Neutral Citation Number: [2024] EWFC 102 (B)

Case No: ZW24C50039

**IN THE FAMILY COURT AT WEST LONDON**

West London Family Court,
Gloucester House, 4 Dukes Green Avenue
Feltham, TW14 0LR

Date: 13 May 2024

**Before :**

**HIS HONOUR JUDGE WILLANS**

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**Between :**

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| **THE LONDON BOROUGH OF EALING** | **Applicant** |
| **- and -** | |
| **(1) AH** | **Respondents** |
| **(2) SH** | |
| **(3) X & (4) Y (by their Children's Guardian)** | |

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**Tara Vindis** (instructed by **Applicant Legal Department**) for the **Applicant**
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**Annie Dixon & Beth Hibbert** (instructed by **Lawrence & Co Solicitors**) for the **Third and Fourth Respondents**

Hearing dates: 2 May 2024

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**JUDGMENT**

**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.**

**His Honour Judge Willans:**

## Introduction

1. Within this judgment I will refer to the First Respondent as AH, the Second Respondent as SH and the Third and Fourth Respondent as X and Y, respectively. No discourtesy is intended. On 2 May 2024 at an urgent direction's appointment the applicant, supported by all parties, sought to withdraw these care proceedings. I indicated I approved this course of action however, given the significance of the decision for the parents I considered it was appropriate to provide written reasons for my decision. I have had regard to the papers contained within the hearing bundle and to the position documents filed on behalf of each party.

## Background

2. These care proceedings have particular focus on X (the older of the two children). X suffers with serious medical complications arising out of an incident when she was a baby. As a result, she has severe hypoxic brain damage with significant neuro disabilities with dystonia[1] and seizures. As a result of the above she has required a significant care package and continuous oxygen. Her condition is life limiting and the parents have received professional advice as to the extent to which she should continue to receive proactive care should her health deteriorate. Y has no relevant issues or concerns for the purpose of this judgment.

3. X is under constant care and medical supervision. Understandably she has had regular hospital attendance, some of which have been precautionary in circumstances in which there are concerns as to her health deteriorating. In fact, such an attendance occurred on 14 January 2024 when X was admitted with concerns as to her being less alert, lethargic and with a raised temperature. On review the clinicians were not unduly concerned and she was discharged. It is important to note that none of the concerns identified two days later were part of her presentation.

4. On 16 January 2024 X returned to the A&E Department of her local hospital following the nurse with care for her that morning (at home) being concerned about her breathing patterns. She was felt to have been gasping and her breathing was very slow. Whilst under observation she started to have a seizure and received medication and was brought into A&E. She was kept under observations which confirmed a very low breathing rate together with gasping. Over time her breathing began to improve and by the morning of the next day was felt to have returned to an acceptable level and was ready for discharge. As part of their review tests were undertaken which indicated X had morphine in her urine. Morphine may have impacted on X's respiratory presentation and may have contributed to or caused her low respiration. An investigation did not provide a satisfactory explanation as to how this had come to be the case.

5. This led to a worry that AH may have administered morphine to X causing her respiratory deterioration. It was as a consequence of this that on 7 February 2024 the applicant issued these proceedings. The threshold in the application stated as follows:

   1. *On 16 January 2024, X was admitted to [ ] Hospital, Paediatric Intensive Care Unit (PICU), less than 24 hours following her first discharge on 15th January 2024 with the following:*

[1] A movement disorder that causes the muscles to contract involuntarily

*a. X presented with severe breathing difficulties, taking 1-2 breaths per minute;*
*b. X appeared barely conscious;*
*c. X's urine sample tested positive for opiates.*

*2. In the morning of 16th January 2024, the night nurse handed over to AH at 7:00 a.m., however, she did not leave the property until 7:58 a.m. as she was tidying up. The day nurse arrived at the home at 7:48 a.m. She started hand over from AH at 8:00 a.m. She noticed X gasping for breath and suggested calling an ambulance. An ambulance was not called straight away, however, the ambulance was called, when X had experienced a seizure lasting more than 5 minutes.*

*3. The treating medical team at [ ] hospital reported that a higher dose of Oramorph could cause or contribute to X's difficult breathing.*

*4. The most recent administrated Morphine (in the form of Oramorph) was 29 December 2023 by a nurse caring for X, as recorded in her medication charts.*

*5. At the Strategy Meeting on 02/02/2024 the possibilities of how and when the opiates entered X's body, were explored and it was stated that there is a likelihood of this happening within a 24 hours window between the two hospital admissions, between 15 and 16 January 2024. At this time, a night nurse, a day nurse and AH were present in the home.*

*6. On 31 January 2024, Dr [ ], Consultant Paediatrician, confirmed X's blood test results also showed positive for opiates.*

*7. X was administered unrecorded high dose of opiates which lead her to admission to PICU at [ ] Hospital on 16th January 2024, such opiates were administered to X whilst she was in the care of AH, therefore, causing X physical harm.*

6. These proceedings therefore had at their heart the following questions: (a) Did X have morphine in her system? (b) Was this the cause of or a material contribution to her respiratory difficulties? (c) If so when was that morphine administered to her? (d) If so, was it administered to her by AH? (e) If so and if administered by AH was this done in circumstances or in a manner which could be said to meet the test set out in Section 31 Children Act 1989, i.e. an act attributable to the care of a parent which has caused a child significant harm (here physical) and which falls below the level of care that the Court can reasonably expect to be given to the child.

7. The proceedings were allocated to me. I did not hear the urgent interim care hearing on 14 February 2024. At that hearing an interim care order was made which caused the applicant to share parental responsibility for X with the parents. A plan was actioned for AH to move out of the family home and for SH to move in[2] to care for both children once X was ready to be discharged from hospital. In the case of X this was to take place once SH and members of the paternal family received training as to meeting X's medical needs at home. A private law order placed Y into the care of his father. Various disclosure order were made. I heard the Case Management Hearing on 29 February 2024. My order maintained the plan for discharge of X into her father's care with extensive supervised contact with AH at the family home. I directed the appointment of an expert Paediatrician and Paediatric Toxicologist. I fixed a Fact-Finding Hearing to commence on 24 June 2024. On 15 April 2024, the children's guardian applied for an urgent hearing in the light of non-compliance with various

[2] The parents are separated

directions. He also raised a question as to the continuance of the proceedings. I listed this hearing before me but it then had to be adjourned for a brief period until 2 May 2024.

**Legal Principles**

8. In ***GC v A County Council & Others***[3] the Court considered and approved previous decisions with the following effect:

   i) Under r29.4(2) Family Proceedings Rules 2010 (FPR) a local authority may only withdraw and application for a care order with the permission of the Court;

   ii) An application to withdraw will fall into one of two categories;

      a) In the first the local authority will be unable to satisfy the threshold criteria for making a care or supervision order. In such cases, the application to withdraw must succeed. For a case to fall into this category the inability to satisfy the threshold criteria must be 'obvious;'[4]

      b) In the second will be cases where on the evidence it is possible for the local authority to satisfy the threshold and the Court will therefore have to consider (i) whether withdrawal of the proceedings will promote or conflict with the welfare of the child concerned, and; (ii) the overriding objective under the FPR. The relevant factors in considering this question are as follows:[5]

         aa) the necessity of the investigation and the relevance of the potential result to the future care plans for the child;

         bb) the obligation to deal with cases justly;

         cc) whether the hearing would be proportionate to the nature, importance, and complexity of the issues;

         dd) the prospects of a fair trial of the issues and the impact of any fact-finding process on other parties;

         ee) the time the investigation would take and the likely cost to the public purse.

9. I was referred to ***K v K***[6] as to the approach to be taken on the question of whether or not a fact-finding hearing should be heard, and ***Derbyshire County Council v AA, BB, X and University Hospitals of Derby and Burton NHS Foundation Trust ("Derbyshire")***[7]. I also have reference to ***P and E (Care Proceedings: Whether to hold Fact-Finding Hearing)***[8] given the cautionary guidance it offers as to over reliance on the Derbyshire case.

10. In this case the applicant contends the circumstances fit into the first category and that it will not on the evidence be able to meet the threshold. However, in the alternative it argues

[3] [2020] EWCA Civ 848
[4] Per Cobb J. in Re J, A, M and X Children [2014] EWHC 4648 (Fam)
[5] Per McFarlane J in A County Council v DP and Others [2005] EWHC 1593 (Fam)
[6] [2022] EWCA Civ 468
[7] [2022] EWHC 3404 (Fam) per Lieven J
[8] [2024] EWCA Civ 403

that even were the Court to disagree then it should in any event give permission having applied the features set out under the second category. The other parties agree with the applicant as to this case falling within the first category.

**Analysis**

11. From the outset of the proceedings, it appeared the applicant would face some evidential challenges. I spent some time at the CMH identifying points which would require greater clarification and upon which I would expect the applicant to reflect. At that early stage it seemed this points might impact on the outcome in the case.

i) First, due to her significant health needs and her treatment at home it was accepted AH was entitled to administer morphine to X without first seeking and obtaining clinical permission. As such this posed an issue for the applicant in that proof of administration on its own would unlikely found a threshold finding. One would need to establish some element to the administration that deserved criticism – whether as to quantum of the drug or an improper motivation at the point of administration. However, simple proof of administration would likely be insufficient.

ii) Second, as a result of the above the presence of morphine in her system would not of itself be probative (without more) of wrong doing;

iii) Third, there was a real issue as to factual causation, i.e. establishing that the morphine had in fact caused the harm identified. In this case the harm was the change in respiratory presentation. However, the medical evidence made clear that two other components of care could also have led to this presentation. This related to benzodiazepine and midazolam. Both drugs had the potential to impact on respiratory depression quite aside from the potential for morphine to have the same impact and had been recorded as being administered on that day. The applicant would have to satisfy the Court that this was not a case in which the child had a non-harmful level of morphine in her system but that her respiratory changes had arisen when this was overlaid by other treatment or that the other treatment was quite separately the cause of the respiratory decline.

iv) Fourth, relating to the timing of the last recorded administration of morphine, which was on 29 December 2023. The question for the clinicians was as to whether or not this might have been the cause of the positive test result obtained by the hospital on admission. In this regard there was somewhat contradictory medical evidence as to the potential for the positive result to be reflective of the December administration. Matters were not assisted by the positive sample being found in urine sampling but not blood sampling.

v) Fifth, there were some evidential points that appeared to undermine the allegation. The morphine available at home was monitored and there appeared to be good evidence that the bottles at home had been reviewed and found to be unopened at the time of hospital admission. This questioned the ability of AH to administer morphine in the relevant period. Further, there was a suggestion that there was no opportunity in any event open to AH to administer the drug on the day in question given her account of constant nursing supervision at the home on that day. Further, the allegation sat rather uncomfortably with a broad canvas point as to AH's consistent push back against medical advice which appeared to suggest efforts

should not be taken to prolong X's life if her position deteriorated. This did not appear to be a parent who would act in the manner suggested by the allegations.

12. It is in this context that the additional evidence has come to shape the applicant's understanding and its application to withdraw.

13. The applicant has received statements from the nursing team who provided the over night and day shift around the point of transfer to hospital. This information has some elements of contradiction but includes the following important points:

    i) It appears to confirm AH's case that she had been asleep around the time of the nursing handover (around 8am) and had entered the room when the second day nurse was in situ;

    ii) It confirms the commencement of the breathing difficulties which led to the hospital admission arose prior to the nursing shift handover, at around 7.30am, whilst the child was being cared for by the night nurse. As such it removed the suggestion of any intermission period when X might have been in the sole care of AH during which the morphine might have been administered;

    iii) It provided no persuasive basis for AH to have the opportunity to administer the morphine prior to the onset of the difficulties. In this regard I note in particular the thorough statement provided by the day shift nurse;

    iv) It provided an account of the deterioration being explained to AH when she entered the room and spoke to the day shift nurse. The strong impression in the statement is of this being her first interaction with the nurse that day.

14. Toxicological evidence was obtained from Professor Allan Jamieson. I am grateful for the speed with which this was provided. In his conclusions the expert made clear the positive morphine result on admission could be plausibly explained by either the agreed administration of the same on 29 December 2023 or a subsequent administration. On the information available (which was unlikely to change) either were plausible and the expert was unable to offer an opinion on which might more readily explain the results. In drawing this conclusion, the expert drew attention to the difficulties arising from the fact that whilst the urine results could establish the existence of morphine in the sample it could not offer any information as to the quantity of morphine in the sample. The expert advised one could not undertake a 'back calculation' so as to better answer the question. 'Without evidence as to the quantity of the drug in the urine and the amount ingested it would be impossible to rationally assess how long the morphine would be detected in the urine.'

15. I should also make clear there remained uncertainty as to the potential for X's own lower metabolism to impact on the results.

## Conclusions

16. I agree with the applicant and have decided this is a case in which permission to withdraw should be given on the basis that the applicant will not be able to establish the legal threshold. In my assessment this is 'obviously' the case.

17. In the light of all the points made above this is a case in which the applicant would need supporting expert evidence to make out its case. Such evidence would need to establish to a

satisfactory level that the drug was not found as a consequence of the acknowledged administration in December 2023. Without this there would be no case that could be brought against AH. There is no suggestion that the December administration was anything other than proper. Yet for the reasons given by the expert this cannot be established. He explains why he cannot select a later administration as being any more plausible than a December administration.

18. In my assessment this inability must also be seen in the light of both the nursing evidence which appears to time the inception of the difficulties to a point outside of that during which AH might have improperly administered the drug and the wide canvas of evidence that sits very uncomfortably with the allegation made against AH. Finally, it elevates as being far more plausible the logic of the treatment regime on the day (benzodiazepine and midazolam) as being contributory to the deterioration in respiration following the noted seizure activity whilst at home.

19. For these reasons I am satisfied the applicant cannot make out the threshold placed before the Court. It is inevitable, on the available evidence, that the threshold will not be crossed and the case will thus be dismissed. I briefly return to the threshold document (and I observe this cannot be improved to make the case a stronger one):

i) Paragraph 1 is an acknowledged fact but does not establish threshold, it simply identifies the presenting circumstances;

ii) Paragraph 2 must now be seen in the light of the statements obtained from the nursing team. These statements do not establish a handover to AH at 7am or a consequential handover from AH to the day nurse at 8am. In contrast they point to a handover between the nurses at around 7.50am with the night nurse updating the day nurse as to a deterioration in the X's breathing in the last hour and whilst in the care of the night nurse. They confirm the night nurse administered Midazalom as per instructions. The statement evidence suggests AH attends the room after the night nurse has left the premises.

iii) Paragraph 3 is accepted as a potential cause for the respiratory presentation but does not establish threshold;

iv) Paragraph 4 is accepted as being the most recent recorded administration of morphine;

v) Paragraph 5 as to timing of the administration of the morphine was always to be read subject to a level of uncertainty as to timing but is now to be revisited in the light of the expert evidence which cannot select between administration on 29 December 2023 and more recent administration as being the most likely date for administration;

vi) Paragraph 6 is accepted to be incorrect. Morphine was not discovered in the blood test result but only in urine;

vii) Paragraph 7 is the key allegation which attempted to pull the threads of the case together but is no longer maintainable given the issue with timing the administration of the morphine; the interaction of the later administered relaxant drugs which may have impacted on respiration, and; the statement evidence which casts doubt on

AH's opportunity to administer morphine in the window of opportunity suggested in paragraph 5.

20. The consequence of the above is that no findings are made against AH or any of the respondents. I give permission for a copy of this judgment to be shared with X's treating team. They will need to be clear the Court has not determined these issues against the family. I need to make clear this decision does not equate to an implied criticism of the applicant for bringing the application. Pending receipt of the updating information, and notwithstanding there were issues with the case, it was entirely appropriate for the applicant to take a safeguarding approach to the circumstances and to bring the application. At first blush the case had a level of complexity and uncertainty and justified a cautious approach.

21. I am most grateful to the professionals in the case including Professional Jamieson for the prompt and professional manner in which they have engaged with the issues. This has permitted the Court to consider the circumstances properly and fully without undue delay. This decision can be seen to have been reached within 12 weeks of the case starting. A focus on avoiding delay was particularly important in a case in which the child in question has ongoing significant medical challenges and in which every moment spent with her family is of immense value both to her and to them. I would finally wish X and her family the best future time together.

His Honour Judge Willans