must accept it. There is, however, no rule that the Judge suspends judicial belief simply because the evidence is given by an expert.'*

17. Butler-Sloss LJ continued –

*'An expert is not in any special position and there is no presumption of belief in a doctor however distinguished he or she may be. It is, however, necessary for the Judge to give reasons for disagreeing with experts' conclusions or recommendations. That, this Judge did. A Judge cannot substitute his own views for the views of the experts without some evidence to support what he concludes.'*

18. In assessing the expert evidence the court must bear in mind that in cases involving a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bring their own expertise to bear on the problem, and the court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see the observations of Eleanor King J (as she then was) in Re S [2009] EWHC 2115 (Fam)).

### Unknown and disputed cause

19. The court is not precluded from making a finding that the cause of harm, in this case the infections, is unknown. In Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam) Hedley J said at paragraph [10] –

*'[10] ... there has to be factored into every case which concerns a disputed aetiology giving rise to significant harm, a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities.'*

20. In Re U (Serious Injury: Standard of Proof); Re B [2004] EWCA Civ 567, Butler- Sloss P explained at paragraph [23] that –

*i) The cause of an injury or an episode that cannot be explained scientifically remains equivocal.*

*ii) Recurrence is not in itself probative.*

*iii) Particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.*

*iv) The Court must always be on guard against the over-dogmatic expert, the expert whose reputation or amour propre is at stake, or the expert who has developed a scientific prejudice.*

*v) The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.*

### Lies

21. The court should be cautious when evaluating the evidence of a dishonest witness; see R v Lucas [1981] QB 720 –

- i. 'If a court concludes that a witness has lied about a matter, it does not follow that he has lied about everything. A witness may lie for many reasons. For example out of shame, humiliation, misplaced loyalty, panic, fear, distress, confusion and emotional pressure...The jury should in appropriate cases be reminded that people sometimes lie, for example, in an attempt to bolster up a just case, or out of shame or out of a wish to conceal disgraceful behaviour from their family.'

22. In Re (1) A (2) B (3) C (CHILDREN) [2021] EWCA Civ 451 the Court of Appeal confirmed that while a Lucas direction was not required in every family case in which a party challenged factual allegations, it would be good practice, when such a direction was required, to seek Counsel's submissions to identify the following:

- i. the deliberate lie(s) upon which they sought to rely;
- ii. the significant issue to which it/they related; and
- iii. on what basis it could be determined that the only explanation for the lie(s) was guilt.

23. Macur LJ stated:

*" [57] If the issue for the tribunal to decide is whether to believe A or B on the central issue/s, and the evidence is clearly one way then there will be no need to address credibility in general. However, if the tribunal looks to find support for their view, it must caution itself against treating what it finds to be an established propensity to dishonesty as determinative of guilt for the reasons the Recorder gave in [40]. Conversely, an established propensity to honesty will not always equate with the witness's reliability of recall on a particular issue.*

*[58] That a tribunal's Lucas self-direction is formulaic, and incomplete is unlikely to determine an appeal, but the danger lies in its potential to distract from the proper application of its principles. In these circumstances, I venture to suggest that it would be good practice when the tribunal is invited to proceed on the basis , or itself determines, that such a direction is called for, to seek Counsel's submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt. The principles of the direction will remain the same, but they must be tailored to the facts and circumstances of the witness before the court."*

*The role of culpability in establishing the threshold criteria in s31 CA1989*

24. In Re D (A Child) Care Order: Evidence [2010] EWCA Civ 1000, Hughes LJ (as he then was) highlighted the objective nature of the threshold test, noting that –

*'...it is abundantly clear that a parent may unhappily fail to provide reasonable care, even though he is doing his incompetent best'.*

25. In Re B (A Child) Threshold Criteria [2013] UKSC 33 Lord Wilson said at paragraphs [30] and [31] that, when establishing threshold, there is –

*'no requisite mental element to accompany the actions, or inactions, which have caused or are likely to cause significant harm'.*

26. In Re S (Split Hearing) [2014] EWCA Civ 25, Ryder LJ held at [19]-[21] –

*[21] The threshold is not concerned with intent or blame; it is concerned with whether the objective standard of care which it would be reasonable to expect for the child in question has not been provided so that the harm suffered is attributable to the care actually provided. The judge is not limited to the way the case is put by the local authority but if options are not adequately explored a judge may find a vital piece of the jigsaw missing when s/he comes to look at all the evidence in the round.'*

27. In the present case, this may mean that even if the court is satisfied that the mother did not deliberately mislead professionals, it is clear that she did in fact do so, and that has placed the child at risk of harm.

#### Cases of Perplexing Presentation / FII

28. In relation to specific matters of Perplexing Presentation, the Court may be further assisted by the following decisions of the High Court, as to the approach to be taken.

- a) BR & Ors (Three Families: Fabricated or Induced Illness: Findings of Fact) [2023] *currently unreported*
- b) Y (A Child: Fact Finding : Fabricated Induced Illness) [2018] EWHC 4020 (Fam)
- c) Re 5 Children (Induced and Exaggerated Illnesses Pattern of Behaviour) [2021] EWHC 3750 (Fam)
- d) H (A Child), re (Interim Care Order: Fact Finding) [2017] EWHC 518 (Fam).

29. In BR & Ors, unreported, it was said that;



- a. Guidance on Perplexing Presentations/ Fabricated or Induced in Children published by the Royal College of Paediatrics and Child Health should be followed by clinicians.
- b. Where Fabricated or Induced Illness (FII) is suspected but there is no evidence that it is probable and there is no immediate risk of harm to the child, clinicians should nevertheless consider referral to social services in cases where a multi-agency approach would be better suited to obtaining both medical and non-medical evidence, and to formulating and pursuing a rehabilitation plan.
- c. Failure to adopt the RCPCCH guidance may result in clinicians making hurried decisions about referral to the police when further concerns arise and when opportunities to avoid referral and/or to gather evidence about possible FII have been missed.
- d. FII is an umbrella term that covers a wide range of conduct, but at a finding of fact hearing, the court is required to focus on particular forms of conduct and their consequences.
- e. Expert witnesses will assist the court by giving opinions within their own fields of expertise but the court makes findings based on all the evidence, medical and non-medical. Experts must not supplant the role of the court and it is not helpful to the court for an expert to seek to advise whether or not FII has occurred.

f. Many allegations of conduct labelled as FII will rely on inference. The first task for the court is to ascertain the objective facts. The second task is to determine whether the facts permit inferences to be drawn so that the allegations are established on the balance of probabilities. The court and witnesses must guard against allowing retrospect to distort an objective view of the facts. A belief that FII has occurred, and that a parent has been deceitful, may cause witnesses to re-interpret past events in a way that hinders the court in its first task.

30. In Re H, Mr Justice Hayden emphasised the importance of the paediatric overview;

*“The importance of a report of this kind, in cases alleging the misreporting, exaggeration or fabrication of the symptoms of illness, can not be overstated. Searching, independent scrutiny of medical records is required, often involving a variety of hospitals and/or General Practitioners. It must be undertaken by a senior and experienced doctor, usually a Consultant, who, unconnected with the various hospitals involved, will bring the obvious benefit of a detached and objective overview.”* §28.

31. In the Re 5 Children decision, Mr Justice T reviews the legal framework at paragraphs 16 onwards and in particular;

*“The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and should have regard to the wide context of social, emotional, ethical and moral factors [A County Council v A Mother, A Father and X, Y and Z [\[2005\] EWHC 31 \(Fam\)](#)].”* §22

T J continues at §27 – 29;

*“ In the Popi M case [\[1985\] 1 WLR 948](#) Lord Brandon identified the dangers of the court reaching a conclusion by reliance on the exclusion of other possible causes.*

*"My Lords, the late Sir Arthur Conan Doyle in his book The Sign of Four, describes his hero, Mr. Sherlock Holmes, as saying to the latter's friend, Dr. Watson: "How often have I said to You that, when You have eliminated the impossible, whatever remains, however improbable, must be the truth?" It is, no doubt, on the basis of this well-known but unjudicial dictum that Bingham J. decided to accept the shipowners' submarine theory, even though he regarded it, for seven cogent reasons, as extremely improbable.*

*In my view there are three reasons why it is inappropriate to apply the dictum of Mr. Sherlock Holmes, to which I have just referred, to the process of fact-finding which a judge of first instance has to perform at the conclusion of a case of the kind here concerned.*

*The first reason is one which I have already sought to emphasise as being of great importance, namely, that the judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has*

*open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so. There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.*

*The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated. That state of affairs does not exist in the present case: to take but one example, the ship sank in such deep water that a diver's examination of the nature of the aperture, which might well have thrown light on its cause, could not be carried out.*

*The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden."*

28. Drawing on this *Lady Justice King in A (Children)* [\[2018\] EWCA Civ 1718](#) stated that:

*"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).*

58. *In my judgment what one draws from Popi M and Nulty Deceased is that:*

*(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.*

*(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.*

*(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."*

29. *In R v P (Children: Similar Fact Evidence) [\[2020\] EWCA Civ 1088](#) the Court of Appeal at paras 24-26 considers when and how the court should rely upon propensity/similar fact evidence:*

*"24. This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible. Secondly, is it in the interests of justice for the evidence to be admitted? This calls for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.*

*25. Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established?...*

*26. Again, this analysis is applicable to civil and family cases, with appropriate adjustment to the standard of proof. In summary, the court must be satisfied on the basis of proven facts that propensity has been proven, in each case to the civil standard. The proven facts must form a sufficient basis to sustain a finding of propensity but each individual item of evidence does not have to be proved."*

32. Finally, the court is referred to the judgment of Mr Justice Gillen in *Re G and A (Care Order: Freeing Order: Parents with a Learning Disability)* [2006] NIFam 8, para 5, specifically endorsed by Munby P in *Re D (A Child) (No 3)* [2016] EWFC 1. In particular, the court's attention is drawn to the appendix in *Re D*, which sets out a number of factors which must be taken into account by courts when considering parenting with learning disability/difficulties. The court's attention is drawn in particular to paragraph 4 of that list, which makes it clear that the court must consider the relevance of learning difficulties when considering the threshold test as well as at the welfare stage of proceedings:

*“This court fully accepts that parents with learning difficulties can often be "good enough" parents when provided with the ongoing emotional and practical support they need. The concept of "parenting with support" must underpin the way in which the courts and professionals approach wherever possible parents with learning difficulties. The extended family can be a valuable source of support to parents and their children and the courts must anxiously scrutinize the possibilities of assistance from the extended family. Moreover the court must also view multi-agency working as critical if parents are to be supported effectively. Courts should carefully examine the approach of Trusts to ensure this is being done in appropriate cases. In particular judges must make absolutely certain that parents with learning difficulties are not at risk of having their parental responsibilities terminated on the basis of evidence that would not hold up against normal parents. Their competences must not be judged against stricter criteria or harsher standards than other parents. **Courts must be acutely aware of the distinction between direct and indirect discrimination and how this might be relevant to the treatment of parents with learning difficulties in care proceedings.** In particular careful consideration must be given to the assessment phase by a Trust and in the application of the threshold test.”*