Case Nos: LS21C00133, KH22C5008, LS22C50104

IN THE FAMILY COURT AT LEEDS

Date: 18/05/2023

Before :

MR JUSTICE POOLE

- -

BR and others (Three Families: Fabricated or Induced Illness: Findings of Fact)

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- -

Family R

Julia Cheetham KC, Sara Anning, and **Emily Chipchase** (instructed by the Local Authority) for **Leeds City Council**
Darren Howe KC and **Iain Hutchinson** (instructed by Ramsdens Solicitors) for the Mother, **MR**
Karl Rowley KC and **Louise McCallum** (instructed by Switalskis Solicitors) for the Father, **FR**
David Orbaum and **Michael George** and (instructed by JWP Solicitors) for the child **AR**

Ruth Henke KC and **Jane Curnin** (instructed by Wilkinson Woodward Solicitors) for the children **BR** and **CR**

Family S

Taryn Lee KC and **Sarah Blackmore** (instructed by the Local Authority) **for East Riding of Yorkshire Council**

Rachel Langdale KC and **James Hargan** (instructed by Williamsons Solicitors) for the Mother **MS**
Paul Storey KC and **Naomi Madderson** (instructed by Symes Bains Broomer Solicitors) for the Father, **FS**
Frances Heaton KC and **Gaynor Hall** (instructed by Lockings Solicitors) for the children, **DS**, **ES**, **GS** and **HS**

Family T

Jacqueline Thomas KC and **Brett Davies** (instructed by the Local Authority) for **Wakefield Metropolitan District Council**

Joseph O'Brien KC and **Justine Cole** (instructed by GWB Harthills Solicitors) for the Mother, **MT**

FT, father of HT, not appearing

FV, father of JV and KV, not appearing

Elizabeth Maltas (instructed by Peace Legal Solicitors) for the Father of LW, **FW**

Martin Todd and **Huw Lippiatt** (instructed by King Street Solicitors) for the children **HT**, **JV**, **KV**, and **LW**

Interveners

Bryan Cox KC and **Luke Berry** for **Sheffield Children's NHS Foundation Trust**

Natalia Levine (instructed by Howard & Co Solicitors) for **AC** and **BC** (carers for JV and KV)

James Ketteringham for **South Yorkshire Police**

Hearing dates: 17 January to 5 April 2023
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JUDGMENT

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

Mr Justice Poole:

SUMMARY

1. Three children, each from separate, previously unconnected families, were treated as long-stay in-patients at Sheffield Children's Hospital during 2020 and 2021. Each child presented with chronic gastroenterological illness and apparent inability to tolerate oral feeding. Each ceased to feed either orally or by tubes delivering feed directly to their stomach or jejunum, and was then given parenteral nutrition delivered intravenously via central venous catheters known as central lines. Each had an exceptionally high number of bacterial infections of their central lines, leading to life-threatening sepsis. Their cases were perplexing to clinicians who could not reach any medical diagnoses to explain the children's presentations. For long periods the three children were treated on the same ward at the hospital. The children's mothers, who all had other, healthy children, would stay at the hospital with their ill children day after day, including in periods of lockdown during the Covid-19 pandemic. In February 2021, the mother of the oldest of the three children was arrested after a urine test revealed that the child had ingested ibuprofen which had not been prescribed. The mother was removed from the hospital. Arrest and removal of the other two mothers followed in October 2021. Each child made a rapid recovery after their mother was arrested – they were soon able to be fed by tubes and then to eat; their central lines were no longer required and so they avoided further line infections. Each mother is accused of inducing illness in their child by administering unprescribed drugs or other agents and by deliberately contaminating their feeding lines with faecal material causing repeated bloodstream infections. It is alleged that their actions led to multiple, avoidable medical interventions, prolonged hospitalisation, brought each child close to death, and, even though each child survived, will have caused them severe and probably long-lasting harm.

2. Leeds City Council, East Riding of Yorkshire Council, and Wakefield Metropolitan District Council have separately made public law applications in respect of the children of each family, respectively referred to in this judgment as families R, S, and T. Proceedings in the case of Family R were issued first and were progressing to a finding of fact hearing in the summer of 2022 when, as the Family Division Liaison Judge for the North East Circuit of England, I became aware of the other two cases and directed that the three sets of proceedings should be heard together at a single finding of fact hearing. This has caused delay in resolving the case involving Family R, but it has become clear during this hearing that justice could not have been served by hearing the three cases separately. In fact, prior to my involvement, but unknown to the families at the time, the police, Local Authorities, and staff from SCH had held discussions at which possible links between the cases had been considered. Given that these three cases, in each of which the mother is alleged to have acted in very similar ways to cause life-threatening harm to their child, occurred during the same period at the same hospital, it has been essential, in my judgement, to explore possible connections or common causes in the three cases. The clinicians and experts in these cases have told the court that the number and nature of the recurrent line infections for each child was unprecedented in their experience, yet three such unprecedented cases happened at the same place and time. Was that coincidence or was there a common cause? Did three mothers whose children happened to be on the same ward, independently decide covertly to poison their children and introduce faecal material into their central lines, or is there a different explanation for these highly unusual and perplexing presentations?

3. This was a finding of fact hearing in family proceedings and was neither an inquiry into the conduct of the clinicians and management at the Trust nor a criminal trial of the three mothers. The issue for the court is whether the allegations made by each Local Authority against the mothers of families R, S, and T are proved on the balance of probabilities. Those allegations, as they stood at the close of the evidence, are set out at Appendix 1 to this judgment. The mother of family R is referred to MR and the child who was a patient at SCH is BR. The mother of family S is MS and the child is HS. The mother of family T is MT and the child is LW.

4. I conclude this judgment with some general observations which include that:

    a. Guidance on Perplexing Presentations/ Fabricated or Induced in Children published by the Royal College of Paediatrics and Child Health should be followed by clinicians.

    b. Where Fabricated or Induced Illness (FII) is suspected but there is no evidence that it is probable and there is no immediate risk of harm to the child, clinicians should nevertheless consider referral to social services in cases where a multi-agency approach would be better suited to obtaining both medical and non-medical evidence, and to formulating and pursuing a rehabilitation plan.

    c. Failure to adopt the RCPCH guidance may result in clinicians making hurried decisions about referral to the police when further concerns arise and when opportunities to avoid referral and/or to gather evidence about possible FII have been missed.

    d. FII is an umbrella term that covers a wide range of conduct, but at a finding of fact hearing, the court is required to focus on particular forms of conduct and their consequences.

    e. Expert witnesses will assist the court by giving opinions within their own fields of expertise but the court makes findings based on all the evidence, medical and non-medical. Experts must not supplant the role of the court and it is not helpful to the court for an expert to seek to advise whether or not FII has occurred.

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

5. For the reasons given in this judgment my key findings are that:

a. MR administered unprescribed medications to BR over a period of several months, namely ibuprofen and piroxicam, causing BR to suffer from gastro-intestinal damage, and bisacodyl, causing or exacerbating diarrhoea.

b. As a consequence of the administration of unprescribed medication, BR underwent prolonged hospitalisation, investigation and treatment, including parenteral nutrition. The central lines used to administer parenteral nutrition repeatedly became infected, causing life-threatening sepsis.

c. MS and MT did not exaggerate or fabricate their sons' illnesses as alleged.

d. MS and MT did not induce illness in their sons by the administration of noxious agents as alleged.

e. MR, MS, or MT did not deliberately contaminate their children's central lines with faecal material or otherwise intentionally cause their children to suffer line infections and sepsis as alleged.

6. This contents of the remainder of this judgment are:

PART A: INTRODUCTION

A1 The Hearing and Case Management

7. The finding of fact hearing was a major undertaking. The evidence was heard over an eleven week period in Leeds. Sheffield Children's NHS Foundation Trust (The Trust), responsible for Sheffield Children's Hospital (SCH) is an intervener in the proceedings. Very many witnesses from the Trust have given evidence and I am very grateful to the Trust for its impressive efforts in assisting the court at this hearing. 90 witnesses gave oral evidence, and I received about 55,000 pages of documentary evidence. The courtrooms used by the Family Court in Leeds were not sufficiently large to accommodate the hearing and I am grateful to the Business and Property Court for allowing the hearing to be conducted in the large court room at Cloth Hall Court, and to the court associate and staff at Cloth Hall Court for their assistance during the hearing. Cloth Hall Court was a Nightingale Court initially used by the court service during the Covid-19 pandemic. Its use as a court building ended when this hearing still had two weeks to run. We moved to a smaller court space at the Leeds Magistrates and Family Court but those last two weeks were used to hear evidence from the family members and the space was sufficient to accommodate the lawyers who needed to attend in person for those witnesses. The majority of witnesses were healthcare professionals and most of them gave evidence remotely. A room was allocated at SCH from which staff could give evidence remotely. I am grateful to Counsel for the Trust and for the Trust's in house legal team and support staff for their help in marshalling the witnesses. All the expert witnesses, family witnesses, and some key witnesses from the Trust gave evidence in person. Documentation was uploaded electronically onto Caselines and, during their questioning, Counsel could use the page direction facility on Caselines to ensure that the witness had the correct document in front of them on a laptop screen. Notwithstanding the occasional loss of a Wi-Fi signal, Caselines worked well for remote witnesses and attendees as well as for everyone in court. I am grateful to the East Riding of Yorkshire Council who took responsibility for organising the documentation on Caselines. The Children's Guardian in the Family R case took responsibility for the expert witnesses and very helpfully made re-arrangements for their attendance as the hearing timetable was varied. At the case management stage I had directed that experts who had already been jointly instructed in the case of Family R were to be jointly instructed in the other two cases. The timetabling of witnesses required constant revision but was efficiently managed with very few delays needed and very little "dead" court time. I allowed counsel to attend remotely when they considered it unnecessary to attend in person – for example when that day's witnesses concerned one or both of the other cases to which their client was not a party. Furthermore, when the mothers and other family members gave evidence, only the representatives of the parties in the proceedings relating to that family were in court – all other representatives attended remotely: this made the experience of giving evidence marginally less intimidating than it would have been in a courtroom packed with lawyers.

8. Such a hearing is a very costly undertaking and is not entered into unless fully justified. Given the seriousness (in terms of both the harm caused and the conduct involved) of the allegations made against each mother, the fact that those

allegations are strongly denied, and that the findings of fact will have a very significant bearing on the welfare decisions to be made in respect of the ten children of the families, I am sure that it has been necessary for the purpose of making welfare decisions about the children to have a finding of fact hearing notwithstanding the size and cost involved in that exercise. Moreover, it became very clear as the hearing progressed that justice could not have been done had separate findings of fact hearings been heard in each of the three cases – there were many common themes and possible links between the cases needed to be explored. It has also been economic to hear the three cases together rather than separately – many witnesses gave evidence in relation to more than one of the cases and they, as well as the experts would have had to attend three separate hearings. Three separate finding of fact hearings would have taken up much more court time. Nevertheless, on reflection, there was scope, with tighter case management, to have ensured more efficiency and to have reduced some costs:

a. There may have been some days during the hearing when the attendance of leading and junior counsel for every party was not necessary, for example when evidence was given that did not directly relate to their client's proceedings. Legal teams involved in large-scale, multiple party hearings of this kind have to give careful consideration to a proportionate level of attendance of members of the team during the hearing.

b. The process for obtaining witness evidence from healthcare professionals at the Trust left room for miscommunication and evidential gaps. The Local Authorities brought the proceedings but relied on the Trust to obtain witness statements: that was a sensible way to proceed but perhaps the scale of the task and the Trust's level of involvement in this hearing was not initially fully appreciated. Extensive liaison and communication was required from the outset to ensure that the right witnesses were identified and that their statements covered the right issues. Furthermore, perhaps because the Trust was mindful of potential criticism from the families, some statements from Trust witnesses had a distinctively defensive tone.

c. There was late disclosure of some key documents in the possession of the Trust. I do not underestimate the burden of disclosure imposed on the Trust and the scale of disclosure required. Some late disclosure of medical records was not unexpected but, for example, recordings of key safeguarding meetings clearly required disclosure, and should have been identified and readily obtained, but they were not disclosed until after the hearing had begun. Furthermore, the Trust ought to have alerted the parties and the court to its commission of a Serious Incident Investigation report from an independent consultant paediatrician, Dr Caroline Grayson. She was instructed to provide a report into "three cases of Fabricated and Induced Illness". As is apparent she was not asked to question whether the three cases were truly cases of fabricated or (or as she was instructed "and") induced illness. The broad purpose of the report was to establish learning points for the Trust. As would have been expected, Dr Grayson spoke to a number of the key witnesses in these three cases. Her draft report was submitted to the Trust shortly after the hearing began. Unbeknown to the parties or the court, witnesses due to give evidence had very recently discussed the matters before the court with Dr

Grayson. At a case management hearing in June 2022 I had ordered that the Medical Director at the Trust should inform the court of any investigations into FII. Information about Dr Grayson's instruction should have been provided. At the hearing I directed that the Trust's solicitor should provide an explanatory statement to the Court in relation to these concerns. In effect she informed the court that the failure to inform the court and the parties of the SII report was due to human oversight. I have taken her statement fully into account. Notwithstanding the considerable burdens imposed on the Trust, the late disclosure of obviously important documents and the failure to alert the court to the SII report process, was regrettable and created considerable additional work for the parties during the hearing. I commend the parties' representatives for their pragmatic approach to these difficulties – I did not receive any submissions that the proceedings were rendered unfair as a result of late disclosure and I was not asked to delay any part of the hearing so that the parties could have more time to consider the delayed disclosure.

d. It is essential in a case of this kind that at an early stage medical records are paginated and that the pagination does not change. A page numbering system sufficiently flexible to allow for additions without changing existing numbering is required. This was done but there was a great deal of duplication in the preparation of chronologies based on the paginated medical records. At case management hearings I had directed that medical chronologies be prepared. Dr Ward, the paediatric expert for all three cases then prepared very lengthy chronologies herself. Other chronologies were also created at various times.

Notwithstanding these observations, the case was dealt with by the parties' solicitors and barristers with conspicuous efficiency and I am particularly grateful for the collaborative approach taken to some difficult issues. The hearing was listed for eleven weeks and it took eleven weeks.

A2: Anonymisation and Abbreviations

Anonymisation

9. In November 2022, the President of the Family Division, Sir Andrew McFarlane, announced that Leeds Family Court would be one of three courts in England and Wales that would participate in the Transparency Reporting Pilot. The pilot began on 30 January 2023 with a view to allowing pilot reporters to report on family cases heard in private but subject to restrictions set out in a Transparency Order made in a case attended by a pilot reporter if the judge thought it fit to make one. Rather than adopting the reporting pilot part way through this hearing, I decided to adopt it early. I made a Transparency Order as explained in my judgment, *Re BR (Transparency Order: Finding of Fact Hearing)* [2023] EWFC 9.

10. In accordance with that Transparency Order, the children, their families, and other carers in this case are anonymised as follows:

    a. Family R

       Mother and Father, MR and FR. Their children (oldest first) are AR, BR and CR. BR is the child with long term illness.

    b. Family S

       Mother and Father, MS and FS. Their children (oldest first) are DS, ES, GS and HS. HS is the child with long term illness.

    c. Family T

       Mother, MT. Her children under 18 (oldest first) are HT (father FT), JV and KV (father FV), and LW (father FW). LW is the child with long term illness. She also has an adult child, NT.

    The carers for JV and KV are AC and BC.

11. Hospitals other than the Sheffield Children's Hospital (SCH) operated by the Sheffield Children's NHS Foundation Trust (the Trust) are referred to as follows:

    a. Hospitals where BR was treated: Hospital A in the North of England and Hospital B in the South of England.

    b. Hospitals where HS was treated: Hospitals A and C, in the North of England, and Hospital B.

    c. Hospitals where LW was treated: Hospitals, D, E and F, in the North of England.

    The ward at SCH where the children all stayed is referred to as ward J. Other wards where they spent time are referred to as wards K and L. The witnesses, including family members, are anonymised in accordance with the table at Appendix 2 to this judgment. The parties have the full names of each witness in the confidential version of the table provided to them.

Abbreviations

12. I adopt the following abbreviations throughout this judgment, listed alphabetically:

GI	Gastro-intestinal
HDU	High Dependency Unit
IV	Intravenous

MDT	Multi-disciplinary Team
NGT	Naso-gastric tube
NJT	Naso-jejunal tube
NSAID	Non-steroidal anti-inflammatory drug
PEG	Percutaneous endoscopic gastrostomy
PEG-J	Percutaneous endoscopic transgastric jejunostomy
PEJ	Percutaneous endoscopic jejunostomy
PICC	Peripherally inserted central catheter
PICU	Paediatric Intensive Care Unit
PN	Parenteral nutrition (TPN : total parenteral nutrition)
RCA	Root Cause Analysis
RCPCH	Royal College of Paediatrics and Child Health
SCH	Sheffield Children's Hospital
SII	Serious Incident Investigation

A3: Fabricated or Induced Illness

13. In February 2021, the RCPCH published new guidance, *Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children*, which I have found of considerable assistance. Professor Sir Roy Meadow first described the condition 'Munchausen Syndrome by Proxy' (MSbP) in 1977. Now, the preferred term is Fabricated or Induced Illness by Carers. The RCPCH guidance distinguishes FII from 'medically unexplained symptoms", and "perplexing presentations".

    a. Medically Unexplained Symptoms (MUS): "a child's symptoms, of which the child complains and which are presumed to be genuinely experienced, are not fully explained by any known pathology. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature). MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body."

    b. Perplexing Presentations (PP): "the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm) when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of

immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour."

c. Fabricated or Induced Illness (FII): "a clinical situation in which a child is, or is very likely to be, harmed due to parent(s') behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm."

14. According to the RCPCH guidance, research shows that the child's mother is nearly always involved or the instigator of FII. Interestingly, "in some families, only one child is subject to FII or has a PP and this child may initially have had a genuine illness which began the relationship between the parent and health professionals. In other families, several children may be affected by FII or have a PP simultaneously or sequentially." There are two possible and very different motivations for instigating FII – the parent experiencing a gain from the recognition and treatment of their child as unwell, and the parent's erroneous beliefs. The most common form of FII is "by presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses." A less common form of FII is by a range of actions "such as putting sugar or blood in the child's urine specimen, interfering with lines and drainage bags, withholding food or medication from the child and, at the extreme end, illness induction in the child."

15. In a 2018 survey of its members the RCPCH found that 92% of respondents recalled seeing at least one perplexing presentation within the previous 12 months and 30% had seen more than five. Respondents described 69 different "condition presentations", with feeding difficulties amongst the most common. 56% of respondents had not witnessed illness induction.

16. Inducing illness by the administration of noxious agents and by the deliberate contamination of central lines are recognised forms of FII, but the RCPCH guidance illustrates the exceptional nature of the allegations of FII in this case. Whether the severity of FII is assessed by reference to parental conduct or harm to the child, each of the three cases with which I am concerned would, if they are examples of FII, come within the most severe category. Each mother is alleged to have induced illness with life-threatening consequences over sustained periods without detection. These are cases at the "extreme end", yet they allegedly occurred simultaneously in respect of three previously unconnected children, who were all being treated in a single hospital and, for some months, on a single ward.

17. Usefully, the RCPCH guidance sets out "alerting features" of possible FII which are not diagnostic, but which should, cumulatively, trigger a response from clinician:

"<u>In the child</u>

• Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context

• Unusual results of investigations (e.g. biochemical findings, unusual infective organisms)

• Inexplicably poor response to prescribed treatment

• Some characteristics of the child's illness may be physiologically impossible e.g. persistent negative fluid balance, large blood loss without drop in haemoglobin

• Unexplained impairment of child's daily life, including school attendance, aids, social isolation.

Parent behaviour

• Parents' insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child

• Parents' insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs

• Repeated reporting of new symptoms

• Repeated presentations to and attendance at medical settings including Emergency Departments

• Inappropriately seeking multiple medical opinions

• Providing reports by doctors from abroad which are in conflict with UK medical practice

• Child repeatedly not brought to some appointments, often due to cancellations

• Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches)

• Objection to communication between professionals

• Frequent vexatious complaints about professionals."

18. The RCPCH recommends responses if such alerting signs are present, which depend on the imminence and seriousness of harm to the child and whether a

consensus is reached of probable FII. If FII is not thought to be probable, but there are perplexing presentations, then a consensus needs to be reached by all clinicians involved in the child's care. This requires a multi-disciplinary meeting. Then, a meeting with the parents should be held and a plan made with them, and with the child where appropriate, for rehabilitation. Liaison with social services may be helpful at this stage to provide information about siblings or past concerns.

19. The National Institute for Health and Care Excellence (NICE) guidance on when to suspect or consider FII is taken from its guidelines on child abuse and neglect [NICE, 2017b] and child maltreatment: when to suspect maltreatment in under 18s [NICE, 2017a]. It reads,

> "Suspect fabricated or induced illness if the child's history, presentation, examination, or investigation does not match a recognized clinical picture, plus at least one of the following is present:
>
> Reported symptoms and signs only appear or reappear when the parent or carer is present and/or are only observed by the parent/carer.
>
> An inexplicably poor response to prescribed medication or other treatment.
>
> New symptoms are reported as soon as previous ones have resolved.
>
> A history of clinically unlikely events (for example, infants with a history of very large blood losses who do not become unwell or anaemic).
>
> Despite a definitive clinical opinion, further opinions from both primary and secondary care continue to be sought and disputed by the parent/carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms.
>
> The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.
>
> Note that inappropriate substances, including prescribed and unprescribed drugs, may be given to induce symptoms of illness. For more information, please see the section on physical abuse.
>
> Consider fabricated or induced illness if:
>
> The child's history, presentation, examination and investigation does not match a recognized clinical picture.

> There are repeated apparent life-threatening events where the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
>
> Note that fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition."

20. In considering the allegations made against the three mothers in this case, the court has to be alert to the range of behaviour that is covered by the term FII, to the possibility that a person may care for a child in a responsible way for months or even years and then began to fabricate or induce illness, and to the possibility of a person fabricating illness and then progressing to induce illness, of them doing both at the same time, or of them fluctuating between fabrication and induction, perhaps with periods of doing neither. A person who fabricates or induces illness in one child may not do it with their other children and may only do it for that one child in specific circumstances.

B: THE LEGAL FRAMEWORK

21. The judgments of Baker J in *A Local authority and (1) Mother (2) Father (3) L & M (Children, by their Children's Guardian)* [2013] EWHC 1569 (Fam) and Peter Jackson J in *Re BR (Proof of Fact)* [2015] EWFC 41 are of particular assistance in guiding the court's approach to a finding of fact hearing. More recently, MacDonald J summarised the principles to be applied in *Re A Local Authority v W and others* [2020] EWFC 68. I derive the following principles from those cases and the authorities that those judges reviewed:

    a. The burden of proof lies on the Local Authority that brings the proceedings and identifies the findings they invite the court to make. There is no obligation on a respondent to provide or prove an alternative explanation.

    b. The standard of proof is the balance of probabilities, *Re B* [2008] UKHL 35. If the standard is met, the fact is proved. If it is not met, the fact is not proved. As Lord Hoffman observed in *Re B*:

        > "If a legal rule requires facts to be proved, a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are nought and one."

    c. There is no burden on a parent to produce an alternative explanation and where an alternative explanation for an injury or course of conduct is offered, its rejection by the court does not establish the applicant's case.

d. The inherent probability or improbability of an event should be weighed when deciding whether, on balance, the event occurred but regard to inherent probabilities does not mean that where a serious allegation is in issue, the standard of proof required is higher.

e. Findings of fact must be based on evidence not suspicion or speculation - Lord Justice Munby in *Re A (A child) (Fact Finding Hearing: Speculation)* [2011] EWCA Civ 12.

f. The court must take into account all the evidence and consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss, President observed in *Re T* [2004] EWCA Civ 558, [2004] 2 FLR 838 at paragraph 33:

> "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to the other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion of whether the case put forward by the Local Authority has been made out to the appropriate standard of proof."

g. The opinions of medical experts need to be considered in the context of all the other evidence. In *A County Council v KD & L* [2005] EWHC 144 Fam at paragraphs 39 to 44, Mr Justice Charles observed:

> "It is important to remember that (1) the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."

h. Later in the same judgment, Mr Justice Charles added at paragraph 49:

> "In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof … The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with nonaccidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established."

i. The evidence of the parents and any other carers is of the utmost importance. They must have the fullest opportunity to take part in the hearing and the court must form a clear assessment of their credibility and reliability.

22. It is not uncommon for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for various reasons, such as shame, misplaced loyalty, panic, fear, distress and the fact that the witness has lied about some matters does not mean that he or she has lied about everything: see *R v Lucas* [1981] QB 720. In the recent Court of Appeal judgment in *A, B, and C (Children)* [2021] EWCA 451, Macur LJ advised at [57],

> "I venture to suggest that it would be good practice when the tribunal is invited to proceed on the basis, or itself determines, that such a direction is called for, to seek Counsel's submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt. The principles of the direction will remain the same, but they must be tailored to the facts and circumstances of the witness before the court."

Similar caution should be exercised in relation to a respondent giving unsatisfactory explanations or failing to give any explanation for the allegations made against them – the fact that they are unsatisfactory or missing may not be probative of the truth of the allegations or of the culpability of the respondent.

23. As observed by Dame Elizabeth Butler-Sloss President in *Re U, Re B* [2004] EWCA Civ 567 supra "The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research may throw a light into corners that are at present dark". In *Re R (Care Proceedings: Causation)* [2011] EWHC 1715 Fam Mr Justice Hedley, developed this point further at paragraph 19:

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

24. In *The Popi M, Rhesa Shipping Company SA v Edmunds* [1985] 1 WLR 948, Lord Brandon considered an appeal from the first instance judgment of Bingham J upon the question of whether a ship had been lost due to "perils of the sea", a matter which the owners had to establish. The owners contended that the vessel had been lost due to a collision with a submarine. The underwriters contended that the loss was due to wear and tear. In his well-known judgment Lord Brandon stated as follows,

“The passages which I have quoted from Bingham J.'s judgment amply support the observations about his approach to the case which I made earlier. These observations were to the effect that he regarded himself as compelled to make a choice between the shipowners' submarine theory on the one hand and underwriters' wear and tear theory on the other, and he failed to keep in mind that a third alternative, that the shipowners' had failed to discharge the burden of proof which lay on them, was open to him.

As regards the shipowners' submarine theory, Bingham J. stated in terms that he regarded it as extremely improbable, a view with which I think it unlikely that any of your Lordships will quarrel. As regards underwriters' wear and tear theory, … he regarded the wear and tear theory not as impossible, but as one in respect of which any mechanism by which it could have operated was in doubt.

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

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

The first reason is one which I have already sought to emphasise as being of great importance, namely, that the judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so.

There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.

The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated. That state of affairs does not exist in the present case …

> The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden.
>
> In my opinion Bingham J. adopted an erroneous approach to this case by regarding himself as compelled to choose between two theories, both of which he regarded as extremely improbable, or one of which he regarded as extremely improbable and the other of which he regarded as virtually impossible. He should have borne in mind, and considered carefully in his judgment, the third alternative which was open to him, namely, that the evidence left him in doubt as to the cause of the aperture in the ship's hull, and that, in these circumstances, the shipowners had failed to discharge the burden of proof which was on them."

25. *Re SB (Children)* [2009] EWCA Civ 1048 confirms that the test for identifying a perpetrator of harm to a child is the balance of probabilities "nothing more and nothing less". There are many potential advantages in identifying the perpetrator of non-accidental injuries but the court should not "strain to find a perpetrator" and sometimes the task is impossible, *Re D (Care proceedings: Preliminary hearing)* [2009] 2 FLR 668. In an appropriate case the court should identify the "pool" of potential perpetrators of significant harm applying the test of "real possibility" *North Yorkshire CC v SA* [2003] 2 FLR 849.

26. Witnesses at this hearing gave evidence in a large courtroom and were questioned by up to twelve Counsel as well as the Judge. Tailored warnings under s98 of the Children Act 1989 were given to the parents. Those warnings add to the pressure on the parents, in particular the mothers in this case who are facing possible criminal charges. Macur LJ in *Re M (Children)* [2013] EWCA Civ 1147 at [11] and [12], cautioned that,

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

I have heeded that warning. In *Lancashire County Council v M and F* [2014] EWHC 3 (Fam) Peter Jackson J made the following observations which are pertinent to the present cases,

> "To these matters I would only add that in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "*story-creep*" may occur without any necessary inference of bad faith."

27. As discussed earlier in this judgment, Munchausen Syndrome by Proxy is no longer the preferred term in the UK for the phenomenon alleged to have resulted in harm to the three children with whom I am primarily concerned. The term now used is Fabricated or Induced Illness. However, the warning given by Ryder J in *A County Council v A mother and others* [2005] EWHC 31 (Fam) at [175] to [178] applies to the present case,

> "The terms 'Munchausen Syndrome by Proxy' and 'Factitious (and Induced) Illness (by Proxy)' are child protection labels that are merely descriptions of a range of behaviours, not a paediatric, psychiatric or psychological disease that is identifiable. The terms do not relate to an organised or universally recognised body of knowledge or experience that has identified a medical disease (i.e. an illness or condition) and there are no internationally accepted medical criteria for the use of either label.
>
> In reality, the use of the label is intended to connote that in the individual case there are materials susceptible of analysis by paediatricians and of findings of fact by a court concerning fabrication, exaggeration, minimisation or omission in the reporting of symptoms and evidence of harm by act, omission or suggestion (induction). Where such facts exist the context and assessments can provide an insight into the degree of risk that a child may face and the court is likely to be assisted as to that aspect by psychiatric and/or psychological expert evidence.
>
> …

> In these circumstances, evidence as to the existence of MSBP or FII in any individual case is as likely to be evidence of mere propensity which would be inadmissible at the fact finding stage (see Re CB and JB supra). For my part, I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner I would caution against its use other than as a factual description of a series of incidents or behaviours that should then be accurately set out (and even then only in the hands of the paediatrician or psychiatrist/psychologist). I cannot emphasise too strongly that my conclusion cannot be used as a reason to re-open the many cases where facts have been found against a carer and the label MSBP or FII has been attached to that carer's behaviour. What I seek to caution against is the use of the label as a substitute for factual analysis and risk assessment."

28. In cases of alleged FII the court will often be tasked with considering whether the evidence establishes a pattern of behaviour on the part of the respondent parent demonstrating their character and propensity to harm their child. Must each individual element of that pattern be proved on the balance of probabilities? In *R v P (Children: Similar Fact Evidence)* [2020] EWCA Civ 1088 the court considered that the approach to similar fact evidence taken in *O'Brian v Chief Constable of South Wales Police* [2005] UKHL is applicable to civil (and family) cases.

> "Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established? That question was considered by the Supreme Court in the criminal case of *R v Mitchell* [2016] UKSC 55 [2017] AC 571, where it was said that the defendant, who was charged with murder by stabbing, had used knives on a number of other occasions, none of which had led to a conviction but which on the prosecution's case showed propensity. Lord Kerr addressed this issue in the following way:
>
> "Propensity - the correct question/what requires to be proved?
>
> 39. A distinction must be recognised between, on the one hand, proof of a propensity and, on the other, the individual underlying facts said to establish that a propensity exists. In a case where there are several incidents which are relied on by the prosecution to show a propensity on the part of the defendant, is it necessary to prove beyond reasonable doubt that each incident happened in precisely the way that it is alleged to have occurred? Must the facts of each individual incident be considered by the

jury in isolation from each other? In my view, the answer to both these questions is "No".

43. The proper issue for the jury on the question of propensity… is whether they are sure that the propensity has been proved. … That does not mean that in cases where there are several instances of misconduct, all tending to show a propensity, the jury has to be convinced of the truth and accuracy of all aspects of each of those. The jury is entitled to - and should - consider the evidence about propensity in the round. There are two interrelated reasons for this. First the improbability of a number of similar incidents alleged against a defendant being false is a consideration which should naturally inform a jury's deliberations on whether propensity has been proved. Secondly, obvious similarities in various incidents may constitute mutual corroboration of those incidents. Each incident may thus inform another. The question … is whether, overall, propensity has been proved.

44. … the jury should be directed that, if they are to take propensity into account, they should be sure that it has been proved. This does not require that each individual item of evidence said to show propensity must be proved beyond reasonable doubt. It means that all the material touching on the issue should be considered with a view to reaching a conclusion as to whether they are sure that the existence of a propensity has been established."

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

PART C: THE EVIDENCE

29. A blow by blow account of the evidence given at the hearing would overwhelm this judgment. I have had regard to all written and oral evidence but, for the purposes of economy and clarity, in this Part I shall set out, in a largely neutral way, the relevant evidence in relation to, first, the operation of SCH; second, each of the families, the treatment received by the children at SCH, and the events surrounding the mothers' arrests and their aftermath; and, third, the safeguarding and investigatory processes including the evidence gathered by the police. I shall then set out the expert evidence received.

C1: Sheffield Children's Hospital: personnel, procedures and practice

30. SCH is operated by the Trust. It is one of only three dedicated children's hospital trusts in the UK and provides integrated healthcare for children and young people, including community and mental health. It has an Emergency Department, a PICU and an HDU, as well as six wards: two medical, two surgical and two specialist. There are over 140 bed spaces. In addition, annually over 200,000 children are seen at outpatient appointments and around 55,000 in the Emergency Department. Some 3000 staff are employed at SCH. Along with the legal representatives, I visited wards J and K at SCH in December 2022 and have viewed a plan of ward J and photographs. Ward J is and was a 24 bed ward. Access is controlled: staff have passes which unlock the entrance door, others have to be "buzzed in" by a member of staff on the ward. There is no record kept of visitors and it is not uncommon for visitors to "tailgate" someone entering. Most patients on the ward are accommodated in cubicles which contain a bed, some furniture including a wardrobe, and an en-suite toilet. Each room has a bin for disposing of waste such as used dressings. Parents staying with their child on ward J may use a pull out bed in the cubicle. Those staying longer term may be allocated a bedroom in Treetops, a facility for parents or family members within the hospital estate. Access to the cubicles from the main corridor on the ward is via a door which can be fully closed. Each cubicle also has a window onto the corridor. A blind covers the window but it can be opened from both inside the cubicle and from the corridor. There is also a two-way drawer which can be accessed from inside or outside the cubicle. Files of observations, nursing notes, and clinical records are kept outside the patient's cubicle. In some cases a black safeguarding file may be opened which is kept separately in a locked drawer. As well as the cubicles there are four-bed bays which are open to the rest of the ward albeit curtains can be used to afford privacy. Other rooms on the ward include a playroom for children, a kitchen and sitting area for family members, a drug preparation room where medications are kept, some in locked cupboards, an office, and a sluice room. At the relevant time, the sluice room on ward J was left open – the door was propped open. Now, it has a keypad lock and is kept closed. The arrangements on ward K were very similar to those on ward J.

31. A large corps of nurses worked on ward J on a shift pattern – the day shift would begin at 7.00 am for a half hour handover. The night shift would similarly begin at 7.00 pm for a half hour handover. The ward manager or senior staff nurse would allocate the nurses on the shift to different patients. Many, but not all, of the nurses were trained in managing PN feeding. Only those trained could care for the lines, change the feeds and so on. Prescribed drugs were prepared in the drug preparation room. This was meant to be done by two nurses but demands on the nursing team meant that often one nurse would prepare the drugs but two were always present to cross-check the drugs against the prescriptions and the patient's name. Drugs could be given orally, via a PEG, PEJ or PEG-J, intravenously or by suppository. The sluice room was used for wet processes, such as weighing and disposing of soiled nappies or measuring fluid output. There was a mobile set of weighing scales on the ward.

32. There was a daily ward round on ward J but the system for the paediatric gastroenterology team was to have a weekly duty doctor. That would mean that a

consultant, say, would see a gastroenterology patient for a week but then not again for perhaps seven weeks. However, each gastroenterology patient had a lead gastroenterologist. Each Thursday there would be a gastroenterology MDT meeting. Other MDT meetings would take place as required. Other doctors such as paediatricians, surgeons, immunologists, infectious disease specialists, and pain management specialists would visit patients on the ward. In addition there would be speech and language therapists, physiotherapists, play specialists, nutritionists and dieticians, support workers, maintenance workers, porters, and cleaners coming on and off the ward.

33. In early April 2020, some vulnerable paediatric patients from other hospitals were transferred to SCH as a protective measure introduced as the Covid-19 pandemic began. BR was moved to SCH at that time for that reason, but HS and LW were already there. During the pandemic, the movement of visitors into and out of the hospital was tightly controlled. The Executive Medical Director, Dr SI gave evidence that,

> "The Covid-19 pandemic has continued to have a number of lasting impacts on the Trust and its operations, performance, finances, colleagues and patients …. The unquantifiable long-term consequences on paediatric waiting lists and the mental health of patients and their families has been significant.
>
> During the Covid-19 the Trust followed the guidance and mandates provided by the Department of Health including limiting the numbers of visitors a patient could have. Whilst adult hospitals introduced a no visitor policy, SCH put in place a single visitor policy for parents and carers alongside social distancing and later mask wearing."

Only one parent was permitted to be with a child in-patient. It was not open to two or more family members to stay with a child at the same time or in a shift pattern. As restrictions were lifted at various times, adult family members could adopt a shift pattern for staying with the child on the ward, but for long periods during the three lockdowns, this was not possible. Hence, in the three cases with which I am concerned, one parent – the mother in each case – spent week after week in the hospital with their child. When masks and protective equipment were worn the environment must have seemed even more alien to a child than in "normal" times. The restrictions on movement that were in place during the pandemic also affected the healthcare professionals at the hospital. As one nurse told me in her evidence, she saw much less of her own friends and family: her colleagues and the patients and parents on the ward became her family.

NG, PEG, PEJ, and PEG-J Feeding

34. Oral feeding is the consumption of food through the mouth. Feeding via an NGT involves the insertion of a tube through the nose and into the stomach. An NJT similarly goes through the nose but it ends in the jejunum. In this judgment I use the term enteral feeding to describe feeding through a PEG, PEJ or PEG-J. A stoma

is fashioned through which a tube is inserted which either delivers feed through the tube to the stomach (PEG) or the jejunum (PEJ). A PEG-J is a tube that passes into the stomach with a smaller tube within it that then passes into the jejunum. The jejunum is the middle part of the small bowel between the duodenum (which is connected to the stomach) and the ileum which is connected to the caecum of the large bowel. The PEG, PEJ, or PEG-J is often secured by means of a small balloon or flange filled with water which acts as an anchor for the tube within the stomach. Once PEGs, PEJs or PEG-Js are established a less obtrusive PEG button, sometimes referred to by a trademark name - Mic-key button – can be fixed in place. To administer drugs or small feeds a large syringe may be screwed onto the button and the contents administered. To administer larger quantities over time, a gravity set or pump may be used. The line should be flushed with sterile water or saline solution before and after the administration of drugs or feed. Diarolyte is a fluid that contains electrolytes to rehydrate a child. It can be administered via an NGT, PEG or PEG-J. Sometimes there may be a backflow of gastric contents into a PEG or PEG-J tube, but that is much less common from the jejunum. Tubes can be clamped to avoid this happening.

35. The evidence from many nurses at SCH was that MR would often be given a filled syringe for the administration of medication to BR enterally. BR preferred her mother to administer medication by this means because she did it very slowly, or she would do it herself. Due to the length of time it would take to administer medication in this way, nurses would often leave MR and BR alone to administer drugs enterally. Syringes were left with them for that purpose. The nurses regarded this as helpful and they would generally encourage parents to participate in the care of their children whilst they were in-patients.

Parenteral Nutrition

36. PN is a means of administering nutrition intravenously. This is sometimes called total parenteral nutrition (TPN) when the patient does not receive any nutrition by other means. A central venous catheter also known as a central line is inserted into a large vein. The evidence before me, most helpfully from Dr SAC, referred to four different lines: insertion into the internal jugular vein through the chest (a Broviac line); into a peripheral vein through the crook of the arm then through to a large vein (a PICC line); through the groin into the femoral vein (a femoral line); or into the subclavian vein through the neck (neck line). Neck lines tend to be used as a last resort and for a limited period. Broviac lines are designed to be used for long durations. A cuff will be placed around the line just under the skin. Tissue grows around the cuff and helps to anchor the line in place. Once inserted the line protrudes for some centimetres outside the body and a bung is inserted on its end. It may be clamped along its length between the skin and the bung when not in active use. The PN feed is contained in a bag to which a giving set will be attached. This includes a filter to ensure to that no sediment passes down the line, and often a Y-valve which allows the administration of iv fluid or iv antibiotics into the central line whilst PN feed is being administered. The giving set is attached to the bung by a simple twisting mechanism. The bung is a valve which, when the giving set is attached, allows the flow of fluid from the giving set into the central line. When the giving set is detached, it operates to seal the central line. Sometimes a

”lock” is put into the central line when the bung is closed. This involves inserting a small amount of either iv antibiotic or “taurolock” (which contains anticoagulant and antimicrobial substances) into the central line just beyond the bung as an additional precaution against infection.

37. The constituents of the PN feed for each child will be prescribed. The PN feed bags are prepared off the ward and then delivered to the ward for the nurses to attach to the central line. They seek to do so aseptically to ensure sterility of all the equipment and feed. At some point when all three children were at SCH, there was a change in the system for assembling the feeding line. Before the change, the PN bags would be “spiked” off the ward when the feed bag was prepared and attached to the giving set. This would be delivered to the ward for the nurses to attach to the bung. After the change, the sealed bag would be delivered to the ward for the nurses to spike and attach to the giving set. They would then attach the giving set to the central line via the bung. The precise date of this change of system is unclear. Once the PN feed has been attached to the line, a pump is switched on to deliver the feed. If a problem is detected with the flow then an alarm may sound.

38. Central lines were inserted in theatre. Sometimes, when insertion was anticipated to be particularly difficult, patients were sent to Hospital A for insertion. A “securacath” device was sometimes used to secure a line on insertion: one photograph of HS’s arm shows a small, bright orange, roughly triangular piece of plastic lying on top of the skin adjacent to a small, grey, kidney-shaped pad. The orange piece is a securacath. The line would be fed through the securacath before penetrating the skin and entering the vein. Inserted lines would be covered with a transparent thin, sterile dressing, and bandaging and/or thicker plaster dressings. Some nurses on both wards A and B had taken to wrapping parafilm – which has properties similar to clingfilm – around the bung or other connecting points, in an attempt to prevent children from meddling with the bung, for fear of them loosening it, or to prevent inadvertent contamination of the line.

39. Some children would be discharged home on PN. In preparation, their parents would receive training in delivering home PN. This involved a number of training sessions which the parent would have to complete to be signed off as competent in various operations they would need to undertake at home. Equipment and feed would be delivered to the child’s home by an agency sub-contracted by the Trust. Home PN would be delivered using a Bodyguard pump. A different pump was used when children were in-patients a SCH.

Key Healthcare Professionals

40. Dr SB was the Lead Consultant Gastroenterologist for BR until January 2021 when Dr SA, Consultant Paediatrician, took over as lead following the investigations at Hospital B. He was also the lead consultant, throughout, for HS. Dr SAN was the lead consultant gastroenterologist throughout for LW. Other members of the gastroenterology team included Dr SAM who was particularly involved in October 2021 when MS and MT were arrested but who acted then largely at the behest of Dr SAA, also a Consultant Gastroenterologist. Dr SAA

was a key decision-maker in October 2021, steering a course towards referral to the police and social services in the cases of HS and LW.

41. Dr SI was the Executive Medical Director at SCH. His role brings with it many onerous responsibilities. He is an anaesthetist by training. He said that the paediatric gastroenterology consultant team was led by a Professor who was a nationally known figure and whose influence set the tone within the team. The approach he encouraged in difficult or complex cases was to carry out exhaustive investigations to identify the underlying physical cause of the child's presentation. Dr SI and Ms SK, Executive Director of Nursing and Quality explained the process for incident reporting using a system called "Datix". Datix reports were considered at weekly patient safety panel meetings. Those meetings could lead to the escalation of concerns to local investigation, an RCA, or an SII. Certain levels of investigation have to be notified to the Care Quality Commission. In September 2020, Dr SI commissioned an RCA to be prepared by Nurse SZ, Lead Nurse for Haematology and Oncology, and an Advanced Nurse Practitioner to investigate incidents of line infection affecting BR and HS. The investigators were not asked to consider FII but rather to look at the nursing practices adopted for parenteral nutrition and central line management. They produced a first draft report in March 2021 (after MR's arrest). Dr SI suggested some changes to the report and a final report was agreed on 23 August 2021. Dr SI commissioned an SII on the missed opportunity to heed and act on a urine test for BR in August 2020 that had been positive for ibuprofen but had not been acted on, and a further SII from Dr Grayson, a Consultant Paediatrician at Newcastle's Great North Children's Hospital and Designated Doctor for Safeguarding Children, North East and North Cumbria. That SII was to consider how the Trust had dealt with what he called three children with FII.

42. The Designated Doctor for Safeguarding for Sheffield was Dr SAO. She is a consultant paediatrician. Her role was to provide safeguarding advice to providers of children's healthcare in the Sheffield area, including at the Trust, and to other agencies providing services to children such as the police and social care. Her involvement in the cases with which the court is concerned began in September 2020 at a meeting with Dr SB and also involved a large MDT meeting on 18 March 2021, after MR's arrest in February 2021, which took place via Microsoft Teams. That meeting was to discuss concerns about repeated iv line infections in the three children. The meeting was chaired by Dr SI. Dr SAO advocated the use of the latest RCPCH guidance on perplexing presentations and FII. She was on annual leave when the MS and MT were arrested.

43. I heard from the ward managers for wards J and K, who were Ms SAE and Nurse SAQ respectively, and a large number of nurses who worked on those wards and who had interactions with the three children and their mothers. It was evident that those responsible for delivering day to day nursing care did not always find it easy to follow consistent practice when the team of gastroenterology consultants worked on a rota that meant that a different consultant might visit the patients on a ward each week for a six or seven week period. The nurses would try to involve the mothers in the care of their children. In the case of MR this and her desire to be involved, led to her carrying out a number of tasks such as administering medication, weighing BR, and visiting the sluice room with stool-soiled items.

MR and BR developed particularly close relations with a small group of nurses. One of them, Nurse SAZ, allowed the lines between professional and personal relations with MR and BR to become blurred. She exchanged messages on Facebook with MR when BR was at Hospital B for example, commenting on what was happening at SCH in their absence. She accepted that this had been inappropriate.

44. Nurse SAX was the PN Clinical Nurse Specialist. She demonstrated the equipment used to the court and spoke to the training and oversight of nurses who managed central lines and delivered PN. I also heard from Nurse SZ, one of the authors of the RCA who had investigated the manner in which PN was delivered and lines were managed. She told me that she and her co-author had been satisfied that proper procedures were followed and that all personnel were properly trained. The evidence from the ward nurses supported that finding but did nevertheless reveal that practices varied and did not always meet the standards expected.

45. I heard evidence from senior clinicians at Hospital B where high level investigations were performed on BR in late 2020. I heard from therapists who worked at SCH, specialising in play, SALT, and physiotherapy. I heard from a number of community based healthcare professionals: health visitors, community nurses and others.

C2: The Three Families and Chronologies of Treatment

46. I have received a great deal of evidence in relation to each family and the treatment of the three children at the heart of this hearing. Based on all the evidence I have seen and heard, I shall give a brief portrait of each family including each mother. Thousands of pages of medical records exist in relation to each child. I shall not reproduce in this judgment the detailed chronologies placed before the court. Instead, I shall endeavour to provide a chronology of their treatment that focuses on what I regard as the key elements. I shall then describe the circumstances of the arrest of each mother and the aftermath of their arrest.

Family R

The Family

47. BR is one of three children of MR and FR. Her mother and father are conscientious parents who appear who have been in a long and apparently stable relationship which has survived the trauma of MR's arrest and the separation within the family caused, first, by BR's prolonged hospitalisation, and then by police bail conditions and interim orders within these proceedings. One of BR's siblings required a short period of hospital treatment after her birth but otherwise BR's siblings have enjoyed reasonably good health. AR is a particularly adept sportsman. BR was also very keen on sports and she and her sister were athletic and energetic, often doing cartwheels or walking on their hands. The family seems to have been a very loving, warm, closeknit family prior to BR's hospitalisation in 2019 and the

subsequent events. BR was a healthy and active child until she was nine years old when in June 2019 she began to suffer abdominal pain. Before long she was not eating and required enteral and, later, parenteral feeding. She was treated with strong analgesia including morphine. As a young in-patient BR became very knowledgeable and often very particular about her care and treatment. She grew distrustful of doctors because she felt she was "not being believed". She would refuse to communicate directly with many doctors but would whisper communications to MR who would then convey them to the clinicians. She preferred certain nurses over others, a group of nurses becoming known as the "fab five". She would know exactly the time when her next medication was due, and would expect it to be delivered on time. She was known to scream and to have tantrums when faced with changes in her treatment which she feared or disagreed with. Her mother would stay with her in her cubicle, very often with the blinds closed and the light inside dim. Her father would visit at weekends and her siblings when they were able to do so, subject to restrictions in place during the pandemic.

48. MR lived with her daughter at the hospital. She declined to use the Treetops facility at SCH, where parents could sleep separately, other than on a few occasions, and on the great majority of nights would sleep in her daughter's small cubicle, sometimes sharing her bed. The room, although kept clean and in an orderly state, was full of their belongings. All accounts are that MR was very quiet and passive with healthcare professionals. She was co-operative and rarely challenged them. She did have sessions with a psychologist at the hospital at which she would "unload" her feelings but otherwise she kept her feelings very largely to herself. In her police interview after her arrest she made it clear that she had found the experience of effectively living in the hospital and caring for GB, away from the rest of her family, understandably very difficult.

49. When she herself was a young person, and again as an adult in her early 20's, MR required periods of in-patient treatment for symptoms which were never fully medically explained. She suffered chronic pain in an upper limb. Screening for Lyme's disease was negative. She suffered fainting fits or "pseudo-seizures", the authenticity of which was questioned by clinicians and by her own family, as is clearly recorded in contemporaneous hospital records. She was also diagnosed as suffering an eating disorder. She has suffered chronic back pain for many years for which she takes pain relieving medication. Following spinal surgery her symptoms deteriorated and investigations revealed no physical cause. She was diagnosed with somatoform pain disorder. More details about her medical history are set out in a report from Professor Payne-James summarised in Part C4 below. From about November 2020 until her arrest she was on repeat prescriptions of tramadol, a strong pain-killer, and piroxicam, a strong NSAID said to be three times more powerful than ibuprofen. She also took laxatives in the form of senna. In addition she would purchase ibuprofen and dulcolax (a brand name for bisacodyl). I have to be cautious about the evidence concerning MR's own treatment many years ago – the authors of the medical records have not given evidence and have not been subject to cross-examination. However, the records and Professor Payne-James' report show that MR has a long history of unexplained symptoms, a diagnosis of somatisation, and mental health issues, and that there was concern about possible fabrication of her own signs and symptoms.

50. After MR was arrested and removed from the hospital, BR was distraught and in low mood for at least a fortnight. The nursing staff made a particular effort to spend time with her. BR said that only her mum understood her and could care for her properly. She was concerned that if her health improved her mother would be blamed for what had happened and for her health not having improved earlier when she was caring for her. Her father and maternal grandmother would come to the hospital to spend long periods of time with her. The family has remained close.

51. FR was very emotional when he started his evidence. He frankly told the court that he had had to contemplate the awful possibility that his wife had harmed their daughter but that he did not believe she was capable of doing so. BR's hospitalisation and MR's arrest had brought about significant changes in his life so that he was now much more closely connected with his children. He described himself as someone who tends to "Disneyfy" his family by which he meant that he can view family life as if it were a fairy tale. His wife, his children and his parents-in-law were all described by him as "absolutely amazing". His mother-in-law MGMR gave evidence. During lockdown CR chose to live with her and her husband rather than with FR and her brother. She is very close to her grandchildren. She told me that after MR's arrest she was looking through BR's cubicle at SCH, in BR's presence, in order to find clothes and other items to take home to MR. She found a strip of tablets in a blue washbag bearing the name of AR on a shelf in the toilet, and a "prescription bag" full of boxes that she assumed were medication, in the wardrobe. She did not discuss them with BR and did not report what she had found to staff on the ward or to the police. She simply took them home to be given to MR. Her understanding appears to be that BR may have Crohn's disease, i.e. that there is an underlying physical condition causing her continuing symptoms which is awaiting a confirmed diagnosis.

<u>BR: Chronology of Events</u>

52. *First nine years and initial illness*: BR was born in the autumn of 2009 at 36 weeks gestation. In her first few years of life she had recurrent colds and coughs and was prescribed an inhaler for asthma. When her sister, CR was young, she required a period of in-patient care for two to three weeks but she has had no significant illness since then. From when she was about four and until June 2019, BR was a very healthy girl, playing sports and enjoying a wide range of activities. On 12 June 2019 she was taken to her GP with a history of abdominal pain and reduced appetite, but no diarrhoea. She was referred to Hospital A for assessment but discharged home with open access. By 14 June 2019 her abdominal pain had moved from being central to the right side and the report was of foul smelling stool. The consensus is that BR had mesenteric adenitis. However, her symptoms did not improve as expected and she was re-admitted to hospital. At this time BR had been prescribed ibuprofen as medical records show. By 19 July 2019, on review by a paediatric gastroenterologist at Hospital A, the impression was of functional abdominal pain. Eating disorder was considered but excluded. BR went on holiday abroad with her family but she was not improving and was eating very little food. Her parents tried to encourage her to drink protein shakes that had been prescribed.

53. *Age nine*: *admission to Hospital A*: On 3 September 2019, after return from abroad, MR was admitted to Hospital A via A&E complaining of worsening abdominal

pain and vomiting for 48 hours. She reported knee and leg pain and that she was struggling to walk. In the first few days of admission diarrhoea and constant pain with intermittent bouts of sharp abdominal pain were noted. She remained an in-patient for just over one month. A C-difficile screen in hospital had been positive. She had continued loose and frequent stools, vomiting, diarrhoea, and abdominal pain. NG feeding was started. She was treated with antibiotics and Oramorph as required. Gastroenterology and psychology referrals were planned.

54. *Age nine years one month to nine years three months:* On 1 October 2019 BR's faecal calprotectin was over 600, which is significantly high and an indication of intestinal inflammation. She had not then been prescribed ibuprofen since 5 July 2019. BR underwent an endoscopy as an out-patient at Hospital A on 24 October 2019 which was reported as showing features in keeping with very early inflammatory bowel disease (IBD) more likely Crohn's disease. Biopsies were taken which provided insufficient evidence to diagnose IBD but the clinicians considered IBD, most likely Crohn's, as the most likely explanation of BR's presentation. On 2 December 2019, BR was re-admitted to Hospital A via A&E, her weight now at below the 0.4th centile and it being reported that she was not tolerating NG feeds.

55. *Age nine years three months to nine years six months*: *admission to Hospital A.* During this three month admission to Hospital A, there were concerns about large blotches of blood in BR's vomit. A PICC line was inserted and parenteral nutrition was begun. Investigations in theatre on 11 December 2019 showed no ulceration or disease and histopathological examination of biopsies did not confirm IBD. Clinicians felt that there was nevertheless an organic pathology albeit with functional overlay (meaning that there was a functional component to BR's presentation which could not be fully explained by any underlying pathology). On 12 January 2020 BR suffered a spike in temperature and PICC line and peripheral blood cultures grew gram negative bacilli. This was her first episode of sepsis. On 22 January 2020 blood culture grew yeast . Her pyrexia continued until 27 January but on 14 February 2020 her temperature spiked again and line infection was confirmed with gram negative bacilli isolated from the PICC line. Later, cultures from the PICC line also grew Enterococcus Gallinarium. On 5 March 2020 BR was transferred to SCH and on 10 March further endoscopic examination was performed and the presence of granulomata and deep ulcers were thought to be "highly suggestive" of Crohn's disease. She returned to Hospital A a few days later and a new PICC line was inserted for TPN. On 6 April 2020 BR was transferred to SCH as part of the arrangements for treating vulnerable, hospitalised children in the early stages of the Covid-19 pandemic.

56. *Nine years seven months to ten years five months*: *In-patient at SCH save for period at Hospital B for investigations*. On admission to SCH on 6 April 2020, BR remained on TPN which had begun in December 2019. She had had two significant episodes of line infection leading to sepsis. The presumptive underlying diagnosis was atypical Crohn's disease but the search for a confirmed diagnosis had been elusive. Functional overlay had also been considered. BR was admitted to ward J where she remained for her entire in-patient period at SCH.

a. On 22 April 2020, evidence of internal bleeding led to blood transfusion. A laparotomy on 24 April 2020 revealed no abnormal findings. Further endoscopic investigations showed inflammation in the duodenum and caecum, and ulcers in the stomach and duodenum which were later clipped. On 30 April, BR's PICC line was removed and a midline inserted. On 4 May 2020, Dr SC, Consultant Pain Specialist had a discussion with MR and BR about pain relief. BR was still using patient controlled analgesia (PCA) for morphine, ten days after the laparotomy, which she regarded as unusual. BR was very distressed at the proposal to move to oral medication. MR was upset also. On 6 May 2020, a new PICC line was inserted. On 11 May 2020, an episode of melaena (bloody stool) with 65 mls of dark red blood was recorded.

b. On 12 May 2020, an additional central line was inserted. On 13 May, tests showed polymicrobial infection of the central and peripheral lines. BR was noted still to be using PCA morphine "+++" on 14 May 2020. On 22 May, the PICC line was removed and replaced at Hospital A. On 27 May, psychologist Dr SE noted that when a nurse had spoken to BR about pain medications she had panicked at the suggestion of weaning off the PCA and changing to non-pharmacological pain relief.

c. Attempts to find an underlying diagnosis continued. BR underwent angiography at Hospital A but no features of vasculitis were found. No cause for the internal bleeding had been found. In early June 2020, BR was being weaned off medication for bleeding and for pain relief. Small volume enteral intake was being attempted. On 10 June peripheral blood cultures yielded growth of E-coli. PN was stopped on 15 June and the PICC line removed the following day. On 17 June, BR was transferred to the HDU with septic shock. Blood from her PICC line grew coagulase negative staphylococcus and candida lucitaniae. A temporary neck line was inserted on 24 June. This was taken out and a PICC line inserted on 30 June 2020. Over the period from 17 to 30 June 2020, multiple infective organisms were identified in blood samples including from BR's central lines.

d. On 9 July, back on ward J, an NJT was inserted under general anaesthetic but feeds via the tube had to be paused due to complaints of pain and abdominal distension. On 4 August, BR was noted to be tachycardic overnight and having required five doses of morphine in 24 hours. Her haemoglobin and platelets were low and a red cell transfusion was given. Culture from her central and peripheral lines both grew gram negative bacilli and later E Coli. The PICC line was removed and a Broviac line inserted in theatre. On 13 August 2020 Dr SB met with MR and FR. FR told Dr SB that he understood that the underlying diagnosis was atypical Crohn's disease. Dr SB told him that investigations had shown that this was "well under control." He explained, as noted in a subsequent letter,

> "we do not know why BR is getting these recurrent bouts of sepsis. It could either be an undefined or unidentified genetic condition … it could also be a dysmotile bowel which is resulting in BR getting bouts of sepsis, intermittent abdominal distension, and lack of tolerance of feed (feed induced pain)".

On the same day, a urine sample was taken that tested positive for ibuprofen as reported on 8 September 2020. This result was not noticed by the treating clinicians until the events of February 2021. Had it been then events would have taken a different, or at least an earlier, course.

e. BR continued to require PN and could not tolerate enteral feeding. On 30 September 2020, she was again transferred to the HDU because of deterioration and a blood culture grew candida albicans. She was returned to the ward on 2 October 2020. On 16 November 2020, BR was again admitted to the HDU and gram negative organism was isolated from the central line.

f. The clinical team at SCH began discussions with specialists at Hospital B in September 2020 which resulted in BR's transfer to Hospital B from 22 November to 5 December 2020. The purpose of the transfer was so that specialist investigations of BR's gut motility could be performed. Hospital B made it a condition of their investigations that morphine was stopped. All results were normal with no evidence of neuromuscular disease, or any genetic or metabolic abnormalities. The recommendation was to re-introduce enteral feeding. BR had no infections whilst at Hospital B but the day after her return to ward J at SCH she became tachycardic. Her PICC line was removed and microbiology reported gram negative bacilli grown in blood cultures from the PICC line, later reported as E coli. Ten days later a new PICC line was inserted and PN re-commenced. Blood cultures on 25 December 2020 grew E coli.

g. On 18 January 2021, an MDT was held to discuss handover from gastroenterology to paediatrics, with Dr SA to become the lead paediatrician. Her plan was to re-introduce enteral feeding so that PN could cease and the central line could be taken out, thus removing the source of BR's recurrent infections. On putting this plan into action, it was noted on 31 January 2021 that BR had loose stools and vomiting. The enteral feed was stopped and replaced with diarolyte via a PEG-J. On 2 February 2021 it was recorded that BR had vomited bright red blood and had loose stools. She was complaining of pain all over her abdomen. On review on 5 February it was recorded that BR had been vomiting blood two to three days and her haemoglobin had dropped. She was on morphine. On 10 February 2021, BR was taken to theatre and endoscopy with biopsies revealed multiple ulcers in her stomach. A Broviac line was inserted. A suggestion was made by an adult specialist to do a urinary test for NSAIDs. The first sample was taken on 2 February but was lost in the system. A second sample was taken on 11 February 2021 and the report, which was positive for ibuprofen, reported to Dr SA on 24 February 2021. SA made a diagnosis of induced illness by ibuprofen poisoning. She regarded this as a "unifying diagnosis" for BR's perplexing presentations. Referral was made to social services and the police and MR was arrested on 25 February 2021.

MR's Arrest and Aftermath

57. MR was arrested at 6.07 pm on 25 February 2021. This followed referral by clinicians at SCH to the police and social services following the report of the urine test of BR showing that she had ingested ibuprofen which she had not been prescribed. Dr SA's firm view was that this result explained why BR had suffered internal bleeding and provided a "unifying" diagnosis. In fact, it did not of itself explain the series of line infections BR had suffered. However, MR was removed from the hospital and conditions were imposed on her preventing any contact with BR (later eased to allow some contact). DC Kirby, DC Johnson and PC Bazley of South Yorkshire Police attended SCH and conducted searches of the room in Treetops used by MR, and of the cubicle on ward J occupied by BR. The officers gave imprecise oral evidence to the court about their searches. They had known that the allegation against MR was that she had poisoned BR but had not ascertained what drugs she had been prescribed and what unprescribed drugs they were looking for. DC Kirby's statement referred to some five exhibits of items retained from the searches. He found a packet of 96 pink ibuprofen tablets on the shelves within the toilet in BR's cubicle. He described some empty tablet strips taken from the cubicle when in fact the exhibit bag showed that they were taken from Treetops. He described one exhibit as being two syringes whereas the exhibit bag contained one syringe only. There were no photographs taken of the search. He searched the toilet within the cubicle and recovered a single, green and yellow Tramadol tablet from a blue washbag. He left the washbag on the shelf where he had found it. He said that it then contained general hygiene items which he could not recall, but he was sure he had removed any pills or drugs. DC Johnson, now Mr Johnson, who undertook a search of the bedroom area of the cubicle could not recall if he looked in the wardrobe. PC Bazley, now a DC, said that he believes he searched inside furniture, but there was no record of what he had searched, and he had no memory of whether he searched the wardrobe by removing clothing and other items but said he would have done so.

58. One item found by DC Kirby was a pill crusher located in the front pocket of a case within the bedroom area of the cubicle. About an hour before the search of the cubicle was conducted, MR told police that there was a pill crusher in the front pocket of the case. She also told them that there were packets of ibuprofen on the shelves in the toilet. There is clear evidence that BR and MR knew that a sample of urine was being taken from BR on 2 February to test for ibuprofen – they were mistakenly given that information by a registrar. That sample went missing but another sample was taken on 11 February 2021. Therefore, both had known for over three weeks prior to MR's arrest that a result for a urine test for ibuprofen was awaited. None of the drugs seized by the police were hidden. The large packet of ibuprofen was on an open shelf in the toilet within the cubicle on ward J.

59. BR remained in her cubicle on ward J. Her mother was excluded from the ward. Her father and other members of her family visited. The police searches I have referred to led to the seizure of a box of ibuprofen tablets, dulcolax in a bag addressed to BR, an external feeding syringe, 3 empty blister packs of Tramadol, two syringes with purple screw thread nozzles, and a pill crusher. The crusher was found on later analysis to contain traces of bisacodyl and ibuprofen. The following day, Nurse SAI removed the feeding tube from BR's PEG-J and stored it before it

was handed over to the police on 3 March 2021. On forensic analysis performed a few months later, the residue in the tube was found to be positive for ibuprofen, bisacodyl and piroxicam, none of which had been prescribed to BR, as well as other prescribed drugs. The family say that BR consumed mashed potato on two occasions prior to MR's arrest but this is not corroborated in the nursing records. After MR's arrest, BR began to accept enteral and then oral feeding. She was recorded as having eaten soup and potato on 1 March 2021. She became gradually more active. She was eventually discharged home into the care of her father on 27 April 2021. However, notwithstanding further searches of her cubicle and then, after her transfer to an open bay on 2 April, her bed area on that bay, together with tight restrictions imposed on the food brought in by her family members, BR's urine tests continued to be positive for ibuprofen on 5 and 27 March, and 2, 14, 16 and 22 April. On 22 March 2021, BR told her children's guardian that she had taken some of her mother's tablets once at Hospital A and once at SCH. She said she had swallowed them. The following day, BR told a police officer that she had taken some medication from her mother's bag about five times at SCH and a few times in Leeds.

60. In her police interview on 8 April 2021, MGMS told the police that on 8 or 9 March 2021 she had noticed the blue washbag in the toilet of BR's cubicle. She said that it had BR's brother's name on the outside of the washbag. She looked inside it and it had drugs in it. She could not identify them and did not notice their colour. She removed them to take them home because she knew they were not for BR. In a later statement dated 29 July 2021, MGMS added that at the same time she also found a paper bag, which looked like a prescription bag, containing boxes of what she presumed to be pills or tablets, in the wardrobe within BR's cubicle on ward J. She removed that and took that away also. If the police search was thorough and all unprescribed drugs were removed from BR's cubicle, then either MGMS is lying about having found the items she says she found in the washbag and the wardrobe, which contained drugs, or those items were brought to the cubicle after the police search on 25 February 2021.

61. BR continued to provide urine samples that tested positive for ibuprofen for nearly two months after her mother's arrest, until after 22 April 2021. The police had carried out an initial search of BR's cubicle. Further searches were carried out by hospital staff. On 2 April 2021 MR was moved to an open bay – usually a four bed bay but occupied only by her until her discharge. On that day a thorough search was performed of her cubicle. Nothing was found. Concerns were raised that ibuprofen may have been mixed in home-cooked food brought in by MGMS for BR to consume. However, steps were taken from mid April 2021 to prevent home-cooked food from being given to BR and still her urine tests were positive for ibuprofen for some time thereafter. Another concern was that ibuprofen might be hidden in clean clothing sent in for BR. BR did have contact with FR, her sister, and her maternal grandparents. Family members other than MR could have covertly given ibuprofen to BR on their visits. However, I have heard evidence from FR and MGMR and find no evidence of them or any other family member having done so.

62. Immediately after her mother's arrest, BR was inconsolable. Her mother had been her almost constant companion for over twelve months whilst she had been an in-

patient, first at Hospital A and then at SCH, whilst she was separated from the rest of her family. She had been very ill and had become reliant on her mother emotionally and physically. Suddenly her mother was gone. She was already distrustful of the medical personnel at SCH, although fond of some of the nursing staff. She was a young and vulnerable girl. The nursing staff made an effort to spend more time with BR. Her father would also spend a lot of time with her. She was visited by her siblings and grandparents. Gradually, her mood improved and she became more active. She began to eat and her condition improved. Prior to MR's arrest, BR had already embarked on the process of enteral feeding with a view to dispensing with her IV line for PN, but it is clear that BR's willingness to take food orally increased after her mother's arrest and removal from SCH. Dr SA decided that she should delay BR's discharge until she was no longer testing positive for ibuprofen and had dispensed with her PEG. Initially, the plan had been for discharge home to the care of her father but he later suggested that BR would benefit from the two to one care her maternal grandparents could provide. On 27 April 2021, BR was discharged into their care. Later she returned home under the care of her father. She has not required PN or PEG or PEJ feeding since then and has not had any bloodstream infections. She attends school. She has continued to complain of abdominal pain and she and her parents and grandmother appear still to believe that there is an underlying condition that has yet to be diagnosed. She remains under the care of Dr AC, Consultant Paediatrician at Hospital A who gave evidence to the court that he has advised the family that BR does not have Crohn's Disease. He believes there is a functional element to her pain, but that it is important to accept that her pain is real to BR even though there is no identified pathological cause of it.

Family S

The Family

63. HS is the youngest of four siblings and one half-sibling. His mother and father were in a long and apparently stable relationship until they separated in late 2021. I am not aware of any child protection concerns regarding his siblings until HS's mother's arrest in October 2021. One of HS's sisters, GS, was born prematurely at 30 weeks gestation and suffered feeding problems which began when she was about 8 months old. She required in-patient treatment at Hospital C for about ten weeks and had an NGT for several months. She then improved and is a healthy child. FS was diagnosed with Crohn's Disease in childhood and has required medication throughout his life. However, he has only very rarely required hospital treatment, one occasion being in 2021 when he had a flare-up. He has worked all his life and was on a demanding shift pattern until the first lockdown in the Covid-19 pandemic in 2020. Due to his condition he had to shield. That first lockdown followed shortly after HS was admitted to SCH in March 2020, after which MS stayed with HS in hospital whilst FS stayed at home looking after the other children. When restrictions were lifted to allow him to return to work the paternal and maternal grandmothers helped him to care for the children who were at home. MS would visit the other children at home when she could, and would stay at home for two nights at a time. She did not drive and the journey to and from the hospital was costly and difficult, but she did it when she could.

64. MS was described by many witnesses, and by herself and FS, as shy. She does not enjoy being the centre of attention. She kept notes for herself towards the end of her time at SCH so that she could explain her thoughts when she met healthcare professionals. She described to the court the difficult life she led whilst staying with and caring for HS at SCH. She would live in the cubicle with him until a room became available for her at Treetops in early 2021. The food shops in the hospital were closed during lockdown. She ate take-away food and the cost, together with the costs for MS travelling to and from home, some distance from SCH, put a strain on the family finances. She got into debt. She has been described by many witnesses as a caring and loving mother who, before her arrest, was considered to act appropriately in the community and in the hospital, providing proper care for HS and interacting well with healthcare professionals. MS is a smoker. About ten times a day she would leave the hospital building for a smoke. She also had to leave HS when she went to buy food and to eat. She would sometimes go for a run in the morning when he was still asleep. When in the cubicle with HS she tended to leave the door open. She became friendly with some of the other parents of children on the ward, and she did strike up a friendship with MT. They would meet up for a cigarette or share a meal together. Their sons were of a similar age and suffering similar symptoms on the same ward. It is natural that MS and MT should form a bond in those circumstances. FS had previously contributed to childcare and household chores when not working but from March 2020 he had full responsibility for the children at home whilst MS and HS were at SCH. Like MS, he does not drive. Fortunately, the extended family was and remains very supportive, and they live close by. The strains on him and MS led to their relationship becoming more fractious and, eventually, to its breakdown. After her arrest MS jumped into a river which was deep and with a strong current. She meant to end her life but something caused her to climb out and she survived. She has not been permitted to live with her children. HS has returned home to live with his father and siblings, except for his step-sister who lives elsewhere but who has a close bond with HS and the rest of the family, often visiting them. MS does see HS under supervision three times a week. She sees the rest of her children daily. She lives with her mother just across the road from the family home. She and FS are on good terms. They could not live together with the children because of bail conditions and court orders, but in fact they do remain separated as a couple.

65. When giving evidence MS was quiet and rather flat in her demeanour, perhaps depressed. However, in general she answered questions directly albeit her memory for details from up to three to four years ago was understandably patchy. She has had countless encounters with medical and nursing professionals, encounters which I suspect she has always found a little difficult, and it was unsurprising to me that she could not always remember what was said, or what symptoms HS was suffering on particular occasions in 2019 to 2021. She consistently and determinedly denied any suggestion that she had exaggerated or misreported HS's symptoms to clinicians or that she had induced illness in him either by giving him some substance to cause him diarrhoea or vomiting and not to accept oral or enteral feeds, or by introducing faecal bacteria into his iv lines. I do not under-estimate the strain placed on MS by having to give evidence over the course of three days. She was robustly but fairly questioned by Ms Lee KC for ERYC. Whilst some of her responses raised questions about her credibility, as I shall address later in this judgment, in general she responded as might be expective from the perspective of

a parent who was as perplexed as the clinicians were about her son's presentation. She remained courteous and never lost her temper during her evidence but she gave a strong impression of being burdened by a sense of great injustice.

66. HS was described by one Nurse who cared for him as an unhappy young boy, which is unsurprising given what he went through during prolonged hospitalisation at SCH. However, when he was well, he enjoyed playing, including with LW when he was also on ward J with him. Many of the witnesses who had dealings with HS suggested that he had a mischievous streak. In particular he would know that he ought not to play with his lines and would wait for someone's back to be turned before doing so. His father said that if there was something HS should not do, he would do it. HS preferred to have the lights on and his cubicle door open. HS would spend hours at a time in his cot watching and playing on a children's ipad. He became very used to nurses entering his room and giving him medication and PN feeds. He loved to play with medical equipment such as syringes, thermometers, and blood pressure cuffs. At his insistence he spent one week wearing plastic hospital gloves. However, the most striking aspect of his behaviour was his interest in his PEG, PEJ and central lines. He was renowned for fiddling with them and for chewing the parafilm that was wrapped around parts of his central line, including over the bung, and chewing the equipment itself. I shall return to this aspect of his behaviour later in this judgment. From March 2021, when HS was moved to Ward K and 1:1 observations were instigated, MS did begin to voice her objections to being deprived of time alone with HS who was very ill such that he might not survive. This was not considered as anything but expected behaviour from her at the time.

HS: Chronology

67. *First six months, September 2018 to March 2019*. HS was born at Hospital D at 28 $^{+1}$ weeks but in good condition, with Apgar scores of 9 at 1 minute and 9 at 5 minutes. He weighed 1295 g. A cranial ultrasound scan was abnormal, revealing a cerebro-spinal fluid space adjacent to the cerebellum. He was transferred to the neonatal unit at Hospital C. His mother visited but was not resident. Within his first month of life he developed tachycardia and suffered desaturations. Antibiotics were commenced but blood samples did not reveal any infection. He needed a blood transfusion due to low haemoglobin on 26 October 2018. At about eight weeks he was bottle feeding on demand and his weight was 2.58 kg (25^{th} to 50^{th} centile) but he still suffered desaturations and tachycardia. He was discharged home at about nine weeks of age. On a home visit he was observed feeding but was noted to be vomiting after feeds. MS took HS to the GP on 6 December 2018 and the GP sent him to hospital by ambulance due to reduced feeding and possible sepsis, but he was discharged home the following day. On 14 January, at the paediatric clinic his weight was noted to be at the 2^{nd} to 9^{th} centile and it was reported that he was vomiting after feeds. He was on ranitidine. On 22 February, his weight was below the 0.4^{th} centile. He was reported still to be vomiting after feeds. Such was the concern about his weight loss that on 25 March 2019, at six months of age, he was admitted to Hospital C for an NGT to be fitted for feeds.

68. *Six months to eighteen months, March 2019 to March 2020*. HS was noted to have pulled his NGT out twice as an in-patient at Hospital C, and then again after

discharge home on 8 April 2019. In May 2019 it was noted that he was gaining weight but later that month it fell again. The mother is recorded as reporting two stools in two days to the health visitor on 23 May but then constipation - no bowel opening for four days - to the GP the following day. On 13 June 2019, HS was admitted to SCH for the insertion of a PEG, being discharged home a few days later. He had a short in-patient admission to SCH in July 2019 when his weight was not increasing as hoped and he had constipation. Two episodes of broken connectors (on the PEG) were noted. He was discharged home on 19 July but re-admitted on 13 August 2019 where he was treated as an in-patient for six weeks. During that period, a swab from his PEG grew coliform bacillus and group A streptococcus and candida. He was prescribed ibuprofen on 19 August. He was recorded to be vomiting and having loose stools. He remained on enteral feed through a PEG. He was then monitored as an out-patient whilst being cared for by MS at home until 15 March 2020. On 8 December 2019, it was noted that he would not take pureed food on a spoon but enjoyed finger foods. He was receiving milk feeds through his PEG. MS reported that he was still vomiting frequently. In January 2020, he swallowed a 5 pence coin as confirmed by x-ray. MS reported a split in his PEG tube in early March 2020 and he was admitted to Hospital C for insertion of an NGT. He remained at Hospital C until he was transferred to SCH on 18 March 2020. Whilst at Hospital C there were multiple occasions when HS vomited out or pulled out his NGT and it had to be replaced, sometimes with great difficulty. He had episodes of vomiting and diarrhoea. He also developed chicken pox.

69. *Eighteen months to two years six months, March 2020 to March 2021*. HS remained an in-patient on ward J at SCH throughout this period save for a period of about four weeks in November to December 2020 when he was cared for on ward L.

    a. The purpose of his transfer to SCH was to fit a new PEG. A PEG with a mic-key button was fitted on 19 March 2021. Over the subsequent week or so there are frequent records of him vomiting whilst receiving feed and diarolyte, but vomiting ceasing on those being stopped. He then developed more persistent diarrhoea. IV fluids were begun. On 30 March 2020 it was recorded that HS had pulled his cannula out and it had to be re-inserted. Vomiting episodes continued. He pulled his cannula out again on 1 April according to the records. His PEG was converted to a PEG-jejunostomy on 6 April. There are nursing notes recording that HS was "clearly in pain" when enteral feeding was ongoing and on 8 April PN was started via a PICC line that had been inserted.

    b. At a gastroenterology MDT on 16 April 2020 it was noted the plan was for TPN for four weeks. There was no overarching diagnosis but HS had repeatedly shown no tolerance of feed and worsening growth parameters. DNA samples were to be sent for exome sequencing. On 29 April it was recorded that HS's PICC line had been found "pulled out", although in another note "fell out", and was re-inserted in theatre. However, on 3 May 2020, the PICC line was removed after swelling had been noted. . A new PICC line was inserted on 6 May and TPN recommenced. On 11 May, it was reported that all genetic testing was normal but the testing performed could

not exclude the possibility of a disorder inherited from a "mildly affected mosaic or non-penetrant heterozygous parent."

c. On 14 May 2020, Dr SB, lead gastroenterologist for HS, was noted to be at his "wits' end" as to the underlying cause of HS's problems. On 21 May 2020 it was recorded in the nursing notes that HS "pulled his PICC line out." He was given fluids through the cannula in his foot. The following day a Broviac line was inserted. Four days later HS was noted to have a raised temperature, heart rate and respiratory rate and blood cultures from the Broviac line yielded staphylococcus aureus. This is his first line infection.

d. From the end of May 2020 to the end of March 2021, HS had a stormy experience on ward J at SCH. There were repeated instances of his line becoming disconnected, "snapped", chewed, and fiddled with. HS was noted to have pulled out his PEG button numerous times also. There were numerous line infections and bloodstream infections requiring antibiotic treatment. Lines had to be removed and new lines inserted. From September 2020 insertion of new lines was performed at Hospital A. Various strategies were adopted to prevent damage to the intravenous lines: parafilm was wrapped around the line, elastoplast was wrapped over the parafilm, lines were tucked under the mattress, a line cover was purchased to wrap around the line.

70. *From two years six months to three years, March 2021 to November 2021*. On 18 March 2021, HS's case was discussed at a high level safeguarding MDT (see below) and a set of actions agreed which included moving HS off ward J. He was moved to ward K on 19 March 2021 and placed under 1:1 observation.

a. On 20 March, he was noted to be playing with his lines and on 25 March his PEG was noted to be deflated on the bed at his side. This was in the early hours of the morning and a note later that morning at 10.00 records, "Mum also informed when she arrived onto the ward". Hence, this incident occurred without her being present. It was then planned to ensure that when MS was not present, a member of staff would be with HS. On 28 March, it was recorded that on a support worker coming onto night shift, she, "found line disconnected and parafilm had a clean break to it and broviac disconnected from PN extension." Again, later notes show that MS was not present because she was kept informed by telephone. On 29 March, three minutes after PN had been set up the nurse "checked lines together and noticed a break in the line under the parafilm, beneath the filter connection no longer intact …. Explained to Mum what had happened." On 2 April, HS had a spike in temperature and blood cultures grew multiple bacteria including E-coli. At the subsequent MDT on 6 April 2021 it was recorded, "Multiple line disconnections last week – likely causing infection."

b. On 14 April 2021 MS called staff into the cubicle to alert them to some blood in HS's bed. On inspection a small spilt was present on a line. On 22 April, a nurse recorded,

> "HS had a large loose bowel movement this morning. Unable to weigh because it was also on the sheets. Cleaned it up, but he does appear to still have some on

> the line. Checked with the nurse in charge and she is happy that there is a good seal between the line and the bung and therefore shouldn't be contaminated." MS was present at the time.

Later that day the nurse recorded that MS was teary and emotional, saying that "she feels like they will still be in the same position in 3 years time. Asked her what she would like and she said that she wants to go home with HS."

Although the microbiology MDT on 27 April noted that the latest blood culture had grown CNS, it appears that HS did not suffer any sepsis – his temperature remained stable and he remained well, according to the nursing notes.

c. On 11 May 2021, HS had a temperature spike. This did not follow any line break or disconnection, nor any other incident of note save that on 10 May it was recorded that two doses of IV antibiotics had been missed. MS had been in Treetops overnight but was probably on the ward during the day. She was noted to be upset because HS had spiked a temperature. Blood cultures grew CNS (as had the last blood culture). Two days later HS was taken to the PICU for femoral line insertion. On 18 May Dr AB emailed colleagues saying,

> "Inspite of the 1-2-1 nursing this child continued to have unusual recurrent septicaemia and I had no further explanation for these and by "elimination" put it down to likely intestinal translocation or extension sets that were not right. The episodes have continued inspite of some of these remedial measures… [following discussions with specialists at another hospital] They report they have NEVER seen such a high number of CVC infections/line changes due to "intrinsic infection" … Top of their recommendation is to continue to consider FII as the main differential diagnosis and although mum may not be the cause of extrinsic FII, they have stated that non family members OR line managing staff OR PN sets OR giving sets etc etc etc could still be the cause of extrinsic sepsis.
>
> …their MDT has now recommended that we move HS out of this hospital … [and ensure there is a period of "three weeks [where] there is no parental presence either."

That plan was not adopted.

d. On 28 May, staff noticed that MS had submerged the TPN line when bathing HS and she was advised not to do that. On 2 June, a nurse noted that the TPN line had been unclamped for 90 minutes when it ought to have been clamped. On 14 June at an MDT, MS questioned why 1:1 observations were continuing and asked if she was being suspected. It was decided to allow MS time alone with HS. On each of 16 June, 28 June, 2 August and 17 September 2021, after

MS had taken HS out of the ward for fresh air, on return there was a problem with a line, with HS vomiting, or similar problems. The incident on 17 September has been the focus of evidence during the hearing. On returning from an outing MS asked the nurse to check the line which she thought was leaking near to the bung. It was found to have a crack in it. The nurse had expressed some concern that the crack was so difficult to find that it was surprising that the mother had known about it. The following day HS had a spike in temperature and blood from his PICC line grew Enterobacter cloacae and E coli, and later another bacteria. On 24 September, some nail clippers were found under HS's blanket.

e. HS suffered further line infections in September and October 2021 and Dr SB proposed a highly unusual course, which was to feed HS enterally under sedation. Some healthcare professionals questioned this plan as did MS. But, ultimately she agreed to it.

MS's Arrest and Aftermath

71. MS was arrested on 19 October 2021 after referral by Dr SAA to the police and social services. The immediate trigger for that referral was an event that day when Nurse SX found HS lying in his cot with his central line completely pulled out and lying by his feet. The context was that,

    a. On 7 October at a meeting that included Dr SV, Palliative Medicine Consultant, Dr SB had informed MS that HS's life was in danger. He was receiving fluids only, not PN, and if he lost another line it would be difficult to insert another central line. He asked MS to leave the hospital for a period of a few weeks. MS refused to leave her son whom she had just been advised might be close to death.

    b. A few days later Dr SB was so concerned about HS's precarious position and the impact of recurrent line infections on the viability of finding another line to deliver nutrition, that he had proposed a trial of enteral feeding under sedation. This would be performed in the HDU. This proposal was highly unusual and not everyone within the team agreed with it. However, MS did give her consent on 12 October 2021. A lack of bed space in the HDU prevented HS undergoing this trial for several days. On 18 October it was thought there was a space at the HDU but that space was then taken by another patient.

    c. On 19 October, it was expected that HS would be moved to the HDU but Nurse SP took the decision not to inform MS until the space was confirmed. Nurse SX saw MS holding HS on her lap. According to Dr SAA, HS was by now in a very poorly condition, thin and weak. He was not the lively child he could be when less poorly. That evidence is disputed. MS and FS say that HS was closer to his usual self than Dr SAA describes. At some point MS placed HS in his cot. Nurse SX entered the room when alerted by an alarm on the pump to the fact that the fluid bag had emptied. HS was in the cot with his blanket. She did not notice whether the line was in place at that time. She went

to fetch fluid with which to flush the line. She re-entered the room and went to clamp the line, the clamp being close to his arm. As she did so she noted that the line had come out completely and was lying by HS's feet "tangled in the blanket". HS had a favourite blanket which was large and had fluffy balls sewn onto its edge. She asked MS what had happened and she replied that she did not know and had not even noticed that the line had come out until Nurse SX had discovered it. HS was unperturbed. The contemporaneous notes record that MS said that the line might have been caught underneath him when she had transferred him to the cot. I am satisfied, having heard her evidence and read the notes, that this was just speculation by her, not a suggestion that she knew this is what had probably occurred. Nurse SX told me that she did not recall any damp patch on the bedding which might have been expected if the line had become detached whilst the fluid was running.

d. Dr SAA told me that he recalled the morning ward round before this discovery and that he had checked the security of the line noting that it had a transparent dressing and, over that, a pink elastoplast dressing covering the point where it entered HS's arm. He felt it was as secure as it could be. He did not know whether there was a stitch in situ securing the line in place. In fact the operation note for the insertion of this line does not refer to a suture, but a Securacath was used – a plastic device that lies on the skin and clamps the line in place. Adjacent to that was a biopatch – a grey, kidney-shaped pad that contains antibiotic. There is no evidence that the dressings or biopatch had been changed since the insertion of the line on 28 September 2021, three weeks earlier. Dr SAA was informed that the line had become detached when only the mother was present and he consulted with the Medical Director. Dr SAA's view was that it was highly suspicious that the mother had been present when a secured line had come out but that she had not noticed. It was decided to make a referral to social services and the police. MS was then arrested and removed from the hospital. She was prevented from returning and seeing HS.

72. On the day after MS's arrest, on Dr SAA's instructions, a feeding plan was begun. HS received diarolyte and feed via his PEG for the first time in many weeks. Feeds were increased over time. On 26 October, his central line was removed. By 27 October he was eating chips in small pieces. His father was allowed to visit and to encourage feeding. HS was noted to have some vomiting and soft stools but enteral feeding continued and oral feeding was encouraged. On 11 November 2021, HS was transferred to Hospital C. His father visited him daily there. PEG feeding continued. On 1 December 2021, HS was discharged into his father's care. He was still PEG feeding but eating food normally, albeit with some fussiness about what he ate. A day after going home he was reported as having pulled out his PEG button. However he continued to thrive and to put on weight. He has made a remarkable recovery. He feeds orally but remains very selective about what he will eat – he mostly eats beige food – biscuits, chips, and toast. He eats chocolate. The only fruit or vegetable he now eats is banana. His language skills are delayed and he will hold his father's hand and lead him to the fridge and point to what he wants, mumbling the word, rather than verbalising a request. It is clear from the evidence that the S family are close knit. The oldest child (now an adult) was expecting her own child during the closing stages of the proceedings. The siblings

are all close to each other and HS is living within a loving family unit. FS has given up work to be the sole carer for the children at home whilst MS is prevented from living with them. He would like the family to be reunited and maintained that position when I asked whether he had any reservations about MS being able to care for HS alone, without him being present – he trusts MS completely.

Family T

The Family

73. LW is the youngest of four siblings, all of whom have different fathers from him (two having the same father as each other). He shares a surname with his own father, FW, who has had little contact with him since his birth although FW has at times briefly visited or stayed in the same household when LW has been at home. FW has been represented in these proceedings and gave oral evidence. NT, MT's eldest daughter, now an adult, also gave evidence. She, like one of her younger sisters, HT, now has a baby of her own and lives independently. JV and KV have been placed with AC, who is FW's sister and a close friend of HS, and her partner BC. LW is in foster care. MT is prohibited from living with any of her children and has supervised contact with them. From the moment of her arrest, her contact with her children was strictly controlled and the family was split apart.

74. LW was born very prematurely and had a stormy neonatal course before being discharged home into the care of his mother. From his birth until his mother's arrest he lived under constant medical and nursing care, even when being cared for in the community. For most of the time when he was an in-patient at SCH he was very unwell and so there was little opportunity for him to reveal his character. However, he appears to have enjoyed playing with HS at times and their mothers formed a good relationship whilst their children, of similar ages and going through very similar experiences, were on the ward together. LW liked to have the door to his cubicle open and his mother was regarded by most of the healthcare professionals as caring and loving towards him, interacting well with the staff, and acting appropriately at all times. MT did not have the benefit of a stable partner at home looking after her other children. She would break away from the hospital to go home to look after her other children whenever she was able to do so.

75. MT has had some challenging relationships in the past - she has said herself that she has not always chosen her partners wisely. She revealed that one partner had become very controlling of her. LW's father, FW was, she asserted, and he partially accepted, a drug user. There is some evidence that she was wrongly thought to have had cancer at a stage when she shaved her head, the implication being that she fabricated having had cancer. There was no solid evidence regarding that matter. At Christmas 2020 some in the community raised money with which they bought some presents for LW. There is no evidence that MT benefited financially. MT presented as a confident person when giving evidence. She readily accepted some suggestions that she had not been accurate when reporting matters

to healthcare professionals, but was also adamant that she had not fabricated or induced illness.

LW: Chronology

76. *First four months, March to July 2019*: LW was born at Hospital D in March 2019 at 24 $^{+2}$ weeks, weighing 840 g. A brain scan showed a right, grade 4 intraventricular haemorrhage and a diagnosis was made of retinopathy of prematurity. A month after his birth he underwent surgery for necrotising entercolitis (NEC) – a high jejunostomy was performed. He was left with 22% of his gut remaining. On 19 July 2019 he had further surgery to reconnect his small bowel to his large bowel, following which 44% of his gut remained, indicating that his small bowel had adapted and grown since the first operation. He had "short gut" but he did not have "short gut syndrome". At three months of age a left PICC line was inserted. He was transferred to SCH on day 96 of life by which time he weighed 2870 g. MT was signed off as trained in the management of an NGT and administration of NG bolus feeds and drugs. LW was able to take milk from a bottle He was discharged home in mid July 2019.

77. *Four months to nine months, July to December 2019*: LW was cared for at home during this period. Home visits were made by the health visitor, the neonatal outreach nurse, speech and language therapists, occupational therapists, and physiotherapists. On discharge home he was feeding via a bottle and his weight was just below the 25th centile (for gestational age). Ten days after discharge home MT took LW to A&E at Hospital F with a possible seizure which was thought more likely to be gastroesophageal reflux disease for which ranitidine (for reducing stomach acid) was prescribed. On review at a neonatal clinic five days later LW advised that she had stopped ranitidine as she did not feel it was effective. A trial of baclofen (muscle relaxant) was prescribed. MT was advised to continue ranitidine. On 6 August 2019, LW reported to the neonatal outreach nurse, Nurse GF, that LW was projectile vomiting twice a day. His weight was now at the 9th centile. A week later Nurse GF noted that MT had increased the baclofen dose earlier than planned because LW remained tense and unsettled. At an outpatient review at SHC on 29 August 2019 MT reported loose stools and Loperamide (to treat diarrhoea) was prescribed. That afternoon MT took LW to A&E at Hospital F reporting a choking episode after taking loperamide. No problems were noted at the hospital. Two days later she again took LW to the same A&E department complaining of diarrhoea and lethargy but there were no abnormal findings on examination. Three days later on review as an out-patient clinic at SCH it was recommended that LW should begin NG feeding to supplement oral feeding. Six days after NG feeding had begun, MT reported to the community nurse, Nurse GC, that LW had pulled out his NG tube but MT had replaced it. The following day Nurse GC observed LW to feed well from the bottle but that he showed fatigue after 80 mls. MT was advised to use NG feeds as top up only. Six days later, in mid September 2019, a dietician visiting LW at home noted that LW was mostly feeding through his NG tube as he was refusing to take milk orally. At the end of September 2019 MT reported an improvement in LW's bowels and reduced vomiting. On 20 October MT took LW to A&E reporting a lump on his chest. She missed an ophthalmology appointment for LW on 14 November and LW was then

reviewed at the paediatric clinic at Hospital F at MT's request on 20 November. His weight was then at the 0.4th to 2nd centile. At a home visit by Nurse GC on 26 November, MT reported that the paediatric consultant had advised giving paracetamol and ibuprofen to LW for screaming episodes. On 2 December LW underwent laser treatment for his vision at SCH as a day patient. That evening MT took LW to A&E at Hospital F and he was "lifeless and unresponsive on admission" but breathing. The clinical impression was of sepsis. He was intubated and ventilated.

78. *Nine months to Fourteen Months, December 2019 to May 2020*.

a. On 3 December 2019 LW was transferred from Hospital F to the PICU at SCH. He was reviewed by paediatric neurologist and prescribed levetiracetam (Keppra – to treat epilepsy). This resulted in an improvement in LW's condition and a week later he was discharged home. However, on 15 December, MT took LW to A&E at Hospital E reporting several seizures during the day and shortness of breath. A seizure was noted in hospital and possible sepsis was considered. The following day LW's Glasgow coma score suddenly fell from 14 to 4 during an episode that lasted for 4 minutes. There were further episodes over the following days. EEGs were abnormal and said to be in keeping with transient diffuse cerebral dysfunction, not like primary seizures but secondary to hypoperfusion. He had loose stools. On 29 December 2019, LW was transferred to ward J at SCH under the neurology team. Urine testing showed ingestion of ibuprofen. Another test in early January also showed ingestion of ibuprofen. These were not considered worthy of particular attention at the time. Keppra was stopped due to abnormal liver function tests. He remained an in-patient at SCH for four and a half months until 19 May 2020. At the beginning of January 2020 he remained under the care of the neurology team but he also came under the care of the gastroenterology team with Dr SAN as his lead consultant.

b. On 2 January 2020 Dr SAN recommended introducing diarolyte (for water and salts replacement after diarrhoea) through his NGT, in increasing dosage if tolerated. At 4.00 pm that day MT was not at the hospital but the diarolyte had been started. There was no diarrhoea but there had been several episodes of desaturation (a decrease in oxygen in the blood) which had recovered. At 9.30 am on 3 January it was noted that "Mum not at the bedside" and increased dosage of diarolyte was being tolerated. LW returned to the bedside later that morning. At about midnight LW stopped tolerating the diarolyte – diarrhoea returned and he vomited. The nursing note records that only Mum was present when this happened but the nurse saw diarrhoea in the nappy and on the floor, and vomit on Mum and the floor. Diarolyte was stopped. On review later during the morning of 4 January it was noted, "Mum not keen on re-starting NG diarolyte today as LW was in pain yesterday."

c. An NJT was inserted and on 7 January NJ diarolyte was started again but after seven hours LW was noted in the nursing record to be screaming in pain. The diarolyte was stopped. At a Gastroenterology MDT on 8 January the agreed plan was four weeks of PN, then challenge the gut (i.e. introduce enteral feeding) and "if not working will consider palliative care". A broviac line was inserted on 10 January 2020 and TPN commenced. LW continued to have

unresponsive episodes and deranged liver function tests, although they appeared to improve over time.

d. On 16 January 2020, only six days after TPN had begun, another trial of enteral feeding began, via an NG tube. However in the early hours of 17 January the nurse noted that LW was unsettled, and he had loose stools. On advice she did not give more NG feed. On 22 January, another NG tube was passed and NG feeding commenced but there was a report of vomiting. The feed was not given. Dr SAL reviewed on 23 January and directed a further enteral feed trial using an NJT which was then inserted. Overnight the feeds were stopped because of reported diarrhoea. MT also reported that the NJT had come out a few centimetres and she had pushed it back in. On 26 January it was recorded that LW woke from sleep screaming and inconsolable before becoming floppy and unresponsive for a few seconds and then recovering. Later, still on TPN, he is recorded as having vomited and opened his bowels several times.

e. After a few days when LW was more settled, it was planned to try NG feeding again on 3 February 2020 but it was agreed to start the following day at MT's request because she would not be present on 3 February and would return to the ward on the following day. Diarolyte via the NGT was started on 4 February and tolerated until 5 February when it was noted that LW did a large vomit. Diarolyte was stopped and LW had two further vomits. Diarolyte was tried again later on 5 February but on 6 February it was again noted that he was vomiting and "in obvious significant pain." Loose stool was recorded.

f. LW remained on TPN but on 18 February 2020, whilst MT was at home, he was fed water through his NJT. He tolerated the water but pulled out his tube. He would sometimes have a drop in his blood sugars when being weened off PN or between PN feed changes. On 24 February, his broviac line became disconnected, for which no explanation is recorded in the records save that it was noted that the line had not been "looped" in the dressing, so a new dressing was applied and the line looped underneath it to "stop LW pulling it out." LW remained settled until on 4 May 2020 MT came running out of the cubicle saying that he had pulled his broviac line. Nurse SAH attended and found blood in the line, but the broviac still in situ. LW remained on the ward on TPN. MT was trained in home TPN and LW was discharged home into her care on 20 May 2020.

79. *Fourteen months to eighteen months, mid May 2020 to 19 September 2020*: LW spent these four months at home under the care of MT on TPN. Dr SAN saw LW at several out-patient clinics during this time. On 23 June, MT reported that LW had swallowed some bath water and suffered diarrhoea afterwards. During this period MT had some psychological support and it was reported in July 2020 that she was anxious and hypervigilant. On 3 August 2020, MT reported spontaneous bruises to LW and was concerned that he bruised easily: blood testing was performed but no abnormalities found. On 19 September, MT took LW to the Emergency Department at SCH with a history of being unwell, a line infection was suspected and antibiotics started.

80. *Eighteen months to twenty-one months, 19 September 2020 to December 2020*: E coli and Enterobacter cloacae were cultured from blood from the broviac line following admission via the Emergency Department in September 2020. The line was removed and a PICC cannula inserted before a new broviac line was inserted on 14 October 2020. Before then, LW was considered to be in septic shock and was treated in the PICU. Numerous pathogens were found on blood cultures during the first month after his admission with infection. The new broviac line was removed on 20 October due to infective pathogens cultured from blood in the line. A jugular line was inserted on 23 October and removed a week later because of infection in the line. On 4 November 2020, a PICC line was inserted in theatre. Dr SAN discussed with MT moving LW to ward L to try to break the cycle of regular line infections but MT did not want LW to be moved to an unfamiliar ward with unfamiliar carers and she would not agree to the proposal. LW's weight was now well below the 0.4th centile and he was unable to have PN for periods of time whilst his lines were infected. However, he recovered and PN was restarted. He was discharged home on 3 December 2020. He was briefly admitted to SCH after reports of symptomatic hypoglycaemia on 29 December 2020.

81. *Twenty-two months to two years, 8 January 2021 to 22 March 2021*:

    a. On 8 January 2021 LW was admitted to ward J at SCH via the emergency department at Hospital E, with a suspected infected broviac line which subsequently grew positive cultures for gram positive cocci and gram negative bacilli and later e-coli. On 11 January 2021 LW was moved to the PICU and was intubated and ventilated for three days. He was back on ward J by 18 January 2021. LW had a series of line infections requiring the removal of central lines and suspension of TPN.

    b. On 2 March 2021, a trial of diarolyte was attempted via an NGT. The Local Authority place emphasis on this incident. The medical record notes that he had only 1.8 mls when he had "vomit + and 2 x watery stools". The nursing record notes similarly that after just 1.8 mls of diarolyte, LW had two bowel movements and vomited a large amount twice. The NGT was removed. Later that day he vomited and became unresponsive for a few minutes. MT came running out of the cubicle to alert staff. Line sepsis was presumed and a blood culture grew gram negative bacilli and central blood cultures later grew salmonella and klebsiella. On 9 March it was recorded that LW had fallen from his mother's lap and he suffered a fractured left femur.

    c. On 18 March 2021, a safeguarding MDT was held (see below) and a set of agreed actions was agreed in the light of what were regarded as LW's perplexing presentations. LW had home leave over the weekend of 20 and 21 March 2021. MT reported to Dr SAL that LW had had diarrhoea after she had brushed his teeth using a pea-sized amount of toothpaste. LW was then discharged home on 22 March 2021 into the care of MT for home TPN.

82. During this period, and subsequently, consideration was given to LW undergoing bowel transplantation or being given palliative care and being made subject to a Limitation of Treatment Agreement (LOTA) and advance care plan. I shall deal with the evidence in relation to those matters now.

    a. On 9 January 2021 it is recorded that the idea of a palliative care plan was discussed with MT.

    b. On 12 January 2021 Dr SAN spoke with MT and it is recorded, "keen to develop a plan - ? palliative pathway" and that LW was "probably not a candidate" for transplantation.

    c. On 21 January 2021 Dr SAN arranged an MDT which was not attended by MT. Dr SD, consultant microbiologist, advised the meeting that "It does seem the bowel organisms are able to translocate easily, colonising his line leading to repeated infections and progressing to frank sepsis." It was recorded that HS was becoming "very anxious and scared of physical contact". It was noted that transplantation could take up to two years to be arranged which raised the question of how feasible it would be to manage recurrent sepsis during that period. It was recorded that "Mum has done really well looking after him during these 2 years." Before transplantation could be considered mitochondrial disease must be excluded. A consultant in palliative care considered that palliative care was reasonable. Dr SAN reported that MT "seems to have come to terms" with palliative care as a path.

    d. Dr SV, Paediatric Palliative Care Consultant then became involved. She told me that she had no concerns about MT's approach to palliative care which was balanced and appropriate. Nor did she, or any other clinician, express any concerns at the time about adopting palliative care for LW.

    e. A LOTA was drawn up and signed by Dr SV and Dr SAN. He then made a submission to the Trust's Ethics Committee in which he stated that the consultants in transplantation (at another, specialist hospital) "are not optimistic about the prognosis following small bowel transplant" and that the burdens of further intervention far outweighed the prospects of benefits to LW. The Ethics Committee unanimously supported the plan for palliative care.

    f. Over the weekend of 29 to 31 January 2021, MT took LW home on home leave. On return to the hospital she was clearly having reservations about following a palliative pathway. She told me that she had had a good weekend at home with HS and the other children. She felt "guilty" at the prospect of allowing him to die. She herself then proposed that there should be another attempt to insert a further line. That was done. At the hearing, the clinicians and experts agreed that MT's request probably saved LW's life. Nurse SAZ told me how emotional MT had been at this difficult time.

83. *Two years to two years six months, 22 March 2021 to 13 September 2021*: during this period LW remained at home in the care of his mother with support from

community healthcare professionals and with out-patient clinic appointments mostly with Dr SAN. Clinic appointments took place on 12 and 19 April, 17 May, 5 July and 6 September 2021. At those appointments MT variously described occasions when LW had had diarrhoea immediately after licking food or drinking some blackcurrant juice. On 6 September 2021, Dr SAN arranged to see LW again in two months.

84. *Last admission, 13 September 2021 to 26 November 2021*: On 13 September LW was re-admitted to ward J at SCH via the Emergency Department at Hospital E with swelling and redness on the right side of his neck, tachycardia and raised temperature. Line sepsis was suspected and the PN disconnected. The infection to his central line that brought him back to hospital after about seven months at home, was not a bowel bacteria but staphylococcus aureus which I was advised is likely to have come from skin. For the next four to five weeks LW suffered a series of line infections. On 3 October 2021 MT took LW off the ward for an hour between his antibiotics being administered but he spiked a temperature whilst out and had to be returned to the ward by ambulance. PN had to be withheld. He was then surviving on fluids only but still had recurrent bacteraemia. His life was in danger. On 21 October, the weekly gastroenterology MDT was attended by Dr SAA and Dr SAM (remotely from another hospital) but not Dr SAN who was off sick. It was recorded that "we should get a chronology … to clarify with Dr SAN." Another meeting was held that afternoon at Dr SAA's request, attended by Dr SAM and, by telephone, Dr SAN. Dr SAA wished to make referrals to the authorities but it was agreed that Dr SAA should ask MT to leave the hospital for a period of time and that if she refused, a referral to social services and the police should follow. Dr SAA made that request of MT and she initially refused, saying that she was worried about the effect on both her and LW if she were to do so, but it is recorded that she agreed to leave if LW became unwell (presumably if he because more unwell, because he was already very unwell). Hence, it was decided, the next step was to make the referral. Dr SAM met with members of the safeguarding team on the following morning, 22 October 2021 and the referral was made. Dr SAA was on annual leave that day and Dr SAN remained off sick. Dr SAO the designated doctor for safeguarding was also on annual leave. Before the referral, an incident occurred which is relied upon by the Wakefield MDC and which appears to have underlined the decision to refer. Nurse ST came on the day shift and went to see LW – she found his "machines" switched off and his fluid line unclamped. She alerted the medical team.

85. LW was therefore at about ten months when he was first put on PN which was when he was an in-patient on Ward J at SCH after he would not tolerate enteral feeding or diarolyte. He was tried on enteral feeding or diarolyte in early 2020 and on 2 March 2021 but otherwise remained on TPN from 10 January 2020 until 22 October 2021. His first line infection occurred when he was eighteen months old and appeared to happen when he was on TPN at home. For the next six months from September 2020 to March 2021 LW suffered a series of line infections: there were some ten episodes when blood cultures from his lines were positive for infection. The infective organisms included E-coli, candida, coagulase negative staphylococci, gram negative bacilli, streptococci, and Salmonella. For all but one month during that time he was an in-patient on Ward J at SCH. When at home in December 2020 he suffered a further line infection that required his re-admission.

On admission in January 2021 E-coli was one of the bacteria isolated. He was then infection free on TPN at home for about six months from March 2021 before suffering a line infection on or about 12 September 2021, which was not a bowel bacteria infection. This was followed by further infections as an in-patient until, after his mother's arrest, he improved sufficiently to be discharged. To that point he had had 15 central lines, over 20 general anaesthetics, 14 blood transfusions.

MT's Arrest and Aftermath

86. MT was arrested on 22 October 2021. LW had been re-admitted to SCH on 13 September 2021. Although the plan in March 2021 had been for him to be placed on another ward, for the same reason that HS was moved from ward J to ward K, LW was in fact re-admitted to ward J. He was admitted with a line infection leading to the removal of his broviac line and insertion at hospital A of a PICC line. He then developed sepsis following infection of the PICC line. On 10 October 2021, PN was withheld. By 21 October 2021, LW was in a precarious position. He had suffered a series of line infections and blood stream infections since re-admission to SCH on 13 September. He had been on fluids only for eleven days. Dr SAA was the weekly lead gastroenterologist for the week commencing 18 October 2021. He was involved in the referral of HS on Tuesday 19 October as already described. At the weekly Thursday gastroenterology MDT on 21 October, Dr SAA raised the question of referring the case of LW to social services and/or the police. It was agreed to start a chronology and to clarify with Dr SAN who was off sick at the time. Dr SAM told me, and I accept, that Dr SAA asked her to attend a hastily arranged meeting with him and, by telephone, Dr SAN, that afternoon. Her perception was that Dr SAA wanted to make a referral immediately, but that he was persuaded first to speak to MT and to ask her to leave the hospital. He did so and I have referred to the discussion above.

87. According to Dr SAM, the decision to refer MT to the police was made at a meeting with "safeguarding" on the morning of 22 October. Dr SAA was not present at the hospital that day. The lead gastroenterology consultant for LW, Dr SAN was on sick leave. The designated doctor for safeguarding, Dr SAO, was on leave. It appears that the decision to escalate to safeguarding had been made at the MDT meeting on 21 October but, after the incident at 8.00 am on 22 October, Dr SAM escalated to safeguarding immediately and a referral was made to the police and social services. The police were informed and they recorded Dr SAM as having informed them that there were suspicions that the mother was interfering with the central line so as to cause infections.

88. The evidence regarding the incident at about 8.00 am on the morning of 22 October 2021 is as follows. Overnight care on 21 to 22 October for LW was provided by, amongst others, Nurse SAS. She came on shift at about 7.00 pm on 21 October. Following handover she would start seeing patients at about 7.30 pm. She told me that she was aware that MT had been asked to leave but had declined to do so. She noted that, before the mother went to Treetops to sleep, which was probably at about 9.30 to 10.30 pm, she asked Nurse SAS to change LW's nappy because her hands were cold, having recently been outside. She also said to Nurse SAS that she had been told that line infection might have been caused by LW's

line having been in contact with his nappy. This struck Nurse SAS as odd but I do not find it so. MT had been asked to leave the hospital. It was evident to her that suspicion had fallen on her. Furthermore, she might understandably have been desperate for LW not to suffer another infection, including one for which she might be blamed. Nurse SAS and the other nurses on duty continued to care for LW overnight in MT's absence. They would check his fluid was running through the line on an hourly basis. Nurse SAS made the last night shift entry at 5.20 am and then ended her shift at 7.00 am. She told me that there would typically be a final check of LW's line at 7.00 am but it might have been her or one of the nurses who should have done that. Nurse ST was on the day shift. She recorded that at about 8.00 am she had entered LW's room to find "all machines" switched off and his line not clamped. She did not know for how long this had been the position. She assumed that one of the nurses on the night shift had mistakenly switched off the machines, perhaps after the drip bag had become empty, and had forgotten to clamp the line and replace the drip bag before unclamping again. Nurse SAS told me that if a bag becomes empty, the pump machine will sound an alarm. After about 30 seconds this triggers the BEMS alarm in the cubicle which then activates an alarm carried by the nurses on the ward. They can see on their alarms from which cubicle the BEMS has been triggered. On attending and finding the drip bag empty they would firstly switch off the machine and clamp the line before fetching a replacement bag. Had they then forgotten to return before the end of their shift, that would explain what she had found at 8.00 am on entering LW's cubicle.

89. Nurse ST told me that when she attended the room at 8.00 am and found the machines switched off, MT was not in the room. She had spent the night at Treetops. LW herself says that she came down to the ward from Treetops, went to LW's cubicle, saw the pump machine was off and went for help. She had been on the phone to AC at the time that she entered the ward. AC confirmed that evidence. MT claims that she then raised the alarm but on Nurse ST's account she had already been in the room and seen the pumps herself. The two accounts are reconcilable: MT may have entered the cubicle when Nurse ST had left the room, between Nurse ST first entering and noticing that the pumps had been switched off and then returning to attend to LW. In her oral evidence Nurse ST repeated her written evidence that she assumed that someone on the night shift had made a mistake. In her contemporaneous notes about the steps she took in the aftermath of the discovery of the switched off pumps she wrote, "Mum present throughout and appropriate."

90. It is clear that LW made a remarkable recovery from 22 October 2021 onwards. By all account he now eats healthily, albeit he has had some difficulty adapting to drinking, probably due to the prolonged period when he did not drink orally. Having been on TPN (other than when line infections reduced him to being fed fluids only) from January 2020 to 22 October 2021, the clinicians then commenced diarolyte via an NGT alongside restarted PN on the very day his mother was arrested. On 25 October, PN was stopped and he was fed enterally. This feeding plan worked and on review on 2 November LW took some pureed oral feed and was sucking on crisps without vomiting, loose stools, or pain. On 10 November, he was noted to have vomited and was refusing food but this was thought to be associated with a viral infection. Norovirus was detected in a stool sample. He improved and on 26 November 2021 he was discharged from hospital to foster

care. He has had no line infections since his mother's arrest, but PN through a central line stopped only three days after her arrest. However, feeding has gone well so that he has not needed PN since 25 October 2021. He has not suffered vomiting or diarrhoea on consuming food which is in marked contrast to reports and observations prior to his mother's arrest.

C3: Safeguarding and Investigations

91. Dr SAO was the designated doctor for safeguarding for Sheffield, and so for SCH. Her role is to "support clinicians to manage cases when they have safeguarding concerns." As early as 3 September 2020, Dr SB spoke to Dr SAO about his concerns about the number of infections that BR was having. During the discussion he mentioned a second child, namely HS, who was on the same ward under gastroenterology care. Dr SAO recalls that "I was asked if I thought that the gastroenterologists should inform the police that they were concerned that HS had too many infections. Dr SAO's advice was that,

> "It was not appropriate to inform the police at this time as the reason for HS's infections needed further assessment by the health team. I suggested that they needed to consider cause of infection in a structured way for example thinking about the environment that HS was in, was there any concern that the environment was contaminated and causing him infection. Was there any concern about the process of giving him his PN for example, was there a problem with the intravenous lines. Did they break or disconnect too easily. Was there a problem with the bag the nutrition came in. Had they ruled out infection within his system. Was there any concern that other recipients of parenteral nutrition were being similarly infected and had we thought about any contamination in the supply of nutrition. I also suggested that it needed to be considered whether any people could be a factor in HS's infections for example, were there any errors in the way that PN was being given, could infection be inadvertently introduced by an infected person or could the child themselves be contaminating their own feeding line…. We also considered whether any of the behaviours could be due to deliberately induced or inflicted illness. My suggested action was that the gastroenterology team spoke to senior nursing and medical staff, the clinical director and the nursing matron to discuss their concerns. I suggested that a root cause analysis was conducted to look at the delivery of parenteral nutrition to the children about whom there were concerns. This root cause analysis needed to consider factors in the environment, the process, and the people. I suggested that it may be useful to look at the last few significant incidents for both patients and analyse their chronology of care before and after the events."

92. In her first statement, Dr SAO omitted reference to her next involvement, even though that involvement was significant, namely at the safeguarding MDT on 18 March 2021. In the meantime, following Dr SAO's involvement in September 2020, the Executive Medical Director, Dr SI commissioned an RCA to be prepared by Nurse SZ, Lead Nurse for Haematology and Oncology, and a senior colleague who was an advanced nurse practitioner. The brief they were given was to consider central line "incidents" of infection, disconnection, and rupture to "identify if aspects of central line care and management practice were a causative factor." The draft report was submitted to Dr SI on or around 19 March 2021. Dr SI then discussed the wording of parts of the report which were then revised, the final report being signed off on 23 August 2021. The reporting process therefore took almost one year to complete.

93. The RCA report included the following:

> "Incident occurred why: multiple line infections and displacements.
>
> Why did this happen? Inherent increased risk of central line infections amongst patients who have complex gastrointestinal problems and also receiving parental [sic] nutrition. Audit of practice and observation of staff performing care did not reveal any issues. Extensive literature review of practice and discussion with colleagues in other centres did not reveal a single causative factor. Lack of documentation detailing care and management of central lines in several areas of the Trust. This did not allow staff to ensure the guideline was adhered to. Changes in practice and evidence base necessitated the Trust policy requiring updating.
>
> Patient Factors: The two patients examined both had complex gastrointestinal medical needs requiring long term PN. It is well documented that central line infections in this population of patients is high … HS developed behavioural issues involving chewing and tugging his line .. it is also of note BR had her PN line found to be disconnected twice and leaking on a separate occasion due to a cracked bung once. Parafilm was used to try to prevent this which has limited evidence of its use.
>
> Individual staff factors: All staff involved … had received training and been deemed competent in the care and management of central venous access lines. This was demonstrated in a snapshot audit… PN practice had changed prior to these incidents and although all staff had received training it was reportedly causing staff stress…
>
> Team factors: a major contributory factor is that there is no unified approach to central line management. This starts with the surgical team …. There is no consistency or clear guidance with regards to infected lines being removed and appropriate time for new ones being inserted. This fragmented care pathway leads to confusion and a lack of evidence based care.

> Root Causes: It has not been possible to identify a root cause for the apparent increased incidence of central line infections in the two patients investigated."

94. The jointly instructed experts have criticised the RCA in that no medical or surgical professional was involved and the ambit of the instructions to the authors was too narrow. The authors were from nursing backgrounds and Nurse SZ emphasised to the court that they were tasked with examining nursing practices. Notwithstanding their criticisms, as set out above, they did not find any systemic deficiencies in nursing practice. Nevertheless, the RCA was not a comprehensive examination of all the factors Dr SAO had discussed with Dr SB in early September 2020.

95. The RCA reporting process was completed long after MR's arrest. The trigger for her arrest was the finding of ibuprofen in BR's urine. In fact a test taken in August 2020 had also been reported as positive for ibuprofen but nobody had heeded its significance. Had they done so, then either an earlier referral would have been made to the police and social services, or further investigations would have been carried out. Either way, a period of BR's suffering may have been prevented. On referring MR to social services and the police, Dr SA noted,

> "I am concerned that BR is suffering abuse in the form of induced illness …. She had been suffering from repeated episodes of line infection which I had concerns could be inflicted – I had thought potentially BR herself was contaminating her central line. In January, her central line was removed … Since this time she has had no episodes of sepsis… about 2 weeks after this she started having evidence of bleeding from her stomach … urine sample shows evidence of ibuprofen. I am concerned BR is at risk of ongoing harm."

96. A strategy meeting involving Leeds CC and South Yorkshire Police, as well as healthcare professionals from SCH, including Drs SA, SB and SAO, took place on 26 February 2021 following MR's arrest. Dr SB reported that BR's bouts of being unwell are "predominantly on weekends" but analysis of the pattern of her infections and other problems does not show this to be the case. A question was raised at the meeting about other children getting line infections. Dr SAO said,

> "We do not have safeguarding concerns about them. What the investigation would show is they had other reasons, leaky guts, and other issues. I would say the cases are not connected."

97. However, on 18 March 2021, a meeting was convened to consider safeguarding concerns in the aftermath of the events leading to MR's arrest. Amongst those attending were the clinical director, Dr SI, the designated doctor for safeguarding in Sheffield, Dr SAO, consultant gastroenterologists, Dr SAN, Dr SB, and Dr SAA, and the executive nursing director and her deputy. I have a transcript of this

meeting which was held on Microsoft Teams with the record function deployed. As might be expected, the participants felt free to raise various possibilities to explain the perplexing presentations of HS and LW, any connections with the case of BR, and whether referrals to social services or the police should be made. A number of different hypotheses were aired. Dr SAO referred to the RCPCH guidance and promoted rehabilitation planning rather than referral on the basis that there was insufficient evidence on which to refer. A minute of the meeting was prepared and shared with the participants. It ended with a statement of "agreed actions" which were, as far as relevant:

> " • Follow RCPCH guidance for perplexing illness, including aim to introduce feeds and remove lines if possible as part of health rehabilitation plan (Gastro team – led by Drs SAN, SB and SAA).
>
> • If further episodes of vomiting / diarrhoea or other symptoms investigate with toxicology etc. and professional curiosity as to possible FII cause rather than organic cause (Gastro team – led by Drs SAN, SB and SAA, supported by Dr SAC and safeguarding team).
>
> • Gather chronologies for 2 cases HS and LW (led by Dr SB and Dr SAN) .
>
> • Move HS and LW to separate wards tomorrow.
>
> • MDT discussion with HS's mother to discuss perplexing illness openly and ward relocation – suggested to be held with Dr SB/SW/nursing prior to ward move.
>
> • MDT discussion with LW's mother to discuss perplexing illness openly and ward relocation – suggested to be held with Dr SAN/nursing prior to ward move. Dr SW to also assist with this conversation or another professional – wasn't clarified.
>
> • Meet again next week to update (Dr SI will organise)"

98. Dr SAO was on leave when referrals were made to the police and social services in respect of MS/HS and MT/LW in October 2021. Dr SAO was anxious to clarify the nature of her role as designated doctor which was to support clinicians. She was not tasked with overseeing safeguarding of particular patients on a day to day basis. I should note that I consider that when she did give advice to clinicians it was very sound advice.

99. After the arrests of MS and MT, strategy meetings were held on 14 December 2021 attended by representatives from South Yorkshire Police, all three local authorities, and SCH. The cases of BR, HS, and LW were considered together. The minutes record that DCI Ronayne of SYP "believes that the cases of HS and LW are linked and that they are too similar but in relation to how they got ill, how

the mothers were involved, who was doing what to whom and how it is proven is very complicated and a lot will be circumstantial." Although he did not rule it out, he did not think that BR's case was linked because there was a different *modus operandi*.

100. In June 2022, Dr SI commissioned an SII report from Dr Grayson, a consultant paediatrician and designated doctor for safeguarding children in Newcastle and Gateshead, asking her to be the external investigator and author of a SII in to "three cases of Fabricated and Induced Illness." The terms of reference were directed to identifying learning points for the Trust such as whether there was a failure or delay in recognition of FII. The presumption therefore was the cases about which the court is now required to make findings of fact, were, in fact, cases of FII. Dr Grayson produced a draft report very shortly after the beginning of this hearing. She had sought permission from the Trust, expecting them to obtain clearance from the police (which the Trust did), to speak to some key witnesses and she kept notes of her discussions with them. Her report and those notes were disclosed into the proceedings but only after it became known to the court and the parties, during the early stages of the hearing, that they existed. The Trust had not informed the court and the parties that the report had been commissioned, or that witnesses had been spoken to and had been asked to reflect on the "three cases of FII".

Police Investigations and Interviews

Family R

101. I have already referred to the poorly conducted searches of BR's cubicle after MR's arrest. It was documented that items recovered at that time from BR's cubicle included, one tramadol tablet within a blue washbag on the bathroom shelf. One large box of ibuprofen was seized from a shelf in the bathroom. Dulcolax (bisacodyl) tablets and piroxicam capsules were found in the suitcase in the cubicle, as a was an external feeding syringe and a purple syringe. A pill crusher was found in BR's suitcase within the cubicle. Forensic analysis revealed traces of bisacodyl and ibuprofen within the crusher. A feeding tube attached to BR's PEG-J was retained by hospital staff on 26 February 2021 and recorded as being handed over to the police on 3 March 2021.. It was photographed and analysed in early July 2021 with a report produced three months later. I heard evidence from Forensic scientist Sophie Jones who had reported on the finding of traces of ibuprofen, piroxicam, and bisacodyl within the contents of the tube. Ethanol and water was used to rinse the contents and dissolve them for testing. Her evidence was not substantially challenged. She could not say for how long the drugs had been in the tube nor their quantity, only that their presence had been confirmed. The presence of prescribed drugs was also confirmed. On the police search, a purple syringe with a screw thread nozzle was seized from a bag in the bathroom. On 2 April 2021, further items were seized after a further search of BR's cubicle, which included scissors and cutters as well as a pack of 24 Rennies (readily available medication for heartburn, indigestion or trapped wind). A search of the home of family R found a large quantity of ibuprofen, senna, immodium, vitamins and supplements, and other medications. Later payment records showed purchases

by MR of two large boxes of ibuprofen and orders from Amazon of two large quantities of dulcolax.

102. The police obtained blood/serum and urine samples taken from BR at SCH and re-tested them. There were positive tests for piroxicam on 19 July, 4 August, 10 August, 18 September, 14 October, and 2 November 2020, and positive tests for ibuprofen on 13 August and 8 September 2020. It will be recalled that piroxicam stays in the system, and is detectable for a few days after ingestion, whereas ibuprofen is detectable only for up to, at most 24 to 36 hours. There were then two positive tests for ibuprofen in urine in February 2021 prior to MR's arrest and seven times between MR's arrest and 22 April 2021.

103. MR and FR's mobile phones were seized. I have a large volume of material from searches of the devices which includes messaging between MR and BR, when MR was not in the cubicle with MR or on those occasions when FR stayed with BR overnight at a weekend and MR went home. There are also a few messages between MR and MS which I do not regard as being of consequence. MR and Nurse SAZ exchanged messages when BR was undergoing investigations at Hospital B, but Nurse SAZ deleted her side of the messaging and that was not available to view.

104. I have been provided with police interviews with MR, FR and MGMR. MR's first police interview was on the day of her arrest when she was investigated by Officer Amy Todd and DC Gibbons in the presence of a solicitor. MR said that BR "can't cope with anything in her tummy. She can't swallow anything … If I even give her medicine, the tiny amount of medicine in her tube she can't stand it. She can't stand it. She can't cope. She is in so much pain." MR maintained her denial of any knowledge of how BR could have ingested ibuprofen since the time when it had stopped being prescribed to her.

Interviews with BR

105. GNA, BR's then children's guardian, visited her at SCH on 22 March 2021. She recalled,

> "… she said that she had taken some of her mother's tablets that she had for her back for her pain as she thought they would help her. I asked BR to tell me when this had happened and she said once in Hospital A and once in Sheffield. I asked BR where the tablets were and she told me that they were in her mother's bag in the toilet. I asked BR how she took the tablets and she said she swallowed them and that she could swallow then. I did not ask BR how many tablets she had taken and on reflection, that was an error on my part. BR told me that she thought it would help her. She was worried that she would get into trouble. I reassured her that she had done the right thing telling me but that I would have to tell other people about it."

106. Amy Todd from South Yorkshire Police visited BR at SCH in company with DC Gibbons on 23 March 2021

> "We were aware that BR had spoken to CAFCASS and indicated that she may have taken some medication herself. I asked BR about what she had disclosed. BR told us the following: She has taken some medication from her mum's bag. It has happened about 5 times in Sheffield and a few times in Hospital A. She took some tablets from her mums bag whilst mum had gone out (for coffee or with the psychologist). Her mum's bag was in the bathroom at the time. She does not know what the tablets were. Some were green and yellow and some were pink. She swallowed them herself. She says she did it because she was in pain and was upset. She did not tell the nurses. She has never told anyone this until yesterday when she told CAFCASS."

107. FR was at the hospital on that day. He was told what BR had said and exchanged text messages with MR who wrote, "You are kidding… shit … they were in the bathroom … am shaking … Is she OK … poor child … I hope she's OK." When Dr Dunham, Psychologist, talked to BR she was very reluctant to discuss having taken her mother's medication but said that she had done so both before and after her mother had been arrested. BR did however tell Dr Durham that her mother had "never given her ibuprofen or any other medication other than when helping the nurses…"

108. An Achieving Best Evidence interview of BR was undertaken at SCH on 3 March 2021, conducted by Officer Amy Todd. I have seen the video recording of that interview, showing BR as a very quietly spoken, rather sad child. Her appearance had been affected by use of steroids. Nevertheless, given the awful situation she was in at the time, she spoke quite freely, very intelligently, and she engaged with the questioning. She was extremely knowledgeable about her medication, treatment and history. Her understanding was that some infections she had suffered had been caused by her "tummy". She had felt as though she might die when she had sepsis. As for her medications, she said that the nurses would give them to her but that once she had a PEG, the nurses would give her mum the syringe, and her mum would pass the syringe to her and she would push the medication in because if it was done too fast it would hurt, and she liked to do it. Her mother would do it also but she would watch her do it to make sure it was done slowly. She was asked about what she knew about ibuprofen and said that she used to have it before but she knew it was not good for the tummy. She recalled being told that a sample would be taken to test for ibuprofen and "we" [MR and her] had asked why. She said the nurse who was with them could not understand it. BR said that she knew she was not allowed ibuprofen and that it t was "just weird" that they were testing for it. She knew what a pill crusher was because her mother had used it "ages and ages" ago. She had not seen it for months.

109. Following court directions given by Mr Tyler KC, sitting as a S.9(1) Judge of the High Court, following a *Re W* analysis, BR was interviewed by Craig Barlow, Independent Forensic Social Worker on 18 March 2022. I have viewed the video recording of that interview. BR looks much better than she did in March 2021. Again she demonstrates her intelligence and knowledge during the

interview. When asked about being given ibuprofen at Hospital A she says, "my mum wasn't very happy because she always told me that it wasn't good for my tummy." She explained how she would sometimes self-administer methotrexate via injection into her thigh. She was then asked about "the thing that you told to GNA". She volunteers, "So, I took, like, erm, medication from the bag in the toilet…. A few times in [Hospital A] but more in Sheffield… I felt like when they reduced the pain meds no-one was helping me … sometimes it worked and sometimes it doesn't … there were some pink ones … there were yellow ones … tablets." She was asked what she was thinking and feeling the first time she took some of those tablets. She said she could not remember. When asked what colour the tablets were [at that time] she said green and yellow ones "but I can't remember." She was asked again why she took them and she said, "it felt like no-one was helping me." At Sheffield she had taken them when "mum went out of the room to make a coffee or to see her psychologist…" The tablets had been in strips in a bag in the bathroom. She indicated that she had done this in Sheffield a lot more than she had at Hospital A, indicating that she had done it some days of the week. Mr Barlow asked her if they had hurt her tummy as had happened when she had been prescribed ibuprofen at Hospital A and she said "no". She said that she would just swallow them. She was asked whether at the time she was taking anything by mouth and she said she could not remember but "No, I don't think so, Sometimes I was but I don't remember."

Family S

110. On the day of her arrest, police searched MS's room at Treetops. They found a bodyguard pump and a quantity of medical equipment including syringes for use with PN, and purple syringes used with PEGs. A number of soiled nappies were found, bagged up. Ibuprofen tablets were found. A notebook was found with notes in MS's handwriting setting out some 22 points about HS's condition and treatment. I also have copies of pages from what might be the same notebook described as a "diary" kept by MS in which she has set out some of her observations and thoughts about HS's treatment and his recurrent problems.

111. MS's mobile phone was seized and interrogated. There is a large volume of material from that process which includes a number of messages between MS and MT. As is stated in the police records summarising a review of the mobile phone evidence,

> "From review of these messages, which have been sent between both mothers, there is nothing to indicate any collusion to harm their children."

Interrogation of MS's mobile device revealed Google searches in September and October 2021 prior to her arrest which included several regarding aspects of TPN and "gram negative bacteria", "Dulcolax suppository", and "How can you cause diarrhoea." Other searches including "y does my child's blood pressure keep dropping", "are blood clots in the neck dangerous", "why are my child's eyes going side to side" and very many searches under medical terms and drug names. None of the searches raises any suspicion related to possible FII save perhaps for

the search about "causing" diarrhoea. MS explained that she was trying to find out the causes of diarrhoea because of her own problems at the time.

112. MS was interviewed by the police on 20 October 2021 in the presence of a solicitor. She said that FS had been "supportive. We've had our arguments throughout it. It's been stressful but he's really supportive of us." She said that she was in debt. She spoke openly about contact she had had with MR, which was limited, and with MT. She explained that the medical equipment that was found in her room was "all his things that we need. His blood sugar needles obviously go with his blood sugar pen. The parafilm is what we locked the lines in … Glucoboost is for if his sugars are low. Nappy cream, normal creams. Hibiscrub is what he gets washed in…" The TPN pump was the one that she would used (a bodyguard pump) but it was not currently in use at the hospital so it was in her room. Similarly, related equipment was for use with that pump. She said that the purple syringes [used for PEG feeding not for PN] were the sort of thing that HS loved to play with and she may well have simply put one or two in her handbag at anytime and they would have ended up amongst her possessions at Treetops. She said that she was also wanted to keep equipment for use for constructing a doll for her youngest daughter so that she could simulate feeding it as HS was being fed. I have no concrete evidence about that doll. She said that she kept some aspirin and ibuprofen for her own use for when she had a period pain or a headache. As for her notebook that was found in her room at Treetops, she said, "Well, they've not accused me outright but made … like insinuated things even or the questions like, when we've been saving the MDT there are questions that I've wanted to ask … so I've wrote them down… these are the questions I'll ask in the meeting." She explained that recently she has been constipated one minute and then having "really bad diarrhoea". She had had some really bad loose stools and she just put nappies inside her pants as a liner. It was not that the nappies were badly soiled. She would bag up the nappies and was planning to dispose of them. She told the police, "obviously it's embarrassing … so I took them to my Treetops room to put them in another bin bag to get rid of them but didn't get round to it before [the arrest]."

Family T

113. I have viewed police body-worn camera footage of MT's arrest at SCH. MT's Treetops room was searched on the day of her arrest. Police seized items including a used nappy, a feeding tube, and two empty syringes. MT's mobile phone was seized and interrogated. She is a fairly prolific user of social media. Messaging between her and MS is as previously described – it provides no evidence at all of collusion between them. There are some harsh comments about one or two doctors at times and the odd description of the children exhibits frustration in forthright language, but the general tone and content is that of two mothers caught up in similarly awful situations, trying to support each other.

114. MT was interviewed by police on the day of her arrest in the presence of a lawyer. She described her other children and how she had handled caring for them during the time that LW had been ill in hospital as well as when he was at home. She described concisely and clearly what she had to do when she managed PN at

home. She explained an incident recently when she had taken LW out in the car to drive home to fetch a pram, after discussion with the nurse on the ward, and he had started being very well, shown evidence of sepsis, "I wouldn't touch him after that because it terrified the life out of me." At one point the interviewing office asks her who could have had access to LW to cause infections in his central line. MT says,

> "MT: nurses, me, doctors … there's cleaners … housekeepers.
>
> IO: What would they hope to achieve by doing this?
>
> MT: Well what would I hope to achieve by doing this …I'd probably kill him. Anything in that line goes to his heart. Anything in that heart is going to kill him. So it wouldn't make an ounce of sense.
>
> IO: How has it been having a child in the hospital for so long?
>
> MT: It's been bloody hard."

C4: Expert Evidence

115. The core medical experts were jointly instructed and gave evidence in all three cases. A joint meeting was held prior to the hearing attended by Dr Ward, Dr Rajendran, Professor Sullivan, and Mr Lander. At the invitation of the Counsel for the mother in the ERYC case, I circulated a note prior to the expert witnesses giving oral evidence in order to enable the parties and experts to focus on the matters that would most assist the court:

a. Experts must not supplant the role of the judge. The judge decides whether the allegations are proved to the required standard.

b. Expert evidence is admissible only if (i) it will assist the court in its task; (ii) where the witness has the necessary knowledge and experience to give the evidence; (iii) where the witness is impartial in his or her presentation and assessment of the evidence; and (iv) where there is a reliable body of knowledge or experience to underpin the expert's evidence – *President's Memorandum*, 4 October 2021.

c. It is not for experts to determine the facts on which their opinions are based. Therefore, the expert witness should not be asked whether a particular event happened or did not happen, but

    i. Expert opinion evidence may assist the court to understand and interpret evidence of fact, for example whether there is a

gastroenterological explanation for a child having explosive diarrhoea after being given 1.8 mls of diarolyte.

ii. Experts' opinions may be challenged on the basis that they have not taken into account relevant evidence or have relied on evidence which should not have been relied upon, or that their reasoning is in error. For that purpose they may be taken to entries in the records or to evidence given by other witnesses.

d. Dr Ward has produced hundreds of pages of chronologies in her reports. It will not be necessary nor proportionate to go through those chronologies with her in oral evidence. Any minor errors that are not relevant to her opinion evidence should not be explored. However, significant errors or omissions in relation to the facts relevant to her opinions may of course be the subject of questioning. The same applies to the other experts.

e. In the present cases, the experts have not been asked to consider the Trust's safeguarding procedures, the management of perplexing presentations, nor the SII investigations (as opposed to the RCA report). I will not be assisted by hearing their opinions on those matters. However, evidence from safeguarding meetings or notes of what witnesses have said to Dr Grayson [author of the draft SII report], may include information relevant to the opinion evidence of the experts.

f. Likewise, the experts have not been asked to consider the Trust's practices in relation to nursing management of central lines (as opposed to medical management of infections in lines). I will not be assisted by hearing their opinions on that issue, but experts may well be able to assist the court as to whether, for example, a failure to use aseptic technique when connecting a nutrition bag to a central line could allow the introduction of infection, or whether a child chewing a line might do likewise.

g. If an expert relies on published material then they may be questioned on their interpretation or application of that material.

h. Expert evidence as to the possible explanations for a child's presentation, for blood results etc. and the likelihood of those explanations based on their expert knowledge and experience, is valuable but it should be remembered that FII is an umbrella term which may cover, amongst other things, exaggeration, falsification of records, or actual induction of illness. Thus, it will not help the court for an expert to be asked whether they believe a child's condition might have been "caused by FII". Further, decisions as to whether a particular person has induced illness or exaggerated symptoms, and when, are for the court to determine.

i. Where an expert has given an opinion it is legitimate to ask whether there is a range of reasonable professional opinion on the matter.

116. I have not found it useful for any expert to give an opinion on whether a child is a victim, or an adult the perpetrator of, FII. Firstly, it is for the court to determine what harm has been caused to a child, by whom, and how. Secondly, the term FII covers a multitude of more or less intentional behaviour that may or may not have caused actual harm to a child. The label FII must not be used as a substitute for an analysis of the facts in each case, see *A County Council v A Mother and others* [2005] EWHC 31 (Fam), above. Hence, I have treated with some caution the parts of the schedule of agreement reached by four of the core expert witnesses following a joint meeting which set out "factors pointing to" and "factors pointing away from" FII in each case. I acknowledge that the experts were endeavouring to be helpful to the court, but I have to be mindful not to confuse evidence of fabrication with evidence of induction of illness, and not to conflate evidence of induction of vomiting, say, with evidence of induction of sepsis. My focus has to be on the particular behaviour alleged.

117. The experts were all disadvantaged by late disclosure in this case. I have commented on the issue of disclosure by SCH above, but the bare facts are that the experts had given their final reports without the benefit of some important evidence, later disclosed. That included the transcripts of the safeguarding strategy meetings in March 2021, a number of nursing records, minutes of the Board of Directors meeting of the Trust 2 November 2021, and the notes of discussions with key witnesses prepared by Dr Grayson for her SII report or her draft report itself. The experts were not giving evidence on safeguarding procedures as such, but the material within those documents was of importance – it included evidence of what clinicians were thinking at the time, and of what healthcare professionals had seen and heard.

118. Professor Shepherd, Professor of Gastrointestinal Pathology and Consultant Histopathologist, reported in the case of Family R only. He was able to review evidence from oesophageal, gastric, duodenal, ileal and colorectal biopsies taken over the course of BR's illness. The first endoscopy was undertaken at Hospital A on 24 October 2019. BR was suffering weight loss, abdominal pain, and had a raised faecal calprotectin. Duodenal biopsies showed some non-specific, mild chronic inflammatory changes and focal gastric metaplasia, but no significant histological abnormalities and no features of chronic inflammatory bowel disease. Gastric, oesophageal, ileal, and colonic biopsies showed no abnormalities and at most, mild chronic inflammation. There is no histopathological evidence of the effects of NSAIDs. Biopsies from an upper GI endoscopy performed at Hospital A on 11 December 2019 show some mild chronic active gastritis.

119. Terminal ileal biopsies from an endoscopy at SCH on 10 March 2020 show mild and patchy inflammation and two epithelioid granulomata within the lymphoid tissue which Professor Shepherd describes as "a little suggestive of Crohn's disease." Colonic biopsies from endoscopy at SCH on 27 April 2020 do not show "active colitis" as contemporaneously reported, but "mild focal active colitis". Biopsies from endoscopy performed three days later show "moderate reactive gastropathy" not previously seen. This is a feature "occasioned by many different causes", amongst which are NSAIDs. Biopsies from an upper GI endoscopy and sigmoidoscopy on 16 June 2020 at SCH were essentially normal.

The final set of endoscopic biopsies were taken at SCH on 22 February 2021. The colonoscopic biopsies show no significant histological abnormalities, no features to suggest chronic inflammatory bowel disease, and no features of NSAID toxicity.

120. On reviewing the histopathological evidence, Professor Shepherd concluded in his written evidence that there was intermittent focal active colitis (FAC) and that the literature suggests that most cases of FAC are due to infection or drugs, particularly NSAIDs, but can "on occasion, presage a diagnosis of chronic inflammatory bowel disease". He advised that, "the presence of focal active colitis provides a little bit of support for a diagnosis of NSAID toxicity but cannot be regarded as specific" and "I personally do not think the pathological evidence is very strong in this case " for NSAID poisoning." In his oral evidence, Professor Shepherd confirmed that he could not rely on histopathological evidence alone as evidence of when NSAIDs might have been ingested, nor the quantity ingested, by BR.

121. Mr Lander, Consultant Paediatric Surgeon, provided expert opinion evidence in relation to all three cases. As well as his expertise from conducting paediatric gastro-intestinal surgery, he has considerable experience of central line insertion and management. His involvement in this case has caused him to examine practices and infection rates within his own hospital in Birmingham. He was anxious to explain his opinions and to do so in sometimes blunt language.

a. Mr Lander was content that the records demonstrated that the line insertions had been competently performed. Upon finding that a central line is infected, difficult judgments have to be made. If the line is removed, a precious means of giving nutrition to a developing child is lost and a new line is likely to have to be inserted. As more lines are lost over time through infection, any remaining line becomes even more precious – a life-saver for the child. However, if a central line is infected, it is a potential source of more infective organisms entering the child's bloodstream, prolonging or exacerbating their sepsis, threatening their life. In retrospect, Mr Lander might have changed one line earlier, or another later, but these are difficult judgment calls and he considered that overall the line management was to a reasonable standard.

b. Mr Lander did note that when line insertion was performed at Hospital A, they would sometimes use devices, such as the securacath, that were not well known to the staff at SCH. Better liaison between the two hospitals might have resulted in more consistency in line care, for example, in relation to the frequency of changing biopatches or dressings.

c. He was critical of the way in which the RCA had been set up. The ambit of the report should have been far wider and the investigating team should have included gastroenterology and microbiology specialist doctors, not just the two nurses who were requested to report. However, he agreed that there was no evidence of systemic deficiencies with line management at SCH at the relevant time.

d. The incidence of line infection at Mr Lander's Birmingham Hospital was about 1 in 1000 central venous catheter (CVC) days, i.e. one infection every thousand days a central line is in situ. This is an average but he would not accept that it could be expected to be higher for children on long term PN. That is surprising evidence given the other evidence I have received about the vulnerability to infection of children on long term PN. Polymicrobial line infections (where two or more organisms are isolated from a central line at the same time) were rare, and repeated polymicrobial line infections as were suffered by each of the three children, were extremely rare.

e. He did not think that any of the three children suffered bloodstream infections as a result of translocation of bacteria from their guts which, for a long time, had been a working hypothesis amongst the gastroenterological team at SCH. He did not doubt that bacteria might move from the gut to the bloodstream but noted that this must happen frequently when he is performing surgery without causing symptomatic bloodstream infection. Given the bacteria isolated, in particular the bowel flora, it was likely that each child suffered bloodstream infections due to extrinsic contamination, whether deliberate or inadvertent. He accepted that if a child was on steroids this might result in immunosuppression which might increase the risk of translocation. Similarly, NSAID ingestion, immobility, stress, and disturbance of the normal bacterial of the gut (for example, due to long term use of antibiotics) may all contribute to an increased risk of translocation and/or sepsis following translocation. However, he was keen to emphasise that the increased risk would be a small increase in relative risk but the absolute risk of bloodstream infection following translocation would remain very small. He considered that the degree of immunosuppression that might make a material difference to the risk of translocation leading to sepsis, was that found with children on chemotherapy or with bone marrow deficiencies, not that suffered by BR due to being given steroids. In the case of each of BR, HS, and LW, it was much more likely that bloodstream infection was due to contamination of the central lines.

f. In his view, polymicrobial line infection would require an abundance of bacteria, not microscopic. However his view on that issue was clearly one of judgment, not one that he backed up with any published research, and it did not fully accord with evidence from Dr Rajendran.

g. Mr Lander did not believe that a neat temporal relationship existed between the introduction of an infective organism into the bloodstream and signs of bloodstream infection such as a spiking temperature, rigors, or tachycardia. Sometimes bacteria would collect in the plastic line and would not cause symptoms until it was flushed into the bloodstream, perhaps by a saline flush when administering intravenous medication, causing a "shower" of bacteria that triggers sepsis. However, he advised that if faecal material were injected into a central line, the child would become ill "very quickly".

h. He accepted that sometimes a child who has apparently been unable to feed enterally, and who has been supported with PN will, after a period of time, spontaneously, unexpectedly, and without apparent cause, simply improve and start enteral or oral feeding.

122. Dr Rajendran, Consultant Microbiologist, helpfully described the many different bacteria that had been isolated from blood samples from BR, HS, and LW at various times. Some were commonly found in the mouth or on the skin. Some were known to be present in the environment. Many were bowel flora. He explained that the presence of one type of bacteria might create the conditions for a different, secondary type of bacteria to grow. If, however, the first bacteria appeared to have been successfully treated but then was later isolated from a further blood sample, that might be a recurrence of the same bacteria which had in fact survived treatment, or be a new occurrence of the same species. It was therefore reasonable to view some clusters of infection as part of a single "event", but that would depend on the particular facts and findings at the relevant time. Dr Rajendran also advised the court that:

a. He considered translocation to be an unlikely explanation of the bloodstream infections suffered in these cases. Initially, he had considered translocation as a more likely explanation but, after reading the reports of Mr Lander and Professor Sullivan, and discussing the cases with them, he had changed his mind. He accepted, as did Mr Lander, that factors which were present in the cases of BR, HS, and LW, to a greater or lesser extent, including prematurity, NSAID ingestions, and steroids, could increase the risk of translocation. Nevertheless, he still considered that translocation was very unlikely to be the cause of bloodstream infections in these cases.

b. Infection was likely to take longer to take hold in tunnelled lines (where the central line passes through tissue before entering the large vessel) than in non-tunnelled lines (when the line goes straight into the large vessel). If faecal material were introduced straight into a line, then signs of bloodstream infection might arise within an hour.

c. A line could become infected as a result of a bloodstream infection, but more often a bloodstream infection will follow a central line infection. Where the same infective organism is grown from a central line blood sample and a peripheral blood sample taken at the same time, then that will confirm a bloodstream infection.

d. Infective organisms have to enter the line to then enter the bloodstream and cause bloodstream infection. The line must be breached in order for contamination with infective organisms to occur. This might be by way of disconnection, the line being pulled out, or deliberate introduction, for example via a syringe. A child who chewed into a line or around a bung that was then released, might introduce oral flora into the line. Some of the infective organisms isolated, such as candida, would fall into that category. If the child handled a line that had been or was then breached, for example by chewing, and its hands were contaminated with bowel flora, for example from contact with the contents of its nappy, then potentially, that might be a source of contamination of a central line with bowel flora.

e. A blood sample from LW on 2 March 2021 grew salmonella. Dr Rajendran had never seen salmonella isolated from a child on TPN.

f. The number of line infections and new central line insertions in each of the three cases I am considering, was exceptional.

123. During the course of the hearing, due to the research of Mr Howe KC and Mr Hutchinson, the court was informed that a National Patient Safety Alert had been issued by the Medicines and Healthcare products Regulatory Agency (MHRA) in respect of certain equipment related to the use of Alaris pumps – the pumps and equipment used at SCH for delivering PN to in-patients. The alert was issued on 11 March 2021 and arose because the manufacturer of the equipment, Becton Dickinson, were unable to guarantee its sterility. I heard evidence from staff members at the Trust as to the actions taken in response to the alert, and from Dr SD, Consultant Microbiologist at SCH, and expert witnesses, as to the relevance of the alert to the present case. It appears that the sterility issue concerned a new contractor who had not complied fully with the standards imposed by Becton Dickinson. There is no suggestion that equipment might have been contaminated with any particular pathogens, let alone bacteria typically found in the bowel. SCH did not systematically trace to which wards and patients the equipment was sent, but most of the Alaris pumps and associated equipment in use was potentially affected by the alert. A risk assessment was performed and it was decided to continue to use the equipment, but as conservatively as possible, until new equipment arrived. I am quite satisfied that there is no chance that the infections suffered by the three children with whom I am primarily concerned were caused as a result of any manufacturing issue that was the subject of the MHRA alert in March 2021. There is not even one case reported internationally of a patient suffering an infection as a result of the sterility issue raised in the alert. Dr Rajendran advised, and I accept, that if the sterility issue had given rise to an infection, one would have expected a single organism, of the kind that might survive the clean manufacturing process, to have been isolated. In the case of these three children, they suffered multiple organisms of a wide variety, but not of the kind that would have been expected to arise from the sterility issue. I am satisfied that the MHRA alert is a red herring in this case and that the sterility issues that gave rise to the alert did not cause any infections of any of the children with whom I am concerned.

124. Dr Alwan Walker, Consultant Paediatric Radiologist with a special interest in gastrointestinal radiology, reviewed the radiological evidence in the cases of BR and LW. He advised that x-ray evidence was not helpful and that, since ultrasound scans are dynamic, he is not in a position to question the reports made at the time. With regard to BR, Dr Alwan Walker noted an MR scan of the abdomen in August 2020 and a CR scan in November 2020, which in his opinion showed equivocal or mild thickening of the bowel. An ultrasound scan in August 2020 was similarly reported. However, a subsequent MRI scan on 25 February 2021 did not show any convincing thickening. He explained that there is no neat correlation between ingestion of NSAIDs and radiological appearances. The radiological imaging in BR's case could not be relied upon as confirmatory of the ingestion of NSAIDs shown by the agreed results of urine and blood sampling, but it was possible that such ingestion was the cause of the equivocal or mild thickening he had noted on the imaging. As I understood his evidence, the absence

of thickening seen on other imaging of BR's abdomen and gut, is not disprobative of longer term or more frequent ingestion of NSAIDs than those revealed by the sampling results. In relation to LW, Dr Alwan Walker had commented in his written evidence on the number of occasions when a central line tip had been noted to be sitting "low", meaning that it was inserted too far and too close to the heart itself. He had raised the possibility that these might be examples of the line having been moved since insertion. However, when he was taken through the evidence in cross-examination, he was unable to identify to my satisfaction more than two or three occasions when a tip appeared to have moved further towards the heart after having been fixed at insertion, and he accepted that those cases might have been caused inadvertently when the line was handled or the child moved around. Therefore, he did not provide evidence of deliberate manipulation of LW's central lines to cause the tips to lie too low.

125. Dr Ward, Consultant Paediatrician, produced very detailed reports in respect of each of the three children, BR, HS, and LW. She impressed as a thoughtful expert who had given considerable care when reporting on the three cases. However, reports in each case of about 400 pages are very burdensome to the parties and the court. The importance of a chronology cannot be overstated in such cases, and I understand an expert's desire to build their own chronology rather than relying on others' work, but the detail within the chronologies provided was not altogether necessary particularly when chronologies had already been prepared as part of the "bundle" of documentation and, in any event, the key aspects of the chronology were then repeated in the "discussion" section of each report.

126. In relation to BR's initial presentation and treatment, including at Hospital A in 2019, Dr Ward's opinion was that there "were indicators of organic disease such as raised faecal calprotectin [and] inflammatory changes on endoscopy and histopathology. However, her behaviour, including escalating pain medication as a result of poor response to analgesia and perplexing presentation suggests that functional abdominal pain may have co-existed with ulceration and inflammation in the bowel." Dr Ward also opined that BR's "ongoing symptoms at present are likely to be a reflection of functional abdominal pain." Dr Ward was anxious to point out that a diagnosis that BR has suffered and is suffering from functional abdominal pain is not synonymous with BR "making it up" as BR seems to believe. Pain perception is complex and involves "visceral sensitivity and psychological processing." As another expert told the court, the nervous system around the gut is extremely complex and is connected to the central nervous system. So, dysfunction of the nervous system around the gut and/or its connection to the central nervous system can lead to an abnormal sensation of pain.

127. Dr Ward explained to the court in her written and oral evidence that diagnosis of Crohn's disease is made on the basis of the clinical, radiological, laboratory, and histopathological findings. In the early stages of her illness, BR was treated for presumed Crohn's disease with multiple drugs and therapeutic agents including infliximab and steroids, with no effect. The investigations at Hospital B were negative, and a diagnosis of Crohn's disease cannot be supported. Instead, in Dr Ward's opinion, "NSAID related intestinal injury would better explain the clinical, radiological and pathological presentation and would also explain the improvement when safeguarding procedures were implemented" i.e.

after MR's arrest. In her comprehensive written report dated 23 March 2022, updated, regarding BR, Dr Ward wrote,

> "it is important to consider tampering with the central line as an aetiological factor, but I have not identified any evidence of this in the chronology. I defer to microbiological opinion in the analysis of the specific organisms."

128. In relation to HS, Dr Ward's substantive report is dated 19 October 2022. In it, she states that HS's

> "neonatal problems were genuine and, although it is difficult to confirm diagnoses of gastroesophageal reflux and cow's milk protein intolerance, these are common problems in infancy; especially in preterm infants. There were no concerns regarding perplexing illness or fabricated/induced illness in the neonatal period and in the weeks following discharge."

Dr Ward also stated,

> "Following chicken pox, HS showed increasing feed intolerance with the development of reported pain on enteral feeding. Eventually this led to the introduction of parenteral feeding and a suspicion of gut dysmotility or post infectious gut hyperaesthesia. Investigations failed to identify any underlying gastrointestinal pathology and HS' presentation was increasingly perplexing with apparent pain and distress on introduction of miniscule volumes of clear fluids, drugs or formula into the PEG."

129. In relation to HS's line infections, Dr Ward's written opinion was that,

> "the number of infections and spectrum of micro-organisms demonstrated in HS was not typical of a child on parenteral nutrition with normal immune function… Although HS was seen chewing lines and fiddling with equipment, the number and nature of disconnections could not be explained by HS causing these himself - especially with the level of supervision afforded. The most likely explanation for recurrent episodes of sepsis was external manipulation/tampering with lines and parenteral nutrition.
>
> "With hindsight HS was exposed to unnecessary investigations, interventions and treatment. However, this only became apparent when there was separation from his mother which resulted in recovery to the extent that he was able to tolerate enteral feeds and introduction of oral feeding … prolonged hospitalisation, investigations, procedures and treatment were the result of extrinsic factors and, more likely than not, induced illness …

> In my opinion, it is more likely than not that HS was the subject of fabricated and importantly induced illness involving manipulation of gastrostomy buttons, peripheral and central venous lines and parenteral nutrition."

This passage is an example, in my respectful view, of an expert trespassing into functions of fact finding that are for the judge.

130. Dr Ward's report on LW is dated 26 August 2022. In it, Dr Ward sets out LW's "complex medical history" – born at 24^{+2} weeks, extremely low birth weight, respiratory distress syndrome, apnoeic spells, bronchopulmonary dysplasia, intraventricular haemorrhage, necrotising entercolitis requiring bowel resection and jejunostomy (later closed), and jaundice. Nevertheless, she states,

> "his presentation, requiring repeated admission and prolonged periods in hospitals was considered to be perplexing. It is not possible retrospectively to analyse the exact cause for his apparent intestinal failure and recurrent episodes of sepsis. However, the dramatic recovery described in October 2021 when his mother was removed from the hospital supports a history of fabricated or induced illness… The cause of severe episodes of life threatening sepsis remains unexplained and the possibility of tampering with the lines/contamination of parenteral nutrition must be considered."

131. Dr Ward considered it "surprising" that MT not only declined transplant surgery but also declined further assessment of second opinion at Hospital B or Hospital G. In Dr Ward's view, consideration of transplant surgery was "reasonable". Dr Ward also wrote that "LW's mother was in favour of a palliative pathway and that "it is of concern that the mother presented the outdated LOTA at another hospital [Hospital E] when LW presented with sepsis and peripheral cannulation was difficult. It is now apparent that a limitation of treatment is inappropriate and unwarranted." She concludes that, "LW's perplexing presentation at the time of implementation of the palliative care/end of life plan and his subsequent dramatic recovery support a diagnosis of FII." Again, this part of Dr Ward's evidence includes assumptions and conclusions about non-medical matters.

132. In relation to certain specific issues, Dr Ward says, firstly, that, given LW's developmental level and past history, the account given by his mother of the accident leading to the femoral fracture was consistent with the injury described. Secondly, Dr Ward notes that on two occasions, in December 2020 and January 2021, LW's urine tested positive for ibuprofen. She describes the findings as "puzzling". Although a widely prescribed drug, there is no record of it having been prescribed for LW. There is no evidence of gastric damage from endoscopic investigations, but such investigations did not extend to the small bowel. Thirdly, Dr Ward addresses the question of whether MT had followed medical advice, saying that, "In general the mother appeared to be compliant with appointments and medical advice [but] On occasions the mother acted independently, not

following medical advice strictly." She gave examples upon which Wakefield MDC rely in their schedule of allegations.

133. In her oral evidence Dr Ward very helpfully described the RCPCH Guidance on perplexing illness/FII. She said that although the guidance was updated in 2021, the principles set out in the updated guidance had already been established practice in many areas for some years. Previously, it had been felt that when there was suspicion of FII there should be no communication with the family about the concerns. Over time a different approach led to evidence-based work and publication of the 2021 guidance. The recommended practice set out in that guidance was that where there were complex issues and uncertainty as to whether symptoms were the result of physical illness or functional illness, but there were perplexing aspects of suspicions, there should be an MDT approach including the child and parents to address the problem. That would usually lead to a health rehabilitation plan so that there would be clear recommendations and points of agreement as to how the case would be taken forward. If evidence then came to light that the child was at immediate risk of harm, that approach could not be continued and referral to social services and/or the police would be made. Dr Ward agreed that an important part of the guidance was to carry out a family analysis and that this was not done.

134. Dr Ward also told the court that with hindsight, LW's gut could have been challenged sooner than it was in 2021, i.e. before MT was arrested, but that the clinicians were being given a history of unexplained responses to very small quantities of food or fluid. She advised that there is a great deal of psychology involved in gastroenterology and parents can become fearful of feeding children due to past difficulties. The parental fear can communicate itself to the child. Therefore the mere presence of a parent could cause an adverse reaction to feeding by the child.

135. Dr Ward told the court that she had originally been instructed in the case of family R and had not then been aware of the linked cases. Later she was instructed in relation to families S and T but "I was not asked to consider potential linkage and considered each case as an individual case." Dr Ward told me that each of the three cases would be a once in a career case for most clinicians given the number and type of repeat line infections. The only connections she could see between the cases were a temporal and a geographical linkage which might give an opportunity of contact between the families, and the similarities in microbiology (the type of infective organisms) and toxicology (ibuprofen ingestion). She had experience of one case where it was concluded that faecal material was injected into a line to harm a child, confirming therefore that it is a known mechanism of induction, not one unique to these cases, as alleged.

136. Professor Johnston, Consultant Toxicologist, confirmed that a dose of ibuprofen would be eliminated from a person's urine or blood within at most 24 to 36 hours. Piroxicam would be eliminated within a few days of use. The elimination times would be the same from the last dose even if the drugs had been taken persistently over a period of time. The elimination times should be regarded as the same for children as for adults.

137. Professor Johnston advised that the HST results for HS were unreliable and uninterpretable. It was important that a reliable sample is collected and "if you start with an unreliable sample you get an unreliable result". It appears the hair samples from HS were "taken randomly, the evidence chain is not established, and "I don't think the results help you." As for the HST for BR, he considered that it did show a likely reduced dosage over time but this was relative – he could not advise what the absolute dosage ingested was at any one time – the HST evidence could not establish that.

138. Professor Sullivan, Consultant Paediatric Gastroenterologist, provided the court with concise, well-targeted reports. He did not profess to have expertise in FII but is an eminent paediatric gastroenterologist whose evidence in relation to symptoms, diagnoses, use of PN, and other matters relating to the care of children with complex gastroenterological presentations was of considerable assistance to the court. He had been party to the joint statement of agreement following the experts' meeting with Dr Ward, Dr Rajendran, and Mr Lander. During his oral evidence, his opinion shifted somewhat as I shall explain.

139. Professor Sullivan explained to the court that although NSAIDs are eliminated from the body fairly rapidly, they need only be taken for a short time, perhaps a few days, to cause gastro-intestinal complications. A single dose might see some "local reaction in the stomach on endoscopy immediately after ingestion or it might not" and a single dose of an NSAID was unlikely to cause GI bleeding or other problems. The mechanism of damage by NSAID ingestion is multi-factorial. Proton pump inhibitors (PPI) such as omeprazole only protect the stomach and duodenum, not the lower tract and they only "turn off the tap of gastric acid" which is one noxious stimulus; they will not protect against the other mechanisms of damage from NSAIDs. Raised levels of faecal calprotectin provide a non-specific indicator of intestinal inflammation. In his opinion, with the benefit of hindsight, raised levels of faecal calprotectin in BR's case, were not due to inflammatory bowel disease which has not been shown on extensive investigation. It is more likely than not, in his opinion, that the raised faecal calprotectin levels at various stages in BR's history, were cause by NSAID toxicity. On occasions the faecal calprotectin level would be masked by steroid use. I found Professor Sullivan's evidence to be compelling that an underlying pathology of IBD has been effectively ruled out in BR's case and that NSAID toxicity has caused her intestinal inflammation, ulceration, and GI bleeding.

140. Professor Sullivan considered it highly unlikely that bowel flora could have translocated from the gut to the bloodstream in any of the cases of the three children, even if some damage were caused by NSAID ingestion. In line with Mr Lander, he took into account various factors such as steroid ingestion and immunosuppression but discounted translocation as a "reasonable explanation".

141. Professor Sullivan, as with the other expert witnesses, had to respond to important further evidence, both from witnesses and that which had been disclosed after the completion of his written evidence and the experts' joint meeting. I found him to be suitably open to consideration of the late evidence and flexible in adapting his opinions to it. Furthermore, he was open-minded, as he should have been, about the question of FII. His thinking about deliberate contamination

evolved. Thus, he spoke to his original written opinion that it was most likely that faecal material had been introduced into central lines deliberately –

> "I could not see how acts of omission – environmental circumstances – could be responsible. The alternative is that it was deliberate but [I accept] there is no objective evidence of anyone deliberately contaminating the line…"

He explained that to deliberately introduce faecal material into a central line one would have to,

> "have faeces, take off the covering of the line and put the faeces in the line with a cotton bud or the end of a finger …. A very small amount – if you put in a large amount you would have endotoxic shock – the patient would collapse – so you don't need very much – it could be just dirty fingers – faecally contaminated fingers – if they handled the line that way it could cause it. There would not need to be a visible amount of faeces."

As to the ward environment or the possible introduction of faecal bacteria by omission, he then modified his view during oral evidence. First, he said that "I had not seen anything that made me stop to question whether the procedures [followed by the nursing team] were responsible – it does not mean to say that there were not, it just means that I had not seen anything." But, when alerted to evidence given about procedures and in particular to the more recently obtained minutes of the Board of Directors of the Trust meeting, which provided evidence of under-staffing on the wards and poor staff morale and stress, he said that there was evidence of "huge staffing difficulties [which] throw new light on the matter and raise the possibility that infections could have been accidental rather than deliberate… I have never seen deliberate contamination of central lines in one case let alone three. What we have is a more nuanced understanding of what was going on on the floor and it alters the balance of consideration."

142. In relation to the case of HS, Professor Sullivan said in answer to a question from Ms Heaton KC who suggested that he had not identified prematurity as a reason for HS's lack of ability to feed in hospital from March 2020 to October 2021,

> "I think I *do* attribute his difficulty establishing feeds to his prematurity – difficulty in establishing feeds has long term consequences … the period you refer to has its origins in prematurity…. The short point I make is that if it is difficult when he starts it increases the chance that it continues to be difficult – his difficulties had their origin in the neonatal period."

Professor Sullivan accepted in oral evidence that chicken pox might have been "the straw to break the camel's back" in that it could have caused an inflammatory intestinal reaction in a vulnerable child. Elsewhere this has been referred to as causing "visceral hypersensitivity". When asked about the instant response HS had shown to enteral administration of a small amount of fluid, he said that "if I was the physician attending, the instant response he had would make me wonder if there

had been leakage from outside the stomach, a bit like peritonitis if you like – some of it getting outside of the stomach…. A leakage from a gastrostomy is painful and could be between the skin and the stomach." This would apply equally to LW's similar response on 2 March 2021 for example. He was sympathetic to MS's reticence about the proposal to feed HS under sedation. He also stated that whilst HS's recovery after the removal of his mother "raises the question that this might be FII …. That could be an over-simplistic interpretation of the facts." Later, in response to Ms Heaton's questioning he said this in relation to the repeated line infections,

> "if the assumption is that this was not translocation then it is either careless handling or somebody doing something to the lines… maternal over-reporting and discrepancy between investigations and the history and poor response to treatment: all those points go to consideration of FII and those were all present in this case but when we start to tease apart the fine detail we get a much more nuanced understanding of how things are happening and it is not at all clearcut that MS was responsible for all these problems HS suffered…"

143. In relation to LW, Professor Sullivan did depart from his original written opinion to a significant extent when giving oral evidence. Responding to the evidence disclosed after he had completed his written evidence he agreed that the steps that were taken in October 2021 after the mother had been arrested were similar to parts of the plan that had been made in March 2021 but which was not implemented before her arrest. He said, "Now we are in possession of a much more nuanced degree of detail we have to come to the conclusion that it is over-simplistic to interpret the absence of the mother and apparent improvement of the child as causally related…" Further, he was "very sympathetic" to MT's preference not to want LW to go to Hospital B for investigations.

144. I received evidence from Dr Jones, Forensic Scientist, including in relation to her analysis of the contents within a feeding tube that had been used for the treatment of BR. I received written and oral evidence from Dr Dunham, psychologist who reported on BR, and written evidence from Professor Payne-James, Forensic Physician instructed on behalf of MR, who reported on MR and her medical history, and Dr Van Velson, Forensic Psychiatrist, again instructed on behalf of MR, who reported on MR's mental health. I take full account of their evidence. Dr Payne-James's general summary and comments show that MR developed left wrist pain in 1992 for which no cause was found despite extensive investigation. In 1995 it was noted that she had a "significant degree of [pain] dysfunction leading to a breakdown in her normal life and activities." It was noted in November 1995 that "I was still concerned to find that her mother [MGMR] is still considering organic illness as cause for MR's persistent pain. I think MR does realise we are unlikely to find a cause for this." After developing back pain in 1999 investigations did show some degenerative back changes but radiological appearances were not substantial. MR's symptoms were nevertheless severe including difficulty passing urine, necessitating catheterisation, and mobility restrictions requiring the use of a wheelchair. She was prescribed significant

amounts of painkillers. She underwent a discectomy in 2001 but her symptoms got worse. She was investigated by neurologists and infectious disease specialists. A neurologist reported a "very strange collapse". Inconsistent signs were elicited on examinations and it was concluded that her pain was not caused by any physical issues. MR was admitted to a psychiatric unit for several months in 2002 and a diagnosis of somatoform pain disorder was made.

145. I also received expert evidence in the form of Hair Strand Testing (HST) reports. The experts producing the reports and evidence on HST were Paul Hunter and Dr Matt Stirling from FTS, and David Nicholson, Georgina Georgiou and Dr Craig Chatterton on behalf of DNA Legal. They produced a schedule of agreement and disagreement following a joint meeting. Professor Johnston's evidence was also relevant to this area of expert evidence. As a generality I observe that whilst HST is well developed in relation to illicit substances such as cannabis or cocaine, there is no similar evidence base for the prescribed medications - in particular, ibuprofen, piroxicam, and bisacodyl - that are of relevance to the present case. There was some debate about various aspects of this evidence during the hearing, but ultimately the parties in the case of family R, to whom the evidence was of most relevance, came to positions that prevented the need to call oral evidence on HST and for me to make detailed findings about the reliability of the evidence. Nevertheless, it is important to note that there is no established limit of detection for ibuprofen, piroxicam or bisacodyl. One testing laboratory might report a sample as containing no ibuprofen metabolite whilst another laboratory might report the same sample as positive because they had used different limits of detection. There is an absence of reliable, peer-reviewed data or studies to establish a common limit of detection. Furthermore, the evidence does not allow the court to make findings of the absolute dosage or the precise dates of ingestion even if there is evidence of ingestion. I also have to take into account the possibility of contamination rather than ingestion to account for positive results on testing.

146. Notwithstanding those caveats, the experts' agreements and the position of the parties in the case of family R allow me to accept the HST evidence as showing as follows:

a. ingestion by BR of ibuprofen during each month for the approximate 12-month period from around April 2020 to April/May 2021 - there is likely to have been a higher frequency of ingestion around March/April 2020, which falls significantly from around May to July 2020, and then falls more progressively over the subsequent months but no conclusions can be drawn about the absolute levels of ingestion.

b. ingestion of piroxicam on what is likely to have been multiple occasions from around April 2020 to early-May 2021.

c. Ingestion of bisacodyl, on what is likely to have been multiple occasions from around April to August 2020, October to December 2020, and late-March to early-May 2021.

Whilst there is HST evidence also of ingestion by BR of Tramadol and Trimethoprim, I am not concerned with the ingestion of those drugs for the purpose of this judgment as I shall explain a little more fully in Part E3 below.

147. I have already noted the evidence of Professor Johnston regarding HST evidence in relation to HS. I disregard the HST evidence of ingestion of unprescribed drugs by HS as unreliable.

148. The joint meeting of Mr Lander, Dr Ward, Professor Sullivan and Dr Rajendran, was of importance, albeit that further evidence was subsequently disclosed. At the meeting, Dr Rajendran changed his opinion in relation to translocation as a possible explanation for bloodstream infections from the gut. He accepted the consensus that this was an unlikely infective mechanism. Thus, the common opinion was that in each case there was no other plausible bacterial route of entry to the bloodstream for faecal bacteria than through the central lines. The four experts agreed that:

a. Medical features common to all three cases included gastrointestinal dysfunction, multiple and varied line infections with multiple organisms (predominantly bowel flora), failure to thrive and issues of gut motility, speed of recovery when each mother was removed, and evidence of unprescribed drugs and concern regarding each mother's behaviour.

Re BR:

b. Factors "pointing to FII" in BR's case were the frequency and number of line infections and rapid recovery when MR was removed. Mr Lander, Professor Sullivan, and Dr Ward agreed that the toxicology and evidence of unprescribed NSAIDs was another relevant factor and Professor Sullivan and Dr Ward agreed that the fact that no organic cause was found was a third factor. As to factors "pointing away from FII" all agreed that lines and tubes can be dislodged accidentally and there was no observed tampering. Dr Ward and Professor Sullivan agreed that BR's own role in fabrication required exploration.

c. All agreed that diagnoses of Crohn's disease, colitis, vasculitis or other IBD were unlikely. Professor Shepherd later agreed with that conclusion. Dr Ward, Mr Lander, and Professor Sullivan agreed that there was a likely to be a psychological element to BR's pain. All agreed that translocation "is unlikely to be the mechanism" by which sepsis occurred in BR's case and that BR was not at high risk of translocation of a whole host of bacteria.

d. All agreed that multiple polymicrobial central line infections are rare and that BR was not at high risk of multiple polymicrobial central line infections.

e. Mr Lander and Dr Rajendran agreed that central line "contamination could be accidental after toileting and failure to wash hands."

Re HS:

f. Factors pointing to FII in HS's case were that the bowel organisms in line infections suggested contamination. Professor Sullivan, Mr Lander, and Dr Ward agreed that there was a discrepancy between the maternally reported history and investigation findings, a lack of a recognised clinical picture, an inexplicably poor response to treatment, and a rapid and dramatic improvement once the mother was removed. Dr Ward added exposure to NSAIDs [but the evidence of Professor Johnston now precludes the court from relying on the HST evidence of exposure to NSAIDs].

g. The experts could not identify any factors pointing away from FII.

Re LW:

h. The experts agreed that factors pointing to FII in LW's case were recurrent line infections and a "turn around in presentation when mother was removed". The experts also included: "agreement that LW's case was complex given his history" and "agreement that mother was right not to pursue bowel transplant" but those do not appear to me to be factors that weigh in favour of a finding of FII. Dr Ward also raised the presence of ibuprofen but noted that it was "difficult to distinguish in this case" between genuine problems and associated anxiety, and FII.

i. As for "factors pointing away from FII" the agreed response of the experts was, "All agree that the evidence supports FII". Dr Ward and Mr Lander point out that there were pre-existing pathologies. Dr Ward cannot pinpoint when the genuine pathology ended and FII began and when perplexing presentation merged into FII. Dr Ward considers the microbiology and, in particular, the toxicology, important the others said, "No disagreement with observations made by Dr Ward."

j. The experts agreed that intestinal failure due to short bowel syndrome and/or intestinal dysmotility were incorrectly diagnosed but considered that those diagnoses were made on the basis of fabricated histories. I observe that the experts cannot have meant that MT was responsible for an incorrect diagnosis of short bowel syndrome which is a technical diagnosis dependant on certain criteria being met.

k. The experts did not think that the seizure like activity or vacant episodes were necessarily linked to FII and could not rule out that they had an organic cause.

149. As is evident from my summary of Professor Sullivan's evidence at court, his position in relation to some of these conclusions changed. In particular, in the light of further evidence and scrutiny he told the court that it was over-simplistic to conclude that the rapid improvements in HS and LW following their mothers' arrests were due to their mothers' removal from their care. He also expressed much more caution about concluding in HS's case that repeated line infections were due to the mother's care, because of the possibility of environmental factors, particularly those that might be associated with a nursing team under stress. It appears to me that, logically, the same caution must apply, if it is right to apply it at all, to the other two cases of BR and LW. Pertinent to that issue is the fact that the four experts at the joint meeting expressed their agreed "disappointment re the

RCA (did not have senior clinical leadership)". In oral evidence, Dr Ward, Mr Lander, and Professor Sullivan all told the court that the RCA did not effectively examine the possible sources of repeated line infections.

PART D: SUBMISSIONS

150. Unfortunately, MT, one of the last witnesses timetabled to give evidence, tested positive for Covid-19 shortly prior to the date on which she was due to begin. Her evidence was expected to last two to three days. She recovered and tested negative the following week and was able to give evidence then, but that was on days provisionally allocated to hearing oral submissions. Arrangements for Counsel to return to court for oral submissions would have significantly delayed the conclusion of the hearing and the delivery of this judgment, so I directed that the parties should provide written submissions only, with an opportunity to provide brief written responses. I am grateful for the extreme care with which Counsel applied themselves to that task. I have had full regard to all the submissions and responses provided.

151. I need not repeat the detailed submissions made but should record that, although some allegations were withdrawn at the close of the evidence, all the Local Authorities have maintained their core allegations against the three mothers. The mothers strongly dispute all the allegations made. In each case the Children's Guardian supports the Local Authority's position. I also received submissions on behalf of AR and from the Trust. I should record that Mr Cox KC and Mr Berry representing the Trust took an active role in questioning witnesses and in properly challenging suggestions of deficient practice at SCH during the hearing.

152. It is of note that the parties could hardly be further apart in their analyses of the evidence. Even when factual evidence has not been disputed, what to one party constitutes clear evidence of induction of illness, to another is evidence of proper parental care of their child. One party's fabrication is another's appropriate reporting. There is very little common ground. The Local Authorities all rely heavily on evidence from clinicians and the experts that (i) there was no underlying medical explanation for the clinical presentations and reported symptoms of the children, and (ii) the number and type of line infections is inexplicable other than as a product of deliberate line contamination and the only persons who could be responsible for deliberate contamination are the mothers. The parents contend that, on close scrutiny, many incidents that supposedly provide evidence of fabrication are perfectly innocent; that in the cases of HS and LW, the incidents that triggered their mothers' arrests have been wholly misinterpreted; and that medical and nursing records of symptoms should be taken as read in the absence of clear evidence that they are unreliable. HS and LW were premature and clearly had significant feeding difficulties. HS was atypical in the way in which he would manipulate and interfere with his lines. There are many factors that could explain the presentations in these cases other than deliberate induction by the mothers.

153. As for the ingestion of NSAIDs by BR, MR's case, supported by FR, is that the evidence points to BR as having self-administered such medication, and that the evidence does not establish MR as having been involved. She denies any knowledge or participation in the administration of unprescribed medication. As for the repeated infections, the parents do not purport to provide an explanation, but do point to factors, such as nursing practices, that may have made a contribution. More fundamentally they strongly caution against drawing a speculative inference that, because no other explanation has been identified, the mothers must have deliberately contaminated the lines. There is no evidence of collusion amongst the mothers and so, it is said using a metaphor that became quite elaborate during some submissions, the court is asked to believe that three highly unusual buses came along at the same time. The coincidence of three mothers happening on the same *modus operandi* to harm their children, in the same place at the same time, is highly implausible. Furthermore, to harm their children, but not to kill them, they must have been capable of knowing just how much or how little faecal material to insert into the central lines. And they must have been extremely adept at acting in that manner without being caught. The circumstances do not permit of the conclusions that the Local Authorities invite the court to draw.

PART E: ANALYSIS

E1: Overview

154. The court is not conducting a general inquiry but, rather, has to determine whether specific allegations made by each Local Authority are proved to the requisite standard, the civil standard on the balance of probabilities. It is important not to allow the label "FII" to obscure the need for rigorous scrutiny of the evidence. In these cases there are allegations of exaggeration, fabrication, and induction of illness. The alleged induction of illness includes two elements: (i) the administration of unprescribed medication or noxious substances to cause gastroenterological symptoms such as diarrhoea, vomiting, pain or gastro-intestinal bleeding, and (ii) the induction of sepsis by introducing faecal material into central lines used for parenteral nutrition and the administration of prescribed drugs. A mother might be guilty of both inducing vomiting and inducing sepsis, but I can only so find if the evidence proves that she did both. It cannot be assumed that if a mother has induced vomiting that she must have induced sepsis.

155. It is in the nature of most cases involving actual FII, that for a period of time professionals will have misunderstood or misinterpreted the child's presentation as a result of parental deceit. To that extent, contemporaneous parental reports of symptoms will be misleading and contemporaneous diagnoses will be unreliable. However, until FII is proved, the court cannot presume that what was reported was misleading or that working diagnoses were unreasonable. How matters appeared at the time might be how matters really were – the report of vomiting might have been true, the child's failure to thrive genuinely attributable to an underlying condition. The views taken by clinicians at the time might have been reasonable.

Often, the contemporaneous evidence is consistent both with fabrication and with fair reporting, with induction of illness or genuine symptoms. The difficulty is in distinguishing between fact and fiction when there is little by way of contemporaneous, objective evidence to determine the difference.

156. Each case requires to be considered separately, but the similarities in these three cases are striking and must also be taken into account. Looked at it the most general terms, if those claiming that the number and type of infections suffered by any one of the children was so unusual that the court should infer they must have been caused deliberately by their mother, does the fact that there were two other children suffering similar numbers and types of infection not undermine the legitimacy of that inference?

157. That these three cases are coterminous raises the question of whether there was some causal link connecting them – something beyond the coincidence of presentation, location, and timing. In respect of the line infections, were there poor hygiene practices at SCH, were there one or two nurses whose practices inadvertently caused repeated line infections, was there a rogue staff member who deliberately caused harm to these three children, was there defective equipment, was there some as yet unidentified common cause?

158. I start by considering the possible explanations of the children's presentations in these three cases in the most general terms. In relation to fabrication or exaggeration when reporting symptoms, in each case the broad possibilities are that,

a. The mother deliberately fabricated and/or exaggerated their child's condition and symptoms either repeatedly and consistently or occasionally with a view to their child receiving unnecessary medical attention or treatment or for some other ulterior purpose;

b. They inadvertently misreported or over-stated their child's condition or symptoms for reasons without wishing to seek unnecessary medical attention or treatment and without any other ulterior purpose; or

c. Their reports to healthcare professionals about their child's condition and symptoms were consistently truthful and accurate.

159. In relation to the induction of gastroenterological signs and symptoms, the possibilities, broadly stated, are that,

a. The mother deliberately administered unprescribed medication or some noxious substance to their child causing them to suffer diarrhoea, vomiting, pain or GI bleeding, doing so either repeatedly or only occasionally. This may have caused all of the child's gastroenterological problems or may have exacerbated or prolonged a pre-existing condition, or conditions, that had a natural cause.

b. Another person deliberately did so;

c. There was no deliberate human intervention but gastroenterological symptoms were caused or exacerbated inadvertently or were entirely or partially due to some underlying medical condition and/or medical interventions.

160. It appears to me that the possibilities I have to consider in respect of the repeat line infections and sepsis suffered by each child are that,

a. There was no deliberate line tampering and all their infections were due to the risks associated with having intravenous lines, translocation of bacteria from the gut into the bloodstream, or to some natural cause, environmental factor and/or other cause(s) that are not understood or have not been identified, including risks associated with medical or nursing practices, or defective equipment;

b. The line infections were due to deliberate contamination and/or tampering by:

i. Their mother;

ii. Another person, be they a healthcare professional, one or both of the other two mothers, or someone else, with or without the knowledge of the child's mother.

161. None of the three mothers in these cases was witnessed causing harm to their child. None was caught preparing to cause harm or obviously covering up harm that they had already caused. In the absence of such direct evidence, the Local Authorities rely in large part on inference. As I listened to and read the statements of witness after witness I was struck by the extent to which underlying assumptions about the mothers' involvement in their children's illnesses affected the way in which many of them presented what they had seen and heard to the court For example, a mother's report of vomiting could be interpreted as a sign that their child genuinely could not tolerate oral feeding, or as an example of the mother fabricating illness. The prism through which the facts are viewed affects the observer's perception of those facts – whether it is the prism of FII or the prism of innocence. The same evidence may lead different people to view the same event in different ways according to their pre-existing beliefs about FII. It is therefore of the utmost importance that I heed the warning of Ryder J in *A County Council v A Mother* (above) and avoid using the label of FII "as a substitute for factual analysis and risk assessment."

162. Before these cases came to the attention of the Local Authorities and the police, the healthcare professionals at SCH had to address evidence that could be interpreted in different ways. The transcript of the safeguarding MDT on 18 March 2021 vividly illustrates the dilemmas the clinicians faced when considering the cases of HS and LW. There were national guidelines for them to follow which advocated a multi-disciplinary team approach, engagement with the family, and the setting of clear goals in a rehabilitation plan, the purpose of those steps being to avoid harm or at least to reduce risk of harm to the child concerned rather than to attribute blame. In my view, in particular in relation to families S and T, the

guidance was not followed as it should have been with the result that when referrals were made to social services and the police in October 2021, the Trust had not gathered the evidence it could have done. Once the referrals had been made, the accepted narrative at the Trust was that each mother was guilty of FII. That assumption has had a number of consequences, leaving the authorities and the court bereft of important evidence which might otherwise have been available.

163. I should also make a general observation about the expert evidence in this case. I have been greatly assisted by the experts' evidence where they have provided the court with the benefit of their knowledge from their particular fields of expertise. I include Dr Ward, but with respect to her, I have concerns that in some respects she and perhaps some of the parties, perceived her role to be to draw from the other experts' opinions in order to present an overview about FII to the court. This was reflected in conclusions such as, "it is more likely than not that HS was the subject of fabricated and, importantly, induced illness", and "LW has a very complex medical history and his genuine medical problems have become intertwined with a perplexing presentation and FII". Professor Sullivan repeatedly said that he was not an expert in FII. He was an expert in paediatric gastroenterology and these three cases involved patients of paediatric gastroenterologists. In many ways therefore he was the expert with the most relevant expertise but, in his oral evidence at least, he properly eschewed the temptation to give a more sweeping assessment of whether he thought the children were victims of FII. Clearly there is a role for paediatric expert evidence as well, but all experts must restrict themselves to their own fields of expertise. Doubtless some paediatricians will have expertise in perplexing presentations and FII and can give useful evidence to the court about the RCPCH guidance, studies of FII and so on. However, there is a danger that a paediatric expert assumes an overarching role enabling them to conclude and advise the court whether a parent is or is not guilty of FII in respect of their child. Such a conclusion can only be reached after consideration of all the evidence, of which expert medical opinion evidence is but one part. I would not criticise an expert such as Dr Ward for failing to consider the wider context such as the child's siblings, relationships within the family, or a parent's medical history. Those are not matters within her expertise as a paediatrician. But, mindful that conclusions made in a court setting about FII require consideration of matters beyond their expertise, it is not appropriate for a paediatrician to purport to reach such conclusions themselves.

164. As it happens, significant further disclosure followed the completion of the experts' written evidence. I found that Professor Sullivan was the expert who most persuasively took that further evidence into account, stepped back from the detail, and adapted his opinion evidence accordingly. I found him to be an authoritative expert witness on whose opinions I can safely rely. Dr Rajendran was also an impressive expert witness, notwithstanding his change of opinion on translocation at and following the experts' meeting. He properly limited his evidence to his field of expertise and so drew back from saying how he thought the bacteria he had expert knowledge of, had entered the children's central lines. He told the court that deliberate or inadvertent contamination could be the cause in any one instance.

165. In making determinations as to the facts, I must avoid the trap identified in *The Popi M* (above) of making a finding of FII solely on the basis that other

explanations are less likely. The question for me is whether the specific factual allegations made by each Local Authority are proved on the balance of probabilities. I must reach my determinations after having surveyed all the evidence in the case. Having heard the three cases together, there is evidence which is relevant to all three families, and evidence that may be directly relevant to one family but which may have some bearing on the facts relating to another. My conclusions have been reached after consideration of all the evidence, but in articulating those conclusions and giving reasons for them, I have to start somewhere. I do so firstly by addressing a core allegation made against each of the mothers separately. I shall then give my conclusions as to why each child required prolonged treatment for gastroenterological issues. Finally, I shall address the allegation common to all three mothers, namely that they deliberately introduced faecal material into their child's central lines thereby causing them to suffer life-threatening sepsis.

E2: SCH: Clinical Practice, Safeguarding, and FII

Clinical Procedures

166. I have had regard to all the evidence I received from nursing staff, PN leads, and ward managers, as well as the RCA report and the expert evidence. I have already set out what the standard procedures were. It would be rare within a large organisation for individuals, occasionally at least, not to fall below the standards they were trained to meet. Furthermore, the court would be unlikely to hear from a nurse, say, that they regularly failed to comply with the required standards of care. The RCA report did not identify systemic deficiencies in nursing practice concerning central line and PN management, nor did they observe any failings in putting standard practices and training into operation on the ward. However, the RCA authors did identify some gaps in communication and documentation that could have given rise to deficiencies in the management and care of central lines. I also heard some evidence of variations in practice, some of which, such as the use of non-sterile gloves, could give rise to inadvertent contamination of lines. There was also a significant change in practice during the period with which I am concerned, involving the preparation of PN feed and the delivery to the wards of spiked bags, which put some stress on the nursing teams, as recognised in the RCA report. However, I have received no evidence of specific failings, systemic or individual, that could account by itself for the number and type of infections suffered by BR, HS, and LW. Furthermore, any outbreak or systemic failings would be expected to affect other children on the ward or in the hospital and there is no evidence that such widespread problems existed. It is not that no other child suffered line infections, but rather that there is no evidence of a particular infection spreading through the ward affecting other children.

167. As to the equipment, I do regard the Becton Dickinson alert as a red herring in these cases. However, there was evidence that bungs, the connectors which can be separated to gain access to the central line for the purpose of attaching a new giving set, did come apart quite easily, sometimes unexpectedly. This was one of

the reasons why the *ad hoc* measure of wrapping parafilm around the bungs was adopted. In retrospect, a more systematic approach to this issue might have been adopted. Nevertheless, I can find no evidence of systemic failings or individual poor practice to provide a satisfactory explanation of the repeat infections suffered by these three children.

Safeguarding and Investigations

168. I found Dr SAO, Safeguarding Lead at the Trust, to be an impressive witness who gave sound advice to clinicians when called upon to do so. In September 2020, in discussion with Dr SB, she set out all the matters that the clinicians ought to consider in relation to concerns about repeated line infections. This led to the RCA being commissioned but the ambit of that report was narrower than the matters Dr SAO had advised upon. Either the RCA should have covered wider issues, or the clinicians should have addressed the issues that the RCA was not going to investigate. Dr SAO also showed a command of the relevant RCPCH guidance and properly brought it to the attention of the relevant clinicians, most obviously in March 2021 after MR's arrest and when the possibility of HS and LW being victims of FII at the hands of their mothers was actively considered. A clear strategy was agreed which sat well with the Royal College's guidance, but it was not followed.

169. HS was indeed moved to Ward K and one to one observation was begun but the observations were not rigorously performed and staff on the ward did not seem certain as to why they were being asked to observe, and for what they were looking out. There was no openness with MS about the purpose of the observations, as had been the plan, and she had a creeping sense that she was being suspected of causing HS's infections.

170. LW and his mother went home on home leave but then, on 22 March 2021 Dr SAN took the decision to discharge LW home in the care of his mother, with community support. He remained at home for a further six to seven months. I asked Dr SAN during his oral evidence how discharging LW home was compatible with the actions agreed at the meeting on 18 March 2021. He told me that support for paediatric patients on PN at home was excellent and that the rates of infection were lower than for patients on PN in hospital. He understood that the expert safeguarding advice had been that there was insufficient evidence of FII and so he considered it appropriate to discharge LW home. He had undertaken to see LW and MT in his out-patient clinic fortnightly. I am afraid that I found his explanation unconvincing:

a. There was no attempt to re-introduce enteral feeding as had been agreed as part of the strategy in March 2021. The out-patient clinic records reveal no plans to do so. At the last clinic prior to LW's re-admission on 13 September 2021, Dr SAN had planned to see LW again in two months' time because he was doing well at home. It is true that MT was reporting continuing events which suggested that LW could not tolerate oral feeding, but there was no attempt to interrogate that information or to consider whether enteral feeding might be successfully attempted. In the circumstances that LW had so recently been on a LOTA and in the light of the plan adopted at the MDTs in March

2021, this lack of professional curiosity and active management is quite striking.

b. Notwithstanding that the safeguarding MDT on 18 March 2021 identified suspicions that deliberate actions by MT might explain LW's perplexing presentations, such as his explosive diarrhoea on being fed tiny amounts of water, or on merely licking food, Dr SAN treated MT's continuing reports of that nature at out-patient appointments as genuine and as reasons for not re-introducing enteral feeds. The agreed action to investigate vomiting or diarrhoea with toxicology was ignored. Hence, there was no investigation of whether noxious agents had been introduced to cause these reported, symptoms.

c. Discharging LW home deprived the Trust of any opportunity to verify the symptoms of vomiting and diarrhoea, and food intolerance reported by MT or to make close observations of the mother and child.

171. Furthermore, no chronologies were prepared as had been agreed. The preparation of chronologies is very important when considering possible FII not least because they reveal patterns that might otherwise be missed, or disprove false assumptions that may have been made. Then, when LW was re-admitted to SCH on 13 September 2021 he was re-admitted to ward J, contrary to the agreed action to move him out of that ward. The result was that when Dr SAA had significant concerns about MT's safety on 21 October 2021, none of the actions agreed on 18 March 2021 had been taken, and so he, and the others making decisions at that time, did not have the evidential base on which to make properly considered decisions whether to refer to social services and the police. Instead, Dr SAA and others had to react to the immediate circumstances against a background of drift and inaction, or inadequate action. At the meeting on 18 March 2021 Dr SAO perceptively advised that if the steps set out in the RCPCH guidance are not adopted, then professionals can find themselves in an acute situation where they have to refer to the police, whereas they could often avoid that by carefully planned rehabilitation as recommended in the guidance. Unfortunately, not only was her advice unheeded and the agreed actions not pursued, but the decisions to refer to the police were not made by the doctors who had been most involved in the cases of HS and LW, and without the input of Dr SAO who was on leave at the time.

172. Given that Dr SB had raised concerns with Dr SAO about BR being the victim of possible FII in early September 2020, it is again noteworthy that no structured investigations had been carried out before MR's arrest in February 2021. For the reasons already discussed, the RCA was not a substitute for consideration of the many issues that SAO advised should be considered. It can be said that Dr SB continued to consider the matters SAO had raised, but I am afraid that it cannot be said that they were considered in a structured way. I have considerable sympathy with Dr SB because his primary role is as a clinician and he was conscientiously trying to find an answer to perplexing presentation. Like all the clinicians he clearly worked very hard to do his best for the children in his care, including through the pandemic. He did not have the advantage of the time

and resources afforded to a judge enabling them to take a broad view. Given the day to day demands on the lead consultants, what was needed was a person to take a lead on the safeguarding aspects of the case of HS (and BR and LW) at an early stage, and to be the point of contact for concerns about FII.

FII: Evidence from Clinicians at SCH

173. The clinicians involved with these three children were put in a very difficult position. For a paediatric clinician, trust in the child's parents is a fundamental expectation. To suppose that a parent might be deliberately or recklessly misleading you, or, worse, deliberately making their child ill, is contrary to all the usual assumptions and practice. I could see for myself the toll that these cases have had on some of the clinicians who gave evidence and who believed that the mothers had deceived them. The same can be said of some of the nursing staff who had the most involvement with these children. It was very clear during this hearing that the paediatric gastroenterology team, and Dr SA, had indeed come to the firm view that each of the mothers, MR, MS, and MT, had deliberately harmed their children. Throughout his oral evidence Dr SAN referred to MT as "the perpetrator". When asked by Mr O'Brien KC, acting for MT, not to do so because it was offensive to his client, he responded, "that is what she is." It was evident that the team, in particular Dr SB and Dr SAN, feel bruised and resentful of the mothers. If they are right, it is understandable that these doctors should be angry, not only about the avoidable suffering these children endured, but also that much of it was inflicted by their hands performing unnecessary investigations and interventions.

174. This belief that the mothers are guilty of FII has become a firmly entrenched narrative at the Trust as exemplified by the commissioning of the SII from Dr Grayson on the express presumption that each of the mothers had fabricated or induced illness in the children. Regrettably, this entrenched belief has infected some of the evidence which I have received from healthcare professionals at SCH. The court has to determine whether or not one or more of the mothers is responsible for the actions that these clinicians believe they undertook. I cannot view the evidence, as some clinicians have done when giving evidence, through the prism of the mothers' assumed guilt.

175. I am bound to observe that Dr SAN in particular has re-interpreted past events in the light of his current beliefs about the actions of the mothers, especially those of MT, the mother of LW, for whom he was the lead clinician. It was very difficult to persuade him to tell the court what his beliefs and understanding were at the time, rather than what he now believes was happening. For example, MT reported to Dr SAN at an out-patient clinic on 8 June 2020 that at home LW had accidentally swallowed bathwater resulting in excessive diarrhoea. In his statement, Dr SAN described this report as being inexplicable, but he had not made any such remark contemporaneously and, when pressed during his oral evidence, he accepted that the mother's report had not been remarkable or incredible at the time.

176. Similarly, during his oral evidence Dr SAN refused to accept nursing records of LW vomiting or having diarrhoea. He said that he was sceptical about whether those events had occurred unless he could verify that the record-maker had seen what had happened with their own eyes. He extended this scepticism even to records which included assertions that the mother was not with LW at the time. He told me that he had learned during his career the importance of such verification. Where the record simply says, "mother reported vomiting" that might leave some room for doubt but most often the records simply record that the child vomited and even in those instances, Dr SAN could not bring himself to accept that vomiting had occurred as so recorded. However, at the time most of these records were made nobody doubted their accuracy. None of the nurses giving evidence said that they had noticed a discrepancy between records of vomiting and what they were witnessing on the ward. There are very few, if any, nursing records expressing doubts about the mother's reports of vomiting. Some records were of LW vomiting at times when it was very likely nurses would be present, such as when he began to receive a feed. Nurses on the ward would be aware of stained clothing and bedding, vomit on a bed or on the floor. It is inconceivable that on every, or even most, occasions that nurses recorded that LW had vomited, they did not actually see any the vomiting or its aftermath for themselves. The nurses who gave evidence did not question that their notes accurately recorded what had occurred, but on being taken to those records during his oral evidence, Dr SAN several times responded, "No comment" by which he appeared to mean that he would not accept what was recorded and so would not comment on it. This was far too sceptical and prevented him from engaging with the issues raised with him so as to assist the court.

177. Even more seriously, Dr SAN's written and oral evidence gave a misleading impression about how some events had appeared at the time. For example, his statement refers to MT's "demands for palliative care":

> "It is very unusual for a parent actively to seek palliation as a route for their child and I have never seen this in my career to date. Throughout my relationship [with MT] an apparent lack of emotion was evident and I found her manner very cold and clinical."

Linked to that issue, he said, "Mum did not want to go ahead to transplant despite good chances of a reasonable outcome."

178. I refer to the chronology of events concerning the LOTA and transplantation. On no reasonable objective view could Dr SAN's comments about MT's conduct or demeanour at that time be considered credible. I am satisfied that Dr SAN wanted to create the impression that the mother unreasonably refused to go ahead to small bowel transplantation and drove the team to the Limitation of Treatment Agreement (LOTA) that was made in January 2021 but that the contemporaneous documentation tells a very different story. Dr SB introduced the issue of palliation in discussions with the mother and Dr SAN himself later raised it again with her. Other consultants, including Dr SB, discussed it with her. An MDT meeting at which the mother was not present agreed that a LOTA should be made. A submission was made to the Trust's ethics committee setting out the basis for the LOTA and a palliative pathway. On 5 February 2021, Dr SAN himself wrote a

very long note of a detailed discussion with MT in which he recorded that there was:

> "unanimous agreement between professionals that bowel transplant wouldn't be in his best interests as success rate is low with high chances of morbidity pre and post transplant."

There were then discussions later in February 2021 with an expert in investigating gut dysmotility at hospital B. Again, in his written evidence Dr SAN portrayed the mother as unreasonably withholding her consent to such investigations, but the contemporaneous documentation clearly shows that the team at SCH agreed with her to try enteral challenge at SCH rather than putting LW through a transfer to Hospital B.

179. Dr SAN agreed that the presumed diagnosis at the time of these discussions and decisions in January and February 2021 was that LW's repeat infections were caused by some underlying gut pathology. The team were running out of lines through which to administer PN. LW was in a very precarious situation. Yet, Dr SAN told me that at the time he had "great unease" about the mother's decisions on the issues of palliative care. I do not accept that evidence. He did not record that unease nor, I find, did he communicate it to other professionals. It is inconceivable that if Dr SAN harboured doubts about the mother's authenticity, about the reasonableness of her decisions on the LOTA, transplantation or investigations at hospital B, that he would have himself supported her in all those decisions and continued to maintain the LOTA (which remained in place until 18 March 2021). His evidence in relation to those matters was manifestly unreliable and not to his credit. I can only think that he has been so scarred by what he now sees as MT's deceit that he has lost the ability to be objective about past events.

180. The trap into which Dr SAN has fallen is one that the court must avoid. It is impermissible to assume that the mother induced illness so as to prompt decisions about palliative care, transplant, and investigations at hospital B if there are other explanations for her conduct at the time given what was then known to her. The evidence as a whole must be considered before determinations are made about what happened, and MT's motivations. I am satisfied that until on or about 18 March 2021 Dr SAN treated LW, and thought it right to treat him, on the basis that the mother's reports and concerns were authentic, that LW would not tolerate enteral or oral feeding, that end of life palliative care was appropriate in the event that he did not unexpectedly improve, and that LW had an underlying but not yet confirmed pathological cause for his presentations. A LOTA was entered into not because the mother drove the clinicians to it, but because the clinicians and mother together believed that it was in LS's best interests given his apparent condition. The decision not to go to transplant was a reasonable one, supported by the teams at SCH, given the understanding of LW's condition at the time. Likewise, the SCH team supported the mother's view that it would be in LW's best interests to remain at SCH for a trial of feeding, rather than being transferred to Hospital B for investigations. A reasonable mother in MT's position, being given the advice MT was given could have come to the same decisions she came to. In my judgement, the mother's views on palliation, transplant, and investigations at hospital B cannot be relied upon as evidence that she was guilty of fabricating or inducing her son's illness, which illness led to the decisions being made about those issues.

181. The reason that I find that Dr SAN's beliefs changed on or around 18 March 2021 is that I have read the transcript of the meeting on that date. The 18 March 2021 meeting, which followed MR's arrest, was the first comprehensive discussion of possible FII within ward J, attended by members of the gastroenterology team, members of the safeguarding team, the executive director and deputy director of nursing, and the medical director. It was a two hour meeting which ended with a clear plan as set out in a note of the meeting which appears above. In respect of MT, that plan was not followed. Indeed none of the actions agreed upon were performed. This deprived the Trust of the opportunity to obtain evidence to verify reported symptoms of food intolerance, to do toxicology investigations to check for the administration of noxious agents that might have caused the reported symptoms, to observe the mother and child on a new ward in the hospital, to consider a comprehensive chronology. Dr SAN and other members of the gastroenterology team had their head down trying to improve MT's health little by little, but did not lift their heads to survey the wider scene. Then, when LW was re-admitted in September 2021 suffering bloodstream infections and there were further infections as an in-patient resulting in a prolonged period without nutrition, the clinicians then on duty found themselves in a critical situation, having to make safeguarding decisions without the evidence they ought to have had at their disposal. The referred the matter to the police and MT was arrested. Only once the mother was removed was enteral feeding immediately commenced. The very fact that it was commenced and continued demonstrated that LW was fit enough to try enteral feeds.

182. Dr SAA's role in the cases of HS and LW is of importance. He was a participant at the safeguarding MDT on 18 March 2021 and so knew of the concerns about possible FII and the plans that were agreed. He was on duty in October 2021 and his decision-making was highly relevant to the arrests of MS and MT on 19th and 22nd October, respectively. Whilst he was not solely responsible, it is convenient to consider the events leading to the arrests at this point of my judgment. I set out my detailed analysis of the circumstances immediately surrounding the arrests below, but my general view is that when Dr SAA came to be the responsible consultant for HS and LW in October 2021, he could not understand why referrals to social services and the police had not already been made given the concerns aired at the MDT on 18 March 2021 and the fact that the problems then discussed had, in his view, continued. It was time for action to be taken. Of HS, he said,

> "… the rapid development of infection, after a new line was inserted, was extremely worrying, as this is often a sign of line tampering …HS had been moved to an alternative ward in case there was an issue of iatrogenic infection (staff associated harm). Line infections occurred under close supervision on an alternative ward."

This was his view prior to the detachment of HS's line on 19th October. His clear view about that incident was that it was likely that MS had removed the line:

> "The likelihood of the mother removing the line could not be ignored .. The only way of removing the mother, as the legal

guardian, from HS's room was to make a formal report to Social Services and The Police. This I did …."

Of LW he said,

" it is impossible by simple observations to prevent a dedicated perpetrator of harm through central line tampering. In practice this would always involve excluding the suspect with a balance of probabilities had been reached. That balance had been reached on 21st October 2021."

I asked Dr SAA whether the fact that he had made the referral of MS on 19 October made him more open to making the referral of MT two days later on 21 October (the referral was made on 22nd October but he had decided that it should be made on 21st October). He said not and that, to the contrary, he was more cautious about referring MT because he had so recently referred MS. I found that assertion difficult to accept having regard to all the evidence about the circumstances of the referrals. In my judgement Dr SAA was concerned that in both cases there had been unacceptable drift and that overdue actions were urgently required. The incident involving HS's line on 19th October was the trigger for him to take decisive action about HS on that day, and to do likewise in the case of LW two days later. Perhaps due to his own perception of drift and delay, he acted fast.

The Arrest of MS

183. I have already set out a chronology of events relevant to MS's arrest, including the incident on 19 October 2021 when it was found that HS's central line had completely come out and was lying tangled in his blanket. Dr SAA told the court that,

"HS was extremely lethargic, he was wasted, his muscles were atrophied and he was weak and listless…. you did not need medical training to see that he was very very weak. He was in a state of malnutrition, he was barely able to move his head … [he was] akin to an African child in a famine, just skin and bones."

In her police interview MS said that he had been lethargic having not been given feed, but this was an observation about his relative condition. In the note of Dr SAA' ward round of 18 October 2021 it is recorded that HS "looks well". Nurse SX told the court that at the time when she went to clamp HS's line on the morning of 19 October 2021, and noticed that the line had become detached, HS was "sat in his cot, knees up always, ipad in front of him, blanket across his feet and the line was entangled in the blanket." HS was "his usual self". During the late stages of the hearing FS produced a photograph from his mobile phone, taken on 18 October 2021, which showed HS playing on his ipad and looking much better than Dr SAA's description to the court. FS recalled playing with HS on the floor of the cubicle that day. Even though HS had not received feed for some time and was at risk of death due to potential sepsis and the difficulty of finding a further site for a central line if needed, the balance of the evidence strongly shows that Dr SAA's

evidence that HS was extremely weak and "just skin and bones" like a starved child, is an exaggeration. I find that as of 19 October 2021 HS was capable of wriggling, turning over, pulling on his blanket or his line and otherwise acting as he typically did act. He was not so weak that he could not do any of those things.

184. Dr SAA placed considerable emphasis on the fact that not only had the line become detached, but the dressing had been removed. On the ward round on the morning of 19 October 2021, he told me, he had checked that the line was secure:

> "strong adhesive dressing was used which nurses would have to use alcohol wipes to life the adhesive in stages … There was no possibility, in my view, that HS would be able to remove the dressing…
>
> [after the line detachment] the strong adhesive dressing had been peeled back … I believed that HS was physically unable to remove the dressing and the central line …."

In her statement, Nurse SX does not refer to the dressing having been removed when she noticed that the line had become detached. She says that the clinical site manager came into the cubicle and "examined HS's PICC dressing which was still intact on his arm … he was later transferred to HDU with the dressing still in place…" She confirmed in oral evidence that the dressing had remained in place. My understanding is that there was a transparent dressing over the line where it entered the skin. There was a securacath under this dressing. There was then an elastoplast type dressing over the transparent dressing and a bandage over that dressing. In his oral evidence Dr SAA confirmed that when he inspected HS's arm the dressing had been peeled back – I understood this to be the elastoplast dressing. The bandage must also have been removed. He had not discussed with the nursing staff whether anyone had peeled back the dressing or removed the bandage. He could not recall the securacath. He told me that he would have expected that the transparent dressing, the elastoplast dressing and the bandage would all have had to be removed in order for the line to become detached. That was supposition and I note that the dressing had not been changed for some three weeks since the line had been inserted. A photograph marked as having been taken on 20 October 2021 shows HS's arm with the securacath in situ under a transparent dressing which is still in place. The dressing is wrinkled and crumpled at the edges. It is not at all clear that this dressing would have to be removed for the line to become detached, as opposed to the line slipping out from under the dressing. The photograph tends to show that it had not been removed in any event. This was not a new dressing put on after the incident the day before.

185. On careful consideration of the evidence relating to the detachment of HS's central line on 19 October 2021, I find that the line probably became detached shortly before Nurse SX noticed that it had become detached. The fact that she only noticed the detachment when she went to clamp the line which involved her exposing the line at a point fairly close to HS's arm, indicates that the line was hidden by his blanket or bedding, which is consistent with what she recalls. There is no evidence in the notes of the line insertion at Hospital A that the line had been stitched in place whereas the records allow for that to be entered onto the record of the procedure. That suggests that there was no stitch inserted on this occasion.

There is evidence that MS queried at the time why it had not been stitched in place. The evidence to me, including the RCA report, suggested that there was a lack of coordination between Hospital A and SCH about line care after insertion, for example in relation to expectations about dressing changes, and some inconsistency about the methods of securing the line. This is a little surprising in HS's case in September/October 2021 given his history and the number of line detachments. I received evidence that a line can come out quite easily if it is pulled and that a securacath device would not necessarily prevent that from happening. There was no blood nor any other signs of any trauma to suggest that removal of the line had been difficult. At all times HS remained calm and was not crying or distressed as he might have been if there had been resistance to the line coming out, if someone had pulled off a well fixed Elastoplast dressing, or if someone had removed a line that was stitched in place. It appears that the clear dressing remained in situ. On the balance of the evidence, although it was less than clear on this point, it appears that the dressing and bandage over the clear dressing were also still in place when the line became detached. I find that when Dr SAA inspected HS's arm, a nurse had already peeled back the elastoplast dressing to inspect the entry site. They had probably also removed the bandage at that point. Nurse SX did not remark that not only had the line become detached but the dressing and bandage had come off. The fact that the bandage had remained in place at the point when the line became detached strongly suggests that the line had not been stitched in place when inserted at Hospital A, which is my finding on the evidence as a whole. Nurse SX's evidence was that the line was tangled in HS's blanket. I have seen photographs of the blanket which was large and had large bobbles sewn into its ends. MS had moved HS from sitting on her lap into the cot, with his blanket. MS could not explain what had happened to allow the line to become detached. She had been waiting for some days for an HDU bed to become available for HS. If it is suggested that her motivation for removing the line deliberately was for HS to have medical interventions, why would she jeopardise the planned treatment in HDU? If on the other hand it is suggested that she wanted to prevent the treatment in HDU, the contemporaneous evidence indicates that she was, by then, quite anxious for the treatment in HDU to begin, even though she, and others, had previously had reservations and that she did not know that an HDU bed was due to become available that day. When considering all the evidence about 19 October 2021, MS had the opportunity to remove HS's line and it is possible that she deliberately did so, but it is also possible that the line became detached inadvertently when HS was moved to his cot, perhaps because it was entangled in his blanket, or that it became detached once he was in his cot when it became entangled in his blanket upon him moving about.

186. If detachment occurred when MS moved HS into the cot, as she speculated at the time, then it would be fair to observe that she had been careless in circumstances when she ought to have been taking great care to prevent yet another line detachment. However, the key evidence in relation to the line detachment on this occasion is that Nurse SX found the line entangled in HS's blanket. It was not caught under the mattress or in the bedding. HS was, as I have found, physically capable of wriggling or moving in his cot. His lines had become detached before. The line had probably not been stitched in place to secure it. The dressings had not been changed for three weeks. On the balance of probabilities the line became detached when it became entangled in HS's blanket when he was

in his cot due to his own movements. However, on any view, the circumstances did not clearly point to MS having deliberately removed the line, which is the assumption made by Dr SAA and others at the time. Dr SAA had placed emphasis on the elastoplast dressing having been removed, which he considered HS could not have achieved, but my finding is that he saw HS after a nurse had peeled back that dressing and had removed the bandage, and that at the time of detachment all dressings and the bandage had remained in place. It was Dr SAA's conviction that MS had removed the line that led to the referral to the police and to MS's arrest and separation from her children.

The Arrest of MT

187. The trigger for MT's arrest was the belief that on the morning of 22 October 2021 she had switched off LW's feeding pumps, leaving his line unclamped and depriving him of intravenous fluid. I have set out the chronology of events earlier, in Part C. MT's evidence about the events of that morning prior to the discovery that the pumps had been switched off was quite clear and was corroborated. She had been in Treetops overnight, as is documented in the contemporaneous records. As she made her way to the ward she spoke to AC on the phone. AC confirmed their conversation and that whilst on the phone MT told her that the pumps had been switched off and that she had to end the conversation. Mobile phone records show that there was a call commencing at 8.12 am and lasting for 3 minutes 42 seconds. Hence, MT would have discovered that the pumps had been switched off at about 8.15 am. The nursing record notes that Nurse ST went into the cubicle and discovered that the pumps had been switched off at 8.00 am. The nurse attempted to flush the line and then left the room for a short while. This could well have been when MT entered the room for the first time that morning.

188. There is no evidence that MT had been on the ward prior to Nurse ST discovering that the feeding pumps delivering feed and medication to LW had been switched off. Nurse ST told the court that at the time she had presumed that a mistake had been made by a member of the night team – in effect, that they had stopped the pumps and forgotten to attach new feed and switch them on again. Nevertheless, the narrative that appears to have been presumed by the medical team, if not the nurse who was present at the time, is that MT had switched off the pumps. I have not hesitation in finding that she was not responsible.

189. Although the incident on the morning of 22 October 2021 immediately preceded MT's arrest and the suspicion that MT had been responsible was an important part of the information given to the police that day, it had been events on the preceding day that had caused Dr SAA to advise that a referral to social services and the police should be made. I regret to say that the decision-making on that day was unco-ordinated and muddled. It seems clear that Dr SAA had decided that MT was a perpetrator of deliberate harm against LW. His evidence was that, "in my mind there was a very high likelihood that a carer (and not a member of staff as we had moved wards to change nursing staff) was tampering with the lines to cause infection." As he should have known, LW had not been moved to another ward – that had been the plan in March 2021 but he had been sent home instead and, on readmission, returned to ward J not to another ward.

Initially Dr SAA had proposed making the referral before speaking to MT because, it appears, he had decided that MT should be taken away from the care of LW, but he was persuaded to speak to her first. It is far from clear that Dr SAA had acquainted himself with the facts since March 2021, including that MT had cared for LW at home for half a year during which time he had had no line infections with bowel flora. He advised MT that LW might die. There is no satisfactory evidence that a full explanation was given to her as to the reasoning behind the request that she should absent herself from the hospital and, if it is assumed that LW was innocent of inducing illness, it is entirely understandable that she would refuse a request to leave her extremely ill son alone for an uncertain period of time. Indeed, Dr SAA himself described the request made to her as "brutal", and in his oral evidence did not seem to be critical of her for refusing to leave. As it happens, the evidence demonstrates that after her conversation with Dr SAA, MT spoke to Dr SAC, and agreed that if LW deteriorated she would leave the ward. MT told me, as I accept was reasonable in all the circumstances, that she thought that she was being asked to leave for a substantial length of time, not merely for a few days.

190. The circumstances in which Dr SAA spoke to MT and asked her to leave were hardly ideal. As long ago as 18 March 2021 Dr SAO had reminded key clinicians, including Dr SAA of the RCPCH guidelines which advocate openness with parents unless that would endanger the child. Seven months later, as Dr SAA ought to have known, there had been no open discussions with MT about concerns that LW might be being harmed due to something she had been doing, perhaps inadvertently. No plan for her to absent herself for a set period, perhaps with some other trusted relative or friend to come in to be with LW in her absence, had been discussed with her. There was no chronology for Dr SAA or anyone else to consider. Dr SAA had already made up his own mind that she had induced illness in LW. Curiously, given the decision made on 21 October, MT was left with LW until she went to Treetops that evening. On 21 and 22 October 2021 when these decisions and then the referrals were made to the police and social services on 22 October 2021, Dr SAA was on leave, Dr SAN, lead clinician was on sickness leave, and Dr SAO, designated doctor for safeguarding was also on leave. It fell to Dr SAM to make the referral. I do not criticise her, but the lack of co-ordination and oversight of the process leading to the referral is clear to see.

E3: BR: Unprescribed Drugs

191. Leeds CC allege that BR ingested unprescribed medication, specifically ibuprofen, piroxicam, bisacodyl and trimethoprim which were administered to BR by (a) MR and/or (b) MR and BR, and that if BR self-administered unprescribed medication MR was aware of it and facilitated it (allegations 1 to 10, Appendix 1.1).

192. The evidence clearly establishes that in mid 2019 BR initially suffered from mesenteric adenitis, a not uncommon condition of abdominal inflammation that causes pain. It usually resolves with time. However, the evidence also establishes

that BR has functional abdominal pain. This is something similar to what her mother experienced in the past albeit related to other parts of the body including her spine. This has caused BR to become, at times, dependent on pain-relieving medication, even on morphine. She would "clock watch" waiting for the time when she could be administered her next dose. Like her mother before her, her symptoms far exceeded medical expectations or explanation. The dynamics of the family are such that they struggle to accept this diagnosis. When giving evidence to the court it became apparent to me that, even though they may sometimes state their acceptance of medical opinion that BR does not have any form of inflammatory bowel disease, MR and the family as a whole have found it hard to accept that there is no underlying organic explanation for BR's presentation. It is fair to record that even as late as February 2021 Dr SB was advising them that there was a possibility of Crohn's Disease returning (whereas later he has given very clear advice, repeated by others, that BR has never had Crohn's Disease) but there is a resistance within the family to treating BR as a child who has sometimes extreme complaints of pain but who has no underlying physical abdominal condition. As I understand the expert evidence, and that of treating clinicians, a diagnosis of functional abdominal pain is not a label that the patient is "making it up" as BR appears to understand it. I have been told that the enteral nervous system is more extensive even than that of the spinal cord, and that it is linked to the central nervous system. Some dysfunction within the enteral nervous system can therefore send nerve signals to the brain causing the experience of pain for an individual with functional pain when it would not to someone without that dysfunction. BR may well be one of those individuals. There is no cure for her functional abdominal pain, rather she has to mitigate it and learn to adapt to it.

193. Whilst an in-patient, BR's relationship with MR became very intense and unhealthy. I am sure that this was exacerbated by the restrictions imposed as a result of the Covid-19 pandemic. The isolation and mutual dependency of BR and MR provided a culture within which unusual and harmful behaviours could develop, such as refusing to speak to doctors, screaming episodes, MR neglecting self-care by sleeping in the same bed as BR even though it caused her back pain, BR demanding attention, both of them pressing for unnecessary medication. I was very struck during the hearing by the clear impression that MR never laid down boundaries for BR. She accepted and responded to all BR's demands, anxieties, and complaints without question. The circumstances and dynamics of their relationship led to a belief that they knew best how to manage BR's condition. They were friendly to those nurses who supported their beliefs, and hostile to doctors, such as Dr SA, who challenged them. MR was intelligent enough not to display outward hostility herself, but she did appear to have done very little to discourage BR from disengaging with medical professionals who gave advice she did not want to hear.

194. MR attended virtually every day of the hearing. When she gave evidence she showed herself to be very knowledgeable about the evidence in the case. She said that she was accepting of the experts' views that BR does not and has not had Crohn's disease and that there is a significant functional element in BR's presentation and her complaints of pain, but I did not sense any conviction and felt that she was aware that it was something she was expected to say. Her mother was less guarded and openly stated that she thought BR continued to suffer because of

an underlying physical condition. She was intense and serious when giving evidence as might be expected. It was during questioning by Mr Rowley KC on behalf of FR that MR mentioned that her pill crusher had been used to crush bisacodyl at Hospital B. She said that this had been done when bisacodyl was administered by tube to BR's jejunum on the ward. This would help explain the finding of bisacodyl in the pill crusher after her arrest. The records did show that bisacodyl had been administered at Hospital B. Enquiries with the nurse who had administered bisacodyl revealed that it was crushed and delivered via a tube inserted up BR's rectum. The nurse denied that she would have used the patient's (or mother's) pill crusher. It is nevertheless right to say that although she gave this evidence late in the day, BR had correctly recalled that bisacodyl was delivered crushed albeit via a different route than she had remembered. Her late evidence gives cause for scepticism which is increased by doubt that Hospital B would use a patient's equipment. However, on balance I am not satisfied that the mother has deliberately lied about the use of her pill crusher at Hospital B – with some hesitation, I accept her account on that particular issue.

195. In contrast, MR's evidence about why she brought large quantities of ibuprofen and bisacodyl onto the ward in early 2021 were not credible. My view of her evidence on that issue is that she had concocted implausible explanations with a view to deflect the court's attention from the fact that she had deliberately acquired large amounts of drugs. I shall return to that issue later in this section of the judgment.

196. Professor Sullivan's opinion was that BR's gut bleeding and ulceration, and much of her pain, was explained by NSAID enteropathy. He accepted that on initial presentation she had mesenteric adenitis. She also had a C-difficile infection in or around September 2019. He told the court that there is also a great deal of evidence that there is a functional element to BR's presentation – that she has functional abdominal pain. However, with the benefit of all the investigations performed it is now clear that she does not and has never had Crohn's Disease nor any form of IBD. Her high faecal calprotectin levels in the autumn of 2019 and at certain other times, were indicative of inflammation due to NSAID enteropathy. They mostly coincided with endoscopic findings of ulceration and/or clinical signs such as blood in BR's stool or vomit. His evidence chimed with other expert evidence in the case: BR's signs and symptoms were consistent with the ingestion of NSAIDs. Furthermore, her symptoms of diarrhoea at various times, including in early 2021 prior to MR's arrest were consistent with the ingestion of bisacodyl.

197. The urine samples taken in August 2020 and February 2021 revealed the ingestion of ibuprofen. The forensic re-examination of blood and urine samples taken between July 2020 and February 2021 revealed ingestion of ibuprofen and piroxicam - neither of which had been prescribed to BR during the material periods. The agreed HST evidence is summarised above and supports the case that BR ingested ibuprofen and piroxicam over many months, and bisacodyl intermittently over several months. Traces of ibuprofen, piroxicam, and bisacodyl were found in the residue within the tube connected to BR's PEG-J that was removed by a nurse on the day after MR's arrest, and later handed to the police. Traces of ibuprofen and bisacodyl were found in the pill crusher device that was found by the police within a pocket of MR's black suitcase within BR's cubicle.

The traces of bisacodyl may have come from its use at Hospital B a few weeks earlier – I have accepted MR's evidence that the pill crusher was used to crush prescribed bisacodyl at that time. Ibuprofen would be undetectable in blood or urine after, at most, 36 hours after ingestion. Piroxicam might remain detectable for a few days after ingestion. Between July 2020 and MR's arrest on 25 February 2021, six serum samples revealed piroxicam ingestion, and four urine samples revealed ibuprofen ingestion. Samples were not being collected for the purpose of testing for NSAID ingestion - except in February 2021 - so a more comprehensive picture is not available. The HST however shows use of ibuprofen and piroxicam fairly consistently over the year after the end of March 2020. I would reject any suggestion that BR only ingested ibuprofen or piroxicam immediately prior to the blood or urine tests for which the court has results, and not at any other times. I accept that it is far more likely than not that the positive urine and blood tests were snapshots but that the bigger picture – supported by signs and symptoms, and HST, is of more substantial ingestion from the end of March 2020 until MR's arrest on 25 February 2021. There was then ibuprofen ingestion by BR until about 22 April 2021 which needs to be explained.

198. As to the evidence of traces of unprescribed drugs within residue in the tube attached to BR's PEG-J, that tube was seized and provided to the police on 26 February 2021. It is submitted on behalf of MR that the evidence does not establish that those unprescribed drugs entered the tube prior to MR's arrest. I do not wish to do a disservice to the detailed submissions on this point, which I have taken fully into account, but they rely heavily on evidence that the tube will have been flushed on multiple occasions between MR's removal from the hospital and its removal and handover to the police. I accept that it was probably flushed on multiple occasions during that short period. The photographs and forensic analysis of the tube and the residue that is visible within it, took place several months after its seizure. Nurse SAP told the court that had the tube appeared that way she would have changed it. Certainly, she and others would have flushed the tube. However, none of the nurses could give reliable evidence of what the tube in fact looked like in the period before it was seized, only what they would normally expect to have done had it looked as it does on the photographs. Further, I cannot find that the residue looked the same in February 2021 as it did when the photographs were taken several months later when it had lain in an exhibit bag and not in whilst in use in a live environment. In any event, it seems to me to be perfectly plausible that even if flushing took place, some residue from previous use of the tube would remain. DC Gibbons observed pink particles within the tube. It is supposed that these were pieces of crushed ibuprofen but there is no evidence that they were. It is submitted that nurses would have noticed those and flushed them out had they been present prior to MR's arrest but that seems to me to be speculative. In other contexts, MR's case is that nurses did not always follow best or even expected practice. It is possible that there might have been some backflow of contents into the tube, if it was not clamped, but that is uncommon from the jejunum and if piroxicam and ibuprofen were in the backflow, they were already in BR's system. In any event, I do not regard the evidence of the residue to be fundamental to the case against MR – there is ample evidence that BR ingested ibuprofen, piroxicam, and bisacodyl prior to her mother's arrest. The residue evidence is relevant to the finding as to whether unprescribed drugs were administered via BR's PEG-J but it is one piece of a jigsaw of evidence on that issue.

199. MR has denied having any knowledge of the ingestion of unprescribed drugs by BR. She says that when ibuprofen was prescribed for BR in June and July 2019, she protested that it should cease because she had concerns about its effects. She was well aware of the potential of NSAIDs to cause gastrointestinal damage. She says that BR was likewise aware of the risks to her of taking NSAIDs. Indeed, upon her mother's arrest, BR said that she knew she should not take NSAIDs. MR said that she would "never" give her daughter unprescribed drugs. I also take into account the fact that no third party ever witnessed MR administering unprescribed drugs to BR, or BR self-administering them. I take into account MR's evidence that she took ibuprofen and piroxicam herself and had used the crusher in the past to help her ingest drugs. She also says she took bisacodyl herself but told FTS in October 2021 that she had been taking senna on a daily basis and bisacodyl on the "odd time" only. She was certainly prescribed piroxicam. She freely admits to purchasing ibuprofen and bisacodyl.

200. MR says that she purchased the pill crusher because she was required to crush pills for BR when she was an in-patient at Hospital A but her evidence that ibuprofen was found within the crusher because it had been used long ago at Hospital A was unconvincing. When oral medications were being given to BR or taken by MR, I find it implausible that ibuprofen would have been crushed before ingestion – it could as easily have been prescribed as a capsule as opposed to a pill, or in suspension if there were difficulties ingesting it, or cut in half. Once crushed, it would have to be mixed with water and then consumed – not a simple task for the patient given that ibuprofen does not dissolve in water. I have accepted MR's evidence that whilst BR underwent specialist investigations at Hospital B staff administered bisacodyl through a tube and on one occasion required the use of MR's pill crusher to do so. This accounts for the finding of bisacodyl within the crusher after MR's arrest. She says that she ordered two deliveries of bisacodyl to the ward at SCH in January 2021 because the first one did not initially arrive, so she ordered a second. Then both arrived. Each was for 240 tablets. She accounts for the purchase of two, 80 tablets of ibuprofen in January and February 2021 by claiming that she lost the first one so went out to buy a replacement pack. She used ibuprofen herself as added pain relief because her prescribed tramadol and piroxicam were sometimes ineffective.

201. BR's own accounts in interviews have varied but she has said that she took medication from her mother's bag because she "felt like no-one was helping … when they were stopping my pain meds." When sensitively asked about the frequency, she described taking them some days a week. She has only disclosed taking medication orally and has not described self-administration by crushing tablets mixing them with water and then drinking them or passing them down a tube into her stomach or jejunum. BR says that she was aware of the adverse effect on her of ibuprofen. In her recorded police interview she explained that she had been given ibuprofen by mistake at Hospital A and "I was really ill that night…" When she learned about a urine test being required to test for ibuprofen (February 2021) she could not understand why because she knew she was not allowed ibuprofen – "it was weird". There were ibuprofen tablets on an open shelf in the toilet area of her cubicle – she will have known what they looked like – they were pink and difficult to mistake for anything else. It is not evident that she will have known what bisacodyl or piroxicam tablets looked like or what they were for.

When the independent forensic social worker asked BR to give some more details about when she had taken tablets from her mother's bag, such as how she felt when she first did it, BR said she did not know. She was able to describe where the bag was (it appears to have been the washbag subsequently noted by the police) and she mentions some colours of the medication (which might suggest she took other medication as well as ibuprofen) but I was struck by the fact that she could not describe how she felt or give an authentic account of why she did it. She said that no-one was helping her but her relationship with her mother appears to me to have been one of mutual dependency and absolute trust. Also, as a child who was very knowledgeable about all her medication, her suggestion that she took medication not knowing what it was, is difficult to accept.

202. There is no evidence to corroborate MR's account as to why ibuprofen traces were within the pill crusher and why she had purchased the quantities of bisacodyl and ibuprofen she did. MR was taking strong prescribed pain-killing medication but it is possible that she wanted to take additional medication, ibuprofen, given her long use of pain medication in excess of what might have been expected. The police search of the family home produced very large quantities of over the counter medication, suggesting frequent use of purchased medication on top of the use of prescribed medication. However, MR told FTS when her own hair was tested, that she had used a different laxative, Senokot, on a daily basis for the 12 months prior to sampling on 21 October 2021, taking up to 4 or 5 a night which were "max strength". It is not credible that MR would then order even one delivery of a large quantity of bisacodyl for her own use in January 2021.

203. Receipts show that MR purchased two large packets of ibuprofen in 2021 prior to arrest. It is improbable that MR would purchase and then temporarily mislay a large packet of ibuprofen in the small cubicle at SCH that she and BR occupied and so choose to go and purchase a second packet. In the context of a paediatric ward, it would be concerning to lose a packet of ibuprofen. I heard no evidence that anyone else was made aware of a large packet of ibuprofen going missing in the cubicle or on the ward. It is improbable that she would simply re-order a large quantity of bisacodyl when the first package did not arrive – there is no evidence of her seeking a refund. I do take into account that boxes and containers of ibuprofen, piroxicam, and bisacodyl were not hidden in the cubicle when MR was arrested. A packet of ibuprofen was found on the open shelving in the bathroom of the cubicle. MR had reason to know that BR's urine had been tested for ibuprofen – if she knew that ibuprofen had been given to BR by her or by self-administration and that the urine test would reveal that, she might have been expected to hide the "evidence". On the other hand, knowing that ibuprofen ingestion was going to be proved, she might have left the drugs out in the open to provide herself with an opportunity to suggest that BR might have taken them herself. I must also take into account the fact that BR continued to test positive for ibuprofen for several weeks after MR had been removed from the hospital on 25 February 2021. HST shows ingestion of piroxicam and bisacodyl also during the period March to May 2021. The evidence that BR ingested these drugs even after her mother's removal, after searches of her room, and after a transfer to an open bay, is difficult to explain. Having heard evidence from MGMR and FR, as well as from the nursing staff, I am satisfied that the drugs were not brought in by family members either in home-prepared food or otherwise. MGMR did raise the

possibility of BR having hidden tablets in the bags of beads she used for her craft activities. The police evidence to the court did not persuade me that their search of BR's cubicle had been well-targeted or thorough. They may well have left drugs in the cubicle. MGMR told the court that she found drugs in a washbag in the toilet of the cubicle, and in the wardrobe on 8 or 9 March 2021, days after the police search. Although it is remarkable in the circumstances that she did not note what the drugs were and did not alert anyone to what she had found, I accept her evidence that there were still some drugs in the cubicle at that time. Therefore, BR had access to drugs not prescribed to her even after her mother's removal.

204. Taking into account all the evidence, I first consider the period January to February 2021. In the weeks before MR's arrest there is a particularly telling set of circumstances. During that period Dr SA had determined upon a course of treatment involving the re-introduction of enteral feeding, persistence with enteral feeding, cessation of PN and therefore the need for central lines, and progression to oral feeding. BR approached this plan with considerable trepidation – she was afraid of being caused pain from enteral feeding. By then she had been weaned off morphine. She was given other pain relieving medication and there is no evidence that she was deprived of appropriate pain relief, but BR probably viewed this as depriving her of her pain medication. As the plan was put into action, after a while, BR began to suffer bleeding from her gut, vomiting, and diarrhoea. Records of her fluid balance suggest that she had repeated measurements of excess fluid (intake significantly higher than output). MR ordered large quantities of bisacodyl to be delivered through Amazon to the ward. Documentary evidence shows that MR purchased large quantities of ibuprofen. Prescribed drugs were being administered enterally by MR, perhaps aided by BR, in the cubicle. HST relevant to that period shows BR was ingesting ibuprofen, piroxicam, and bisacodyl. Urine testing reveals the ingestion of ibuprofen. As already mentioned, the PEG-J tube had traces of ibuprofen, piroxicam, and bisacodyl within it. On MR's arrest, ibuprofen, piroxicam and bisacodyl tablets were found in the cubicle. BR had signs and symptoms consistent with NSAID toxicity and laxative use. The evidence proves beyond doubt that BR was ingesting ibuprofen, piroxicam, and bisacodyl during January and February 2021 in sufficient quantities to cause her persistent and significant signs and symptoms of bleeding in her gut, ulceration, abdominal pain, and diarrhoea. The excess fluid balances are consistent with unrecorded fluid being introduced when these un-prescribed drugs were administered enterally. The analysis of the tube residue adds some weight to these unprescribed drugs having been administered enterally. The bisacodyl residue in the pill crusher may have been leftover from Hospital B but the reason to crush ibuprofen tablets would have been to administer them enterally rather than orally. I do not hesitate to conclude that during January and February 2021 BR ingested ibuprofen, piroxicam, and bisacodyl enterally through her PEG-J, and that she did so more than occasionally so as to cause the findings, signs and symptoms to which I have referred.

205. Could BR have self-administered the unprescribed drugs without MR being aware? As was the usual pattern, MR was an almost constant companion to BR during these two months at the beginning of 2021. Nurses would leave the prescribed drugs in syringes for MR to administer through BR's PEG-J. MR told the court that most often BR would take over the administration of the drugs through the syringe into the PEG-J. Her evidence about that practice, including in

police interviews, has been inconsistent. Even if she did so, MR remained with her. To administer the unprescribed drugs enterally, they would need to be crushed and then dispersed in water (none of them dissolve in water) before being injected into the PEG-J. It is inconceivable that BR managed to do this repeatedly during January and February 2021 without MR being aware. MR herself accepted during oral evidence that it would be unlikely that BR could self-administer unprescribed drugs enterally without MR being aware. As BR ingested the unprescribed drugs, the quantity of tablets left for MR's own use would have diminished. MR claims that she would not have missed one or two tablets but I find that difficult to accept: she received piroxicam on repeat prescription of 56 tablets which would last her 28 days. The records show that she would request the next prescription in advance of the 28 days (no doubt to ensure that she did not run out of the analgesia). She was very troubled by back pain, so much so that she says she purchased ibuprofen to add to the tramadol and piroxicam she was prescribed. Piroxicam is significantly stronger than ibuprofen. MR is someone who has a long history of taking large quantities of analgesia. If she had become short of piroxicam because her daughter was taking even one or two tablets a month, she would, in my judgment, have been aware. Indeed MR requested an early repeat prescription on 29 January 2021 which is a further indication that she was aware that she had become short of piroxicam at that time. She did not tell the court that she herself was taking more piroxicam than prescribed. Indeed, she told FTS in October 2021 that she had had a "gap of a few weeks" in her piroxicam use prior around January 2021. Whilst the timing is imprecise, this evidence, with evidence of the early repeat prescription request is consistent with the excess tablets having been administered to BR at about that time. Likewise, her ibuprofen came in strips, and she would have noticed if a strip, or tablets within a strip had gone missing when she had not taken them. In any event, to cause the findings, signs and symptoms suffered in January and February 2021, BR must have been taking more than one or two unprescribed tablets every now and then. Having found that BR did ingest unprescribed drugs enterally I am sure that MR was aware of that ingestion via the PEG-J.

206. I have to consider whether MR was not merely aware but was the person who administered these unprescribed drugs via BR's PEG-J and the extent to which BR herself was involved or was aware of what she was ingesting. Is it likely that MR administered these drugs without BR knowing what she was doing? The evidence is that BR was very aware of all aspects of her treatment, especially her analgesia. Indeed at times she was demanding in respect of her analgesia and became extremely upset when faced with the prospect of not receiving the level of analgesia she considered she required. She was highly anxious about the plan to re-introduce and persist with enteral feeding. She was very particular about the manner of administration of enteral drugs – she would want them to be given exceptionally slowly. The balance of the evidence is that sometimes if not always, she would hold the syringe to control the rate at which the drugs were administered to her. I have also noted that it is likely that BR knew what an ibuprofen tablet looked like. However, BR was also extremely trusting of her mother – her trust was almost absolute and was much greater than her trust in the doctors treating her, some of whom she could not bring herself to speak to. To administer the unprescribed drugs enterally, as set out above, would involve several steps of which BR could not but be aware. The nurses would bring prepared syringes of

prescribed medication to the cubicle. The administration of further, unprescribed drugs, crushed and dispersed in water, would involve using a further syringe or the same syringe more than once. Whilst pink ibuprofen tablets, in water, turn the fluid pink I do not know what colour the liquid would be if it contained ibuprofen together with other unprescribed medication. However, whilst I am sure that BR must have known that her mother was adding some form of medication to her prescribed medication, and delivering it via the PEG-J (sometimes with the assistance of BR) it does not follow that BR knew what those medications were. Even if the fluid was pink, BR may not have associated the pink fluid with the pink tablets in the cubicle toilet. BR was a young girl at the material time. She trusted her mother absolutely.

207. On the balance of probabilities I find that MR administered ibuprofen, piroxicam, and bisacodyl via BR's PEG-J in January and February 2021, that BR knew that her mother was giving her additional drugs to those already prescribed in order to help her, but that she did not know exactly what medication her mother was administering to her.

208. It cannot be absolutely discounted that BR took some of the unprescribed medication orally prior to MR's arrest but I consider it unlikely. Oral medication was not being prescribed to BR: there is a record of amitriptyline being prescribed to be given "PO" meaning per oral, in early February 2021 but MR was quite clear in interview on the day of her arrest that BR was not taking anything orally, and I note that in the preceding week the drug chart recorded that the same drug was to be given via PEJ. I am satisfied that the reference to "PO" was likely to be a recording error. Manifestly, no-one could covertly administer oral medication to BR – she would have known what she was doing if she was swallowing a tablet. The tablets were in her cubicle – they were not locked away. Dr Ward said that she was "absolutely horrified" at the idea that ibuprofen tablets could have been stored on an open shelf in a child's cubicle in hospital, but the evidence is that they were in BR's cubicle. She would therefore have had access to the tablets if she chose to take them. BR has claimed that she took ibuprofen, and perhaps other drugs, without her mother's knowledge – she has never claimed to have self-administered drugs enterally. However, in her initial police interview MR said that BR took no medication by mouth – it caused her pain. Furthermore, the ibuprofen tablets were pink and it is likely BR would have been familiar with them. She associated them with being made ill at Hospital A. BR has disclosed that she did ingest oral medication taken from her mother's bag but her evidence was not convincing, it was inconsistent over time as to the number of occasions on which she did it, and, as I find, she was probably trying to cover up for her mother. I also take into account the evidence that BR ingested ibuprofen after her mother had been arrested and removed from the hospital. For the reasons set out below I consider it likely that she did so orally and therefore in full knowledge that she was taking ibuprofen that might make her ill and that was unprescribed. Nevertheless, on the balance of probabilities it is unlikely that BR took unprescribed drugs orally during January and February 2021 before her mother's arrest. She was not at that time ingesting anything orally (the only evidence of oral ingestion for months prior to her mother's arrest was the family's claim that she consumed some mashed potato very shortly prior to the arrest). Had she ingested

large pink ibuprofen tablets orally she would have been aware that she might make herself ill and, at that time, prior to her mother's arrest, I do not believe that she would have taken that risk behind her mother's back. She appeared to be genuinely confused about the purpose of a urine test for ibuprofen (February 2021) because she knew she should not take ibuprofen. I am satisfied that on the balance of probabilities, BR did not ingest unprescribed medication orally prior to her mother's arrest. The unprescribed drugs were all administered enterally by MR as described above.

209. I must now consider whether the same conclusion may be reached for the months from March 2020 until January 2021. The toxicology and HST evidence shows ingestion of ibuprofen and piroxicam throughout that period, with bisacodyl ingestion throughout save for a period of about six weeks from the beginning of September 2020. For much of the period from March 2020 to the end of 2020, BR was on TPN, but she had a PEG or PEG-J in situ which was used for the administration of some drugs. BR had evidence of internal bleeding with melaena and a drop in haemoglobin in April 2020, findings of duodenal inflammation on endoscopy on 27 April 2020, and a stomach ulcer found on endoscopy three days later. BR had severe abdominal pain in July 2020. In November 2020, a colonoscopy revealed a deep ulcer in the roof of the duodenum. I have already found that MR administered ibuprofen, piroxicam, and bisacodyl via BR's PEG-J in 2021. The evidence supports the same reasoning leading to the same conclusion that she did likewise, via PEG-J or PEG from March 2020 to the end of that year, except that bisacodyl was not ingested for about a six week period from the beginning of September 2020.

210. There is no HST evidence and no urine or blood samples to prove ingestion of ibuprofen, piroxicam, or bisacodyl prior to March 2020, but LCC allege that there was ingestion of those three drugs from "at least August 2019". Professor Sullivan's evidence supports that conclusion. In particular he told the court that BR's significantly raised faecal calprotectin levels (over 600 on 1 October 2019), together with abdominal symptoms and findings on ileo-colonoscopy on 24 October 2019, were, in the absence of any other diagnosed underlying condition, consistent with NSAID enteropathy. In fact, BR was initially prescribed ibuprofen in June 2019 but I am satisfied that she was not administered prescribed ibuprofen after mid July 2019. MR began to be prescribed piroxicam on 30 August 2019. I cannot find that on the balance of probabilities BR took bisacodyl before about March 2020, but I am satisfied that the evidence establishes to the requisite standard that she ingested ibuprofen and/or piroxicam from late September 2019. Again, I am satisfied that MR administered these drugs enterally using a syringe and that BR was aware that her mother was giving her additional medication to help her but did not know what that medication was.

211. Even though I have found that BR was aware that she was being administered additional drugs, the responsibility for their administration lies with MR. I have carefully considered the difficult question of why she caused her daughter to take unprescribed drugs when she knew that they could cause her harm, and when there was clear evidence, as there was in February 2021 for example, that they were causing her harm. In my judgement, the answer lies in the relationship between

MR and BR, BR's experience of pain, and MR's own relationship with pain and analgesia.

212. For nearly 18 months, BR and MR spent hour after hour with each other in a small cubicle, often with the blinds closed and with the lights switched off, with no other company save that of hospital staff. This was exacerbated by the restrictions imposed as a result of the Covid-19 pandemic – BR and MR were isolated. Naturally, their focus on BR's condition, her levels of discomfort and pain, and her need for different medications, was intense. MR would very often sleep alongside BR in her hospital bed rather than on the camp bed in the room, or in the parents' accommodation at Treetops. When MR did leave BR on her own, perhaps to spend a night at home – which was seldom – text messages show that they would continue to discuss BR's medication and her nursing care. At times BR could hardly bear to let MR out of her sight. BR was highly dependant on MR. MR was obviously focused almost entirely on BR and giving her comfort. She would help with the administration of medication, daily care, weighing, collecting fluids and taking them to the sluice room. She was intimately involved in all aspects of BR's care. The evidence suggests that she virtually never denied BR what she wanted. BR wanted her to sleep in her bed, so she complied. She did not want to speak to doctors and so MR did it for her. She wanted to take medication in a certain way and MR went along with it.

213. I do note MR's own history. Medical records from when she herself was a young person and then a young adult, reveal troubling periods when clinicians, and it appears her own family, thought she was fabricating symptoms, for example by faking vomiting episodes and collapses, and causing herself harm, for example by picking at stitches to cause bleeding. She denies that she ever did so and I only have hearsay evidence about the events from her past – I have not heard from those who made the medical records at the time. I do not make any findings that she did fabricate or induce her own illnesses but, even on her own admissions during cross-examination, it is clear that she has a complex medical history of symptoms for which no physical cause was found, and she has accepted that some of her past presentations have been related to psychological factors including stress. She has had a complex relationship with pain and with analgesia, with evidence of a dependency on morphine. Whilst staying in hospital with BR she was purchasing and ingesting ibuprofen in addition to her prescribed tramadol and piroxicam.

214. BR herself was suspicious of doctors and of their belief, as she understood it, that she was "making up" her symptoms and pain. She developed and to an extent cultivated close relations with some members of the nursing staff, a small group of whom became known as the "Fab Five". It was as if MR and BR would allow some into their circle, but not others. Anyone who presented a challenge to them was not allowed into the circle. The deep inter-dependent relationship between BR and MR, the experience of extreme pain, the feeling of "not being believed", the distrust of the doctors managing BR's treatment, their unhealthy relationships with analgesia, all led to MR taking matters into her own hands by giving her additional pain relief – ibuprofen and piroxicam. MR thought she knew best how to help her daughter. Ranitidine had been prescribed for BR in September 2019 and MR may well have thought that this would give some protection against the side-effects of NSAIDs of which she says she was aware. Within a short time from the admission

in September 2019, after the holiday abroad, BR was not ingesting food orally, there was concern that she may have Crohn's Disease, and the picture MR and BR would have had is of a girl with a dysfunctional gut, suffering intractable abdominal pain, unable to eat, for whom prescribed analgesia was not effective. MR could provide BR with other analgesia which she may have thought would, at least sometimes, give BR some relief from her pain. BR said in interview that sometimes ibuprofen worked, sometimes it did not. MR may have convinced herself that findings of ulceration and evidence of bleeding in the gut were due to an underlying medical condition and not the NSAIDs she was giving to BR. MR has used laxatives regularly herself. She has an understanding that some analgesia can cause constipation. She may have thought that giving BR bisacodyl to ensure that the gut was cleared out in a misguided attempt to help her daughter. The evidence does not allow me to conclude that MR gave her daughter unprescribed medication in order to hurt her, out of malice, or in order to keep them both in the "safe haven" of a hospital ward. Any of those motivations may have been present but, equally, MR might genuinely have considered that she would help her daughter by giving her additional pain relief. However, MR's categorical denials about her involvement in administering unprescribed drugs to BR do lead me to conclude that she knew that what she was doing was wrong and that she had to cover it up by deceit. Her actions have drawn her daughter into lying in order to cover up her mother's actions.

215. In reaching these conclusions I have taken into account the apparently confounding evidence that BR continued to test positive for ibuprofen when urine samples were given after MR's arrest. She did so notwithstanding searches of her cubicle which found no drugs secreted there. No witness could identify how BR managed to possess and ingest ibuprofen between 25 February and 22 April 2021, but:

a. The evidence establishes that BR did ingest ibuprofen, but probably not piroxicam or bisacodyl during that period;

b. Unless a healthcare professional was covertly administering ibuprofen to BR during that period, BR must knowingly have ingested ibuprofen herself.

c. No member of the family would have had the means covertly to administer ibuprofen to BR during those few weeks via her PEG-J and if she took the ibuprofen orally she would have known she was doing so. The evidence does not allow me to conclude that FR or anyone else from BR's family were covertly administering unprescribed drugs to BR or supplying them to her for her to take herself, either of their own initiative or under encouragement from MR.

d. Given the difficulty for BR to self-administer ibuprofen via her PEG-J, it is likely that BR will have ingested the ibuprofen orally. MR submits that it would have been a simple matter for BR to self-administer drugs via her PEG-J. She was used to injecting herself for example. I disagree – the process is much more complex than self-injection. In any event it would have been so difficult for her to do it alone and undetected that I discount it as a possibility.

At one point after her mother's arrest BR said that if she got better "they" would think that her mother was responsible for her condition. BR and MR had an enmeshed relationship and BR trusted her mother absolutely. I have found that BR did not know what additional drugs MR was administering to her via her PEG-J, only that her mother was administering some drugs to her. BR had experience of ibuprofen causing her to become unwell when she was at Hospital A. My findings about the police officers' search upon MR's arrest, is that they left drugs in the cubicle. The only unprescribed drug found in BR's system after MR's arrest was ibuprofen. On balance, the conclusion I have reached is that ibuprofen tablets were left in BR's cubicle even after the police search following MR's arrest. That was the supply used by BR in late February, March and April 2021. I conclude that it is likely that after MR's arrest, BR secreted some of the ibuprofen tablets left behind and that for a few weeks she sometimes took those tablets in an attempt to make herself unwell so that her mother would not be blamed for her condition. MGMR told the court that BR had a drawer full of craft beads in bags. It is certainly possible that BR hid the tablets in those bags and that they were not noticed during the later searches. The nursing staff might not think to look inside the bead bags. However she did so, I find that BR did secrete ibuprofen tablets and took some after her mother's arrest. By then she was beginning to consume food orally and I find that she took the ibuprofen tablets orally also.

216. I am sure that BR was very conflicted at that difficult time. Even though BR took some ibuprofen tablets in an attempt to make herself ill, to cover up for her mother, she did in fact make a swift recovery after her mother's arrest. It is notable that the concerns about abdominal symptoms largely evaporated after a short time. Notwithstanding the positive urine tests for ibuprofen, BR's diarrhoea and GI bleeding resolved. She continued to complain of abdominal pain, and still does, but not to the extent that was helping to keep her in hospital. She had been ingesting piroxicam, as I have found, but the evidence is that that ceased at about the time her mother was arrested. That will have been likely to improve her gastroenterological symptoms. The cessation of PN upon her beginning to take on food, and the removal of a central line clearly helped to improve her general condition and to remove the risk of repeated line infections and sepsis. As discussed later in relation to HS and LW, the court has to be careful not to assume that the removal of the mother caused the improvement in the child's condition – other factors may have changed other than the simple fact that the mother was not present to administer unprescribed medication. One issue to consider is whether BR was so motivated to get home that she started to eat, and stopped taking quantities of medication she had been taking. That theory does not sit easily with my finding that BR probably knowingly took ibuprofen after her mother's arrest so that she might become ill (as she had done when she had previously been given ibuprofen at Hospital A). As I have found, BR did not know that she had been administered piroxicam, ibuprofen and bisacodyl by her mother before her mother's arrest. She did not know, and I do not know how much ibuprofen or piroxicam MR was administering to her. Considering all the evidence, including BR's improvement after MR's arrest, I remain satisfied that MR had covertly administered unprescribed medication to BR and that BR's improvement is consistent with the fact that, other than some voluntary oral ingestion of ibuprofen, the administration of unprescribed medication ceased.

217. For the avoidance of doubt, LCC did not plead as part of their case against MR that she administered unprescribed Tramadol covertly to BR, or encouraged her to take it, and I make no findings that she did so. The Local Authority have continued to allege that MR was involved in the administration of Trimethoprim to BR but I accept fully the submissions made on MR's behalf that that drug was prescribed to BR under a different drug name and that there is no evidence that BR ingested unprescribed Trimethoprim.

218. No allegations are made against FR or any other member of family R. For the avoidance of doubt, I am sure that FR was not at all involved in the administration of unprescribed medication to BR and did not know what MR was doing. Nor did any other members of family R, including MGMR.

219. I consider below the allegation that MR deliberately contaminated BR's central lines so as to cause infection and sepsis. However, it is clear to me that the administration of unprescribed medication caused the symptoms and unnecessary medical interventions set out at paragraphs 3 to 8 of Appendix 1.1 and that the avoidable siting of central lines led to the repeated polymicrobial line infections and sepsis suffered by BR – without the lines in situ she would not have suffered those serious complications (whether caused deliberately or otherwise).

220. It is further alleged that MR encouraged BR to think of herself as a sick child. In particular MR:

> i) Has facilitated/encouraged the use of a wheelchair by BR which was not prescribed.
>
> ii) Fostered a belief in BR that her pain could only be managed by opiate pain relief.

The reality is complex and nuanced in that BR has, I am sure, functional abdominal pain and a complicated relationship with pain and pain relief that includes an experience of widespread pain, including in her legs, and a dependence, at times, on opioid pain relief. However, there is no doubt that MR's actions in administering unprescribed medication over a prolonged period, for whatever motive she had, exacerbated BR's self-perception as a sick child who needed a wheelchair and opiate pain relief. Of course she was a sick child in large part because of MR's actions in giving her unprescribed medication over a prolonged period. However, I am not satisfied that, beyond creating the conditions for BR to feel and believe herself to be a sick child, MR further encouraged the use of a wheelchair. The use was at times supported by hospital staff. Opiate pain relief was of course prescribed. MR was responsible for the core conditions that gave rise to the use of a wheelchair and opiate pain relief. She induced illness in BR rather than encouraging a false belief of sickness in an otherwise well child. Accordingly, I do not believe that these particular allegations properly reflect the true position and I make no findings in relation to them.

221. It is convenient at this point of the judgment briefly to comment on MR's arrest. It was the reporting of the urine test, positive for ibuprofen, which triggered the referral to social services and the police, and MR's arrest. The test was of great significance. It is now realised that a similar positive test had already been reported (August 2020)

and ignored. It was right, in my view, for social services to be contacted and I understand why an arrest followed. However, whereas Dr SA considered that the finding of ibuprofen in BR's urine provided a solution to all BR's perplexing presentations - they were due to NSAID toxicity - in fact, the urine test did not conclusively prove that MR had administered ibuprofen to BR, nor did it prove that MR had been responsible for causing infection in BR's central lines. Those matters required a lot of further investigation. In those circumstances, hospital staff who liaised with the police might have exercised a little more caution when expressing views, as they did, as to matters such as MR's contact with her children, including with BR. They had a strong influence on safeguarding and welfare decisions taken at the time.

E4: MS: Exaggeration, Fabrication, and Misrepresentation

222. ERYC allege that during periods between April 2019 and October 2021 MS fabricated and/or exaggerated HS's ill-health and symptoms and provided misleading and/or inconsistent information about his nutritional intake and bowel movements to healthcare professionals (allegations 1 to 3, 5, and 10, Appendix 1.2). The Local Authority puts these allegations from August 2019 to 23 September 2019, and from 18 March 2020 to 8 April 2020, on the basis that MS "fabricated or exaggerated and subsequently induced HS's symptoms" including diarrhoea and vomiting by administering an unprescribed agent. I consider the allegations of induction of symptoms by poisoning in section E6. Other allegations related to those of misrepresentation are that MS interfered with HS's feeding regime by either fabricating or exaggerating the extent to which he was eating or withholding or reducing the volume of his feed (allegation 3, Appendix 1.2), that MS failed to present HS to hospital within a reasonable time of discovering a split in his feeding tube (first part of allegation 4, Appendix 1.2) and failed to accept advice from healthcare professionals (allegations 7 and 8, Appendix 1.2). I shall consider those allegations in this section. I shall consider allegations regarding interference with feeding equipment and lines (second part of allegation 4, allegations 6 and 9) in conjunction with the allegations of induction of line infections and sepsis, in section E7.

223. I found MS to be a careful witness who tried her best to answer detailed questions about specific events many of which occurred amidst a sea of other similar events (for example events when HS vomited or had diarrhoea) three or four years ago. Unsurprisingly she could not always recall details. At times, MS showed some frustration with questioning that she thought did not reflect her own experience of events. I thought that her responses in cross-examination at such moments were sincere and reasonable from her perspective. MS had made some written notes at around the time of her arrest and those notes, her police interviews, her written evidence and her oral evidence were conspicuously consistent. She was cross-examined by Ms Lee KC at length but maintained a consistent stance. She became upset at times as was understandable. Given the difficulties in recalling specific details from the past I found that she had a generally reliable recall for events. In contrast, FS was less reliable on detail. He was very clear in his support of MS. They are now separated and he has care of the children. Perhaps, as has been submitted, he wishes to reconcile with MS and that is why he is supporting

her, but I asked him directly to contemplate MS having care of his children knowing, as he now does, all the allegations against her and some of the evidence in the case. He maintained his support for her and his belief that she was not guilty of the allegations made against her. It was notable that in his written evidence, prepared with the help of legal representation, he did give some evidence that contradicted evidence given by MS, for example about HS's feeding difficulties or vomiting. However, at times during cross-examination he would spontaneously volunteer evidence, such as having repeatedly to fetch a mop in a café to clean up HS's sick, which contradicted his written evidence and corroborated MS's evidence. It showed that he had not thoroughly reflected on his true and full recollections when making his written statements. I found his oral evidence to be spontaneous and authentic.

224. Between them, MS and FS gave convincing evidence of what had been a close and loving family prior to the events under consideration. At odds with that impression were text exchanges between them in the summer and early autumn of 2021 when, at times, they were vituperative and deeply offensive to each other. The tone of some of the exchanges is unpleasant but given the extreme circumstances in which they both found themselves, I do not find the substance of the exchanges particularly surprising. MS resented FS being at home with the other children; FS was critical of MS for freezing him out. In fact, as Mr Storey KC and Ms Madderson, for FS, submit, SCH had not included FS in discussions about HS. He was to a large extent effectively excluded. He was a vulnerable person, having Crohn's disease and having to shield during the pandemic, but he was looking after the other children and had a role to play in the management of HS. His anger was directed against MS but it was partly engendered by the circumstances in which he found himself and his lack of understanding due to there being so little communication with him from the treating team.

225. The context within which HS's feeding difficulties and gastroenterological condition and presentation must be considered is that he was premature. Professor Sullivan impressed on the court that prematurity can lead to feeding difficulties and that in his opinion it did so in HS's case. HS was born prematurely but at two months his weight was at the 25th to 50th centile, as adjusted, and he was able to be discharged home. At six months he was admitted to hospital for the insertion of an NGT due to difficulties with feeding. MS had reported that he vomited after feeds. When admitted his weight was below the 0.4th centile. He was not dehydrated or lethargic but he was not gaining weight as he should and the situation was concerning. The Local Authority has not included any specific allegations against MS for the period prior to the fitting of an NGT in March 2019 but it was put to MS in cross-examination by Ms Lee KC that she had "made things up" when reporting symptoms to clinicians. It is the case that on 9 January 2019 at a paediatric outpatient clinic MS reported that HS "seems to be bringing up clear liquid all the time" whereas the day before, on a home visit a paediatric nurse recorded, "symptoms much improved according to parents … less vomiting." However, on 9 January 2019 it was also recorded that HS had been "much more settled" on Neocate but was still being sick; and on a home visit on 31 December 2018 it had been reported that the vomiting had been "bad again". The out-patient appointment was the first for one month and the community records show MS, and apparently FS, had reported vomiting as a significant problem over that

month, albeit it had recently improved. On careful examination, the mother's reporting was not inconsistent. FS did say in a witness statement that he does not recall HS having problems with vomiting at home, but he was apparently party to discussions about HS's vomiting with at least one community nurse. His memory of these matters was clearly awry when he was questioned on this issue, and in later questioning he recalled having to fetch the mop in a café every time they went with HS because he would vomit on the floor. MS was also taken to task by Ms Lee KC for stopping using Carobel, an over-the-counter feed thickener, without medical advice. It seems to me however that MS was trying to see what worked for her son. Carobel is a product rather than a prescribed medicine, and she was entitled to take action as she felt fit when HS responded in certain ways to different strategies she was trying. This was not an example of a mother defying or ignoring medical advice. She told the consultant paediatrician at the next out-patient appointment on 27 February 2019 and he recorded what she had done without comment or criticism.

226. On 11 February 2019, the community paediatric nurse discharged HS from their care and advised MS to talk to a dietician but told her that usually they would try a child on their previous milk if the mother wanted to try without Neocate. The following day another community nurse recorded that MS reported that the community paediatric nurse had advised "to reintroduce cows milk to see how HS tolerates this. Mum unsure about what to do as he has previously had high calorie prescription milk as he was prem." It was put to HS that she had lied to this healthcare professional about the advice she had been given but I do not see any significant discrepancy once allowance is made for discussions being reduced to brief notes. The mother was discussing feeding issues with professionals openly. Notes were being made of advice given and of the discussions. She was seeking advice and I can see no evidence that she was manipulating professionals or fabricating evidence to them at this stage. One of HS's sisters had had similar difficulties in her early childhood and had required an NGT for feeding problems that subsequently resolved. MS had experience of dealing with a child with feeding difficulties of the kind that HS was suffering. Witnesses who were involved with MS and HS at this time said that they had no concerns about her interactions with them or her care for HS.

227. ERYC do allege that from 23 April 2019 to 17 July 2019 MS fabricated and/or exaggerated HS's ill-health. They allege that MS misleadingly reported that HS was vomiting up to 20 times per day, and gave misleading information to clinicians about his nutritional intake and bowel movements (allegation 1, Appendix 1.2). It is plain from the evidence that the clinicians' understanding of HS's presentation led to the insertion of a PEG under general anaesthetic at SCH in June 2019 and subsequent enteral feeding via the PEG. Looking at the records for the period:

    a. On 23 April 2019 HS was seen with MS at an out-patient clinic by a paediatric gastroenterology registrar who noted that he was on omeprazole (antacid) and Movicol (laxative). He was diagnosed with probable gastro-oesophageal reflux disease and treated as having a cow's milk protein allergy. He was recorded as having constipation and "only opens his bowels every seven to ten days" as must have been reported by MS. He had only recently started on

Movicol. On examination he was bright and alert. He had still not gained any weight. He took a dummy and put his hand in his mouth which suggested he did not have a true oral aversion but he was not gaining adequate weight. On 10 May, the Community Paediatric Nurse noted on a home visit that "Mum reports that HS is tolerating 90 ml feeds of Neocate 3 hourly". Neocate is a formula for children with cow's milk allergy. On 23 May, at an out-patient clinic, a Paediatric Registrar noted that MS had reported that HS had been a bit better in terms of symptoms four weeks ago, but "for the last 2 weeks he has gone back to square one in that he can vomit up to 20 times a day between mild to moderate amounts and he brings out orange to brown liquid." Expert witnesses expressed doubts as to whether HS could truly have been vomiting 20 times a day but, as MS pointed out during cross-examination it is recorded that there were times when he was more settled and what was recorded on 23 May 2019 was that he was vomiting "up to" 20 times a day and that the vomits were mild or moderate. I note that on 6 July 2019, Nurse GA visited HS at home and witnessed MB vomiting three times "all projectile" after which HS was admitted to hospital for projectile vomiting. Nurse GA recorded that both parents were "very down and upset due to HS vomiting and losing weight." The vomiting appeared to be related to bolus PEG feeds. It appears therefore that MS was not alone in witnessing vomiting at about this time when HS was at home.

b. On admission to Hospital C on 7 July 2019, it was recorded that HS was vomiting 15 times a day. On moving from the assessment room to the ward it was observed by a nurse and recorded that HS vomited over his mother's arm. He was put onto continuous feeds and did not vomit overnight but then vomited large amounts the following morning. Further vomiting was recorded during the day but it was noted that there was "much improvement from bolus feeds." Vomiting was noted on many occasions over the following days of this admission, including as observed during a ward round on 16 July 2019. Despite continuous PEG feeding in hospital under nursing and medical guidance, HS only gained 100 g in weight during this 12 day admission. In her oral evidence MS said that she knew the difference between a baby vomiting and a baby posseting, and that in this period from about May to July 2019 HS was vomiting frequently. She has never reported that he was vomiting 20 times a day every day over a long period, but she did report very frequent vomiting. The evidence clearly establishes that HS was vomiting virtually every day when in hospital in July 2019 even after an improvement when he changed to continuous PEG feeding. Furthermore, he failed to gain weight during this period, which would be explained by frequent vomiting. MS's presentation, as recorded when in hospital, is consistent with more frequent vomiting at home on bolus feeds, as reported by MS. It was Nurse GA who referred HS for hospital admission in July having herself witnessed three projectile vomits on her visit alone. It is possible that HS was vomiting less frequently than MS reported at times – she may have been keen to emphasise how worrying HS's vomiting and lack of weight gain was – but the evidence does not persuade me that she was exaggerating MS's symptoms to cause him to have hospitalisation or medical treatment.

c. On 31 May 2019, MS took HS to hospital following "self removal of nasogastric tube. Mum reports that HS removed and lost the tube when they were at the park … Mum reports that HS is self removing his tube up to three times a day. Mum has not previously informed the Children's Community Team of this or the fact that Dad is resiting the tube each time at home without being assessed as competent to do so." In fact, FS had been shown how to replace the NGT and had been observed to do so competently, as recorded by a community paediatric nurse on 10 May 2019. Earlier, on 27 April 2019, there is a record of FS having reinserted the NGT after it had come out. MS told the court that she would push it back in when it had partially but not fully come out but she remembered FS resiting the NGT when it had fully come out on a couple of occasions. I heard evidence from FS about this also and am satisfied that the note of 31 May 2019 records MS's report of HS dislodging but not necessarily fully removing his NGT up to three times a day, with FS resiting it when it was fully removed as he had been shown to do. I do not consider that the record of 31 May 2019 is evidence of fabrication or exaggeration by MS.

d. It was put to MS that at an out-patient gastroenterology clinic on 23 April 2019 she had fabricated a report of HS having had blood in his stool but there is no reason to believe that this was a fabrication – it is feasible that there was a little blood on passing stool after constipation – FS recalled that that had occurred.

e. On 23 May 2019, MS is recorded as informing the Health Visitor that HS had passed two stools in two days. The following day it is recorded in the GP notes that she had reported that he had not opened his bowels for four days. That is an inconsistency but it might be explained by the GP wrongly noting a report that HS would *sometimes* go four days without opening his bowels. Again, even if there was an inconsistency in reporting on this occasion, it is difficult for me to find that this was due to deliberate fabrication or manipulation by MS as opposed to an understandable inconsistency given the number of reports she was giving and the nature of HS's condition.

f. The records suggest that HS's parents failed to take him to two appointments for barium scans (when eventually performed the scan was normal). MS said that she was aware there had been one appointment which was missed. I accept that in a busy family (with no car) these appointments can be missed. There is no pattern of MS missing appointments at this time, indeed she appears to be engaged with a large number of different healthcare professionals trying to look after HS.

228. I have addressed this period, from birth to August 2019 at some length because by the end of the period HS had a PEG inserted and was failing to thrive, yet, in my judgment, the evidence does not establish any fabrication or exaggeration of illness by MS, no pattern of conduct of that kind, and certainly none that resulted in the interventions that healthcare professionals considered necessary. There was no diagnosis of an underlying cause but nor does there seem to have been any consideration at the time that HS's symptoms were perplexing or that his mother's reports were questionable. Indeed, those witnesses who were involved with MS at the time speak to her love and care for HS, her good

communications with professionals and her positive interactions with them at visits and consultations. As Nurse GA, who saw a lot of MS and HS at this time, told me in oral evidence, she was shocked when allegations of FII against MS later emerged. Nothing in MS's conduct between HS's birth and his discharge home from Hospital C on 19 July 2019 aroused suspicion and, even looking afresh at the evidence from and about that period, I cannot find any evidence to persuade me that MS was fabricating HS's illness. If there was occasional exaggeration of the frequency of vomiting it was not manipulative but out of anxiety for HS's continuing condition.

229. On 13 August 2019, HS was admitted to SCH for six weeks for faltering growth. ERYC allege that during that admission MS fabricated or exaggerated and subsequently induced symptoms of excessive diarrhoea and vomiting by administering a unprescribed agent to him (allegation 2, Appendix 1.2). I deal with the allegations of induction by poisoning in section E6. It is also alleged that MS interfered with or allowed HS to interfere with feeding equipment at that time. I deal with allegations of interference with equipment in section E7.

230. It is alleged that during this admission (August and September 2019) MS did not want HS to be discharged home but the evidence provided to me suggests that MS had a close bond with her other children, and a good relationship with FS at this time. It is difficult to accept that she wanted to stay in SCH rather than go home. ERYC state that the records suggest that on 3 September the treating doctor was happy for HS to go home but that MS wanted to talk to the dietician and this delayed HS's discharged. MS said in oral evidence that she was anxious to have clear advice about feeding HS on taking him home. Given her understandable concerns about looking after him, when he was not gaining weight, her position was not unreasonable. In fact, HS's condition did not deteriorate significantly over the next two days or so but he was kept as an in-patient until discharged on 23 September 2019. He had not gained very much weight given that the purpose of his admissions was to correct his faltering growth. It is difficult to find records of his weight but the nursing notes record that on 16 September his weight was within 2g of his weight on admission. During the admission to SCH in August and September 2019 MS underwent multiple investigations including endoscopies and scans and no explanation for his failure to thrive and his feeding difficulties was found. He tolerated dioralyte without any adverse effects during this admission. However, he did not put on weight.

231. Just prior to the admission to SCH, MS made two apparently contradictory reports to community nurses at clinic appointments. On 9 August 2019 MS reported that she had been advised not to try weaning HS and that the family had taken to eating only when not in his presence. On 12 August 2019 she reported that HS would not take anything from a spoon, which they had tried recently, and that she had been making up purees for him herself. In cross-examination MS said that maybe she had tried the pureed food earlier. Although her explanation was not wholly satisfactory, these events were a long time again and it might well be that the later report was more general in nature – that when she had tried pureed food off a spoon, HS would not take it, but that since then the advice had been not to try to wean him. Nursing notes are not verbatim records of questions asked, answers given, and accounts offered.

232. Whilst HS was an inpatient at SCH on 17 August 2019 MS took him out for some air. On returning she reported that his PEG site was a little gunky and a swab was taken that yielded coliform bacillus and group A streptococcus. Three days later nurses noted the site was gunky again and a swab sample grew candida, a fungal culture. HS developed a high temperature. Occasional vomiting was noted and reported by MS. The nursing records during this admission sometimes record "Mum reported a large vomit" or similar, and sometimes "HS had three vomits…." or similar. When the latter style is used, I see no reason not to accept that the nurse making the record was satisfied that HS had indeed vomited as described. HS was given some laxatives and he did have some loose stools. I can find no pattern that gives rise to concerns that the mother was fabricating symptoms. It is true that after some outings with HS she reported problems on return to the ward, but at other times she did not do so, and similar problems emerged when HS was on the ward. Whilst there are records of MS reporting vomiting or loose stools, just as there are records which appear to show that the nurses had themselves noted the same, the tone of the mother's reports is not at all alarmist. For example, just before discharge, she took HS home on home leave. She returned to the hospital and reported some small vomits. HS was discharged home from hospital soon thereafter. Had MS been deliberately exaggerating or fabricating (or administering unprescribed agents) with a view to prolonging HS's hospital admission, she had a chance to do so then, and to talk up the vomiting so as to dissuade staff from discharging HS home. She did not do so.

233. ERYC allege that between 24 September 2019 and 17 March 2020 MS deliberately interfered with HS's feeding regime by either fabricating or exaggerating the extent to which he was eating, or withholding, reducing, or diluting his feed (allegation 3, Appendix 1.2). During this period, HS gained weight from about 5 kg to nearly 7 kg (on 28 February 2020). I have already noted that during his in-patient treatment at SCH for six weeks in August to September 2019 HS did not put on any weight at all. So, although HS's weight continued to be below the 0.4th centile, he was at least gaining weight when cared for at home. HS's parents have said that he would take some finger food in this period – not pureed food, but items such as soft crisps or chips. There continued to be some reports of vomiting and diarrhoea, particularly after a sickness bug in early December 2019. In February 2020, HS was admitted to the A&E department at Hospital C having swallowed a 5 pence coin (when an in-patient at SCH in August 2019 he had been observed by medical personnel picking up a small ball of screwed-up paper and swallowing it). In early March 2020 there was a split in the tube that carried enteral feed to HS's PEG. MS reported the split but was advised that HS would need to be admitted to SCH for its replacement. She patched up the tube with elastoplast but it continued to leak. She was criticised in cross-examination for not taking HS to hospital for the leak to be remedied. FS appears to have urged her to do so. However, the records show that she sought and followed the advice she was given by professionals at the time. HS was admitted to Hospital C on 6 March 2020 for his leaking tube and with the onset of chicken pox. The period from 24 September 2019 to 6 March 2020 was one when HS made some progress with his weight, albeit well below normal growth patterns. There is no evidence of significant problems with his enteral feeding, save the split line on 2 March, and MS appears to have been encouraging HS to try oral feeding. There

is no evidence of any over-reporting of problems or under-delivery of enteral feeding during this period.

234. HS was transferred from Hospital C to SCH on 18 March 2020. ERYC allege that during the period 18 March to 8 April 2020 MS fabricated or exaggerated and subsequently induced HS's vomiting, diarrhoea, and pain following feeds (allegation 5, Appendix 1.2). The significance of 8 April 2020 is that PN was started on that day. Prior to transfer to SCH, during his in-patient stay at Hospital C, HS had suffered a number of problems with his NGT becoming dislodged, and with vomiting and diarrhoea. He was put on diarolyte and, for some periods, milk feeds were stopped. The notes show that vomiting was witnessed by healthcare professionals (for example on 15 March 2020) and was not just reported by MS. On 15 March 2020 there is a nursing note "Called to room. HS had a moderate vomit. Mum was pulling NG tube out of nose when staff nurse entered the room… NG tube repassed." MS explained in her oral evidence that HS was retching and causing the NGT to become dislodged. As had been done on previous occasions she wanted to remove the tube and then replace it. She buzzed for the nurse ("called to room" is recorded) which she would not have done if she had been surreptitiously removing the NGT. I accept her account. There is no hint in the records that what MS did on this occasion was untoward in any way. She was clearly not hiding what she was doing.

235. After transfer to SCH vomiting continued, for example it was noted in the nursing records for 19 March 2020 "on arriving back from theatre patient vomited shortly before his feed went up", and later, "started diarolyte alongside [feed] in order to increase fluid volume, "had a few vomits". On 20 March 2020 at 0630, "vomiting ++ and retching…". On 22 March, "Neocate increased via PEG today and titrated with diarolyte but vomited several times so reduced back, has tolerated since." On 23 March 2020, "Has had 2 x small vomits". On 24 March, "has vomited 3 x today". So, the notes continue. These notes do not state "mother reported" vomiting. Nurses are on the ward and would soon notice if vomiting were reported but there was no evidence of it. The vomiting noted at Hospital C was also noted at SCH after the transfer there, so there was consistent recording of frequent vomiting. I see no reason to suppose that these records of vomiting were inaccurate or did not reflect HS's true symptoms.

236. Loose stools were noted in the nursing records on 26 March 2020. The following day it was recorded, "vomiting and loose stools +++. Feed stopped and full rate diarolyte commenced due to crying out in pain. Vomiting stopped since feed stopped and stools slowed down … needs dietician review. ? milk needing changing. HS settled and slept after feed stopped." Once again I cannot see any reason to find that this was not an accurate note of what actually happened. There are further notes of vomiting and loose stools for the remainder of March and until 8 April 2020. On 4 April 2020 it was recorded, "HS appears in distress/pain ?diarolyte via PEG. Diarolyte stopped and paracetamol given with good effect. Mum happy to restart diarolyte…". Three hours later a further note reads, "Diarolyte re-started …. HS in distress/pain diarolyte stopped." And later, "HS has remained settled since dioralyte stopped. On 6 April, there is a nursing record, "Diarolyte increased … tolerated for approx. 6 hours then 2 x loose stools and in distress…" On 8 April 2020 shortly before TPN was commenced, the following

note was recorded by a nurse, "Once feed was restarted last night within an hour HS was screaming and in distress … turned off feed as it's not fair when he's clearly in discomfort."

237. In my judgement these notes clearly record what nurses had witnessed or were satisfied had occurred. HS's responses to feeding and sometimes to increased rates of diarolyte, would have caused much professional curiosity amongst healthcare professionals, because they were unusual. I find no evidence that MS was fabricating these events or responses or exaggerating symptoms of vomiting, diarrhoea and pain as alleged.

238. Stepping back to survey the evidence in relation to the allegations of fabrication, exaggeration, and misrepresentation by MS, I am struck again by Professor Sullivan's persuasive evidence that feeding difficulties are a very common problem with premature infants. HS's progress to around March 2020 was not, he told me, particularly unusual for a baby of his prematurity. Even if there is apparently good progress in the early months, there can be problems on further development during infancy. The fact that HS was not dehydrated is not inconsistent with his failing to thrive. He was feeding and taking liquids even though they were not in the amounts he needed to grow. He was vomiting but he was also taking on food and fluid. The working assumption amongst the team of very experienced clinicians at SCH was that HS had genuine feeding problems and that his chicken pox had caused a deterioration in his gut function and experience of pain. I am also struck by the compelling evidence, and the clear impression I gained from oral evidence from the parents as well as from community healthcare professionals and hospital nurses, that MS was a caring mother who put her children's interests before her own. Of course, the court has to be wary of deceit in a case of alleged FII, but the consistency of views about MS and her parenting are striking. Overall, I can find no pattern of exaggeration, fabrication, and misrepresentation by MS as alleged. Rather, there is consistent corroboration of her reports of vomiting, diarrhoea and the other problems she raised.

E5: MT: Exaggeration, Fabrication, and Misrepresentation

239. Wakefield MDC allege that MT has misrepresented LW's symptoms to healthcare professionals by exaggerating or fabricating them, that she fabricated, induced or exaggerated accounts of gastroenterological symptoms, and that she presented an out of date advance care plan to staff at Hospital E which referred to limitations of treatment (Findings 1, 2 and 3, Appendix 1.3). As to Finding 2 sought by the Local Authority, it is alleged that MT made a series of reports to healthcare professionals about LW suffering vomiting and/or diarrhoea which the Court may find:

a. Were genuine but not causally related to enteral [including oral] challenges "and instead something he had been given, therefore induced, or

b. An exaggeration of genuine episodes in order deliberately to mislead clinicians; or

c. Entirely fabricated; or

d. A combination of a, b and c.

I shall consider the possibility of induction of diarrhoea and vomiting within this section but deal more fully with that allegation, and related allegations, in the next section, E6. A related finding sought, which I shall consider in this section of the judgment, is that MT refused to agree reasonable requests for treatment of LW (Finding 6, Appendix 1.3).

240. LW was born even more prematurely than HS, and Professor Sullivan's opinion about the effects of prematurity on feeding difficulties applies equally, if not more so, to LW. I was pleased to hear evidence from MT's eldest daughter, NT, who impressed me as completely open and credible. She gave me a strong impression of a close family in which LW's siblings were very affectionate towards him and MT was a conscientious and caring mother. She also told the court, convincingly, of the steps MT had taken in the home to keep LW safe, including cleaning, insisting visitors cleaned their hands before handling him, and changing the carpets to solid flooring to help her keep the house clean, especially as LW would crawl on the floor and was prone to picking up food from it.

241. A number of the allegations initially made by Wakefield MDC against MT were quite properly withdrawn at the close of the evidence. One was that the mother had induced or increased the risk of LW suffering from hypoglycaemia. Dr SAN had said in his written evidence that he suspected that MT's hypoglycaemia "could be as a result of withholding his PN or induced by injecting medication or simply falsifying events." The evidence did not support his suspicions and the Local Authority has rightly taken the view that it cannot prove those allegations. It will be recalled that a large number of LW's attendances on healthcare professionals were due to his hypoglycaemia and absences. I proceed on the basis that these reports and concerns were genuine. I accept the submission made on behalf of MT that Dr SAN's views on this issue are illustrative of his wider views regarding MT. Furthermore, they show the danger of over-speculation as against reliance on objective evidence. Other withdrawn allegations included that MT had tampered with LW's central lines so as to move them and cause them to lie low, as seen on radiological imaging. The Local Authority relied on Dr Alwan Walker's written evidence to support that allegation. Dr Alwan Walker's oral evidence, under scrutiny, did not support that case and it is no longer pursued. For the avoidance of doubt, the Local Authority still maintain that MT tampered with LW's central lines but not that the radiological evidence supports that allegation.

242. MT was an articulate witness who seemed to me to be intelligent and with an ability to think clearly about difficult issues affecting her son. However, in analysing the evidence in relation to these allegations it is important to understand that she was a lone parent with four other children in her care, one of whom then had a baby herself, that she does not have any specialist knowledge, and that she was very reliant on the advice she was being given. During her oral evidence, MT unhesitatingly denied the key allegations made against her but she also accepted that she had at times used the "wrong words" when speaking to healthcare professionals. The Local Authority contends that this was a euphemistic

description of deliberate exaggeration and fabrication. Certainly, some of MT's reports of LW's symptoms cannot be dismissed as just careless wording. However, I have to take into account that (i) the contemporaneous medical notes and correspondence were not written by MT, they are reports of what she said and may not record exactly the wording she used; (ii) MT was under great stress having to care for a very premature baby with significant health problems, as well as his elder siblings – if her reports of what had happened to LW in the preceding days or weeks before a consultation were not entirely accurate, that would be understandable; and (iii) with respect to MT, although she struck me as intelligent, she has not had the educational background of the healthcare professionals she was dealing with or the lawyers cross-examining her. Her vocabulary might not always coincide with theirs.

243. MT has been consistent in her evidence, from first questioning by the police to her oral evidence in court. She has, from her own evidence, entered into more than one relationship in the past that has not been healthy for her. FW gave evidence and did not give any impression of being a reliable parent or partner. I did not find his evidence to be helpful to the court. It is evident that on occasion MT allowed him back into her life even though they had a relatively short relationship, during which LW was conceived, and FW had shown very little interest in his child, leaving MS to care for him alone. I hope that I take a realistic view of MT as a woman who has faced many difficult challenges in life but who has survived them through her resilience. She has largely supported her older children and been a good parent to them. NT seemed to think so and she was a guileless and credible witness.

244. There was some evidence to suggest that in the past LW had fabricated having cancer as part of a money raising exercise. I did not receive evidence of sufficient cogency to make any findings that she did so. It is the case that at Christmas 2020 a local newspaper reported on members of the local community rallying round to buy Christmas presents for LW and to arrange for people to dress up and give him the presents in his home at a sort of party. I am satisfied that there was no financial advantage to MS from this endeavour. Some comments she is reported by the journalist to have made appear to have been exaggerations but I bear in mind that at that time clinicians had given MS grounds for thinking that this could indeed have been LW's last Christmas. Any exaggeration in the report could well have been motivated by a desire to emphasise how ill LW was and that the generosity of others towards her son was well justified.

245. LW was born very prematurely at 24 weeks. MT freely admits to having been anxious about being able to care for him safely on bringing him home when he was discharged from hospital at four months of age, and again when she was given the responsibility of administering home PN. By her admission and the evidence of her daughter and her friend, MT was very anxious about keeping LW's environment clean. In 2021, after LW contracted salmonella she took up the carpets at home and replaced them with laminate flooring – LW would spend a lot of time sitting on the floor playing and she wanted to keep the flooring as clean as she could. She would insist on visitors cleaning their hands before handling LW. This does not strike me as worryingly obsessive behaviour – she was caring for a very vulnerable boy with central lines who was prone to life-threatening

infections. MT had a large number of healthcare professionals visiting her at home, or treating and caring for LW in hospital. LW's prematurity, his cerebral palsy, his ROP, his NEC and gut dissection, were all reasons for MT to be more easily triggered to report her concerns to those professionals. This is the context in which her reports and her dealings with professionals must be considered.

246. The evidence from professionals who witnessed MT caring for LW at home was uniform in praising her for her parenting and attention, and her communications with them. There is no question, on the evidence I have received, that LW could have diarrhoea and sometimes explosive diarrhoea, that he could appear to be in distress on being fed even small amounts, that he would sometimes vomit repeatedly even though he had not consumed orally, and that he would have absences. All of these symptoms were observed by others as well as by MT. I heard evidence from NT that I accept without hesitation, that she saw LW have a bout of diarrhoea in the bath at home.

247. I do not find reports of "projectile vomiting" to constitute exaggeration or fabrication. It is an imprecise term and would not, to MS, have any technical meaning beyond that LW had vomited a lot rather than a little. It is alleged that the mother exaggerated or fabricated LW's condition by claiming to a health visitor that she expected him to be registered blind. MS denied this and the health visitor, Ms GB, did make an error elsewhere in her notes where she recorded that LW had CF (cystic fibrosis) rather than CP (cerebral palsy). In any event, it is the case that he had retinopathy of prematurity (ROP) and had very recently been seen by an ophthalmologist, so it would not have been surprising if MS had discussed his vision and had been concerned about him going blind or having a visual impairment. Furthermore, I cannot see the relevance of this allegation – no harm was caused to LW, the assertion, if made, did not lead to any unnecessary intervention, nor could it possibly have been designed to do so. Similarly, the allegation that MS falsely reported to Nurse CG, the community nurse, that LW had had a screaming fit in front of a consultant who had advised ibuprofen. It is known that LW was prone to having a screaming fit at around that time, and there was no advantage, sinister or otherwise, to MS from giving this information to Nurse CG. It did not lead to any change in management or treatment. MS told the court that what she had told Nurse CG was true and I accept that it was true.

248. Wakefield MDC point to MS's report on 9 December 2019 during neurological investigations for LW that he had had vacant episode lasting "hours". MS told the court that his episodes would be for a much shorter time but that together they could occur over several hours. Again, I do not find this record to be evidence of exaggeration or fabrication, only of imprecision or lack of clarity either in reporting or recording. I find similarly in relation to the record of the mother reporting that LW had had diarrhoea for 12 weeks (31 December 2019).

249. MT reported circle-like bruising to LW's legs and an arm on 3 August 2020. Haematological investigation showed no disposition to easy bruising. There is no allegation that MT caused the bruising. In my judgement, particularly given LW's stormy medical history and the involvement of a number of healthcare professionals, she cannot be criticised for raising the issue which was properly investigated with no adverse consequences for LW beyond a blood sample being taken. Nurse CG confirmed in her evidence that it had been entirely appropriate

for MS to have raised this concern. It is understandable, in the absence of an obvious cause for the bruising, that MS was concerned about a propensity to bruise easily and what might be the cause of that.

250. Hence, I do not find that the matters set out in support of Finding 1, Appendix 1.3 are established on the evidence before me. They do not provide evidence on which I can find that MS exaggerated or fabricated LW's symptoms to medical professionals as alleged, nor that she placed him at risk of inaccurate diagnosis or inappropriate treatment thereby. There is certainly no pattern of exaggeration, fabrication, or misrepresentation.

251. The allegations at Finding 2, Appendix 1.3 concern reports by MT to healthcare professionals in the period June 2020 to September 2021 of loose stools or diarrhoea, pain (on one occasion), and, on two occasions, vomiting. I have already noted that there can be no doubt, from the evidence received from witnesses other than MT, that LW suffered from diarrhoea, sometimes explosively so. The concern underlying the reports listed by the Local Authority in relation to this proposed finding, is that the causal connection between the reported precipitating event and the diarrhoea, is not credible. For example, it is recorded that MT reported to Dr SAN on 7 June 2021 that LW had had explosive diarrhoea after drinking some blackcurrant juice. The obvious question that struck me when hearing the evidence on these reports, is that if they were so incredible, why did no healthcare professional at the time say so, or record their doubts about them? Dr SAN, for example, simply recorded them in his letters following out-patient clinics. He did not interrogate MT about what had happened, question the credibility of the reports, or investigate whether there could have been another cause of LW's diarrhoea. At all times MT was evidently anxious about hygiene and about avoiding LW eating. This was because of his experiences in hospital as well as at home when he had suffered diarrhoea. That history is well documented. Listening to the NT's account of LW having diarrhoea in the bath after taking in some bathwater, I can see that she presumed cause and effect whereas it is may have been that the consumption of a little bathwater did not provoke instant diarrhoea. It may have done, but it is not really for NT or MT to know that. This was something that was in line with his past responses to feed and fluids in hospital. Whether the bathwater caused the diarrhoea or not, whether licking a pizza caused diarrhoea or not, MT was reporting what she witnessed or knew from others in the family. Her reports were not questioned at the time and were apparently treated as credible. It is only with hindsight that they are now treated as incredible. I shall consider whether what MT was reporting was induced diarrhoea, but the evidence does not persuade me that the reports of diarrhoea that MT made, as set out under Finding 2, Appendix 1.3, were fabricated or exaggerated.

252. MT did accept that she had mistakenly reported vomiting alongside diarrhoea in relation to the incident with the bathwater. She said that she occasionally loosely referred to diarrhoea and vomiting rather than simply to diarrhoea. I accept that "d&v" are often mentioned together although it is more difficult to accept that she would have reported vomiting when there had not been any had she taken any care over accuracy. It is unfortunate that she was loose with her language and, as she put it "used the wrong words" but on balance I do not believe that she was

deliberately exaggerating or fabricating reports of vomiting. There is no pattern of her doing so, in my judgement, and I do not regard these occasional mis-reports as evidence of fabrication or exaggeration as claimed. I do not find the report on 31 March 2021 that LW was having stomach pains and hitting his stomach to be incredible in the least – I accept that it was an accurate report.

253. Finding 3, Appendix 1.3 concerns the presentation of an out of date version of the advance care plan to staff at Hospital E on 12 September 2021. I refer to my earlier review of the evidence in relation to the LOTA/advanced care plan and my analysis of the evidence of Dr SAN about those matters which I found to be misleading and unreliable. This particular allegation concerns the presentation of the advance care plan some months after the events of February 2021 when the original LOTA was agreed. At the outset of the hearing the Local Authority alleged that what MT had presented was the out of date LOTA but that allegation has been revised. After HS had a new line inserted he rallied and it became evident that the LOTA was no longer appropriate. Nevertheless, it appears from the evidence I have received that the advance care plan following the withdrawal of the LOTA, involved some limitations on treatment in the event that LW suffered another severe bloodstream infection. There is a lack of clarity as to what steps were taken to remove the LOTA from the records at other hospitals including Hospital E. MT says that she had been given a bag by SCH which she handed over on arrival at Hospital E and perhaps that included the advance care plan to which the Local Authority refer. If so, she had been given it by SCH. It is right to note that MT told the court that she had not wanted LW to undergo more than three attempts at cannulation. She was frank about that at court and explained that cannulation attempts were deeply distressing to LW. I have to remind myself that at the time it was still considered that LW had repeat bloodstream infections due to an underlying condition, albeit not fully understood, and that all that could have been done for him had been done for him. It was not known that he would make the remarkable recovery he subsequently made. Of course, if MT had induced his illness, she would have known that his life was not in peril other than by her hand. However, I do not find her approach to the advance care plan in September 2021 to be suspicious or evidence in support of her misleading healthcare professionals. The responsibility was surely on SCH to communicate effectively with Hospital E, where they knew LW would attend in the event of an emergency, about these very important matters.

254. Standing back and reviewing the evidence as a whole, I am not persuaded that the evidence establishes that MT exaggerated, fabricated or misled healthcare professionals about LW's condition or symptoms. There may have been imprecision in some of her reporting, and some loose phrasing used by her, but that is far from being evidence of fabrication or intentional exaggeration as alleged. Indeed, all the evidence points to the contemporaneous view that MT was doing well caring for LW, that she was reporting matters appropriately and engaging well with healthcare professionals who did not express any concerns about the truth of what was being reported or about her parenting at the time. Even as late as March 2021 at an MDT that month, shortly before LW was discharged home into her sole care (supported by community healthcare professionals), it was agreed by clinicians with long experience of her that she was very capable. She was trusted to look after LW by herself even after the discussions at the important

safeguarding MDT on 18 March 2021 at which FII had been openly considered. The clinicians had no qualms about her caring for LW at home and cannot have harboured any doubts about the sincerity of her reporting of symptoms. It must not be forgotten that LW was born extremely prematurely, had numerous health challenges, and that his feeding difficulties and gastroenterological problems were not unexpected. Dr SAN and others at the time did not question what she was reporting as obviously incredible. What she reported was treated as credible and it is only hindsight, and the assumption that she was a deceitful person, maliciously manipulating professionals, that has lead those like Dr SAN to believe that her reports were untrue. It is of course possible, and I have carefully considered, that she might have been extremely deceitful and managed to fool all of the healthcare professionals over a very long time and when in the intensive environment of the hospital ward for weeks on end. However, if one considers the evidence objectively, it does not support that interpretation. I can find no pattern of exaggeration, fabrication, or misrepresentation as alleged.

255. The related finding sought at Finding 6, Appendix 1.3, is that MT has refused to agree to reasonable requests from the treating team, placing barriers in the way of proposed treatment which placed LW at risk of significant harm. These are stated to be on 4 November 2020 when she refused to move LW to Ward L from Ward J, that in February 2021 she refused to allow LW to be assessed at Hospital B, and on 21 October 2021 she refused to remove herself from SCH. I have largely dealt with the second and third instances already. In each case I am satisfied that MT acted as would many reasonable parents in the same circumstances and given the advice she had been given. As to the first, whilst many would have complied with the request to move wards, MT's reasons for not moving were not unreasonable – LW was scared of being handled by strangers and he was used to the staff on ward J. MT did not understand what the reason was for the proposed move and I cannot see satisfactory evidence that it was openly explained to her. Her actions were not unreasonable and I do not find a pattern of obstruction here, placing barriers in the way of proposed treatment. Nor can I find that MT's actions placed LW at risk of significant harm.

E6: HS and LW – Administration of Agents

256. The allegations:

a. ERYC allege that between 13 August and 23 September 2019, MS fabricated or exaggerated and subsequently induced HS's symptoms of excessive diarrhoea and vomiting by directly administering some non-prescribed agent to him, and that she did so again, inducing pain also, between 18 March and 8 April 2020 (allegations 2 and 5, Appendix 1.2). I consider the allegations of the administration of unprescribed agents (poisoning) in this section.

b. Wakefield MDC allege that one explanation for MT's reports of LW vomiting and having diarrhoea at home was that she was reporting symptoms that she had induced (Finding 2, Appendix 1.3). It is further alleged that MT altered

medication regimes without prior consultation and introduced inappropriate medication, including that in late 2019/early 2020 MT administered ibuprofen to LW when it was not prescribed. (Finding 4, Appendix 1.3). A related finding sought is that MT allowed LW to be exposed to cocaine (Finding 8, Appendix 1.3).

MS

257. During the admission to SCH between 13 August and 23 September 2019 there are a number of nursing records of vomiting and loose stools which, I have found, were accurate records of actual events. On 14 September 2019, it was recorded, "Doctor has advised that HS [reduces feed and diarolyte] because the volume of milk on its own is making his stools and vomits increase…" The notes suggest that HS could tolerate feeds and diarolyte until the rate or quantity increased to a level that triggered symptoms. On 17 September it was noted that he was tolerating "well" what was then a reduced level of feed and diarolyte. Indeed, I cannot find any notes of vomits or diarrhoea in the hospital up to the point of his discharge on 23 September 2019.

258. The Local Authority is not able to identify what agent MS gave to HS to induce vomiting and diarrhoea during this admission. Nor do they identify what kind of noxious agent would trigger symptoms only when feeding rates or volumes were increased, because HS was largely tolerating feeds and diarolyte at lower levels during this admission. Was it a different agent than that administered in later periods when vomiting began as soon as a fluid or feed was given? They allege that MS fabricated or exaggerated such symptoms "and subsequently induced" them. They do not specify when fabrication and exaggeration changed to induction but, as noted, the records tend to show that symptoms actually subsided in the last week or so of the admission which is inconsistent with the allegation made.

259. As to ERYC's allegation that MS induced vomiting, diarrhoea and pain in HS during the period of admission to SCH between 18 March 2020 and the commencement of TPN on 8 April 2020 by the administration of "an unprescribed agent", I note again that the contemporaneous nursing records clearly show that HS did suffer vomiting, diarrhoea and pain. They demonstrate that he did so in response to being administered feed and/or diarolyte. It is plain that HS's symptoms were triggered by feed or diarolyte. Some of the nursing notes during this period, reviewed above, record that he would tolerate feed for six hours before having an adverse reaction, at other times, his response was much sooner. The Local Authority do not identify what noxious agent was used by MS nor what kind of agent would trigger the symptoms sometimes hours after feeding had commenced and sometimes as soon as it feed was given. The Local Authority allege that MS fabricated or exaggerated symptoms "and subsequently" induced them. They do not specify when exaggeration and fabrication changed to induction during this period, but the records do not suggest any significant change in HS's symptoms during this period of his admission to SCH.

260. In relation to these allegations of induction of vomiting, diarrhoea and/or pain by poisoning, there is no direct evidence of MS having obtained any noxious agent. There is no evidence from urine samples, analysis of vomitus or stool, or otherwise that HS had ingested any noxious substance. No witness saw MS

administering anything to HS or acting suspiciously. At the time it was accepted by the healthcare professionals caring for him that for whatever reason he was not tolerating enteral feeding but there was no suspicion that HS was reacting to some noxious substance. The noxious agent or agents have not been identified. I do not even have a description of the kind of agent that might have been used to produce the signs and symptoms observed. I have no explanation of how these noxious agents had been administered – orally, enterally, injection or otherwise, or when they were administered. Were they single dose agents or something that was given regularly? I accept that there is no neat medical explanation of why HS suffered the symptoms he did but I did receive evidence that,

a. His feeding difficulties were rooted in his prematurity (Professor Sullivan);

b. Psychological factors including maternal anxiety transmitting itself to a child could account for adverse reactions to feed – Dr Ward said that a young child's response to even the smallest amount of fluid could be related to the dynamic between parent and child (Dr Ward).

c. An extreme pain reaction to a small feed could be due to the feed leaking under the skin (Professor Sullivan).

d. He may well have had a genuine intolerance of some feeds.

I also note the deterioration in HS's tolerance of feed and diarolyte between his admission in August/September 2019 and his admission to SCH in March 2020. This small child had suffered repeated episodes of vomiting and sometimes diarrhoea and distress/pain, on feeds and diarolyte being increased in rate of volume. He was tube fed in various ways which I have no doubt can be uncomfortable for some young children. His symptoms subsided when feeds were stopped, and by March 2020 when diarolyte was stopped. It can be imagined that he associated the administration of both with distress and discomfort. It might not be surprising therefore that his responses to the administration of feed and diarolyte would become increasingly adverse. MS witnessed his symptoms and distress. Dr Ward said that the dynamic of anxiety that could arise between parent and child, could be caused by the past administration of a noxious agent. However, it appears to me to be equally possible that it can arise as consequence of previous adverse reactions to feeds and fluids.

261. ERYC do not press their case that there is evidence of HS having been given levetiracetam (an anticonvulsant drug), ibuprofen and piroxicam, but neither have they withdrawn the allegations and in closing submissions they refer to the HST evidence of ingestion of NSAIDs as "a significant aspect of this case". The only evidence of ingestion of these unprescribed drugs was from HST. In my judgment the allegations should have been withdrawn in the light of the evidence from FTS and Dr Johnson that the way in which the hair samples were taken meant that the evidence could not be relied upon. In addition, Mr Hunter of FTS confirmed that the ibuprofen found on HST of HS was below the limit of detection that FTS set for itself. There is no evidence that MS obtained or administered NSAIDs or Levetiracetam to HS. Neither is there evidence that the administration of NSAIDs or Levetiracetam would have triggered diarrhoea and vomiting on the commencement of feeding or fluids.

262. The Local Authority strongly rely on the fact that HS recovered rapidly after MS's arrest. This is evidence from which the court is invited to infer that it was the mother's presence that caused HS to suffer distressing symptoms on enteral feeding and that the reason he did so when she was present in the hospital was that she was administering something to him to trigger those symptoms. At first sight it may appear to count strongly in favour of the Local Authority's case that as soon as MS was removed from the hospital, HS's seemingly intractable feeding difficulties rapidly improved. The evidence shows that there certainly was a remarkable recovery – HS soon began to eat finger foods and to gain weight allowing him to be discharged from hospital into the care of his father. Dr Ward provided the court with growth charts which undeniably show how HS's weight trajectory was transformed.

263. Professor Sullivan remarked of the case of MT and LW during his oral evidence that, "Now we are in possession of a much more nuanced degree of detail we have to come to the conclusion that it is over-simplistic to interpret the absence of the mother and apparent improvement of the child as causally related…" The same caution must be applied to the relationship between HS's recovery and the absence of MS. Coincidence is not the same as causation. When MS was arrested and removed from the hospital, a number of factors changed:

a. The clinicians at SCH had arrived at what they regarded was a definitive explanation of HS's inability to tolerate enteral or oral feeding, namely that his mother had been fabricating or inducing illness. For months they had been perplexed by his presentation and had not been able to explain it. They had carried out many investigations and explored all manner of possible diagnoses, to no avail. On the mother's arrest, triggered by what was regarded as a clear case of her interfering with HS's central line to avoid him receiving beneficial treatment, the clinicians suddenly had confidence that there was no underlying condition preventing HS from feeding. So, they could introduce feeding without fear of causing him undue distress or harm.

b. Linked to (a), there was a multi-disciplinary approach to re-introducing enteral and oral feeding. There was a clear plan formulated to re-commence feedings. Therapists were involved in introducing HS to the idea of eating food. Clinicians could advise that if there was any vomiting or diarrhoea it was acceptable to press on with the plan.

c. In contrast, no attempt had been made to introduce enteral feeds to HS for several months. Such previous attempts, at least the most recent ones, had been abandoned at the first setback. Thus HS did not have recent experience of enteral feeding when it was re-started in October 2021 after his mother's arrest. Any Pavlovian response may well therefore have been avoided by the sheer passage of time since his last distressing experience.

d. Until MS's arrest in October 2021 the conventional wisdom amongst healthcare professionals, shared by MS, was that HS should not consume orally. Much of the evidence suggests to me that he wanted to do so – there is evidence of him swallowing a coin, paper, parafilm and hospital gloves. He had not been given permission to eat but had done so when backs were turned, using what was available. Once his mother had been arrested and the

presumption was that he could eat, he was given permission, indeed encouraged to do so. As it happened, he could eat and hold down food, but it is entirely possible he could have done so at an earlier point, before his mother's arrest, if he had been given permission to consume food orally.

e. Very soon after the removal of MS, HS's central line was removed. I shall address the cause of HS's repeated line infections and sepsis in section E7 but with the removal of his central line came relief from further bouts of sepsis which had made HS very unwell. His general health improved significantly.

f. If, which Dr Ward advised should be considered, HS was affected by maternal anxiety about feeding then the source of that anxiety was removed from him.

264. Thus, once one considers the quite dramatic changes in the management of HS that coincided with and followed MS's arrest, it is much less easy to infer that the single factor that brought about HS's improvement was that she was not present deliberately to induce illness so as to prevent him from being fed.

265. To an extent ERYC has sought to have its cake and to eat it when it comes to the inferences it has invited the court to draw from the evidence. When they consider that MS exaggerated HS's symptoms the court is asked to infer that she was harming her child by securing unnecessary medical attention for her child. When she failed to do so, missed appointments, or delayed taking HS to hospital, they allege that she was harming him by avoiding medical attention. If it is assumed that MS was manipulative and deceitful then just about any form of behaviour involving HS can be prayed in aid of the Local Authority's case. However, when the evidence as a whole is considered, there is no pattern revealing a deceitful and manipulative mother intentionally or recklessly causing harm to her son by exaggeration, fabrication, or induction of vomiting and diarrhoea, or feeding difficulties. It is perhaps illustrative of the lack of evidence, that ERYC couch so many allegations on an either/or basis or on the basis that one form of FII changed at some unspecified point to another form. At a number of points in the chronology ERYC cannot say whether MS was guilty of exaggeration, fabrication or induction and so they invite the court to choose which one applies.

266. Standing back once more to survey all the relevant evidence, I am unable to find that MS deliberately administered noxious agents to HS to provoke diarrhoea, vomiting or other symptoms. My view of her credibility has already been given. As well as the specific matters set out above, I also note that for MS to act as alleged would have involved considerable and quite sophisticated subterfuge: obtaining the necessary noxious agents, knowing exactly when to give them and in what dose so as to create the impression, which all the healthcare professionals had, that it was the feeds or fluids that were making HS vomit or to have diarrhoea, concealing her activities from all others. Having seen and heard MS give evidence, and in the light of all the evidence in the case, I do not believe that she is capable or would be so motivated to act in that way.

267. Whilst I cannot fully explain why HS was so intolerant of enteral feeding that he required TPN by 8 April 2020, I am quite satisfied that there is no evidence on which I could reasonably find that his intolerance was due to his mother administering a noxious agent. I accept that direct evidence may not always be available in cases of FII and that it is legitimate to invite the court to make inferences, but I have to base any such inference on evidence, not on mere speculation. I find the allegation that MS "subsequently induced" HS's diarrhoea and vomiting by administering "some non-prescribed agent to him" to be unsubstantiated by the evidence. As it happens, ERYC has not made a specific allegation that the mother administered noxious agents after 8 April 2020 when TPN started (other than the allegations about NSAIDs and Levetiracetam which I have dismissed). From that date, the allegation is of induction of sepsis through line contamination, not induction of diarrhoea or vomiting through poisoning. For the avoidance of doubt, I find that MS did not induce diarrhoea, vomiting or pain in HS through the administration of noxious substances or unprescribed medication at any point.

MT

268. Finding 2 , Appendix 1.3 is expressed in the alternative. If, as I have found, the reports by MT of LW's condition and symptoms were genuine and not exaggerated, then they were in truth "a reaction to something he had been given, therefore induced." Much of what I have observed in relation to the case against MS that she administered noxious agents, applies equally to the allegations against MT:

a. LW's prematurity gives an important context in which later feeding difficulties must be viewed – they were not wholly unexpected (Professor Sullivan).

b. LW had a number of other health challenges in the neonatal period, including resection of a large part of his bowel, which might reasonably have been expected to have an impact on his feeding and gastroenterological problems.

c. There is no evidence of any person witnessing MT administer "something" to LW to make him vomit or have diarrhoea.

d. The Local Authority is unable to identify what kind of agent might have caused him to react in this way, how it was given, how often, or when.

e. There is no toxicological evidence to establish that over the time period alleged, LW ingested any substance liable to cause the reactions reported by MT.

f. As analysed in detail below, LW's rapid recovery after MT's arrest does not easily permit the inference that she had been administering an agent to him to prevent him from feeding enterally or orally or to trigger diarrhoea and vomiting: "it is over-simplistic to interpret the absence of the mother and

apparent improvement of the child as causally related…" (Professor Sullivan).

269. Furthermore, although it is possible that a perpetrator who induces illness in their child may do so intermittently rather than consistently, it is striking that MT wanted to care for LW at home and that when she did so she was punctilious about avoiding him becoming ill. She was not asking for him to have medical interventions between March and September 2021, the period to which most of the specific allegations under Finding 2 relate. For what purpose would she deliberately poison him to make him ill so that she could report diarrhoea to healthcare professionals? Her reports made no difference to his treatment at the time. It is said now that her reports prevented enteral challenges taking place, but I am quite satisfied that Dr SAN did not contemplate instigating enteral challenges during that period. He put down a lot in writing following out-patient appointments but did not refer to any consideration of enteral challenge. And, if the purpose was to deceive, why poison him to cause diarrhoea when she could simply have reported that he had had diarrhoea? MT was not reporting constant diarrhoea, only episodes of it. It is an odd allegation to make against her, when it is known that LW did suffer diarrhoea in hospital, that at home she would every now and then poison him to make him have diarrhoea and report it to Dr SAN when those reports made no difference to anything.

270. It is alleged that on 29/30 December 2019 and on 8/9 January 2020 MT administered ibuprofen to LW when it had not been prescribed (Finding 4, Appendix 1.3). Urine testing supports findings being made that LW must have ingested ibuprofen within 24 hours or so prior to those tests being performed, i.e. at the dates alleged. MT was adamant in her evidence she would never have given LW ibuprofen, even in a form readily available in shops. It would have been easy for her to say that she had done and she would not perhaps have been unduly criticised for an error - there is no evidence that these particular ingestions caused LW any harm - but she did not. It is fair to observe however that there are no prescription records for ibuprofen for LW. Dr SAN did say that ibuprofen and paracetamol were first line analgesia for children of LW's age and it is perfectly possible that ibuprofen rather than paracetamol was given to LW at the relevant times. At the time of the test results, clinicians at SCH thought them of no significance. It should be emphasised that the situation here is very different from that of BR's case where the evidence is of ingestion over a long period sufficient to cause observed GI changes and symptoms. There is no evidence of any pattern of ibuprofen administration to LW and none has been alleged. I am concerned with two isolated instances and, on balance, my view of the evidence is that they are more likely to have been given as simple pain relief in the hospital than covertly or otherwise by MT.

271. It is alleged that in 2021 MT allowed LW to be exposed to cocaine either through her own use or that of associates. This allegation is based on hair samples taken from LW on 23 October 2021. Hair sampling was not carried out by trained forensic investigation officers according to a validated protocol. As Mr Todd for the Children's Guardian put it, somewhat euphemistically, it is unfortunate that the nurse taking the sample and the police "failed to record which end of the

sample had been taken from the scalp". HST of MT's hair is reported as being likely to represent passive exposure to cocaine from mid July to late October 2022 and not evidence of the use by her of cocaine during the period November 2021 to mid July 2022. MT was adamant that she had not used cocaine herself. It is more likely than not that she did not use cocaine during those period. Professor Johnson told the court about how passive exposure to cocaine could affect a HST for a child if someone in the house with them had used cocaine. Although the HST of LW was deficiently performed, on the balance of probabilities, at some point in 2021 LW was passively exposed to cocaine by being in the vicinity of someone who had used or was using cocaine. Having heard evidence from MT and FW I think it probable that FW or some other adult, not MT, had used cocaine, perhaps shortly before attending MT's house and LW was exposed to cocaine in that manner. There is no evidence that MT was aware that FW or any other person might expose LW to cocaine in that way. There is no evidence that FW or any other person who might have used cocaine had any caring responsibilities for LW or that LW came to harm in any way. I do not believe that this finding is of any significance as far as welfare decisions about LW are concerned.

272. As to MT's removal, I refer again to the analysis above in relation to MS's removal and adopt the same reasoning in relation to MT's removal. LW certainly made remarkable progress after his mother's arrest, but there were a number of other factors that changed upon and after her arrest beyond the simple fact that if she was poisoning him, she was no longer able to do so. In LW's case, there had been no enteral challenge since March 2021, seven months earlier. Evidently, he was ready to accept enteral and then oral feeding and it was a mistake, even if an understandable one, to think otherwise immediately prior to MT's arrest. Lines were removed within a short time of MT's arrest and, as with HS, LW was then not vulnerable to line infection and sepsis and his general health improved as a result. LW, like HS, had a history of distress and adverse symptoms on enteral feeding and may have developed a Pavlovian response to it. Given the gap since his last enteral feed, that response may well have waned by October 2021. He had not been tried on oral feed for even longer. His experience of having diarrhoea after consuming juice or licking a pizza may well have been due to some other cause than that assumed to have been the cause at the time. The dynamics all changed with the arrest. The clinical team approached reintroducing feeding immediately and with the view that it was likely to succeed, rather than being de-railed at the first setback.

273. As with MS, I have considered MT as a character and the evidence she gave to the court along with the evidence of others. It is fair to say that in her case the alleged poisoning set out under Finding 2, Appendix 1.3 would have happened at home, not under the watchful gaze of healthcare professionals in hospital. I have to accept that MT had the opportunity to do what is alleged, but my judgement of her as a caring mother is that she did not give "something" to her son to induce the symptoms alleged. When the evidence is considered as a whole, it does not allow me to draw the inference that MT acted as alleged.

E7: BR, HS, and LW: Central Line Infections

274. The allegations:

a. Leeds CC allege that BR's multiple polymicrobial infections of the central lines were caused "by MR deliberately contaminating the lines with infective material" (paragraphs 13-15, Appendix 1.1)

b. ERYC allege that MS interfered with HS's feeding equipment and central lines (second part of paragraph 4, and paragraphs 6 and 9, Appendix 1.2) and "introduced sepsis (caused predominantly by bowel pathogens) via external manipulation and contamination of feeding lines and PN … deliberately or recklessly" (paragraph 6, Appendix 1.2)

c. Wakefield MDC allege that MT induced infection in LW's central line, causing LW's readmission to hospital on 19 September 2020. 8 January 2021, 12 September 2021, repeated line insertions and life threatening sepsis (Finding 5, Appendix 1.3)

The only infective material that it has been suggested was used in the three cases is faecal material.

275. MS and MT became friends after meeting at SCH – their boys were of a similar age with similar medical problems. The two mothers both liked to leave the ward for a smoke every now and then. They would also get meals and eat together. MR is a different character from MS and MT and comes from a different background. She did not strike up a friendship with the other two mothers although she did have some communications with MS after her arrest. It has not been suggested and there is no evidence at all that MR had any covert discussions with MS and MT about the treatment of their children or how to cause sepsis. As for the relationship between MS and MT, they had the opportunity to collude together, to discuss ways in which they could ensure their children presented as unwell, or in which they could give them line infections, but there is no evidence at all that such discussions ever took place. Naturally, had such discussions taken place, it is unlikely that MS and MT would admit so to the court. I find it difficult to see how such a topic could have been initially broached between them but, in any event, I do have evidence of text messages between them over time and there is no hint in those messages of any collusion or understanding that gives rise to a suspicion that they shared information about how to harm their children. The messages are unguarded: some exchanges are disrespectful of doctors, but the tone of the exchanges suggests to me sincere mutual support and encouragement with a little bit of dark humour – both wholly understandable in the extreme circumstances in which the mothers found themselves. As the police had concluded, there is no evidence of collusion between the mothers in their private text messages, unguarded though they were. There is no evidence either that the mothers accessed the same websites concerning FII or group chats at which FII or harming children in a medical context was discussed.

276. Having heard the mothers give evidence and having heard the evidence from staff at SCH about the mothers' behaviour and interactions, the absence of any evidence of collusion in messaging or otherwise amongst the three mothers drives

me to find that there was no collusion. If any of the mothers contaminated their child's central line with faeces they did not do so having learned about that practice from one of the other two mothers, or having been encouraged to do so by them: they must have done so having decided independently to act in that way. Therefore, when the three cases are considered together, the conclusion which the court is invited to reach is that, in the absence of collusion, three mothers whose children happened to be in the same hospital, suffering similar presentations, at the same time, independently chose deliberately to harm their children and expose them to a substantial risk of death by covertly contaminating their central lines with faecal material. Clearly, the relevant wards at SCH were used to treat, amongst others, children with complex gastroenterological problems. Furthermore, during the first Covid-19 lockdown, SCH was chosen for the in-patient treatment of children from around the region with such problems. Therefore it was not wholly a coincidence that BR, HS, and LW were all treated on the same wards of SCH at that time. However, if the conclusion is reached, as I have found, that there was no maternal collusion, it would follow that it was purely a coincidence that the three mothers happened upon the same method of harm.

277. This feature of the cases - the coincidence of three mothers inducing illness in the same way at the same time in the same hospital - has not been given due consideration by the expert witnesses: perhaps it can be said to be a matter that is outside their fields of expertise. I have evidence on the incidence of line infections and evidence that each one of these children had an exceptional number of polymicrobial line infections, but no evidence as to the chances of three such cases occurring together in one time and place. The very fact that such a coincidence is manifestly unlikely might lead some to conclude that there must have been some common factor. I have found that there is no evidence of maternal collusion. Nor is there any evidence that one of the mothers could have injured the other two children as well as her own – the layout of the ward, the way in which the ward was staffed and operated, the presence of other parents, would all mean that it was virtually impossible for that to have happened. There might have been a rogue healthcare professional who deliberately caused harm to these three children. If so, they stopped harming each child after their mother was arrested (but a malicious individual would stop so as to avoid suspicion) and they did not repeatedly harm other children on the wards. In BR's case, line infections occurred at Hospital A as well as at SCH. In HS's case infections occurred on ward J and ward K which were generally differently staffed. However, in LW's case his infections with bowel flora nearly always, but not always, occurred in hospital, not at home, which might suggest that there was something happening at SCH, other than the mother's interventions, to cause the line infections. This is speculative: there is no evidence at all of a rogue healthcare professional.

278. The Local Authorities rely on inference because there is no direct evidence of any of the mothers contaminating central lines with faecal material. No-one saw them do it. No-one found macroscopic evidence of faecal material on or in a line, a dressing, or a connector. No tests of the exterior parts of lines or equipment were performed to reveal microscopic evidence of faecal material. No-one saw a mother disconnect a line when they should not have done so. No nurse or doctor even saw a mother acting suspiciously when they entered the child's cubicle. The Local

Authorities each invite the court to infer that each mother induced illness in their child by line contamination with faecal material because (i) each child suffered a highly unusual number and range of bacterial infections found in their central lines; (ii) amongst those infective organisms were an unusual number of bowel flora; (iii) there is no other rational explanation for the presence of those infective organisms in the central lines other than line contamination – gut translocation was a working hypothesis but with the benefit of hindsight it is not a plausible explanation; (iv) inadvertent line contamination with faecal material due to systemic issues such as poor nursing hygiene is very unlikely not least because other patients were not affected in the same way as these three children; and (v) inadvertent line contamination with faecal material due to careless maternal handling or the child's actions is very unlikely. Accordingly, the only plausible explanation for the repeated line infections and the presence of bowel flora in the central lines of these children is that their lines were deliberately contaminated with faecal material. The mothers are the only adults with the opportunity to have contaminated their children's lines in that way. Once the mothers were removed from their children's care their children's conditions rapidly improved.

279. It is undoubtedly the case that each child suffered a highly unusual number of polymicrobial central line infections and that the infective pathogens included a high number of bowel flora. I have been provided with a summary of the bacteria isolated: E-coli was isolated 10 times from BR and HS's lines each, and 12 times from LW's. Coagulase Negative Staphylococcus (CNS) was found 16 times in HS's lines. Candida albicans was found nine times in his lines and four times in LW's. Multiple other organisms infected their lines, many of them being bacteria that originate in the bowel. Joint police disclosure includes a comparative list of blood culture results which identifies 9 central line infections for BR, 12 for LW, and 22 for HS. There is some overlap and inconsistency in the labelling of cultures and reports but those figures give a clear impression of the incidence of central line infections for these three children. At one point there is an approximate coincidence in time when all three children are found to be infected with candida (not a bacteria from the bowel, but a fungal infection usually from the mouth), but otherwise there are no discernible patterns or coincidences in the occurrence or nature of the infections.

280. In each case, the evidence I received from experts and clinicians alike was that the number of repeat central line infections was unprecedented. It appears that other children on wards J and K were not suffering repeated infections, or infections with faecal material anything like these three children. On the other hand, I did receive evidence in the form of a table, discussed below, that suggests that repeated line infections were not unknown in other patients on long term PN. Mr Lander advised that infections for severely immunocompromised patients, such as cancer patients, are more likely, but that these three children did not fall within that category. BR was given steroids but that did not lead him to conclude that she would be as vulnerable as children on chemotherapy for example. These three children could not be said to be severely immune-compromised. I had differing evidence from Mr Lander and Dr Rajendran as to the incidence of central line infections generally and Mr Lander had done some work on data from his own hospital, but in any case it is clear that the incidence for these three children was many times greater than for children on PN in general.

281. No-one can give a satisfactory explanation of the number of infections by reference to the children's underlying conditions, procedures used at the hospital, or defective equipment. A working hypothesis at SCH had been that translocation accounted for bloodstream infections: bacteria from the gut, which would be "bowel flora", would find a passage through the gut wall into the blood stream causing sepsis. Dr Rajendran initially accepted translocation as a possible mechanism but ultimately agreed with Dr Ward, Professor Sullivan, and Mr Lander that it could be discounted as a reasonable possibility. Mr Lander persuasively explained that if translocation were to occur, it would be far more likely to happen following surgery when the gut wall is actually breached by the surgeon, but that, in practice, problems with sepsis do not follow. Furthermore, Dr Rajendran explained that it is much more likely that central line infection causes bloodstream infection rather than the other way around (which would be the mechanism if translocation was the original cause). Notwithstanding the consensus expert opinion reached about translocation, which is that it is not a reasonable or probable explanation for the incidence of bloodstream infections and central line infections in these cases, which I accept, I am bound to record that it was the working hypothesis amongst a very experienced gastroenterological team at SCH and that Dr Rajendran did initially countenance it as a possible explanation.

282. If translocation was not the mechanism of infection then it is highly likely that infection entered through the children's central lines and then into the bloodstream. The very fact that a child has a central line renders them vulnerable to infection – it provides a conduit by which bacteria can enter directly into the bloodstream. The body's natural barriers, for example skin, are breached and the bloodstream opened up to possible extrinsic contamination. Bacteria can enter an exposed central line and make their way into the blood stream to cause sepsis. To do so the line must itself be breached – it must be exposed. The line is usually protected by bungs but it might be exposed when the line is disconnected, for example to connect it to a new PN feed supply. If a line is breached by being cut or chewed, then that would expose the line to the risk of contamination. In the present cases it is not surprising to clinicians and experts that the three children suffered line infections, it is the sheer number of them, the fact that many infections were polymicrobial, and that there was a high incidence of bacteria that originate in the bowel, which is perplexing.

283. Dr Rajendran and Professor Sullivan in particular, but also Mr Lander and Dr Ward, accepted that inadvertent contamination could occur and, in principle, could explain an incidence of line infection. Ordinarily, the infective organism isolated after inadvertent contamination due to handling of the line would be what Dr Rajendran described as an environmental organism which could include Klebsiella for example. It would be much less expected for bowel flora to infect a central line through inadvertence, but it is possible that part of an exposed line could come into contact with a nappy containing faeces. Professor Sullivan advised,

> "This contamination could occur either accidentally or deliberately. In these particular cases, there is no objective evidence to positively prove deliberate contamination."

Dr Rajendran told the court that an action such as not washing one's hands after using the toilet could be sufficient to transmit infective micro-organisms. However, whilst such inadvertent contamination with bowel flora might occur very occasionally, the challenge in these cases is to explain the sheer number of such infections.

284. I have already noted that LW suffered from infections much more frequently in hospital than when on PN at home. I have considered the evidence as to nursing practices and hygiene standards within the hospital. I bear in mind (i) that during the covid-19 pandemic hospital staff would, if anything, be more mindful of the importance of hygiene than at other times, and (ii) as these three children suffered repeat infections it could be expected that nursing staff would be particularly careful to avoid inadvertent line contamination when nursing them. Nevertheless, the evidence from nursing witnesses was of some variations in practice and some departures from their training. According to Professor Sullivan, handling of the lines should have been done with nurses wearing sterile gloves, but the weight of the evidence was that at least some of the time nurses would use gloves from a cupboard within a child's cubicle where they were stored in non-sterile conditions. The ward manager for ward J said that the sluice room door was now locked and required a swipe card to open it. That was not the case at the material times when these children suffered repeat infections. Indeed, the door was propped open and MR seems to have come and gone from the sluice room as she pleased. Moreover she did so whilst carrying stool or dirty nappies. Professor Sullivan was clearly very concerned that pressures on staff due to shortages as reported by the Trust during the pandemic may have had an adverse effect on standards including in relation to the management of PN. I refer again to what he said in evidence, as already set out in Part C.

285. A pass gives any hospital employee access to any ward or room in the hospital. Any number of individuals from maintenance employees to therapists could enter the ward. There was clearly a risk of people carrying infection onto the ward, although that risk would be common to all patients, not just the three with whom I am concerned and for whom there was an exceptional number of infections.

286. The Becton Dickinson alert was, I have found, immaterial to these cases, but there might theoretically have been some defect in equipment that was not recognised but which particularly affected these three children, causing repeat infections.

Interference with HS's Central Line

287. HS's time at SCH from 18 March 2020 to his mother's arrest on 19 October 2021 was plagued with feeding problems and repeated infections. His PEG was changed to a PEG-J in theatre on 6 April 2020 and at the same time a PICC line was inserted and, on 8 April 2020, PN was started with an initial plan for it to

continue for about four weeks. In fact he continued as an in-patient on PN for about 18 months.

288. HS was known for fiddling with his line. One nurse, Nurse SS, told the court that there were occasions when she would see HS calmly chewing on the parafilm covering his line, "it was a recurrent thing." He was frequently seen to have his feeding line in his mouth, chewing it. On 28 September 2020 she observed HS with the line in his mouth and then noted a bite mark in the line and a hole within it. On 1 November 2020 she recorded, "HS caught numerous times with blue filter [the bung] in his hands chewing parafilm. Tucked away under mattress then found in his mouth." Then the following day it was recorded, "HS decided to pull his PEG out last night." Earlier, on 20 July 2020 she noted that, from his cot, HS had managed to pull the stand holding the PN feed over to him, presumably using the attached line, and to press buttons on the pump control to stop the feed. She wryly observed to the court that the attempt to protect the bung and line by wrapping parafilm around it only seemed to attract HS's attention all the more. On 1 July 2021, on Ward K, HS was observed by a support worker to unscrew the cap on the end of his bung.

289. On various occasions when HS's mother was not on the ward with him, there were recorded incidents which demonstrate that he was capable himself of damaging his feeding line:

a. On 10 October 2020 at 3.45 pm it was recorded that HS had "snapped the PN line at a time when his mother was not present. It was then noted that he opened his bowel and his stool was noted to contain 17 pieces of parafilm, a piece of glove, and paper within it.

b. At 10.55 pm, later on the same day, he was noted to have "PN line in mouth". Three parafilms and two bungs were "?chewed/ripped off".

c. On 11 October 2020 at 10.15 am, with the mother still away from the ward, it was recorded, "HS managed to snap his TPN line", and later he was "caught chewing at line … parafilm missing."

d. On 29 October 2020, with his mother having left the ward, he was on several occasions trying to chew parafilm off his IV fluid line.

e. On 1 November 2020, he was caught "numerous times" with the blue filter in his hands chewing parafilm.

f. On 1 January 2021 at 5.33 am it was recorded that he had chewed through his line leading the nurse to disconnect it, start iv fluids, and to inform the doctors. Again, his mother was not present.

g. On 25 March 2021, when MS was not present on the ward, HS's PEG was found deflated and lying next to him on his bed.

h. On 28 March 2021, HS's line was found to be completed disconnected when MS was not present and could not have been responsible. On 29 March 2021, a break in the line was noted only three minutes after PN had been set up and the

position was explained to the mother, indicating no thought at all that she could have been responsible. HS was under 1:1 supervision during March 2021. On 6 April 2021, after HS had developed signs of infection and blood cultures had shown line infection, the MDT concluded, "multiple line disconnections last week likely causing infection." The mother could not have been responsible for those line disconnections as set out above.

In addition, I heard evidence from Nurse SAP that from her reading of the nursing records, MS was "probably" not present at 8.00 pm on 5 September 2020 when she recorded that on checking on HS she found blood on the bedsheets and that the TPN was fully disconnected at the filter with the parafilm split. Further, on 22 August 2021, when MS was at home, it was recorded that HS's line was disconnected at the filter when he was picked up by a staff nurse.

290. There are numerous records of HS having interfered with his lines and equipment when MS was present. Numerous witnesses who had dealings with HS attested to his tendency to meddle with lines and equipment. He could pull the pump stand over to his cot by pulling on the attached line. He could disconnect a bung, he could chew off parafilm. He would watch until a nurse's back was turned and then start fiddling with the lines or equipment. He loved to use medical equipment such as syringes as toys – I was told that he seemed to prefer them to his actual toys. It was suggested that his repeated activity might be a sign that he had autistic spectrum disorder. Therapists did conduct initial assessments of possible ASD, but they had no qualifications to diagnose it and no diagnoses were made. Nevertheless, that concern speaks to his character and in particular to his obsessive interest in his lines and medical equipment. This was an exceptional child when it comes to his capacity and determination to meddle with medical equipment including his PN equipment and central lines.

291. ERYC have set out a long list of incidents when, they allege, MS interfered with HS's lines and equipment. These allegations are relevant to the allegation of deliberate line contamination because the lines had to be exposed in order for infective material to be introduced. None of MS's alleged acts were witnessed. On none of those occasions was she seen preparing to interfere with lines or covering up having interfered with lines. All of these allegations are based on the inference. However, the incidents are also consistent with HS's known behaviour in relation to his lines and equipment. Perhaps no other child has ever meddled so much with their lines before, but I have evidence about this child and he was certainly capable of pulling at, disconnecting, chewing through, and meddling with his central lines. Hence the number of incidents of that kind do not cause me to conclude, without more, that MS was responsible. Nor would I be unduly critical of MS for "allowing" HS to meddle with his lines – the nurses and therapists told me they had been unable to stop him.

292. In their closing submissions Ms Lee KC and Ms Blackmore set out a detailed table of incidents after HS's move to ward K and when HS (and therefore MS) was under close observation, which they say show that MS was probably taking the opportunity when she was off the ward with HS to disconnect his lines and contaminate them. Having looked at the evidence with care I notice from the records that there are many occasions when MS was off the ward with HS with no incidents, and occasions when there were problems with lines on the ward. There

may have been fewer infections once HS was under observation but that would be compatible with a reduction in inadvertent contamination – everyone was on their guard to prevent it – rather than being only compatible with a reduction in opportunity for deliberate contamination by MS. I am not persuaded that there is a telling pattern during this period, as claimed by ERYC.

293. There was a particular incident on 17 Sept 2021: MS reported a break in the central line near the bung. The nurse found it difficult to find but there was a crack in the line. HS developed sepsis and blood cultures grew bowel bacteria showing line infection. A few days later a pair of nail clippers were found under HS's blanket. The inference the court is invited to draw is that the clippers might have been used to cut into the line, perhaps to allow the introduction of faecal material. I note however, that MS alerted the nurse to the break in the line, she did not hide it. Baby nail clippers would be part of a mother's kit when caring full time for a young child. No faecal material around the break in the line was observed. It is not surprising that MS had noticed the break in the line if there had been leakage as she reported. On the other hand, I accept that there is no doubt that this incident gives rise to understandable suspicion.

Specific Incidents involving MT

294. As against MT it is now alleged that the incident on 2 March 2021 in which LW reacted immediately by having diarrhoea and vomiting after being administered a tiny amount of fluid, was caused by MT introducing salmonella and klebsiella into his central line in advance of what she knew was a planned attempt to reintroduce enteral feeding (Finding 5(c) Appendix 1.3). Those pathogens were later isolated so it is known that LW was infected with them. The evidence I have received is that klebsiella is not an uncommon pathogen found in hospital environments, but that blood infection by salmonella is rare. It is possible, however, that LW had become infected when playing on the floor or during some other such activity or contact with someone who had was carrying salmonella and somehow this got into his bloodstream perhaps when a line was exposed and it was touched. What is not explained to my satisfaction is how MS could have planned to insert salmonella infected material into a central line so as to have caused an adverse reaction to the administration of fluid. I also notice that LW's response settled when the fluids stopped. If salmonella poisoning was causing him to vomit and have diarrhoea, why would that stop as quickly as it started? LW did not appear to be ill at the time when the enteral fluids were started, but he did appear distressed: LW pulled his NGT out even before fluids were given, and it had to be repassed. He appears to have been in a state of anxiety therefore before the enteral fluids were administered. He was noted to be showing signs of pain. Perhaps LW experienced the NGT as a painful or distressing intervention, and the vomiting and diarrhoea were a stress reaction. Perhaps there was a leakage of the kind explained by Professor Sullivan. The episode was perplexing but there are a number of possible explanations and the allegation that MT planned LW's responses by giving him infective material some point earlier, is not an inference that I believe can properly be made.

295. It is further alleged that MT induced infection on 3 October 2021 (Finding 5(e), Appendix 1.3). On that day she took LW off the ward in her car, intending to pick up a buggy from home. She had discussed doing so with the nurse on the ward, Nurse SAP. MT told the court that she had been concerned that LW was not himself that morning but the nurse reassured her. There is a note of a discussion between the nurse and the mother about taking LW off the ward but not of the contents of that discussion. Nurse SAP told me that she thought MT wanted to take LW out to "perk him up" because he had not seemed quite himself that day. On the drive to her home, she noticed that LW was becoming suddenly very unwell. She pulled over and rang the hospital who advised her to call an ambulance to take LW to A&E. She did so. There is no doubt that LW's line had become infected and he developed sepsis – blood cultures grew gram negative bacilli, streptococci, E-coli and enterococcus faecalis. The expert evidence I received was that if a sufficient amount of faecal material were put into a central line, it could cause symptoms within an hour. That is the sort of deliberate contamination, had it occurred, that would be life-threatening for LW. MS would have had the opportunity to insert faecal material into LW's line as she put him into the car, out of sight of hospital staff. However, the plan had been for LW to have an hour off the ward only, between IV antibiotics, and MT was on the way home at the time when she called the ward. Nurse SAP took that call and said that MT seemed unsure what to do and "quite worried". The time when she left the ward is not recorded, nor is the time of the call, but since the whole trip to and from home was expected to take no more than an hour, and MT stopped and called on the way to her home, it is likely that LW became ill within 20 minutes or so of leaving the hospital. LW had not, I find, been himself prior to leaving. On balance I consider it to be highly unlikely that MT inserted faecal material into his central line on leaving the hospital such as to cause him to become unwell within 20 minutes or so. If this was a mother who had repeatedly inserted faecal material into LW's central lines to induce infection, and had done so undetected in hospital, why would she need to wait to leave the hospital to do so on this occasion? She had looked after LW at home without such infections over several months. LW was showing early signs of being unwell even before he left the hospital and I reject the suggestion that MT used her departure from the hospital to introduce infection into LW's central line on 3 October 2021.

Competing Explanations

296. I have given the question of what, other than deliberate contamination, could explain the numbers and types of infection suffered by these three children a great deal of thought and in doing so reflected that the search for a single explanation was misguided. It is natural to look for patterns and explanations for those patterns, but perhaps the patterns are not as stark as they seem at first sight, and perhaps the explanations for those patterns are multifactorial, nuanced, and difficult to identify. First, consider the evidence about the number and type of line infections:

a. On analysis of the infections suffered by the three children, some are explicable as skin flora or, in particular in HS's case, oral flora, of the kind that do not give rise to any suspicion of deliberate contamination, certainly not with faecal material.

b. Some of the recorded infections that were identified were recurrences of infections within a single bout of infection.

c. Each of these children was treated with PN using central lines for very long periods. The presence of a central line creates a risk of infection and that risk is constant over the duration of the PN. The absolute number of infections was therefore liable to be greater for these children than had they been on PN for shorter periods. Focus ought to be on the incidence of line infection per catheter day rather than the absolute numbers of infections.

d. Mr Lander's research and Dr Rajendran's evidence showed that the average incidence of line infection to be expected would be between 1 and 4 per 1000 catheter days. Evidence from the Trust in the form of a table reveals that a number of other patients on long term PN at SCH did suffer rates or incidents of infection much more comparable with BR and LW, and closer to those suffered by HS than a rate of 4/1000 catheter days. For example patient 25 on the table had 17 positive blood cultures in 119 days of TPN. There were other patients with high rates of infection when on PN at SCH.

e. That is not to say that SCH had an unusually high rate of line infection across the board. As well as showing that some other patients at SCH have suffered quite high rates on blood infections whilst on PN, the table also shows a very high degree of variability. Some patients suffered no line infections at all, some suffered a high number. Focusing therefore on the national average incidence of line infection, or the average incidence within a hospital as Mr Lander produced from his own, can be misleading if it is intended to demonstrate that wide deviation from the average in the case of any one child is indicative of a particular cause such as deliberate contamination.

f. I have referred previously to the table setting out a breakdown of bacteria that were isolated in the cases of the three children, produced as part of disclosure by South Yorkshire Police. The most common organism amongst the three children was E-coli. There were 32 incidences of E-coli which was twice as many as the next most common: and the respective incidences of E-coli for BR, HS and LW, were 10, 10, and 12. So that particular infective organism was common to all three children. Other bacteria did not necessarily affect all three, but E-coli did, and it did so quite commonly. It may be that E-coli is the most common bacteria in faecal material, but its incidence in these cases does raise the question of whether there might have been a common cause of the infections with that particular organism during the relevant time.

297. Then consider the particular circumstances of the three children and their mothers:

a. BR was cared for in very close proximity by her mother – they slept together in the same bed, they spent hours together in the same room. MR has reported that she took strong laxatives daily. She was not only dealing with her own motions but also with her daughter's. They shared a toilet in the cubicle. MR

would "nurse" her daughter far more than most parents would in hospital and that included collecting stool and taking it to the sluice room.

b. MS and MT also spent hour after hour caring for their children, changing nappies, handling them and, sometimes assisting with line care as they had received training in PN management.

c. HS, in particular, was exceptional in the frequency and manner in which he himself manipulated his lines and equipment. This was witnessed by healthcare professionals as I have discussed.

d. MS herself had bowel problems including diarrhoea, at least towards the end of HS's admission, and had to handle dirty nappies she had used as liners.

e. LW and HS were themselves in nappies. I have no data as to the relative incidence of line infections for infants in nappies on long term PN as opposed to older children. LW and HS frequently had loose stools or diarrhoea. I have seen photographs of nappies filled with explosive watery and mucousy stool. On one occasion staff were concerned that after a particularly loose stool, faecal material may have got into HS's line.

f. The mothers would bathe HS and LW and any faecal material on the children's bottoms might contaminate the water. MS was advised on one occasion not to allow HS's line to become submerged in the bath water after it was observed that she had allowed that to happen. How many times had that happened previously, unobserved or unremarked upon? Did the same happen with LW? The mothers may not have realised that in doing so they might create an infection risk. Did BR inadvertently contaminate her own line when bathing?

g. All three mothers were caring for their children during the covid-19 pandemic lockdowns with the pressures that brought to bear. They were not sharing the caring responsibilities with another family member for much of the time, they were solely responsible with very little respite. And yet they all had children at home – they were under huge strain for very long periods. Perhaps that strain led to mistakes being made by them increasing the risk of inadvertent contamination.

298. Then there are particular features of the ward and the hospital staff:

a. Staff were in lockdown too, they had concerns about their own loved ones, about the risks to the health and lives of others. This was a difficult time for many and preoccupations with the effects of the pandemic might well have led to behaviours amongst staff that were different from normal.

b. Some staff had become very familiar with BR and MR and were within an "inner circle" with them. It is clear that in the case of one nurse, Nurse SAZ, that familiarity led her to become unprofessional in her dealings with MR and in some of her conversations with BR. It is not inconceivable that she may

have allowed herself to have fallen below her usual professional standards in other respects when dealing with them.

c. The rota system used by the paediatric gastroenterology consultant team at SCH, which meant that there might be a different consultant leading the clinical care of a child each week for about seven weeks, did lead to some frustration amongst nurses about a lack of consistency of care.

d. Lines were sometimes inserted at Hospital A and techniques used, such as the securacath, that were not always familiar to the staff at SCH. Communications, about dressings changes, for example, were not always as they should have been, as was recognised by the authors of the RCA.

e. The aseptic technique required when disconnecting and re-connecting a line for a new PN bag to be set up, is difficult to adhere to. The authors of the RCA observed nurses managing PN equipment in accordance with their training, but nurses knew they were being observed and so were likely to be on guard to abide by the standards they had been taught. Even so, the authors noted in their first draft the "disjointed management of central lines, in that the surgical teams inserted the lines but then the management of those lines was immediately passed back to the team caring for the patient. There were also different practices between areas … there was no consistency in the management of line infections … more clarity and standardisation is required around decolonisation of skin and dressings used to cover the insertion site … there was a lack of designated areas for the setting up of PN."

f. Some rather *ad hoc* ideas were adopted for protecting central lines, such as the use of parafilm to be wrapped around bungs and other connection points. The authors of the RCA considered that this "may potentially be making the situation worse."

g. There were changes in practice in relation to PN line management during the period I am considering such as the spiking of PN bags on the ward as opposed to at a dedicated unit. I do not conclude that this particular change increased the risk on infection, but it was quite a significant change in practice, change requires adaptation and errors can be made during the process of adaptation. The authors of the RCA recognised the "stress" caused by such a change.

h. The sluice room was left open when entrance to it should have been controlled.

i. Sterile gloves were not always worn when handling the central line and connectors.

I mention these matters not to be critical nor to lay the blame on staff at SCH, but rather to illustrate that there were many factors at work all or some of which might have played a part in making a small contribution to the number and type of line infections these three children suffered.

299. In addition, I return to the fact that translocation was considered as a possible explanation for the number and type of infections being suffered by the children

by the experienced team of consultants at SCH. This view was supported by the jointly instructed Dr Rajendran as a possible explanation for at least some infections, until he changed his opinion at the joint meeting with other experts. Mr Howe KC for MR took a number of witnesses to a published paper setting out factors that might increase the risk of translocation leading to a bloodstream infection, including use of steroids and PN, which applied to BR. Notwithstanding the consensus amongst the experts that translocation is not the likely cause of infections in these cases, I cannot rule out entirely the possibility that it may have played some small role in some of the instances of infection.

300. I cannot find that any one of these factors explains the number and type of central line infections suffered by these three children but taking a view of all the evidence and all the factors that might have been in play, it can be seen that the number and types of infections might not be quite so extraordinary or quite so inexplicable as has been presumed. I have to weigh the evidence in the light of the many factors I have identified, and bear in mind the wise caution of Hedley J that "… there has to be factored into every case which concerns a discrete aetiology giving rise to significant harm a consideration as to whether the cause is unknown". That applies equally to these three cases as it does to alleged inflicted traumatic injury. When I do so, I also remind myself that,

a. Whilst the experts at the joint meeting identified factors pointing to FII, including the number and type of line infections, they have also expressed caveats. For example, Dr Ward wrote in her report on HS, "It is not possible retrospectively to analyse the exact cause for his apparent intestinal failure and recurrent episodes of sepsis." Professor Sullivan in his oral evidence spoke of "getting into the weeds" of the case and finding that it was more nuanced than might have at first sight appeared.

b. None of the mothers were caught interfering with the children's central lines, taking steps preparatory to contaminating lines, or covering up actions of deliberate contamination.

c. There was a great deal of human traffic on the wards and in and out of cubicles, so that a mother would not know whether someone might walk into the cubicle at any particular time.

d. The alleged deliberate contamination, in each case, would have taken place over many months, and so would have had to have remained wholly undetected for many months. The degree of sophisticated deception involved would have been considerable. Of the three mothers, the only one who I believe might have been capable of a sustained deception of that kind would have been MR.

e. MR could not have deliberately contaminated BR's lines with faecal material without BR's knowledge or at least her suspicions, but there is no evidence from BR of any actions by MR that could be interpreted as revealing deliberate contamination.

f. After MR's arrest, Dr SAO, designated doctor for safeguarding, said that they [the team at SCH] had "no safeguarding concerns" about HS and LW. In the case of MT, those clinicians who worked closely with her had such confidence that she could safely care for LW, that they sent LW home in her care. Nursing staff working day by day with MR, MS, and MT did not suspect deliberate contamination.

g. Too much faecal material inserted into the central lines could have killed the children. Repeated insertions of faecal material would therefore have to have been at just the right amount to cause infection and sepsis but not to cause death. Either each mother was very lucky or very skilled not to have killed their child by inserting faecal material into their central lines, repeatedly over many months.

h. Albeit newly inserted lines were infected, and that is a feature that causes concern, there is no discernible pattern of infection following or preceding certain events, such as a child being taken off the ward, or planned or actual changes in treatment or indeed infections only or mostly occurring to newly inserted lines.

i. Although there is no discernible pattern connecting line infections to other events, there is no significant change in the overall occurrence of line infections, when on PN in hospital, for BR and LW. There was some reduction in incidents for HS when he had been moved to ward K and was under observation, but that is consistent with focused attention reducing inadvertent contamination. The overall continuation of line infections whilst central lines were in situ in hospital, points away from the mothers deliberately contaminating lines at particular times of stress or for some ulterior purpose. In each case their deliberate contamination would have been persistent over time.

j. There is no evidence at all of maternal collusion even from the frank messaging between them that they did not know would be subsequently examined by the police.

k. There is no evidence of any internet searches or other online activity by the mothers that indicates they were gathering information about how to interfere with central lines.

l. MS and MT had brought up several other children without concerns of FII either contemporaneously or in retrospect. The same can be said of MR, although her own medical history indicates a difficult relationship with pain-relief and a number of medically unexplained presentations.

301. I have found that MR administered unprescribed drugs to BR. That is a factor that I must weigh in the balance when considering the allegation that she also caused harm by deliberately contaminating her daughter's central lines. On the other hand, I have found that MS and MT did not administer noxious substances

to HS and LW and that is a factor I have to weigh when considering whether they deliberately contaminated their sons' central lines.

302. I have considered the possibility of deliberate contamination by one of the mothers acting alone – if so, and it explains the contamination of all three children's lines, it would have to be MS or MT because MR was not present from February 2021 and line infections continued for HS and LW thereafter. But that possibility is entirely fanciful – there was no opportunity for one mother to contaminate the lines of the children who were not theirs. I have also considered the possibility of a rogue healthcare professional or other member of staff deliberately contaminating the central lines. It cannot be discounted but no-one has fallen under suspicion and there is no evidence to allow such an inference to be made. That said, if circumstantial evidence is relied upon to support the inference of an inherently unlikely scenario – three mothers independently choosing to harm their children in the same, unusual way, on the same ward at the same time – then arguably the scenario of a rogue healthcare professional, although also inherently unlikely, must be taken into account. Although these cases might be presented as ones in which the court has to consider a pool of perpetrators, including some unidentified member of staff at SCH, or even BR, I do not approach them in that way. These are not cases where there is a mechanism of injury which might have been inflicted by one or other perpetrators. It is the mechanism of injury itself which is in question.

303. I return to the dicta from *The Popi M* – a judge should not regard themselves as "compelled to choose between two theories, both of which he regarded as extremely improbable, or one of which he regarded as extremely improbable and the other of which he regarded as virtually impossible." The allegations of deliberate line contamination by the mothers are theories. Just because other theories are less likely does not mean that the theories propounded by the Local Authorities are more likely than not.

304. The evidence of deliberate line contamination by the mothers in each case is said to be circumstantial – the court is invited to infer induced illness by line contamination. When I have regard to all the evidence I am unable to make that inference in respect of any of the mothers. Circumstantial evidence is still evidence – there must be some evidence from which the facts the court is invited to find may be inferred. Speculation is not a basis for making findings of fact. I am not satisfied that in any of the three cases the evidence permits the inference that on the balance of probabilities deliberate line contamination is the explanation, either by the mothers or by anyone else. However, in family cases such as this, it is important to be clear as to whether the finding is that the case against each mother is simply not proved but that welfare decisions should nevertheless take into account the possibility that they did act as alleged. In these cases, having regard to the evidence, I think that it would be improper to proceed on that basis in respect to line infections. The evidence does not establish that the mothers were responsible for deliberate line contamination. The evidence also persuades me to conclude that, although I cannot identify a single probable cause or set of causes for the repeated line infections, it is more likely than not that a coincidence of many different factors brought about a highly unusual incidence of polymicrobial

line infections, including infection by bowel flora, in these three long term PN dependent patients.

305. As part of my consideration of all the allegations of FII, I have found it instructive to consider the RCPCH guidance. I refer to it at this part of my judgment for convenience, but the matters set out below have informed my analysis of the evidence. The RCPCH guidance includes a list of "alerting features" of possible FII. I set them out in full in Part A and summarise them now, with comments relating to each mother and child:

In the child:

• Reported symptoms and signs not observed independently: for the main part I find that there was a large degree of consistency in all three cases between reported symptoms and signs, and what healthcare professionals observed.

• Unusual results of investigations: this is certainly a feature of all three cases where unusual infective organisms, in particular bowel flora, were found.

• Inexplicably poor response to prescribed treatment: most of the treatment given to these three children was a mixture of investigation and fire-fighting. Whilst BR did not respond to prescribed treatment for suspected Crohn's disease that differential diagnosis is now discounted so her lack of response is explained. HS and LW were managed and investigated rather than treated as such and I do not believe it can be said that they inexplicably failed to respond to treatment which ought to have made them better.

• Physiologically impossible features: whilst the number and type of central line and blood stream infections were highly unusual there were no characteristics that were physiologically impossible. It has been said that immediate responses by way of diarrhoea or vomiting to small oral or enteral intake were physiologically inexplicable, but some explanations were given by Professor Sullivan that there might have been leakage of fluid or feed on enteral administration, or that the diarrhoea reported by MT when at home with LW was not caused by the immediately proceeding action observed , e.g. ingesting bathwater, but by some earlier trigger.

• Unexplained impairment of child's daily life: these three children were hospitalised for very long periods which obviously impaired their daily lives, as did long term TPN. It might be said that HS and LW's inability to feed was unexplained but Professor Sullivan explained that prematurity offered a possible explanation.

Parent behaviour

• Parents' insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child: I do not believe that this could be said of the mothers in these cases: they followed clinical advice by accepting most suggested investigations. There is no evidence of them pushing for investigations.

• Parents' insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs: again, I do not believe that the evidence demonstrates parental insistence of this kind in any of these cases.

• Repeated reporting of new symptoms: early on in BR's illness she developed a series of new symptoms, such as leg pain, which was probably a product of her functional pain. Looked at more generally the symptoms reported in these three cases were constant. There was no "moving of the goalposts" by the mothers by reporting new problems.

• Repeated presentations at medical settings: most presentations at medical settings were arranged or, if not, appear to have been justified in the eyes of the healthcare professionals at the time.

• Inappropriately seeking multiple medical opinions: I do not believe that this can fairly be said of any of the mothers.

• Providing reports by doctors from abroad which are in conflict with UK medical practice: this does not apply

• Child repeatedly not brought to some appointments: there were some missed appointments but not any repeated pattern of significance given the pressures on each mother. Missed appointments were eventually attended when rearranged.

• Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches): this did not happen in these cases: the mothers were largely accepting of medical advice.

• Objection to communication between professionals: I do not believe this was a feature in these cases. It has been alleged that MT unreasonably objected to a referral or even to discussions taking place about bowel transplantation and investigations at Hospital B, but I have found those allegations to be unfounded.

• Frequent vexatious complaints about professionals: that is not a feature of these cases.

Reviewing those "alerting features", I am struck by how few apply to these cases, in particular in relation to the features relating to the parents. Of MS and MT, I would add that when their children were in-patients at SCH there is no evidence that they were suffering any kind of mental health problem, let alone exhibiting any mental health issues that might explain or give a context to the behaviour alleged in these cases. The position of MR is more nuanced. Her relationship with BR was not healthy for the reasons I have discussed earlier – it was intense interdependent, MR did not lay down boundaries, BR's behaviour was sometimes demanding, they gathered around them an inner circle of nurses whilst BR eschewed discussions with doctors and communicated with them largely through MR. MR had had mental health interventions in her past life and she was seeing a

psychologist in SCH, but the contents of her discussions with the psychologist are not troubling to the extent that she was revealing thoughts or behaviour consistent with someone who would induce illness in their child. I have found that she did give unprescribed drugs to BR but that finding was not based on any evidence about her having a mental health problem at the time. In short, there is no psychiatric or psychological evidence concerning the three mothers that, in my judgment, weighs in favour of finding that they deliberately contaminated their children's central lines. As for MS and MT, to the contrary, I consider that their characters and behaviour in hospital tend to show that they would have been very unlikely to act in that way – their emotions were congruent with their circumstances.

306. When FII is alleged it raises the question of why, here, a mother might have acted as they did. The RCPCH Guidance, 2021, states,

> "There are two possible, and very different, motivations underpinning the parent's need: the parent experiencing a gain and the parent's erroneous beliefs. It is also recognised that a parent themselves may not be conscious of the motivation behind their behaviour. Both motivations may be present although usually one predominates."

For MR, it appears to me probable that the second motivation was present – she had an erroneous belief that her daughter was suffering great pain because of an underlying physical condition and that she needed additional medication because she was not receiving sufficient help from the clinicians. If MR accepts my findings of fact then perhaps she will reveal more to the court about her thinking and motivation, but I am satisfied that an erroneous belief that she was helping BR fits with the findings of fact that I have made. In the case of MS and MT, I do not believe that the evidence points to them having any erroneous beliefs about their children's conditions or treatment. I have considered whether there would have been "rewards" or "gains" to the mothers from fabricating or inducing illness. It is arguable that MR's history and conduct shows that she achieved some gain from receiving medical attention for herself, and may have done likewise for her daughter. As for MS and MT, I cannot identify any possible gain. It is possible to make a case that MS did not wish to return home because of her relationship difficulties. In the case of MT it is possible that she did not want to return home because of the overwhelming responsibilities she had for LW and her other children when out of hospital. However, the overwhelming evidence in both those cases is that the mothers did want to be at home: MS told nurses that she just wanted to go home. MT did go home with LW for periods of time, including for six to seven months in 2021. Both mothers were close to their other children and wanted to be with them. It might be contended that one or both of them enjoyed the attention of healthcare professionals but that is not at all the impression gained from the oral evidence nor the messaging between each other and with those outside the hospital. At various points it has been insinuated that MT sought financial gain – for example when gifts were given from members of the community at what was thought might be LW's last Christmas. However, I discount that possibility because there was clearly no financial gain from MT

having to remain in hospital with LW for so long, and having to travel backwards and forwards from home to hospital as she did. Likewise there were adverse financial implications for MS and FS from HS's protracted hospitalisation. Finally, if anyone should suggest that MS and MT enjoyed being in hospital with their children for months on end and therefore harmed them deliberately in order to prolong that experience, I suspect that MT spoke for both of them in this response during her police interview on the day of her arrest:

> "IO: How has it been having a child in the hospital for so long?
>
> MT: It's been bloody hard."

F: CONCLUSIONS

307. I have set out my findings as to maternal conduct in the detailed analysis of the evidence at Part E. Having regard to all the evidence both as to maternal conduct and the consequences of such conduct, having considered the submissions of the parties, and having applied the legal principles set out in Part B, I reach the following conclusions in relation to the allegations made for the court's determination:

308. In the case of Family R:

a. From September 2019 until 25 February 2021, MR administered unprescribed medication, namely ibuprofen and piroxicam to BR. From March 2020 until 25 February 2021 MR administered unprescribed bisacodyl to BR.

b. MR so acted without BR knowing what unprescribed medication she was being given but knowing that MR was adding drugs to the prescribed drugs to be given to her.

c. The ingestion of the unprescribed non-steroidal anti-inflammatory drugs ibuprofen and piroxicam caused NSAID enteropathy in BR as a result of which she suffered,

   i) Recurrent abdominal pain.

   ii) Nausea and vomiting

   iii) Abdominal inflammation.

   iv) Recurrent ulceration in the stomach and duodenum.

   v) Gastro-intestinal bleeding.

d. The administration of Bisacodyl contributed to BR's symptoms of recurrent diarrhoea.

e. During the course of her in patient admission BR also suffered the following symptoms brought about indirectly as a result of the administration of NSAIDs,

   i) Side effects of multiple potent drugs including steroids and immunosuppressants

   ii) Poor kidney function

   iii) Liver impairment

   iv) Gall bladder changes

f. The ingestion of the unprescribed medication and the consequent significant adverse physical effects on BR's abdominal and gastrological function directly led to the following unnecessary medical procedures,

   i) Naso gastric tube feeding;

   ii) Gastrojejunostomy;

   iii) Siting of PICC lines;

   iv) Siting of Central lines;

   v) Siting of a Portacath;

   vi) Multiple endoscopies;

   vii) 10 blood transfusions;

   viii) Ultrasound investigations;

   ix) Surgery to clip ulcers.

g. The ingestion of the unprescribed medication and the consequent significant adverse physical effects on BR's abdominal and gastrological function directly led to the prescription of unnecessary drugs (including opioid analgesia) and prolonged periods of inpatient treatment for BR.

h. BR suffered prolonged periods where she was nil by mouth or had severely restricted oral intake including medication between 24.04.2020 and 01.03.2021. As a result of an inability to maintain nutrition via an enteral route BR received long term parenteral nutrition.

i. I would add, given my findings that MR was not responsible for deliberately contaminating BR's central lines but that the need for central lines being in

situ was due to MR's administration of unprescribed medication to BR - (f)(iv) above):

As a consequence of the unnecessary siting of central lines:

i. BR suffered multiple instances of polymicrobial infection of her central venous catheter.

ii. As a result of those infections BR suffered life threatening sepsis necessitating admission to the paediatric intensive care unit at Sheffield Children's Hospital on 5 occasions

j. During the period of her admission BR suffered significant emotional harm by reason of her separation from her father, sister, brother, extended family and friends.

k. During the period of her admission BR suffered significant emotional harm by reason of being unable to access mainstream education, extracurricular activities and the social aspects of school.

l. As a result of the above matters BR suffered significant psychological harm including; fear of death, distress, anger, anxiety and trauma.

309. In the case of Family S, I find that none of the allegations against MS have been proved.

310. In the case of Family T I find that none of the allegations against MT have been proved save that I accept that LW was passively exposed to cocaine whilst in the care of MT when another adult came into the family home – I do not regard that finding as having any welfare implications for MT's ability to care for LW.

311. I wish to repeat that my findings do not imply that personnel at SCH were wrong to consider or even to suspect FII in the cases of MS and MT, or that repeat infections were caused by bad practice at the hospital. However, there are some lessons that might be learned for the future.

312. Firstly, I commend the RCPCH guidelines. It is difficult for clinicians to appreciate when the line is crossed between taking a rehabilitation approach and referring to social services and/or the police but, when there are perplexing presentations but no evidence of deception or induction of illness or of immediate risk to the child's health or life, then the path of rehabilitation set out in the guidance should be followed. I would add that it is essential that clear minutes of safeguarding meetings are kept and that all safeguarding records are kept in one place to be readily accessible when required.

313. Secondly, care must be taken to avoid expert witnesses from assuming the role of the judge to determine whether there has or has not been parental conduct that amounts to fabrication or induction of illness. Determinations of that kind require consideration of both medical and non-medical evidence and the

assessment of non-medical evidence, and the evidence as a whole is a judicial function, not a matter for expert medical opinion. A particular danger is that a paediatric expert who is instructed to review other experts' evidence as well as the documentary evidence in the case may be expected, or may assume, to give an opinion as to whether a case is or is not one of FII.

314. Thirdly, to underline the observations of Ryder J in *A County Council v A mother and others* (above), FII is an umbrella term that covers a wide range of behaviours. It is unhelpful in a forensic context to be so unspecific as to enquire only whether there has been FII or factors "point to FII". The question will always be precisely what conduct is alleged: is it exaggeration, fabrication of symptoms, presenting false evidence such as contaminated samples, misreporting the advice or findings of other healthcare professionals, forging documentation, encouraging a child to behave in certain ways, pestering doctors to perform unnecessary interventions, giving excessive medication to a child, withholding necessary medication, inducing illness recklessly or intentionally? FII may be a useful shorthand label, but its use must not be permitted to obscure the necessary focus on particular conduct.

315. Fourthly, in those cases where the court is invited to infer harmful conduct that comes under the umbrella term FII, the first role of the court is to establish the facts – what are the actual circumstances from which the inferences can be drawn? It is important to put aside assumptions about whether a parent is guilty when establishing the facts. Then, when considering what inferences can be drawn from those facts, the court must avoid the trap of concluding that because one proposed explanation for the facts is more likely than any other, it is more probable than not. Witnesses and the court must be careful to avoid retrospect distorting an objective analysis of the facts. In the great majority of cases that come before the courts, certain key witnesses will have made their own minds up about whether a parent has fabricated or induced illness. The temptation, which must be avoided, is to interpret past events in the light of those views. Perhaps a particular incident was indeed caused by a mother poisoning her child, but such an inference will usually require a review of all the evidence including a consideration of patterns within a chronology and an assessment of the mother concerned, before a secure inference about the events in question can be drawn. An objective view of the facts is hindered if each event is interpreted according to the retrospective views of particular witnesses.

316. Fifthly, a highly collaborative approach is required between Local Authorities and NHS organisations in cases where there are likely to be a large number of healthcare professionals giving evidence, and where a large amount of medical documentation needs to be disclosed. It is difficult sometimes to identify all the issues in a case before all the witness evidence has been assembled, but witness statements taken must at least cover the issues that have already been identified. Obviously, any safeguarding records, investigations, RCA and SII reports will be disclosable. The burden on the Trust in these cases has been extremely heavy and I am grateful to the Trust for all the work done to facilitate this hearing, but the late disclosure of important documentation was very unfortunate and created difficulties for the parties and expert witnesses. The Trust had an interest in this case but it should treat itself as neutral when obtaining

witness statements and protect against the possibility of influencing the witness. Furthermore, a Trust that intends to commission an investigation into matters which are before the court, should inform the parties and the court accordingly, in particular if it is proposed that witnesses in the court proceedings will be interviewed.

317. Finally, it is instructive to reflect on the process that led to the arrests of MS and MT. Those arrests have split their families apart. As soon as police referrals were made by SCH the mothers were removed and prevented from having contact, or normal contact, with their children. It does not follow from my findings that those referrals were wrongly made in the circumstances that prevailed at the times they were made - although I have particular concerns about the referral of MT - but I do conclude that they were probably avoidable. Lessons may be learned for other cases. The observations that follow are made with humility – a judge making findings in a case such as this can only make those findings on the available evidence. Judges are certainly not infallible and a judge cannot look into the minds of the alleged perpetrators of FII. Both HS and LW had perplexing presentations. It was right for the staff at SCH actively to consider the possibility of FII. Clinicians are in an invidious position when they have to contemplate FII. However, in my judgement the referrals to the police and the mothers' arrests, with all the harm then caused to them and more especially to their children, would probably have been avoided if,

a. In March 2021, if not before, the RCPCH guidelines on perplexing presentations and FII had been followed so that,

    i. The nature of any possible FII was identified, even in the broadest terms, and steps to obtain evidence, such as toxicological analysis of vomitus or stool, and appropriate blood or urine tests for noxious agents, were planned and taken.

    ii. Variables that could be changed were changed, such as each child moving ward, having a different lead consultant, appointing a lead nurse to oversee the management of PN, or introducing another parent or family member, where available, to look after the child for a period of time.

    iii. A single person was appointed for each child who was responsible as the lead for safeguarding and the gathering and examination of evidence in relation to suspected FII.

    iv. Chronologies were prepared.

    v. Further non-medical information was gathered, for example from partners or other family members, and in relation to the mothers' other children.

    vi. Staff on ward K were fully aware of the purpose of their observations of MS/HS.

vii. The mothers and other relevant family members were fully included in the formulation of the rehabilitation plan and the actions taken under that plan. This would have allowed for a managed attempt to re-introduce enteral feeding, for example.

b. In October 2021 it had been recognised that the plans agreed in March 2021 - and a later plan to move HS to another hospital - had not been put into action - there were no chronologies, no toxicological analysis, no further trials of enteral challenge, and no consideration of the mother's other children, or of involving FS.

c. In those circumstances, the events that triggered the referrals in October 2021 had been investigated in a much more sceptical manner. MT was spoken to only briefly about what had happened. MS was not asked to give an account. Nurses who had witnessed the events were not all spoken to. Their views about what had happened were not fully canvassed. In particular, the circumstances in which LW's pumps had been turned off required much more careful consideration.

d. Immediate referral to the police is justified where there is an immediate concern for the safety of the child or clinicians have evidence to show that fabricated or induced illness, harming the child, is probable. Here, FII had been actively considered by the clinical teams at SCH but until the week of the arrests of MS and MT, there had been no collective view that the mothers were probably responsible for harming their children. Here, it cannot be said that the incident that triggered referral of HS's case to the police was exceptional or significantly different from previous incidents affecting him. The incident involving LW was quite different from any previous incidents but if there had been any kind of investigation into what had happened to LW's feeding pumps, the incident would not have been considered as evidence against MT. There had been no significant changes in patterns of outcome or behaviour since March 2021 to heighten concerns. The view that had been taken was that there was insufficient evidence for referral. The events in October 2021 did not add significantly to the evidence supporting referral. The clear impression is that the decisions to refer were led by Dr SAA who was more inclined to refer than the lead clinicians or designated safeguarding doctor had been. He was understandably concerned about drift, and took a different view from some of his colleagues. Key members of staff were unavailable to give their input. In both cases it seems to me that there was not such urgency that at least 48 hours could not have been used to consider the evidence and review whether and what referrals were needed.

e. As it happens, in my judgement, referral to social services could and should have been made much earlier but solely on terms that the clinicians at SCH did not know whether they were dealing with perplexing presentations due to parental involvement or due to some other factor(s). Although the clinicians' concerns about FII centred on periods of in-patient care, the wider context was highly relevant and a multi-agency approach was required at the stage of considering evidence of possible FII. The cases were better suited to a multi-agency approach rather than clinicians continuing to act alone. Perhaps social services might have involved the police at that stage but neither mother had a

forensic history and I doubt whether arrests would have been made. Instead circumstances were allowed to drift so that ultimately an urgent referral to the police was made hurriedly and in circumstances where opportunities to have gathered evidence had been missed.

318. The arrest of MR followed a concerning urine test result. The test had been initially planned some weeks before the result was finally reported, but it does not appear that there had been any planning for the possibility that it would be positive for ibuprofen. The earlier positive urine test had been overlooked. On receipt of the February 2021 urine test result it is understandable that the clinicians feared that BR was at immediate, indeed ongoing risk of harm from the actions of her mother. I would not criticise the decision to refer the matter to social services and the police in those circumstances. I would question whether an earlier, more structured approach to investigating possible FII, and safeguarding as Dr SAO had recommended in September 2020, might have led to better evidence being available and earlier, proportionate intervention.

319. The arrests of MS and MT in October 2021 more clearly followed a period of avoidable drift and delay, even though a clear and well thought out strategy had been adopted in March 2021. This drift and delay led to opportunities to gather evidence being missed, and hurried referrals to the police being made. Dr SAO's role was as an adviser to clinicians, and she gave good advice to them, but there is conspicuous lack of a safeguarding lead for each case, or even for the cases together – someone who could have followed up the agreed strategies, monitored how safeguarding and evidence gathering was being progressed, and who could act as a single point of contact to collate minutes of meetings, action plans, evidence, discussions with parents, and contact with other agencies.

320. I have written letters to the children of the three families explaining my judgment in terms that I hope they will understand. I will leave it to others to decide whether and when those letters should be shown to them.

321. I end by recording again my gratitude to the court staff, to the Trust, and to all the legal representatives for the way in which the hearing was organised and conducted, and to the families, in particular the mothers who, under great strain, conducted themselves with dignity.

322. Welfare decisions regarding the children of the three families will now have to be made and I shall give directions accordingly after considering submissions.

Postscript:

The publication of this Judgment was deferred pending consideration by the Crown Prosecution Service but is now published with its consent.

Appendix 1

Schedules of Allegations

1.1 Leeds CC v MR and others

1. The threshold criteria were met at the time of intervention by the local authority on the basis that at the relevant time the child concerned BR had suffered and was likely to suffer significant emotional, psychological and physical harm, such harm being attributable to the care given to him, not being that which would be expected of a reasonable parent.

Facts

2. In June 2019 BR attended at Hospital A complaining of abdominal pain. In the period that followed from at least August 2019 until 25th February 2021 BR ingested unprescribed medication specifically,

a. Ibuprofen (NSAID)

b. Piroxicam (NSAID)

c. Bisacodyl

d. Trimethoprim

3. The ingestion of the unprescribed non-steroidal anti-inflammatory drugs ibuprofen and piroxicam caused NSAID enteropathy in BR as a result of which she suffered,

a. Recurrent abdominal pain.

b. Nausea and vomiting

c. Abdominal inflammation.

d. Recurrent ulceration in the stomach and duodenum.

e. Gastro-intestinal bleeding.

4. The administration of Bisacodyl contributed to her symptoms of recurrent diarrhoea.

5. During the course of her in patient admission BR also suffered the following

symptoms brought about indirectly as a result of the administration of NSAIDs,

a. Side effects of multiple potent drugs including steroids and immuno-suppressants,

b. Poor kidney function

c. Liver impairment

d. Gall bladder changes

6. The ingestion of the unprescribed medication and the consequent significant adverse physical effects on BR's abdominal and gastrological function directly led to the following unnecessary medical procedures,

a. Naso gastric tube feeding;

b. Gastrojejunostomy;

c. Siting of PICC lines;

d. Siting of Central lines;

e. Siting of a Portacath;

f. Multiple endoscopies;

g. 10 blood transfusions;

h. Ultrasound investigations;

i. Surgery to clip ulcers.

7. The ingestion of the unprescribed medication and the consequent significant adverse physical effects on BR's abdominal and gastrological function directly led to the prescription of unnecessary drugs (including opioid analgesia) and prolonged periods of inpatient treatment for BR.

8. BR suffered prolonged periods where she was nil by mouth or had severely restricted oral intake including medication between 24.04.2020 and 01.03.2021. As a result of an inability to maintain nutrition via an enteral route BR received long term parenteral nutrition

9. The unprescribed medication listed at paragraph 1 above was administered to BR by

a. MR and/or

b. MR and BR.

10. Any self-administration of the above unprescribed medication during the inpatient period by BR occurred in circumstances where

a. MR was aware of the self-administration and facilitated it by buying/ordering and storing large quantities of drugs in BR's hospital cubicle; and

b. BR had become involved in the harmful behaviours of her mother.

c. MR knew that NSAI drugs were the cause of BR's gastro-intestinal symptoms.

11. BR has been encouraged to think of herself as a sick child. In particular MR:

a. Has facilitated/encouraged the use of a wheelchair by BR which was not prescribed.

b. Fostered a belief in BR that her pain could only be managed by opiate pain relief.

12. Following the removal of MR from the ward BR's symptomology reduced, BR began to eat and to mobilise.

13. During the course of her hospital admissions to Hospital A and Sheffield Children's Hospital BR suffered multiple instances of polymicrobial infection of her central venous catheter . Such infections were caused deliberately and not as a result of any failure on the part of surgical or nursing staff.

14. As a result of those infections BR suffered life threatening sepsis necessitating admission to the paediatric intensive care unit at Sheffield Children's Hospital on 5 occasions

15. Such infections were caused by MR deliberately contaminating the lines with infective material.

16. During the period of her admission BR suffered significant emotional harm by reason of her separation from her father, sister, brother, extended family and friends.

17. During the period of her admission BR suffered significant emotional harm by reason of being unable to access mainstream education, extracurricular activities and the social aspects of school.

18. As a result of the above matters BR suffered significant psychological harm including; fear of death, distress, anger, anxiety and trauma.

1.2 ERYC v MS and others

At the time that protective measures were instigated, (namely 10 January 2022); the date on which the Local Authority issued proceedings in respect of DS, ES, GS and HS, HS had suffered, was suffering and was likely to suffer significant harm (both physical and emotional) and DS, ES and GS were likely to suffer significant harm. In the case of all four children such harm and likelihood of harm being attributable to the care given to them or likely to be given to them if orders are not made, not being what it is reasonable to expect a parent to give to a child.

The following findings are sought in support of that contention:

1. During the period between 23 April 2019 and 17 July 2019, MS, the children's mother, fabricated and/or exaggerated HS's ill-health, symptoms in that she variously reported to medical professionals at both Hospital C and SCH that HS, was vomiting up to 20 times per day. In addition, she provided misleading and/or inconsistent information about HS's nutritional intake, and his bowel movements. HS's clinical presentation did not always match that, which was being reported by MS. As a result, HS was listed for PEG placement under a general anaesthetic. During this period HS's Naso-Gastric Tubes ("NGT") were repeatedly pulled out and had to be re-passed on several occasions by FS who had not received training in how to do so. Further, HS missed two appointments for a Barium Study at a time when MS was reporting that HS's symptoms were increasing in severity. She failed to contact Sheffield Children's Hospital ("SCH") to explain the nonattendance. MS's intention was to present HS as a more unwell child than he actually was and her approach to his health needs was inconsistent.

2. During the period 13 August 2019 and 23 September 2019, whilst HS was an inpatient at SCH, MS fabricated or exaggerated and subsequently induced HS's symptoms of excessive diarrhoea and vomiting, by directly administering some unprescribed agent to him, with a view to persuading the medical professionals responsible for his care, not to discharge him from hospital and leading those professionals to undertake numerous invasive medical investigative procedures, including undergoing a general anaesthetic and numerous blood tests. All tests undertaken returned with normal results. In addition, during this admission MS either deliberately interfered with or failed to stop HS interfering with his feeding equipment in that HS's PEG snapped and required replacing and the PH probe was pulled out on three occasions leading to interruptions in the PH studies.

3. During the period between the 24 September 2019 and 17 March 2020 HS had a period of growth, the medical professionals stating that no identifiable gastrointestinal or genetic cause had been found for HS's failure to grow. MS was reporting symptoms/features which were considered 'perplexing' to the medical professionals including:

(a) HS taking all of his nutrition but being constipated (which is unusual for a patient on a continuous feed). This led to the prescription of a laxative, Movicol;

(b) Despite HS taking all his feeds and in addition having commenced some oral feeding (and no vomiting and diarrhoea being reported), he was losing weight and falling down the centile chart.

MS was deliberately interfering with HS's feeding regime by either:

(a) fabricating or exaggerating the extent to which HS was eating, or;

(b) withholding/reducing the volume of/or diluting HS's feed and thereby failing to provide him with his medically prescribed nutritional requirements.

4. Between 2 to 15 March 2020 MS presented an inconsistent approach to HS's health in that, despite reporting that HS's CORFLO tube had split and was leaking badly she did not present him to the hospital until the 6 March 2020, she having been 'strongly advised' to take him to A&E. In addition, from 6 March 2020, MS interfered with HS's feeding equipment. She was unable to give any clear explanation for how the PEG had split as well as HS's NGT being repeatedly removed and having to be replaced. MS was directly observed to remove HS's NGT on the 15 March 2020 and was either directly responsible for all of the other occasions when the NGT was removed, or she failed to prevent HS from removing it, she being the person providing all supervision and cares for him.

5. Between 18 March 2020 and 8 April 2020, following HS being transferred from Hospital C to SCH, MS, fabricated or exaggerated and subsequently induced HS's symptoms of vomiting, diarrhoea and pain following feeds by administering an unprescribed agent. This resulted in an escalation of his treatment plan and necessitated him being subjected to ever increasingly invasive medical procedures, culminating in total parenteral nutrition ("TPN") being commenced.

6. On and between, 18 March 2020 and 19 October 2021, whilst HS was an inpatient at Sheffield Children's Hospital, MS, induced illness in HS and has introduced sepsis (caused by predominantly bowel pathogens), via external manipulation (including repeatedly dislodging or removing lines) and contamination of feeding lines and parenteral ("PN"). This induction of illness and introduction of sepsis has been either deliberately or recklessly inflicted on at least each of the following occasions:

(i) 6 April 2020: She removed HS's Peripherally Inserted Central Catheter ("PICC") line

(ii) 29 April 2020: At some time after 13:05 she pulled out HS's PICC line. This resulted in a new line having to be inserted under general anaesthetic.

(iii) Between 29 April & 2 May 2020: She caused and/or allowed bacteria to enter HS's PICC line, causing an infection, which required the PICC line to be surgically removed.

(iv) 21 May 2020: She removed HS's PICC line or allowed HS to remove it whilst under her direct supervision, knowing how essential the PICC line was.

(v) 3 June 2020: She pulled out HS's Broviac line, which was stitched into place, slightly, causing it to bleed.

(vi) 9 June 2020: She removed HS's Broviac line, which was found hanging out by nurses. A decision was taken by the Gastroenterology Team to not reinsert another line until further investigations had been completed, in an effort to establish the reasons for the difficulties with the lines. A new line was inserted on the 17 June 2020 under a general anaesthetic.

(vii) Between 2 and 8 July 2020: She caused and/or allowed bacteria to enter HS's Broviac line, causing sepsis and which required the Broviac line to be surgically removed under a general anaesthetic and an intraosseous needle to be placed into HS's leg following 6 failed attempts at placing a cannula.

(viii) 20 July 2020: She pulled out HS's mini-PEG button or allowed HS to remove it whilst under her direct supervision. The PEG was replaced and the nurse checked and secured the connection and MS then loosened the connection and informed the nurse that the PN had become disconnected, following which HS suffered a further line infection. A risk assessment was undertaken and vest recommended which MS then failed to use.

(ix) Between the 3 August and 23 September: She removed PEG buttons, disconnected the PN on several occasions or allowed HS to remove or disconnect them whilst under her direct supervision, leading to further infection. This led to HS requiring a further general anaesthetic to try and insert a new PICC line, there were 6 failed attempts and so the Broviac line was left in situ.

(x) 23 September 2020: MS reported that HS had disconnected his own PN line whilst under her supervision, which ultimately allowed bacteria to enter the line, causing sepsis and which then required HS to undergo surgery on 25 September 2020 at Hospital A to insert a new line under general anaesthetic.

(xi) Between 20 and 21 October 2020: She caused and/or allowed bacteria to enter HS's PICC line, causing sepsis and which required the line to be surgically removed on 24 October 2020 there having been several unsuccessful attempts to cannulate HS.

(xii) On 2 November 2020: She pulled HS's PEG out overnight.

(xiii) Between 14 and 16 November 2020: She caused and/or allowed bacteria to enter HS's Broviac line, causing sepsis and which then required HS to undergo surgery on 18 November 2020 at Hospital A to remove the Broviac line and insert a PICC line under general anaesthetic.

(xiv) Between 1 December 2020 & 1 January 2021: She removed the PEG button on a number of occasions and caused and/or allowed bacteria to enter HS's PICC line, causing sepsis, which resulted in the line being surgically removed on the 5 January 2021 under general anaesthetic following multiple attempts at cannulation.

(xv) Between 13 and 17 January 2021: She caused and/or allowed bacteria to enter HS's Broviac line, causing sepsis and which required a femoral line to be inserted under general anaesthetic on the 17 January 2021 and the Broviac line to be surgically removed on 19 January 2021 under a further general anaesthetic.

(xvi) Between the 21 to 25th January 2021: She caused and/or allowed the PEG Button to be removed and caused and/or allowed bacteria to enter HS's line, causing an infection which led to line removal under general anaesthetic on the 25 January 2021.

(xvii) Between the 12 to 27 February 2021: She caused and/or allowed the PEG button to be removed and caused and/or allowed bacteria to enter HS's Broviac line, causing sepsis and which required the Broviac line to be surgically removed under general anaesthetic on 28 February 2021.

(xviii) Between 1 and 29 March 2021: She caused and/or allowed bacteria and other organisms to enter HS's Femoral line, which had been inserted under ketamine sedation on the 2 March 2021, causing fungal sepsis, which caused HS to be very unwell and leading to an intraosseous needle being inserted on the 10 March 2021 followed by a further PICC line being inserted under general anaesthetic on the 11 March 2021. There were numerous episodes of line disconnection and breaks in the line. The professionals were perplexed by the number of line difficulties and episodes of sepsis.

(xix) 11 May 2021: She caused and/or allowed bacteria to enter HS's Broviac line, causing sepsis and which required the Broviac line and the intraosseous needle to be surgically removed under ketamine sedation on 13 May 2021 and a femoral line to be inserted.

(xx) 14 May 2021: She caused and/or allowed bacteria to enter HS's Femoral line, by pulling the line back, causing the site of the line to become infected. A new Broviac line had to be inserted under general anaesthetic on the 19 May 2021

(xxi) 8 August 2021: She caused and/or allowed bacteria to enter HS's Broviac and Jugular lines, causing sepsis and which required the Jugular line to be surgically removed on 8 August 2021 and the Broviac line to be surgically removed on 11 August 2021 and a further PICC line inserted on the 26 August 2021 all under general anaesthetic.

(xxii) 6 September 2021: At some time before 20:13 she unbandaged HS's PICC line and removed it, which allowed bacteria to enter the line, causing sepsis.

(xxiii) Between 17 September and 19 September 2021: On return to the ward from an outing with HS, she informed the nursing staff that his PICC line was cracked and leaking and as a result, she caused the line break and caused and/or allowed bacteria to enter this line, causing sepsis and which required a new line to be surgically inserted on 19 September 2021 under general anaesthetic, which was subsequently removed under general anaesthetic on the 21 September 2021 and a left internal jugular line was fitted. On the 24 September 2021 there was concern that the jugular line had been pulled out slightly and two nurses found nail clippers in HS's bed. On the 29 September 2021 a further PICC line was inserted under general anaesthetic. On the 30 September 2021 the professionals considered HS to be in a 'dire situation'.

(xxiv) 19 October 2021: At a time when HS was critically unwell, suffering the consequences of repeated and serious line infections and in circumstances where the medical advice was that HS should be admitted to the High Dependency Unit ("HDU") for enteral feeding under sedation, and therefore unable to remove any line himself, she pulled out, completely, his PICC line.

(xxv) On multiple occasions between, around July 2021 and mid-October 2021, MS has exposed HS to and/or administered to him, Levetiracetam (an anticonvulsant drug), which induced or with the intention of inducing in HS, vomiting, bowel disturbance and abdominal pain.

(xxvi) On one or two occasions between July 2021 and October 2021, MS has exposed HS to and/or administered to him, Piroxicam (NSAID) which has had/may have had an adverse effect upon his gastrointestinal tract.

(xxvii) On a few occasions from July 2021 to September 2021 and from September 2021 to October 2021, MS exposed HS to and/or administered to him Ibuprofen, which has had/may have had an adverse effect upon his gastrointestinal tract.

7. On 23 August 2021, at a time when there were mounting concerns about repeated line infections that were causing HS to be increasingly unwell, MS was reluctant to accept the advice of Dr SB and the Gastroenterology Team caring for HS who were advising that it was in HS's best interests to be moved to Ward I to have 1-1 nursing care provided. This was considered necessary to attempt to keep HS infection free. On the occasions when 1:1 nursing care was put in place MS asked for it to be removed.

8. On or around 7 – 14 October 2021, when it had become clear that HS's clinical situation had become extremely dire and the only option for his continuing treatment was to provide him with enteral feeds, under sedation in the HDU, MS sought to resist this plan and tried to prevent it going ahead. She planned to induce symptoms of excessive diarrhoea in HS by following advice she had obtained from the internet as to how to cause diarrhoea and seeking to borrow a syringe from a friend to administer it.

9. Despite high levels of supervision HS was reportedly able to repeatedly remove his PEG button, disconnect his PN, chew and snap his lines, remove the parafilm coverings from his line, chew/eat parafilm and rubber gloves, a Curly Wurly and was deliberately given Skips crisps by MS. MS was most likely directly responsible for the majority of the PN and line disconnections, PEG removals, line removals (see above) and she sought to blame HS for the same and / or she failed to prevent HS from engaging in behaviours that put his life at risk by damaging and disconnecting his lines.

10. By fabricating, exaggerating and/or inducing HS's symptoms over the course of his life up to 19 October 2021, MS has ensured that HS was:

(a) deprived of appropriate developmental and social stimulation, such that he was developmentally delayed beyond what would be expected of a child of his age and prematurity;

(b) denied the opportunity to build relationships with his father and siblings;

(c) caused significant physical harm as a result of inducing physical illness in him, both by administering unprescribed agents and by the deliberate and repeated removal of his tubes and equipment;

(d) caused to suffer Iatrogenic harm by the repeated, but at times unnecessary, invasive medical investigations he was subjected to.

Such deliberate actions placed HS close to death, with palliative care being discussed and as a result of the aforementioned caused HS significant emotional harm.

11. Since MS has been removed as HS's primary carer, namely from 19 October 2021, there has been a rapid recovery from his physical symptoms, such that, very quickly, he was able to tolerate enteral feeds and thereafter the introduction of oral feeds. In addition, there has been a rapid catch up in his growth and improvement in his overall development.

1.3 Wakefield MDC v MT and others

The relevant date on which protective measures were undertaken for LW is 16 November 2021. The relevant date for the older children is 21 February 2022.

As at the relevant date, it is submitted that the child LW had suffered significant physical and emotional harm, and that the children HT, JV, and KV were likely to suffer significant harm, such harm being attributable to the care given to them not being what it is reasonable to expect at parent to give.

The local authority rely on the facts below to support the contention that the statutory threshold is met;

Finding 1 – The mother MT has misrepresented LW's symptoms to medical professionals, either by exaggeration or fabrication. This placed him at risk of an inaccurate diagnosis and inappropriate treatment.

a) On 6 August 2019, the mother reported to Nurse GF that LW was *projectile vomiting twice daily* and coughing during feeds. Dca262
b) On 30 August 2019, the mother informed the health visitor that she expected LW to be registered as blind. Dca255
c) On 26 November 2019, the mother falsely informed the community nurse that LW had had a screaming episode when seeing the consultant last week and that the consultant had advised ibuprofen be given. Dca995, Cce664
d) On 9 December 2019, during the ongoing neurological investigations for LW, the mother reported that he had had vacant episodes, lasting "hours," Dcd1436
e) On 31 December 2019, the mother reported that LW had had diarrhoea for a "considerable duration, 12 weeks?" Dcd2158
f) On 3 August 2020, the mother reported to Dr SAN, that LW had spontaneous circle-like bruising especially at the tops of his legs and lower arm. The resulting haematology has shown no disposition to easy bruising. Dca840
g) During haematological assessment, the mother stated that LW had a history of excessive bleeding and easy bruising, which was not objectively observed. Dca761

Finding 2 – During 2020 and 2021 the mother reported fabricated, induced or exaggerated accounts of gastrological symptoms, which presented barriers to commencing enteral challenge and delayed the commencement of feeding.

a) The mother told Dr SAN on 8 June 2020 that LW had vomiting and loose stools following a few sips of bath water, and gave the misleading impression that the water had caused the symptoms, Dcd1010, Dca882. She repeated this to Dr SAV Dca820, Nurse GC Dca188, and Nurse SAX Cce633e.
b) The mother told Dr SAN on 14 December 2020 that LW had “explosive stools” after licking pizza, Dca770. This gave the misleading impression that the pizza had caused the symptoms.
c) On 22 March 2021, the mother told Dr SAN that she had tried brushing his teeth with a pea-sized piece of toothpaste, and LW had had loose stools, Dcd2088.
d) On 31 March 2021, the mother reported to Dr SAN that LW was having stomach pains and hitting his stomach, Dcd1205.

e) On 7 April 2021, the mother told Dr SAM that LW's medication was giving him explosive stools, Dcd1206.
f) On 12 April 2021, the mother told Dr SAN that his stools remains explosive 1 – 2 times per day, Dcd1209.
g) On 19 April 2021, the mother told Dr SAN that when LW has had food or licked something, he immediately had stools and they lasted for a few hours, Dcd469.
h) On 25 April 2021, the mother told Nurse GC that LW had had an explosive nappy and she thinks he ingested something, Dca114.
i) On 17 May 2021, the mother told Dr SAN that if LW licks something, this immediately causes diarrhoea, Dca639.
j) On 7 June 2021, the mother reported explosive diarrhoea after LW drank blackcurrant juice, Dca631.
k) On 6 September 2021, the mother told Dr SAN that he had picked something up left from his sibling and immediately came down with loose stools and discomfort, Dc568.
l) On 20 September 2021, the mother told a clinician that if LW gets anything in his stomach, he vomits and diarrhoea gets worse, Dcd1293.

The local authority submit that it is open to Court to conclude on the evidence that these accounts were either;
a) genuine but not causally linked to enteral challenges and instead a reaction to something he had been given, therefore induced, or
b) an exaggeration of genuine episodes, and wrongly attributed by the mother to whatever LW had put in his mouth, in order to deliberately mislead the clinicians, or
c) entirely fabricated by the mother, or
d) a combination of a, b and c.

Finding 3 - On 12 September 2021, the mother presented the incorrect and out of date version of the advance care plan to staff at Hospital E, which referred to limitations upon LW's treatment, Ccd14, Ccd109.

Finding 4 – the mother has amended LW's medication regimes without prior consultation and has introduced inappropriate medication, placing LW at risk of physical harm as a result of potential side effects, and causing or contributing to the perplexing symptoms.

a) On 31 July 2019, the mother stopped a trial course of Ranitidine, medication previously prescribed for reflux. On 1 August 2019, the treatment was confirmed as needing to continue, Dcd2589, Dcb61.
b) On 13 August 2019, the mother increased the dose of Baclofen earlier than planned and without prior discussion, Dca259.
c) On 29 – 30 December 2019, the mother administered ibuprofen when it was not prescribed, Dcd7478
d) On 8 – 9 January 2020, the mother administered ibuprofen when it was not prescribed, Dcd7461.

Finding 5 – the mother has induced infection in LW's central line, causing LW's readmission to hospital on 19 September 2020, 8 January 2021, 12 September 2021, repeated line insertions and life threatening sepsis. Annex II sets out the extent of the infections.

a) During the admission 19 September to 3 December 2020, 8 different episodes of bacterial infection were found in LW's line, including bowel flora.
b) LW was admitted on 8 January 2021 with life threatening sepsis. In the admission between 8 January and 22 March 2021, he was found to have 4 episodes of infection, including bowel flora.
c) Blood cultures were taken on 2 March 2021 which were later found to be positive for salmonella and klebsiella. This was introduced into LW's line by the mother at a time when she was aware that an enteral challenge was to be trialled on the 2 March 2021.
d) During the admission 12 September 2021 until 22 October 2021, 5 episodes of infection were identified.
e) On 3 October 2021, LW became unwell with a polymicrobial infection whilst on home leave for approximately one hour. His blood sugar was also found to have dropped, Dcd818. The mother had introduced that infection whilst off the ward.

Finding 6 – The mother has refused to agree to reasonable requests from the treating team, placing barriers in the way of proposed treatment which placed LW at risk of significant harm.

a) On 4 November 2020, the mother refused a request made by Dr SAN to move LW to Ward L, Dcd1025.
b) On 5 February 2021, the mother refused to agree to a short inpatient assessment for LW at Hospital B, Dcd1047.
c) The mother refused to remove herself from the ward for a period of absence when requested by Dr SAA on 21 October 2021, Dcd1421. She has subsequently exaggerated the extent of that request, Ccd16.

Finding 7 – On 22 October 2021, the mother switched LW's pumps off and left his line unclamped, leaving LW without intravenous fluids Dcd5059.

Finding 8 – During 2021, the mother has allowed LW to be exposed to cocaine, either through her own use or that of associates, placing him at risk of physical harm, Ccg544.

Finding 9 - As a result of the induction of infection in his lines, LW has required repeated invasive medical procedures. His hospital admissions have led to him being deprived of social and child developmental opportunities.

HT, JV and KV

Finding 10 - The children HT, JV and KV were likely to suffer significant emotional and physical harm arising from the care given to LW by his mother.

Appendix 2

Witnesses and Anonymisation

Named individuals are expert witnesses (EW) or police officers

Order of Giving Oral Evidence	Anonymisation	Position
1	Dr SA	Paediatric Consultant, SCH, Lead Paediatrician for BR from January 2021
2	Dr SB	Consultant Paediatric Gastroenterologist, SCH, Lead for BR until January 2021, Lead for HS
3	Dr SC	Consultant Anaesthetist and Pain Specialist , SCH
4	Dr AA	Consultant Paediatric Gastroenterologist, Hospital A
5	Dr SD	Consultant Microbiologist, SCH
6	Dr AB	Consultant in Paediatric Infectious Disease and Immunology at Hospital A
7	Dr SE	Senior Clinical Psychologist, SCH
8	Dr SF	Lead Consultant Clinical Psychologist for Paediatrics, SCH
9	Ms SG	Dietician, SCH
10	Ms SH	Advanced Physiotherapist in Respiratory Care, SCH
11	Dr AC	Current Paediatric Consultant to BR, Hospital A
12	Dr SI	Executive Medical Director, SCH
13	Nurse SJ	Paediatric Nurse, SCH
14	Ms SK	Executive Director of Nursing and Quality, SCH
15	Nurse SL	Lead Safeguarding Nurse, SCH
16	Nurse SM	Parenteral Nutrition Nurse Specialist, SCH
17	Nurse SN	Staff Nurse, Ward K, SCH
18	Nurse SO	Complex Care Nurse, SCH
19	Nurse SP	Nursing Sister, Ward K, SCH
20	Nurse SQ	Staff Nurse, Ward K, SCH
21	Nurse SR	Senior Staff Nurse, Ward K, SCH
22	Nurse SS	Staff Nurse, Ward J, SCH
23	Nurse ST	Staff Nurse, Ward J, SCH
24	Ms SU	Advanced Occupational Therapist (Neuro-Oncology Team), SCH

25	Dr SV	Consultant in Paediatric Palliative Medicine, SCH
26	Dr SW	Consultant Paediatric Immunology, Allergy and Infectious Diseases, SCH
27	Nurse SX	Staff Nurse, Ward K, SCH
28	Ms SY	Speech and Language Therapist, SCH
29	Nurse GA	Paediatric Nurse/Community Generic Nurse
30	Nurse SZ	Lead Nurse for Haematology & Oncology and Co-Author of Root Cause Analysis
31	Dr SAA	Consultant Paediatric Gastroenterologist, SCH
32	Dr SAB	Paediatric Gastroenterology Registrar, SCH
33	Dr BA	Anaesthetic Clinical Fellow, Hospital B
34	Dr BB	Consultant in Paediatric Gastroenterology, Hospital B
35	Dr SAC	Paediatrician with Speciality in Gastroenterology, SCH
36	Ms SAE	Ward Manager, Ward J, SCH
37	Ms GB	Health Visitor
38	Nurse GC	Community Children's Nurse
39	Ms GD	Occupational Therapist
40	Ms GE	Physiotherapist
41	Nurse SAF	Clinical Specialist Pain Management Nurse
42	Nurse CA	Paediatric Nurse, Hospital C
43	Nurse GF	Neonatal Outreach Sister
44	Nurse SAG	Staff Nurse, Ward J, SCH
45	Nurse SAH	Staff Nurse, Ward J, SCH
46	Nurse SAI	Staff Nurse, Ward J, SCH
47	Nurse SAJ	Staff Nurse, Ward J, SCH
48	Nurse SAK	Staff Nurse, Ward J, SCH
49	Dr SAL	Paediatric Gastroenterology Registrar, SCH
50	Dr SAM	Consultant Paediatric Gastroenterologist, SCH
51	Dr SAN	Consultant Paediatric Gastroenterologist, SCH, Lead for LW
52	Dr SAO	Designated Doctor for Safeguarding, SCH
53	Nurse SAP	Staff Nurse, Ward J, SCH
54	Nurse SAQ	Ward Manager, Ward K, SCH
55	Dr FA	Consultant Paediatrician, Hospital F
56	Nurse SAR	Staff Nurse, Ward J, SCH
57	Nurse SAS	Staff Nurse, Ward J, SCH

58	Ms SAT	Healthcare Support Worker, Ward J, SCH
59	Nurse SAU	Deputy Director of Nursing, SCH
60	Dr SAV	Consultant Paediatric Neurologist, SCH
61	Nurse SAW	Senior Staff Nurse, SCH
62	Nurse SAX	PN Clinical Nurse Specialist, SCH
63	Nurse SAY	Staff Nurse, Ward J, SCH
64	Nurse SAZ	Staff Nurse, Ward J, SCH
65	Professor Shepherd	Consultant Gastrointestinal Pathologist and Consultant Histopathologist (EW)
66	Nurse SBA	Senior Staff Nurse, Ward J, SCH
67	Nurse GG	Staff Nurse, responsible for reviewing BR's Comprehensive Health Assessment Plan
68	Mr Lander	Consultant Paediatric Surgeon (EW)
69	Dr Rajendran	Consultant Medical Microbiologist (EW)
70	Dr Alwan Walker	Consultant Radiologist (EW)
71	DC Gibbons	South Yorkshire Police
72	DC Kirby	South Yorkshire Police
73	Mr Johnson	South Yorkshire Police
74	GNA	Former Guardian of BR
75	SWA	SW, Leeds CC
76	PC Bazley	South Yorkshire Police
77	Dr Ward	Consultant Paediatrician (EW)
78	Professor Johnston	Consultant Toxicologist (EW)
79	Professor Sullivan	Consultant Gastroenterologist (EW)
80	Sophie Jones	Forensic Scientist. Eurofins Forensic Services (EW)
81	Dr Dunham	Consultant Clinical Psychologist (EW)
82	MGMR	Maternal Grandmother Family R
83	MR	Mother, Family R
84	FR	Father, Family R
85	MS	Mother, Family S
86	FS	Father, Family S
87	NT	Half sister of LW
88	AC	Carer for JV and KV, close friend of MT, sister for FW
89	FW	Father of LW
90	MT	Mother of LW