Neutral Citation Number: [2017] EWHC 518 (Fam)

Case No: FD16P00365

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/03/2017

Before :

MR JUSTICE HAYDEN

- -

Between :

WESTMINSTER CITY COUNCIL	**Applicant**
- and -	
M	**1ST Respondent**
- and -	
F	**2nd Respondent**
- and -	
H	**3rd Respondent**

- -
- -

Mr A Verdan QC & Mr C Poole for the Applicant Local Authority
Ms J Bazley QC & Ms S Bradley (instructed by **Bindmans LLP**) for the **1st Respondent**
Ms Sarah Morgan QC & Mr S Momtaz (instructed by **Goodman Ray Solicitors**) for the **2nd Respondent**
Mr Charles Geekie QC & **Ms S King** (instructed by **Freemans Solicitors**) for the **3rd Respondent**
Ms J Brown on behalf of the **Guardian**

Hearing dates: 30th, 31st January 1st, 2nd, 3rd, 6th, 7th 8th, 9th, 10th, 13th & 14th February 2017

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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.

.....

MR JUSTICE HAYDEN

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.

Mr Justice Hayden :

1. I am concerned in this case with H, who was born on the 9th June 2001 and is therefore 15 ½ years of age. H is presently subject to an Interim Care Order, having initially been made a Ward of Court. His parents are M (the Mother), aged 53 and F (the Father), aged 67. In August 2016 I approved the Local Authority's Interim Care Plan permitting H to move from the St Mary's Hospital, London to a residential unit in Hammersmith, where he continues to reside.

2. This matter is listed before me for a 15 day fact finding hearing. The case has generated 40 volumes of evidence. A chronology has been prepared by the Local Authority but virtually every aspect of H's childhood, education and medical treatment is the subject of different interpretations or impressions between the parties. Thus, even a bare chronological outline presents a challenge.

3. H is referred to throughout the documents, both those generated in hospital and in the legal proceedings, as having 'complex needs'. Certainly H's present situation is complicated and requires patient, skilful intervention, but I, for my part, would draw back from burdening him with this label. What can be said for certain is that H has been diagnosed with a connective tissue disorder which is associated with joint laxity, bowel problems, pain and hypermobility. H also has orthostatic tachycardia. This, as I understand it, is a relatively unknown but, nonetheless, common condition affecting the autonomic nervous system (the blood pressure control system), causing an increase in heart rate on standing. It can produce a range of heart symptoms which include dizziness and blackouts, palpitations, breathlessness and chest pain. The condition can also be associated with hypermobility (high range of joint movement) which can cause joint discomfort or pain. Fatigue is often a prominent feature.

4. Neither one of these conditions is 'life limiting' and I have been told by Dr Nelly Ninis, Consultant Paediatrician, that there is no reason that H cannot live a full and active life. Whether it is genuine or not, both H's parents have paid tribute at this hearing to Dr Ninis' skill and expertise. In the circumstances, I can see no reason why they would take issue with her encouraging diagnosis of H's potential.

5. H has been subject to multiple medical interventions. He has been heavily medicated on opiates and spent lengthy periods in hospital throughout his life including: The Great Ormond St Hospital (GOSH), The Royal London and St Mary's. H has been within the purview of the Local Authority's Disabled Children's Team since he was 8 years of age. He was most recently in St Mary's Hospital, Paddington, between November 2015 and September 2016, where the lead consultant in charge of his care was Dr Ninis. In March 2016, the Local Authority received a referral from the hospital raising numerous concerns about the parents' behaviour towards hospital staff and their general care of H. A strategy meeting was convened on 17.03.16 and an Initial Child Protection Case Conference on 18.04.16.

6. On the 15.04.16 H's mother was arrested for allegedly tampering with H's medical equipment, which I will address in detail below. On the 26.04.16 H's father was arrested on a separate allegation of tampering with H's medical equipment. Both parents were bailed pending further investigation. Bail conditions required there to be no contact with H other than supervised by the Local Authority. During the police investigation various statements were taken from health professionals in respect of

this alleged tampering. In addition, the police requested a report from Dr Ninis. In early November 2016 the police confirmed that no further action would be taken on the tampering allegations made against both parents and bail conditions were discharged.

7. At a hearing on the 22.07.16 the court ordered the removal of H's Hickman Line (a feeding line that H had been using for some time). The removal was supported by the treating medical team, the Local Authority and H's Guardian. The Hickman line was successfully removed in early August.

8. During these proceedings the court ordered the instruction of a Consultant Paediatrician, Dr Yadav, to undertake a paediatric overview of the case. This was to include an analysis of: treatment and medication received by H; the parents' co-operation with professionals; any suggestion of exaggeration or fabrication of symptoms or conditions by the parents. The instruction was supported by the parents and, as I understand it, it was they who identified Dr Yadav as suitable to undertake this forensic exercise.

9. Before I turn to the allegations specifically, I should like to record two further important factors. Firstly, H wishes, more than anything else, to be able to leave institutional care. He would very much like to go home to live with his parents. This strikes me as so instinctive as to require no further comment. Secondly, Dr Ninis told me, in powerful language, what in her view, the future medical/emotional/educational objectives should be for H:

> *'[H] has been taught how to die, he now has to learn how to live'*

10. The Local Authority's Schedule of findings sets out the following allegations:

    i) The parents have misreported and over-reported symptoms in H;

    ii) The parents have fictitiously presented H's condition and H has learnt to present accordingly;

    iii) The parents have provided misleading/misinformation to professionals;

    iv) The parents each tampered with H's TPN pump, which could have impeded his treatment and caused him harm;

    v) The parents have misused medication for H;

    vi) The parents have failed to cooperate with professionals;

    vii) H has learnt behaviour;

    viii) The parents' behaviour exposed H to medical and health risks;

    ix) The parents prevented H from attending and engaging in education.

11. In their closing submissions on behalf of the Local Authority, Mr Verdan QC and Mr Poole emphasise that the Schedule was intended to be 'illustrative' rather than

'definitive'. More particularly they amend their findings at para (iv) and (v) above in this way:

> *"Having heard the oral evidence the LA amend those findings in two respects. Firstly, in respect of the tampering with the pump, the evidence is now clear that the tampering caused an alarm which stopped the pump; thus making it impossible for any air bubbles to enter [H]'s system. The LA therefore accept that the tampering did not and could cause direct physical harm. However, the LA contend that the mere fact of tampering by his parents, which [H] has since learnt of, has exposed him to emotional harm particularly given that he was so anxious about his pump. Secondly, in respect of misusing medication the LA accept that the evidence is not that the parents overused medication by administering more than was prescribed but rather that they did not cooperate with the weaning programme, a subtle but important difference.*

12. In considering these allegations it is necessary to say something of the scope and range of the available evidence and how it should be approached. Ms Bazley QC, on behalf of M, has consistently signalled the importance of forensic rigour. She identifies the 'potential unfairness' of placing reliance on disputed records and the inherent dangers of relying on hearsay evidence. Notwithstanding the 40 bundles of evidence filed in the case Ms Bazley identifies deficiency (correctly) in the absence of the Chelsea & Westminster Hospital records or any notes of the 'psychological intervention' by Ms Becky Armstrong during the period January 2016 until September 2016.

13. Ms Bazley roots her argument in case law, particularly emphasising the judgment of Sir James Munby (P) in **Re A (A Child) (Fact-finding hearing: speculation) [2011] EWCA Civ 12 (see also: Re B [2008] UKHL 35)**:

> *"It is an elementary proposition that findings of fact must be based on evidence, including inferences which can properly be drawn from the evidence, and not on speculation or suspicion."*

14. Ms Bazley allies herself with the President's reasoning and places significant weight upon it. The argument requires to be set out in full:

> As to the evidence required to prove the fact and the use of social work, medical and other records, it is clear law that the best evidence is required. In **Re A (A Child)** [2015] EWFC 11, the President said that the proposition in Re A (above) that findings must be based on evidence, carried with it the fundamental principles that:-
>
> > *'..the local authority, if its case is challenged on some factual point, must adduce proper evidence to establish what it seeks to prove. Much material to be found in local authority case records or social work chronologies is hearsay, often second-or third-hand hearsay. Hearsay evidence is, of course, admissible in family proceedings but ….a local authority which is unwilling or unable to produce the witnesses who can speak of such matters first-hand, may find itself in great, or indeed insuperable, difficulties if a parent not merely puts the matter in issue but goes*

into the witness-box to deny it. As I remarked in my second ***View from the President's Chambers, [2013] Fam Law 680****:*

"Of course the court can act on the basis of evidence that is hearsay. But direct evidence from those who can speak to what they have themselves seen and heard is more compelling and less open to cross-examination. Too often far too much time is taken up by cross-examination directed to little more than demonstrating that no-one giving evidence in court is able to speak of their own knowledge, and that all are dependent on the assumed accuracy of what is recorded, sometimes at third or fourth hand, in the local authority's files.

It is a common feature of care cases that a local authority asserts that a parent does not admit, recognise or acknowledge something or does not recognise or acknowledge the local authority's concern about something. If the 'thing' is put in issue, the local authority must both prove the 'thing' and establish that it has the significance attributed to it by the local authority. The second practical and procedural point goes to the formulation of threshold and proposed findings of fact. The schedule of findings in the present case contains, as we shall see, allegations in relation to the father that "he appears to have" lied or colluded, that various people have "stated" or "reported" things, and that "there is an allegation". With all respect to counsel, this form of allegation, which one sees far too often in such documents, is wrong and should never be used. It confuses the crucial distinction, once upon a time, though no longer, spelt out in the rules of pleading and well understood, between an assertion of fact and the evidence needed to prove the assertion. What do the words "he appears to have lied" or "X reports that he did Y" mean? More important, where does it take one? The relevant allegation is not that "he appears to have lied" or "X reports"; the relevant allegation, if there is evidence to support it, is surely that "he lied" or or "he did Y". 11. Failure to understand these principles and to analyse the case accordingly can lead, as here, to the unwelcome realisation that a seemingly impressive case is, in truth, a tottering edifice built on inadequate foundations.

12. The second fundamentally important point is the need to link the facts relied upon by the local authority with its case on threshold, the need to demonstrate why, as the local authority asserts, facts A + B + C justify the conclusion that the child has suffered, or is at risk of suffering, significant harm of types X, Y or Z. Sometimes the linkage will be obvious, as where the facts proved establish physical harm. But the linkage may be very much less obvious where the allegation is only that the child is at risk of suffering emotional harm or, as in the present case, at risk of suffering neglect. In the present case, as we shall see, an important element of the local authority's case was that the father "lacks honesty with professionals", "minimises matters of importance" and "is immature and lacks insight of issues of importance". May be. But how does this feed through into a conclusion that A is at risk of neglect? The conclusion does not follow naturally from the premise. The local authority's evidence and submissions must set out the argument and explain explicitly why it is said that, in the particular case, the conclusion indeed follows from the facts."

15. This argument requires properly to be engaged with. It also important that the President's observations are placed in context and read, as he plainly intended them to be, alongside the statutory framework and the wider jurisprudence. Hearsay evidence in family proceedings is governed by FPR 2010, rr 23.1- 23.6 (which is plainly modelled on CPR 1998, rr 33.1-33.6, though it omits the definition of 'hearsay' in CPR 1998, rr 33.1). These require to be stated in full in order properly to appreciate their range and objectives:

> 23.1
>
> Rules 23.2 to 23.6 apply to evidence to which the Children (Admissibility of Hearsay Evidence) Order 1993[1] does not apply.
>
> Notice of intention to rely on hearsay evidence
>
> 23.2
>
> (1) Where a party intends to rely on hearsay evidence at the final hearing and either –
>
> (a) that evidence is to be given by a witness giving oral evidence; or
>
> (b) that evidence is contained in a witness statement of a person who is not being called to give oral evidence,
>
> that party complies with section 2(1)(a) of the Civil Evidence Act 1995[2] by serving a witness statement on the other parties in accordance with the court's directions.
>
> (2) Where paragraph (1)(b) applies, the party intending to rely on the hearsay evidence must, when serving the witness statement –
>
> (a) inform the other parties that the witness is not being called to give oral evidence; and
>
> (b) give the reason why the witness will not be called.
>
> (3) In all other cases where a party intends to rely on hearsay evidence at the final hearing, that party complies with section 2(1)(a) of the Civil Evidence Act 1995 by serving a notice on the other parties which –
>
> (a) identifies the hearsay evidence;
>
> (b) states that the party serving the notice proposes to rely on the hearsay evidence at the final hearing; and
>
> (c) gives the reason why the witness will not be called.
>
> (4) The party proposing to rely on the hearsay evidence must –
>
> (a) serve the notice no later than the latest date for serving witness statements; and

(b) if the hearsay evidence is to be in a document, supply a copy to any party who requests it.

Circumstances in which notice of intention to rely on hearsay evidence is not required

23.3

Section 2(1) of the Civil Evidence Act 1995 (duty to give notice of intention to rely on hearsay evidence) does not apply –

(a) to evidence at hearings other than final hearings;

(b) to an affidavit(GL) or witness statement which is to be used at the final hearing but which does not contain hearsay evidence; or

(c) where the requirement is excluded by a practice direction.

Power to call witness for cross-examination on hearsay evidence

23.4

(1) Where a party –

(a) proposes to rely on hearsay evidence; and

(b) does not propose to call the person who made the original statement to give oral evidence,

the court may, on the application of any other party, permit that party to call the maker of the statement to be cross-examined(GL) on the contents of the statement.

(2) An application for permission to cross-examine(GL) under this rule must be made within 14 days beginning with the date on which a notice of intention to rely on the hearsay evidence was served on the applicant.

(Rules 35.3 and 35.4 contain rules in relation to evidence arising out of mediation of cross-border disputes.)

Credibility

23.5

(1) Where a party proposes to rely on hearsay evidence, but –

(a) does not propose to call the person who made the original statement to give oral evidence; and

(b) another party wishes to call evidence to attack the credibility of the person who made the statement,

the party who so wishes must give notice of that intention to the party who proposes to give the hearsay statement in evidence.

(2) A party must give notice under paragraph (1) within 14 days after the date on which a hearsay notice relating to the hearsay evidence was served on that party.

Use of plans, photographs and models etc as evidence

23.6

(1) This rule applies to –

(a) evidence (such as a plan, photograph or model) which is not –

(i) contained in a witness statement, affidavit(GL) or expert's report;

(ii) to be given orally at the final hearing; or

(iii) evidence of which prior notice must be given under rule 23.2; and

(b) documents which may be received in evidence without further proof under section 9 of the Civil Evidence Act 1995.

(2) Except as provided below, section 2(1)(a) of the Civil Evidence Act 1995 (notice of proposal to adduce hearsay evidence) does not apply to evidence falling within paragraph (1).

(3) Such evidence is not receivable at the final hearing unless the party intending to rely on it (in this rule, 'the party') has –

(a) served it or, in the case of a model, a photograph of it with an invitation to inspect the original, on the other party in accordance with this rule; or

(b) complied with such directions as the court may give for serving the evidence on, or for giving notice under section 2(1)(a) of the Civil Evidence Act 1995 in respect of the evidence to, the other party.

(4) Where the party intends to use the evidence as evidence of any fact then, except where paragraph (6) applies, the party must serve the evidence not later than the latest date for serving witness statements.

(5) The party must serve the evidence at least 21 days before the hearing at which the party proposes to rely on it if –

(a) there are not to be witness statements; or

> (b) the party intends to put in the evidence solely in order to disprove an allegation made in a witness statement.
>
> (6) Where the evidence forms part of expert evidence, the party must serve the evidence when the expert's report is served on the other party.
>
> (7) Where the evidence is being produced to the court for any reason other than as part of factual or expert evidence, the party must serve the evidence at least 21 days before the hearing at which the party proposes to rely on it.
>
> (8) Where the court directs a party to give notice that the party intends to put in the evidence, the court may direct that every other party be given an opportunity to inspect it and to agree to its admission without further proof.

16. These rules are too often honoured in the breach rather than in the observance. What is clear is that the civil rules as to hearsay apply equally to family proceedings, except where exempted by the **Children (Admissibility of Hearsay Evidence) Order 1993, SI 1993/621**, which I will consider below.

17. It is also necessary to consider **The Civil Evidence Act 1995** which endeavours to strike a balance between technical rules of hearsay evidence and the need, in civil proceedings, to take a proportionate view as to the forms of evidence that may be admitted. Section 1 provides:

> *"(1)In civil proceedings evidence shall not be excluded on the ground that it is hearsay.*
>
> *(2)In this Act—*
>
> *(a)"hearsay" means a statement made otherwise than by a person while giving oral evidence in the proceedings which is tendered as evidence of the matters stated; and*
>
> *(b)references to hearsay include hearsay of whatever degree.*
>
> *(3)Nothing in this Act affects the admissibility of evidence admissible apart from this section.*
>
> *(4)The provisions of sections 2 to 6 (safeguards and supplementary provisions relating to hearsay evidence) do not apply in relation to hearsay evidence admissible apart from this section, notwithstanding that it may also be admissible by virtue of this section."*

18. The Court will always want to analyse the cogency and weight of hearsay evidence. Section 4 provides guidance as to the considerations relevant in weighing hearsay evidence.

> *(1)In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances*

> *from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.*
>
> *(2)Regard may be had, in particular, to the following—*
>
> *(a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;*
>
> *(b)whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;*
>
> *(c)whether the evidence involves multiple hearsay;*
>
> *(d)whether any person involved had any motive to conceal or misrepresent matters;"*
>
> *(e)whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;*
>
> *(f)whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."*

19. **The Children (Admissibility of Hearsay Evidence) Order 1993, SI 1993 /621** also requires to be stated:

> *"Admissibility of hearsay evidence.*
>
> *In—*
>
> *(a)civil proceedings before the High Court or a county court; and*
>
> *(b)(i)family proceedings, and*
>
> *(ii)civil proceedings under the Child Support Act 1991(1) in a magistrates' court,*
>
> *evidence given in connection with the upbringing, maintenance or welfare of a child shall be admissible notwithstanding any rule of law relating to hearsay."*

20. By way of example, in **Re H (Care: Changing Care Plan) [1998] 1 FLR 193** the Court of Appeal indicated that an unsworn and very serious allegation was nonetheless capable of being admitted in evidence in circumstances where the Court was satisfied that it could be evaluated against other testimony on oath:

> *"Obviously the statement unsigned represented a very serious cause for concern and it had to be evaluated against the mother's testimony on oath. Had the Judge specifically considered whether he could accept the mother's rejection of this unsworn statement or whether he could not and reached the conclusion that he rejected her evidence, then of course it was open to him to go on to make the order of separation. But the fundamental deficiency is that the Judge nowhere considers the mother's credibility"*

Per Thorpe LJ at page 195

21. Further, again by way of illustration, a Local Authority is also entitled, to adduce in evidence both the written and video taped record of a child's ABE interview (in which e.g. very serious allegations of sexual abuse maybe made). The Court can decline (and frequently will) any application to require the child to be called to give oral evidence, see: **Re P (Witness Summons) [1997] 2 FLR 447**: Lady Hale's judgment in **Re W (Children) (Abuse: Oral Evidence) [2010] UKSC 12** emphasises the essential test as being 'whether justice can be done to all the parties':

> *"30. It will be seen that these considerations are simply an amplification of those outlined by Smith LJ in the* Medway *case, at para 45, but without the starting point, at para 44. The essential test is whether justice can be done to all the parties without further questioning of the child. Our prediction is that, if the court is called upon to do it, the consequence of the balancing exercise will usually be that the additional benefits to the court's task in calling the child do not outweigh the additional harm that it will do to the child. A wise parent with his child's interests truly at heart will understand that too. But rarity should be a consequence of the exercise rather than a threshold test (as in* Huang v Secretary of State for the Home Department *[2007] UKHL 11, [2007] 2 AC 167, para 20). "*

The weight that is to be attached to any particular piece of hearsay evidence is a question for the Court to decide, see: **F v Child Support Agency [1999] 2 FLR 244; Re W (Fact Finding: Hearsay Evidence) [2014] 2 FLR 783.**

22. It is perhaps worth noting, by way of completeness, that the criminal justice system has, over the course of a decade and more, relaxed its approach to the nature of the circumstances in which the admission of hearsay evidence is permissible, see: **R v Ibrahim [2008] EWCA Crim 880; R v Riat & Ors [2013] Crim LR 60, [2013] 1 Cr App R 2, [2013] 1 WLR 2592, [2013] 1 All ER 349.** Though the Court of Appeal was there considering the 'principal questions' that arise in the context of the statutory framework of the **Criminal Justice Act 2003**, much of the Court's analysis has broader application. Thus, matters such as the reliability of the hearsay evidence; the practicability of testing and assessing its reliability in the courtroom; the material available which can help to test the hearsay; the interests of justice in determining whether hearsay evidence should be admitted; the strength and weakness of the evidence; the importance of the hearsay evidence to the case as a whole; fairness in the context of an overall appraisal of the case.

23. Perhaps most importantly, sight must not be lost of the fact that these are public law care proceedings, where the guiding philosophy of the Court is investigative, non adversarial, sui generis. Driven by its obligation to regard the welfare of the subject child as the paramount consideration, the Family Court will instinctively permit a broad range of evidence in order ultimately to weigh and assess its quality and worth in the context of the evidence as a whole.

24. A Local Authority faced with allegations of this kind is simply not going to be in a position to call as a witness every nurse, doctor or teacher who makes a note (usually recorded contemporaneously) in order to provide what Ms Bazley identifies as 'the best quality of evidence on each individual point'. The material being considered

here, spans a number of years and is qualitatively of a different complexion to witness statements taken on key issues. These are largely clinical and nursing notes which provide contextual material by which the central evidential conflicts may be resolved.

25. The Local Authority must, ultimately, assess the manner in which it considers it can most efficiently, fairly and proportionately establish its case. The weight to be given to records, which may be disputed by the parents, will depend, along with other factors, on the Court's assessment of their credibility generally. Here, the reliability of the hearsay material may be tested in many ways e.g. do similar issues arise in the records of a variety of unconnected individuals? If so, that will plainly enhance their reliability. Is it likely that a particular professional e.g. nurse or doctor would not merely have inaccurately recorded what a parent said but noted the exact opposite of what it is contended was said? The reaction of witnesses (not just the parents), during the course of oral evidence, to recorded material which conflicts with their own account will also form a crucial aspect of this multifaceted evaluative exercise. At the conclusion of this forensic process, evidence can emerge and frequently does, which readily complies with the qualitative criterion emphasised in **Re A** (supra).

26. I would add to my analysis above the observations of Dame Elizabeth Butler Sloss in **Re T [2004] EWCA Civ 558, [2004] 2 FLR 838** at 33:

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

27. Though it is now trite law I should recite, in the light of my observations above, that in the fact finding process, the Local Authority bears the burden of proof, see: **Re JS (A Minor) [2012] EWHC 1370 Fam**; the standard of proof is the balance of probabilities **(Re B [2008] UKHL 35)**. In considering allegations of the nature advanced in this case it is always helpful to bear in mind the observation of Lord Hoffman in Re B (supra):

> *"If a legal rule requires the facts to be proved (a 'fact in issue') a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1."*

The Paediatric Overview

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

29. Ms Bazley is highly critical of Dr Yadav who undertook the independent overview here. She submitted that his assessment and conclusions were *'seriously flawed'* and

that his evidence was weak on detail. He had, Ms Bazley suggested, clearly not read the papers sufficiently. Most of each report was *'cut and pasted'* from the material provided to him. There was, she said, no evidence of his having made a thorough or proper analysis of the material.

30. It is correct to say that at the conclusion of Dr Yadav's evidence I invited the Local Authority to assess whether it wished to continue to press for a finding that the parents had misused medication by administering opiate doses greater than that prescribed. Through her characteristically thorough preparation of the core material, Ms Bazley had been able to demonstrate significant and fundamental errors in Dr Yadav's method. She established that he had: ignored the discharge doses clearly set out in the records; transposed a dosage from one particular part of one day during a hospital admission and failed accurately to read the drug charts used at home, resulting in an assertion that the dosage was up to 160 mg a day. Dr Yadav's conclusion that the parents had been escalating the opiate usage and effectively overdosing H was Ms Bazley submitted, entirely unsupported by the evidence. I agree.

31. The Local Authority has abandoned this allegation (see para 11 above) but it is important not to lose sight of the fact that it was an extremely serious one, advanced entirely on the analysis of Dr Yadav. Ms Bazley reminds me in her closing submissions that I expressed my own concern to Dr Yadav that his report lacked any cross referencing to the records sent to him. All this leads Ms Bazley to submit:

> *"Thus apart from where he is in error, none of his sweeping conclusions is supported by any direct reference to any of the records or other documents. It appears that Dr Yadav was deeply impressed, if not overawed by the qualifications and expertise of Dr Ninis and was wholly unable to come to an independent view."*

32. This goes too far. Nonetheless, I consider that Dr Yadav's report was too superficial and lacked the detailed knowledge of the medical records that was essential if he was to make the kind of contribution to the case that had been contemplated by his instructions. I regret to say that I accept the broad thrust of Ms Bazley's submission that I can place little if any weight on Dr Yadav's evidence.

33. Before leaving this witness I think it appropriate to record that he was taken to H's medical records where it was noted that M breast fed H until he was 7 years old. Mr Verdan asked Dr Yadav whether he thought this was in anyway odd or unusual. Dr Yadav responded that it fell within the broad parameters of what was acceptable, allowing for wide social and cultural variations. No counsel returned to the matter after that response. However, I am bound to say, that breast feeding until 7 years of age struck me as, at very least, unusual. I asked F what he thought about it and he responded, that looking back on it now, he could see how it might seem odd. He told me that he had said nothing about it at the time.

Complaints against and intimidation of professionals involved in caring for H.

34. My survey of the core material and medical evidence in this case begins with this issue because it is not directly challenged by M. She accepts that she made so many complaints against various individuals that she could not even begin to estimate how

many there might have been. In relation to professionals who were plainly intimidated by her she tells me that she had not appreciated how she was perceived by others.

35. Early records of M's complaints begin with her admonishments of the teaching staff at the private preparatory school where H had been enrolled. At the centre of the dispute was a conflict between the perception of the school as to H's physical abilities and M's insistence that he was less physically capable than he appeared. The conflict between M and school led to vituperative criticism of the teaching staff and, eventually, withdrawal of H from the school. Subsequently, there are multiple complaints against the Royal London Hospital, Dr Rawat (treating clinician), a battery of nurses and virtually all involved in H's treatment at the Great Ormond St Hospital. What these complaints have in common is their extreme and uncompromising use of language and the fact they invariably strike at the heart of the professional competence of the individual complained of. It is important to consider the impact of these complaints because they are key to understanding the distorted dynamics between the family, H and the medical staff in the hospitals. These relentless complaints generated, in my judgement, an atmosphere of wariness, distrust and general confusion. It is also clear that they resulted in a general unwillingness to confront M or to challenge her views and assertions.

36. I do not believe that M failed to understand the impact of what I find to have been, her loud and bombastic behaviour towards others. On the contrary, I consider that she was fully aware of it, deliberately deploying it, to get her own way and to silence any resistance. A few weeks in December 2015 provide a convenient forensic example. On the 16th December 2015 there were no fewer than 9 separate complaints recorded 'by parents' in relation to H's care. Whilst I am satisfied that these were driven by M, I have equally no doubt that F was a willing cipher. On the 18th December 2015 M is described as 'loud and verbally aggressive' to the Matron of the ward. M is recorded as calling the Matron a 'liar' and though there was much demand on nursing time M required H to have a one to one nursing ratio, despite the absence of any objectively evaluated or clinically driven need. On the 19th December M was again aggressive to staff asserting that she was doing everybody's job for them (a recurring theme of her complaints, observed by many nurses). As Christmas approached M threatened that whoever was on consultant duty on Christmas day would 'not be able to leave the cubicle' as she will be 'ranting and raving' at them all day. To my mind this signals very clearly her level of awareness of the impact of her behaviour.

37. There are at least two occasions when M's attitude and conduct towards the staff necessitated formal verbal warnings from the Deputy Divisional Director of Nursing. I note too that on New Years Eve 2015, M is again described as 'aggressive' and, in response to H's medication being delayed, (apparently by 7 minutes) she stated that she intended to buzz every time **she** considered H to be in pain, 'to disturb the nurses'.

38. It is difficult to understand how this behaviour was permitted to continue. Dr Ninis told me that the nurses had become intimidated and afraid of M. I also sensed that from the demeanour of some of the nurses who gave evidence before me. Dr Ninis reports that a number of the nurses who had dealings with M are still receiving counselling support, some 5 months after their last contact with her. This I find to be telling. Two of the nurses who gave evidence at this hearing (Nurse Sigg and Sister Davis) both told me that they had barely heard H speak during their time caring for

him. The phrase 'passive' was used by a number of witnesses to describe H's presentation. I have heard that he is otherwise an articulate and intelligent young man. I consider that his voice was not heard in the hospital situation because it was ultimately drowned out by M. In this tense, unhappy and fraught situation the channels of communication between patient and medic had been sabotaged by M's bullying behaviour. It is clear, on a review of the records, that it was M who communicated with the staff, for most of the time. It was she who assessed and reported H's pain levels. It is almost impossible to find an example of nurses undertaking their own independent evaluation. What is clear however, is that the nurses frequently considered H's behaviour (he was often to be found tapping away on his computer) to be inconsistent with the levels of pain M was describing. It is significant that M does not really directly challenge this feature of the evidence. She believes it was she who was best placed to assess her son's pain. Such was her dominance, that she appears only to have needed to request additional pain relief for it frequently to be provided without resistance.

39. Thus a consistent picture emerges from several strands of evidence: the medical records; the nurses' accounts; H's presentation and M's own belief structure. The confused clinical scenario, which M was able to create, undoubtedly led, as events have shown, to a regime of treatment and an approach to H's care that was entirely inimical to his welfare. I do not doubt that it is for this reason that some of the nurses have been 'traumatised', to use Dr Ninis' word, by their experience in this case. Even Dr Ninis who is an experienced, impressive and, if I may say so, independent minded person told me that she found herself regularly having to devote 'half her week to H and his parents'. This was notwithstanding that there were other patients who genuinely and, on occasions desperately, required her attention. Much of this chaos was due to M's manipulative harnessing of the complaints process, her bombastic manner towards medical staff and the barrage of emails sent virtually everyday. All this, I consider, ought properly to be indentified as bullying. In her evidence, Dr Ninis said that in 28 years, this was the most difficult case she has ever had to manage. By this she did not mean that H's condition was exceptionally challenging (it is not!) but that organising any structured routine of treatment and care defied any strategy that she was able to put together.

The evidence of Dr Ninis

40. Dr Nelly Ninis is a Consultant Paediatrician at St Mary's Hospital, Imperial College. She became a Consultant in 2006. In addition to her clinical work she has been involved in academic research and contributed to the work of the National Guideline Committee at NICE. Dr Ninis is particularly interested in children with hypermobility syndrome and dysautonomia. For this reason H appeared especially fortunate in having Dr Ninis responsible for his care. When Dr Ninis first became involved with this case in 2012 the parents were at loggerheads with the GOSH. Dr Ninis undoubtedly championed their cause, both they and I accept without any doubt that she approached H's case with an entirely open mind.

41. I found her to be an impressive and objective witness. In the early stages of her involvement in the case, in the face of resistance, she told me that she had pressed for the acquisition of a wheelchair for H. At the end of her evidence she told me that had been a mistake on her part. Ms Brown, acting for H's Guardian, identifies this as a key development in M's escalating control of her son's presentation. I was very surprised to hear the mother tell me in her evidence that it was Dr Ninis who had suggested that H obtained a wheelchair. It is certainly correct to say that Dr Ninis was persuaded by M's argument. Chiefly, in my assessment, she was influenced in her judgement by the difficulties with accessibility at the parents' accommodation. It is however a total distortion of the history to say, as M contends, that the wheelchair was, in effect, Dr Ninis' idea. It is paradigmatic of the way M distorts information.

42. Ms Joanne Brown, has, despite joining this case at a late stage, been diligent in mastering the core material. As I have just foreshadowed, she identifies the introduction of the wheelchair into H's life as a pivotal moment and has carefully traced, in the GP records, the communications between M and a variety of professionals on this issue. These are illuminating and require, at least in part, to be set out:

> **27 Mar 2012**
> *Nicola Leigh – Long home visit as [M] had lots to discuss. Very concerned that he suffering from chronic fatigue which seems to be getting worse….I said I would discuss with Rachel his OT from social services and would refer [H] to the wheelchair service if she felt was appropriate.*
>
> **2 April 2012** GP Surgery Dr McCamley
> *[M] has asked for a wheelchair for him – feels by not being given one is being told that must stay indoors.*
>
> **2 April 2012** Home visit Laura Holt Community Nursing
> *[M] continued to raise concerns around [H]'s chronic fatigue. [H] confirmed this and said that he is often feeling tired. [M] said that she feels [H] is housebound and will be until a wheelchair is provided. It was explained by Nichola that although the referral for the wheelchair was completed it is waiting to be signed by Sheena Lorusso, (OT)*
>
> **3 April 2012** T/C Laura Holt to Sheena Lorusso
> *I explained that [M] had self-referred for the wheelchair for [H] as he suffers from chronic fatigue and cannot manage on his feet for long distances.*
>
> **4 April 2012** Laura Holt discussion with M
> *[M] still had concerns surrounding [H]'s chronic fatigue and the referral for a wheelchair. I explained to M that I will be speaking with Sue Maillard about the referral. I discussed the importance of a routine for [H] and felt that this needed to be put in place. [M] agreed but felt that this could be done when a wheelchair is provided.*

43. The email correspondence on the 5th April highlights the professional concern that was surrounding M and the growing appreciation that she gave inconsistent accounts to different professionals. The following emails provide a stark contrast to those set out above:

> **5 April 2012** Emails from OT to Social worker, Safeguarding Dr GOSH, Laura Holt and others
> ***At no point would I have considered that his physical needs would require a wheelchair.*** *I am very concerned by the request and feel a professionals meeting would be appropriate to share information around the child.* ***(my emphasis)***

> **5 April 2012** Email from Sue Maillard, Clinical Specialist Physiotherapist
> *From my perspective [M] has always said she worked hard to keep [H]out of a wheelchair (ie by doing his exercises) and she knows I would be completely against it. So for her to be applying for one goes against everything she says to me to my face.* ***I do not think he needs one at all and I would strongly suggest that if he does get one that it would be extremely detrimental to his wellbeing. I think this is another situation of M saying one thing to certain professionals and doing another with others. (my emphasis)***

44. A telephone call to Dr McCamley on the 25th April illustrates, once again, the extraordinary invective that M is capable of deploying as well as her calculating and disingenuous behaviour:

> **25 April 2012** t/c Dr McCamley with M
> *She reports that GOSH is vindictive and that she intends to report all involved to GMC and that she will destroy their families as her family has been. Again requesting wheelchair as says unable to get up and downstairs, wants to be able to take him out to museum, says is fighting to keep him out of a wheelchair, looked at hiring a wheelchair for trip to Devon privately but were unable to afford.*

45. This really requires properly to be deconstructed. M was not 'fighting to keep [H] out of a wheel chair', the truth was entirely the opposite, she was fighting to get him into one. These are the facts. What is however interesting, is why she should behave so deceitfully. It seems, to me, at least potentially to indicate some flickering of understanding on her part that her true agenda was in some way reprehensible or, at least, contrary to her son's interests. This will be for others to explore at the next stage of this case.

46. In early June there is a conversation between M and the Occupational Therapist in a strikingly similar vein. I include it because it illustrates a jigsaw of different and unconnected professionals recording a similar pattern of behaviour on M's part. The written material gathers cumulative evidential weight:

> **1 June 2012** t/c Sheena Shasan (OT) to M

> *M very upset as she related awareness of the safeguarding case against her and her assumptions as to why this is as she is not allowed to be told anything. She feels [H] is being treated worse than a dog and abuse of his human rights. She stated all medical intervention has stopped as he is not sick as far as GOS are concerned …..She has lost her job as a teacher due to the investigation……She states they are housebound now aside from urgent medical appts. Mum is not able to carry [H] down the 65 steps as he is too tall now so they have been housebound since 24/2/12 when he came home from GOS. She stated that 'hadn't she always said, her child would never be in a wheelchair? And he is now" which she is very upset about….*

47. The observations of the school, only a week after M's telephone call to the occupational therapist above, are quite impossible to reconcile. Dr Ninis could not draw from this any clinically recognisable scenario.

> **6 June 2012** t/c Sheena Shasan to Janette Steele, Chelsea & Westminster Hospital School
> *When seen, Stephen* [teacher from school] *reported that [H] has had fun and they have been out of the house with [H] managing the stairs on these occasions.*

48. It is disturbing that almost as soon as the wheelchair is ordered, M's account of H's presentation escalates in gravity, to the point that M does not consider the wheelchair will help.

> **19 June 2012** Emails Nichola Leigh and M
> ***M*** *Details extreme pain and disability – [H] is not in a very good situation at the moment and just* ***cannot appear to move****. I do not feel he is in a fit state to actually go to Chelsea and Westminster School like this****, it is dangerous.***
> ***NL*** *Do you think the wheelchair currently on order will improve the situation and aid [H]'s school attendance?*
> ***M Also today he cannot even walk round our house or get dressed. The wheelchair will not help that.***
> ***M*** *Please do not forward my email to social services as we are still under investigation and I do not wish to cause further issues. The tutor can come to our home and teach him, that is not an issue and I do wish social service to believe that we are not letting him go to school as that is not the case. I am very concerned about [H] but will not hinder what little education he gets.*
> ***NL*** *All emails you send me go into nursing notes that social services have access to*
> ***M*** *Given our situation with social services that has upset me. Had I known that I would not have emailed you. I thought that you guys were there for [H], not to report to Social services. So far our situation with social services has been nothing but negative.*

49. Dr Ninis is very clear that there is no reason why H will not be able to eat and walk. I have been told that H now orders sour sweets on Amazon Prime and that they are

delivered to him. This came out unexpectedly, at least to me, during the course of F's evidence. I am not sure whether Dr Ninis or H's present consultant is aware of this but it should be passed on to them both. Dr Ninis has traced the evolution of her care for H in a detailed but succinct report, dated 14th June 2016. Perhaps the most striking feature of the report lies in its analysis that, since 2012 and ongoing, M has been convinced or at least representing that H's condition is immeasurably more serious than it truly is. On 27th February 2016 Dr Ninis relates that she was presented with a Facebook post made by H's mother. It reads as follows:

> *"[M] 'Feeling heartbroken at St Mary's Hospital, Paddington. Our news today is not good but we have known it was coming for a very long time. [H] is comfortable but as parents we cannot describe our pain. Thank you everyone for your continued support. We are devastated.' "*

50. The 'devastating news' was in fact that the parents had been informed that a discharge planning meeting was to take place for H the following week. Dr Ninis told me this was arranged because H had progressed in physiotherapy to the extent that he was assessed to be able to manage at home with the community physiotherapy service. M says that her 'devastation', the word she accepts using in her Facebook post, resulted from her despair that nothing had been accomplished for H in hospital. Further explaining this in her oral evidence M said 'I didn't believe he was dying… it was worse'. Mr Verdan describes this response as 'unconvincing and bizarre'. I agree. With respect to Ms Bazley, who advances M's case in a measured and careful way, this aspect of M's evidence tortured belief. I reject it entirely. The simple fact is and it requires to be stated unambiguously, M was presenting H to the outside world as a child who was dying. He was not.

51. Dr Ninis also reports that the person who passed that Facebook post on to her confirmed that M had requested that H be sent home with 'palliative care'. M did not dispute this but asserts that she did not mean to imply that this was somehow 'end of life care' but regarded it as a reference to pain care specialism. Again, I reject that. M is an educated and articulate woman, she knows well that palliative means terminal. This was the impression she intended to convey and is consistent with the broader canvass of evidence.

52. Running in parallel to M's increasingly bleak descriptions of H's condition is his own developing belief that he was dying. He talked regularly of 'dying' or 'not getting better'. H even suggested that he would 'prefer to die'. In addition M also told the medical professionals that H talked frequently to her about dying. On the 16th November 2015 there is the following entry in the medical records entered by the Children's Community Nurse, Alexandra Carlsson:

> "[M] explained that [H] has not been able to sleep very much and is very tired… pulse nurse also informed us that he spoke of dying to her while we were there. [M] informed us that he has been speaking more of dying lately and how long he has got left to live and he would rather die than have this pain. Pulse nurse told us that he is deteriorating everyday. [M] told us that [H] is now experiencing pain when given enteral

> medications and she feels that he needs IV paracetamol rather the enteral paracetamol "

53. I was struck by the observations of the nurses who gave evidence that they had very few conversations with H. On my assessment, M was and to a large extent remains, the conduit by which H's views are communicated to the outside world. My overwhelming impression, not least from the parents themselves, is that the mother/son relationship is stiflingly, almost claustrophobically enmeshed. I have no hesitation in concluding that H was talking about dying because his mother had generated this morbid narrative between them. I note from one of a number of examples that during the course of occupational therapy and physiotherapy on the 17th December 2015, H enquired why he had to do physiotherapy… 'as it won't stop the inevitable'. When he was asked what he meant by 'the inevitable'? he said "well what do you think it is?". A week earlier H had been speaking to a Dr Lucas with whom he also expressed concerns 'about death and dying'. Of course, all this when viewed through a wide forensic lens, further undermines M's explanation of the Facebook entries.

54. The enmeshed relationship between H and his mother is undoubtedly supported by F. F is by no means as voluble or as intimidating as M but, having heard his evidence, it is plain that he takes the same dystopian view of H's health as his wife does. F has recorded and/or filmed professionals on a number of occasions. F has also filmed H in pain. It is more than mere coincidence that H insisted on filming his first meeting, a few months ago, with his new consultant Dr Begent. In this H merely mirrors his father's oppositional behaviour towards the medical profession.

Manipulation of Opiate Medication

55. Although it might be regarded as a statement of the obvious, opiate based pain killers are very dangerous in the long term. Dr Ninis told me that they are not helpful in chronic pain management in children and contra-indicated in the research informing good practice. She makes the following observation in her report:

> *"[Opiates] cause physical and psychological dependency, lack of sexual maturation, immune dysfunction and lethargy. All of these side effects have been explained to [H]'s parents. In 2014, when he was discharged from the Royal London he was on approximately 200 mgs morphine a day (converting the tramadol and fentanyl to morphine).*
>
> *This was a very high level of morphine to be on long-term. The normal starting morphine dose for a child post-operatively would be 30-60 mgs/day.*
>
> *The full MDT team have become very concerned about [M]'s behaviour around opiate medications. She is very reluctant to reduce medications, to have them delivered into the gut instead of intravenous and to seriously engage in non- medication based pain management*
>
> …

> *There have been numerous discussions with [H] and his parents about the long-term side effects of opiate medication for [H]. This has been discussed by myself, Dr Platt and Dr Rawat. His liver is at risk of cirrhosis and failure due to the long-term administration of TPN. The best protection against this is to have a low volume of feed with drugs that help the liver. It has proved to be impossible to start this feeding regime before [M]'s arrest (at the time of writing this report, he is on 25mls /hr without any problems or pain related side effects). [M] has always claimed he wouldn't be able to tolerate the feed. Morphine based drugs reduce gut motility as a side effect; and we stated repeatedly that the morphine needed to be reduced to protect his gut and liver.*

56. Ms Brown identifies the following entries in the notes as illustrative of M's longstanding manipulative approach to opiate medication:

Year	Date and reference	Event
2011	29 Sept Vol 26 M354	Clinical notes*:* *I have clarified to [H]'s mother that regular paracetamol can only be used for short term NOT long term usage. I understood she has been asking for paracetamol to be given to [H] regularly*
	25 Oct Vol 29 M1258	Note of telephone conversation between Mother and Kirsty Keen, Pain Nurse: *Mum verbalised that she is aware that drugs may not be the answer and is willing to try anything, although also that if drugs were available she is happy to use them. She would like something to take the edge off.*
2012	16 Jan Vol 26 M403	Clinical notes*:* *Ward nurse requested clarification on use of IV Tramadol as mum had reportedly requested it regularly. [H] not currently complaining of any pain.*

57. To this needs to be added the recording by Nurse Nicola Leigh in an email to Dr Ninis in July 2012: '*Sorry [H] needs pain medication urgently according to mum any ideas??? Who should I speak to regarding medication apparently he is in agony? to which the reply was: I have refused to give opiates at home.*'

58. In her report Dr Ninis tracks specific examples of M's manipulative behaviour relating to opiates. These also require to be set out:

1. December 2014 - Dr Platt, Dr Alexander and I stopped his IV Tramadol as we felt this was a very inappropriate drug for him to be having at this age and intravenously. Subsequently *[H]*'s fentanyl patch was increased from 12mcgs/hr

to 50mcgs/hr in a short period time due mainly to [M]'s insistence that *[H]* was in pain.

2 Summer 2015 – after surgery at RLH, *[H]* was discharged on a strong opiate drug called Oxycodone. There was a weaning plan made to decrease the doses of this medication. At the end of this weaning plan, he was to be converted onto a morphine equivalent. When I was sent the weaning plan from RLH, I noticed that he would have ended up on 160mgs morphine a day instead of 80mgs (plus the other medications he was on, therefore the daily dose of morphine would have been in excess of 300 mgs/day) This would have represented a vast increase in daily morphine dosage. The pain team at Royal London Hospital stated [M]'s claimed he was on 10-20mgs oromorph up to 8 times a day. He was in fact on a total of 80 mgs oromorph a day as a ceiling, to be given as 20mgs doses or 10 mg doses as required but no more. It is my belief she misled the team. The pain nurse at the RLH, Ulricke Sigg agrees that she was misled and is writing her own report. When I insisted that a further wean took place, [M]'s obstructed this. The Chronology from the community Nurses,(see appendix 7) documents what happened in the community but the summary points are these:

3. 10.08.15 – [M] requests more bottles to be prescribed than needed.

4. 14.08.15 – [M]'s not happy with the way charts are written and despite nurses acting to sort this out, she blocks the reduction.

5. 14.08.15 – Nurse Ulrike Sigg – pain nurse at RLH noted that [M] does not always tell the truth.

6. Resulting effect of the above and attached appendix 7 illustrates [M]'s obstruction to the weaning of this high dose opiate.

7. 24th September 2015 – admitted to St Marys with broken peg –j tube so morphine cannot be given into gut. Morphine changed to IV boluses. *[H]*'s mother requests extra boluses of morphine when child not keen to have it. Mother observed to be insistent. *[H]* was subsequently transferred to the RLH. I called the RLH to inform them he was on morphine IV every 3 hours and the total dose was 40 mgs/24 hours. I spoke to his consultant gastroenterologist and his pain team. When *[H]* arrived there in the evening, I was called at home to say that [M] stated he was on morphine every 2 hours. I stated this was not the case. The notes from the RLH (appendix 8) show that *[H]*'s parents interfered with the management at the RLH and also claimed he was in agony, clammy and crying out but this was not seen.

   Prior to *[H]* being discharged on 25th September, [M] made a nurse write an incident report (datix) in relation to above and it contained allegations against myself. [M] also insisted on having a printed copy of this for her records (pg73). I later received an email apologising once this had been investigated (appendix 8). [M] had coerced a nurse into making a false report about my instructions regarding the pain killers

8. IV Paracetamol weaning regime in the community was also obstructed by *[H]*'s parents (pg 80-85). They insisted on drug charts being written in a certain way, insisted on emails going from myself to the GP, wanted a protocol for A&E with the result that there was a 27 day delay in weaning the paracetamol despite being instructed that his liver was showing signs of severe dysfunction

9. Admission from 17 November 2016 demonstrating abnormal parental behaviour in relation to opiates and other pain medications:

10. 17/11/2015(pg87): on attendance to hospital mother requests immediately IV medication and is unhappy when this is deemed not to be appropriate by medical team.

11. 23/11/2015 (pg98): child states pain is improved overall but mother insistent that this is not the case.

12. 25/11/2015 (pg102): Child does not want the sedation overnight due to drowsiness but mother observed to tell him to just take it anyway.

13. 09/12/2015(pg 119): unwilling to decrease morphine dose from 7.5mgs to 7mgs.

14. 16/12/2015 (pg 129): father requests IV paracetamol requires to be restarted although no indications noted for same.

15. 05/01/2016 (pg153): mother requests more analgesia for child to be able to progress with therapy although child is progressing as noted above.

16. 2/2016 (pg211): Child offered entonox to try as an alternative. Child noted to wish to try but mother refuses.

17. W recently insisting that all parecetamol given (for a fever) *must* be intravenous not jejunal despite being instructed that jejunal paracetamol is adequate.

59. Ms Bazley marshals her material on this question resourcefully. She notes that there are entries in the logs which suggest that M was fully supportive of the 'weaning regime', confirming the decision of the nurses to refuse pain relief and expressing a willingness to implement distraction techniques to divert H's attention from the pain she, at least ostensibly perceives him to suffer. Much focus centres upon the availability of the Drug Charts, in respect of which Ms Bazley submits:

> *"81. On the 14th August 2015 the drugs charts are delivered and are incorrect [Vol 24, 580-1]. The mother at this point insists that amended charts are provided by the Monday and until then the oxycodone dose should remain at 10 mg as charted. This is the only hiccup in the weaning regime causing a delay of some 6 hours in the plan. The mother was concerned that the doses being administered were not consistent with what was recorded and considered this would be in breach of the nurses' licences."*

60. It has to be said that M's stated reason for non compliance i.e. she 'considered this would be in breach of the nurses' licences' also fits easily with the way the Local Authority advances its case. It illustrates M's domination of H's medical regimen. There are many other illustrations of this. On the **21st September 2015** the Community Nursing Notes record:

> *M has stated that she will not be chasing up the drug charts as it is not her job, nor her idea to reduce the dosage of paracetamol, and that she intends to video H in pain and then sue everyone.*

On 3rd November 2015:

Text messages exchange with Dr Ninis…:

'M emailed to say that Mr Cleeve had suggested H needs more pain relief but that he knows Dr Ninis is dealing with pain management. Dr Ninis contacted Mr Cleeve, but he has not advised anything to family'

61. In what I find to be a prescient insight into M's behaviour, I note that Mrs Sandra Hall, Community Nurse, made the following observations at the very beginning of her involvement in early June 2014:

> *"Today main purpose of my visit was to introduce myself…M was happy to talk about everything to do with H's pain as need to speak about how much it had affected her.* ***She appears to want to control the situation.*** *(my emphasis).*
>
> *She talked about the pain management … and professional lack of understanding about H's pain"*

62. Dr Ninis used the term '**disguised compliance**' in her report to describe much of M's behaviour. It is a phrase which requires no amplification and, to my mind, encapsulates the method by which M repeatedly confused the clinical picture. In simple terms it involved telling some people what she knew they wanted to hear while giving an entirely different account to others. Dr Ninis draws the following measured and careful conclusion:

> *"There is evidence that [M] misleads the medical team as to the amount of opiate medication [H] is on, is very reluctant to allow us to wean any of his drugs and this has resulted in [H] being on very high doses of opiates with toxic side effects. Our opinion is that the requests for pain medications would escalate very fast again if he were to be discharged home."*

63. I heard evidence from Nurse Ulrike Sigg who was taken through the notes of the Royal London Hospital admission in July 2015. It was my impression of Ms Sigg that she continued to struggle to understand what had been happening in the hospital with H. As a caring, professional nurse she appeared unable to comprehend, on an emotional level, the facts which confronted her. A somewhat obtuse consequence of this was to render her evidence particularly clear and convincing. She had no hostile animus towards M and was extremely courteous to her throughout. In response to Ms Brown she was clear that the escalating use of morphine in H's case was entirely contrary to her own professional experience and her understanding of good practice. She also told Ms Brown that M's discovery of a leaking pump, delivering H's analgesia, was an unprecedented event in her own experience. Later it is recorded that M suggested that the leaking pump presented a risk that H had not received all his medication.

64. In what Mr Verdan describes as the 'overwhelming' material within the medical records illustrating M's manipulation of pain relief medication, one further nursing note demands to be recorded:

> *"Whilst coming out of X-ray…H said to his mother 'I might not need the chloral because I am already sleepy' and she replied 'well, let's have it anyway"*

65. Finally, in the course of her evidence M was asked to confirm that the Royal London Hospital had repeatedly emphasised the danger inherent in maintaining H on high levels of opiates. She agreed that to be the case in unambiguous terms. She was then taken to a note from the Victoria Medical Centre dated 22nd September 2015 which records as follows:

> *"M says that the pain team at the London have told her on several occasions that* ***H will not be able to reduce the morphine****… (my emphasis) ".*

66. This I find to be a clear example of M's duplicity, saying different things to different professionals and confusing the lines of communication. The effect of this ingrained behaviour was dangerously to compromise her son's care and to sabotage the efforts of the medical professionals. She is further recorded, in the above note, as stating:

> *"She feels the planned reduction in medication has* ***the potential to be cruel*** *and that H will suffer and not be given an alternative. Given his illness she wonders if this is fair and what it to be gained by making him miserable. When the tramadol was removed she describes his withdrawal as going 'cold turkey' and does not think he has been the same since. Pain has since affected his education and she worries that further reductions in pain meds will make this aspect worse."*

67. None of this is remotely reconcilable with M's stated position at this hearing i.e. that she was supportive of and cooperative with the plan to reduce H's opiate regime. On the contrary, I find that she was deeply resistant to it and, to the extent that she periodically expresses a contrary view, that is disingenuous or as Dr Ninis terms it 'disguised' compliance.

68. It is important to reflect on the impact of this behaviour on H. We know that H had difficulties with gut motility, Dr Ninis informs us that this is also a side effect of morphine based drugs. It is the case that H has not (aged 15 ½ years) attained puberty. I have been told that opiates impede sexual maturation. I have heard the extent to which H slept and his limited communications with the nursing staff, which it seems reasonable to attribute, in part, to the inevitable lethargy of 'a very high level of morphine to be on long term', as Dr Ninis put it. There were clear medical signs that H's liver was compromised and at risk of cirrhosis and failure. This was due to long term administration of TPN but inevitably exacerbated by high level of opiate use. Additionally, it seems to me only logical to infer that H will have developed both a psychological and physical dependency on these drugs and that withdrawal will have involved discomfort and distress. Perhaps most important of all as I have

emphasised, M's duplicity created a confused clinical situation which increased the prospect of medical error which might easily have led to serious repercussions for H.

Tampering with the TPN Line

69. On the 13th / 14th April 2016 the Local Authority contends that M deliberately tampered with H's TPN line. It is the case that a TPN has to be set up by two people, the second checking the process. These are the guidelines at St Mary's Hospital. On the night of the 13/14th, Sister Davis was responsible for setting up the pump and Nurse Henry was, in effect, the 'checker'. The pump has been here in court and I have had it explained to me how it works. The nurses proffered their own account of its functioning but the definitive explanation came from Ms Moira Kallis (a qualified nurse now specialising in training for the use of the mini rhythmic PM and Ambulatory Pump for the infusion of parenteral nutrition and fluid). Ms Kallis has been employed in this capacity for 5 years. She qualified as a state enrolled nurse in 1982, a registered general nurse in 1984 before becoming a community nurse and regional nurse manager. Her present role fits well with her experience because, as she reminded me, this particular pump is ambulatory i.e. it is designed for home use. Although that should have been obvious to me from what I had read, in fact, it came as rather a surprise. This is because H has been bed ridden and inactive for so long. To illustrate her point Ms Kallis told me that one of her patients using such a pump is a very successful competitive kayaker. Ms Kallis had no experience of a line ever having become trapped in any pump of this type at any stage of her career.

70. The line that the food flows down is separately loaded into the pump under a clear plastic hinged cover. The line fits exactly into a moulded area with a hinge screen door which, when closed, secures it to the pumping section. The line will only fit in the device this way, otherwise the small hinge flap will not shut. Ms Kallis told me that this is designed to avoid 'user error'. The clear larger lid clips closed and fits the corresponding part of the device leaving no gap. I found it difficult to open the clips. Those familiar with it however had little difficulty. Key to its understanding is that it operates in 'a clutch bag' fashion. The whole structure fits very tightly. For my part, I could not easily see how anybody setting this up could accidently trap the line. Moreover, both Sister Davis and Nurse Henry were clear that they had primed the line and that the pump was running before being set up in H's room. Ms Kallis made it clear that the pump can not run if there is an occlusion. Because it was thought that H struggled to tolerate feeding, initially the pump would run at a much slower rate before 'ramping up'. Even so the pump would alarm within a short time of a blockage or occlusion.

71. I am entirely satisfied, from the witnesses' accounts and from the pump recordings, that the pump was operative when set up in H's room. Both nurses gave a clear description of the line being trapped within the case when they responded to the alarm. If I am convinced, as indeed I am, that the line was set up properly by the nurses, then I find it very difficult to contemplate a situation in which the line could have become trapped accidently in this very compressed structure. I remind myself that this is an ambulatory device designed to be used by those with active lives. It seems to me quite impossible for the line to have become trapped haphazardly, in the way that Ms Bazley hypothesises on behalf of her client. Ms Kallis rejected that as a realistic explanation, as do I. For the avoidance of doubt I find that M deliberately tampered with the TPN line.

72. Contrary to what the Local Authority appeared to understand at the commencement of the hearing, the trapping of the line did not compromise H's health or safety in any way. The device cuts out as soon as the alarm sounds. Mr Verdan postulates that M, having been banned from using the pump a few days earlier, pursuant to Dr Ninis' directive, was motivated to prove the nurses to be incompetent in their use of the pump. I confess the same explanation had occurred to me but it can only be speculation. This said however, it is inherently dangerous for a parent to manufacture alarm in a clinical situation. It is a further way by which confusion and anxiety is generated in the hospital ward, which is in itself inimical to H's care.

73. In this case lightning struck twice! The mother was arrested and interviewed and for a period was prohibited from having contact with her son. On the 26th April 2016, whilst the father was having contact with H, precisely the same incident recurred. Again the line was trapped in the plastic cover in circumstances which were strikingly similar to the first episode. In the light of my reasoning above, the real issue on this occasion is not whether it was deliberate or accidental but who did it. I was unsure until I heard the evidence of F. Though I will set out my impression of him more generally (below) I found the father's account to be hollow and unconvincing. He told me and I broadly accept, that he habitually had left H's feeding and medical care to M. He also stated that he was uncomfortable with the TPN device. It is unusual therefore, that presented with an apparent alarm, his first reaction was to telephone somebody (either M or his solicitor) rather than run immediately to get the nurse. Whether F was uncomfortable with the TPN or not, it was very clear from his evidence that he was entirely familiar with the principles of how it operated. He was also, to my surprise, as familiar with the 40 files of evidence in this case as M was and equally fluent in medical terminology. I have no difficulty at all in concluding that F deliberately trapped the line. Why he should have done so is again speculation but I think it likely to have been a desperate and bungled attempt to assist M.

Physiotherapy

74. Crucial to H's health and development is his need for physiotherapy. During the course of this hearing the family presented me with a bundle of photographs taken between 2012 and 2017. They make disturbing viewing not least because some of the activities, sailing and camping etc., indicate a physicality which is difficult to reconcile with parental concerns about H's health at the time. Striking are two photographs in the summer of 2012, one showing H sailing a Laser dinghy on the Thames in physically challenging circumstances, the other showing him in a wheelchair with an NG tube in place and a blanket over his knees. The tube can not easily be reconciled clinically. Dr Ninis is very clear that H is capable of normal physical activities for a child of his age. She has repeatedly impressed this on the parents as they both accept. M's position is that she supports H participating in physiotherapy and claims she has always done her best to facilitate it. Ms Brown points to multiple references to M actively preventing physiotherapy from taking place. Some, but by no means all, are incorporated by Ms Brown into a schedule which I propose to incorporate into this judgment and requires no amplification:

Year	Date and reference	Event

2011	21 July Vol26 M269	*Mother did not attend pain management appointment and did not allow [H] to attend gym because of being given Movicol and feeling disbelieved.*
	28 Sept Vol26 M352 29 Sept Vol 26 M353	Nursing entry: *I told Mother [H] can try physiotherapy this morning with less intense exercise but she thinks [H] will not be able to cope. She would like a doctor not nurse to tell physio that [H] is not fit for physiotherapy.* Further entry written retrospectively: *I called physiotherapy department and informed [H] was not able to have physio yesterday morning. In the afternoon I saw [H] was running along the corridor joyously.*
2012	30 May Vol 36 N641	Letter from Deneil Fernandez, Specialist Paediatric Physiotherapist to Claire Robinson: *I spoke to [H]'s mum yesterday….She was really aggressive and upset that we contacted her and that she didn't know that he had been re-referred to us. She told me that she was furious as [H] is still extremely unwell, losing weight and has not had any medical input since February this year…..When I suggested physiotherapy to help build up [H]'s mobility, she said that she did not see the point as he was far too unwell and she feels that it would be too risky, as he has POTS, is losing weight, has abnormal potassium levels and is so fatigued that he is sometimes unable to hold up his head. She said that he is unable to leave the house as he can't manage the 64 stairs. She felt that until [H]'s medical needs were addressed physiotherapy would not be helpful.*
	9 July Vol 7 1106	Report of Deneil Fernandez *Whilst both parents want [H] to have physiotherapy input and fully understand the need ….they are anxious about carrying out any activities that involve physical exertion with [H], due to the risks of him suffering automnomic symptoms, particularly fainting. The family feel that he is medically unstable and that physiotherapy in isolation of his medical issues being addressed could potentially cause harm to [H].*
2013	3 May Vol 16 K379	Recording by physiotherapist from Royal London *Discussion with Mum re. physio input whilst on ward. Mum reports she has spoken with patient's consultant at St Mary's and she has and she has*

		advised against mobilising at present.
2014	Vol 16 1 April 576	From physio notes: *Had rehab at GOSH, unhappy with care, now under Jane Simmonds. Mother reports reluctatnt to engage with PT, mobilising short distances prior to adminssion, since admission just transferring bed to chair but struggles with POTS during transfer.*
	2 April 579	*Mother and Father not happy for PT when Mother is not there.*
	4 April 582	*Attended ward this am to arrange time for PT, spoke to [H]'s mother who was unsure of a 'good time' but agreed for 1100. Bleeped by Sister who advised [H] not feeling well and to return this pm to see if he was feeling better. [H]'s mother advised that he is not feeling well, currently having an obstruction and not able to tolerate feeds. Asked me to return for PT on Monday. I explained I may not be able to as I only work within the team Wed – Fri.*
	10 April 597-8 and 601	Long discussion with Mother. Complaint that there had not been physio each day. Explanation given that it would be x3 a week, Wed to Fri. *She also wanted to know why [H] had not been given a programme from Jane Simmonds. I explained that Jane had not provided one to which [H]'s mother accused me of lying….I also explained I would need another member of the team with me to which she advised was not acceptable to [H] as he would think they were writing reports on him. …She also wanted to know why another parent was seen over her child yesterday and why we did not see [H]. …She continued to request a discussion with my manager….Returned to the ward with Manager. [H]'s mother requested Jo Lawler (Senior Sister) present for the discussion….[H]'s mother became very angry and accused Nicole of being rude for using the word 'allow' saying that it was not that it was not that she had not allowed it, she then advised she wanted Jo Lawler present and stormed off.*
2015	19 Nov Vol 8 J1771	Ward Round with Charles Tagore: *Dr Charles discussed how every illness has a psychological effect and overall [H] would benefit "He would throw them out and throw a hissy fit" "The same goes for the physios –*

		unless you sort out the gut it won't work" "The word rehab fills me with horror" "That's a while down the road until the gastro is sorted"

75. Following the police investigation, the parents were prevented from having contact with H for some time. There were some striking developments. It should be remembered that H was on full TPN feeds via a Hickman line for two years. In summer 2015 the RLH had asked M to give H 2mls/per hour feeds. In her emails M stated that H was in excruciating pain as a consequence of the feeds. The email reads as follows:

> *"I am continuing but this morning at 5 am **[H] was screaming with stomach cramping** and at 10am his stomach was so bad he was **curled up screaming and crying**. Nurses have noted a big change since the milk started"). (By late evening meds and at 5 am this morning he was screaming and banging his fist on the walls. His stomach pains are usually bad every night but his pain had increased quite dramatically).(my emphasis)*

76. In her report Dr Ninis describes the reaction of the medical team to the cessation of milk:

> *"This was very disappointing as we are aware that TPN on its own will inevitably lead to liver failure over time and this has been explained explicitly to both of [H]'s parents. Milk feeds into the jejunum protects the liver. "*

77. In her evidence Dr Ninis unpacked that paragraph in simple terms. She told me that patients who go on to TPN 'do not come off it'. As I understand it, TPN is synonymous with complete intestinal failure. As Dr Ninis emphasised and as both parents clearly understood, milk being fed into the jejunum was the first line of defence in protecting the liver. Thus, the TPN was inevitably regarded by the doctors as 'life limiting'.

78. Dr Ninis could plainly not have been more surprised nor more delighted with events following the parents' removal, subsequent to their arrest. She observed this:

> *"Since the parental arrests, we have managed to increase the jejunal feeds without any problems **(no pain, pump alarm, signs of gastro-intestinal dysfunction)** to 42 mls an hour (at time of writing). The TPN is now stopped and this has been achieved in a very short period of time without any problems at all.*
>
> ***This is an incredible achievement given we have all thought that he had complete intestinal failure. This will mean [H] no longer has a life-limiting condition and should have a normal life expectancy."***

79. From this scenario, which is inexplicable in clinical terms and properly described by Dr Ninis as 'incredible', flow certain irresistible conclusions. Dr Ninis articulates them in a short paragraph, with which I agree:

> *"Conclusion: previous maternal reporting of gastro-intestinal pain was exaggerated and has led to [H] being fed unnecessarily via a hickman line, exposing him to many risks in the short term (infection, fluid issues) and liver failure in the long-term. It is our opinion that parents would continue to report these levels of pain and jejunal feeding would not be sustained if he was to go home."*

80. Those carefully chosen phrases deliver a powerful message which I again consider needs to be emphasised in clear and unambiguous terms for all those who may read this judgment. I have in mind, particularly, those who will be responsible for H's care and welfare in the future. M's exaggeration of her son's pain led to an unnecessary Hickman line. M's continued misrepresentation of H's pain compromised his liver function and accordingly threatened his life. This is the risk M represents, that is to say she is a risk to her son's life.

81. Various counsel have commented on M's presentation in Court. I do not propose to do so other than to record that she has been polite, courteous and respectful of the process. There has been none of the voluble behaviour that characterised her time in the various hospitals. However, as is clear from my reasoning above, I found her an entirely unreliable and dishonest witness. Moreover, I found her approach to this litigation to be artificial and unconvincing. She has in the past condemned Dr Ninis in withering and offensive terms. At this hearing, in her evidence, she was keen to deliver a paean of praise. As Ms Bazley had cross examined Dr Ninis on the basis that she held *'strongly negative views of the parents'*, this was not immediately easy to reconcile. M's position in the witness box simply, in my judgement, illustrated once again her capacity to articulate what she believes to be expedient at that particular moment.

82. I found it much more difficult to evaluate F. Part of the challenge as Ms Morgan QC and Mr Momtaz QC, have emphasised, on F's behalf, is that many of the records refer to 'the parents' without necessarily clarifying whether this relates to one or both. Inevitably this was not easy to tease out in the course of oral evidence, given the passage of time. This raises a wider point. It is axiomatic that when keeping medical records, particularly for children, they are recorded as accurately as possible. Children frequently have to rely on adults to communicate their symptoms. Whilst I appreciate that it is easy to be fastidious in the relative calm of a courtroom and that circumstances on a busy ward are much more challenging, it is not unduly challenging to indicate, in the notes, who is describing the symptoms. The problem is frequently more pervasive e.g. a history given by a parent that a child is in obvious pain is not recorded helpfully if the note states: *child in obvious pain*. Later review of note may create the impression that this has been independently observed by a doctor or nurse. This strikes me (and Dr Ninis endorses my observation) as unsatisfactory both clinically and forensically. I record this view not to be in anyway critical of the extremely conscientious medical personnel in this case but to exchange experience in order both better to protect and diagnose children in future cases.

83. Ms Morgan emphasises the fact that Dr Ninis appeared to have identified F as more open and receptive to the various professionals. In the report St Mary's Hospital prepared for the Child Protection Case Conference on 18.04.16, Dr Ninis listed as one of the 'Strengths/Protective Factors' the '*multiple occasions in which father attempts to engage with professionals and enable his child to achieve tasks and develop'*.

84. This enabled Ms Morgan and Mr Momtaz to advance the following proposition: '*It is submitted that it is telling that she [Dr Ninis]could identify him [F] as such and express such a conclusion even as recently as ten months ago at a time when her evidence otherwise was that the earlier positive relationship with 'the family' had broken down. This characterisation was borne out by all the treating medical professionals who gave evidence during the hearing albeit it is accepted that the father had limited interaction with some of them.'*

85. Further, Ms Morgan, in her careful cross examination, was able to elicit the following acknowledgments from Dr Ninis: she generally found the father easier to talk to where there was a difficulty; she felt the father listened more; the hospital had felt the father dealt with things somewhat differently; she generally found the father more accessible.

86. F gave evidence over a number of hours in the afternoon. The Court then adjourned overnight. I detected a rather different approach by him to the questions asked of him the following day. He was far more irascible and avoidant. To simple and uncomplicated questions he responded by diving into the bundles to check context and detail. Frequently his answers were entirely disconnected to the question. He was wholly supportive of M's perspective of the case and plainly shared it. I also noticed that he struggled to contain his anger at times.

87. F is in a difficult position. Ms Morgan and Mr Momtaz make the following observation:

> *"The father is very worried that [H] will only thrive and make the required progress if he is or has the prospect in the near future of living with one of his parents. This seemed to be the joint position of all the parties in this case prior to the hearing commencing."*

88. Mr Verdan submits that I should conclude that F is 'unable to protect' H from the harm caused by his mother. With respect to Mr Verdan, that does not go far enough, nor does it fit with his broader analysis of the evidence or indeed the specific findings he invites me to make against F.

89. Having concluded above that F shares M's distorted perspective of H's health and that he has tampered with the TPN machine himself, he must be regarded as more than a merely passive figure. He has caused significant harm to H and continues to present a risk to H in the future. I entirely accept Ms Morgan's submission that he now will require time to absorb these findings.

H's Education

90. In a case which has been characterised by contradiction, confusion (frequently deliberately created) and inconsistency, there emerges one constant. Everybody who has met H has been impressed by the vibrancy and curiosity of his intellect and his sophisticated powers of expression. Very late in the day he became a party to these proceedings; his guardian is now separately represented. He has listened into the hearing at his own request. He is, at present, too weak to attend court. I also have glimpsed something of what I have been told about him.

91. As a consequence of his parents' actions in the medical sphere, H has received no adequate education for approximately 3 years. This is a boy who won a place in a very highly regarded public school. He now will not be able to take his GCSEs along with his cohort. His real academic potential has been seriously jeopardised. The two people in his shrunken world who H was entitled to expect to protect him became agents of harm to him. He has not only been deprived of structured academic education, he has also missed the stimulation of his peers on which I sense he would have thrived.

92. It is perhaps not surprising that, as an only child, living in this small household, subjected to his parents' distorted beliefs, H has learnt both to respond to and copy his parents' behaviour. This is the consequence of their actions for which they and not H are responsible. H's challenging behaviour is the result of the harm inflicted upon him for which he must not be blamed but in respect of which he must now take responsibility. Counsel have made extensive submissions as to the manifestation of this learnt behaviour. However, I do not think it necessary further to burden this judgment with the details of it. I think it would be counter-productive to do so and, after careful reflection, I do not think it is forensically necessary. One point which does require to be recorded is that H shares his parents' profound and in the circumstances of this case, entirely irrational opposition to psychological support. H will most certainly require it in the future.

The Interim Care Orders

93. For some months now under the aegis of the ICO H has been placed in a residential unit. I have been extremely disappointed by the Local Authority's lack of attention to his care. In the unit H has received inadequate educational provision; virtually no opportunity for socialisation; negligible physiotherapy (his most vital and pressing need) and no satisfactory medical review (though the latter is predominately the responsibility of UCLH). I appreciate that this is, as Dr Ninis put it, 'a [most] difficult family' but that is precisely why the Local Authority intervened and, as I have said, on the basis of a very compelling body of evidence. They sought public law care orders in order to protect H from harm. They have not done so satisfactorily. This cannot be permitted to pass without censure.

94. H's parents have had contact with him, 'supervised' by agency supervisors. It is quite clear that these individuals have no understanding of what they are in fact there to supervise. They simply take notes.

95. When the full extent of the Local Authority's failures began to emerge I indicated that I intended to follow a 'special measures' regime in which a fortnightly report in respect of H, countersigned by the Children Services Director, would be sent directly to my clerk. I am happy to record that within 12 hours of my requiring immediate physiotherapy for H the Local Authority was able to secure it. At present H is cooperating enthusiastically with it. My direct intervention should not have been necessary.

96. At a Case Management Hearing shortly before the final hearing Mr Verdan told me that irrespective of the outcome of the hearing, it was the Local Authority's plan to return this child to the parents' care. The Local Authority therefore questioned whether this hearing was necessary at all and seemed prepared to concede to some

limited and anodyne concessions proffered by Ms Bazley. I make it very clear that I do not criticise Ms Bazley in any way. By contrast, the Local Authority's position was entirely misconceived. There are, as I have already indicated, some 40 lever arch files of reports, statements and medical records cumulatively identifying child protection concerns at the most serious end of the index of gravity. Mr Geekie QC, who then represented H via his Guardian and now represents him directly, along with Ms King, made the following observation:

> *"At both the meeting with Mr J and the advocates' meeting there was discussion as to whether, given the realistic option(s) for [H], there is a need for a wide ranging exploration of the facts, as presently provided for, with a 3 week listing. The local authority indicated at the advocates' meeting that it would be proposing a return of [H] to the care of his parents but with a supervision order in place. That necessarily requires the threshold conditions to be met. The local authority was inviting the parents to make such concessions as are necessary to traverse the threshold, but no more, with a view to resolving the case without a fact finding hearing. "*

97. The Guardian rejected this approach, he was entirely right to do so. In fairness to the Local Authority, faced with the combined resistance of the Judge and the Guardian they quickly revaluated their position.

98. Subject to submissions from counsel, as to ambit and extent, I intend that this judgment should be made available to a wide range of medical practitioners presently and historically involved in H's care. I propose that key staff at the unit should read it. I am determined that it should be placed on H's medical records. I intend that H's parents be distanced from any involvement in his medical care, physiotherapy or therapeutic support in order that H may be afforded the opportunity to assert his most basic of rights, his own personal autonomy.

99. In order that my intentions can be effective and conscious that this is a lengthy judgment, covering a wide range of issues, my findings require to be set out clearly and accessibly. Thus:

i) The parents have misreported and exaggerated H's medical symptoms, which has led to his physical and emotional harm;

ii) The consequence of (i) above, particularly the exaggerated gastro-intestinal pain, led to the unnecessary insertion or prolonged use of a Hickman Line which exposed H not merely to risk of short term infection but to the risk of liver failure in the longer term;

iii) M, through her bullying and bombastic behaviour has intimidated medical professionals and others, to the extent that she has confused and undermined their confidence in their own professional judgement. This generated a febrile atmosphere in which there was an elevated risk of clinical error, thus compromising H's safety;

iv) In April 2016, both parents and on separate occasions, covertly tampered with H's TPN pump. The effect of this was to cause confusion and alarm on the ward and jeopardise professional objectivity;

v) F has both directly supported and passively acquiesced in M's distorted perspective of H's medical needs;

vi) M presented H to the world as dying and inculcated in him a view that he was;

vii) The parents' actions above led to H's prolonged stays in hospital and denied him his opportunity for education and socialisation.

100. Again, in order that the point is not lost in the detail of the judgment the harm caused to H by his parents, protracted over many years, exposed him to significant harm at the most serious end of the spectrum, ultimately risking his life.