Case No: MK16COO164

IN THE FAMILY COURT AT MILTON KEYNES
IN THE MATTER OF THE CHILDREN ACT 1989
AND IN THE MATTER OF ES (A CHILD)

28th April 2017

B e f o r e :

His Honour Judge Antony Hughes
(sitting as a s.9 Judge)

Between:

MILTON KEYNES COUNCIL	**Applicant**
NI (1)	
RS (2)	
ES (3)	**Respondents**

Martina van der Leij of Counsel for the Applicant Local Authority
Simon Miller of Counsel for the Mother
Jonathan Sampson of Counsel for the Father
Matthew Stott of Counsel for the Child
Hearing dates -3-7th April , 10th-13 April 2017

HTML VERSION OF JUDGMENT

Parties and Introduction

1. The court is concerned with three children namely LS, year of birth 2011, BS, year of birth 2012 and ES, year of birth 2016. It is their welfare that is the court's paramount consideration and at this stage the court is primarily dealing with a fact-finding hearing regarding the mother's care of ES and more historically, BS. The father of all the children is RS and the children all currently live with him. He is represented in these proceedings by Jonathan Sampson of Counsel.

2. The mother of the children is NI and she is represented by Simon Miller of Counsel.

3. The children are represented through their guardian, Shaheda Kahar by Matthew Stott of Counsel.

4. The proceedings are brought by a local authority represented in this hearing by Martina van der Leij. The application currently before the court is for the local authority's application for care orders having been issued on 3rd October 2016.

Background

5. I take the background to this case from the local authority's helpful opening document and the useful record of ES's admissions to hospital in tabular form. Where any assertions or statements in this section of the judgment conflict with my findings, my findings of course prevail.

6. "The children came to the attention of the local authority because of a referral received from G Hospital (G) in 30.09.16 which resulted in an EPO being made on 3.10.17.

7. The concerns raised are set out in the report of the treating paediatrician Dr A and relate to mother's care of ES, and I come to a review of her evidence in due course.

8. ES was believed to be a baby with complex medical problems in that mother has repeatedly reported problems with vomiting, retching, coughing, seizures, high temperatures, diarrhoea, intolerance of any feeding and abnormal movements. In his short life, he has had multiple hospital admissions and medical interventions. He was under the care of numerous paediatric specialists both at the O (O) and at G (G) hospitals.

9. ES has had some medical difficulties. He is a premature baby. He was considered to have an unsafe swallow, and has suffered with reflux. He has had chicken pox and suspected bronchiolitis, and it is likely that he has the same chromosomal abnormality that his brother has (inherited from each parent). However, despite extensive investigations and numerous interventions, the problem with ES's weight gain and

feeding intolerance, as well as reported seizures have been of ongoing and perplexing concerns to the medical professionals involved in his care.

10. The table below summarises the most relevant hospital admissions. For all admissions, mother was resident on the ward and taking charge of all of ES's care:

Dates	Description
7.04.16	Into G discharged home same day
8.05.16-12.05.16	G admission bronchiolitis NG tube fitted 48 h
25.05.16-3.06.16	G admission- still bottle fed
13.06.16-16.06.16	G admission NG tube fitted
23.06.16 – 2.07.16	G admission – vomiting, seizures, cough & fever
23.07.16-29.07.16	G admission – vomiting every feed. Has chicken pox
30.07.16	Transfer to Q for long line insertion
30.07.16-1.08.16	Return to G from Q
01.08.16-03.08.16 3.08.16	O admission – to assess intussusception NJ tube fitted, back to G
3.08.16-10.08.16	G admission due to reports that MP vomiting large amounts
10.08.16-18.08.16	Re-admission to O due to vomiting on milk feed
18.08.16 – 22.08.16	Transfer to G to establish feeding regime admission
26.09.16-7.10.16	Admission G – worsening seizures, vomiting ? temp Discharge to foster care under EPO

11. Throughout these hospital admissions, various paediatric specialists attempted to establish the cause of ES's ongoing problems that caused him not to tolerate feeds, even when given via a nasogastric (NG) or nasojejunal (NJ) tube, and the cause of his reported seizures.

12. During the last admission to O from 10-18 August (ES was then transferred back to G to establish a feeding regime), the medical professionals raised concerns about mother's behaviour on the ward and the care she provided to ES. These concerns were communicated to Dr B at G, who informed Dr A – safeguarding paediatrician. The team at O had become concerned because:
    - Mother did not appear to want to interact with ES and declined encouragement to engage in play and stimulation with him.
    - Mother frequently presented "well caught vomitus" to nursing staff when he was on NJ feeds, with no evidence on bedlinen or clothes. Vomiting was not witnessed and only ever described by mother.
    - A well secured NJ tube had been dislodged – mother claimed that ES had pulled it out and that he did this frequently, however the way that the tape had come away caused staff to question if MP had managed this.

- ES was not heard to vocalise.
- ES provided conflicting information to different professionals.

13. ES was discharged from G on 22 August able to tolerate NG feeds on a regime where he was gaining weight. There were no seizures. Mother stated that these had ceased. Mother brought ES back to hospital on 26 September, reporting that he had had a large seizure, a temperature of 39.1 and severe vomiting. She reported a further 5 seizures while on the ward, although none of these were witnessed by staff.

14. The trigger for the referral to Social Services was that the medical professionals concluded mother had misrepresented to medical staff that ES was vomiting. The vomiting was seldom observed, and no signs (such as smell, vomit on baby or bedclothes or the retching that mother kept describing) was observed or heard by nursing staff. It is said that she presented staff with a bowl containing ES's vomit, which on testing was not vomit. The allegation is that she did this twice during that hospital admission.

Local Authority evidence

15. **Dr A** is a consultant paediatrician with the Paediatric Department at G Hospital employed by G University Hospital NHS Foundation Trust and is also the Trust's named doctor for child protection.

16. She has been concerned with the treatment and care of ES and provided a report of 6th October 2015 which traces ES's medical history involving a diagnosis of gastro-oesophageal reflux and the history of previous hospital admissions which I shall come to presently.

17. As a consequence of events taking place on Ward 5 involving ES and his mother between Monday, 26th September to Friday, 30th September, it is right to record that her concerns and her professional opinion that ES had been subjected to the effects of either over reporting of symptoms by his mother or his mother providing a history of medical presentation that could not be relied on.

18. I took from her evidence that the starting point is for doctors to rely on histories provided by parents unless other indicators occurred which went to the unreliability of any histories presented.

19. It is important in this case, she states in her written evidence, to understand ES's medical history and his historical difficulties with feeding and hydration.

20. He was born slightly prematurely at 35 weeks. At the age of 3 months, during the course of an acute admission, he was determined to have an unsafe swallow by the speech and language therapy team (SALT) and was commenced on a naso-gastric tube (NG) for feeds. In July 2016, when he was about 4½ months old, he developed chicken pox and needed an intraosseous needle into his bone temporarily followed by a surgically inserted intravenous line for fluid hydration because of concerns about ongoing vomiting causing dehydration. At some stage, he was transferred to the Children's Hospital, F for insertion of a nasojejunal tube (NJ) to assist with nutritional support. It is significant that while he was in F his mother reported frequent vomiting

while on NG tube feeds to the consultant surgeon and it is material in this case to record that it was decided that if ES's reflux failed to improve with adequate nutrition it was the view of his consultant surgeon that he would be a candidate for laparoscopic gastrostomy with fundoplication, a major operation.

21. His mother had reported fitting and he was being assessed for treatment for non-epileptic events despite a number of EEG tests certifying that he was normal.

22. It was because of the mother's reported continued vomiting on NJ feeds that ES was transferred back to F for review by the paediatric surgeons on 10th August and it is clear from a letter written from "T Ward" by a registrar for the surgeon, Mr G, on 3rd August, that ES was a candidate for the PEG insertion and fundoplication in two month's time which means that he would have been certainly due for that procedure in or towards the end of October. It was by any account a serious surgical procedure that was being contemplated.

23. A decision appears to be made at that time to insert NG and NJ tubes at the same time and the NG tube was helpful for aspirating gastric contents. It seems that Dioralyte was being introduced to help with hydration at the rate of 10mls an hour and 1ml of fluid was being collected by aspiration. The notes reveal that it was a matter for concern at F that not only were the team concerned about ES's mother's lack of interaction with him, she would present "well caught vomitus" in a bowl to nursing staff as evidence of ES vomiting although these episodes were not witnessed by staff and, in addition, his NJ tube was found to be displaced and the mother had told staff that ES had pulled the tube out. Mother was also reporting seizures and abnormal movement raising the suggestion that ES had epilepsy. ES returned to G Hospital from the O Hospital on or about 18th August with these concerns being noted and eventually discharged home on NG feeds.

24. In effect therefore before the September events that led to a multi-agency referral and subsequently care proceedings, there were a range of recorded concerns involving mother's lack of interaction with ES, her reportage of vomiting episodes that had not been witnessed by staff and how she would present staff with vomit that she had collected, multiple normal EEGs against a background of reportage of abnormal movements from mother and, in effect, a complaint from mother that ES's reflux had failed to improve he being at that time scheduled for an appointment for surgery at the end of October.

25. Dr A was on duty on Monday, 26th September when she was informed by Dr B that ES had been brought to the paediatric assessment unit by his mother in the morning with reports of a fever at 39.1, "being sick a lot" and a non-epileptic episode. The hospital notes indicate that mother had reported that she was concerned about ES's hydration as he was "vomiting all feeds." She also said that his head control was poor with a possible weakness to the left side of his body. He also records that ES was due to have a SALT assessment on that particular Monday, 26th September, which would have assessed the safeness of his swallow and whether he was able to go onto oral feeding. It is not perhaps without significance, in my judgment, that ES was brought in on that particular day with a range of reports as to his condition by mother against the background of that forthcoming assessment which, in any event, had to be postponed because when ES was admitted to ward and it is Dr A's evidence that

nursing staff reported that ES's mother was observed to encourage ES to go to sleep before that later assessment on 30th September. The net effect of that was that his assessment was delayed until 3rd October, after ES's removal into care.

26. ES was admitted, as indicated, on the 26th September, and a small volume of Dioralyte was administered through his naso-gastric tube. Significantly perhaps, again the doctor's review confirmed that ES was clinically well and his blood results including infection markers were normal. This is in stark contrast to the picture represented by the mother on admission. In my judgment, this is an important feature of this case.

27. She met with mother for discussion on the ward round on 27th September and took a detailed history which appear in the hospital notes. Mother reported that ES's behaviour had changed on Saturday, 24th September, she reported a high temperature on 25th September with "seizures," she reported his urine smelling different and possible constipation (for which in any event he was given a suppository). Dr A's observation however was that ES looked well and there was no evidence of fever.

28. During the night of 27th September it seems that overnight further vomits were reported to nursing staff but not witnessed by them. As a consequence, ES had his intravenous cannula re-sited and went onto full intravenous fluids and fluids through his NG were stopped in view of the reported vomits.

29. Again on 28th September she reported that ES was well. Significantly she was perplexed by the frequency of what the mother said was continued vomiting and checked with nursing staff that all vomits were being measured. The retching and vomits continued to be reported by his mother four to five times a day.

30. After discussion with F and advice from them she decided to aspirate his NG tube intermittently to see whether or not he was emptying his stomach appropriately. The reasoning was that if the aspirates were minimal then it would be difficult to conceive how he was still vomiting considerable amounts of fluids despite his stomach being empty. In my judgment, and on review of the relevant records for that period, the aspirates were indeed found to be minimal making the reports of vomitus in the volumes recorded just not tenable

31. On Thursday, 29th September, she was present by ES's bedside when the paediatric nurse, HA, aspirated the NG tube and the aspirate was 1ml and she was relieved to see that his aspirate "was minimal." When she looked across to ES's mother she noticed her expression and she described her as seeming to be "unsettled by this observation" and said, "the fluid collects and he was likely to bring it all back later." After this conversation she had a discussion with parents of another child in the same bay as ES. She had her back to ES's bed and did not hear him wretch or vomit. She had to leave the bay briefly to answer her mobile phone as she was expecting a call from the surgical doctor at F.

32. She returned to ES's bed space to explain a new strategy to advance ES's NG tube by 2cm every hour and the nurse him on his left side and was told by ES's mother that ES had been retching and had vomited and she said "she swung round" to show me the

vomit bowl. This contained clear fluid. She was suspicious that the fluid did not look viscous and recorded that the fluid moved.

33. The nurse drew the reported vomit into a syringe and it appeared clear having the appearance of water. The pH of the reported vomit was tested as indeed was the nasogastric aspirate, the Dioralyte and tap water. The tests were repeated several times, the nasogastric aspirate and Dioralyte both had a pH of 4.5, the pH of the reported vomit and tap water was 7.5.

34. This, in the opinion of Dr A, suggests subjective evidence of fabrication with ES's mother presenting staff with a vomit bowl full of fluid which was unlikely to be vomitus with the intention of escalating medical and surgical intervention and on that basis a multi-agency referral form was completed and a strategy meeting organised for Monday, 3rd October to which she was a contributor.

35. In addition, she says in her report there had been six episodes of 30 seconds to 1 minute of self-resolving "seizures" reported by ES's mother which had not been witnessed by nursing or medical staff during the period of this admission. Additionally, green watery stools had been reported to the dietician but not seen by a member of staff. It seems that the SALT review was to take place on a revised date of Friday, 30th September and the therapist was told by ES's mother that he was asleep and it had to be deferred until Monday, 3rd October.

36. Dr A says there is objective evidence of fabrication of vomit, no other evidence of vomit on ES's clothes or the bed linen and no smell to suggest frequent vomiting, although I know that the mother's evidence was that she had to change ES's vest and bedclothes.

37. If that is right, what is of concern is the mother's continued reportage of vomiting knowing that the history would influence the continuation of intravenous fluids and subsequently, given his poor venous access, a decision for surgery which in fact had already been provisionally organised.

38. It is noteworthy, according to her evidence, that since the emergency protection order has been in place, ES was initially looked after by paediatric nurses on the ward. He did not vomit his milk feeds back although had two small possets with winding. Of course, there have been reports of ES vomiting at contact, but such in my judgment to indicate that he was unwell.

39. The F medical team also have raised concerns regarding mother's lack of interaction and he has some developmental delay being presented as a sick child although there is no clinical evidence of any illness.

40. The SALT assessment duly took place on 3rd October 2016 and the recommendation was that ES could be fed orally and he subsequently has been feeding successfully by bottle. She reported that he was expressing an interest in food, is eating well now, and on an age appropriate oral feeding plan which at the time of her report, consisted of four hourly bottle feeds and solids three times a day. He no longer needs an NG tube to provide nutrition and seems to enjoy the process of feeding. It is by any account, a dramatic change.

41. In terms of his development and interaction, he has been observed by nurses to be more alert, awake and interested in his surroundings. Dr A indicates in her written evidence that "the observations and objective findings identified during ES's admission are supportive of fabricated illness perpetuated by ES's mother" and ES's subsequent ability to feed normally and gain weight on a normal feeding regime adds support to this proposition. The evident danger to ES would have been him having to undergo invasive procedures and an operation in circumstances where it was not required.

42. On 6th October, ES was reported by staff to have had a 'brilliant morning' with feeds progressing normally and him interacting in the playroom.

43. She was able to confirm that ES had historically presented with genuine complex medical problems including developmental delay, a concern for chromosomal abnormality, gastro-oesophageal reflux and had been assessed by a physiotherapist in relation to weakness in the left side although this latter condition was not witnessed on the ward.

44. The original diagnosis of gastro-oesophageal reflux which had been made by a paediatric surgeon, was dependent on history from the parents but it was right of course that ES had a wide range of difficulties and was considered to have an unsafe swallow. The difficulty in this case has been to assess precisely the level of difficulty experienced by ES although a health assessment had indicated that ES had tracheobronchomalacia (a floppy larynx). She was clear that this would not cause vomiting or increase the propensity to vomit.

45. She was asked on his admission to hospital with chicken pox in July 2016, confirmed after looking at medical notes that she would expect a raised fever or temperature and vomiting and there was no need at that stage to doubt the descriptions of his condition given by the mother. Mother was expressing concern about what she reported as his increased level of vomiting and it was recorded in the notes of 24th July that mother was not keen for ES to receive Dioralyte through an NG tube as she claimed that ES was not keeping fluids down. However, cannulation was not possible as no veins were visible and a cannula was more invasive than the NG tube and in fact the notes make it plain that, subsequent to mother's objection, there were four attempts to find a vein without success and there is little doubt that insertion of a cannula is more invasive than that of the NG tube.

46. She could not explain how a note recorded "trial of water vomited this morning" because it would not be possible for water to be substituted for the other fluid without nursing intervention and if this was a true entry it would raise the question about the ability of the stomach to tolerate water and no water is identified on the patient intake record which made her think that this was not administered by nursing staff.

47. Apart from a suggestion that ES was not able to tolerate Dioralyte (resisted by this witness), the history at this particular time seems to be that ES was genuinely ill with chicken pox and had definite symptoms and the staff did not record any history of fabrication although a feature at that time was the mother's continuing reportage of unwitnessed vomits.

48. By the time of ES's admission to hospital on 26th to 30th September, matters had moved on somewhat in relation to the case. On 19th August, F had formally raised their suspicions and certainly after the incident on 29th September the nurses had increased supervision with a feature of ES's admissions is that the reported vomits do not appear to have been observed by staff although appear on the face of it to have been presented to staff for measurement. On 27th September ES was admitted to ward 5 and no vomits were reported and therefore she agreed no attempt at fabrication at that stage, but ES was admitted with a reported fever although on the ward was found, according to Dr A's note, not to be unwell. For example, mother reported that his urine smelt different and that could be either due to dehydration or infection and tests indicated that there was no urinary infection and it is clear from the notes that Dr A reviewed ES's care, as is apparent from her careful clinical notes, on 27th September at about midday when a decision was made to change his reflux drug back to Ranitidine. Mother was reporting seizures prior to admission and a fever but ES arrived on ward with a normal temperature. Reporting on the feeding charts of 100mls of vomit for example, would have been measured by a nurse because it is a precise measurement, but the act of vomiting would not necessarily be witnessed by a nurse and certainly 37mls of what the mother said was vomit was recorded as clear liquid at 14.20 on 27th and Dr A was clear that ES could not have vomited water as any vomit would have an acidic contact. She was clear that ES was not being offered water because of his unsafe swallow but agreed it was a subjective view by a nurse who had merely observed it as a clear liquid.

49. She was challenged on the evidence that she had given regarding mother presenting the clear liquid as vomit and mother's explanation that in fact she had been washing ES with water and the bowl containing the water had been the one that had been subjected to the analysis. It was clear from her cross-examination, however, that she took careful steps to analyse the pH content in the reported vomit which she compared with tap water and recorded, as I have said, 7.5 and the nasogastric aspirate and Dioralyte both had a pH of 4.5. For the avoidance of doubt, I accept Dr A's evidence that the liquid that was tested was the liquid in the bowl handed to her by the mother.

50. She said that she authorised the nursing staff to take further samples after 29th September and it is clear from the nursing feed charts that subsequent recording of the aspirate records the pH at 6. It was not known at the time of giving her evidence whether the original samples had been retained in the hospital or whether indeed other samples had been retained after pH testing but it may well be that her instructions were ignored.

51. In relation to the difference of the recordings of the aspirate, namely 6 as against 4.5, subsequent to the bowl incident she said as a consequence of advice having been given by F to advance his NG tube by 2cm every two hours so that it would migrate into the upper part of his small intestine could provide an explanation as to why the reading was higher and the acid content thereby lower as the tube had invested into the intestine and it was an issue that was to be canvassed with Dr Robinson.

52. The other point she made was that the litmus paper test and the graduations against which the pH could be measured depended on interpreting the change of colour against a scale and that may be open to slightly different interpretation by other individuals. What is clear is that subsequent to the bowl incident there are a series of

tests in the feedings notes of aspirate that makes it clear that the pH reading was 6 and 5 on one occasion.

53. She agreed that she had been considerably assisted by a face to face discussion with the visiting paediatric surgeon, Mr L from F, who had been plain when she saw him on 29th September to discuss ES's case, that the vomiting reported did not require surgical intervention and that formed a focus for his concern and it was the view of that surgeon endorsed by her own views of course that if the aspirate levels were minimum then fluid was going into the intestinal tract and it would not have been possible for ES to vomit the volumes that are recorded; that formed a focus to her thinking and the subsequent encounter with the mother when she presented the bowl of clear liquid provided her with the opportunity for this to be tested.

54. She underlined the importance of understanding the degree to which ES was vomiting. It went directly to his hydration and his presentation and if he was vomiting more than he was consuming then this would lead to invasive procedures such as an IV tube through cannula, an intra-osseous procedure and subsequently surgery.

55. She predicted at the strategy meeting as recorded in the minutes, that there would be a change if ES did not go home with his mother namely a decrease in the reports of retching and vomiting, a new SALT assessment (subsequent to which of course ES was orally) and weight gain and at 2 o'clock on 3rd October ES did indeed have his SALT assessment and started to feed and his weight has increased over the last few months. Incidentally, it is apparent from the statement of the foster carer that ES became, within a short time, an enthusiastic feeder without the assistance of tubes. They had been ready to receive a child with severe reflux but ES did not present in this way.

56. It was suggested at one stage that there was some significance in relation to the night of 27th/28th September when ES was reported as remaining settled and asleep with no further vomits at a time when it was suggested that Dioralyte had been stopped but Dr A explained that all feeding had taken place through the cannula at that stage and there was no fluid in the stomach or in the intestine and therefore nothing of significance to vomit.

57. It is also plain that the vomit levels reported by the mother did not correspond with the intravenous fluids being introduced giving rise to the inference that they were false reports.

58. Dr A was a quiet and considered witness and gave highly probative evidence in relation to the issues that fell within her direct knowledge and expertise. I also remark that she was a most careful historian and note taker.

59. **Dr J B** is a consultant paediatrician at G Hospital and has provided two statements and became involved in ES's care in 2016 when ES was admitted with breathing problems and bronchiolitis and at that time his mother raised numerous additional concerns including his vomiting, rapid weight gain, abnormal movements and abnormal head shape.

60. Subsequently ES had several admissions with febrile illnesses and reported vomiting that required periods of observations and, in between admissions, he was discharged home on naso-gastric feeding. Concerns over ES's vomiting and, in particular, his inability to swallow safely and the difficulty of ensuring that he had an adequate fluid supply led to him to have procedures including naso-gastric (NG) tube insertions, venous cannulations and at one stage the insertion of an intra-osseous needle. He recorded mother's concerns about nutrition and, as a consequence, ES had a number of invasive treatments including a central line insertion and a naso-jejunal tube (NJ).

61. From time to time ES was transferred to the O Hospital for investigations and interventions and the plan was for him to have a more definitive surgical solution in the form of a percutaneous gastronomy tube and a fundoplication procedure.

62. He was more closely involved when ES was admitted in August when lots of vomiting was reported but for some reason ES was not clinically dehydrated and his symptoms were therefore difficult to understand and this escalated his concerns. He was involved in ward rounds on 9th August and he records on 16th August that ES had had to undergo, over a period of time, multiple EEGs and lumbar puncture.

63. He was able to produce as part of his evidence a letter from the dietician in relation to ES's progress as at 8th February 2017 and saw a great change between the child that he had seen on the ward when he was being tube fed. ES, as reported in the letter, had made weight gains and was on full formula feed and his care is now being transferred to a community paediatrician.

64. He confirmed however in cross-examination that ES as presented to him and when he was involved in ES's care from June 2016, did present with genuine problems with breathing and other difficulties in relation to gastro-oesophageal reflux, developmental delay and an unsafe swallow. At that stage there was no reason to suppose the case was one of fabricated illness and he presented in the same way as any other child in the ward. It was subsequent to ES's admission in early August that he received a letter from the O at F outlining their concerns but subsequently he did not see mother again on the ward and had nothing to do with the September admission.

65. In addition to the invasive procedures that ES has received as a consequence, in particular, of the mother's accounts of repeated vomiting, ES had at one time been referred to a consultant paediatric neurologist who was investigating abnormal movements reported by ES's mother. This raised the spectre of ES having to undergo the possibility of a muscular biopsy in addition of course to the other extensive investigations that had taken place in the past including lumbar puncture, blood and urine tests, a brain MRI scan and numerous EEG tests.

66. **H A** is a staff nurse at the paediatric unit at G Hospital and was on duty at 7.30 on 29th September and looking after ES. She has provided a police witness statement and a further statement in these proceedings. ES was on a continuous feed of Dioralyte by his nasal gastric tube, his mother having been present throughout the day, and the mother reported that ES had two vomits during the time she was on shift. Although she weighed the vomits and recorded the volume in the records the vomit was presented to her by the mother in a hospital cardboard bowl.

67. In relation to the second vomit as presented to Dr A, she noted this to be clear and similar in appearance to water and, following instructions from the consultant, that was aspirated into a syringe and a sample obtained of the aspirate through the NG tube.

68. The vomit that had been in the vomit bowl she described as clear and the aspirate more clouded and, as we know, a pH testing procedure was completed by another nurse, Sister W, together with Dr A.

69. She at no time has ever seen ES vomit, and she has cared for ES from time to time during various admissions, and what the mother has described as vomit has always been presented to her by the mother, rather than collected from ES himself. She has never seen any trace of vomit on the sheets or on ES's clothing and it would seem that mother had a knack of catching it in a bowl.

70. ES normally lay on his back with his back on a pillow and the bowl by his head and normally she would expect to see drops of vomitus on the child's bed or on the child's clothing.

71. She was asked about the degree of vomiting that mother had reported to police and how ES presented when he was vomiting sometimes as much as eight or nine times a day with the mother describing projectile vomiting. She said that she had never seen projectile vomiting or ES behaving in an agitated way by arching his back and/or coughing but she had certainly seen him upset and could recognise him as being unsettled at times.

72. She was not at the bedside when the mother was said to have passed the bowl containing the liquid to Dr A but her reaction was that she had been surprised when she heard about it as ES had been aspirated and there therefore should not have been much in his stomach to vomit.

73. It was her task to get things ready for testing and the testing was carried out by Sister W and Dr A but she did carry out an uncontrolled test of her own before the formal process invoked by Dr A of the alleged vomitus when she said, "things didn't look right." It was Sister W who provided further information in relation to that in that she said that it was a recollection that Staff Nurse A had tested the substance with a urine dip stick rather than a pH testing stick. In relation to her uncontrolled test in any event Staff Nurse A thought that there should have been higher acidity if indeed it was vomit and she went onto describe how she set up the syringes for the testing. It seems that she was caring for ES on 26th July when two reported vomits had taken place. I note that it was despite ES being connected to an IV line.

74. She was challenged on a number of occasions in relation to the appearance of the fluid content and was clear that it looked like water she was also clear that what is described as vomit in the medical notes is the description given to the substance by the mother and recorded by either her or other nursing staff.

75. In general terms up until the September incident, she had no concerns on the mother's general care of ES and found her behaviour attentive.

76. In answer to a question posed by the guardian's Counsel, it is clear that there was a great deal of significance in her mind at the apparent inconsistency in relation to the way vomits allegedly going out of the child as against the fluid which was clearly documented as going in.

77. She was also clear that the vomit given to her by Dr A as presented to Dr A by the mother, looked like water and although a child given Dioralyte may produce clear vomits it would not be as clear as any vomit that came from the stomach area would have "flecks and bits in it."

78. **Nursing Sister N W**, also from Ward 5, has had the care of ES for previous admissions and has never seen him vomit although has seen him uncomfortable and crying and the entries in the Fit chart are not entries made by her. She has made a police statement and a statement in these proceedings.

79. When she took over on 29th September shortly after midday, she noted that there had been a discussion about a possible transfer to F, discussions on the telephone between Dr A and F and a discussion between Mr L, the F paediatric surgeon who was visiting G at the time.

80. She became aware of an issue that had arisen in relation to the liquid passed by mother to Dr A which the mother said was vomit and was involved in the sampling with Dr A and was also involved with advancing the naso-gastric tube in accordance with advice given by F on a couple of occasions during her shift.

81. It is recorded as coming from her in the strategy meeting minutes that there was an occasion on 1st October that mother had the curtains closed around the bed, contrary to instructions and presented what purported to be vomit in a bowl. She also reported that once at handover the feed pump had been set at zero and it is clear that she did not believe that this had been done by nursing staff and the danger of that it was not possible to understand what the fluid was going into ES as a consequence and if ES became dehydrated this would lead to further invasive procedures.

82. She very fairly said on the issue of taping NG tubes to the sides of a child's face, it could easily get dislodged even with neonates and it was not unheard of that the plaster securing the tube could be dislodged.

83. She also said, as a matter of fairness, that mother had been entirely appropriate with ES and nothing untoward had been noticed during the course of the previous admissions.

84. After the incident and until the end of her shift, she collected the aspirate and vomit in separate bottles which she labelled accordingly and took to the laboratory in case it was required for future testing.

85. She had no reason to suppose that ES could not tolerate Dioralyte and had an adverse reaction to it.

86. I should say that in relation to the evidence of Staff Nurse A, Nursing Sister W and Dr B that their statements were not in the proper form as prescribed by the Family

Procedure Rules and the Children Act. Statements must be filed in proper form and carry the proper endorsements and I understand that there will be ongoing work with the Hospital Trust and their advisers to address what effectively I see as poor practice.

87. I should say that both nurses are aware of ES displaying vacant looks and was lethargic and unresponsive at certain times but were unable to any more specific in relation to that observation.

88. **LB** is a specialist speech and language therapist of some 19 years experience and part of the SALT team who investigated dysphagia (unsafe swallow) and she made various assessments of ES. She is the author of a report dated 4th October which plots in condensed form, ES's progress and subsequent oral assessment on 3rd October which led to him feeding safely orally.

89. Within these proceedings she has filed a statement with a more detailed chronology starting with the first referral in May 2016 when a SALT swallow assessment was sought and her assessment on 16th June in which she diagnosed that ES appeared to be at risk of aspiration due to an unsafe swallow.

90. She clarified that the letter from Dr R of 5th September indicating that the SALT review in F in August 2016 resulted in a normal swallow was in fact not correct as only a barium test had been carried out and her colleague in F had confirmed to her that that assessment was not good enough to determine a safe swallow and, in any event, this was not followed up because ES had continued to have an oral aversion and she was satisfied therefore that the swallow was not safe at that particular time.

91. She acknowledged that ES had been bottle fed for three months initially in his life but had noticed herself that he did frequently cough and clearly stood by her diagnosis of June notwithstanding that ES may have initially fed safely. For some reason she said his suck-swallow-breathe pattern had been disrupted.

92. Her chronology plots telephone reviews with the mother and in particular on 19th September mother reporting that she had been using the dummy dips as advised by the O but felt that he was bit "rattled" no doubt referring to the prospect of coughing and reported severe reflux and highlighted the forthcoming need for a surgical intervention from Mr G. A review was booked for 26th September and we know that ES was admitted to the ward and a subsequent review was attended by PD from her office and, as we know, when she attended to assess ES, he was swaddled and presented by the mother as being asleep. It was not until 3rd October when the mother was not present that a full assessment was carried out by her and she was able to feed ES with 20 spoons of smooth puree and there was a trial of milk using an orthodontic teat.

93. So far as she was concerned, the evidence from the O was that ES had an unsafe swallow in August and mother was reporting difficulties as late as 9th September prior to ES's admission.

94. For her part, she had no concerns regarding the mother's engagement with her service and she had observed in the past that ES had a frequent cough as opposed to the single cough he gave in his positive assessment on 3rd October.

95. She was asked how it came to be that there was a fairly dramatic change so far as ES was concerned and she said it was difficult to say why it had happened and described it as "unusual." She has come across it recently again in another case and a common feature in the case that she recalled and the present case appears to be that the mothers were not present when the positive SALT test was undertaken leading to oral feeding.

96. **JH and SJ** are both dieticians at G Hospital and both have provided evidential witness statements giving much detailed evidence regarding ES's feeding tolerance and nutrition needs. They both explain that ES's presentation, as described by the mother, was perplexing and eventually suspicious because despite exhaustive investigations and despite attempts to try different regimes and formula, nothing seemed to bring about much sustainable approval while mother was in ES's care in contradistinction to the rapid improvement he made when removed.

97. S J gave oral evidence and explained the various interventions in relation to different feeding regimes were tried but the vomiting (on the mother's reportage) continued and she had never seen ES vomit on the ward and she described what had been described as ES's tolerance problems as unusual and I drew from her evidence that ES's presentation and clinical signs so far as dietary matters were concerned, were inconsistent with reports that had been provided by nursing staff as reported to them by the mother.

98. The most clear evidence both from S J and J H on ES's progress post removal was in stark contrast to the picture presented throughout last summer when ES seemed to be struggling to tolerate feeds on the mother's account and they were becoming concerned about weight and growth. It was a matter of concern that, despite all the interventions, ES did not seem to tolerate even tiny amount of feeds with the mother reporting vomiting.

Expert evidence

99. **Dr Robinson** is the jointly appointed expert in this case. He is a consultant paediatrician and has provided a chronology, a report and an addendum report which incorporates all the detail in relation to his first report. He has expertise in relation to the area of factitious illness and has provided an analysis of medical evidence in the light of that expertise.

100. His task was made considerably more difficult by missing medical records that he was only able to look at on the day that he gave evidence but was up to date with all the evidence by the time he came to give his oral evidence after reviewing medical notes and the chronology, together with updating statements.

101. It is apparent from both his written and oral evidence that in relation to his summation of medical information from 5th March until 6th June 2016, that ES was presented appropriately for medical problems to include viral infections, bronchiolitis and excessive crying. The prescription of anti-epileptic drug, Midazolam, suggests a medical basis for accepting that there were some seizures at least.

102. We know from the medical chronology that, in any event, ES was diagnosed to be at risk of aspiration on 16th June an unsafe swallow having been identified and he took this to be an established fact.

103. The thrust of his report indicates that so far as he was concerned that there was evidence of exaggeration and fabrication in relation to the narrow time period of 26th September to 30th September and was clear that there had been a risk that there would be continued invasive treatments such as naso-gastric feeding, placement of an NJ tube and the forthcoming surgical intravenous surgery which happily was prevented due to what transpired in the hospital period at the end of September.

104. He was satisfied in the early part of July when ES did have a chest infection, his seizures were seen by a professional and observed in mid-July and ES was properly admitted for chicken pox on 23rd July.

105. In August, as we know, there were concerns from F regarding mother's interactions with ES and an issue regarding his NJ tube dislodgement and Dr Robinson was clear that it was possible for the tube to be dislodged by the infant himself saying as he did an active baby can pull it out.

106. It is of no little significance in this case that he records that the SALT review was held on 5th September. Incidentally the SALT review took place in F and the swallow was felt to be normal. He records that ES was discharged back to G on NG feeds after apparent breakdown of relationship between the parents and the mainly surgical team but the safe swallow issue was not followed up as he would have expected by the SALT team to recommence oral feeding and there is an issue as to whether or not the mother reports to the SALT team after the F admission that F had told her that ES was to continue to receive nil by mouth.

107. In any event, Dr Robinson would have expected a re-introduction to oral feeding and, in any event, a little over two weeks later at the end of September, ES was re-admitted to G and was still fed by tube.

108. Dr Robinson said very fairly that he would expect a baby of ES's age to exhibit some vomiting and had clearly accepted, for the purposes of his report, that some of those vomits had been witnessed by staff at G, although in my judgment, that did not happen. He comments in his report that if the level of retching or vomiting reported by mother at four to five times a day on the ward whilst nurses did not witness vomiting, he said it would be highly unlikely for an infant to be repeat vomiting without this being noted by staff and, in any event, he did not accept a proposition that the mother was able to catch vomit in the volumes recorded on the vomit chart. He endorsed Dr A's view that a baby vomiting in this particular way would leave evidence of vomit on clothes and bedding and, in any event, seen by staff and, at the conclusion of his evidence when asked to look at the feed charts and the recorded volume of vomit, clearly observed that the amount recorded comprised a massive amount of vomit that would lead, if true, to dehydration, effectively half of ES's body weight, and therefore was not credible. This in turn reinforces the evidence that it was the mother that presented the vomit in a bowl for staff to measure, and that staff relied on mother's reportage of vomit, and of vomitus to measure.

109. There was no existing research on a possible reduction of the precise degree by which the measurable pH of acid in a baby's body could be determined as a consequence of Ranitidine being administered, but in short form, the fact that Ranitidine was being administered twice a day in his mind clearly did not invalidate the observations of Dr A and the comparison of the contents of the bowl presented by mother with that of the pH of water and he clearly also thought that the measurement of the Dioralyte and aspirates were within reasonable parameters.

110. In his report he went onto consider the position in relation to the other children and their medical notes. So far as LS is concerned, there was no evidence of either exaggerated reporting or factitious illness but he was clearly concerned in relation to a possible connection in relation to an admission of BS in April 2013 who it seems also had a range of medical issues and admissions to hospital including a SALT assessment and also appears to have been NG fed. It seems, when the nurse checked, she found that some clear liquid was in a vomit bowl and the last feed given to BS was Nurtramigen which is a milk based foods. He also considers that the symptoms and presentation of BS, as described by Mother on 20.08.13, were likely to be exaggerated or fabricated. What concerned Dr Robinson was that often in cases of suspected FII there is a pattern of similar behaviour with siblings with similar presentations and concerns and this particular episode in relation to the clear liquid in the vomit bowl bears some striking similarities to this case and he felt therefore that elements of BS's difficulties had been exaggerated. However the time between the last feed and "the vomit" was not known and the pH of the liquid not checked although blood in the stools reported by the mother was considered to be highly unlikely and he took the view that subsequent reports by the mother on 20th August 2013 of head banging, falls, drowsiness, slurred speech, flicking of eyes were, on the balance of probabilities, fabricated particularly as the GP referral makes no mention of them and there was resolution after hospital observation with no apparent recurrence.

111. By way of summary and in relation to the findings of Dr A's reports, his opinion was that, on the balance of probabilities, the liquid presented to the doctor by the mother as "vomitus" was water and this constituted illness fabrication.

112. So far as seizures were concerned, if it is right that there were reports of six self-resolving seizures by the mother and not witnessed by nursing or medical staff in the September period, then it would be highly unlikely for an infant to experience recurrent seizures on a children's ward for up to a minute long without mother calling to alert staff or professionals observing them although ES did have previously observed abnormal movements which required treatment.

113. On the balance of probabilities, seizures reported by the mother for this admission were exaggerated or fabricated and I remind myself that in all other respects ES seemed to be clinically well. The medical admission for September notes are interesting with mother reporting an enhanced temperature of 39.1 including sickness and a non-epileptic episode, possible dehydration, poor head control, weakness on the left side of the body for which there were no clinical signs. As a consequence of which ES was commenced on a small volume of Dioralyte to counter possible dehydration. Incidentally, he knew of no adverse effects in relation to Dioralyte that would tend an infant to vomit accepting as he did that babies of this age are inclined to vomit.

114. He also found it significant in relation to the volumes of vomit reported by the mother on the ward inconsistent with measured amounts of aspirate and the observation that I have already recorded as to the implausibility of the volume of vomit reported in circumstances where ES was being fed intravenously and there were minimal aspirates collected from the stomach indicating that there was very little in the stomach for him to vomit.

115. This was material in his opinion to the fact that ES was being presented with more significant problems that he had in reality, was that subsequent to ES's removal from mother's care he had been feeding successfully by bottle, eating purees and his weight has gone from strength to strength.

116. He was able to reach no conclusion regarding concerns about mother's lack of interaction with ES although it is recorded whilst in hospital he is being presented by his mother as ill with him lying in his cot swaddled in a blanket with his mother patting him.

117. Of course, he had in mind that Dr A was concerned that the mother's possible intention with her alleged false reportage of vomit and ES's apparent inability to feed orally, was to proceed with the forthcoming surgical intervention which, in the circumstances, would have led to an unnecessary and invasive procedure including an operation. It is clear that he thought it significant that the crux of the dispute between the mother and the local authority was the measurement of the aspirate collected which was 4.5 the same in any event as Dioralyte and therefore the aspirate and what purported to be vomit, could not be the same liquid.

118. He was asked to comment on what could be a subtle progression in this case of exaggeration leading ultimately to fabrication. Certainly the thrust of his evidence was that there were indicators of exaggeration prior to the September week where he found there to be fabrication.

119. He agreed with the general proposition that practitioners rely on what parents tell them but this is only up to a point as matters ultimately are checked by testing and so far as the seizures are concerned, and there have been multiple EEGs, he has had an opportunity of looking at videos presented by the mother and nothing he has seen suggested an epileptic focus and he would describe what he saw as "normal infant movements."

120. It was clearly a matter of concern to him that after the seizures issue apparently had been resolved prior to the admission in September, the mother was once again reporting a large seizure and if a carer repeatedly reports events that are not witnessed and which are subsequently resolved on a change of residence, then they are probably fabricated and it is significant that on admission on 29th September, the mother reported "worsening seizures."

121. He could not of course rule out that seizures had in fact happened on earlier admissions because they had been treated by medical practitioners.

122. He was also clearly concerned at the marked change in ES's presentation with the mother portraying a sick child in her police interview that now he no longer needs the NG tube and is developing as a normal child.

123. He agreed that if the mother had said in admission in early August that ES had always had issues with feeds, this was an embellishment because there was a time in ES's early life where he was fed quite properly on bottle feeds and unlikely that the baby had always choked on feeds of more than 3ozs and he said that the mother could well be elevating concerns although ES, in fairness, did have reflux.

124. Exaggeration or embellishment is one thing but the issue is whether or not it leads to an invasive procedure and although he was clear in relation to mother's actions in the September admission, he was troubled by the lack of clear evidence in relation to earlier admissions but did go on to say that during the admission on 3rd August when ES had an NJ tube, it would be highly unlikely for him to be able to vomit half his daily input as recorded on 9th August and was just not credible although of course he said that fifty per cent of babies do vomit three or four times a day but I drew from his evidence that there was therefore clear evidence of exaggeration or false reporting, prior to September.

125. In fairness to the mother, there was evidence in August from the SALT team that ES continued to have a severe oral aversion and therefore the mother could not be told that he now had a safe swallow. Although there was evidence of exaggeration prior to 26th September, there was no cogent evidence of FII.

126. What appeared to be determinative in his oral evidence was the feed and vomit chart of 27th September when asked to compare ES's oral and intravenous intake with what was recorded as output by way of vomit which he calculated that approximately a third of ES's body weight was being discharged in alleged vomitus. If this was the situation the child would present as seriously dehydrated and it is plain that he thought this was just not tenable giving rise, in my judgment, to the presumption on the balance of probabilities that the volumes of vomit presented for measurement were in fact not vomit and as clear evidence as one could find that the mother fabricated ES's symptoms.

Father

127. **RS** is the children's father and the author of one statement together with a response to the threshold findings. He was also interviewed by police in relation to a domestic violence incident that took place in 2013 which reveals an acrimonious relationship between the parents from time to time and an adverse effect on the children which have formed the basis of some of the father's concessions in relation to the findings sought.

128. ES and the other children are in his care and his case is that he had limited involvement or knowledge in how the mother was addressing ES's medical needs as she perceived them. Although he was not living with the mother, it is clear that he spent a lot of time at her address and the parents accept that they were parenting the children together.

129. His Children Act statement contains a number of assertions in relation to his position within the proceedings. He admits that he was in denial when speaking to professionals initially and when concerns first arose at the start of the proceedings and says that he is now open and honest with professionals. What is certainly the case is that ES has been thriving in his care and that since being removed from the mother's care, ES is feeding orally.

130. However upon closer analysis of his oral evidence and comparison with his written evidence, it is clear that his position regarding the mother is somewhat conflicted. He says in his statement that he has only known her as a good mother dedicated to keeping their children safe and nurturing them. He himself never ignored any medical advice on ES's feeding or ever untruthful about his health or wellbeing and it did not cross his mind that mother was either exaggerating or falsifying an account which he now sees as a possibility but that is qualified by his assertion that it was very much down to the court to decide the issues. Although he had no present intention of resuming cohabitation with the mother, it was quite clear from his evidence that that may form some consideration at a future date and his assertion that they had "separated for good at the moment" certainly had the effect of undermining what he said in his statement about there being no prospect of reconciliation.

131. Certainly he seems to have accepted at face value whatever the mother has told him about ES's medical presentation and needs. He says in his statement that the mother never mentioned the possibility of permanent medical interventions such as gastronomy and fundoplication although distanced himself from that in his oral evidence saying that the mother mentioned it at some stage and there was a tendency, in my judgment, for him even now at this late stage to ally himself with what the mother has said, and thereby bolster her position.

132. There are a number of examples of this. The thrust of the medical evidence is that for the first three months of ES's life he was bottle fed. Mother asserted in the interview by police that it was the father who raised concerns on ES's second feed that he wasn't taking it very well and father confirmed that he did notice that ES struggled with his second feed but nevertheless he continued to feed well and there was a suggestion that he was putting on too much weight and ES continued to be bottle fed until his first admission for bronchiolitis after which he was fed by an NG tube. In other words, he added credence to the mother's inflation of that aspect.

133. At the time the mother was interviewed by police ES had been with him for two or three weeks and had not reported any seizures and no vacant looks. He had regurgitated small possets very different from the quantities of 100mls as suggested by mother.

134. In relation to the scale of vomiting reported by the mother, he lent support for this orally to say that he had seen ES vomit but in the end, it came down to him having seen this may be six or seven times during the whole of ES's life and it was difficult therefore to reconcile that observation with his observation that ES was "a sickie baby."

135. Mother reported in her police interview that father had rang her on the morning of the interview saying that he was taking ES to the doctors as he'd had a

really bad night. It subsequently confirmed that although ES had exhibited a bit of a temperature and been sick a few times, in the morning matters were better so he didn't bother to take him to the hospital.

136. Mother represented to police later on in the selfsame interview her reports about ES being sick over his clothes and bedding up to eight or nine times a day.

137. Father claimed to recognise the scenario but couldn't reconcile that scenario with his overall observation of limited observation of vomiting i.e. six or seven times. He presented a confused picture of what he actually had observed and seemed from time to time to ally himself with the mother by not wishing to contradict her stated position.

138. He did not appear to be alive to the strong probability that mother was inflating ES's symptoms even while ES was in his care against the very good and positive reports of the dieticians at about the same time in early November when he is described as eating well. In reality ES was doing well and drastically differently from when he was in the mother's care but the father lent support in his oral evidence to the misgivings voiced by the mother in police interview.

139. Significantly also he did not tell the dietician when asked about vomiting of the occasion that the mother said that he had told her when ES had had a bad night and vomited three or four times on the basis that he didn't think about it and forgot. It raised the issue as to whether ES had been ill to the extent that was reported by the mother.

140. Mother described ES as sleeping a lot and being poorly while in father's care when having a cough. ES may well have had a cough and may well have a cough even now but the medical evidence is that he is thriving and if there is a strength in the father's care of ES it seems to be this: he merely just gets on with it.

141. The mother said in her police evidence, ES in the past had had seizures and the father by way of support indicated that these had been videoed and described two episodes since ES has been in his care when, in effect, ES lay back and his eyes went back into his head for a couple of seconds. Mother represented that to police as "seizures" and said, "RS has said he is not having them as often but he is having his rolls … his eye … eye rolling."

142. He was asked about the admission of ES to hospital on 26th September and the wide range of serious issues that the mother was concerned about and father is noted as being present but he was clear that he did not go to hospital.

143. Mother represented in her interview that father had gone to hospital prior to ES being discharged asking to see his son and asked why he had a cough. Father went to hospital and at that time ES was reported to be doing well but the father could not assist the court with what was said.

144. He accepted that he had said in evidence before that the mother was always protective and worried about the smallest things and exaggerated symptoms but not about ES's ability to feed.

145. At the conclusion of his evidence I was left with the impression of a man who is conflicted. He clearly has great affection for the mother. He was able to accept that the reporting of false symptoms could lead to ES having an operation that he did not need but I was uncertain as to whether he really understood the serious nature and consequences of surgical intervention for ES and its invasive nature which would carry its own range of risks.

146. He had said initially to the guardian that the medical staff were making false allegations and in the witness box he said, "I just don't know."

147. What he was able to accept is the difference in ES's presentation after removal from the mother as predicted by Dr A, and I take nothing away from him in relation to ES flourishing in his care, but his equivocation after having heard the medical evidence gives rise to a concern about his future protective role, and the need for assessment prior to the welfare stage.

Mother

148. **NI** is ES's mother and the author of two statements within these proceedings. Furthermore, she has prepared a document responding to the findings sought by the local authority. Her last statement contains photographs of ES on the night before she took him to hospital on 25th September, and photographs of his admission to hospital in June 2016.

149. Furthermore, she was interviewed by police on 2nd November 2016 and her observations to police, as recorded in the transcript, are material in relation to the forensic examination of what she has said in her witness statement and what she has said on her oath to determine the truth or otherwise of the allegations made by the local authority upon whom the burden of proof lies.

150. For her part, she vehemently denies that she has fabricated or exaggerated ES's symptoms in order to ensure that he has further unnecessary medical treatment. It was clearly an ordeal for her to give evidence and it is plain that she loves all her children but there is little doubt, even on her own admission, that she has presented as an anxious mother and there is an apparent gulf in relation to how she has seen ES's historical medical difficulties and how he has presented to professionals.

151. It is implicit that medical professionals are, to a great extent, dependent upon the accounts and reports of a baby's mother and in particular ES being presented as "a sickie baby" with oesophageal reflux problems, seizures and vomiting was clearly a crucial part of the medical evidence gathering to determine his treatment.

152. It is an accepted fact in this case that for the first three months of ES's life until he was determined to have an unsafe swallow on 16th June 2016, ES was bottle fed and mother accepted that she was concerned that he was gaining weight too quickly and reported him being sick on a daily basis, normally small amounts but often a large vomit and the same thing apparently happened to BS in the past. She was clear that up to his admission in September where the local authority say there is positive evidence of fabrication she has not exaggerated his symptoms and maintained there are often

staff present in hospital when he was being sick with her requesting either a change of sheets or changing of his clothing.

153. Her case is that ES had to be admitted to hospital in September and she described on the Friday before his admission his temperature was at 38.7 and 39.1 on the Monday morning of his admission although of course this was recorded as normal on admission to hospital with mother advancing the explanation that she had given ES Calpol and that's why his temperature was normal on admission.

154. She denies the suggestion made by Dr A that there was no sign of vomit and no member of staff had reported vomit on the ward by saying that on 30th September when ES was sick, she asked Katie (a nurse) for spare sheets and he had been sick on his vest which she changed. She did not catch all his vomits when he was sick and he was sick on her from time to time but she agreed that she would try and catch the vomit in a bowl and then present that bowl to staff who ultimately measured it. She did not see the recordings of the charts which were the province of the nursing staff and when the bowl was presented, the nursing staff would take it away but did not say that it was being measured. The fluid chart of 27th September is a crucial document in relation to the examination of the issues in this case as comparatively large amounts of vomit were presented for measurement by comparison with the fluid intake and, in any event, the majority of ES's feed was being taken by way of intravenous fluid against that I have the evidence of Dr A and Dr Robinson that if that volume as recorded was correct, the child would be seriously dehydrated and the exodus of this amount of fluid was not in fact sustainable or indeed credible.

155. At the centre of this case has been the primary evidence of fabrication arising from the vomit bowl that Dr A says the mother gave to her on the 29th September. Mother's oral evidence as indeed what she told the police, was that this was water because she was cleaning ES with cotton wool as her mother was coming into see him and she left the bowl on one side and when she returned from the toilet, the bowl had gone. I have in mind of course she has given somewhat contradictory accounts in relation to the "bowl of water incident." She maintains that she did not give the bowl to Dr A but her first statement, filed on 24th October and before her police interview, describes Dr A having to take a call and when she was doing so ES was retching and being sick and she showed her his vomit bowl which did contain clear fluid. That accords broadly with what Dr A has said in contradistinction to the mother's later account. By the time she was interviewed by police on 2nd November, she denied that she'd ever handed the bowl to Dr A maintaining that her mother was with her at one stage, in her oral evidence, but then going onto say that her mother had gone to the shop at that particular time when challenged that there was no witness statement from her mother. Against her inconsistent accounts, the account of Dr A is clear and corresponds broadly with what the mother said in her first statement. Furthermore, Dr A describes the swirl and movement of the liquid, which adds to its credibility.

156. Her second statement, dated 29th March of this year, maintains that the bowl that was taken for testing was in fact the bowl that she used to wash ES and she did not hand the bowl to anyone.

157. In her evidence in chief she made reference to the various accounts in the contact notes in relation to ES being sick in the months October, November and

December in support of her proposition that ES continued to present as a "sickie baby" maintaining as she did that "the proof was in the paperwork."

158. The mother's reportage of ES's vomit is an enduring feature in this case but she was happy to accept that he had undergone a huge change since his removal but still maintained that he was being sick. She maintained, and this is an essential plank of this case, that he had large amounts of sick in hospital and he was more sick in hospital than after his discharge but did not accept that her reporting of what amounted to in excess of a third of his body weight in a 24 hour period, was just not tenable according to the expert view, particularly in circumstances where he was being fed either by an NG tube where there were minimal aspirates (indicating that there was nothing effectively in the stomach for him to sick up) or intravenously. It was plain from cross-examination that she clearly understood that the aspirates were necessary to check the pH level of the contents of ES's stomach because if they were over 5.5 it would indicate that the NG tube was not in the right place and unable to accept that from a medical standpoint there was no good reason for ES to vomit in the quantities that had been reported by the her. This was particularly true, it would seem, in relation to the advancement of the NG tube into the duodenum and when an NJ tube was placed into the duodenum. She was not able to accept the physical and medical impossibility of her reportage of the volumes of ES's vomit with the various procedures in place merely maintained her view "that is what was happening."

159. Before that crucial admission in September she reported that ES was continuing to have what she thought was seizures and presented, as we know, a range of symptoms on admission which were not found to be present when ES was on the ward.

160. It is part and parcel of the local authority's case that she fabricated evidence on 29th September but prior to that, so far as ES was concerned, she exaggerated his presentation. Although of course it is accepted that ES had been designated as having complex needs and was under the care of the complex needs team in the community and there is little doubt that he was very ill when he had chicken pox in July.

161. She was resistant to any notion that while ES was in F and indeed on an occasion in G, that she had not stimulated ES sufficiently and there were concerns about his muscle tone with somehow the mother portraying him as a sick child that had to be confined to his cot. The mother said that she had occasionally taken ES to the park in F but accepted some of the time in F she was lonely and finding things difficult. The live issue here was whether the mother, by not stimulating ES, was representing him in some way to be a sick child.

162. She was asked about a worrying entry in the F medical notes relating to August when there was a recorded vomit not witnessed by medical staff and what looked like milk was recovered in a bowl with no saliva and no evidence of stomach content. Staff recorded that the liquid looked like "pure milk" and the NG tube was aspirated with minimal aspirate which was found to be clear. In capital letters in the notes are the words "NO MILK" with an asterisk next to it and it seems already the content and reportage of what the mother said was vomit was becoming a concern on 13th August 2016.

163. I should say that there is a mirror of that concern in relation to BS in 2013 which I shall come to in due course.

164. In the selfsame report of 13th August mother reported that ES had been retching for the previous ten minutes but the mother did not inform the nursing staff. There would have been a bell pull for a nurse's call in order for her to do so. As a consequence, ES was moved so that he could be better observed by staff.

165. In the selfsame admission there were tensions with the F surgical team as mother reports a divergence of opinion between the doctors and mother indicated that she did not want ES treated by the F surgical team. Of course, it is known that Mr G recommended an operation but Mr L had reservations about that procedure. It was about this time that staff were concerned that ES was spending too much time in his cot and the nursing staff highlight issues of lack of interaction which I know the mother resists accepting as she did in her evidence that she could have played with him more and expressed a sadness at being parted from her other children, and clearly felt isolated.

166. We know that ES was discharged to G on 16th August and reported to be doing well and mother remained on the ward in G to gain training in relation to the operation of the NG tube and it is the G staff that note lack of interaction between mother and ES and mother accepts that it was not as good as it could have been as she was tired and emotional but mother accepted in cross-examination that ES was doing well and ultimately transferred once again into mother's care. There is an indication that mother had wanted G medical team to be removed from ES's care although in the witness box she said that she was happy with G although did have an issue with Dr A over BS in 2013.

167. What is apparent however is mother's representation of ES's difficulties to medical professionals and she was taken in her evidence to a report that she'd made to Mr G on 2nd August which no doubt informed his opinion in relation to the need for major surgery. Mother reported that ES had **always** had issues feeding and this was before the chicken pox incident when he would always vomit half his feeds and mother was in the end reduced to giving him 4oz feeds. He had not had a proper feed for two weeks according to the mother and that is when there was a discussion regarding an NJ tube but the mother would not accept that she was exaggerating these symptoms and the use of the word "always" was such as to give a false impression particularly, as she said in the witness box, that he was frequently sick and not "always." Even when the mother was prepared to accept that "always" was not the right word she was unable to understand or accept that she was representing a situation as being more serious than it was particularly as the nursing record of the same day contains a more positive picture of ES. It is an illuminating piece of evidence to understand the mother's mindset and proof positive of exaggeration. The mother indicated that she was just saying what was happening and not exaggerating, but I do not accept this.

168. Another example of potential exaggeration was put to the mother in relation to the note of 9th August where the mother maintained that ES had vomited 300mls in the last 24 hours and 150mls in the previous 24 hours to that, but the child was still "well hydrated" and could not accept that her report was inconsistent with the

presentation of the child. I accept the medical evidence that the reports of these vomits was just not credible.

169. She accepted that she did zero the feed pump despite being clearly aware from staff that she should not touch the equipment but her case is that she immediately told the staff that she had done this as it is something that she does at home and reported to staff what the ingoing volumes had been prior to her zeroing the equipment.

170. It was suggested to her that she delayed the swallow test because, in effect, ES was not that unwell on 26th September. She said that she did not try and avoid this test by having ES admitted and was advised by the SALT team to ring Ward 4 and that is why he was admitted.

171. In any event, we know that it was rescheduled for 30th September and it is suggested by the local authority that she deliberately made ES comfortable so that he would sleep to avoid or delay the assessment. Her accounts in relation to this are inconsistent. In her witness statement she says that she was not presenting avoidance behaviour. The therapist "did come over to see him but he fell asleep. It was between 12 and 1 which was usually when he has a nap." This is in sharp contrast to the report from the SALT team when P D in fact arrived at 1 o'clock and was not able to proceed with an assessment because mother was in the playroom and she needed, in any event, to look at the notes. Apparently mother settled ES down on her lap with a dummy and swaddled him and when a preliminary assessment was attempted, ES fell asleep. As the therapist reported "as mum was giving me ES's feeding history she laid a faux fur blanket over ES and nestled him close to her body. The heat, cuddles and dummy soon made ES very sleepy so that when it was time for the feeding assessment, 14.40 ES was fast asleep." In effect therefore it was just not true to suggest that the therapist came at the time of ES's scheduled sleep but the mother felt in the witness box that she had a genuine reason for her to later allow ES to go to sleep and said that he had been "on and off sleeping all day" because he was tired and agitated and that would have made testing more difficult. Incidentally there is no explanation of this reasoning in her statements, and I found her evidence as just not credible.

172. So far as BS was concerned, there were three areas of concern on 9th April, 16th April and 20th August 2013, as indicated by Dr Robinson, which amounted to allegations of exaggeration and fabrication.

173. On 9th April 2013 mother reported a bluish episode after vomiting milk which was described by Dr Robinson as possible but reports of four blue episodes with blood on one occasion is unlikely and it suggests exaggeration.

174. On 16th April 2013, mother reported a vomit which the nurse observed to be clear liquid. The last feed had been milk. Of significance here it is similar to what is suggested in relation to ES but Dr Robinson goes onto say the time between the last feed and the vomit is not known and the pH of the liquid is not checked. However, blood in the stools reported by the mother is considered very unlikely are the reasons he sets out in his analysis.

175. Perhaps more starkly on 20th August 2013, reports of head banging, falls, drowsiness, slurred speech, flicking of eyes were, on the balance of probabilities, fabricated as the GP referral makes no mention of them and there was "resolution" after hospital observation with no apparent reoccurrence.

176. The mother said it was hard to comment on that as it was four years ago but BS did have a lot of issues and was a poorly child. The passage of time does have an impact on the court's ability to examine that issue fairly.

177. Mother suggested in her witness statement that she had been keen for ES to stay on the bottle if possible and indeed that was a theme that she reiterated in her live evidence to the court. She says in her witness statement that when the surgeon (Mr G) recommended a gastronomy and fundoplication, she was keen for that only on the basis that she was told that this would help ES's reflux. However, there was no acceptance from her that that opinion was formed on the basis of what the surgeon was being told and she is recorded in the notes, of 24th July, as indicating that she was not keen to give ES NG as she said that ES was not "keeping it down." She expressed a preference for IV although at that particular time it was very difficult to access a cannula into ES because of difficulty with his veins. The mother said in evidence that she would have liked ES to have tolerated an NG tube, but that is not the impression given by the notes.

178. It is suggested that the mother pulled out his NJ tube, which of course would have to be sited by x-ray on 16th August and mother's case is of course that ES pulled it out on his own and when asked about that she said that he had pulled it all out when she went to the toilet. The nursing notes describe the tube as well stuck down prior to starting the feeds and that "mum reported that she left ES to go to the toilet, came back and was playing with ES. Then said ES "again got cross and just pulled it out."" But the mother said in her oral evidence that she did not see ES remove the tube although it is apparent from the nursing notes that it happened when she was with ES. The notes make it plain that 20mm was drawn out but mother was clear that she saw the end of the tube and it had all been removed.

179. In her witness statement she described ES's retching as not being loud or particularly obvious and it was suggested that that was because Dr A had said in her evidence that staff did not notice ES retching. In contradistinction, and to police, she described projectile vomiting, ES arching his back and an extreme presentation whereby ES would get distressed but she denied any suggestion that she had changed the description in her latest statement to fit in with Dr A's report of this not being witnessed on the ward.

180. The mother was clear in her evidence that she did not enjoy having multiple professionals involved with her and her baby and hated seeing him uncomfortable and in pain but denied any suggestion that she was seeing things that were in fact not there because of her anxious nature and her anxiety about ES.

181. She was keen for the fundoplication operation to take place because she was told that it would help ES's reflux [on the basis of information largely taken from her] and that his sickness would subside but was unable to explain how it came to be that there has been such a dramatic change in ES's presentation since removal from her

care. She reiterated in her evidence how much she loves all her children and would dearly love to be reunited with them and I have little doubt that this is the case.

The law

182. The parties' advocates have agreed the legal framework which I endorse and will form Appendix 1 to this judgment and there can be no better distillation of the law relating to fact finding than in the words of Baker J in ***Re: JS (A Minor),*** **[2012] EWHC 1370.** The burden of proof lies on the local authority and the standard of proof is the balance of probabilities. I have also absorbed the more lengthy summary of case law provided by Mr Miller. I have all these principles in mind.

Preliminary conclusions

183. At the core of this case is the mother's anxiety. In my judgment, there is ample evidence to suggest that the mother is a highly anxious woman notwithstanding her sometimes confident and robust presentation. The issue in this case has been the extent to which that anxiety about ES (and, say the local authority historically, BS) has caused her to exaggerate symptoms in children who already have had complex health needs. Following on from that, the issue has been the extent to which exaggeration borne out of anxiety has caused the mother to cross the threshold from exaggeration into fabrication, with consequent harm to her children and the risk of further harm if her conduct continues.

184. It is by no means trite to say that this mother loves her children and is devastated at being parted from them. The issue has been as to whether her evident love for them, and ES in particular, has become somewhat distorted in the way that she has reported his symptoms and, knowing as she must do, that any history that she gives to doctors plays a pivotal role in diagnosis and treatment, and some of the treatments are invasive in relation to a small child. If a false report or a series of false reports in relation to his presentation leads to an unnecessary or invasive treatment it clearly crosses the threshold in terms of significant harm.

185. There is little doubt that ES has had complex needs. There is little doubt that those needs formed the basis of medical diagnosis and treatment. As Dr Robinson suggested, there is no evidence for the court to go behind some of those diagnoses but there is a subtle distinction on the facts presented in this case in relation to an examination as to whether the mother presented ES as a more sickly child than he really was to satisfy some complicated emotional need of her own. That of course is an analysis for another day after an investigation of mother's psychological and psychiatric wellbeing and the extent to which her background and her own experiences of medical treatment are relevant, if at all.

186. I should add, that after the close of submissions and before I had formulated my judgment, I was referred by Counsel for the local authority to a recent case before Mr Justice Hayden of March 2017 :**Westminster City Council and M, F and H [2017] EWHC 518 (Fam).** That case also involved allegations of misreporting and over reporting of symptoms and fictitious presentation of a child's condition thereby exposing the child to medical and health risks and involved a helpful debate in the judgment of the Learned Judge as to the apparent tension between the President's

judgment in **Re A (A Child) (Fact Finding Hearing – Speculation)** **[2011] EWCA Civ 12** and the evolution of the admissibility of hearsay evidence in children's proceedings. Suffice it to say that I have considered that judgment which involves a proper engagement of conflicting arguments not least of which has been a helpful rehearsal as to the features that the court should have regard to in analysing the cogency and weight of hearsay evidence. It is not necessary or proportionate for the purposes of this judgment for me to set out that debate *in extenso* save and except to record that I have the competing principles in mind. I am driven by the obligation to regard the welfare of the child as the paramount consideration and this permits me to "instinctively permit a broad range of evidence in order ultimately to weigh and assess its quality and worth in the context of the evidence as a whole." Never losing sight of the principle that it is for the local authority to prove its case, the striking similarities between the O recordings in medical notes in August 2016 with those recordings at G and attested to on oath just cannot be ignored as I set out in my findings.

187. I confine myself to an examination of the facts and the extent to which the local authority has satisfied the burden of proof. The expert evidence in this case has been part of the holistic picture that I should view but nevertheless has been helpful and highly probative in relation to many of the issues raised by the local authority but obviously have had to be balanced against the evidence from the parents.

Findings

188. I turn now to the local authority's schedule of findings.

189. **Findings 1 – 3** relate to allegations of domestic violence and emotional harm caused to the children in 2013 and are broadly agreed by the parents.

190. **Finding 1** relates to the children having been exposed to domestic violence and this relates to an isolated incident on 10th October 2013 as a consequence of which the father pleaded guilty to ABH, undertook a six-month domestic violence perpetrator programme and demonstrated acceptance of his role. There have been no further incidents or issues recorded.

191. **Findings 2 and 3** relate to inappropriate parenting and name calling and this is accepted by the parents and there seems to be broad acceptance that the parenting style of both parents has changed. Although these allegations are accepted and are therefore proved, I agree with the submission that they do not assist me so far as threshold are concerned and are relevant issues for the welfare stage insofar as accepted facts may inform assessment for welfare purposes.

192. **Findings 4 – 8** relate to specific incidents or behaviours that are raised by Dr A in relation to the mother's conduct on the ward; in that the mother has misled the medical professionals in charge of ES's care about the extent of his inability to tolerate food and medication by fabricating or exaggerating the frequency that ES has retched and/or vomited and deliberately falsified incidents of vomiting and misrepresented water or other substances as "well caught vomitus."

193. The principle source of this evidence is Dr A's observations which I have found to be probative even after hearing the mother's account. I prefer her account to

the mother's evidence as I hope will be plain by my previous summary of their respective evidence.

194. I turn firstly to the events of 29th September and I am entirely satisfied that the local authority have proved to the necessary standard that the mother represented water as vomit in order to persuade medical staff that ES was vomiting comparatively large volumes of vomit. After balancing the mother's account with that of Dr A and the other nursing staff, I reject mother's account as being not credible and there is clear evidence therefore of fabrication and falsification in relation to reported vomitus.

195. It may well be that from time to time vomiting was observed or noted by staff and the volumes of alleged vomit presented by the mother for measurement are wholly inconsistent as ES was receiving all his fluids by his IV line.

196. It is against the background of that key finding that the court is entitled to carry out a forensic exercise in relation to the seven clearly documented incidents when the mother was suspected of falsifying vomitus and passing it to the medical staff as vomit. There are a series of five entries recorded at the O Hospital and it has been submitted that the court should leave those to one side due to the absence of primary evidence but the incidents between 11th August and 13th August at the O Hospital are consistent entirely with evidence given in relation to what happened in G on 29th September when, inter alia, small volumes of aspirate were recovered and volumes reported were inconsistent with ES's method of being fed. There is direct evidence from Dr A in relation to what happened at G on 29th September and, in particular on 29th September, the vomits which appeared clear would just not have been possible with the aspirates reported and that is a common theme at F as well as G notwithstanding the absence of a witness statement from a nurse. It has been submitted that the absence of direct primary evidence in the form of witness statements from nursing staff in relation to the O entries prevent me from making any particular finding of falsification or fabrication other than to record the stark similarities between the concerns that were expressed in F and the evidence that I have found proved in G. However, the features recorded in the notes are so strikingly similar and proximate as to what occurred at G and in respect of which I heard evidence on oath, and as such I have been able to objectively assess the quality of the hearsay evidence in the medical notes to determine that they are not only admissible but probative in relation to the incidents recorded

197. I find that the mother has exaggerated and been inconsistent in relation to ES's ability to tolerate feeding and that exaggeration has progressed to the admission on 26th September and it is a significant feature that there are numerous records of the vomitus being described as a clear liquid. It is unsurprising therefore that the medical professionals were concerned about getting fluid into ES given mother's reportage. On 29th July when ES was recovering from chicken pox, the major concern raised was that he continued to vomit clear liquid. That led to a transfer to Q for a long line insertion and thence back to G where his temperature was described as normal.

198. The mother continued to report vomiting despite ES having a long line inserted to provide intravenous fluids leading, in my judgment, to formulation for a more definitive plan involving an NJ tube.

199. Mother continued to report increased retching and large vomits in or about 1st August 2016 and Dr A noted "persistent vomiting despite recovery from acute illness." The vomiting was described as "unexpected and no longer related to the chicken pox" and significantly by early August large volumes were reported greater than the volumes flushed down and despite nil by mouth. As a consequence, ES was transferred once more back to the O to discuss a possible intussusception of the bowel and it is quite plain that the reportage of vomiting played a key role in that decision and the mother continued to provide an exaggerated account, for example, to Mr G, that ES "always" had issues feeding and that even before chicken pox he "always" vomited half his feeds and that he had not fed properly in two weeks. This is just not tenable in relation to his presentation on the ward with minimal aspirates and the fact that he was still fitted with a long line.

200. I have already made reference to the fact that on his subsequent transfer back to G on 3rd August, fitted with an NJ tube and an NG tube and a long line mother continued to report vomiting. On 6th August mother reports six vomits in a day despite the fact that ES presented to nursing staff as "normal." I therefore determine on the balance of probabilities, that these were either false or exaggerated reports.

201. The evidence does permit me, as I have indicated, to find that mother substituted what she said was vomit for water in relation to the F admission and there is clearly proof to a cogent standard that she did so on the G admission.

202. Having found, as I do, that the mother progressively exaggerated and misreported ES's position and ultimately in September fabricated and falsified that she would have inevitably known that this would lead to ES undergoing painful unnecessary medical procedures as ES had to be fed intravenously.

203. The finding I therefore make in relation to the state of the mother's knowledge is more limited. As Dr Robinson has indicated, the court cannot go behind the SALT assessment and the decision for ES to be fed intravenously with the insertion of tubes into his body. It may well be that the mother would not have wanted ES to suffer unnecessary pain or distress but the effect of her various interventions and reportage was to cloud the clinical decision making process to do just that and it remains a stark and agreed fact of this case that ES has not needed to receive food and nutrition by these invasive means since he was removed from his mother's care.

204. **Finding number 5** in relation to the dislodgement of the nasojejunal tube. The evidence in relation to this aspect is equivocal and, in any event, there was an absence of primary evidence from the nursing staff involving so that this aspect could be adequately tested and is therefore not proved to the requisite standard.

205. **Finding number 6** – the mother's zeroed ES's feeding pump.

206. After initial denial this is accepted by the mother and I make no finding other than the mother knew she should not have done this. Her motive for doing so remains unclear. The fact that she did so at all is troubling.

207. **Finding number 7** – the mother misreporting, exaggerating or falsifying reports of non-epileptic fitting or seizures.

208. I confine myself to the admission on 29th September for this purpose and accept Dr Robinson's evidence that the video that she provided of ES apparently having seizures are not seizures. The seizures, such as they were, were not observed and I accept Dr Robinson's evidence that it would be highly unusual for these to resolve in a small child (as apparently they had done) and then reoccur. The mother's accounts are therefore fabricated and I observe that no seizures have been observed since removal from mother's care.

209. **Finding number 8** – no finding is sought.

210. **Finding number 9** –that the mother has invented or exaggerated ES's inability to swallow and manage eating solids and also misrepresented the occurrence of fevers and dehydration.

211. No finding is made in relation to the inability to manage solids in view of the SALT team's various diagnoses but it is significant that ES's temperature was found to be normal on admission on 26th September (and I confine myself to that admission) and her report of dehydration was just not made out or found to be true.

212. **Finding number 10** – falsification or misleading information regarding ES's health and his ability to swallow.

213. I find that there probably wasn't anything wrong with ES when he was admitted on 26th September. The effect of the admission was to delay the SALT test but that was a decision made by professionals that the effect of the mother's activities on 30th September was to delay the SALT test until 3rd October and I find that the mother probably avoided the test being done and evidence that she has given in relation to that issue I found wholly unconvincing.

214. **Finding number 11** – the mother has not taken active steps to keep ES's development and ability to swallow and tolerate feeding by mouth under review: I make no finding other than to observe that immediately after ES's removal from his mother's care he underwent a SALT test not in the presence of his mother and was able to tolerate oral feeding and, in my judgment, this signifies that he probably could have tolerated oral feeding at an earlier date.

215. **Finding number 12** – the mother has not taken active steps to ensure ES's wellbeing and he has failed to thrive in her care.

216. I find that ES's difficulties have been deliberately misrepresented by the mother as a consequence of the findings that I have already made and it is deeply significant that in less than a week, ES was feeding properly, gaining weight and there were no problems with seizures. I do however take into account that the contact notes do indicate some vomiting, but nothing, and I stress this, to indicate any concern of a medical nature.

217. **Finding number 13** – this is accepted by the parties.

218. **Finding number 14** – I am prepared to find that the mother was aware that accurate reporting of ES's health and condition was crucial in assisting the medical

professionals to make the correct medical decisions in respect of ES and, as a consequence of the findings I have made, her exaggerated reportage and fabrication has undermined the medical decision making process and the mother confirms in evidence that she understood the implications of ES being presented consistently as being difficult to hydrate and constantly vomiting.

219. **Finding number 15** – I find that ES has been subjected to numerous medical procedures of an intrusive nature and in particular, attempts to insert cannuli and lines so that he could be fed. There have been blood tests, x-rays, general anaesthetics, IV insertions, barium imaging and scans, to name but a few procedures, but I am not persuaded that in behaving the way that she did the mother intended to cause ES pain and distress. There is little doubt however, that many of these procedures would have done so.

220. **Finding number 16** – I find that there have been examples of failing to engage and play with ES despite encouragement but I take into consideration that there were times when the mother felt necessarily low, lonely and isolated but there are stark examples in her police interview of her promoting, beyond the realms of the medical evidence, ES as a sick child. Once again, direct sworn evidence supports what is suggested by way of hearsay evidence in the F medical notes. It has been a feature of this case that mother has reported ES as being unwell, and in particular, on 26th September, admitted him to hospital when to all intents and purposes, he was found to be well.

221. **Findings numbered 17, 18 and 19** – of course I have Dr Robinson's opinion which I have rehearsed in this judgment based on BS's medical notes and certainly there appears to be a broad mirror of the concerns in relation to ES but there is an absence of any primary evidence in relation to the findings after a period of some years and it would not be safe for the court to make the findings as requested. Given the ambit of this case, findings additionally would not be necessary or proportionate, even if the evidential threshold permitted it, which it does not.

222. **Findings numbered 20 and 21** – I find, as accepted by the father, that with hindsight he failed to pay sufficient attention to ES's health and wellbeing and how his medical health was managed and addressed by the mother who had primary care at the time. With hindsight, he accepts he could have done more to investigate ES's failure to thrive and ongoing feeding difficulties (finding number 20) and insofar as finding number 21 is concerned, while the father asserts he engaged openly and honestly with the local authority, accepts that he was initially in denial in relation to mother's behaviour. He also accepts that when he first discussed the possibility of exaggeration and fabrication with professionals, he was defensive and protective about the mother's role and at first sought to blame the medical professionals for scapegoating her to cover their own mistakes. He has since revised this view and is now taking an independent and involved role. He works with medical professionals involved in ES's care as well as with the local authority.

223. I therefore endorse the agreed concession made by the father in relation to those findings which I have rehearsed for the purposes of this judgment. In contradistinction to findings 1, 2 and 3 which do not go to threshold, these findings do go to threshold, in my judgment, and materially are linked to the mother's

management of ES's care. I should of course say that it is to the father's great credit that ES has thrived in his care and he should be congratulated but the findings, as above, relate to the time when protective measures were taken and I am satisfied form a proper part of the threshold document for the purposes of s.31.

224. This judgment contains serious findings in relation to the mother's activities so far as ES is concerned and threshold is clearly crossed so far as s31 Children Act is concerned. However, having seen the mother and appraised her in the witness box, I am satisfied that she never intended, in her mind, with malicious intent, that ES should come to any serious harm and there is little doubt that she loves her son. However, her actions were such as to mislead the professionals who had the charge of ES's medical care and, as a consequence, ES was caused unnecessary harm, and would have continued to do so if he were left in her care. Perhaps the most compelling evidence in this case has been the extent that ES has flourished once he was removed from his mother's care.