Neutral Citation Number: [2018] EWHC 4020 (Fam)

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/02/2018

Before:

THE HONOURABLE MRS JUSTICE KNOWLES

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Fact Finding: Fabricated induced illness

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Miss Jacqui Gilliatt and Miss Bibi Badejo for the Applicant
Ms Jo Delahunty QC and Miss Manjeet Kaler for the First Respondent
Mr Paul Storey QC and Mr Stephen Chippeck for the Second Respondent
Miss Isabelle Watson and Mr James Norman for the Third and Fourth Respondents

Hearing dates: 27 November 2017-15 December 2017; 15-17 January 2018

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APPROVED JUDGMENT

If this Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE KNOWLES

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

Mrs Justice Knowles:

INTRODUCTION

1. Over a period in excess of three weeks, I have conducted a fact-finding hearing in care proceedings relating to two young boys, X, born on 28 May 2013 and thus 4 years 7 months old, and Y, born on 12 January 2016 and thus almost 2 years old. The focus of that hearing has been to establish whether, on the balance of probabilities, Y suffered significant harm due to his mother's interference with his medical treatment. In summary, the local authority alleged that the mother exaggerated and/or fabricated reports of Y suffering vomiting and pain; that she caused him physical pain whilst he was feeding; that she interfered with his feeding lines; and that she contaminated those lines so as to cause infections.

2. No findings were sought by the local authority against the father. The Children's Guardian supported the making of findings as sought by the local authority.

3. This case demonstrates all too clearly the difficult task faced by the court when it is asked to determine the cause of harm to a very young child in circumstances where (a) that child had pre-existing health problems; (b) much, though not all, of the alleged harmful behaviour took place at times when Y was a hospital in-patient on a busy children's ward; and (c) much of the evidence relied on by the local authority was circumstantial in nature. Numerous nurses and doctors stated that they had no reason to be concerned about the mother's behaviour and regarded her as a committed and caring parent. Throughout the mother vehemently denied harming Y in the manner alleged by the local authority.

4. As MacDonald J observed in paragraphs 5-6 of Cheshire East BC v PN and Others (Finding of Fact) [2016] EWFC 61, it is axiomatic that a judge trying a case such as this was not present with Y at all times so as to witness the events in issue when they occurred. Though this case was superficially distinct from those cases where children are harmed in the family home by their carers in that there was evidence from witnesses unconnected with the family, nevertheless the court remains heavily reliant on all the witnesses but especially on Y's carers giving a truthful and frank account of what occurred.

5. When deciding matters in dispute, the court is not required to determine what did happen as a matter of objective truth – it cannot do so because the judge was not present to witness the events in issue as they unfolded. Rather, the court must determine what is more likely than not to have happened having regard to the totality of the evidence available.

6. In determining the issues of fact in this case, I have carefully considered 9 bundles of documentary evidence together with photographs and video material produced by the mother. In addition, I have had the benefit of a bundle containing a detailed medical chronology prepared by the advocates together with a variety of other case management material. All of the advocates assisted me by making detailed written submissions and speaking to those submissions.

7. I heard oral evidence from the expert instructed in these proceedings, Dr Yadav, a consultant paediatrician. Additionally, I heard from a number of medical personnel

who were involved in Y's treatment during his admissions to three different hospitals, namely Dr F (consultant microbiologist), Dr G (paediatric gastroenterologist), Dr U (consultant paediatrician), Dr B (consultant paediatrician), Dr D (paediatric surgical registrar), Dr P (consultant neonatologist), Dr H (consultant paediatric gastroenterologist), and Mr D (consultant paediatric surgeon). I also heard oral evidence from nursing and other health personnel who had been involved with Y namely, Nurses B, Neale, L, W, O, G, H and T. I also heard from SP, Y's health visitor, and from CS, a paediatric dietician. Finally, I heard from both the mother and father and from a friend of the mother's, LW.

8. I also had the benefit of a number of statements from witnesses who were not called to give oral evidence, namely Dr S, Dr V, Nurse C, Nurse WE, Nurse R, Nurse C, Nurse S, Nurse A, Nurse WA, Nurse SH, Nurse WAL, Nurse M, Nurse BR, and Nurse CA. I have considered all of this material in coming to my conclusions.

9. This judgment is very lengthy. That was necessary not only in order to adequately address the history and submissions made by the parties but also to do justice to the complexities of Y's presentation over time. I have anonymised the identities of the family and of the three hospitals where Y was treated in order to prevent identification of him and his brother.

10. I want to pay tribute to the advocates who appeared before me and who, I understand, were instructed in either late August or early September 2017. The circumstances in which they were instructed were not promising as, despite the very best endeavours of Her Honour Judge Lazarus, it was painfully apparent that the evidential issues in this case had not been appreciated or grappled with by those previously instructed. All of the advocates worked extremely hard to make sure this matter was capable of being heard at the end of November 2017 and in January 2018. That was no easy task for reasons which will become obvious from this judgment. Further, throughout the hearing, they have co-operated with each other and with the court in matters great and small to the ultimate benefit of the children with whom I am concerned. I am enormously grateful to them.

11. This case has caused me some disquiet. What follows are some observations about case management in cases where fabricated induced illness is suspected.

12. It is apparent that those originally instructed failed at an early stage to grapple with what was evidentially necessary for the proper resolution of the issues in this case. Cases as complex as this one require careful analysis by all the advocates on issue of the proceedings and on an ongoing basis thereafter. That analysis should be driven by the local authority and focussed on what is required to prove the allegations it makes about a parent's behaviour towards a child. The early collection of medical notes and reports is vital as is obtaining statements from relevant medical and health personnel. A significant proportion of this work was not done until about two months before the fact-finding hearing was due to commence.

13. Early identification of what expert evidence might assist the court is also particularly important. In this case the parties were in early agreement that a report from a paediatrician was required but, despite it being evident that Y's treatment focussed on his feeding and the gastroenterological response thereto, none of the advocates then instructed appeared to consider that an expert report from a paediatric

gastroenterologist might assist the court. Though Part 25 of the Family Procedure Rules 2010 requires the court to control the expert evidence it receives and to determine that only expert evidence necessary to assist the court in resolving the proceedings is adduced, cases of factitious or induced illness are ones in which the necessity for expert evidence is often self-evident. These cases axiomatically often involve children with significant medical histories and with a wide range of actual as well as alleged medical problems. Given that, the court is likely to be assisted by expert evidence - in many cases not limited to the instruction of a paediatrician - to illuminate and refine the forensic issues.

14. I note that, at the very start of the proceedings, it was evident from the report of Dr H, consultant paediatric gastroenterologist, dated 29 March 2017 that the hospital had concerns that the mother may have been contaminating Y's central venous catheter. No microbiology report which addressed this issue was filed until 19 September 2017 and, as will be apparent from this judgment, I found myself unable to rely on its conclusions. The absence of any medical report addressing this issue - on which the local authority sought findings - until September 2017 illustrates the lack of thought given to the evidential issues in this case at an early stage. The late arrival of the consultant microbiologist's report in September 2017 also prejudiced any application - consistent with the fact-finding hearing starting in late November 2017 – of an expert paediatric microbiologist.

15. Finally, even if it might have been thought advisable to await the view of Dr Yadav, the paediatrician instructed as an expert in these proceedings, as to whether the instruction of another expert or experts would be of assistance, he was never asked to inform the parties at an early stage if this might be desirable. That omission from the letter of instruction was ill-advised. By the time Dr Yadav's first report was available in late July 2017, time for the identification and instruction of a paediatric gastroenterologist and/or a paediatric microbiologist was extremely limited if not impossible.

THE BACKGROUND

Family Composition and present Care Arrangements

16. The mother of X and Y is A who was born on 21 July 1990 and is thus 27 years old. The children's father is B born on 21 June 1985 and is thus 32 years old. The father is an electric and gas engineer who works between 8am and 5pm on weekdays and who is on call once a month at weekends. He shares parental responsibility with the mother for both children. The parents met in about 2007 and began cohabiting initially at the paternal grandparents' home before moving to a property owned by the paternal grandfather. They rented that property first before purchasing it in 2016. On 2 September 2017 the parents separated in circumstances which did not have bearing on the matters of fact which I was invited to determine.

17. X is presently in the care of his father who has been living with the paternal grandparents since 11 May 2017. X is the subject of an interim supervision order. Y is in the care of the paternal grandparents and is the subject of an interim care order. The mother has contact with both boys which is supervised by the local authority.

18. Care proceedings commenced on 5 May 2017 and this matter was case managed by HHJ Lazarus before transfer on 31 August 2017 to the High Court for a fact-finding hearing.

12 January 2016 – 2 June 2016: Hospital 1

19. Y was a premature baby, born at 34 weeks gestation on 12 January 2016 at H1. He spent two weeks in neonatal care and required support with his breathing though he was not intubated. He was fed orally and by 10 days old he was taking bottle feeds and was discharged home on 23 January 2016. His weight at that point was 2.24 kg.

20. Following discharge, Y had several readmissions to H1 with reported episodes of vomiting and breath holding. Some of these episodes were associated with Y not feeding and vomiting. On 14 February 2016 Y was diagnosed with gastro oesophageal reflux disease ["GORD"] and was admitted to H1 on 14 February 2016 for nasogastric ["NG"] feeding. On admission Y was described by his mother as vomiting and making high pitched crying noises. Y was discharged on 19 February 2016 when he weighed 3.18 kg.

21. On 26 February 2016 Y was seen with his mother by the health visitor, SP. The mother reported that Y held his breath for over 20 seconds many times during the day and night and had not gained weight in over a week. The health visitor noted that Y was covered in many layers of blankets with a vest, babygro, cardigan, and outdoor suit. She advised the mother to remove the excess layers of clothing and, once this was done, Y was seen to be awake alert and active. During their discussions, the mother reported that she only gave Y lactulose (a medication to help with bowel movements) every five days even though this had been prescribed to be given twice a day. The health visitor advised the mother that she should give Y all medication as prescribed.

22. Y's admissions to hospital with a variety of symptoms reported by his mother continued. These symptoms included abnormal body movements followed by floppiness; breathing issues; and coughing and gagging.

23. On 15 March 2016 Y was seen in clinic by Dr P, consultant neonatologist, in the light of his frequent admissions to hospital. The problems at that consultation included conjunctivitis, suspected bronchiolitis with breathing difficulty, breath holding spells, constipation and inconsolable spells of crying. Despite all this apparent sickness Y was still gaining weight and taking bottle feeds. He was prescribed anti reflux medication and further lactulose for suspected constipation. On 23 March 2016 a barium meal swallow test confirmed that Y had GORD though there was some confusion in the medical records about the degree of the reflux disorder noted at this test. I note that on 20 April 2016 Y was seen by Mr D, consultant paediatric surgeon, who concluded that Y had significant GORD. Mr D felt it might be necessary to consider surgical intervention, for example, a fundoplication, if medical management of Y's GORD failed. A fundoplication is a surgical procedure whereby the upper part of the stomach is wrapped around the lower end of the oesophagus and stitched in place, thereby reinforcing the closing function of the lower oesophageal sphincter and preventing vomiting.

24. On 5 April 2016 Y was admitted to hospital, his mother reporting that he had a temperature, constipation, had not eaten for six days, had noisy breathing, apnoeic episodes, black stools and was vomiting after his feeds. In hospital Y tolerated NG feeds but was unable to take his feeds orally. ENT investigation showed no obvious pathology which would account for the reported breathing difficulties although Y was observed to have a slight deviation of his nasal septum. Y was discharged on 10 April 2016.

25. On 29 April 2016 following several intervening attendances at hospital, Y was admitted because of excessive vomiting and not feeding well as reported by his mother. On admission Y was started on NG feeds but he continued to vomit as reported by his mother who was resident with him in hospital. On 30 April 2016 Y's weight was 6kg. On 2 May 2016 a naso-jejeunal [NJ] tube was inserted in order to help Y feed. A NG feeding tube is placed through the nose into the stomach and is used to convey food into the stomach. By contrast, NJ feeding is a method of feeding directly into the duodenum bypassing the stomach. A feeding tube is inserted via the nose through the oesophagus, the stomach and into the duodenum. An x-ray is required to confirm that the naso-jejeunal tube is correctly sited.

26. On 5 May 2016 an x-ray confirmed that the NJ tube was correctly sited and Y had a contrast study which showed that there was no obstruction of feed through that tube. Shortly after Y returned from these investigations, his mother reported that Y had pulled out the NJ tube. The tube was repassed and a further x-ray was taken in order to confirm that it was correctly sited. On 6 May 2016 Y was reported by his mother to have pulled out the NJ tube again whilst she was out of the cubicle. The tube was reinserted and once more an x-ray was required to confirm that it was correctly sited.

27. By this time nursing staff had become concerned about the number of times the mother was reporting that Y was vomiting as nursing staff had not witnessed Y vomiting themselves. There were also concerns about the frequent dislodgement of Y's feeding tubes. A decision was taken to commence safeguarding notes in order to monitor the situation.

28. On 7 May 2016 Y had not been fed since 6.30am so that the NJ tube could be inserted deeper into Y's stomach. Feeding was restarted at 12.30 pm but within 20 minutes Y's mother had reported a large vomit on the bed. At that stage only 4 mls of feed had been given. The amount of feed given appeared to be inconsistent with the large wet area on Y's cot sheet where he was said to have vomited.

29. On both 8 May 2016 and 9 May 2016 Y's NJ tube became displaced and needed to be reinserted. On 10 May 2016 whilst the mother was bathing Y, Y was said by her to have pulled out both his NG tube and his NJ tube. On the evening of 10 May 2016, the mother showed nursing staff a large vomit on an incontinence pad but nursing staff were concerned that the smell of that vomit was of formula milk and that it did not smell of Neocate or digested milk (Neocate being the type of feed Y was being given).

30. On 11 May 2016 the mother showed nursing staff another incontinence pad with Y's vomit on it. The pad was weighed and the amount of vomit was said to be 98mls. This vomit occurred some 45 minutes after Y had started feeding again following a break from feeding of 2 ½ hours. Y was being fed at a rate of 25mls an hour. Earlier that

morning the mother had produced another incontinence pad with vomit on it but the vomit was noted to be freezing cold and not warm as might have been expected if it had come from Y's stomach. The vomit also did not smell like Neocate formula.

31. On 13 May 2016 Y's naso-gastric tube was on free drainage and the secretions appeared to be pink in colour. The mother claimed these were bloody but nursing staff noted that the secretions smelled like a summer fruits drink which was in the cubicle.

32. By this stage the paediatric team treating Y had decided that he needed to have a 24 hour pH study with three days off anti-reflux medication. To that end Y was discharged on 16 May 2016 with NJ feeding and a pH probe in situ. The probe was to be removed on 17 May 2016. Y's weight on discharge was 5.54kg. The pH study did not show appreciable GORD but this result was considered to be inconclusive as the presence of a NJ tube may have affected the outcome.

33. Y was readmitted to hospital on 17 May 2016 with vomiting. On 18 May 2016 Y saw Mr D, consultant paediatric surgeon, and Professor B, consultant at H2. As the pH study did not indicate that surgery was needed, it was felt NJ feeding should continue in hospital in order to inform a decision about surgical intervention. Though the mother was keen to go home with Y, she accepted the plan for Y to be monitored in the High Dependency Unit [HDU]. The feeding plan for Y was to increase his NG feeds whilst gradually reducing his dependency on NJ feeding.

34. On 25 May 2016 Y's progress was reviewed by Mr D, Dr P and Dr S, an associate paediatric specialist doctor. Y had tolerated NJ feeds despite further instances of these tubes being dislodged but he had not tolerated NG feeds. He was however no longer losing weight. The plan was to discharge him home with a NJ tube in place but no NG tube. His weight was to be monitored and he could be offered a small bottle of food for comfort as he had taken bottle food from the nurses whilst on HDU. If this plan to medically manage his reflux failed, the paediatric team would consider surgical intervention. On discharge Y weighed 5.4 kg.

35. Y was brought to hospital on 27 May 2016 as his mother reported that the NJ tube was blocking and that he had had a blood-stained stool with mucous. Y had lost weight [5.28 kg]. Whilst at the hospital, Y took two feeds from the bottle without problem. He was sent home to return for a weight check on 29 May 2016 but, if he lost weight or failed to gain weight, he was to be re-admitted for close observation of his feeding.

36. On 29 May 2016 Y once more returned to the ward with his mother and was found to have lost yet more weight [5.18 kg]. It was decided to remove his NG tube and feed him by bottle with close observation by nursing staff. Over the next three days Y was observed to feed well and importantly he gained 300g during this time. However, on 31 May 2016 having agreed with Dr P that Y would stay in hospital until 3 June 2016, the mother took Y home later that day saying that X was missing her. She agreed to return for Y to have daily weight checks.

37. On 1 June 2016 the mother reported that Y had been vomiting and was extremely unsettled. She felt that the transition from tube to bottle feeding had been too abrupt for Y. Y had lost 100g in weight over 24 hours. The mother refused to allow Y to be admitted overnight against the advice of Dr S. After a meeting with Dr P, the mother

agreed to bring Y to the hospital on the following two days for weight checks. Dr P recorded her in the medical notes as being keen for a referral to another clinician.

38. On 2 June 2016 Y was brought to the hospital and had lost weight from the day before. The mother reported him as being distressed on feeding and arching his back when he did so. The mother wanted Y to have a NG tube and for oral feeds to be introduced more slowly. Whilst the mother was discussing matters with Dr W, the paediatrician on duty, Y was fed a bottle of Neocate feed by Nurse C without showing any distress. After discussion with Dr P, Dr W explained to the mother that Y should be admitted because of concerns about his poor weight gain. The medical notes record that the mother stated she was being accused of starving Y which Dr W denied. Shortly thereafter at 4.30pm the mother took Y and left the ward despite having been told that Dr P would come to see both her and Y at 5.30pm.

39. The mother left H1 and went to Accident and Emergency at H2 where T was admitted. H1 had no further direct involvement in Y's care after this date. H1 staff informed H2 staff about their concerns relating to Y's poor weight gain and about the safeguarding incidents which they had documented. They also informed the local authority about those concerns and attended a strategy meeting on 15 June 2016 at H2.

2 June 2016 – 21 November 2016: H2

40. It is plain from the H2 medical notes that the mother took Y there because of her unhappiness with H1. Almost immediately Y had a NG tube inserted and was admitted. On 3 June 2016 Nurse C spoke to Nurse E at H2 about H1's concerns and suggested she liaise with her safeguarding team. Dr U, the consultant paediatrician who was responsible for Y, was told about H1's safeguarding concerns but felt that Y's ongoing vomiting and irritability justified the re-insertion of a NJ feeding tube on 5 June 2016. On handover to Dr B on 6 June 2016, Dr U considered that Y had improved on tube feeding and that there were no obvious concerns about the mother's care evident at that time. Y had put on weight by 7 June 2016 [5.57 kg]. Though Dr U told me in his oral evidence that, in the light of H1's concerns, he had directed close monitoring of the mother and Y by staff, the medical record contained no specific reference to the need for close monitoring arising from the concerns expressed by H1.

41. On Monday 6 June 2016 Y's care was taken over by Dr B, consultant paediatrician. Dr B became aware of H1's concerns early that week though he did not acquaint himself with the details given by Nurse C. He accepted in his oral evidence to me that there was no specific nursing plan at H2 to address H1's safeguarding concerns. Until his discharge on 15 June 2016. Y was fed through the NJ tube and appeared to respond well as his weight continued to increase [5.71 kg].

42. On 15 June 2016 the local authority convened a strategy meeting which was attended by staff from H1 and H2, social workers and a representative from the police. The meeting was to address the concerns raised by H1 that Y was a victim of fabricated induced illness by his mother. It was apparent during that meeting that H2 paediatricians were of the view that there was nothing to support H1's concerns given what they had seen of Y and his mother. Dr B described the mother as being accurate and truthful with better knowledge than the nurses and said he had no concerns about

her. Significantly, the meeting recorded that staff at H2 had told the mother about the referral to the local authority though Dr B said this was done in error.

43. The meeting concluded that the threshold was not met for a child protection investigation by the local authority and decided that a child and family assessment would be undertaken by the local authority. Both Dr P and Dr B were in agreement with the plan and with the need for close monitoring.

44. It is noteworthy that the meeting considered the displacement of Y's feeding tubes which had been an issue whilst he was an inpatient at H1. Dr B said that the tubes had been attached differently after he had discussed this with the mother and, since then, H2 had had no problems with Y's feeding tubes being displaced. Dr B said it would be concerning if the tubes suddenly fell out as, though tubes do come out, this did not happen very often.

45. Y was discharged home on 15 June 2016 with his NJ tube in place. On 19 June 2016 Y was taken to hospital to have his NJ tube replaced. His mother reported that he had pulled it out. On 23 June 2016 Y was taken to hospital by his mother as he had apparently pulled his NJ tube out once more. By late June 2016 the paediatric team at H2 decided that Y needed to be admitted to the ward every week day for a period of a fortnight, the aim of this admission being to remove all feeding tubes and to allow Y to be fed by bottle only. The day admissions began on 27 June 2016 but were not a success. By 4 July 2016 the mother wanted a NG tube to be reinserted she felt Y was very unsettled and did not look well. Dr B attended the ward to speak with the mother in order to reassure her about the feeding plan. The following day the mother spoke with CS, the paediatric dietician, and told her that she felt Y was worse on bottle feeds and weaning foods. Y had not been brought to the ward that day by the mother who had told ward staff she was unhappy with the plan and would wean Y at home but would come in to see the doctors at the end of the week. She had also told Nurse T by text on 5 July 2016 that she would wean Y at home rather than come into the hospital. CS suggested to the mother that Y could be admitted without her on the ward in order to offer her some support. On 6 July 2016 the maternal grandmother spoke with CS and reported that the mother had given Y a rusk and frozen banana, foods which were not on the feeding plan.

46. On 8 July 2016 when Y was seen in clinic by Dr B, he weighed 5.45kg. This was a loss of 350g over the two weeks of the daytime admission which CS described as alarming. A NG tube was re-inserted. Thereafter Y's weight gradually increased though he continued to vomit and also was reported by his mother to have some blood in his stools.

47. In August 2016 Y was admitted to H3 for a pH impedance study to assess the extent of his GORD. A Speech and Language assessment by H3 at that time described Y as being eager to feed from the bottle but after a few sucks he arched his back and cried. The pH impedance study found no evidence of acid reflux but revealed some concern over non-acid reflux.

48. On 25 August 2016 Y went on holiday with his brother and parents to Lanzarote for two weeks. On 2 September 2016 the mother rang H3 to ask for advice about Y's health and spoke to Dr C, a senior house officer. She reported that Y was having bloody, mucous-filled stools. Dr C told her to take Y to see a doctor urgently as he

might need medical intervention. Dr C recorded in the notes that he was little concerned as the mother was reluctant to take Y to see a doctor. He reported this to the ward sister who agreed to contact the paediatric, gastroenterology and the safeguarding teams.

49. An undated entry in the medical records with an unclear signature recorded a telephone call from the mother whilst on holiday in Lanzarote. She stated that Y was spiking temperatures up to 41C and had been admitted overnight to hospital where he was prescribed erythromycin (an antibiotic). He had been discharged but still had a mild temperature and had about 10-12 loose stools containing blood on a daily basis. The mother was advised to take Y back to hospital if his temperature went up or he did not tolerate his nasogastric feed. The mother also spoke to Dr G, clinical fellow in paediatric gastroenterology, on 2 September 2016, reporting that Y had been having frequent loose stools. Dr G advised the mother to take Y to the local hospital for a medical assessment to make sure he was not dehydrated or anaemic. Finally, on 7 September 2016 the mother telephoned Nurse T, paediatric gastroenterology specialist nurse, and told her that Y had been unwell with high temperatures and loose stools. The note of the conversation recorded that the mother stated that Y had been admitted to hospital overnight and had been given intravenous fluids. Nurse T told the mother that she must take Y back to hospital if he was unwell and should bring him into H2 for review immediately on the family's return on 9 September 2016.

50. On 9 September 2016 the mother brought Y to H2 where he was admitted with fever and diarrhoea. The hospital records noted that the mother told staff on admission that Y had been admitted to hospital overnight whilst in Lanzarote with diarrhoea and a temperature. Y's weight on admission had dropped to 5.17 kg. He was discharged on 12 September 2016 on a Neocate feed and it was noted that Y had gained weight whilst in hospital [5.3 kg].

51. On 14 September 2016 Y was seen by Dr G. He was said to be having 5-6 stools a day with blood present in the stool. There was also reportedly some blood in his vomit. The clinical impression was that Y had an anal fissure which could explain the blood in his stools. Blood in his vomit could be attributed to the NG tube and the need for it to be replaced on an almost daily basis. Within 2 days Y was once more admitted to H1 on 16 September 2016 with vomiting and having suffered a choking episode. He had lost weight [5.21 kg]. Y was transferred to H2 and remained in hospital until 22 September 2016. On discharge he had a NJ tube and had gained a little weight [5.31 kg].

52. Mr D saw Y on 5 October 2016 in his clinic. Y continued to be NJ fed but struggled to keep the feeding tube in position. Mr D noted that, when fed into his stomach, Y reportedly lost weight and started coughing and vomiting. Mr D noted that Dr GU, paediatric respiratory consultant, and Dr V, paediatric gastroenterologist, were both of the view that surgery in the form of fundoplication might assist. Mr D indicated his willingness to undertake such an operation given Y's difficulties.

53. On 31 October 2016 Y was admitted to H3 for an upper and lower gastro-intestinal endoscopy, a colonostomy and jejeunostomy extension. This was done on 1 November 2016 and Y was discharged later that evening. The outcome of these investigations showed a degree of inflammation in the oesophagus but nothing else of significance. Y was admitted to H2 on 5 November 2016 with vomiting and required

repositioning of his NJ tube. He was discharged on 9 November 2016. That same day he saw Mr D in clinic who confirmed that, in the view of Y's persistent problems, he would operate to do a fundoplication and PEG insertion. Y's problems were noted to be (a) persistent gastro-oesophageal reflux, (b) the failure to medically manage this condition, and (c) Y's failure to retain his NJ tube.

21 November 2016 – May 2017: H3

54. Y was admitted to H3 on 21 November 2016 and had a fundoplication and the insertion of a PEG on 22 November 2016. A PEG is a percutaneous endoscopic gastrostomy where a tube is passed into a patient's abdominal wall to provide a means of feeding where oral intake is inadequate. On 23 November Y was seen by the dietician and his weight was noted to be 5 kg. The dietetic plan was to start and progress with gastric feeds via the PEG to a more home friendly regime, the long-term aim being to improve Y's growth and reduce his oral aversion to food.

55. Late on 25 November 2016 the mother reported that Y was gasping/retching and gulping and a decision was made to stop his Neocate feeds. He was also said to have had a large vomit that evening. Following discussion, the medical team decided to give dioralyte and to slowly restart feeds. Y vomited several times on 27 November 2016. Unfortunately Y became mildly oedemic and his fluid intake was decreased to resolve this. By 28 November 2016 Dr G reported that Y was vomiting with Neocate feeds and was suspected of having gastroparesis (delayed gastric emptying in which the movement of food from the stomach to the small intestine is either slowed or stopped and which can sometimes occur after surgical intervention). Later that evening Y was reported to have pulled out his NJ tube. Discussion between the surgical team and the gastroenterological team about Y's nutritional plan agreed that he should have a PICC line inserted together with a change from a gastrostomy tube to a gastro-jejeunostomy tube which would bypass the stomach. I note that a PICC line means a peripherally inserted central catheter to provide intravenous access that can be used for a long period of time to give either drugs or nutrition.

56. Mr D and Dr H operated on 29 November 2016 but during the operation stomach stitches separated from the abdominal wall and so a laparotomy (a large incision through the abdominal wall in order to gain access into the abdominal cavity) became necessary. Following the operation Y was seen by the dietician on 30 November 2016 who noted that he had had very limited nutrition since surgery on 22 November 2016. Y was described as very poorly nourished with chronic poor weight gain since birth. The feeding plan was to start parenteral nutrition [PN] which is a method of feeding that bypasses the gastro-intestinal tract. Nutrition is given intravenously where a patient cannot receive food by mouth or into the stomach. PN began to be administered that same day but Y continued to receive no food or liquids orally [NBM].

57. On 2 December 2016 Y continued to be oedematous and so his fluid was once more reduced. His oedema had apparently resolved by late on 3 December 2016 but Y became increasingly unsettled after he was said to have pulled out the cannula which delivered intravenous pain relief and medication. On 4 December 2016 Y was described as inconsolable and continued to be unsettled for the remainder of that day despite regular pain relief given rectally. The notes recorded that the medical team

were unable to pinpoint the cause of his discomfort. Y started having enteral feeds via his jejeunal tube that day.

58. On 5 December 2016 Y was reported to have vomited four times that morning and vomiting continued throughout the day. He did not appear to have vomited from about 28 November 2016 until this date though he had clearly been rather unwell following surgery on 29 November 2016. The reason for Y's vomiting was a matter of concern for the medical team who stopped Y's enteral feeds. Y was said to be unsettled and in pain – Dr SH who examined Y late on 5 December 2016 described obvious weight loss with Y looking like an old man.

59. Y had a barium meal on 5 December 2016 via the jejeunostomy. This showed that fluid emptied quickly through Y's intestines and the contrast dye did not enter his stomach. Mr D's statement explained that there was thus no reason why fluid placed in Y's jejeunum entered his stomach which he then vomited.

60. By 7 December 2016 Y's vomiting had not improved and he was reported as vomiting 7 times that day, the vomit being described as thick and green. He remained NBM though he continued to receive PN. On 8 December 2016 the medical team had decided that if Y continued to vomit, his gastro-jejeunal tube would be removed as it might be keeping his pylorus open thereby allowing him to vomit. Y's appearance that day was described as "cachetic" [a term used to describe physical wasting with loss of weight and muscle mass]. T weighed 5.1 kg. Dr G's entry in the medical record that day noted that, in the light of Y's malnutrition, a decision was taken to withhold surgical procedures for the time being.

61. On 9 December 2016 Y had a mild infection but continued to vomit. His mother described that Y would scream in pain, then vomit and then rest. It is apparent from the medical notes that the clinical team were liaising with Dr U at H2 in an effort to try to understand if Y had any developmental problems which might account for his prolonged vomiting. Any such difficulties were excluded as a result of that liaison.

62. Over the weekend 10/11 December 2016 Y continued to vomit and was crying inconsolably with abdominal pain. That discomfort seemed to resolve when he vomited. Y continued to be fed PN.

63. From 13 December 2016 Y appeared to be suffering from cramp like pains but when the clinical team suggested using gripe water on 14 December 2016 the mother said Y had come out in hives when he had had gripe water in the past. Dr G's entry in the records that day stated that the gastroenterological team were of the view that Y's jejeunal extension was contracting against the stomach and causing his symptoms. The view was that this should be removed as soon as possible. On review by the dietician later that day, it was noted that Y had been unable to feed via his jejeunostomy. He was receiving all his nutrition via PN into his bloodstream.

64. On 16 December 2016 Y had a Hickman line inserted. A Hickman line is along flexible plastic tube inserted underneath the chest wall skin and into the large vein draining into the heart. Its main purposes are to deliver medication, nutrition and to obtain blood sample. Y began to be fed PN via his Hickman line later that same day. Over the weekend of 17/18 December 2016 Y was reported to have vomited several times. By 19 December 2016 the clinical team felt there had been some improvement

in Y's symptoms since his gastrostomy tube had been draining better and Y was noted to be slowly gaining weight. On 20 December 2016 Mr D put a smaller tube through Y's pylorus in an attempt to quell Y's vomiting. However this procedure made no difference.

65. By 23 December 2016 Y continued to be fed PN and remained NBM. On that date he is reported to have pulled out his jejeunal tube. On 24 December 2016 Y's Hickman line was reported to have split at about 10pm so his PN feed had to be stopped. The line was repaired on Christmas Day.

66. On 28 December 2016 Y was running a temperature and his PN nutrition was stopped. A blood culture taken from Y on 27 December 2016 showed two strains of E coli (a normal inhabitant of the gastrointestinal tract) and Streptococcus salivarius, which is part of normal mouth flora. He was immediately started on antibiotics. By 30 December 2016 the clinical view was that Y's PICC line was also infected but it was thought unwise to remove the PICC line that day due to the risk of septic shock and embolism. It is noteworthy that a blood culture taken from the Hickman line on 30 December 2016 showed mixed organisms typical of those found in faeces.

67. On 31 December 2016 the mother asked if she might take Y off the ward for a walk. The Senior House Officer, Dr T, advised the mother not to go as Y had been more unwell with fever the previous day. He told the mother that he would discuss her request with the consultants and if they thought it was in order for her to leave, he would tell her. The mother did not wait to find out what the consultants thought and asked Nurse CAI if she could leave the ward. He considered that Y was well and so allowed the mother to leave. About 15 minutes after leaving the ward and whilst he was in Ronald McDonald House with this mother, Y became unresponsive and stopped breathing. With the help of another parent, Y was brought to Accident and Emergency where he was found to be unconscious on arrival. He responded to stimulation and oxygen via a facial mask. The clinical impression was that Y had suffered septic shock. He was admitted to the Paediatric HDU where he remained until late on 1 January 2017.

68. Y slowly seemed to recover but then appeared to deteriorate on the morning of 4 January 2017 with a low heart rate. This was thought to relate to one of his prescribed medications, hyoscine, which was stopped. Y improved and his PN nutrition was restarted that evening. He was still NBM. On 6 January 2017 Y had his femoral line removed as this was thought to be a probable source of infection and a neck line was inserted in its place. His feeding was also disrupted. On 10 January 2017 Y had a second Hickman line reinserted and a surgical jejeunostomy. During that operation Y was found to have multiple adhesions (scars) between his pylorus and his liver necessitating the widening of his pylorus [pyloroplasty].

69. By 11 January 2017 Y was noted to have had minimal nutrition since 26 December 2016 because of his line sepsis. His need for nutrition was urgent and PN was restarted later on 11 January 2017. Thereafter he remained stable until about 16 January 2017 when he developed another temperature later found to be associated with another line infection. The Hickman line was found to have two strains of E coli as before and Enterococcus faecalis. The reappearance of the E coli bacteria was hard to explain given that Y was on antibiotics.

70. By 19 January 2017 Y's overall nutritional status was deteriorating. He was unable to have PN as his Hickman line was infected and he remained NBM and was not being fed via his jejeunostomy. He had only had 6 days of PN nutrition in the last three weeks and the dietician felt he was severely malnourished. Later that day he had a contrast study which showed a slow transit through his stomach though there was normal passage through his jejeunum. Mr D said he could not explain how feed was entering Y's stomach to be vomited. The plan was to start jejeunal feeds slowly the following day. This did not happen as Y once more developed a temperature that evening.

71. By 23 January 2017 Y's abdomen had become increasingly distended. He restarted jejeunal feeds on 24 January 2017 but vomited several hours later and those feeds were thus discontinued. Y was said to be at very high risk of refeeding syndrome as he had had very limited nutrition for the last month against a background of chronic malnutrition. Refeeding syndrome is a syndrome of metabolic disturbances which occur as a result of restarting nutrition to patients who are starved or severely malnourished or who are metabolically stressed due to severe illness. On 25 January 2017 the clinical team agreed to carry out a variety of investigations to exclude a number of metabolic or other conditions which might account for Y's poor response to feeding.

72. PN was restarted on 27 January 2017 via Y's PICC line but stopped the next day when Y appeared to be unwell with spiking temperature. By 1 February 2017 the need to get some food into Y's digestive system was urgent and Dr H made clear that enteral feeding must not be stopped for minor changes eg small vomits, loose stools and so on. Despite that clear instruction enteral feeding via the jejeunostomy was stopped later that day after Y vomited.

73. Later on 1st February 2017 the clinical team met to consider the cause of Y's difficulties. It was thought that factitious induced illness might explain his repeated e coli infections but all agreed that such a diagnosis should be very low down the list of explanations for Y's problems. The team planned to continue investigating organic causes for Y's problems. I should note that by this date the team agreed that Y had ascites [the abnormal accumulation of fluid in the abdominal cavity] which caused his abdomen to be swollen. By 6 February 2017 Y was discovered to have chylous ascites [fluid containing fat].

74. By 1 February 2017 Y began to have jejeunal feeds and on 3 February 2017 these were to be increased. The mother told staff that evening that the plan was to stop Y's jejeunal feeds for 48 hours. The following morning the mother told the paediatric locum house officer that the surgicial/gastroenterology team were keen to stop Y's feeds over the weekend. Despite the need for Y to be feed enterally, his jejeunal feeds were stopped at 15.30 that afternoon as he was continuing to have small vomits. Vomiting was said to have stopped after the jejeunal feeds ceased.

75. On 6 February 2017 jejeunal feeds were restarted at 16.00 but by the evening Y had vomited 3 times. These feeds were stopped overnight due to Y's vomiting. Further attempts to feed enterally failed on 7 February as Y continued to vomit. By 8 February 2017 Dr H decided to stop the enteral feeds and to conduct further investigations into the cause of Y's gut failure. It was noted that Y had not tolerated enteral feeds since his fundoplication on 22 November 2016.

76. Thus, on 9 February 2017 Y had a muscle biopsy, an open rectal biopsy and an upper and lower endoscopy. The latter revealed no abnormalities in Y's gut and the other investigations likewise showed no abnormalities. Over the weekend of 12/12 February 2017 Y was unwell with another line infection. On 13 February 2017 a review by the dietician recorded Y's weight at 5.52 kg and he was described as looking emaciated. On 15 February 2017 another Hickman line was inserted which allowed Y to have PN that evening.

77. On 16 February 2017 the gastroenterology team decided that jejeunal feeds would restart at 3ml/hour. When Dr G asked for feedback on how Y was doing on this regime, she was told that feeding had not started as the staff were unaware of the plan and the mother did not want feeds restarted in the evening. Dr G spoke to the mother who was very reluctant to start the jejeunal feeds because she felt Y might be in distress. In the light of the mother's reluctance, Dr G agreed enteral feeds could start at 6 am the following day and informed the nursing staff of this.

78. Y began having feeds at 2ml/hour at 6.00 on 17 February 2017 but Y was reported to have vomited after feeding started. By lunchtime Y was reported to have had 4 vomits. Dr G spent some time explaining to the mother the importance of establishing enteral feeding. By 17.36 the mother told Dr G she felt the feeds should be stopped because Y had ascites. Dr G explained the rationale for feeding once more and consulted with her senior colleagues, all of whom agreed that feeding should continue. On returning to speak with the mother, Dr G was told that the feeds had in fact been stopped after Y came back from ultrasound. This was done by the nursing team after discussions with the mother without reference to the medical team. Later that evening the mother explained her concerns to Mr AA, a consultant gastroenterologist, namely that Y vomited and tired himself out. She felt the clinical team were making no progress and felt Y needed a break after multiple episodes of line sepsis to recover whilst having PN. Mr AA acknowledged the mother's frustrations and apologised that H3 had not been able to diagnose Y or make progress with his feeding. He reinforced the importance of enteral nutrition for a healthy gut. It was agreed feeds would be restarted the following day and would be gradually increased.

79. On 18 February 2017 feeds at 1 ml every 3 hours began and were to be increased to 1ml/2 hourly later that evening. The mother did not allow this to happen that evening as she felt Y would not tolerate the increase. On Sunday 19 February 2017 Y's PN line was somehow disconnected even though it was firmly attached an hour earlier. Feeds at 1ml every 2 hours were being given until Y was reported to have produced 5 vomits. Thereupon the feed was reduced to 1ml every 3 hours.

80. On 20 February 2017 Y was described by the dietician as looking emaciated. On 21 February 2017 a safeguarding meeting took place which was prompted by the disconnection of Y's PN line on 19 February 2017 and Y's unexplained increase in vomiting 30 minutes after his enteral feed was increased. For the first time it was noted that only the mother had witnessed these vomits. The agreed plan as a result of that meeting was, amongst other matters, to discuss Y at a further safeguarding meeting and for Y to be observed by nursing staff for an hour after he had been fed enterally.

81. Nurse B was able to feed Y after the mother left the ward at 17.00 and she observed him for an hour after this. Y did not vomit. He had vomited within 30 minutes of two earlier enteral feeds that day though neither occasion of vomiting was witnessed by nursing staff. Later that evening the mother became upset after she had spoken with Mr D, saying that she felt Mr D had no trust in her and everyone was pinning the blame on her. She said she wanted to transfer away from H3. Mr D had spoken to the mother and said he could not explain why Y was having such large vomits as were reported and that Y required closer observation so that his vomiting could be seen. It was suggested that the mother video Y vomiting on her phone. The mother agreed to do so but on 22 February 2017 Mr D was told that the mother had refused to allow him to treat Y any longer. Y's surgical care was thus transferred to Mr AA.

82. On 22 February 2017 Y was reported as screaming uncontrollably and arching his back and drawing his legs up after he had been fed. This was unusual so the nursing team informed medical staff. Notwithstanding this information, the medical team stated that Y's feeds were not to be stopped. That was reiterated following a safeguarding meeting that morning which, amongst other matters, recommended a plan for Y to be closely monitored and observed.

83. The events which followed on 22 and 23 February 2017 are matters which are hotly in dispute. What follows is a brief summary. I will return to these matters later in this judgment.

84. Later that day Nurse O gave Y his feed. Whilst she was doing so she noticed the mother's hand moving under the blanket covering Y's lower limbs whereupon he started to scream. She spoke to the nurse in charge about what she had seen and was told to observe the mother. At the next feed the same thing happened. Finally, when giving a feed in the presence of Mr AA, Nurse O said she noticed the mother digging her nails into Y's back to make him scream as milk was being given. Nurse O later reported seeing a red mark and old nail marks on Y's foot which she showed to her colleagues. No records were made of any of these issues at the time by any member of staff.

85. That night the mother refused to allow Y to have his enteral feeds. The following day, 23 February 2017, Y's screaming during a feed was witnessed by Nurse N, a student nurse and the mother's friend, LW. Nurse N recorded that the mother had her hand under the blanket she was using to comfort Y each time the feed was given. At 21.35 Nurse G gave Y a feed in the presence of the mother, a student nurse and Ms LW. Nurse G recorded her suspicion about (a) the mother's insistence that she had been told by the doctors to cuddle Y as he was being fed and (b) the mother's hand being under the blanket which covered Y's leg. As soon as Nurse G announced Y's feed had finished she saw movement under the blanket and Y screamed. Nurse G believed Y was being hurt by his mother and told the nurse in charge who asked her to look at Y's leg. Nurse G saw a pin prick mark on Y's leg and told the mother she would get a doctor to come and see Y as he was so upset after his feed.

86. Dr D, specialist registrar, was told about Nurse G's suspicions. She went to examine Y whilst speaking to the mother about Y's feeding. She did not see a red mark on Y's left leg but saw some marks apparently associated with his injections. Whilst she was examining Y, Dr D noticed that the mother had her hand under the blanket over his arm and when Dr D moved the blanket away she saw the mother tightly

gripping/digging her nails into Y's left wrist. As the blanket was removed, the mother started to stroke Y's arm whereupon he immediately stopped crying and was relaxed and settled. Y was examined later that night by a surgical registrar who did not see any suspect red marks or scratches.

87. The following day, 24 February 2017, the mother was told about the allegations that she had hurt Y and she asked for Y to be moved to another hospital. A decision was made for the mother to be supervised at all times when with Y and to exclude her from caring for him. The matter was reported to the police and to the local authority. The father took over care for Y and Y was transferred to a different ward.

88. Y began having enteral feeds at 9 am on 25 February 2017. He did not vomit at all that day. I note here that Y is not recorded as having vomited more than once or twice during the period from 24 February to 4 May 2017 when he was discharged from H3. His enteral feeds were increased on 1 March to 5mls/hour and on 2 March he was tolerating 8mls/ hour. By 3 March 2017 it was reported that Y had been enjoying food tasting sessions, had shown an increase in stamina in physiotherapy and had been engaging in play activities at a higher developmental stage than had previously been observed.

89. On 7 March 2017 Y had an operation to repair a hernia which was discovered the previous day. He continued to suffer from chylous ascites but this did not prevent him from tolerating enteral feeds at a significantly increased rate compared to when he was in the care of his mother. By 10 March 2017 Y's weight was beginning to increase at a good rate and his measurements on height, weight and head circumference centiles were improving.

90. On 8 March 2017 the parents made a complaint about many aspects of Y's care at H3. That complaint was answered and resolved on 17 July 2017 in circumstances where only three of the parents' complaints were found to be warranted.

91. On 16 March 2017 Y had another line infection with enterococcus faecalis found in his Hickman line. Though he had a brief temperature spike with this infection, Y seemed to get over it quite quickly. On 19 March 2017 Y's Hickman line was found to be stretched and to have a hole in it.

92. By early April 2017 Y's chylous ascites was improving. This condition had meant that Y was unable to have enteral feeds from mid-March until 10 April 2017, thereby slowing his weight gain. After mid-April 2017 Y made good progress and was discharged to H2 on 4 May 2017 weighing 7.54 kg.

SOME PRELIMINARY OBSERVATIONS

93. Y was a child who was visible to both the community and to the hospital health services. At no point in the chronology I have outlined, did his mother refuse visits in the home from SP, the health visitor. Y spent lengthy periods in hospital as an in-patient and was presented to hospital whenever his mother (if not hospital staff) thought he was unwell. When the mother was unhappy about the care given by H1 and by H3, she made her discontent plain to staff. She did not attempt to conceal from H2 that Y had been receiving care from H1 when she took him there on 2 June 2016.

94. The care that Y received from H3 was the subject of a complaint by the parents made on 8 March 2017. The parents complained about 13 aspects of Y's care, only three of which were upheld by H3's internal reviewers. The first matter upheld was when Y was fed 24 hours' worth of PN over a 3 hour period because of a nursing error. H3 accepted the error and apologised unreservedly. It likewise offered a fulsome apology when the parents complained about a nurse falling asleep on 4 March 2017 when that nurse should have been supervising the mother's care. Neither of those matters bear on the findings I am invited to make though the remainder of the parents' complaints do touch upon some of the issues which I will need to determine.

95. Ms Delahunty QC submitted that, in addition to those matters accepted by H3 set out in its response to the parents' complaint, H3 did not come to this case with an unblemished record of care. She relied on the evidence of Nurse B who had given one example in her oral evidence of poor hygiene and dressing management on the ward. I do not accept that submission. H3 acknowledged its failings in its response to the complaint but the overwhelming content of the written and oral evidence before me underlined the high standard of care Y received from dedicated and caring medical and nursing staff.

96. I record here that there was no evidence before me that the mother's care of X, her older son, had been anything other than loving and appropriate. X also had reflux disorder but the mother was able to manage this condition in him without frequent resort to medical services.

97. No findings were sought against the father. He adopted a neutral position in this litigation for reasons which are entirely understandable. When these legal proceedings are long over, he and the mother will still be the parents to X and Y. His response to the findings in this judgment will form a very important part of my assessment at the welfare stage of these proceedings.

THE MEDICAL EVIDENCE

98. I address the evidence of the treating clinicians and then that of Dr Yadav, the consultant paediatrician, instructed by the parties and approved by the court, to provide a paediatric overview in this case.

Dr P, Consultant Neonatologist, H1

99. Dr P had been involved in Y's treatment since birth because of his prematurity. He confirmed that GORD is common in premature children but usually self-resolves. In his opinion, Y had GORD based on (a) his presenting symptoms such as arching his back when being fed and the difficulties he had in feeding and (b) the barium meal swallow test results in March 2016. I note that Dr P questioned whether all Y's reported symptoms were truly present. He confirmed that NG tubes can be easily dislodged and come out of place whereas NJ tubes – as their lower end is sited deep in the digestive system – are more difficult to dislodge. It would be unusual and difficult for a 3-4 month old child to dislodge a NJ tube. He had never been made aware that the mother had removed Y's NJ tube when she had seen it dislodged.

100. He had established a good working relationship with the mother in contrast to the difficulties she apparently had with the paediatric team at H3. On 31 May 2016 he had

attempted to reassure the mother and persuade her to keep Y in hospital for observations. He confessed surprise that she had left the hospital less than 1 hour later as he thought his proposal for Y to remain an in-patient had been accepted by her.

101. He confirmed that the minutes of the safeguarding meeting on 15 June 2016 were accurate. He contrasted the clinical experience of Y available to H1 with that available to H2 who, he said, made a very quick decision that there were no concerns about Y's mother. Had he been confronted with the concerns of H1, he would have been mindful of these and made careful observations about Y and his mother. He stated that staff at H2 had quickly rejected the information shared with them.

Dr U, consultant paediatrician, H2

102. Dr U had only fleeting involvement with Y and his mother. He was the paediatric consultant on call and was involved with Y from 3-6 June 2016. He had some minor involvement with Y after that date.

103. Dr U was made aware of H1's concerns and said he asked for there to be close monitoring of the mother and Y. He explained that he understood that Y had been admitted to H1 for a significant period of time and that there were some issues which H1 were unable to explain medically. He contrasted this with the nursing observations made by H2 nursing staff of Y's symptoms which he regarded as genuine medical symptoms. He felt there had been careful scrutiny of the mother's interactions with Y whilst he was in charge.

104. Dr U confirmed that NJ tubes required a bit of effort to dislodge and that it was really difficult for these to come out altogether. It was possible for a severe episode of vomiting to dislodge this type of feeding tube. The mother interjected during his evidence and on behalf of the mother it was suggested to Dr U that the mother would occasionally remove the NJ tube if it had become dislodged and then take Y to hospital. Dr U thought this not unreasonable. The mother's account of this action was confirmed through her lawyers and repeated by the mother to the court directly.

Dr B, consultant paediatrician, H2

105. Dr B was again briefly involved with Y during the time he was an inpatient at H2 from 2-15 June 2016. He also had some brief contact with Y in late June/early July 2016 when there was an effort to feed Y by bottle in the absence of any feeding tubes.

106. Like Dr P, Dr B accepted that GORD was a self-resolving condition which improved with age. He said he had not been told of the full nature of H1's safeguarding concerns and had not read either the notes recorded by the nurse who took the telephone call from Nurse C [H1] or the chronology of concerns sent by the safeguarding paediatrician. Dr B acknowledged that this was an omission in his oral evidence. He also accepted that there was no specific nursing plan to address the concerns identified by H1 with a view to monitoring Y's symptoms and the mother's reporting of them. He told me candidly that he had been influenced by the mother's evident distress at what she said was "chopping and changing" at H1.

107. Dr B accepted that the minutes of the safeguarding meeting on 15 June 2016 were accurate. He described the difference between what was seen at H2 and at H1 as

seeing two different behaviours rather than there being a difference of medical opinion as was recorded in the minutes of the safeguarding meeting. I observe that this is not what the minutes stated.

108. Dr B agreed that the repeated displacements of the NJ tube were unusual because of the length of that tube.

Dr G, specialist registrar in gastroenterology, H3

109. Dr G was involved with Y when he was on both wards at H3. She confirmed that she had never seen Y vomit.

110. She told me that Y's continued vomiting after the fundoplication was clinically perplexing. By 30 December 2016 Y was not tolerating enteral feeds and Dr G agreed that he had made no progress and had not gained weight. This was worrying as she had described Y as being cachetic on 8 December 2016 – in layman's terms, Y was "skin and bones" – and that was, in Dr G's eyes how Y looked throughout his time at H3 until his care was altered in late February 2017.

111. She confirmed that the presence of ascites would not increase or cause either vomiting or symptoms of pain. She accepted that the coiling of Y's jejeunal extension in his stomach on 14 December 2016 may have caused pain but would not cause vomiting.

112. Dr G had seen Y on 31 December 2016 before he left the ward and was clear that she would not have advised that he should go to Ronald McDonald House given that he had line sepsis.

113. Dr G confirmed that in her discussion with the mother on 16 February 2017 she had emphasised the importance of feeding Y through his small intestine. The mother's reason for refusing was that Y's aspirates would increase and this would cause him pain. Dr G considered the mother to have been reluctant to establish enteral feeding on both 16 and 17 February 2017.

Dr H, consultant paediatric gastroenterologist, H3

114. Dr H was the only doctor who gave evidence in these proceedings whose specialism was paediatric gastroenterology. He was clinically involved with Y from 18 January 2017.

115. Dr H confirmed that ascites (including chylous ascites) would rarely cause pain. This would not have caused Y problems with feeding as it did not compress the stomach.

116. By 8 February 2017 Dr H confirmed that the clinical team could not explain why Y continued to vomit and undertook a large number of investigations to exclude rare conditions which might cause Y's symptoms such as pancreatic disorders. Y had a gut biopsy to find out if he had a metabolic disorder which might cause vomiting and more unusual blood tests were carried out to exclude genetic disorders. All of these investigations were negative.

117. On 23 January 2017 Y had had no enteral nutrition and very limited PN nutrition for the previous month. Dr H described him as "starving" with severe malnutrition, weighing at the age of one year what he had weighed as a six month old child [6 kg].

Dr H was clear that he had told the mother Y was starving but despite this she was resistant to increase his feeds believing this would cause him pain. Dr H explained there was no reason clinically why Y would experience pain on being fed enterally but, if he did experience some pain on enteral feeding, it was better to manage any pain given that the consequences for Y of not being fed enterally were so "dire". Dr H pointed out that the amounts of feed which the team were trying to give to Y were extremely small – 1 ml being about one fifth of a teaspoon – that it made no sense why Y should vomit after such a tiny amount. His evidence was that the mother was in no doubt by 1 February 2017 that Y needed feeding via his stomach despite any apparent pain this might cause him.

118. Dr H confirmed that there was no medical explanation for the cessation of Y's symptoms after 24 February 2017 when the mother's time with him became supervised. He could not think of a gastroenterological explanation for why Y was able to tolerate 15 ml of milk by 1 March 2017 only a week after he had been reported by the mother to experience significant pain on 23 February 2017 when given 1.5 ml of milk.

119. Dr H was of the opinion that the mother "played the gastroenterological and surgical teams against each other". An example of this was the weekend of 3-5 February 2017 when there was confusion over whether the jejeunal feeds should continue. The mother had told the paediatric senior house officer on 4 February 2017 that the surgical/gastroenterological team were keen to stop the feeds.

Dr D, paediatric surgical registrar, H3

120. Dr D had been involved with Y since his admission to H3 and had seen him regularly. Like Dr H, she confirmed that the clinical team were perplexed by Y's presentation especially during February 2017 when his condition continued to deteriorate. No one could explain why he continued to vomit on an almost empty stomach. On 17 February 2017 the mother was advised by Mr AA and Dr D that if enteral feeding was not established, there was a real risk of damage to Y's liver and gut mucosa.

121. On 21 February 2017 Dr D asked for a safeguarding meeting in respect of Y. Her reasons for doing so related both to events on that day and shortly beforehand. Dr D was worried by: (a) Y's overall state of health and the medically inexplicable persistence of symptoms of vomiting and pain with miniscule amounts of enteral feed; (b) nurses stopping Y's feed after an ultra-sound scan the previous Friday based on what mother had told them even though the clinical team had given clear instructions to stop feeds only after discussion with the doctors; (c) unusually the PN line had become disconnected the previous Sunday even though the nurse was happy with the connection; (d) the mother agreed with the feeding plans but then would hinder these being implemented; (e) Y had apparently vomited twice about 30 minutes after his feeds even though he was being fed about a drop of water into his bowel which was some distance from his stomach; and (f) the vomiting had not been seen by the nursing staff.

122. Dr D gave clear evidence about seeing the mother gripping Y's wrist so as to cause him pain on 23 February 2017. She was able to see what the mother was doing without impediment and described how she saw the mother's fingernails digging into Y's arm. She told me that she had not mentioned the mother's fingernails in her

written account because she did not want to incriminate the mother in a way which was unfair to her.

Mr D, consultant paediatric surgeon, H3

123. Mr D was involved with Y from April 2016 when he saw Y in his clinic following a referral from Dr P. He carried out the fundoplication on 22 November 2016 and confirmed that surgically speaking this operation had been satisfactory (as confirmed by the laparotomy on 29 November 2016). A variety of other surgical procedures were carried out in response to Y's continued vomiting and deteriorating presentation. These included the adaptation of the PEG tube into a PEG J tube to provide feed directly through the stomach into the jejeunum on 29 November 2016 and then a surgical jejeunostomy to bypass the stomach altogether. From a surgical perspective Mr D was unable to explain why Y continued to vomit. Additionally, central venous catheters were inserted to allow for PN as enteral feeding was so difficult to establish after the fundoplication. The Hickman line was inserted on 10 December 2016 because of continuing difficulties even after the PEG insertion.

124. Mr D confirmed that, if it had been possible to feed Y via his NJ tube, he would have LWd until Y could sit up before assessing whether a fundoplication was necessary.

125. Mr D told me that he simply could not explain why Y continued to vomit despite all the surgical procedures.

Dr F, consultant microbiologist, H3

126. Dr F reported on the microbes responsible for infection in Y and advice to the clinical team in response. Her own involvement with Y was limited so she could not speak directly to the interface between the clinicians and the microbiologists. She was not an expert witness instructed by the court and prepared her report having been told by Dr DA, the safeguarding lead consultant, about the safeguarding concerns. She specialises in neonatal and adult microbiology but is not a paediatric microbiologist. She explained that it was unusual for a hospital to have a specialist paediatric microbiologist if it was not a specialist children's hospital but H3 did have a paediatric microbiologist. She was asked to assist the court by Dr DA because the paediatric microbiologist was unavailable.

127. Dr F explained how the microbiological samples were tested in order to exclude false positives. It is clear that clinical urgency meant that samples were taken and tested regardless of the gold standard which might be preferred in a forensic setting.

128. Dr F identified two episodes of infection which could not adequately be explained – on 30 December 2016 when Y's Hickman line was found to have organisms typically found in faeces and on 17 January 2017 when his Hickman line was found to have organisms again typically found in faeces. The presence of these organisms could not be explained by line infection or infection from a deep source within Y such as that associated with a gut perforation. Dr F was of the view that accidental contact with faecal matter on the ward would not explain the presence of these micro-organisms since the Hickman line itself would have to be breached as well to allow the organisms to penetrate. This might happen if the line split or if the hub became disconnected. Additionally, the presence of such organisms was not understandable

given that Y was on antibiotics at both times and the organisms detected would have been susceptible to those antibiotics.

129. Y experienced many other line infections but Dr F wisely did not commit herself to identifying the source of those infections as suspicious. She confirmed that, with the exception of those on 30 December 2016 and 17 January 2017, the numerous line infections experienced between December 2016 and March 2017 were explicable and could not therefore be said to be suspicious.

130. However, she noted the number and apparent frequency of intravenous line related bloodstream infections and the presence of apparent breakthrough infections with antibiotic susceptible organisms despite Y having broad spectrum antibiotic cover before, during and after these episodes.

Conclusions: The Clinicians

131. Having listened carefully to their evidence, I found the clinicians who treated Y were straightforward and anxious to explain the often bewildering presentation of this child during the times he was under their care. To each of them the mother presented as a caring parent who was anxious about Y's welfare and they treated Y on the basis that what she reported to them was correct. It was only when (a) her reporting of symptoms could not be clinically explained and (b) she appeared to be resistant without apparent good reason to Y's enteral feeding that their suspicions were aroused. None of the H3 team were able to explain medically how it was that Y recovered so quickly after 24 February 2017.

132. None of these witnesses were motivated to fabricate or embellish their evidence – when unable to answer a question or recall the minute detail of events, each said so clearly. Though Dr H was frank about the lack of trust between the mother and H3, his account of Y's clinical presentation accorded with the medical records and, most tellingly, with the photographs I saw of Y during this time. They show a child who was literally wasting away before the eyes of the staff and of his parents. It was plain to me that Y's presentation during this time was a source of enormous concern to the doctors treating him. I note that, as late as 16 February 2017, the doctors were saying to the mother that they had failed to diagnose what was wrong with Y.

133. There was clearly a difference of opinion between Dr P and Dr B as to whether safeguarding concerns arising from the mother's behaviour existed on 2 June 2016 when Y was taken to H2. Having listened carefully to the evidence on this issue, I was struck by how quickly the team at H2 came to its view. Even allowing for the evidence of Dr U who had recognised the need to monitor the mother carefully, there was no evidence in the medical records from 2 June to 15 June 2016 detailing how this was to be done. The safeguarding concerns raised by H1 do not seem to have been fully appreciated and Dr B told me that he had been influenced by the mother's distress so as to accept her version of events about what had happened at H1. To add to the difficulties, the notes of the safeguarding meeting on 15 June 2016 recorded that the mother had been told by H2 staff about H1's concerns. This was apparently done in error. The medical records do not contain any detail of when or what she was told but it was recognised that this information may have altered her behaviour during this particular hospital admission. For reasons which will become apparent, I am

unable to accept the mother's account that she was told the safeguarding concerns arose from her decision to discharge Y from H1 rather from her behaviour as a whole.

134. Having rejected any safeguarding concerns by mid-June 2016, H2 proceeded thereafter to treat Y's GORD without considering the possibility that what was reported about his presentation might not be entirely accurate.

The Expert: Dr Yadav, consultant paediatrician

135. Dr Yadav is a consultant paediatrician. With the consent of the parties he was instructed by the order dated 26 May 2017 to provide a paediatric overview in this case. His report was to be filed by 14 July 2017. At the time that report was due, Dr Yadav would not have had available to him a comprehensive statement from the mother setting out her case as this was timetabled to be filed and served on 4 August 2017. Dr Yadav was directed to file an addendum report by 28 September 2017 and thus had available to him additional statements from the parents.

136. Dr Yadav's reports are dated 17 July 2017 and 11 October 2017. The later report addressed questions posed by the parties in an addendum letter of instruction. It also detailed but did not comment on the contents of the parents' most recent statements.

137. To summarise, Dr Yadav concluded that, after Y's fundoplication, his presentation could not be explained by any organic cause. His symptoms were rather secondary to or complications of his deteriorating presentation rather than the causes of it. The line infections, chylous ascites and the abdominal distension seen so clearly on the photographs provided to me stemmed from the interventions undertaken during Y's time in hospital rather than the causes for his difficulties in feeding. Dr Yadav excluded all the alternative explanations advanced by the mother for Y's recovery post 24 February 2017 and told me that none of these could provide an explanation for the cessation of Y's difficulties.

138. Dr Yadav's report and evidence were strongly criticised by Ms Delahunty QC. I summarise the main features of her submission as follows. She said that Dr Yadav failed to properly evaluate the mother's written evidence, particularly her alternative explanations as to why Y got better after 24 February 2017, in his second report. He had simply failed to consider her case as he should have done. He had also formed a view that Y had been the victim of physical assault by his mother on 22/23 February 2017 and justified that view on the basis that medical staff (including nursing) should be believed above non-medical witnesses. He had failed to identify any contra indications to the allegations of abuse and had mis-stated the evidence against the mother by using absolutes such as 'vomits had never been witnessed' and 'pain on feeding had never been seen'. His approach to this case had not been that required of the independent expert. Ms Delahunty QC commented adversely on Dr Yadav's experience of factitious illness disorder in that he had seen two such cases as a clinician and two as a court-appointed expert. In one of those cases he had been the subject of adverse criticism by Hayden J but had not been previously aware of the same [Westminster CC v M, F and H [2017] EWHC 518 (Fam)]. The criticisms made by Hayden J were put to Dr Yadav by Ms Delahunty QC. Her submission was that Dr Yadav had fallen so far short of what was expected of an expert that I should disregard his evidence in its entirety.

139. Unsurprisingly the local authority and the children's guardian said that, notwithstanding some problems with Dr Yadav's approach, I should rely on his evidence. His assessment was fair and balanced in that, despite the possibility of earlier reports of vomiting being exaggerated by the mother, Dr Yadav concluded that Y had genuine symptoms of reflux disorder such that the decision to treat by way of a fundoplication was well founded.

140. I find myself in agreement with Hayden J when he stated in paragraph 28 of Westminster CC v M, F and H [see above for reference] that:

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

I have regrettably come to the conclusion that I cannot rely on Dr Yadav's report and evidence in this case. As a whole, both his report and evidence failed to demonstrate the searching independent scrutiny required in a case such as this. My reasoning is as follows.

141. First, though I have already commented upon the disadvantage occasioned to the contents of Dr Yadav's first report by the absence of a comprehensive statement from the mother, Dr Yadav's failure to address her explanations for how Y came to recover post 24 February 2017 was a serious omission from his second report. Though he summarised this aspect of the mother's case in his review of the new material provided to him, he did not comment on it at all within the body of his report. The first time the mother heard Dr Yadav's view about this aspect of her case was when he was being asked questions by the local authority. That was profoundly unfair to the mother who was entitled to know what the expert made of this issue before he went into the witness box. Dr Yadav told me that he had complied with the instructions posed to him, namely to answer the questions posed by the parties in the second letter of instructions and do no more. He did not consider that more was required of him than this. That approach seems to me to ignore the expert's duty to take account of all the material facts when coming to his opinion [see paragraphs 4.1(g) and 9.1(f)(i) of Practice Direction 25B of the Family Procedure Rules 2010]. It should have been obvious to Dr Yadav that this aspect of the mother's case should have been addressed in his second report whether or not he was asked a question about it. Had he been unclear whether he should address this issue as he was not specifically asked about it in his second letter of instruction, it was open to Dr Yadav to clarify this with the lead solicitor. He did not do so.

142. Second, Dr Yadav had come to a clear view that the mother had assaulted Y as described by a number of nurses and Dr D. He told me that he had not believed this was a matter in dispute which I find astonishing given the way in which the mother has consistently denied causing Y any harm whatsoever. Dr Yadav's explanation for so doing, namely that the accounts of health professionals should be believed in preference to those of lay witnesses suggested a mind closed to the possibility that health staff may have, for example, been mistaken in what they saw. Though this

would not be the first occasion in which an expert has strayed into territory which is that of the judge and ultimate decision maker, I was troubled by the assumptions driving Dr Yadav's conclusion on this particular issue and his failure in the witness box to appreciate what was contested by the mother despite having had sight of the voluminous material in this case.

143. Third, Dr Yadav's admitted to me during cross-examination by Ms Delahunty QC that he had failed to carefully and correctly summarise the contents of the medical records for example by stating that no one [the father or medical staff] had seen Y vomit after the fundoplication. This was clearly inaccurate given the contents of the father's statement and that of Nurse N. His report also stated categorically that Y had not been seen to have pain after feeding. This again was inaccurate and Dr Yadav admitted that he had overstated this feature of the medical records. Though these are but two examples, I formed the view that Dr Yadav had not been as careful in his analysis of the medical records as was consistent with the duties placed on a court-appointed expert. The matters complained of were not trivial – they lay at the heart of the mother's case.

144. Whilst Dr Yadav's opinion accorded with that of the treating clinicians, that coincidence does not mean that I should rely on his evidence given the matters outlined above. I regret having reached this conclusion especially in a case as complex and unhappy as this one.

THE NURSING AND OTHER HEALTH EVIDENCE

145. I record that no nurse from H1 was called to give oral evidence before me. Nevertheless, I have taken careful account of the statements of Nurse C and Nurse WE whose evidence is thus unchallenged.

SP, Health Visitor

146. SP had relatively little contact with Y as he spent so much time in H1. She told me that she had no problems communicating with the mother who would let her know how Y was getting on. From her observations she saw no difficulties in the mother child relationship and the mother appeared to accept and follow her advice, for example, on 2 March 2016 when SP, on observing Y to appear unwell and to have problems breathing, advised the mother to take him to hospital.

147. When SP saw Y on 26 February 2016, the mother told SP he had severe constipation but said she was not giving Y the prescribed amount of lactulose. SP advised her to follow what had been prescribed and the mother said she would.

148. On 7 July 2016 SP saw Y with his parents and brother. The mother reported that she was struggling with the feeding plan at H2 and felt Y coped better if he was fed by tube a little at a time. SP advised the mother to feed Y a little at a time over a two hour period.

Nurse H, H2

149. Nurse H was briefly involved with Y towards the end of his June 2016 admission to H2 and again briefly in September 2016 when she cared for him on 9 September

2016. She confirmed that in June 2016 Y had his own cubicle on the ward which had a door and blinds at the internal windows. This was sited at the end of the ward, the nurses' station being half way down the ward. He was then moved to a cubicle opposite the nurses' station. Nurse H was aware of some safeguarding concerns but had no real detail about these.

150. Nurse H saw Y vomit after the administration of medication but not after feeding.

Nurse T, H2

151. Nurse T is a specialist paediatric gastroenterology nurse. She saw Y in clinic with his mother over the summer 2016. She observed no safeguarding concerns about the mother.

152. Nurse T witnessed Y dislodging his NJ tube and confirmed this happened suddenly. It was however only slightly dislodged and could be inserted without the need for an X-ray. It was put to Nurse T by Ms Delahunty QC that, if the mother saw numbers on the NJ tube, the mother would take it out. Nurse T was not aware of this and said she would not have advised the mother to do this. She was concerned with the frequency with which Y pulled out his NJ tube as this usually required an X-ray to re-site.

153. Nurse T reported the mother's unhappiness with the feeding plan being trialled at the end of June/early July 2016. The mother refused to bring Y into the hospital after 4 July 2016 for ongoing daily observation of his feeding. At that time the plan was for Y to be weaned as Dr B explained to the mother on 4 July 2016 when she seemed happy for this to continue. The mother told Nurse T by text on 5 July 2016 that she would keep Y at home until he was due to see the consultant. When Y saw the consultant on 8 July 2016 he was fitted with a NG tube. Nurse T thus did not witness Y's apparent problems as reported by the mother which led to the re-instatement of tube feeding.

154. Despite cross-examination to the contrary, Nurse T was also clear that the mother had rung her on 7 September 2016 to report Y's diarrhoea whilst the family were on holiday in Lanzarote. Nurse T was clear that the mother had said Y had been admitted to hospital and had been given IV fluids.

CS, paediatric dietician, H2

155. CS had contact with Y in out-patient clinics and also on the ward. She found the mother personally engaging when they spoke and had no safeguarding concerns.

156. She spoke about the failure of the weaning plan and expressed surprise that the mother had not followed her advice about the weaning food to give to Y (the grandmother having told her on 6 July 2016 that the mother had given Y a rusk and frozen banana rather than the recommended baby rice or the specialist Neocate weaning foods). CS confirmed that Y would not have been harmed by what the mother gave him.

157. She was surprised that Y failed to gain weight despite all the interventions he had at H2.

Nurse B, H3

158. Nurse B provided a great deal of care to Y during his in-patient stay from late November 2016 onwards. She confirmed that latterly Y occupied a cubicle right by the nurses' station.

159. Nurse B had never seen Y vomit though she had cleared up after Y had vomited. She explained that when Y's tubes were on free drainage this was in order to drain his stomach contents. If Y was on free drainage, she found it hard to understand how he would vomit in the way this was reported by the mother.

160. She confirmed that, though nasogastric tubes came out quite often, the same was unusual for a NJ tube. She described how she had made a pacifier from a piece of tube to distract Y when he wanted to fiddle with his tubes. NJ tubes might be dislodged but it was unusual for them to come out completely.

Nurse N, H3

161. Like Nurse B, Nurse N had provided a great deal of care to Y from December 2016 onwards. She was the only nurse who reported actually witnessing Y vomit. This was in early December 2016 when the mother was away from the ward. She had not recorded this in the notes as she was not Y's named nurse that day.

162. On 23 February 2017 Nurse N was conducting a milk trial with Y to see if he could accept a small amount of Neocate milk feed enterally. She had done this many times with other children but Y screamed and appeared to be in considerable distress throughout the trial. She had never seen such an extreme reaction before. Y was being held by his mother on her lap. He had his blue blanket covering his body and his mother's hands were under the blanket throughout the trial. She had noted that the mother's hands were underneath the blanket each time the feed was given in the medical records as this struck her as unusual. She aware of safeguarding concerns and had been asked to note anything unusual.

Nurse L, H3

163. She again had been regularly involved with Y during his lengthy admission. She had never witnessed him vomiting during his stay.

164. She told me that she had not nursed a patient whose Hickman line had split and thought it would take some force to make it do so. She recalled the mother saying that Y had pulled on it but was not asked about whether Y had bitten it. She confirmed that the line was properly secured when the split was discovered [24/25 December 2016].

165. She confirmed that there would be limited bruising at the site of Y's insuflon injection (which was being given to him in mid/late February 2017), She told Ms Delahunty QC that it was unlikely insuflon would be inserted in the area where Y had bruising on 23/24 February 2017 as this would be an uncomfortable place for an injection. She also explained that Ametop cream (a numbing cream used to make injections less painful) can leave a red mark.

Nurse O, H3

166. Nurse O had cared for Y throughout his time at H3 from November 2016 onwards. She got on well with the mother and told me that all the nurses thought highly of her. She had never seen Y vomit. The questions put to Nurse O focussed on what she had witnessed on 22 February 2017.

167. Nurse O was clear that the mother had placed a blanket over Y's leg and that her hand was underneath the blanket. Nurse O could not say what it was the mother's hand might or might not be doing under the blanket but she suspicious about this feature and its possible correlation with Y's expressions of pain on being fed. During both the feeds, the amount Y was being fed was tiny yet Y reacted with apparent pain as soon as the feed was started.

168. During the second feed Nurse O told me that she had a clear view of the mother's hand as she was directly opposite the mother who was on the other side of the bed. Mr AA and his colleagues were standing at the foot of the bed and could not see the mother's hand in the same way that Nurse O could. Nurse O was clear that the mother stopped rubbing Y's back and instead her hand was in a gripping claw like position with her nails digging into Y's back causing him to cry out as if in pain. The mother's nails were not short. Nurse O saw the mother do this each time Mr AA asked Nurse O to push more feed into Y's feeding tube.

169. Nurse O told me that at about 5pm that day she had seen a red nail mark on Y's foot. She accepted that her nursing entry had mentioned marks in the plural but this was wrong. She had asked her colleagues to look at Y's foot which they had done.

170. Nurse O's entry in the nursing notes about this behaviour was found on 24 February 2017. She was very upset by what she said she had seen and had been advised by her manager to record her concerns in an email. She did so and sent this to the ward manager the following day.

171. Ms Delahunty QC took Nurse O to task about her failure to both make a proper note about what she said she saw and to bring this to the attention of the doctors treating Y. Nurse O accepted that she had not made an entry at the end of her shift as might have been expected of Y's named nurse that day and apologised for this oversight. Nurse O said she had been profoundly shocked by what she had seen and suggested that this explained the failure to write the normal entry at the end of her shift. She denied discussing what had happened with the other nurses.

Nurse G, H3

172. Nurse G gave her evidence by video-link. Unfortunately, because of the time delay, her answers were sometimes difficult to hear and she likewise had some difficulty hearing and understanding the questions put to her.

173. Nurse G confirmed that she had spoken with Nurse O about what Nurse O had reported seeing the mother do to Y. Nurse G told me that she had felt more suspicious during her shift on 23 February 2017.

174. Her recollections of what she witnessed the mother do were clear. She had delayed Y's evening feed so that the mother could go out and get a Chinese takeaway meal. Nurse G's evidence was that the mother had her hand under the blue blanket which was positioned over Y's left leg while he was being fed. She was clear that during the feed the mother could not see her as she was standing behind the mother. Ms LW, the mother's friend, was at the foot of the bed. She was clear that Ms LW was incorrect in saying that Y screamed as soon as the feed was set up. Y only screamed once she had told the mother the feed was over and in response to the movement of the mother's hand under the blanket.

175. Nurse G confirmed that she had seen a red mark on Y's left leg when she went to administer medicine and suggested a change to Y's nappy.

Nurse W, H3

176. Nurse W too had cared for Y on a regular basis but had no recollection of ever seeing Y vomit. She confirmed that the mother always seemed happy to care for Y and that she got on well with her.

177. She became concerned about the mother on the night of 21/22 February 2017. At 9.15 pm of 21 February 2017 Y had been reported by the mother to have vomited copiously 15 minutes after his 9 pm feed. During the night whilst the mother was asleep Y had fed without incident and had not vomited. The mother was awake for the 3 am feed on 22 February 2017 and at 3.10 Y began to scream for about the next hour. He was in the same bed as the mother and was covered with a blanket. Nurse W could not remember where the mother's hands were during this time. She told me that she had no idea what was causing Y to scream in this way. The same thing happened with the feed at 6.30 am when Y began screaming at about 6.45 am.

178. Nurse W said that she had spoken about Y's case with friends at work but in response to cross-examination by Ms Delahunty QC she denied that her evidence about what she had seen had been contaminated by these discussions. She specifically denied discussing her evidence with work colleagues.

Conclusions: The Nursing/Health Evidence

179. As with the clinicians, the nurses from H3 were confused about Y's failure to get better and about aspects of his presentation. All conceded that the mother seemed to be a caring parent concerned for Y's welfare. I have also considered written statements from Nurses R, Cn, S, A, WA, SH, WAL, BR, CA and Ward Manager Nurse WH. None records these members of staff seeing Y vomit.

180. I am not satisfied that these H3 witnesses sought to fabricate or embellish their evidence – Nurse O readily admitted discrepancies between her statement and her police statement when these were put to her and Nurse W likewise readily admitted not being able to remember what the mother had been doing when Y screamed after the two feeds early in the morning of 22 February 2017.

181. I was not surprised to hear that some of the nurses had discussed this case amongst themselves in the aftermath of the events of 22-23 February 2017. Several had described being extremely upset and shocked at what the mother was reported to have

done but that is insufficient of itself, in my opinion, to submit that their evidence had been contaminated and was thus unreliable.

THE LAY EVIDENCE

The Mother

182. The mother gave evidence to me for over three days. I acknowledge that this will have been an ordeal for her and I also bear in mind that she was asked to tell me about events which occurred some considerable time in the past. The frailties of human memory are well known to courts up and down the land and I acknowledge these are likely to be magnified by the passage of time.

183. The mother was Y's primary carer throughout and was the only witness who could tell me about all the problems she reported Y to have experienced. She was with him each time he went to hospital and each time he stayed in hospital until 24 February 2017. There is no doubt that Y had GORD which made him difficult and time-consuming to feed. I have taken into account the burden this would have placed upon her at the same time that she was also caring for X who was still a small toddler. In the video material I have seen spanning the period from June 2016 to December 2016/January 2017, I observed the mother often looking drawn and exhausted.

184. In her evidence the mother denied each and every aspect of the local authority's case. As Ms Delahunty QC observed in her closing submissions, she failed to take up any invitation by the court to acknowledge that she had, in good faith, and with the benefit of hindsight, exaggerated or misinterpreted Y's sickness or reaction to food. Her accounts to me of Y's difficulties were essentially unchanged from the accounts given to medical and nursing staff at the time. She did however accept that her inability to tolerate his distress and pain on being fed made her unable to carry through the feeding plan which required him to experience pain before experiencing the benefit of forced feeding.

185. When evaluating the mother's evidence, I have also taken into account that no evidence has been adduced in which the mother has been seen tampering with Y's lines or producing and distributing fake vomit over Y and/or his room. The mother and Y were resident for extended periods of time in hospital and Y was latterly placed in a cubicle right by the nurses' station. Whilst it might be thought surprising that no such behaviour was seen by hospital staff, common sense suggests that children's wards are busy places where staff are simply unable to observe each patient and their carer at length and at all times. The mother herself told me that in H1 the nurses' desk was some distance away from Y's cubicle and staff often did not put feed up on time because they could not hear the alarm going off which would have alerted them to the need to do so.

186. My impression was that the mother is an intelligent young woman. She gave her evidence calmly though there were times when she became distressed, for example, when she acknowledged her error in removing Y from the ward on 31 December 2016. I found that she had a tendency to be evasive or claim forgetfulness when pressed on matters central to the local authority's concerns.

187. There were two matters which troubled me and which have led me to the conclusion that I should approach the entirety of the mother's evidence with considerable caution.

188. First, in cross-examination of Dr U, it was suggested on behalf of the mother that she had removed Y's NJ tube when it became dislodged and she could see the numbers on the tube. This had never been part of the mother's case before Dr U gave his evidence – in fact in her statement she denied pulling Y's feeding tubes out and said Y had done this himself. In the context of Nurse T describing witnessing Y dislodge his NJ tube, the same suggestion was made to Nurse T again on instruction by the mother. Nurse T said she would not have advised the mother to do this and said to the local authority that she had never been told by the mother that she had taken the NJ tube out.

189. However, when the mother came to give her evidence, her position changed and she asserted that the only tube she ever pulled out herself was the NG tube. She said she had simply forgotten to mention this in her written statements to the court. Apart from my concern that the mother had not mentioned removing feeding tubes of whatever description in her evidence before the hearing, I found it difficult to understand why the mother would modify her case that she had removed NJ feeding tubes when these had dislodged. I have come to the conclusion that the mother modified her stance because she realised that removing a NJ tube was far more serious for Y than removing a NG tube because it would require an X-ray to check it was in the right position when it was re-inserted.

190. Second, I found the mother's evidence about Y's health whilst the family were on holiday in Lanzarote wholly inconsistent with the calls she made to medical professionals at the time. The mother told professionals and the medical notes recorded that Y had been admitted to hospital whilst on Lanzarote and had received IV fluids and/or antibiotics. In cross-examination by Miss Gilliatt, she denied giving this account but could not explain why the notes said otherwise. At the time the notes recorded the mother saying that Y had worrying symptoms such as 15 loose stools a day and also blood in his stools. She denied to me that Y had experienced such symptoms on a daily basis. Even allowing for the passage of time, the discrepancy between what she was reported to have said and what she claimed in her oral evidence was happening to Y was stark and unaccounted for by her answers to me. I note that neither Dr G nor Nurse T was cross-examined about the discrepancy between their notes and the mother's account in any detail though the mother sought advice from both whilst she was in Lanzarote.

191. Despite ringing two hospitals and being told she should take Y to hospital, the mother told me that she did not do so. This was because "I felt he looked OK". The father told me that she told him all they needed to do was make sure Y was hydrated. It is beyond doubt that on the family's return from Lanzarote Y was very ill and had lost a significant amount of weight.

192. If the mother's account of Y's symptoms was accurate, it would appear that she failed to seek the necessary medical attention for Y. If it was not accurate, then it appears to be the clearest case of the mother exaggerating to medical professionals both Y's symptoms and treatment whilst in Lanzarote. Overall, her evidence on this particular issue struck me as evasive and I came to the conclusion that she was not telling me

the truth. Nothing about her case explained why it was that Y was so poorly on his return to the UK. Her denial that she was aware of how ill Y was by the time of his admission to H2 on 9 September 2016 struck me as implausible given (a) what she said she saw to those she rang whilst on holiday and (b) her profound involvement with this child's health difficulties prior to that holiday.

The Father

193. The father was not able to help me with the detail of Y's medical problems as Y spent so little time in his care. When Y and the mother were in hospital, the father was at work and looking after X with the help of his parents. He had relatively little contact with the medical staff prior to 24 February 2017. He and X would visit the hospital most weekends.

194. The father told me that Y had feeding problems at home and that he had seen Y vomit at home on many occasions. He had not seen Y vomit at H1 or at H2. He saw Y vomit twice after his fundoplication operation but when he took over care of Y from the mother, Y did not vomit.

195. When on holiday in Lanzarote, the father confirmed that Y had significant diarrhoea but he told me that the mother had told him that she was advised by the hospital in the UK to keep Y hydrated. He was not aware of the advice to take Y to hospital though he admitted being worried about Y during the last 5/6 days of the holiday.

196. It was clear to me that the father was wholly dependent on the mother for information about Y's health, his symptoms, his medical needs and treatment. He told me that he trusted her because she knew all about the medical issues. They had not disagreed about matters concerning Y's health.

197. The father's evidence also laid bare the enormous strain on the family of Y's health problems. He admitted that this had affected his relationship with the mother. He was visibly moved when looking at the pictures of Y in late January /February 2017 when Y looked so skeletal and ill. I formed the impression that he was struggling to understand why it was that Y had been so ill and why he was now apparently healthy and how it was being said that the mother was responsible for causing harm to Y. He was also anxious, in my view, not to say anything overtly critical about the mother.

LW

198. She was the mother's friend and had got to know her when her son and Y were together on the same ward in H3. She has a great deal of experience of caring for a child on PN and of line infections.

199. Ms LW confirmed that she had seen Y vomit whilst he was at H3. She denied that she had seen the mother hurt Y on 23 February 2017 but accepted that Y was under his blue blanket being held by the mother. She confirmed that the blanket remained in place whilst Y appeared to be in pain and accepted that her denial in her statement of the blue blanket being evident was wrong. She also confirmed that Y was settled before the feed began but cried when the feed entered his stomach.

200. Miss LW has a very negative view about the treatment her son received whilst at H3. This negative view coloured the value of her evidence to me and in this regard, I note that she accused the nurses of lying about not witnessing Y in the act of vomiting. Her understanding of the cause of Y's medical problems latterly was flawed in that she told me she believed his problems were attributable to the splitting and subsequent infection of his Hickman line.

201. She had advised the mother not to take Y out on 31 December 2016 and described Y as looking fragile and ill. She blamed the nurses for letting Y leave the ward – "it was 100% a mistake by [the hospital]".

THE LAW

202. I was given what was described as an agreed document setting out the law I needed to apply. What follows draws on that document with some modifications of my own.

203. To establish the threshold criteria, I need to be satisfied that Y is suffering or is likely to suffer significant harm and that the harm or likelihood of harm is attributable to the care given to the child or likely to be given if the order is not made, not being what it would be reasonable to expect a parent to give [section 31(2), Children Act 1989].

The burden and standard of proof

204. The burden of proof is on the local authority. It is for the local authority to satisfy me, on the balance of probabilities, that it has made out its case in relation to disputed facts. The parents have to prove nothing and I must be careful to ensure that I do not reverse the burden of proof. As Mostyn J said in Lancashire v R [2013] EWHC 3064 (Fam), there is no pseudo-burden upon a parent to come up with alternative explanations [paragraph 8(vi)].

205. The standard to which the local authority must satisfy the court is the simple balance of probabilities. The inherent probability or improbability of an event remains a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred [Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35 at {15]]. Within this context, there is no room for a finding by the court that something might have happened. The court may decide that it did or it did not [Re B at [2]].

206. Findings of fact must be based on evidence, and the inferences that can properly be drawn from the evidence, and not on speculation or suspicion. The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and should have regard to the wide context of social, emotional, ethical and moral factors [A County Council v A Mother, A Father and X, Y and Z [2005] EWHC 31 (Fam)].

207. The court is not limited to considering the expert evidence alone. Rather, it must take account of a wide range of matters which include the expert evidence but also include, for example, its assessment of the credibility of the witnesses and inferences that can be that can be properly drawn from the evidence. Thus, the opinions of medical experts need to be considered in the context of all of the other evidence. When considering the medical evidence in cases where there is a disputed aetiology giving

rise to significant harm, the court must bear in mind, to the extent appropriate in each case, the possibility of the unknown cause [R v Henderson and Butler and Others [2010] EWCA Crim 126 and Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam)].

208. The evidence of the parents and of any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them [Re W and another (Non-accidental injury) [2003] FCR 346].

Lies

209. It is common 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 at all times that a witness may lie for the many reasons, such a shame, misplaced loyalty, panic, fear, and distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything [R v Lucas [1981] QB 720]. It is important to note that, in line with the principles outlined in R v Lucas, it is essential that the court weighs any lies told by a person against any evidence that points away from them having been responsible for harm to a child [H v City and Council of Swansea and Others [2011] EWCA Civ 195].

210. The family court should also take care to ensure that it does not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt but should rather adopt the approach of the criminal court, namely that a lie is capable of amounting to corroboration if it is (a) deliberate, (b) relates to a material issue, and (c) is motivated by a realisation of guilt and a fear of the truth [H-C (Children) [2016] EWCA 136, at paragraphs 97-100].

211. In this context I have borne in mind the words of Jackson J (as he then was) in Lancashire County Council v The Children [2014] EWHC 3 (Fam). At paragraph 9 of his judgement and having directed himself on the relevant law, he said this:

> *"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 and relaying the accounts. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person 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."*
>
> These comments strike me as apposite in this case as well as in the cases of death and serious injury to children.

DISCUSSION: Y'S HEALTH

212. Before I address the findings sought by the local authority, the following require my consideration:

i) Y's present state of health;

ii) Y's health after 24 February 2017;

iii) The mother's submission that Y was a medically challenging child;

iv) And the significance of Y continuing to vomit after fundoplication.

Y's Present State of Health

213. I have read a report from Dr H dated 16 August 2017 which was written to Y's GP after Dr H saw Y in clinic on that date. There has been no challenge to its contents.

214. Y looked well and, in Dr H's words, was making rapid progress towards age appropriate eating and drinking. He enjoyed eating solids at meal times and drank ordinary full fat milk three/four times a day. His bowel movements were normal and he did not vomit. He was walking and communicating verbally and was not on medication. Though his gastrostomy was still in place, he had needed no supplemental nutrition via that means. Dr H in fact removed the gastrostomy peg that same day. He concluded that, "as Y no longer has complex nutritional or gastroenterological needs, it will be more appropriate for him to see a local paediatrician for follow-up". Y was discharged from H3 that day.

215. There is no suggestion that Y is anything other than a healthy little toddler who eats and drinks normally without any adverse consequences such as regular vomiting. I have not been told that he suffers from any congenital or metabolic or other organic condition and H3 conducted extensive investigations to exclude the same. The contrast between Y's presentation now and his prolonged ill-health since birth is a very significant feature of this case.

Y's Health After 24 February 2017

216. On 24 February 2017 H3 excluded the mother from providing care for Y and the father took over this role. Strikingly, given the frequent reports of vomiting prior to that date, my analysis of the medical records, for example from 25 February to 15 March 2017, revealed that Y was not recorded to have vomited at all during that time. I note that he had a hernia operation on 7 March 2017 but even this did not cause him to become unwell so that he vomited. The local authority submitted that Y vomited once or twice after 24 February 2017 and I accept that as this accords with the medical records and the evidence I have heard.

217. It is also apparent from the medical records that Y began to slowly gain weight after 24 February 2017. The clear pattern beforehand was that of decreasing weight.

218. None of the clinical team at H3 were able to explain medically how it was that Y's symptoms abated so quickly after 24 February 2017. The mother put forward a number of matters which she said, taken in combination, might do so. These

included: (a) the move to another ward (to which the mother ascribed the greatest significance); (b) a change in Y's medication (domperidone); (c) a new feeding plan; (d) a change in the type of milk Y was given; (e) his hernia operation; (f) the regular aspiration of his stomach so as to remove the contents; (g) the diagnosis of chylous ascites, treatment for which would have reduced the pain during feeds; (h) increased calories given via PN; (i) the use of octreotide (a drug which reduced blood flow to the gut); (j) a change from NJ feeds to feeds via his jejeunostomy; (k) the cessation of milk and oral foods on 23 March 2017; (l) the removal of the NJ tube on 18 April 2017; and (m) an increase in feeds on 19 April 2017.

219. I have concluded that none of these matters either individually or in combination explains what the mother herself described as "huge improvement" in Y's health shortly after 24 February 2017. First, the clinical team's evidence is important – Dr H told me that, on 28 February 2017 when he saw Y on his ward round, Y was doing very well. He looked well and had not been vomiting and the problems seen/reported earlier had stopped. He told me that "we never found a diagnosis to explain this". The improvement in Y's symptoms was thus relatively rapid and predated much of the later events on which the mother relies. Dr H was equally clear that the change in the ward was not significant as both wards had a good standard of care. The evidence was that the feeding plan after 24 February 2017 was the same as had been attempted prior to that date but which had failed.

220. Further, Y was having octreocide prior to 24 February 2017, for example, on 18 February 2017. Y's chylous ascites was not associated with pain on feeding and he had begun to improve prior to his hernia operation on 7 March 2017. The adjustments in the type of feed, the amount of feed, mechanism for feed delivery and the medication used to support feeding (domperidone) I regard as ancillary to the one factor which I am satisfied on the balance of probabilities improved Y's health so quickly, namely that he was actually and consistently being fed enterally. That had simply not happened for many weeks before 24 February 2017 because of the symptoms of vomiting and pain which Y was reported by his mother to have.

221. Finally, to illustrate Y's rapid improvement, the medical records showed that Y was seen on 16 March 2017 by Dr SH, a specialist paediatric registrar. She recorded that Y had gained weight and "looks like a different child" to when she had seen him a month earlier.

Y: A Medically Challenging Child?

222. Ms Delahunty QC submitted that Y was a medically challenging and complex child from birth and that he had an unusual response to medical treatment. I have no difficulty with the submission, based on Mr D's evidence, that Y was a child whose GORD warranted surgical intervention. That seems to me to account for many of the matters set out in paragraph 6 of Ms Delahunty QC's closing submission.

223. However, I have difficulty accepting the wide ambit of Ms Delahunty QC's submission given the significant improvement in Y's health and his response to treatment after 24 February 2017. Y is not a medically challenging little boy now and Ms Delahunty QC has been unable to point me to the presence of an over-arching condition or of a variety of conditions which might explain all of what I have read and heard about Y's health. Y has been investigated for just about every type of organic

condition known to the skilled doctors treating him at H3 which might have explained his response to treatment after the fundoplication. None has been established. I have considered very carefully the possibility that Y suffered from an unknown condition at the time he was an in-patient in H3 but, on the balance of probabilities, Y's presentation at that time and the almost complete resolution of his feeding difficulties are explicable by other factors.

Post Fundoplication Vomiting

224. Mr D accepted that Y had been seen to vomit post fundoplication once by Nurse N and twice by the father. He was unable to explain why Y would continue to vomit after this procedure. Ms Delahunty QC submitted that any vomits after this operation rendered Y's presentation unusual. Whilst that might well be true, Mr D was most puzzled by the sheer number of times Y was reported to have vomited. It is that factor which I too regard as the most puzzling.

225. If Ms Delahunty QC's submission is correct, one might hypothesise that, given the amount of times Y vomited thereafter, this surgical procedure [fundoplication] had failed. It had not as Mr D's evidence made clear – nothing had gone awry with the fundoplication as the operation on 29 November 2017 confirmed. Given that, this aspect of Ms Delahunty QC's case for the mother is really part and parcel of her submission that Y was a medically challenging and complex child who may have been suffering from an, as yet, undiscovered medical condition. Y's response to treatment which was neither novel nor experimental after 24 February 2017 militates against this submission. I have already explained why I do not accept that Y was a medically challenging child in the way Ms Delahunty QC suggested and that reasoning is also applicable to the issue of the post fundoplication vomiting.

FINDINGS: GENERALLY

226. The findings sought by the local authority are numerous. After the hearing concluded, the local authority amended its Schedule of Findings Sought to include matters arising from the evidence. Those representing the mother were made aware of the changes to that document in a timely fashion. Ms Delahunty QC submitted that many of these additional findings were unnecessary given the broad thrust of the local authority's case.

227. I have tried to group my discussion of the findings sought by theme and in date order though there are some which I will need to address separately. I have done so wherever is most convenient in what follows. In coming to my conclusions, I have stood back and taken careful account of all of the evidence before me and applied the law which I have summarised.

228. I have also taken into account that the local authority is obliged to prove its allegations fact by fact and that it must satisfy me that avoidable harm was caused to Y as a result of the facts its seeks to prove. I have also been careful to ensure that one positive finding against the mother does not become a Trojan horse (as Ms Delahunty QC put it) for an inferior set of facts attempting to prove other allegations.

229. Given the complexity of this case, my findings are set out in the annex to this judgment.

Exaggeration/Fabrication of Vomiting

230. Y spent a month in H1 from 29 April to 31 May 2016 (barring one or two very brief stays at home). The unchallenged evidence shows the clinical team to have been very concerned about the number of times Y was reported to vomit. Nursing staff had never seen Y vomit and he was witnessed vomiting only once by a doctor. The mother accepted in her evidence that vomits were rarely seen by staff. When Y was nursed in the HDU between 29 May and 31 May 2016, he was seen to vomit once yet he was reported to have vomited within 20 minutes of the mother being alone with him. When fed by nursing staff, Y took his feed without apparent difficulty and generally did not vomit.

231. The unchallenged evidence is that some of vomit reported by the mother had features inconsistent with actually being vomit. First, a large amount of vomit seen on Y's bed shortly after 1 pm on 7 May 2016 was inconsistent with the 4 mls of liquid which Y had just been fed. I note that Y had not been fed since 6.30 am that morning and so I infer that, in this context, the amount of vomit produced shortly after 1 pm was of concern. Second, some of what was said to be vomit smelled like formula milk or Neocate milk and not curdled milk which is what might have been expected. Third, on 11 May 2016 the temperature of the vomit reported by the mother was freezing cold rather than warm as might be expected. Fourth, the pH of a number of alleged vomits was tested and found to be the same as that of the formula milk Y had been given. That would not be the case if the alleged vomit had come from Y's stomach. The mother accepted that the pH levels found were inconsistent with vomit.

232. The mother's own evidence accepted that the cubicle where she was with Y was some distance from the nurses' station and suggested that this was the reason Y's vomiting was not seen by nursing staff.

233. Ms Delahunty QC cautioned me against making the assumption that output (vomit) was necessarily correlated with input (feed). I have taken this into account as well as the fact that Y had GORD. Nevertheless, I am struck by the fact that nursing staff did not witness what on the mother's account was a significant issue for Y, namely persistent vomiting. Not only did they not see this but their experience of feeding Y was that he took his food well from the bottle and did not vomit. The inconsistent features of what was reported to be vomit and what might have been expected had Y actually vomited are matters for which there is no obvious or sensible explanation.

234. I also bear in mind the mother's admission to me that, on 20 April 2016 when she had reported to hospital staff that Y was pulling his NG tubes out twice a day, this was a "bit of exaggeration". This is an example of the mother misreporting Y's behaviour to medical staff and is directly comparable to a misreporting of symptoms to medical staff.

235. On the balance of probabilities, I am satisfied that the mother exaggerated and/or fabricated Y's vomiting whilst he was an inpatient at H3 in May 2016.

236. Turning now to Y's time at H3, the local authority alleged that between 21 November 2016 (the date of the fundoplication) and 24 February 2017 (when the mother's contact with Y was supervised) the mother made numerous exaggerated and/or fabricated reports of vomiting and Y experiencing pain. It pointed to the evidence

which was that only one nurse had ever witnessed Y vomiting. Ms Delahunty QC cautioned me against accepting at face value the contents of the vomiting schedule produced by the local authority though the mother did accept that there was a significant difference in the number of times she said she saw Y vomit and the number of times this was witnessed by hospital staff. Ms Delahunty QC also pointed to deficiencies in the medical records, for example, Nurse N not making a note of the time she saw Y vomit because she was not his named nurse. She also drew my attention to the video material which showed Y as having vomited.

237. I do not place reliance on the contents of the vomiting schedule for the reasons advanced by Ms Delahunty QC. I have also approached the medical records with a degree of caution given the evidence of Nurse N. However, I am not persuaded that the video material produced by the mother helps me resolve what happened at H3 since there is no video material taken during Y's stay which shows him either vomiting or the immediate aftermath of vomiting. The photographic material does not help me resolve this issue either. I have considered the evidence of the father who saw Y vomit twice very shortly after the fundoplication and that of LW. Ms LW claimed to have seen Y vomit on a regular basis but I have come to the conclusion that her evidence on this issue is not reliable given her evident grievances against H3 staff and her mistaken beliefs about the cause of Y's problems.

238. The mother also suggested that the nursing staff who did see Y vomit during his stay at H3 were simply not prepared to say they did so as, by the time of the hearing, she was viewed by them as the abuser of her child. I reject that submission. The nursing staff were, in my view, very upset by the realisation that Y's failure to get better may have been attributable to the mother's own actions. All had emphasised their belief that the mother was a caring and committed parent.

239. I note that vomiting did not take place when the mother was sleeping either at H1 or at H3. It was also not reported when Y was on holiday in Lanzarote and I note that staff at H2 did not see Y vomit save on one occasion after he had been given medication.

240. I have been assisted in resolving this issue by the accounts of the H3 treating doctors who were wholly unable to explain why Y continued to vomit and who undertook surgical and investigatory procedures post fundoplication in an effort to resolve this reported problem. The barium meal on 5 December 2016 showed no reason why fluid placed in Y's jejeunum entered his stomach which he then vomited. The pyloroplasty on 20 December 2016 made no apparent difference to Y's vomiting and the contrast study on 19 January 2017 left Mr D wholly puzzled as to how feed was entering Y's stomach to be vomited. Y was said to vomit even when he had received no nutritional intake either by way of enteral feeds or PN. Other causes of vomiting were investigated, none producing any explanation for why Y continued to vomit. The absence of any apparent medical reason for Y's continued vomiting at the rate reported by the mother raised the real concern that this symptom was being exaggerated by her. That impression was reinforced by what happened after 24 February 2017 when Y simply stopped vomiting after his mother was no longer involved with his care.

241. I have described why I do not consider the explanations advanced by the mother can account for the virtually total cessation of Y's vomiting after 24 February 2017. That

factor has weighed heavily in my analysis of this issue alongside the other matters I have itemised and, on the balance of probabilities, I have concluded that the mother also exaggerated and/or fabricated the number of times Y vomited whilst he was an in-patient at H3.

Feeding Plans

242. It is asserted by the local authority that the mother failed to carry out Y's feeding plans because of over-reporting of vomiting, claims Y was experiencing pain, and direct challenges by her to the medical and nursing staff.

243. I look first at what happened at H1 at the very end of May 2016. The events of 25 May to 2 June 2016 summarised above demonstrated clearly that Y could feed and gain weight without requiring tubes to do so. The medical records showed that, when he went home during this time, Y lost weight and was reported to be unsettled. The mother was clearly unhappy about bottle feeding and wanted the reinstatement of tube feeding. She plainly refused re-admission on 1 June 2016 when this as recommended by Dr S and gave the excuse of X missing her when she removed Y from the hospital on 31 May 2016, contrary to what had been agreed with Dr P. When told on 2 June 2016 that Y should be readmitted because of his weight loss, she removed him from H1 saying that the medical staff were accusing her of starving Y.

244. There was no challenge by the mother to the above evidence. I found her explanation as to why she had behaved in this way deeply unconvincing despite her evident upset when asked to recall these events. Her excuses about X missing her and being fed up with hospitals seemed to me to be ruses to avoid Y's feeding being monitored and, for reasons which are unclear to me, to achieve her real aim which was the reinstatement of tube feeding. In her evidence to me, the mother accepted that she should have taken the H1 doctors' advice and should not have discharged Y from their care on 2 June 2016. When I look at these events, I conclude that the mother's deliberate behaviour over those days hindered the delivery of the plan to feed Y by bottle.

245. Though not directly concerned with feeding, it is convenient for me to address now the mother's decision to discharge Y from H1 and have him admitted to H2. She admitted to me that this was the wrong thing to have done. In her evidence to me, she claimed that Dr S had been rude to her on 1 June 2016. This was an allegation never made beforehand and which did her little credit given her concession that she had been untruthful to the police in interview on 28 February 2017 by suggesting that she had removed Y from H1 because the staff were "pinning him down" to get him to feed. It was obvious to me from the sequence of events and her evidence that the mother had felt her own behaviour was coming under scrutiny at H1. She asked for a referral to another clinician in circumstances where Dr P's sensible advice to her was that Y's weight required daily checks and where Y had lost weight when he was at home. Her angry and critical behaviour at the hospital on 2 June 2016 was not in response to any fault by the clinical staff but allowed her to walk out of H1 on the basis of a disagreement with the clinical team. Her behaviour prior to 2 June and her behaviour on the day itself spoke strongly of someone putting her own interests to the fore rather than those of her son. I agree with the local authority that she behaved in this way to avoid more intense scrutiny of her feeding of Y.

246. Returning to the feeding plans, the evidence from H2 showed that when the plan was for Y to be admitted daily for a trial of bottle feeding at the end of June 2016, the mother failed to comply with that plan. I find that she did so and reject the explanations she proffered for her behaviour. When asked about this time in her oral evidence, the mother was unable to explain convincingly to me why she had failed to do what had been asked of her. First, she said that she failed to bring Y into the hospital for daily weighing as she had had a row with the father and his parents and thus had to take X to nursery herself instead of relying on them. This practical problem (if not the reason for it) would have been easy to explain to the hospital at the time but the mother did not do so. Then, she told me that Y had refused the baby rice but also screamed when she offered rusk and banana. If that was so, it is difficult to see why the mother would not have sought advice from CS or Nurse T about what else might be tried to get Y to bottle feed. She did not do so. Instead, Nurse T reported the mother asking on 4 July 2016 for a NG tube to be reinserted, a request which was refused. I am of the view that this refusal, coupled with the hospital's advice to continue with weaning and bottle feeding, led to the mother's decision to absent herself and Y from daily visits to the ward until the end of the week when Y was due to see the consultant. By then Y had lost weight and a NG tube was reinserted.

247. During Y's time at H3, the local authority alleged that the mother interfered with feeding plans during the latter part of Y's admission for reasons which are unclear. That interference it said was undertaken by the mother in the clear knowledge that Y had a pressing need for enteral feeding and urgently needed to gain weight.

248. Dr H's evidence was that the mother was in no doubt by 1 February 2017 that Y needed enteral feeding despite any apparent pain which this might causing him. That message was reinforced by Dr G on 16 February 2017 and by Dr D and Mr AA on 17 February 2017. The mother told me that she had forgotten this advice. I do not regard that as credible evidence for the following reasons. By 1 February 2017 the photographs showed that Y had lost weight and he looked very unwell. He had been in hospital for a long time without apparent improvement in his feeding and had spent many days receiving no nutrition at all. The advice from the doctors – none of whom were challenged about this aspect of their evidence – coupled with the evidence of her own eyes could have left the mother, an intelligent woman, in little doubt that Y needed enteral feeding as a matter of the utmost priority.

249. Despite this, the records showed that the mother persuaded the nurses to stop enteral feeding on 4 February 2017 because Y was having small vomits. She had already given nurses inaccurate information about the feeding plan the previous evening by saying that the plan was to stop enteral feeding over the weekend. This cessation of feeding was in defiance of Dr H's instruction that feeds should not be stopped for minor matters such as small vomits or loose stools.

250. The chronology recorded that from 16 February 2017 the mother was resistant to restarting enteral feeding at night. On the following day the mother successfully stopped feeds because she said Y had vomited and tired himself out. On 18 February 2017 the mother refused to have Y's milk feed increased in accordance with the plan as she felt Y would not tolerate the increase and on 22 February 2017 she refused to allow Y to be fed at night.

251. The mother accepted that she should have been stronger in the short term so that Y could have tolerated food in the medium to long term. She also accepted that she should have allowed nurses to feed Y even though she found it very difficult to tolerate his reactions to being fed. She also told me that she believed that Y could get all his nutritional needs met by PN. She said that her interference with feeding plans was not done as part of a deliberate programme of starvation but was done either to give Y an uninterrupted night's sleep or if there were insufficient staff available to aspirate Y as was required by the plan.

252. Given the clearly expressed advice from Y's treating clinicians, it is difficult to accept the mother's behaviour as either being motivated by misguided beliefs about the efficacy of PN or being done to benefit Y in the immediate short term (a good night's sleep). It was suggested to me that, in order to make this finding, I would need to be satisfied that the mother deliberately intended to starve Y. The mother's motivation is not relevant if I am satisfied that, on the occasions about which I am invited to make findings, the mother interfered with his feeding plan and knew that she was doing so against medical advice. Having considered the evidence in the round and on the balance of probabilities, I make the findings sought by the local authority.

Other Medical Issues

253. The local authority sought a variety of findings about medical issues which I have loosely grouped together. It is convenient to deal with these at this stage.

254. The local authority sought a finding that the mother lied to medical staff about taking Y to hospital in Lanzarote. I can deal with this shortly as I have already discussed the evidence about this in my assessment of the mother's evidence. I have come to the conclusion that the mother did not tell me the truth about what happened during the holiday in Lanzarote and I am satisfied on the balance of probabilities that she lied to medical staff about taking Y to a hospital on Lanzarote.

255. Additional findings were sought with respect to the following matters: (a) Y would gain weight in hospital and lose weight when at home; (b) the mother falsely reported symptoms of Y having suffered fits whilst he was under the care of both H1 and H2; (c) the mother exaggerated Y's symptoms whilst the family were on holiday at Butlins in April 2016; (d) the mother exaggerated Y's symptoms during the pH impedance study so as to give a misleading picture to medical professionals; and (e) the mother falsely reported family health history so as to mislead medical professionals.

256. I have decided that, given the findings I make in relation to the mother's conduct towards Y, it is disproportionate to make these additional findings. Such findings if made would not refine the risk posed by the mother to any meaningful extent or assist with any future assessment of her. Further, insufficient evidence has been adduced which either might allow me to establish precisely how a pH impedance study is carried out and what the opportunities might be for the mother to manipulate the same or, for example, permit Ms Delahunty QC to challenge the findings sought in relation to fitting.

Interference with Equipment

257. The local authority alleged that the mother interfered with Y's equipment resulting in several incidents when Y's feeding tubes fell out or were dislodged or contained a foreign substance.

258. The medical evidence was that a child can relatively easily pull out and dislodge NG tubes. Nurse B explained that Y had done so and so she had made a toy from tubing to distract him when he was irritated by a nasogastric tube or other feeding tube. The mother told me that she had removed Y's NG tube when it had dislodged or when it had been partially pulled out. Even though the mother's evidence that she had pulled out Y's NG tube was something she had not said before, my assessment of the medical evidence was that the pulling out or dislodging of NG tubes was not an uncommon event for small children who would be irritated by the presence of a tube in their nose and throat. Given that, it would be unwise of me to make the findings sought by the local authority about the frequency with which the NG tube was dislodged whilst Y was an in-patient at H1 and the mother's responsibility for this occurring. I am however satisfied on the basis of the mother's own admission to me that, on occasion, she removed Y's NG tube when it had dislodged or been partially pulled out but did not tell hospital staff she had done so.

259. NJ tubes are however more difficult to dislodge. That was the evidence of both Dr U and Dr B. Only one member of the medical or nursing staff, Nurse T, had ever seen Y pull out his NJ tube during the entire period with which I am concerned. The mother's oral evidence to me was that she had not pulled out Y's NJ tube and I note that she never told anyone prior to the fact-finding hearing that she had removed either NG or NJ tubes. I have already explained how the mother's position in this regard altered from what was put to Dr U and Nurse T. I concluded that the mother modified her position during the course of the hearing because she realised that removing a NJ tube was far more serious for Y because it would require an x-ray to re-site that tube. These shifts in the mother's position mean that I cannot rely on her denial that she removed Y's NJ tube from time to time. I find that she did so and did not tell either the medical or the nursing staff at H3 what she had done. I find that she was also aware that the NJ tube was a crucial part of the attempt to manage Y's enteral feeding.

260. The local authority sought a specific finding that on 25 May 2016 when the mother was unsupervised with Y she dislodged his NJ tube. Though I am suspicious about this incident, I have concluded that the evidence about it is insufficiently clear for me to make the finding sought by the local authority. I am also not satisfied that I can make the other specific finding sought by the local authority namely that, in H1, the mother was responsible for removing Y's NJ tube at a time when Y was not being observed on HDU because nursing attention was required for another seriously ill child. By contrast when Y was being observed on HDU, his NJ tube did not come out. The records are unclear when this incident occurred and are unclear about how many times the NJ tube was dislodged when Y was with his mother unsupervised.

261. The local authority also sought a specific finding that on 13 May 2016 the mother had put liquid from a summer fruits drink into the drainage from Y's NG tube. At the time the mother told nursing staff that the drainage from this tube was bloody and confirmed that Y had had nothing to eat or drink. However, a number of nursing staff smelt the drainage which had a fruity smell similar to a summer fruits drink which was in Y's cubicle. The nursing evidence on this issue has not been challenged.

262. If the local authority was correct, this was an attempt by the mother to fabricate the existence of blood in Y's NG discharge and thus to mislead clinical staff about Y's health. For reasons which will become apparent later in this judgement, I am unable to make the findings sought by the local authority that the mother contaminated medical equipment resulting in infection to Y. Thus, the summer fruits incident, if I found it had taken place as alleged, would stand alone as an example of the mother introducing a foreign substance into equipment which was part of Y's treatment. This incident was however qualitatively different from those in which lines/equipment were allegedly contaminated simply because the substance introduced into the NG discharge could not have harmed Y directly in any way. Y would potentially be harmed by the mis-reporting of what was said to be in his NG drainage in the same way that mis-reporting of symptoms might lead, for example, to unnecessary medication or intervention. As I understand the local authority's case, foreign substances allegedly introduced into lines/equipment had the potential to contaminate and cause infection thereby directly harming Y.

263. In the light of that analysis and having thought carefully about this incident in the context of my findings about the mother's exaggeration and/or fabrication of Y's symptoms, I find that the mother did behave as the local authority assert. The fabrication by the mother of what she described as blood in the NG discharge went one step further but still part and parcel of her exaggeration and/or fabrication of Y's symptoms.

264. I turn now to findings concerning interference with Y's Hickman line. The first finding sought by the local authority is that the mother was responsible for the splitting of the Hickman line on 24 December 2017 and its subsequent infection.

265. On 24 December 2017 the mother said that she left Y alone for a few minutes and came back to find the Hickman line snapped in half, with a bit of plastic in Y's mouth. In her oral evidence she said there was a lot of blood on Y's mouth and chest. The first mention of blood when the Hickman line snapped was in the mother's police interview in February 2017. At the time she did not report to staff, the father or to her friend LW that Y had blood on his mouth, the inference being that he had bitten and thereby split his Hickman line. The mother told me that she was constantly telling the nursing staff that the Hickman line was stretching (though this is not recorded in the medical records) but confirmed that nursing staff had put extra dressing on Y's Hickman line to stop him pulling at it.

266. Nurse L told me that she had not nursed someone whose Hickman line had split but there was a possibility that this might happen. She told me that to detach the Hickman line would need some force. Her recollection was that the mother had told her that Y had pulled on the Hickman line and thus split it but she could not be sure about this.

267. I remind myself that after 24 February 2017 Y had a split Hickman line on 19 May 2017 whilst in the care of his paternal grandparents. There were also problems with his Hickman line on 19 March 2017 when it was said to be weakened and stretched and to have a hole in it.

268. Having thought carefully about this particular incident, I have concluded on the balance of probabilities that the mother was responsible for the damage to the Hickman line on 24 December 2017. My reasoning is as follows. First, such an

incident was unusual. Second, though it is unclear whether Y had teeth at this time, he had never bitten through a line before and nor has he since this incident despite the mother's assertion that he would often put lines in his mouth. Third, the Hickman line had been secured with extra dressing in order to prevent Y pulling at it and I accept Nurse L's evidence that to detach the line would need some force on Y's part. Fourth, it is inexplicable why on her account the mother left Y alone when she claimed to have been afraid that the Hickman line was not securely attached. Fifth, the mother simply did not mention at the time that Y had blood and plastic in his mouth or indeed that she thought he was responsible for the damage to the line. If this had been the case, I have little doubt that the records would have recorded this. Nurse L was Y's named nurse and thus responsible for making a note about significant matters relating to Y's care that evening but her record is silent as to the reason why the Hickman line split.

269. Y was found to have an infection in his Hickman line on both 29 December 2016 and 30 December 2016. It is not possible on the evidence before me to link those infections to the split in the Hickman line which occurred on 24 December 2016. A blood culture collected on 27 December 2016 showed contamination by bacteria that it was not possible to determine the site from which this blood culture had been collected as this information was not recorded at the time. I thus am unable to find on the balance of probabilities that the mother's behaviour was the cause of line infection to Y.

270. The second incident concerning the Hickman line took place on 19 February 2017. Y's lines were checked at the start of the nursing shift and when his nappy and bed sheets were changed at 10 am. They were securely attached at those times. At about 11 am Y's feeding line became disconnected from the Hickman line and was described as leaking on the bed. Dr D told me that it was very unusual for this to happen but the mother told me that she felt the nurses had not secured Y's feeding line properly. She denied disconnecting the feeding tube herself.

271. All of Y's lines were securely attached and checked several times that morning. I am satisfied that there was no accidental disconnection of Y's feeding line. At the time Y was due to have a bath and, on the balance of probabilities, I have concluded that the mother disconnected Y's feeding line in order to bathe him.

Y's Collapse on 31 December 2016.

272. The local authority invited me to find that the mother knew there was a high risk to Y if she took him off the ward on 31 December 2016. It was also alleged that she failed to seek prompt medical intervention when Y became seriously unwell at Ronald McDonald House and instead made contact with the father and LW by telephone.

273. The mother accepted in her oral evidence to me that she had made a very serious error of judgement in taking Y off the ward on 31 December 2016 and she bitterly regretted doing so. Y had been unwell since 29 December 2016 though, on the morning of 31 December 2016, his temperature was normal and he was alert and smiling. Though Dr T had advised the mother that Y should not be taken off the ward due to the line sepsis which had made him unwell, the mother did not follow that advice and was permitted to leave the ward by Nurse CAI. Y became seriously unwell within 15

minutes of leaving the ward and was taken to Accident and Emergency by another parent.

274. I am not persuaded that it is necessary to make the finding about this incident sought by the local authority. The mother accepted she had made a serious error of judgement in removing Y from the ward. Her panic-stricken phone calls to the father and to her friend when Y collapsed are understandable though her first priority should have been to seek urgent medical attention for Y.

275. The local authority also invited me to find that the mother had interfered with Y's cannula that morning so that she would be able to take him off the ward. The medical evidence was that Y's cannula often tissued such that another site needed to be found in which to reinsert it. In those circumstances, it would be unwise of me to make finding sought by the local authority.

Contamination of Medical Equipment Causing Infection

276. The local authority alleged that the mother interfered with or contaminated medical equipment resulting in multiple unusual and frequent line infections putting Y at risk of sepsis. When investigated, medical staff found six positive blood cultures with gut/stool bacteria including E coli, Clostridium and Strepterococcus salivarius in the Hickman line; E coli in the arterial line; and Candida albicans following line removal. These infections led to surgical procedures to replace the lines, recurrent interruption of intravenous nutrition and long courses of antibiotics for Y.

277. I make this preliminary observation which is that the finding sought by the local authority is too wide in its scope. The microbiological evidence given by Dr F was that there were only two episodes of bloodstream infection - namely that on 30 December 2016 and 17 January 2017 - which were attributable to organisms typical of mixed faecal flora for which there was no obvious source.

278. After challenge to the evidence of Dr F by Ms Delahunty QC in cross-examination, it was accepted by the local authority that I should approach the evidence of Dr F with some caution. First, Dr F was not instructed as an independent expert. Second, she had limited involvement during the time of Y's treatment and so could not speak directly to the clinical/microbiological interface at the time the clinicians were making their assessments. Third, clinical urgency dictated that blood and other samples were taken and tested regardless of the "gold standard" which might be preferred in a forensic setting and which cannot now be made good given the samples taken at the time. Reference to the gold standard is that good clinical practice dictates that two samples should be taken from each source for testing since the reliability of the results depends on the number and source of the samples.

279. I make no criticism of Dr F's expertise and experience. In her evidence to me she quite properly accepted the limits of that expertise and the reliability/ambiguity of some of the testing and the interpretation of it particularly if each test was looked at in isolation. Nevertheless, and in the light of the caution which I was asked to exercise with respect to Dr F's evidence, I have come to the conclusion that the uncertainties about the microbiological evidence are such that I cannot make the findings sought by the local authority even if those findings were to be confined to the two episodes of

bloodstream infection on 30 December 2016 and 17 January 2017. My reasoning is as follows.

280. First, Dr F's view should not be preferred to the microbiologists who gave their opinions at the time taking into account Y's clinical presentation. For example, I note that there was no concern about the presence of enterococcus faecalis found on 17 January 2017 recorded at the time. Second, there was no research data placed before the court so that the significance of foreign or unusual organisms could be evaluated by me. An expert instructed to report as an expert would have done so. For example, it would have been helpful for me to know the prevalence of enterococcus faecalis in a hospital environment. Third, there was no opportunity to instruct a paediatric microbiologist given the late hour counsel with a grip on the forensic issues were instructed. I accept Ms Delahunty QC's submission that the mother should not be penalised by that gap in the evidence which could not be made good by any other evidence properly available to me. The finding sought was that of introducing bacteria into Y's bloodstream – in effect poisoning. So serious an allegation required in my view a safe evidential foundation. That was simply not present here. Fourth, I do not know whether Dr F has been asked in the past to provide an opinion about paediatric microbiology findings with reference to alleged contamination as opposed to such findings having a benign cause. Fifth, there was no letter of instruction which explained to me the basis upon which Dr F was asked to report.

281. For the avoidance of doubt, it thus follows that I also cannot make the specific finding that the mother caused the line infection on 6 January 2017.

Physical assault: February 2017

282. The local authority alleged that on 22 February 2017 during a feed Nurse O observed the mother holding Y's foot underneath a blanket causing him to scream as if in pain. Nurse O looked at Y's foot and noted his foot looked sore with what looked like old fingernail marks. Later that same day Nurse O is said to have seen the mother dig her nails into Y's back causing him to scream. On the following day, 23 February 2017, Nurse G noticed the mother had put Y's blanket over her left hand which was on his leg. Although he had been smiling and playful during the feed, when Nurse G announced the feed was finished there was movement under the blanket and Y screamed. When Nurse G changed Y's nappy she noticed a red mark on his leg. Finally, on 23 February 2017, Dr D went to examine Y. He was crying during the examination and Dr D observed the mother had her hand under a blanket over Y's left arm. When Dr D removed the blanket, she saw the mother had a very tight grip on Y's wrist but when the blanket was removed the mother began stroking Y's wrist. Y stopped crying immediately and was relaxed and settled after this when the mother was no longer touching him and the blanket was no longer covering him.

283. I deal first with the feeds observed by Nurse O. I note that the mother accepted that Nurse O was one of her favourite nurses with whom she had an excellent relationship. Ms Delahunty QC criticised Nurse O's record keeping in relation to both of the feeds which caused her concern. The only entry she made about the mother's care on 22 February 2017 was positive and she failed to make any record until 23 February 2017 about what she said she had witnessed the mother do to Y. Nurse O, it was submitted, did not act consistently with her suspicions and Ms Delahunty QC invited me to

conclude that poor and delayed record-keeping cast significant doubt on the reliability of what Nurse O told me.

284. Nurse O told me that she had raised her concerns on 22 February 2017 with her ward manager. Her ward manager advised her to put her concerns in writing and to send them in an email. The email was dated 23 February 2017 and I have seen a copy of it. It is evident from the medical notes that the entry relating to Nurse O's concerns post-dated the events in question. Whilst the advice Nurse O was given seems to me to have been misconceived and, were the mother to have acted in the way Nurse O alleged, could have placed Y at risk of further physical harm, I consider it unfair to criticise Nurse O for following her manager's instructions. In saying that I am of the opinion that good nursing practice, both for Nurse O and her manager, would have indicated the immediate reporting of and action on Nurse O's observations.

285. Nurse O accepted that she could not actually see what the mother was doing under the blue blanket. She drew a not unreasonable inference that the movement of the mother's hand had caused Y to scream. Her reaction was in keeping with what she believed that she had seen as she left Y's cubicle and asked the doctors to review Y once more and she told her ward manager about what the mother had done. Her ward manager told her to continue with her observations of the mother.

286. During the second feed Nurse O noticed the same behaviour from the mother and the same reaction from Y. Ms Delahunty QC criticised the inconsistency in Nurse O's accounts as to whether she could or could not see the mother's hand in contact with Y's foot under the blankets. On reviewing that evidence, I have concluded that Nurse O was doing her best to answer the questions put to her accurately but was clearly unable to say that she had seen the mother's hand as this was under the blanket. Y's reaction and the movement under the blanket had led her to conclude that the mother was responsible for Y's screaming. Ms Delahunty QC also submitted that during the second feed members of the paediatric team were present but did not appear to have observed anything consistent with Nurse O's observations. There is no entry in the medical records from any of the paediatric team about what they saw during that feed.

287. During the third feed Nurse O was accompanied by Mr AA and three members of his team. This time Nurse O said she saw the mother digging her fingernails into Y's back causing him to scream. Unlike the medical team who were standing at the foot of the bed, Nurse O who was standing on the left-hand side of the bed had a clear view of the mother's hand. Nurse O was also clear that the amount of feed being given to Y was tiny and yet Y experienced pain immediately when she pushed the syringe to start the feed. Her email also indicated that each time Mr AA asked her to push more milk into Y's feeding tube, the mother would dig her nails into Y's back to make him scream.

288. Following this feed Nurse O did not ask a doctor to examine Y. When the mother left Y in her care to leave the ward, Nurse O noticed that Y's foot was red and sore and that he had old nail marks on his right foot. Nurse O showed these to her ward manager and to another member of staff. Criticism was made of Nurse O for failing to have Y properly examined in the aftermath of what she said she had witnessed. I do not know why she did not report her suspicions to the medical staff though I suspect that her responses would have been guided by the advice of her ward manager.

289. Standing back and evaluating the evidence on this issue, I have concluded that on the balance of probabilities the mother did behave during the first two feeds in such a way as to cause Y to scream when he was being fed. I have also concluded that during the third feed the mother did take her nails into Y's back causing him to scream. Though Ms Delahunty QC has made some telling criticisms of the poor record-keeping associated with what Nurse O saw, none of these explain why a nurse with whom the mother had an excellent relationship would accuse the mother of harming Y.

290. I turn now to the incident involving Nurse G. I note that the mother had requested that Y's feed was delayed until she returned to the ward after getting herself a Chinese meal. This was not in dispute. Nurse G was extremely clear about what she had observed and her account of a blanket covering most of Y was supported by the account of the student nurse who was also present during this incident. LW accepted in her evidence that there was a blanket covering Y lying across his legs and moving when he moved. That was not the account that she had given in her written statement. I note that the mother initially denied to the police that there was a blanket though later in her interview she accepted the presence of the blanket but said it did not cover Y's foot.

291. Nurse G made an entry shortly after the incident in the medical records. She accepted that she could not see what was happening underneath the blanket though she was clear that the mother made great efforts to ensure that the blanket also covered her hand. Nurse G explained that she had positioned herself so that the mother was unable to see the syringe which administered the feed to Y. During the feed Nurse G observed that Y was smiling but when she announced that the feed had finished, she saw movement under the blanket and Y screamed out. This continued at intervals though Nurse G tried to move the blanket without success as the mother repositioned it to cover her hand. The student nurse who was present noted that Y started crying shortly after Nurse G said that the feed had started. Nurse G said that she saw a red pinprick mark on Y's lower left leg following this incident. The presence of this mark was not confirmed on examination either by Dr D or the surgical registrar, both of whom examined Y later that night and saw marks on his leg consistent with injection sites.

292. Ms Delahunty QC submitted that the discrepancies between the account given by Nurse G and the student nurse should not be resolved in favour of finding that the mother had indeed assaulted Y in the manner Nurse G recounted. She complained that Nurse G was obstructive under cross examination and that, having discussed with Nurse O on the telephone what Nurse O had allegedly seen during her shift, Nurse G had come to the ward that evening with the intent to prove a point against the mother.

293. I do not share the view that Nurse G was obstructive in cross-examination and have already made reference to the technical problems which bedevilled her evidence via video-link. Discussion between Nurse O and Nurse G is not, without more, sufficient to found the submission that Nurse G's account on the day itself was contaminated and motivated by dislike for the mother. As my analysis of all the findings sought has, I hope, made clear, it is not for the mother to prove her innocence but for the local authority to prove its case allegation by allegation. Having thought very carefully about this incident, I have concluded that there was no reason for Nurse G to invent or exaggerate what she saw and that I can rely on her account made in the immediate aftermath in preference to that of the student nurse made nearly 24 hours later.

294. Finally, Dr D's account of what she witnessed was not undermined by cross-examination. Ms Delahunty QC submitted that Dr D had a genuine and honest belief in what she saw but was mistaken and had been influenced by what she had been told had happened by others. I do not accept that submission. Dr D's evidence was fair and measured and she was clear in her recollection, having had direct sight of what she was seeing albeit for a very short time. She was adamant that she saw the mother gripping/digging her nails into Y's arm and what she saw correlated with Y's reaction. There was no reason for her to be untruthful about what she saw that evening even if there was no apparent injury visible to Y thereafter.

295. Thus, with respect to the incidents of physical assault by the mother, I make the findings sought by the local authority.

CONCLUSIONS

296. Having made the majority of the findings contended for by the local authority, I am satisfied that the mother's behaviour caused or was likely to cause Y to suffer significant physical and emotional harm. That harm was measured by the many unnecessary months in hospital during which Y was separated from X and, notwithstanding the visits made by the father and X to the hospitals where Y was an in-patient, Y was unable to enjoy family life with his father, X, and his wider family. Y also had numerous investigations and interventions - multiple x-rays, biopsies endoscopies, blood tests - in the vain pursuit of a medical explanation for his feeding problems and weight loss. As the events following 24 February 2017 demonstrated, Y's recovery was entirely attributable to the removal of his mother from caring for him which allowed him to be fed enterally for a sustained period of time in contrast to what had gone before. Thus, on the balance of probabilities, I infer that it was his mother's behaviour which accounted for his feeding difficulties and his weight loss. For the avoidance of doubt, I am also satisfied to the requisite standard that surgical interventions – namely, the insertion of the Hickman line on 16 December 2016 and the operation to insert a tube into his pylorus on 20 December 2016, and the pyloroplasty on 10 January 2017 - which took place after 22 November 2016 were medically unnecessary. These procedures were associated with Y's continued inability to feed and his vomiting.

297. To be blunt and as is painfully apparent from the pictures, Y was by late February 2017 a starving child who weighed little more at the age of 13 months than he had done at the age of six months. His well-being was, in my judgement, seriously compromised by the mother's behaviour. It is fortunate that he has made a good physical recovery.

298. The findings I have made will be the basis for further assessment of the mother. The father's response to my findings will also be a matter for me to consider in due course.

299. I was invited by the Children's Guardian in her closing submissions to make some observations about the actions of the hospitals involved and also of children's services. I indicated at the conclusion of the hearing that this was a matter on which I had heard insufficient evidence to be able to make informed and appropriate observations. I remain of that view.

300. That is my decision.

Postscript:

The judge noted that the mother was subsequently charged with child cruelty to Y. She pleaded guilty and was sentenced to two years and nine months imprisonment.

SCHEDULE OF FINDINGS

Exaggeration/Fabrication of vomiting

1. During Y's admissions to H1 between 29.04.16 and 31.05.16, the mother exaggerated and/or fabricated reports of vomiting to medical staff. Vomiting was witnessed on only one occasion by medical staff (and never by the father) and her reports of the vomiting had unusual features inconsistent with it being vomit:
    a. The vomit was of a similar volume/weight as pre-made volume of milk (9.05.16; 10.05.16; 11.05.16);
    b. At pH 9 some of the vomit and milk were the same pH level (8.05.16 at 16:50, 8.05.16 at 19:00);
    c. Some of the vomit smelled like formula milk and not curdled milk or Neocate which Y was being fed (7.05.16; 10.05.16; 11.05.16; 30.05.16);
    d. The temperature of the vomit was very cold on 11.05.16;
    e. On 30.05.16 Y was fed by nurses, settled and did not vomit during the 6 hour period he was being cared for by nursing staff. Within 20 minutes of being returned to the care of his mother she reported that he had vomited;
    f. On 7.05.16 the mother reported vomiting within 15 minutes of Y being fed a small amount of feed.

2. Between 21.11.16 (the date of Y's fundoplication) and 24.02.17 (when the supervision of all handling of Y by mother commenced) the mother made numerous exaggerated and/or fabricated reports of vomiting and Y experiencing pain. Vomiting was witnessed on only one occasion by medical staff. The mother reported symptoms with volumes as small as 0.5 mls and as soon as the feeds were started but the milk had not yet got to Y. The effects of over-reporting vomiting and symptoms were a significant reduction or cessation in the level of feeds, leading to malnutrition, weight loss, associated developmental delay and unnecessary and invasive medical procedure and treatment.

Feeding Plans

3. Y's feeding plans were not carried out as prescribed due to over-reporting of vomiting, claims he was experiencing pain (as set out above) and direct challenges by the mother to medical staff feeding him including:

    a. On 27.05.16 at H1, when it was suggested that Y should be seen alone on the ward so that nurses could feed him and document any associated problems, the mother removed him from hospital**;**
    b. On 16.02.17 the mother was resistant to starting feeds in the evening**;**
    c. On 17.02.17 she asked for feeds to be stopped. The mother was unhappy for feeds to continue and did not want feeds re-started over the weekend**;**
    d. On 18.02.17 the mother refused to have his milk intake increased to 1 ml 2 hourly overnight as requested by Mr AA**;**
    e. On 22.02.17 she refused for Y to be fed at night**;**
    f. Despite the surgical team on 31.01.17 requesting that Ys feed must not be stopped for minor changes such as small vomits, loose stools or increase on

girth, the mother convinced nurses feeding Y that feeds would cause him pain and was successful in stopping feeds on 1.02.17**.**

4. The mother failed to follow the advice of H2 that she should bring Y in daily for weighing at the end of June 2016 and she failed to follow the feeding plan recommended by the dietician.

5. The mother was fully aware of the lack of nutritional intake by Y between 25.12.16 to the end of January 2017 and lied about it to the court in order to minimise her responsibility for his cachectic state and from the knowledge of how detrimental it was to him not to be given milk feeds as soon as possible. She was repeatedly made aware of the serious implications of Y's malnutrition, specifically by the dieticians, Dr D and Dr H.

6. The mother chose to transfer Y's care from H1 to H2 primarily to escape scrutiny and not to promote Y's wellbeing.

Other Medical Issues

7. The mother lied to medical staff about taking Y to hospital in Lanzarote.

8. The surgical procedures which Y underwent on 16 December 2016 [insertion of a Hickman line], 20 December 2016 [insertion of a tube into his pylorus] and 10 January 2017 [pyloroplasty] were not medically necessary.

Interference with Equipment

9. The mother interfered with equipment resulting in several incidents where Y's feeding tube and lines fell out, were dislodged or contained what appeared to be a foreign substance:
    a. On 13.05.16 the NG tube was on free drainage and appeared pink. The mother claimed it was bloody but the smell of the drainage was the same as the summer fruits drink in the cubicle;
    b. On 19.2.17 Y's lines were checked at the start of the shift and when his nappy and bedsheets were changed at 10:00 his lines were connected. At 11:00 Y's PN became unattached from the Hickman line and was in the bed prior to lifting him into the bath. The mother did so in order to bathe Y.

10. On occasion the mother herself removed Y's NG tube when it had dislodged or partially come out but did not tell hospital/medical staff what she had done.

11. The mother removed Y's NJ tube from time to time without telling medical or nursing staff at H3 that she had done so. The mother knew that the NJ tube was a crucial part of the management of Y's enteral feeding.

12. The mother was responsible for the splitting of the Hickman line on 24.12.17.

Physical Assault

13. The mother inflicted pain on Y so that he cried during feeds. On 22.02.17 during a feed Nurse O observed the mother holding Y's foot underneath a blanket and causing him to scream as if he was in pain.

14. On 22.02.17 at 3.30 pm Nurse O saw the mother dig her nails into Y's back and he screamed.

15. On 23.02.17 Nurse G noticed the mother had put Y's blanket over her left hand which was on his leg. Although Y had been smiling and playful during the feed, when Nurse G announced the feed was finished there was a movement under the blanket and Y screamed. The mother caused Y to cry out.

16. On 23.02.17 Y was crying when Dr D went to examine him. Y was crying during the examination and Dr D observed the mother had her hand under a blanket over his left arm. When she moved the blanket, Dr D saw the mother had a very tight grip on his wrist but when the blanket was removed she began stroking his wrist. Y stopped crying immediately. The mother's actions caused Y to cry out as if in pain.

Y's Recovery

17. After 24.2.17 when the mother was prevented from further direct involvement in Y's care and feeding, Y made steady progress. There were virtually no further witnessed or reported episodes of gagging, retching, vomiting or pain associated with feeding