Neutral Citation Number: [2021] EWHC 3750 (Fam) Case No: ME20C00364

IN THE FAMILY COURT
SITTING AT THE ROYAL COURTS OF JUSTICE

Royal Courts of Justice,
Strand, London, WC2A 2LL

Date:10/12/2021

Before:
THE HONOURABLE MR JUSTICE WILLIAMS

- -

Between:

Kent County Council **Applicant**
- and -
(1) The Mother
(2)-(3) MGM and MGF
(4) AB
(5)-(9) V, W, X, Y and Z (By their Children's Guardian, Ms KR)

Respondents

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- -

Sarah Morgan QC and Steven Ashworth (instructed by Invicta Law) for the Applicant
Damian Woodward-Carlton QC and Katie Phillips (instructed by Fraser Hollands Solicitors) for the First Respondent
Penny Howe QC and Lydia Slee (instructed by Boys & Maughan Solicitors) for the Second and Third Respondents
Paul Storey QC and Stephen Chippeck (instructed by Patrick Lawrence Partnership LLP) for the Fourth Respondent
Sally Stone QC and Patrick Paisley (instructed by Creighton & Partners) for the Fifth to Ninth Respondents

Hearing dates: 1-5, 8-12, 15-16, 18, 22, 24-26, 29 and 30 November and 1, 6-7 and 10 December 2021

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Approved Judgment

I direct that 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 WILLIAMS

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.

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Williams J :

1. This is my judgment in respect of fact finding in respect of care proceedings brought by the Local Authority. The subject children are: V, a boy born on 4 January 2008 (13 years old); W, a girl born on 4 September 2014 (7 years old); Y, a boy born on 29 July 2016 (5 years old); X, a boy born on 22 September 2017 (4 years old); and Z, a girl born on 22 December 2020 (11 months old). The Mother is the mother of all the children ('the Mother'). The maternal grandparents are MGM and MGF; they are currently caring for V, W and Y. The father of V is unknown; the Mother has indicated that she only knows his name to be EF. The father of W and Y is reported to be CD. He has not sought to be involved in the proceedings. The father of X is AB At the point these proceedings began X had had no contact with his father since birth. The father of Z is also now known to be the same as that of W and Y. The man identified by the Mother as Z's father was briefly joined as a party, but his party status was discharged after paternity testing revealed that he is not Z's father. Subsequent DNA testing showed W, Y and Z were all full siblings.

2. The Local Authority asserts that, at the respective relevant dates, V, W, Y and X were suffering and likely to suffer significant harm and that Z was likely to suffer significant harm; and that the harm and likelihood of harm was attributable to the care given to each of them, or likely to be given to them if an order was not made, not being what it would be reasonable to expect a parent to give to them. The significant harm concerned falls within categories of neglect, physical and emotional harm but can largely be described as a case of Fabricated or Induced Illness (FII) which has been the principal focus of this fact-finding hearing.

Threshold

3. The allegations under the FII heading in the Local Authority's schedule are interlinked. They effectively amount to a course of conduct in which the Mother has exaggerated, over-reported and/or fabricated the medical symptoms of four of her children, escalating in severity until she injected bleach into X's gastro-feeding tube on 19 September 2020. Such behaviour, even in isolation, is self-evidently a cause for very serious concern but the Local Authority allege that the Mother has been engaging in similar behaviours which fall under the FII umbrella over a period of several years and in respect of four of her children, which if established would raise the level of risk to be considered at the welfare stage of proceedings very significantly indeed. An application made at the outset of the hearing on behalf of the Mother, to the effect that the hearing should only consider the allegations in so far as they related to X, I rejected in part because of the potentially broader ramifications of more extensive findings.

4. The threshold schedule in its final form A(i)-11 runs to some 12 pages. The LA allege that the children have suffered or been at risk of suffering significant harm through repeated unnecessary medical appointments and examinations, being given unnecessary medicine, through X's nutrition being hindered, through the risk of harm to him from introducing bleach into his stomach and confusion over their state of health. The LA also allege that the children suffered emotional harm through the unavailability of the Mother due to her pre-occupation with medical issues and from experiencing X's condition. In a more summary form, it sets out the following allegations *with the Mother's responses indicated.*

i) A. Fabricated or Induced Illness (FII)

a) Allegation (1) relates to the Mother's exaggeration, over-reporting and/or fabrication of V: (a) asthma; (b) joint/hypermobility problems; and (c) constipation.

b) Allegation (2) relates to the Mother's exaggeration, over-reporting and/or fabrication of W's: (a) symptoms of cow's milk protein intolerance; (b) symptoms of gastro-oesophageal reflux disease; and (c) symptoms of asthma.

c) Allegation (3) relates to the Mother's exaggeration, over-reporting and/or fabrication of Y's: (a) difficulties in swallowing and choking/gagging on food; and (b) symptoms of wheezing/suspected asthma

d) Allegation (4) relates to the Mother's

i) exaggerating, over-reporting and/or fabricating the frequency of X's cough and vomiting;

ii) inducing his vomiting, thereby hindering his nutrition and development;

iii) further or alternatively, depriving X of nutrition; and

iv) inducing illness on at least one occasion on 19 September 2020 but likely on other occasions in particular on 16th January 2020 when X had produced a "very different" vomit, which was brought up effortlessly and accompanied by an "unusual smell".

The Mother does not accept these assertions save that she accepts that the evidence shows she must have introduced bleach into X's stomach tube, but she says she has no recollection of doing so and does not know why she did it. She says she misled police and professionals because she feared going to prison.

ii) B. Physical Harm: Attempted Poisoning Of X By The Mother

a) Allegation (6) relates to the events of 19th September 2020, addressed above.

iii) C. Neglect

a) Allegation (7) relates to V's very low school attendance. *This is accepted by the Mother, albeit she proffers some mitigation for what she says was a struggle on her part to encourage V to attend.*

b) Allegation (8) alleges that it is likely that X's developmental delay was exacerbated by neglect (including under-stimulation) whilst in his Mother's care, the Local Authority relying upon the significant progress that X has made since leaving her care. *The Mother does not accept this.*

c) Allegation (9) particularises, in 16 subparagraphs from (a) to (p), what the Local Authority submits was the Mother's neglect of X's health and developmental needs. The matters pleaded include cancelling or missing important medical appointments, refusing to agree to medical tests, resisting HV visits and in-patient admissions and, ultimately, discharging X from his elective admission to Hospital A on 11th September 2020 against medical advice. The Mother had to be persuaded by children's social care to return X to the hospital two days later. *The Mother's response, in terms, is that whilst it is accepted that these appointments did not go ahead, mother would assert that there was a reasonable reason why those appointments were not attended. She also asserts that all would have been re-scheduled. The reasons were likely, illness of one or all the children, time clash with other pre-booked appointments, lack of travel time to get from one appointment to another, time clash with school/nursery pick up/drop off, family being on holiday, no childcare, signalling issues (when remote appointment) and around the time of Planned Admission to Hospital for X*.

d) Allegation (10) particularises, at (a), (b) and (c), missed/cancelled appointments or non-engagement with services for V, W and Y respectively *The Mother's case is that she does not accept there was non-engagement although accepts some appointments may have been missed for good reason*.

iv) D. Exposure To Domestic Abuse And Mental Health Difficulties

a) Allegation (11) avers that V, W and Y were exposed to domestic abuse in the relationship between the Mother and CD, and that she returned to that relationship despite the risks she was aware that he posed to her and the children. *The Mother accepts she suffered domestic abuse but does not accept the children witnessed it.*

b) Allegation (12) relates to alleged domestic violence in AB's previous relationships, and the allegations made by the Mother about her own relationship with him. The Mother alleges AB stalked her around the time X was born. AB denies stalking the Mother in May 2017 and whilst he accepts the fact of findings made against him by HHJ Davies and of criminal convictions for breaching a non-molestation order he denies he poses a risk of domestic abuse.

c) Allegation (13) particularises the harm which exposure to domestic violence can cause to children and pleads that efforts to support the Mother to develop insight into the impact of domestic violence were not successful, as she did not engage with the domestic abuse programmes made available to her. *The Mother's response to this paragraph of the schedule is that she does not accept it.*

d) Allegation (14) relates to the Mother's significant history of mental ill-health as a child and adolescent *The Mother accepts, she has suffered from mental health problems.*

e) Allegation 15 relates to the emotional availability of the Mother when low. *The Mother accepts that at times when she has been feeling low, she is likely to have been emotionally unavailable to the children.*

v) E. AB

a) Allegation (16) pleads that at the relevant date AB had no involvement in X's life whatsoever and had been unable or unwilling to mitigate the significant harm he sustained in the care of his Mother. AB's response to this allegation accepts that he had no involvement in X's life at the relevant date but submits this was not unreasonable "in light of him being unaware of X's existence" and given that he "had no knowledge of X until after the commencement of these proceedings".

b) Allegation (17) pleads that AB was the subject of adverse findings in care proceedings. He denies having a history of domestic violence although accepts being involved in verbal arguments. He accepts findings made by HHJ Davies including that he was in a pool of perpetrators of a bruise to a child, that he had sought to frame a child's father, that he neglected a child.

5. The Mother's position thus was of a very limited acceptance of the allegations made against her even in respect of the bleach incident. She attended court regularly throughout either in person in London or in Canterbury and remotely.

6. The maternal grandparents were not the subject of allegations within the threshold. They were in an uncomfortable position particularly having regard to the domestic arrangements that had been implemented following the events of September 2020. The maternal grandmother had moved into the Mother's home to care for V, W and Y whilst the maternal grandfather had remained in the family home and the Mother had returned to live there. This changed only at the conclusion of the evidence when the maternal grandfather moved in with the maternal grandmother and the three children. They were thus caught, the grandfather quite exquisitely, between their daughter and their grandchildren. At the outset of the case they accepted the strength of the bleach allegation and expressed considerable concern about the extent to which the Local Authority's other allegations might be substantiated. Given their childcare commitments, their ability to participate in the hearing face-to-face was limited but they sought to join remotely whenever they could. They attended by the time they came to give evidence themselves and having listened to much of the other evidence they both acknowledged that the evidence supported more extensive findings against the Mother than the bleach incident alone. I appreciate how difficult this must be for them and it was self-evident that the grandfather found making that acceptance very hard. They wanted to understand as much as possible about what had happened in order to better support the children.

7. AB's employers agreed to vary his working hours so that he was able to join the hearing remotely mid-morning. He attended on a regular basis and in due course attended court to give evidence face to face. His position remained broadly that he put himself forward as a long-term carer for X on the basis that, whilst he accepted the findings made against him in the judgment of HHJ Davies, he said that the allegations made against him had been exaggerated by the Mother and that he had been tainted by other unsubstantiated allegations. By the conclusion of the evidence it was accepted that his assertion that he

had been unaware of X's existence was not correct but it was not accepted that his involvement at any earlier stage would have made any difference to the trajectory of X's life.

8. The Guardian's position at the outset was in general terms broadly supportive of the Local Authority's formulation of the case. The Guardian attended remotely and was not called to give evidence. By the conclusion of the evidence, the Guardian found herself more clearly in support of the Local Authority's case.

Fast Forward

9. In order to avoid further lengthening this judgment I have not included an executive summary of my conclusions at this stage. The part of this judgment sub-headed **Evaluation** contains the core of my reasoning and the **Conclusions** what my ultimate findings are on the allegations made**.**

Preliminary Issue

10. At the commencement of the hearing an application was made on behalf of the Mother that the court should exercise its Case Management powers to exclude certain of the Threshold issues – essentially all those save those FII related issues which did not concern X – from the ambit of the fact-finding hearing. The parties were essentially in agreement that the principles to be applied were those set out by McFarlane J (as he then was) in Oxfordshire County Council v. DP, RS and BS [2005] EWHC 1593 (Fam),; principles recently endorsed by the Court of Appeal in Re H-D-H (Children) [2021] EWCA Civ 1192 . The principles are,

"[24] The authorities make it plain that, amongst other factors, the following are likely to be relevant and need to be borne in mind before deciding whether or not to conduct a particular fact-finding exercise:

a) The interests of the child (which are relevant but not paramount);
b) The time that the investigation will take;
c) The likely cost to public funds;
d) The evidential result;
e) The necessity or otherwise of the investigation;
f) The relevance of the potential result of the investigation to the future care plans for the child;
g) The impact of any fact-finding process upon the other parties;
h) The prospects of a fair trial on the issue;
i) The justice of the case.

[25] I am well familiar with the concept of 'necessity', arising as it does from ECHR Art 8 and, indeed, from the pre-Human Rights Act 1998 case law to which I have been referred. It is rightly at the core of Mr Tolson's submissions in this case and, without overtly labouring the issue by including substantial descriptive text in this judgment, it is at the forefront of my consideration of the point. Amongst the pertinent questions are: Is there a pressing need for such a hearing? Is the proposed fact-finding hearing solely, as Mr Tolson puts it, 'to seek findings against the father on criminal matters for their own sake'? Is the process, which will be costly and time

consuming, with potentially serious consequences for the father if it goes against him, proportionate to any identified need?"

11. In their Position Statement the application was summarised as follows

The enquiry put before the court by the Local Authority is too broadly drafted to be capable of a fair hearing and the court will be left with evidence that is of poor quality and little value. It is submitted that this would apply to allegations 1 (V), 2 (W) and 3 (Y), 4 (in relation to X) – save for 4(d) which relates to specifically pleaded allegations capable of identification and determination.

In his oral submissions Mr Woodward-Carlton broadened this a little more and submitted that the court should confine its enquiry to matters relating only to X as they covered exaggerated, over-reported and/or fabricated allegations, inducing vomiting, depriving X of nutrition, and inducing illness by introducing bleach into his feeding tube which essentially covered all the behaviours alleged in relation to V, W and Y. This he submitted was what was necessary to properly inform any risk assessment of the Mother and thus the welfare evaluation and was proportionate having regard to the nature of the issues engaged, the huge amount of non-specific evidence contained in the bundle and risk of unfairness to the Mother in seeking to evaluate her evidence so long after the event. He also submitted that the allegations relating to missed appointments for X and the other children (allegations 9 and 10) were disproportionate and impossible to adjudicate fairly.

12. It was accepted that the court can properly consider allegation 5 (amended in relation to X only), allegation 6 and allegations 7 and 8, and from allegation 11 onwards. Allegations 7 and 8 form a separate category ('neglect') as do allegations 11 onwards ('domestic abuse') and it is accepted therefore would be relevant to determine the sort of risk the children might be exposed to.

13. The Local Authority and the Guardian were wholly opposed to the application. The maternal grandparents in a light touch way supported a broader enquiry and were thus opposed to the narrowing of the ambit of the hearing and AB was neutral as the application envisaged a near complete evaluation of the allegations relating to X (save for the failure to attend appointments)

14. Having read the Mother's position statement and listened to Mr Woodward-Carlton's submissions I was clear that the fact finding hearing would need to cover the entirety of the allegations made in the threshold schedule in order to ensure that as full an understanding of the Mother's behaviour over a protracted period of time and in respect of four separate children was captured. This I considered was necessary in order to inform any risk assessment of the Mother in the future but also that it was important too that for the children and the wider family the history of what had happened to them was established both individually and collectively. I wondered whether such an evaluation could be achieved by focusing in the hearing on the evidence relating to the three years prior to September 2020 which would potentially have addressed some of the concerns about the historic evidence and how reliably it could be considered and also might have focused the enquiry in a way which addressed the concerns about the very diffuse nature of the evidence and its volume. However both Miss Morgan and Ms Stone persuaded me that this would not be appropriate as the court would need to consider the beginning of the alleged behaviours in relation to V and how this shifted

over time to the other children culminating in the events of September 2020. Significant aspects of the continuum of behaviour might well have occurred earlier and ought properly to be encompassed by the hearing. I was thus persuaded that the application should be refused on the basis that it was both necessary and proportionate in particular having regard to the interests of the children and the need to establish a clear narrative of their history to inform risk assessment and welfare determinations.

15. I indicated that, unless specifically invited to, I did not propose to give a discrete judgment on that issue but would incorporate some observations and my conclusions within the main judgment. In the course of submissions the issue of the extent to which the court should seek to make findings in relation to particular facts which supported an allegation was raised and the parallel with looking at patterns of behaviour in domestic abuse cases rather than particular facts which might be innocuous on their own but which when put into a much broader evidential picture might form part of a pattern. In particular, Mr Woodward-Carlton as part of his main submission, cautioned against the danger of drawing inferences from certain facts when other facts pointed to a different conclusion. As I indicated at the time, it seemed to me that all of these matters would ultimately fall to be considered at the conclusion of the evidence when the court would be able to stand back and consider the weight which could be given to particular aspects of the evidence and how the evidence fitted into the overall landscape and whether it was possible to determine a pattern without making discrete findings or not.

The Legal Framework

The burden and standard of proof

16. In order to make a care or any public law order the Local Authority must prove that the situation justifies the intervention of the State. This means that the Local Authority must establish the statutory threshold set out in s.31(2) Children Act 1989.

> *(2) A court may only make a care order or supervision order if it is satisfied –*
>
> *(a)that the child concerned is suffering, or is likely to suffer, significant harm; and*
>
> *(b)that the harm, or likelihood of harm, is attributable to –*
>
> *(i)the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or*
>
> *(ii)the child's being beyond parental control.*

17. The relevant date for determining whether the threshold is met is the date at which protective steps were initiated: in this case 29 September 2020 for X (when he was accommodated in foster care pursuant to section 20 of the Children Act 1989); 30 September 2020 for V, W and Y (when public law proceedings were issued); and 23 December 2020 for Z (when an emergency protection order was made in respect of her).

18. In respect of the task of determining whether the threshold 'facts' have been proven, the following points must be borne in mind, as referred to in the guidance given by Baker J in *Re L and M (Children)* [2013] EWHC 1569 (Fam) confirmed by the President of the Family Division in *In the Matter of X (Children) (No 3)* [2015] EWHC

3651 at paragraphs 20 – 24. See also the judgment of Lord Justice Aikens in *Re J and Re A (A Child) (No 2)* [2011] EWCA Civ 12, [2011] 1 FCR 141, para 26.

19. The burden of proof is on the Local Authority. It is for the Local Authority to satisfy the court, on the balance of probabilities, that it has made out its case in relation to disputed facts. The parents have to prove nothing, and the court must be careful to ensure that it does not reverse the burden of proof. As Mostyn J said in ***Lancashire v R*** [2013] EWHC 3064 (Fam), there is no pseudo-burden upon a parent to come up with alternative explanations [paragraph 8(vi)]. Therefore, there must be real care not to assume that if the court finds that the parents are unable to provide an explanation for any of the injuries or in this case medical conditions etc that a child has sustained that this therefore results in the conclusion that the explanation must be a malevolent one.

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

21. Findings of fact must be based on evidence, and the inferences that can properly be drawn from the evidence, and not on speculation or suspicion. Mr Woodward-Carlton observes that much of the case against the Mother amounts to no more than assumption or speculation and in particular assumptions emanating from the Mother's actions on 19th September, which he submits have come in many professionals' minds to dominate their approach and to remove the objectivity which ought to be the gold standard for evaluating the evidence and the actions of the Mother. I observe that the boundary between legitimate inference and inappropriate speculation is not a bright line but I am acutely aware of the need to conduct a broad survey of the evidence, looking at it from a variety of perspectives rather than allowing the fact of the bleach incident to infect every other facet of the case. In a case such as this, as with cases of domestic abuse involving controlling and coercive behaviour the court may make findings which are essentially of patterns of behaviour rather than discrete incidents which on their own might be of little obvious significance but when seen as part of a pattern may be seen differently. In such a case the court is not making a finding of fact on balance of probability of each discrete incident but is making a finding of fact of a **pattern**. There is clearly the potential in determining a pattern that a series of suspicions could be found to amount to a pattern but it seems to me that in most cases that will be a theoretical rather than a real risk. In most cases there will be rich strands of documentary, digital and witness evidence which the court will be able to evaluate in order to determine whether a pattern of behaviour has been established to the requisite standard. In this case where the volume of evidence is vast there is no difficulty in seeking to identify patterns although as I will turn to later in this case, there are also some discrete matters on which findings are possible and which contribute to the ability of the court also to determine a pattern. See also Re P (Similar Fact) below.

22. The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and should have regard to the wide

context of social, emotional, ethical and moral factors [*A County Council v A Mother, A Father and X, Y and Z* [2005] EWHC 31 (Fam)].

23. The court considers expert evidence alongside all the other evidence. It must take account of a wide range of matters which include the expert evidence but also include, for example, its assessment of the credibility of the witnesses and the inferences that can properly be drawn from the evidence. The court must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. The court invariably surveys a wide canvas. 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 a conclusion.

24. Thus, the opinions of medical experts need to be considered in the context of all of the other evidence. Appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. It is important to remember that the roles of the court and the expert are distinct and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision. Cases involving allegations of this nature often involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others. When considering the medical evidence in cases where there is a disputed aetiology giving rise to significant harm, the court must bear in mind, to the extent appropriate in each case, the possibility of the unknown cause [*R v Henderson and Butler and Others* [2010] EWCA Crim 126 and *Re R (Care Proceedings: Causation)* [2011] EWHC 1715 (Fam)]. Today's medical certainty may be discarded by the next generation of experts. Scientific research may throw a light into corners that are at present dark. “That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."

25. In *BR (Proof of Facts), Re* [2015] EWFC 41 Peter Jackson J (as he then was) stated:

“8. Each piece of evidence must be considered in the context of the whole. The medical evidence is important, and the court must assess it carefully, but it is not the only evidence. The evidence of the parents is of the utmost importance and the court must form a clear view of their reliability and credibility.

9. When assessing alternative possible explanations for a medical finding, the court will consider each possibility on its merits. There is no hierarchy of possibilities to be taken in sequence as part of a process of elimination. If there are three possibilities, possibility C is not proved merely because possibilities A and B are unlikely, nor because C is less unlikely than A and/or B. Possibility C is only proved if, on consideration of all the evidence, it is more likely than not to be the true explanation for the medical findings. So, in a case of this kind, the court will not conclude that an injury has been inflicted merely because known or unknown medical conditions are improbable: that conclusion will only be reached if the entire evidence shows that inflicted injury is more likely than not to be the explanation for the medical findings.”

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

27. In the *Popi M* case [1985] 1 WLR 948 Lord Brandon identified the dangers of the court reaching a conclusion by reliance on the exclusion of other possible causes.

> *"My Lords, the late Sir Arthur Conan Doyle in his book The Sign of Four, describes his hero, Mr. Sherlock Holmes, as saying to the latter's friend, Dr. Watson: "How often have I said to You that, when You have eliminated the impossible, whatever remains, however improbable, must be the truth?" It is, no doubt, on the basis of this well-known but unjudicial dictum that Bingham J. decided to accept the shipowners' submarine theory, even though he regarded it, for seven cogent reasons, as extremely improbable. In my view there are three reasons why it is inappropriate to apply the dictum of Mr. Sherlock Holmes, to which I have just referred, to the process of fact-finding which a judge of first instance has to perform at the conclusion of a case of the kind here concerned.*
>
> *The first reason is one which I have already sought to emphasise as being of great importance, namely, that the judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so. There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.*
>
> *The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated. That state of affairs does not exist in the present case: to take but one example, the ship sank in such deep water that a diver's examination of the nature of the aperture, which might well have thrown light on its cause, could not be carried out.*
>
> *The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden."*

28. Drawing on this Lady Justice King in *A (Children)* [2018] EWCA Civ 1718 stated that:

> *"57. I accept that there may occasionally be cases where, at the conclusion of the evidence and submissions, the court will ultimately say that the local authority has not discharged the burden of proof to the requisite standard and thus decline to make the findings. That this is the case goes hand in hand with the well-established law that suspicion, or even strong suspicion, is not enough to discharge the burden of proof. The court must look at each possibility, both individually and together, factoring in*

all the evidence available including the medical evidence before deciding whether the "fact in issue more probably occurred than not" (Re B: Lord Hoffman).

58. In my judgment what one draws from Popi M and Nulty Deceased is that:

(i) Judges will decide a case on the burden of proof alone only when driven to it and where no other course is open to him given the unsatisfactory state of the evidence.

(ii) Consideration of such a case necessarily involves looking at the whole picture, including what gaps there are in the evidence, whether the individual factors relied upon are in themselves properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.

(iii) The court arrives at its conclusion by considering whether on an overall assessment of the evidence (i.e. on a preponderance of the evidence) the case for believing that the suggested event happened is more compelling than the case for not reaching that belief (which is not necessarily the same as believing positively that it did not happen) and not by reference to percentage possibilities or probabilities."

29. In *R v P (Children: Similar Fact Evidence)* [2020] EWCA Civ 1088 the Court of Appeal at paras 24-26 considers when and how the court should rely upon propensity/similar fact evidence:

"24. *This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible. Secondly, is it in the interests of justice for the evidence to be admitted? This calls for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.*

25. Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established?...

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

30. I mention this because the administration of bleach might be said to amount to similar fact in respect of earlier allegations of induced vomiting. I do not consider that the allegations of the 19 September administration is strictly similar fact, but it is more in the nature of potentially supporting a propensity to behave abusively.

Lies/Withholding Information

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

32. The Family Court should also take care to ensure that it does not rely upon the conclusion that an individual has lied on a material issue as direct proof of guilt but should rather adopt the approach of the Criminal Court, namely that a lie is capable of amounting to corroboration if it is (a) deliberate, (b) relates to a material issue, and (c) is motivated by a realisation of guilt and a fear of the truth [*Re H-C (Children)* [2016] EWCA Civ 136 at paragraphs 97-100]. Mr Woodward-Carlton reminds me that lies about one aspect of the case, for instance Z's paternity or in the Mother's police interview should not lead the court to conclude that the allegation of frequent induction of vomiting is established or even that they are corroborative of other material or that the Mother cannot be trusted on any matter of contested fact. I have no difficulty in accepting this proposition. If the Mother has been dishonest in various ways it does not mean she has been dishonest in every respect and it does not mean her evidence can, in effect, be ignored. However, conversely if I find her to be dishonest in a significant way on one category of allegation inevitably it will impact upon the weight that I'm likely to attribute to her evidence on other issues and thus the balance that is likely to emerge. The weight rightly to be given to the evidence of parents who are transparently honest and reliable might outweigh medical and other factual evidence leading to a Local Authority being unable to prove a case on the balance of probabilities. On the other hand, the same medical and other evidence might establish the Local Authority's case when the parents' evidence can be given little weight because it is transparently dishonest and unreliable. That does not reverse the burden of proof but is simply the outcome of the evaluative exercise of the weight to be given to the various pieces of evidence before the court. Most importantly of course even a lie on a highly material issue which is clearly deliberate may be motivated by matters other than guilt and I am acutely aware of the caution to be taken in this regard. In particular, Mr Woodward-Carlton submits that the Mother's lie about the paternity of Z (if it was one) does not support the Local Authority case of the Mother exposing the children to a risk of harm from CD because it could be explained by the Mother's embarrassment or shame at having to tell the world that she alleged the conception was the result of CD raping her. He also submits that the lies told in interview do not corroborate the inducing of vomiting on other occasions as the lie may have been motivated by fear of the criminal consequences of that act. I bear both of those explanations in mind.

33. I am also alert to the danger of placing too much weight on inconsistencies which may emerge from the giving of multiple accounts over time or the problems inherent in recalling events many years on. See *Lancashire County Council v The Children* [2014] EWFC 3 (Fam), Jackson J (as he then was) and the observations of Leggatt J in the *Gestmin* case [2013] EWHC 3560 (Comm) where he made observations on the fallibility of memory. That is particularly of relevance in this case where the Mother is

being asked to recall events from many years ago and which were in essence 'run of the mill' at the time.

34. I have, in the particular circumstances of this case, reminded myself when assessing and weighing the impression I form of the parents of the observations of Macur LJ in *Re M (Children)* [2013] EWCA Civ 1147:

> *[12]* Any *judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so.*

35. The need for caution in how one evaluates the credibility of a witness and the reliability of their evidence by reference to demeanour and the need for caution in the weight to be given to demeanour in the evaluation of evidence was also articulated by Leggatt LJ in *Sri Lanka v Secretary of State for the Home Department* [2018] EWCA 1391. How does one differentiate between the confident liar and the confident teller of truth or the anxious and hesitant liar as compared to the anxious and hesitant teller of the truth; self-evidently it is not purely in their delivery. I should emphasise that this is not to say that the demeanour of a witness or party in giving evidence or their behaviour in the witness box is irrelevant to the evaluation of their credibility. What the cases caution against is placing too much reliance on demeanour or behaviour in the witness box alone, in particular where there is other evidence against which the reliability of evidence can be evaluated. A more reliable guide to credibility is to be found not in demeanour of itself but in an over-arching appraisal of many facets of their evidence including the consistency of their evidence both internally and by reference to other accounts and contemporaneous documents, to how they deal with material and challenges to their accounts in written evidence and in the witness box, by reference to what others who know them make of them as a historian, and to some extent by how they manage themselves in court and in giving evidence.

36. Although the general approach is that any fact which needs to be proved by the evidence of witnesses is generally to be proved by their oral evidence (r22.2(1)(a) FPR 2010) facts may also be proved by hearsay evidence. The effect of Children Act 1989 s.96(3), Children (Admissibility of Hearsay Evidence) Order 1993 is to make all evidence given in connection with the welfare of a child admissible notwithstanding its hearsay nature. This would commonly include Local Authority case records or social work chronologies which are very often hearsay, often second- or third-hand hearsay but also extends to witness statements. The court should give it the weight it considers appropriate: *Re W (Fact Finding: Hearsay Evidence)* and where hearsay goes to a central issue the court may well require the maker of the hearsay statement to attend to give oral evidence.

37. I mention failure to protect because in essence that is part of the case against AB; the Local Authority alleged that had he acknowledged X and been a part of his life earlier that he could have abated some of the Mother's harmful activities. The authorities make clear (i.e *Re L-W (Children)* [2019] EWCA Civ 159; *G-L-T (Children)* [2019] EWCA Civ 717**)** that the courts should be careful not to make an unjustified leap from culpable behaviour on the part of one parent to failure to protect by the other. There must be a causal nexus between the behaviour of the one and the actions or inactions of the other. Usually (although not necessarily because FTP comes in numerous guises) this will

involve knowledge (possibly constructive) by the non-perpetrating parent of the abusive behaviour of the other.

38. Medical evidence was received both from the children's treating clinicians and from experts instructed pursuant to FPR 25. The possible distinction in status was explored in Sunderland CC v AB (Re-hearing: Fact-Finding: Expert or Professional Evidence) [2019] EWHC 3887 (Fam) (22 November 2019)

"Evidence from an individual instructed pursuant to FPR Part 25 clearly results in 'expert' evidence. In a general sense expert evidence though is in reality opinion evidence. The court permits an individual to give opinion evidence because they have an 'expertise' in a particular field. A report from a treating clinician will contain opinion evidence. That clinician is qualified to give an opinion in the medical sense because they are a qualified doctor. The more senior that individual is the more likely the court would accept that they had expertise which allowed them to offer opinion evidence to the court. A consultant level medical professional would I think barring some oddity, bring them into the bracket where the court would be likely to view them as an expert qualified to give an opinion. The opinion of a relatively junior doctor on a relatively straightforward issue might also be accepted by the court as qualifying as expert evidence because it would fall within expertise on that issue. Conversely the opinion of a relatively junior doctor on a matter of considerable complexity might not.

However there is at least one significant potential limitation on the weight that might be given to the opinion evidence of the treating professional. The situation of the medical professional who is called upon to treat a child generates an opinion in a very different context to that of the part 25 expert. The focus of the treating professional is to treat the child by ascertaining the most likely cause of the condition or injury. This may be undertaken as a result of a process of elimination or otherwise. The imperative is to address the condition and to adopt an appropriate plan to treat or protect the child. The treating professional may develop a personal relationship with the child or indeed with the carers. Having formed an opinion in the crucible, perhaps of an emergency it may be difficult for the treating professional to detach themselves from that and apply a purely objective approach. The situation of the part 25 expert is of course entirely different.

In assessing the relative weight to be given to the evidence of a treating professional as against that to be given to the part 25 expert a court ought to bear these factors in mind."

RCPCH Guidance

39. New guidance on 'Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children' was published by the Royal College of Paediatrics and Child Health on 2 March 2021. At paragraph 3.2.2 of the guidance FII is defined as follows:

"*FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their*

motivations may not be initially evident.

It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (and in Working Together to Safeguard Children, fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning."

40. The guidance introduces a new term, Perplexing Presentations ('PP') which is defined at paragraph 3.2.2 as follows:

> *"The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour."*

41. At paragraph 4.1 it is said that clinical experience and research indicate that the mother is nearly always involved in, or the instigator of, FII. The involvement of fathers is variable. The father may be unaware, suspicious but side-lined, or may be actively involved. Rarely, fathers are solely involved.

42. The guidance continues as follows:

"*FII is based on the parent's underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is (when the child has a verified disorder, as many of the children do). FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. There are two possible, and very different, motivations underpinning the parent's need: the parent experiencing a gain and the parent's erroneous beliefs. It is also recognised that a parent themselves may not be conscious of the motivation behind their behaviour. Both motivations may be present although usually one predominates.*

(i) In the first, the parent experiences a gain (not necessarily material) from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. There are a number of different gains - some psychosocial and some material. Some parents benefit from the sympathetic attention which they receive; they may fulfil their dependency needs for support, which might include the continued physical closeness of their child. Parents who struggle with the management of their child may seek an inappropriate mental health diagnostic justification in the child such as Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD). Material gain includes

financial support for care of the child, improved housing, holidays, assisted mobility and preferential car parking.

(ii) The second motivation is based on the parent's erroneous beliefs, extreme concern and anxiety about their child's health (eg nutrition, allergies, treatments). This can include a mistaken belief that their child needs additional support at school and an Education Health and Care Plan (EHCP). The parent may be misinterpreting or misconstruing aspects of their child's presentation and behaviour. In pursuit of an explanation, and increasingly aided by the internet, the parent develops a belief about what is wrong with their child. In contrast to typical parental concern, the parent exhibiting such behaviour cannot be reassured by health professionals or negative investigations. More rarely, parents may develop fixed or delusional psychotic beliefs about their child's state of health. The parent's need here is to have their beliefs confirmed and acted upon, but to the detriment of the child.

… It is important to stress that understanding the parents' motivation is not essential to the paediatric diagnosis of PP/FII in the child. This is important because a paediatrician is not expected to understand parental motivation, but simply to understand the cause of the child's presenting illness.

In FII, parents' needs are primarily fulfilled by the involvement of doctors and other health professionals. The parent's actions and behaviours are intended to convince health professionals, particularly paediatricians, about the child's state of health. It is important to note that, as is common in child neglect, the parent is not usually ill-intentioned towards their child per se. Nonetheless, they may cause their child direct harm, unintentionally or in order to have their assertions reinforced and believed. Parents engage health professionals, in the following ways:

(i) The most common form is by presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. There may be exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception. In their reports, the parents may not be actually intending to deceive, such as when they hold incorrect beliefs and are over-anxious, to the child's detriment…

(ii) A less common way of engaging health professionals is by the parent's physical actions. These actions nearly always include an element of deception. They range from falsifying documents, through interfering with investigations and specimens such as putting sugar or blood in the child's urine specimen, interfering with lines and drainage bags, withholding food or medication from the child and, at the extreme end, illness induction in the child. All of these are carried out in order to convince health professionals, especially paediatricians, about the child's poor state of health or illness.

43. Parental mental ill health may help to explain the motivations and behaviours of some of the parents as well as indicating prognosis for change. It considers the role played by doctors (paragraph 4.2):

> *"In children with FII, iatrogenic harm is caused by the doctor's need and wish to trust and work with parents, which is fundamental to most elements of paediatric practice, and not to miss any treatable cause of illness. Even in cases where FII might be suspected, there is still a tendency to believe parents, to avoid complaints, and sometimes uncertainty about how to proceed in what are usually complex cases. A child often has an existing medical diagnosis, or had started out with an underlying illness, which will make assessment more difficult. The parent's accounts may therefore be true, partially true, or mixed with other accounts that are fabricated or misconstrued. This makes it more difficult to explore their credibility."*

44. At paragraph 4.3 the guidance identifies different forms of harm to the child:

    i) the child's health and experience of healthcare: undergoing repeated (unnecessary) medical appointments, examinations, investigations, procedures and treatments which are often experienced by the child as physically and psychologically uncomfortable or distressing; genuine illness may be overlooked; illness may be induced.

    ii) Effects on child's development and daily life.

    iii) Child psychological and health-related well-being.

    The guidance notes that the severity of FII can be considered in two ways; the severity of the parent's actions and the severity of the harm to the child. In relation to the severity of the parent's actions the guidance notes that this can be placed on a continuum of increasing severity which ranges from anxiety and belief related erroneous reports, to deception by fabricating false reports, to interfering with samples through to illness induction. The earlier 2009 guidance contained a table "spectrum of cases where FII concerns may arise" which would appear to be reflected in paragraph 4.3.1 of the 2021 guidance. Dr Rose referred to this as a helpful reference point but it does not appear to repeated in the 2021 guidance which supersedes the 2009 guidance. It seems to me that the continuum more accurately reflects the clearly blurred boundaries between the examples included within the table. Indeed it seems the parent's behaviour may fall concurrently at various points along the continuum particularly where there is more than one child involved and that the behaviour may ebb and flow along the continuum and back, particularly where events occur over many years. Indeed the continuum would seem to contemplate rightly that at the lowest end of the continuum the behaviour of the parent is no more than simple anxiety, lack of knowledge, over interpretation or other relatively benign behaviour which may be simply addressed. At the other end of the spectrum is the most serious form of induced illness, for instance poisoning. In between are many other variations. The guidance emphasises that FII can coexist with other genuine illnesses in a child.

The Parties' Cases: A summary

45. I am reluctant to burden this judgment with too lengthy a recitation of the arguments that have been deployed by each of the parties in support of their respective cases and shall seek to address many of them either in the chronology or in my evaluation later. What follows is therefore a summary.

The Local Authority

46. Miss Morgan and Mr Ashworth on behalf of the Local Authority made the following essential points.

i) The totality of the evidence supports a conclusion that the Mother has exaggerated illnesses, misreported illnesses and induced illnesses. The expert evidence remained unshaken in their conclusions; indeed, Dr Rose was more supportive of X's developmental delay being more attributable to the Mother's care than he had been in his report. Dr Salvestrini was more supportive of the Mother having induced vomiting than she was in her report and the possible presence of an underlying illness contributing to vomiting does not undermine this.

ii) The evidence shows an escalating pattern over time culminating in the bleach incident in September 2020 which is clearly an induced illness. There is evidence of the Mother sabotaging referrals, misreporting and exaggerating symptoms.

iii) The Local Authority seek a finding of deliberate administration of bleach. It was witnessed by Nurse J, the Mother went to extensive lengths to dispose of the evidence in different bins outside the hospital, she used a decoy syringe, she lied for as long as she could in police interview and in her witness statement and now lies about her lack of recall. Her lies meet the modified Lucas test and support not only deliberate administration on that occasion but on other occasions. Her removal of X from the hospital demonstrates a lack of concern which corroborates her having done it before. Her preoccupation with cleaning at home and elsewhere may have masked her administration of bleach to X before.

iv) The evidence supports a conclusion that the Mother induced the overwhelming majority of the vomiting that X experienced up until his removal from her care in September 2020. That the precise cause cannot be identified does not prevent the court inferring that she was responsible; there is an analogy with nonaccidental injuries where the precise mechanism cannot be determined but the medical evidence supports that conclusion. In particular, the following support that conclusion:

a) The expert evidence identifies no condition which would explain his vomiting in the way evidenced in the documents. Whilst occasional vomiting related to secretions or discrete illnesses might have occurred, they cannot explain the extensive vomiting described by the Mother and witnessed by others including Mr K.

b) Dr Salvestrini's opinion is that it was either induced or exaggerated but she could not say 100% which.

c) The Mother's complaints of dampness in the house would not be relevant to vomiting and there is no real likelihood of unknown explanation.

d) After his removal from her care, the vomiting ceased almost entirely which both rules out an unknown explanation and points to the Mother's culpability,

e) The circumstances of the 19 September 2020 incident in particular the use of a decoy syringe and the Mother's lack of concern after the administration of bleach support the conclusion that she had done so before. How could she have been so relaxed about X's well-being such that she took him out for an hour and away from medical support if she did not have experience of him being well after vomiting?

f) The description of 16 January 2020 effortless vomiting of clear liquid and a funny smell which caused Ms L such concern that even as a supporter of the Mother (and not looking through the lens of September 2020) she felt compelled to write about her concerns to Ms M.

g) The Mother's description of the vomit on 15 September together with its close connection in time with her having purchased bleach and the gastric trial also suggests this was an identifiable incident of induced vomiting.

v) X's failure to thrive was a result of the Mother failing to give him the nutrition that he required, and which had been prescribed by the clinicians. His failure to thrive led to multiple hospital admissions, the insertion of a PEG- J, his being fed by pump rather than normally and led to his being identified as a sick child even by his siblings which interfered with the development of relationships as well as his general development.

a) His progress in terms of weight gain since the Mother was removed from his care supports her role.

b) The fact that he was able to gain weight both in her care and subsequently shows that there is no underlying condition with absorption or gut dysmotility.

c) Dr Salvestrini and the dietician were of the opinion that the changes in his nutrition could not explain his failure to thrive.

d) The evidence of his Vitamin B12 deficiency at a time when his feed should have been delivering in excess of 1000% of his daily need shows he was not receiving the nutrition.

e) The Mother was solely responsible for the delivery of his nutrition for almost the entirety of his life. She understood clearly what she had to do.

f) The Mother's anger at her removal from his feeding regimes whilst at Hospital B point to her preoccupation with being involved in his feeding.

g) It is relatively straightforward for the Mother to have either interfered with feeding in a hospital environment but more importantly to have failed to give him feeds whilst at home.

vi) X's development was significantly delayed as a result of the interplay of lack of nutrition, tiredness from vomiting and lack of stimulation. The evidence of Mr K and the developmental charts together with the assessments of the paediatricians and others show very significant delayed development. Targets which were set were put back because he was incapable of reaching them. His progress since the Mother was removed from his care has been variously described as miraculous, remarkable, a different child, exceptional. His progress across the centiles in terms of weight and his developmental progress in foster care is steady and significant.

a) Dr Rose amended his position having seen the portage worker developmental charts and opined that the contribution of any potential underlying developmental delay was less than he had originally considered might be the case.

b) He considered that lack of nutrition leading to tiredness and lack of interest could be a significant contributing factor as could lack of stimulation.

c) If there was an underlying developmental issue the Mother's actions are potentially more harmful.

d) The evidence of the hospital play therapists seen by Ms N to potentially show a higher level of development then she had considered was present and which thus undermined her evaluation of his remarkable progress when she saw him in October 2020 has to be considered in the light of him being in hospital and receiving nutrition and not vomiting.

e) Ms L emphasised the difference in X between when she saw him on 18 September and when she saw him again on 28th of September, and likened it to the change that had been observed when he came back from Hospital B in May 2018.

vii) In relation to V the Mother has exaggerated and overreported in relation to constipation, asthma and hypermobility.

a) The dosage he was on for Movicol was extraordinarily high and for a very prolonged period. The maternal grandmother's evidence of his lack of problems when she was caring for him both prior to September 2020 and subsequently illustrate there was no underlying chronic constipation as reported by the Mother.

b) Dr Rose's evidence supports the conclusion that the Mother exaggerated V's asthma. The maternal grandmother's evidence of his lack of problems since living with her supports the Mother's exaggeration. He may have had some mild problem but it was not at the level the Mother reported and hence the concerns that Dr O had over the Mother's reports and the conclusions from tests carried out. The extensive investigations carried out at Hospital C were unnecessary and may have left V with a legacy of believing he is more unwell than he is.

c) The Mother pressed for a specialist buggy for V when the assessments by the paediatricians simply did not support any hypermobility issue which required specialist provision. This was generated by the Mother.

d) The Mother also neglected V's development in relation to his education by failing to get him to school. The maternal grandmother has had no difficulty.

viii) The evidence establishes that the Mother has exaggerated and overreported conditions in each of the other children. They have all suffered harm as a result of the Mother's behaviour which has spanned many years and a range of conditions concurrently and sequentially.

a) The children have been worried and distressed by X's condition; V speaks of crying and being worried about X.

b) The children's needs have been overlooked by the Mother's preoccupation with X.

c) In respect of Y the Mother clearly exaggerated his difficulties with eating and swallowing. Although he had enlarged tonsils the evidence from Dr Rose was that this would not have caused any difficulty with his ability to eat or swallow.

d) In relation to W the distance between her alleged dairy allergy or cow's milk protein intolerance and the Mother's reporting that the school yet giving general dairy products in her picnics illustrates her inaccurate reporting.

e) The grandparents have not experienced any of the health problems with V, W or Y that the Mother says she had.

ix) The Local Authority do not need to prove a motive for the Mother's actions. It may be that subsequent assessment of the Mother may shed light on this.

x) The Mother knowingly exposed the children to the risks of domestic abuse in pursuing and resuming a relationship with CD. She knew V was affected by what he had witnessed. She alleges she was raped but the court does not need to determine the allegation. The court should be sceptical of her account of Z's conception and her reasons for not disclosing CD was the father simply do not add up; her family did not disown her. The truth is that she was well aware that a resumption of any relationship with CD would lead to Local Authority concern. His track record in terms of abusive behaviour is serious and the risks to the children were clear and acknowledged by the Mother and yet she resumed some sort of relationship with CD despite having undergone domestic abuse work in the Freedom Programme.

xi) The evidence establishes that AB presents a risk to the children in relation to abusive behaviour within a relationship including convictions, findings by HHJ Davies and the evidence of the lists. In addition the pool of perpetrator finding raises a risk directly to children. The Mother embarking on a relationship with

him and conceiving a child represent another exposure of the children to a risk of domestic abuse.

47. Mr Woodward-Carlton and Miss Phillips on behalf of the Mother made the following essential points.

i) The court should be wary of approaching this case from a perspective dominated by the bleach incident. Other clinicians have allowed that to happen. The court should also consider the case from the starting point chronologically with V's birth. The court should also consider the case through the perspective of the Mother's mental health.

ii) At least two of the professionals have allowed the events of 19 September 2020 to reframe their evaluation of the case to the extent that a malign interpretation is now put on all of the Mother's actions which were previously regarded as benign. That was most obviously the case with Ms P whose August assessment which identified many positives was entirely overlooked when she came to write her almost entirely negative statement following the bleach incident. The same is true of Ms M whose chronology is clearly written with an infected viewpoint. She was unable to explain why her chronology was not balanced by what were clearly genuine entries from the records. Dr Q's opinion letter together with Dr T also demonstrates this infection.

iii) In the evaluation of the Mother's evidence in particular in relation to her memory for events, she cannot be expected to recall all that has happened down the years even with the benefit of the medical notes.

iv) The court should be alive to the risks which arise from the subjective nature of language. Ms L described videos showing vomiting, which they did not by the definition given by Dr Rose. Dr O described V's asthma as significant, but this was not a recognised category according to Dr Rose, but it is hardly surprisingly Mother understood it to be serious. Care has to be taken in evaluating whether the Mother has exaggerated when one takes account of the language used by others.

v) The Mother's anxiety that has been a feature of her mental health for many years indeed since childhood is key to understanding what has happened in the case.

a) Her anxiety has led her to consult her GP or other medical professionals when others might not have. Dr U confirmed she was an anxious mum, indeed quite anxious at times and so she presented her children more often than normal, but Dr U did not say abnormal. She tends to be overprotective and to focus on the worst possible explanation. It is possible she has imported anxieties over her older children into her younger children when she has spotted similar signs. Dr Rose confirmed this could lead to misinterpretation not necessarily exaggeration.

b) What she as a mother interpreted as pain may not have been seen by a medical professional as pain, but this is interpretation not exaggeration.

c) The medical records demonstrate more frequent attendance in relation to younger children and less frequent attendance in relation to the older children this is a commonly encountered pattern.

d) Her anxiety makes her wary in relation to professionals who she considers have judged her unfairly. She was aware in 2018 that medical professionals were suspicious about her and her care of X. She was right to be concerned; this was why she was side-lined from X's feeding. It is not surprising that she felt suspicious about professionals judging her constantly.

e) Having regard to the RCPCH guidelines her anxiety is part of the acceptable anxiety on that spectrum. It is not accepted that it has become harmful to the children.

vi) It is clear that the Mother has experienced multiple stressors over the years which will have impacted upon her anxiety and thus her behaviour. It is clear that the Mother's mental health deteriorated at the point that social services first became involved because of concerns about V's school attendance and possible exposure of V to domestic abuse. Both Ms M and Ms L gave evidence that they had sought support for the Mother because they witnessed genuine problems but had been blocked by children services. This is most obvious in relation to the bleach incident. At that time there is strong evidence that she was experiencing a constellation of stressful events which impacted on her mental health. Professionals such as Ms P commented upon her presentation whilst at hospital in September 2020. Moving house, the stress of CD's abusive behaviour, being pregnant, the anxiety about X being admitted, the worries about childcare would all explain why her mental health deteriorated to the extent that she did something inexplicable; namely injecting bleach into X.

vii) What many of the professionals have referred to over the years falls into the category of perplexing presentation. They do not describe significant harm having been caused to the children.

viii) It is clear that there have been significant periods of time when there have not been concerns about the Mother's care of the children. The children were stepped down from a child protection plan to a child in need plan and subsequently to Early Help because of the progress the Mother made. X's perplexing presentation was not considered a sufficient child protection concern to lead to more extensive social services involvement. Had events with X not occurred in September 2020 there is no indication that children's services would have intervened or that threshold would have been met in relation to the other three children. In respect of various aspects of the Local Authority's case in relation to W and Y Dr Rose may have said it was a pain but it cannot be equated with harm, still less significant harm.

ix) It is clear in relation to each of the children that professionals and the experts identified genuine conditions that they experienced.

a) V clearly had constipation at times; Dr Rose and Dr Salvestrini confirm this from the x-rays. The Mother accepts that at times V was not reliably taking

all of his medication because she could not force him to and she managed his condition until it no longer presented a problem.

b) V clearly had chest infections and doctors observed wheeze, creps or crackling that was seen on examination. The lung function tests carried out by the RBH showed a deterioration in lung function between December and June which supported his having asthma according to Dr Rose. The RBH bronchoscopy also identified an abnormality consistent with mild asthma. V himself reported symptoms consistent with asthma. It was clearly reasonable for the Mother to approach V's condition as him having asthma.

c) It was the RBH who diagnosed V with reflux on the basis of medical tests they conducted. Dr Rose confirmed that on their findings reflux was indicated although Dr Salvestrini disagreed, but it is clear that it was reasonable for the Mother to rely on their diagnosis. It would take a brave parent to go against it.

d) The Mother's request for a specialist buggy (not a wheelchair) was supported by her own and her mother's experience of hypermobility and by physiotherapists' examinations which confirmed a degree of hypermobility. The fact that the school and others did not observe it does not detract from the fact that it was reasonable for the Mother to rely on physiotherapists' evaluations.

e) In relation to W, when she had a rash the doctors advised avoiding dairy as did the health visitor and the dietician. This narrative was reinforced by repeated professional advice. The issue did not persist beyond summer 2020 and it is hard to see how W sustained any harm from it.

f) In relation to W the commencement of the trail in relation to her asthma is to be found at her admission to A & E when she was considered to have a wheeze and salbutamol was prescribed. The continued prescription of that medication was the decision of doctors not her and Dr Rose was quite clear that he could not point to anything in the medical records which amounted to an exaggeration or fabrication of symptomology. When further medication was experimented with, no one then stopped it. The Mother in any event says that she stopped giving medication in summer 2020.

g) In relation to Y, he was assessed as being hypermobile and Ms N said that following her examination specialist boots would assist him. It is clear that Y had large tonsils; he has now had them removed. It was not unreasonable for the Mother to associate difficulties in choking and swallowing with his enlarged tonsils.

x) The evidence in relation to the Local Authority's allegations in relation to X are based largely on inference or speculation.

a) Issues with X started with the diagnosis that he had an unsafe swallow which was diagnosed by the SALT team. It was the surgical team which recommended the insertion of the PEG-J which Dr Salvestrini has subsequently criticised as not being founded on an adequately objective

evidence base of X's feeding difficulties. This cannot be laid at the Mother's door.

b) The delay in X's admission to hospital between late 2019 and September 2020 is entirely explicable by the obstacles that existed, ranging from childcare difficulties through to concerns about Covid, bad weather, the logistics of getting a move organised. They are documented. Prior to the bleach incident Ms M was positive about the Mother's willingness to work with them to get X in, having regard to the barriers that faced the Mother.

c) The evidence in relation to his nutrition and vomiting does not establish a clear pattern which could be said to be the Mother's responsibility. For a considerable period of time he gained weight in the Mother's care. Whilst he was in hospital and subsequent to September 2020 his weight patterns have been intermittent which would suggest that something else is at play. In particular, the trajectory he followed after going into foster care appeared to mirror that which he was demonstrating prior to his admission to hospital.

d) The evidence supports X having a long-standing problem with vomiting which took a variety of forms. It was witnessed by many professionals including doctors, occupational therapists and the portage worker. This is not consistent with the Mother being the cause. There is evidence of genuine conditions which would have explained X vomiting; Dr Rose identified various childhood illnesses which would contribute to him vomiting. Dr Salvestrini also identified that secretions and mucus accumulations could cause vomiting. The pattern of X's vomiting over the years is not static but changes. A number of other factors point against the Mother inducing vomiting.

    i) Dr Rose confirmed there was no evidence in the medical records to support a conclusion of induced vomiting.

    ii) Dr Rose confirms there is no derangement in X's physiology which would support the administration of any substance.

    iii) Dr Salvestrini confirms that had bleach been administered in undiluted form, serious damage would have been evident. Her view on balance was that if diluted bleach was administered there would have been evidence of damage.

    iv) The evidence as to how vomiting might be induced by the introduction of water was very uncertain.

    v) There was no evidence of overfeeding.

    vi) If the Mother was inducing vomiting, she was doing it in a variety of different forms with a variety of different results in terms of the nature of the vomit and when it was initiated. There is no explanation of how this could be achieved.

e) In relation to September 2020, the first time the Local Authority has alleged that 15 September was an example of bleach induced vomiting was in their closing submissions, although some questions were put to the Mother to that effect. There is no evidence in relation to the wet babygro that suggests bleach was a factor in this vomiting.

f) In relation to 16 January 2020 the contention that effortless vomiting of clear fluids is unusual is not supported because others (Ms E) had experienced similar events. Nobody at the meeting expressed concern when it occurred and, despite Ms L's email, no other professional was sufficiently concerned to follow up.

g) It seems clear on the basis of Dr Rose's opinion that X probably has an underlying developmental disorder which is contributing.

xi) The totality of the evidence shows a complex pattern of weight loss and weight gain which was the subject of consideration by professionals over some time as to whether it was a perplexing presentation or a fabricated or induced illness. They did not reach a conclusion that it was FII. The following matters point against the Mother being responsible for X's failure to thrive:

a) Even whilst X was in hospital with his feeding being monitored, in particular when he was at Hospital B, there is a fluctuating pattern which suggests an underlying cause not the Mother's intervention.

b) There are other factors in play including the regular changes in feeds or feeding patterns, the impact of medications which may all contribute to the fluctuating weight loss and gain.

c) There are causes of unknown aetiology or at least an identified aetiology such as delayed myelination, immunoglobin responses which might explain the fluctuating pattern.

d) The Mother's behaviour for instance in stopping the pump whilst at hospital is explicable; a parent seeing a child vomit would naturally stop feeding.

e) The Mother's evidence is clear that she delivered the nutrition that she was advised to deliver and there is no direct evidence that she did not. Those who were involved with X's care saw him attached to his feeding pump and there is no issue raised in the documents of the Mother not complying with the regimes imposed.

xii) In relation to the September admission once she had arranged matters the Mother attended on 7 September late at night having completed her move that day. She left having been told by Dr A that it was up to her whether she left or not. With social services intervention it is legitimate for her to say that she believed she had the approval of the professionals to leave.

xiii) It is clear that in relation to 19 September, the Mother was terrified by what had happened and that the multiple stressors she was working under at the time may have influenced her actions and memory. In the police interviews it is clear she

was shocked. She is an intelligent woman and knows that it might be to her benefit to admit it; this supports the genuineness of her inability to recall what happened.

xiv) The Local Authority's case that events after 19 September demonstrate the Mother was the cause of X's difficulties does not withstand scrutiny.

a) The evidence of his alleged very significant developmental progress was put into context by Ms N's evidence that the hospital records of the play therapy showed that X had indeed developed significantly prior to his admission to hospital and that his trajectory of development was smoother than had originally been suggested.

b) The alleged significant weight gain is not supported by the centile and weight evidence which shows that for a period of several months after his discharge from hospital X's weight was essentially static and Dr Rose said that had this static position occurred whilst in the Mother's care it would have raised concerns. The errors in the recording of weight have to be taken into account.

c) A very significant change which may explain his subsequent improvement in feeding is that the Peg J was abandoned, and he began to be fed into his stomach. If Dr Salvestrini is right that the Peg J was inserted without adequate consideration this might explain why X made better progress when it was dispensed with.

d) In relation to the other aspects of X's health the changes have not been as stark as have been suggested. He continued on prophylactic medication for some time which has helped with his asthma and chest infections. He continues to have some mobility issues.

xv) Ultimately the court must be cautious not to evaluate the case on the basis that the events of September 19 explain all. A far more nuanced picture emerges on careful consideration.

48. Mr Storey and Mr Chippeck on behalf of AB had a more limited interest in the medical issues which related almost entirely to the Mother but in relation to the Threshold allegations against AB and more generally in relation to the way ahead made the following essential points.

i) The court should be alive to the risk of expecting too high a standard of conduct of AB. He may be a rough and ready character, but he is hard-working and committed to his children.

ii) The evidence from the protracted private law proceedings demonstrate that AB is committed to his children despite the obstacles put in his way and that his relationship with the children is positive. The Cafcass reports on him are positive. These proceedings paint a different picture to that which has been put before the court in this case and the conclusion reached in the parenting assessment in these proceedings which is infected by the assertion that there are 73 police reports concerning him, including allegations of sexual misconduct

and the Mother is also given information that he has serious offences including firearms offences. These are inaccurate. The court should make clear that those are not findings which can be held against him. In fact, many of the police reports involve him being the victim of unpleasant assaults. This court should set the record straight.

iii) The psychiatric assessment of AB gives him an essentially clean bill of health.

iv) The findings by HHJ Davies stand. The pool finding does not justify a finding that he presents a risk to children. The correct approach from Re J is that a pool finding may be taken together with other evidence but not on its own. His previous convictions are of little relevance.

v) The evidence supports the conclusion that this was a short relationship; a one-night stand and social messaging. The children have never mentioned him and nor has the maternal grandmother. The Mother did not stand by her assertion that he had taken her to antenatal appointments.

vi) The police report of May 2017 does not support the Mother's allegation that AB was domestically abusive; either in May 2017 or during the course of their relationship. Her assertion that he had demonstrated controlling behaviours she recognised was inadequately evidenced.

vii) The evidence is that he was sent a photo of a pregnancy test with an assertion that he was the father. Given it was a one night stand he was entitled to be sceptical. Thereafter there was almost no attempt to involve him until early 2020 and this was not then pursued. The Local Authority face a fundamental problem in causation in relation to their allegation that his failure to be involved in X's life could have lessened his exposure to harm. Given the extensive medical involvement the father's ability to alter the trajectory would have been non-existent.

viii) Ultimately, he is committed to developing a relationship with X and providing a home for him and he should not be ruled out as a result of previous findings without any further findings made.

49. The maternal grandparents were not the subject of allegations in the threshold schedule but having been involved in the lives of the children for many years and now having the care of three of them, they had a clear interest in this stage of the proceedings. Miss Howe and Ms Slee on behalf of the grandparents made the following essential points.

i) They find themselves in a very difficult position trying to balance prioritising the care of their grandchildren whilst also having a naturally protective instinct in relation to the Mother.

ii) Their commitment to the children has been immense. The maternal grandmother is the rock on which the family has rested. She has stepped up whenever required moving in with the children in 2015, 2016 and 2020, having V live with them and otherwise providing often daily support to the Mother and the children. There are very many examples over the years of the extensive support that the grandparents had been prepared to offer often at a moment's notice.

iii) They have made huge efforts to understand what has occurred both since 19 September last year but in particular during the course of these proceedings.

iv) The maternal grandmother is clearly an honest and sincere witness who has done her best to help the court understand what has happened. The maternal grandfather has found himself in a harder position having continued to live with the Mother in September last year. He has made direct efforts to seek to establish from the Mother what happened, and she has told him variously that she couldn't remember or that she didn't know. It is clear that the account the Mother has given to her father has not been an accurate one in relation to what happened at the hospital or the actions of social services and medical professionals beforehand. The maternal grandfather cannot be blamed for accepting at face value what the Mother said that has influenced the way he frames responsibility for events.

v) It is clear to the maternal grandparents that the Mother seeks to externalise responsibility for matters away from herself. She experienced mental health problems in her teenage years but was unwilling to accept support to address the problems.

vi) They were worried about X whilst he was in the Mother's care and believed him to be a very ill baby whose condition was unexplained.

vii) Now they have heard all of the evidence a clearer picture has emerged although they are still trying to understand how their daughter could have acted in the way it seems she did.

viii) The children appear to be doing well in their care and many of the problems which were apparent when they were living with the Mother have abated either entirely or to a very significant extent. They accept that the children have suffered harm in a variety of ways but, in particular, they believe that what has happened has been emotionally harmful to the children and the relationships they have developed. They have had to re-educate Y and W in relation to X; they saw him as a baby incapable of very much but now they are learning that he is a normal toddler not a sick baby. That failure of the children to develop relationships with X in the way that they might have done is a form of harm.

ix) The grandparents continue to offer a home for the children and have now made a further commitment to that by the maternal grandfather moving in with the maternal grandmother and the three children.

50. By the conclusion of the evidence the Guardian's opening and less committed position had developed into broadly complete support for the Local Authority's formulation of the case. In support of the Guardian's invitation to the court to make findings across the full spectrum of threshold allegations, Miss Stone and Mr Paisley on behalf of the Guardian made the following essential points

i) the RCPCH Guidance of 2021.

a) The Guidance and table 1 in its predecessor illustrate that the behaviour which falls within the categorisation of perplexing presentation or FII is a continuum rather than compartmentalised categories.

b) As Dr Rose emphasised FII is an uncomfortable diagnosis to make and before clinicians reach that conclusion it may often be characterised as a case of perplexing presentation. That is evident in this case where the issue of V and his constipation and his asthma were clearly perplexing to the clinicians who could not marry up the Mother's descriptions of his problems with their findings; with X where professionals were unable to explain his vomiting or his failure to put on weight and with W where she was said to have a dairy allergy but was actually being given dairy products by the Mother.

c) The reasons why a parent might act in this way are explored in the guidance but clinicians don't need to understand or identify a motive in order to identify behaviour consistent with FII.

ii) The evidence supports a finding that the Mother has induced illness in X, has exaggerated symptoms in all of the children and has misreported symptoms. She has also failed to comply with recommended medical treatments.

iii) Harm: a variety of forms of harm or risk of harm can be identified from the actions of the Mother. The RCPCH Guidance identifies the range of harm and in this case the following harm can be discerned:

a) the obvious physical harm and risk of the administration of bleach on more than one occasion;

b) the harm and risk of harm of the placement of a PEG-J under general anaesthetic, with replacements under general anaesthetic, with the risks of infection and the ongoing medications;

c) the harm and risk of harm of ongoing and extensive invasive investigation and examination leading to the risk of a child who sees himself as seriously unwell;

d) the developmental delay consequent upon the lack of nutrition and vomiting;

e) the harm to the sibling relationships caused by X's condition and the other children's belief that he was a sick baby;

f) the emotional harm to the other children of their worrying about X; illustrated by V's expressed fear that he didn't want to go to school because he feared that X might die;

g) the harm to each of the children who were over medicalised by taking unnecessary medication (or medication carrying some risk of side effects even if not carrying medium to long-term ill effects as a matter of course),

the extensive and invasive investigations including bronchoscopy and blood tests which were unnecessary;

h) the risk of the children coming to see themselves as unwell and that affecting their emotional development;

i) the risk of physical and emotional harm arising from their Mother engaging in relationships with men who were abusive to her either in or out of their presence. V's fear and potentially his allegedly aggressive behaviour to the Mother are direct examples of this;

j) there are some examples where further harm might have insulated had the events of September 2020 not occurred; planned neurological and immunological investigations were not pursued after he began to thrive following the Mother's removal from his care.

iv) Approach.

a) In terms of general approach to the evidence the bleach incident is important in informing the evaluation of earlier events but it is not determinative.

b) There is no reason to question the accuracy of the documentary records.

c) The Mother's evidence is clearly not credible.

i) There are obvious lies; illustrations ranging from the lies about the bleach incident itself during interview; in relation to holiday activities; in relation to Z's paternity; she says there was a trial of water on 11 September which contributed to her decision to leave hospital but there is no record in the medical notes of this occurring.

ii) The Mother's current account that she cannot remember what happened on 19 September is unbelievable. In particular having regard to the contents of the interview of 19 September when she is lucid, calm, responsive and answers questions in a natural and descriptive matter.

iii) She had a selective memory, being able to remember apparently innocuous details but unable to recall other significant matters which one would expect her to remember. The claimed lack of memory of the events of the 19th is undermined by her apparent ability to remember events in the police station.

iv) She was evasive or obstructive in aspects of her evidence

v) In oral evidence she gave evidence or adopted positions which she had not articulated before; Z's conception by rape and the definition of vomiting being two examples.

vi) It is clear that despite her assertion that she follows medical advice, she does not; the most obvious is her failure to agree to X's admission to hospital in November 2019.

v) The relevance of History. A particular challenge in FII cases is the fact that all clinicians will have a starting point that a history given by a parent is reliable. That is critical in any case but in particular in relation to some of the conditions which are said to be present in this case. Dr U and Dr Rose emphasised the reliance placed by clinicians on parental history particularly in relation to constipation, asthma and reflux and vomiting.

vi) X and Feeding. The evidence supports the conclusion that his failure to thrive was attributable to a failure by the Mother to reliably deliver nutrition to him.

a) Both experts conclude there was no problem with X's ability to absorb nutrition; his weight gain in 2018/19 and since September 2020 demonstrates this. That also rules out gut dysmotility which was queried by Dr B but which Dr Salvestrini comprehensively rejects.

b) Dr Salvestrini says there is no known condition which would result in fluctuating weight gain and loss. His progress since September 2020 also points against any unknown or unidentified fluctuating condition.

c) The combination of medications does not provide an explanation according to the experts and in any event both in 2018/19 and after September 2020 he continued on various medications but began to thrive.

d) The weight charts provide a vivid depiction of his fluctuating state prior to September 2020 and his steady progress since. His dramatic weight loss of 16% from summer to autumn 2019 points plainly to a failure to deliver nutrition. The clinicians were simply unable to explain it and had tried everything including additional supplements in order to address the issue; delivering nutrition which was usually reserved only for children with severe neurological or other conditions which compromise their ability to thrive. The Mother consistently told them that she was giving him the nutrition that they were prescribing.

e) Despite the Mother's attempts to suggest that others including the children would have known had X not been receiving his feeds, this was quickly demonstrated to be unsustainable.

f) He was not vomiting his feeds; apart from one example when he was being bottle-fed and was observed to vomit nearly a full feed long after it was said to have been consumed or reports of vomiting are not of feed.

g) He continued to be reported to vomit extensively even whilst he was thriving in terms of weight gain. During that period he was reported to be ill on 17 occasions with coughs, fevers, sort throats and was on antibiotics and other medications.

h) The start of the issues with feeding can be seen in the Mother's lies about his difficulty latching on in January 2018.

i) The insertion of the PEG-J was the end product of a process that commenced earlier in the year and arose out of the continued concerns about X vomiting.

vii) Induced vomiting. The Guardian does not disagree with the way the Local Authority puts the case on vomiting. Although one cannot identify precisely what was happening the evidence points to induced vomiting.

a) The evidence of 19 September is clear and it has ramifications for the likelihood of her inducing vomiting on other occasions.

b) It is clear that the Mother could have induced vomiting by introducing something either into his gastric port or into his feeds.

c) The effortless vomiting observed by a number of individuals is unusual in a child one year of age or more. That was observed from September 2018 onwards by Ms L, Ms C, Dr D, Ms E, and at the child in need meeting on 16 January 2020.

d) Ms L was a supporter of the Mother and whose opinion in January 2020 was unaffected by the bleach incident and yet she was sufficiently concerned by what she saw in terms of the effortless nature of the vomit, the unusual smell and the difference between that vomit and what she had previously experienced, such that she felt it necessary to write to the safeguarding lead.

e) Whilst there is evidence of other vomits (and one needs to bear in mind the differing definitions) which are probably genuine in origin there are others which are inexplicable.

f) Both Dr Rose and Dr Salvestrini were unable to identify any medical reason which might cause X to vomit in clusters as the Mother described and as were witnessed by Mr K. Dr Salvestrini considered that some vomits might be the accumulation of mucus or saliva in the gut but, once vomited, it would take time to accumulate again and thus would not explain clusters of vomiting.

g) At the time of reports of clusters of vomiting the medical records do not demonstrate that X was suffering from any other illness such as a chest infection or tonsillitis which might contribute to vomiting.

h) When X was admitted to hospital in September 2020 the medical records demonstrate that frequent vomiting was not a feature.

i) Since his discharge X's vomiting has been limited to isolated occasions with identifiable causes.

j) There is nothing identifiable which explains a change in his vomiting since September 2020.

viii) Non-co-operation: the Mother's reasons for not wishing to have X admitted to hospital do not stand up to scrutiny; a "suggestion" was clearly medical advice; his case was clearly not too complex for Hospital A; there clearly was input from Hospital B where necessary; childcare would have been available either from the maternal grandmother or from the hospital if requested; there is no evidence X was distressed by admissions; the house move had been a possibility since March and when dates arrived that the Mother said it was due to occur, they did not materialise; the Mother clearly was not overly concerned by Covid given her actions in the summer of 2020. This all amounts to clear evidence of her seeking to avoid admission. At this time, there was also an increase in X's weight which suggests the Mother was seeking to take steps to avoid an admission by maintaining a proper feeding regime. The Mother seeking to avoid admission and her anger at being excluded from X's feeding at Hospital B begged the question of why she was so anxious to maintain sole control over X's feeding.

ix) Development. The evidence supports the conclusion that the Mother's actions delayed X's development for a number of reasons.

a) Her failure to feed him properly meant he was physically unable to follow normal developmental patterns.

b) Her inducing vomiting led to him being exhausted.

c) She failed to stimulate him adequately; the multiple observations of how much time he spent in his buggy and her inability or failure to implement advice

d) Although the hospital observed signs of a higher level of development in X in September 2020 than were visible beforehand, Ms N attributed this to the fact that he was not exhausted by vomiting whilst in hospital. The evidence of Mr K and others was that when he was not exhausted, he showed signs of great promise.

x) V. There is clear evidence that the Mother exaggerated or misreported symptoms which led to unnecessary medication and investigations.

a) The Mother's request for a specialist buggy for V was clearly an exaggeration. He had been seen by paediatricians and others who confirmed he had no problems with mobility or balance and yet within days of being seen by Dr O or by Dr F the Mother was reporting to her GP that he had pain or mobility problems requiring a specialist buggy from the wheelchair service. The contrast between the Mother's reports and the observations of the professionals and of his nursery is obvious.

b) Although there is evidence that at times V was constipated, the Mother's portrayal of V as chronically constipated was not supported by the examinations of him over time. In particular, her portrayal of him as chronically constipated and in considerable discomfort if he did not have his medication, led to him being on unusually high prescriptions of movicol and lactulose. The Mother maintained to professionals that he was taking

his full dosage and that left them perplexed as to his apparently continuing severe constipation. The evidence supports the conclusion that the Mother was not in fact giving him the full amounts; the x-ray findings and the opinions of Dr Rose and Dr Salvestrini confirmed that it is highly improbable that he could have had continuing severe constipation if he was taking that level of medication. The Mother's more recent explanation that he occasionally did not take his medication is not something that begins to appear until 2016 although he had been on very high levels of medication since 2009.

c) In relation to V's asthma, he may have had mild asthma but the Mother's reports led doctors to be concerned that he had much more serious asthma than in fact was the case and which led to extensive investigations at Hospital C.

d) There may have been some underlying mild genuine issues, but they were substantially exaggerated and misreported by the Mother.

xi) W. The evidence supports the conclusion that the Mother exaggerated her dairy or cow's milk protein intolerance. The Mother was maintaining to her school that she had a dairy allergy and yet she was providing dairy products in her picnic. Her account was inconsistent. This attitude encourages a child to believe that they are ill when they are not.

xii) Y: The Mother maintained over a considerable period of time that Y was suffering from repeated choking and swallowing difficulties which in her evidence she effectively described as a one-off. This was entirely inconsistent with what she was reporting at the time.

xiii) Domestic Abuse: The Mother failed to protect the children from exposure to domestic abuse or the risk of exposure.

a) The evidence including CD's PNC demonstrates his history of abusive and dangerous behaviour is extensive.

b) The Mother reported physical, sexual and emotional abuse at his hands. She underwent domestic abuse programmes such as the Freedom Programme and maintained that she had learned from it.

c) However, she allowed CD back into the children's lives both in 2015 and 2016 and subsequently prior to Z's conception. Her account of how she came to allow him to have contact with the children and how she came to conceive Z are inconsistent and hard to understand.

xiv) Mental Health. The Guardian does not accept that the Mother's mental health was as the Mother now portrays it. Throughout 2016, 2017 and 2019 the evidence demonstrates that the Mother was offered support in relation to her mental health including medication and referrals to Highland House but declined them. She had extensive offers of support and actual support from health and other professionals and her attempt to attribute responsibility to a lack of support is unfounded.

The Evidence

51. The threshold schedule contains allegations which cover the period from 2008 – 2020. The documentary evidence which covers that 12 year period consisted of an electronic bundle of around 16,700 pages. In addition, there were documents provided by the parties including a detailed chronology prepared by Mr Ashworth extracted from the medical records which in itself ran to 112 pages and a weight chart prepared on behalf of the Guardian of 15 pages. The scale of the forensic exercise undertaken by counsel and by the court has thus been immense. If it has been immense for seasoned lawyers, how much harder it must have been for the Mother in particular but also the other lay parties.

52. In addition to the documentary evidence I have heard oral evidence from 20 witnesses including two expert witnesses, four parties and 14 clinical or other health or social work witnesses.

53. The case was originally given a time estimate of four weeks but this was revised upwards at a case management hearing earlier this year to 6 weeks. Evidence from the lay parties, clinicians and experts has been heard over some four weeks with the remainder being taken up by judicial reading, submission preparation and delivery and judgment writing.

54. Much of the detail of the evidence of the witnesses who have been called together with extracts of the medical records and other relevant material is summarised (if I dare to call it that given its length) in the detailed chronology which is appended to this judgment. Although the combined length of this judgment and the chronology is substantial, in reality, it represents only a tiny fraction of the totality of the evidence that I have read and heard and ultimately represents my selection of the material which it seemed to me necessary to fairly evaluate the allegations made. Self-evidently, a huge amount of the evidence does not appear either in this judgment or in the chronology and thus this record is surrounded by a penumbra of unrecited evidence, argument and evaluation which have contributed to the ultimate conclusions I have reached but which it would not be proportionate, necessary or possible in my view to record.

Expert Medical Evidence

55. Dr Rose (consultant paediatrician) and Dr Salvestrini (consultant gastro-enterologist) were instructed as Part 25 experts. They discussed the case at an experts' meeting (Transcript E508-519) and they agreed a Schedule. That Schedule, annotated *with further input* from their oral evidence is as follows.

Child	**Issue**	**Dr Rose**	**Dr Salvestrini**	**Agreement**
V	Constipation	*The x-rays do show constipation in 2012 and 2013 and in 2013 he would have prescribed a disimpaction regime. The problem was though the*	Does not consider that V had intractable constipation. Does not agree with the interventions to increase his laxatives [E509-E510].	Agreement, by deferral.

		constipation did not resolve despite a high level of medication.	Of the four abdominal x-rays only one showed faecal loading [E486-500; E510].	
	Level of Movicol	There were very high doses of Movicol, up to eight sachets, which is virtually impossible to take, and seemed to have no effect. Highly unlikely that V was treated with the prescribed level of Movicol [E405; E510]. *At that level it would be unsurprising if V didn't want to take it. It being prescribed at that level which is consistent with a dis-impaction regime would likely be because Dr O was told it was not working at lower levels.*	V has been on an incredibly high dose of Movicol. Suspect he did not receive the entire prescription. He received some Movicol, but impossible to quantify how much [E510].	Agreement.
	GORD	Agrees with Dr S [E511].	V did not suffer from GORD as a baby. The diagnosis of GORD was not appropriate [E230; E280-E281].	Agreement.
	Asthma	Mismatch between the amount of inhaled steroid, courses of oral steroids and V's reported continuing respiratory problems. The referral to Hospital C resulted in extensive and invasive investigations, all of which were normal. V's exacerbation of asthma was exaggerated both in	V was prescribed multiple asthma treatment, but Dr S cannot comment on appropriateness [E282].	Agreement as to multiple asthma treatment save that Dr S cannot comment on appropriateness

		extent and frequency [E404]. *He may have had mild asthma which warranted some medication.*		
	Exaggerated Symptoms	Severity of asthma exaggerated. Cannot say as to seizures [E404; E511]. No need for wheelchair or boots [E405] Hypermobility possibly exaggerated [E511].	Has been exaggeration of symptoms; limit as to areas upon which able to comment given area of expertise [E230; E511].	Agreement as to exaggeration.
W	CMPI	No objective evidence that W had CMPI [E406]. *Reliant on M's report and may resolve with maturation*	Dr S agrees [E289-90; E512].	Agreement
	GORD	No independent medical evidence that W had gastro oesophageal reflux. [E406]	Dr S agrees [E512]. Distinguishes between gastroesophageal reflux and gastroesophageal reflux disease.	Agreement
	Asthma	No independent medical evidence that W had asthma. [E407]	*Dr S does not comment on asthma in respect of W.*	
	Healthy child or not	A healthy child with normal development and no underlying medical problems [E406].	Dr S agrees [E512].	Agreement
	Exaggerated Symptoms	Considers M exaggerated W's symptoms [E513].	Considers that M has exaggerated W's symptoms [E231; E513].	Agreement
Y	Excessive Drooling	Dr R agrees no clinical evidence.	No clinical evidence [E513].	Agreement
	Choking	Dr R agrees no clinical evidence.	No clinical evidence.	Agreement

	Feeding / swallowing Difficulties	Dr R agrees no clinical evidence	No clinical evidence. [E231; E295]	Agreement
	Healthy child or not	Developmentally age appropriate and has no underlying medical problems [E407; 513].	Agrees [E513].	Agreement
	Exaggerated Symptoms	Y is a normal healthy child. All the reported symptoms have been exaggerated [E514].	Dr S agrees [E231; E514].	Agreement.
X	Vomiting & Choking	Defers to Dr S [E514]. *The evidence suggests he did not vomit milk but gastric juices, mucus, bile or saliva.* *Vomiting in clusters as described by the Mother is hard to understand physiologically.* *There is no medical evidence to support the Mother having induced vomiting.*	X did not choke, as he did not feed. X did bring up mucus and water, that was not a fabricated symptom, but the frequency, intensity, and importance of that has been exaggerated [E514]. Induced vomiting on 19.9.20 if court finds M administered bleach. [E231]	Agreement, by deferral.
	PEG, PEG-J, NG tube and NJ tube	Dr R agrees [E515].	PEG, PEG-J, NG tube and NJ tube all unnecessary [E252-253; E514]. *Lack of robust assessment by clinicians.*	Agreement
	Sufficient Nutrition or not	Dr R agrees. The only reason that X would lose weight, or gain weight, or has his weight pausing, is down to the number of calories [E516]. *His low B12 is also likely due to lack of feeding not non absorption as the gastric juices and intrinsic factor*	X has had weight loss, faltering growth and weight gain. From 1 year of age to 1 1/2 years, X gained weight in the care of his mother. Apart from this period, the reason for X's weight loss and scarce weight gain is not receiving appropriate calories [E515].	Agreement

		should be present in the jejunum		
	Weight & Gut Functioning	Dr R agrees [E517]. *There is no medical evidence of an underlying condition currently affecting his ability to absorb nutrition, including B12 and agrees gut dysmotility in the past is not indicated.*	X's faltering weight is due to number of calories. No issue with X's gut functioning [E516-E517].	Agreement
	Exaggerated Symptoms	Agrees with Dr S that vomiting exaggerated [E517]. Adds that X *may have some level of* undiagnosed global developmental delay, which is not exaggerated [E517]. *Incapable of conclusion until further time has passed given his more recent improvement.*	Vomiting exaggerated [E230].	Agreement in respect of exaggerated vomiting.
All Children	Inherited Connective Tissue Disorder	No evidence of any inherited connective tissue disorder [E518].	Dr S agrees. No evidence that any of the children are suffering from EDS [E518].	Agreement.

56. Dr Rose, prepared reports on the 19th July 2021, 26th July 2021 and 13th October 2021. His written evidence is summarised below.

GP Attendance

i) V and X attended their General Practitioners on multiple occasions. W and Y on fewer occasions. A previous General Practitioner commented that V was one of the most frequent attenders at the GP surgery. X does have underlying physical and developmental abnormalities which would be a reasonable factor in explaining his frequent attendances at his General Practitioner's surgery. There were multiple occasions when X attended his General Practitioner following which a diagnosis was made, for example upper respiratory tract infection, ongoing cough, otitis media for which he was frequently treated with

antibiotics and intermittently treated with short courses of steroids. It would appear that neither W or Y attended the General Practitioner Surgery excessively frequently.

V

ii) The medical notes indicate that V has eczema, asthma and constipation and had evidence of moderately severe gastro-oesophageal reflux disease. The General Practitioner notes indicate that he attended surgery frequently but for minor childhood illnesses only such as upper respiratory tract infection, otitis media and chickenpox. He was admitted with a possible seizure on 20/7/09 and 3/11/09, his EEG was normal. The diagnosis of seizures depends almost exclusively on the history in that seizures are not frequently seen in the GP surgery or in the acute hospital setting. The diagnosis of febrile seizures therefore was dependant on the history given by the Mother. There is insufficient medical information though to be able to determine whether the seizures did or did not occur. The EEG is normal following a febrile fit so is not helpful in determining whether V did or did not suffer febrile seizures.

iii) V suffered recurrent otitis media resulting in documented glue ears. There was independent ENT assessment that he required adenotonsillectomy with bilateral grommet insertion… V's referral for further management of his asthma to Hospital C was initiated by the paediatric team at Hospital A. The severity of a child's asthma is largely dependent on parental history unless there are admissions for acute exacerbation of asthma on a frequent basis which was not V's history. It is clear that Dr O was concerned at the apparent mismatch between the Mother's indication of frequent respiratory problems and V's appearance as being robust during the appointment on 12/4/11… Dr O's referral to Hospital C for further investigations was prompted by the mismatch between the amount of inhaled steroid, courses of oral steroids and V's reported continuing respiratory problems. The referral to Hospital C resulted in extensive and invasive investigations, all of which were normal. The biopsy of the lining of the lung in my interpretation is that it was not consistent with a diagnosis of asthma. In my experience it is unusual for a child to have such frequent exacerbations of asthma requiring moderate doses of Flixotide and repeated courses of oral steroids without hospital admissions. Clinically it is possible therefore only to indicate that there is some evidence that V's exacerbation of asthma was exaggerated both in extent and frequency.

iv) On 2/8/12 when V was 4 1/4 years of age the Mother requested a special buggy from the GP. There seems to be no physical reason why V needed a buggy at that age and no reason why the GP should have referred V on for measurement by the practice nurse. It is equally unclear who told the Mother that V had joint hypermobility when she requested prescription of a wheelchair from Dr U on 17/10/12. It is my opinion that there is, as a minimum exaggeration of V's problems. It is unclear to me how the Mother managed to acquire medically unnecessary Piedro boots for V in early 2013. There appears to be no medical indication for the use of such boots although on 6/9/13 Dr O notes that V had marked joint hypermobility. V was only 5 years of age and would be likely to be still fairly flexible. Physiotherapy assessment on 15/4/16 returned a Beighton score of 6/9 which is consistent with benign hypermobility. Such children do

experience some discomfort but do not require Piedro boots or wheelchairs. V's hypermobility resolved with age, being described by Dr D on 14/1/15 as having mild hypermobility only. Dr D was unclear as to why V needed Piedro boots. V had intractable constipation. Chronic constipation in childhood is very common the reasons for which are rarely determined in that the presentation with constipation with such symptoms as infrequent bowel actions and abdominal pain presents many months after the initiating trigger leading to that constipation. V's constipation was confirmed by abdominal x-ray showing marked colonic faecal loading for which he was appropriately treated with laxatives…. I find it difficult to believe that V was actually treated with 8 sachets of Movicol Paediatric daily. This is at the upper but not top end of a Movicol Paediatric disimpaction regimen which if used on a daily basis would have resulted in rapid colonic evacuation. V's continued faecal loading was confirmed on abdominal x-ray. It is my opinion therefore that it is unlikely that V received 6 - 8 sachets of Movicol Paediatric on a daily basis. Non-compliance with his medication led to protraction of his chronic constipation. There seems little doubt that V suffered from eczema. Recurrent otitis media resulted in glue ears requiring ENT operative intervention. It is unclear whether he had anything other than mild asthma. Asthma does improve with time so the lack of need for anti-asthma therapy now does not negate the possibility that he had asthma as a younger child. His hypermobility has resolved.

v) W: It is my opinion that W is a healthy child with normal development and no underlying medical problems. She was diagnosed as having possible cow's milk protein intolerance (CMPI) by her GP based on a rash on 21/10/14 and from a history of vomiting and rash in clinic on 13/12/16. W has not had formal investigations to determine whether she had cow's milk protein intolerance. The suggestion that she had CMPI continued following a dietetic review on 12/1/17 and continued following a telephone consultation with the GP when the Mother indicated that W had had an allergic rash on 14/4/20. However, following transfer of care to her maternal grandmother W: W was placed on a normal diet with no ill effects. Cow's milk protein intolerance tends to improve with age so her lack of intolerance whilst in the care of her grandmother does not negate the possibility that she may have had cow's milk protein intolerance as an infant, however, there is no objective evidence that she had CMPI. The diagnosis was made on the history from her mother as was the diagnosis of gastroesophageal reflux on the history of W vomiting. There is no independent corroborative medical evidence that W ever had CMPI or gastro-oesophageal reflux. W was treated with a significant amount of asthma therapy, Ventolin, Clenil and Montelukast, the diagnosis was made on the history. W was not admitted for exacerbation of asthma. There is no independent medical confirmation of the diagnosis. She is no longer using anti-asthma therapy. It is highly unlikely that W's asthma could have improved to such an extent that she was on 3 modalities of anti-asthma treatment in mid 2019 but then did not need any medication towards the end of 2020.

vi) Y: It is my opinion that Y is a healthy young child with no underlying medical problems. The developmental assessment indicates that he has been functioning at an age appropriate level although he did walk late, at the age of 21 months (normal range 9 - 18 months). Y was reported to be dribbling excessively by the

Mother. I could not determine that he had any significant feeding problems. He was diagnosed as being hypermobile, using a scale that is unclear, by physiotherapy on 16/10/19 at the age of 3 years 3 months. xlv. I would hesitate to diagnose hypermobility in a child of that age all of whom have inherent inflexibility. However, on 30/1/20 there was a further physiotherapy comment about hypermobility requiring supportive boots. There is therefore independent medical evidence of hypermobility. Y had enlarged tonsils requiring adenotonsillectomy, however they would not cause him to choke on food as enlarged tonsils are very common findings in children and even if the tonsils virtually meet in the mid line so are grossly enlarged normal swallowing can occur. The only suggestion of Y choking on his food emanated from his mother. There is no independent medical corroboration that Y had any difficulty in his swallowing.

vii) X: X has undiagnosed developmental delay. The foster carer diaries and Dr Q's report indicates that following placement in foster care X's development has improved but he was not functioning at an age appropriate level. X has now been in foster care for some 10 months….. [a further developmental assessment] would aid determination as to whether a factor of his developmental delay was neglect. X's developmental skills were assessed on multiple occasions by different medical professionals. It is clear that he had significant global developmental delay. He was investigated intensively and exhaustively both at Hospital A and Hospital B and no diagnosis has been forthcoming. The cause of X's developmental delay is therefore unknown. X was admitted for faltering growth. He was extensively investigated for causes of faltering growth both at Hospital A and Hospital B. No cause for his faltering growth was determined. His growth faltered following the PEG-J insertion regardless of whether he was at home or was in hospital. Indeed, when he was discharged into foster care his discharge weight was lower [subject to his views on weight recording] than his hospital admission weight. In foster care X was beginning to take all feeds orally and was experimenting with solid feeds. However, even if his weight and length have moved through the centiles it could not be suggested that the cause of X's faltering weight was related to maternal neglect as he failed to gain weight in hospital [qualified by oral evidence] A factor in X's faltering weight was considered to be his recurrent vomiting. Could the extent of X's vomiting have been exaggerated by the Mother, could X's vomiting have been induced by the Mother? It is not possible to determine whether the Mother exaggerated the extent of X's vomiting whilst in her care. He continued to vomit in hospital observed by medical professionals and his weight gain was poor at home, in hospital and initially in foster care. There is therefore no medical evidence that the Mother exaggerated X's vomiting. Vomiting can be induced by the use of outside agents such as excess salt. X continued to vomit in hospital, he was extensively investigated, and no electrolyte nor metabolic abnormality was determined. There is therefore no medical evidence of induced vomiting by a chemical agent. It is possible to induce vomiting by overfeeding; vomiting could therefore have been induced by introducing extra bolus feeds to X's gastric tube or by increasing the hourly volume into his PEG-J tube. However, it is likely that the extra volume of feeds would have been noticed by the nursing staff. X vomited when fluid was introduced into his stomach. It was also commented on that his difficulties with gastric contents was such that a gastric bag to allow free

drainage of gastric contents was suggested. Deliberate administration of fluid into X's stomach could have induced vomiting. There is no independent medical evidence. X was not tolerating gastric feeds although he was tolerating jejunal feeds albeit with occasional vomits by 19/9/20. Following the removal of the Mother from his care X was tolerating full gastric feeds within 4 days. There can have been no physiological change in that short period of time which would have altered his gastric function from being intolerant to tolerant. The implication is that X's vomiting was induced. X continued to vomit in hospital and failed overall to gain weight despite being in a controlled environment when the volume of feed infused into the PEG-J was carefully monitored. There is therefore no medical evidence of excess vomiting and faltering weight at home followed by a period of reduced vomiting and weight gain either in Hospital B or in Hospital A. The cause of X's food aversion and faltering weight remains undetermined. His food aversion has now resolved. X is reported to have suffered a seizure on 7/5/18. When he was reviewed by the paramedics his GCS (Glasgow Como Score) was grossly depressed at 3 (normal 15/15). He was also described as unresponsive. His later blood gas was consistent with a period of hypoxia (low oxygen) consistent with a prolonged seizure. X had a further episode of abnormal movements witnessed in hospital requiring active treatment. There is therefore independent medical evidence that X suffered from seizures. X was described as having arthrogryposis at birth. This is untrue. It is unclear as to who gave that history. Arthrogryposis is flexion contractures of joints such that the limbs cannot be extended fully. However, he did develop metatarsus adductus which required active treatment. It is unclear therefore whether the term arthrogryposis was an interpretation of the history given by the Mother did not initiate his treatment, but X's treatment depended largely on the history given by his mother. Exaggerated symptoms influence the decision process of the medical professionals when determining the appropriate treatment regimens. Should the Court find that the Mother was either fabricated or exaggerated.

57. X has developmental delay which is neither fabricated nor induced. He had faltering weight and abnormal gut function which was not fabricated, however, there is evidence that his vomiting was induced. It is my opinion therefore that X presents with a combination of proven medical problems, a. undiagnosed developmental delay, b. undiagnosed faltering weight, c. seizures iv. but with evidence of exaggerated/fabricated symptoms, a. frequency of cough, b. frequency of vomiting, c. induced vomiting suggested by the rapid tolerance of feeds in hospital after exclusion of the Mother v. and induced illness if the Court finds that bleach was administered.

58. Addendum of Oct 2021

i) Since being in care X has shown catch up through the centiles in both his height from below the 0.4th to the 0.4th centile and his weight from the 0.4th to the 9th. The cause for his faltering weight was unclear. X had a protracted admission to Hospital A during which time his weight fluctuated. There are concerns that X's vomiting and choking may have been exaggerated by his mother leading to a reduction in his calorie intake affecting his weight gain.

ii) Since being in foster care X has been able to feed himself orally, his PEG J tube has not been used for nutrition, he had not choked on his food and he has gained

weight indicating there is no underlying medical problem which restricts X's ability to thrive. X demonstrated significant developmental delay when Dr G undertook a video consultation on 15/10/20, when X had been in care for some 3 weeks, and then the face to face consultation on 4/1/21 when he had been in care for some 4 months. Dr G notes developmental progress following her review on 9/6/21 when X had been in care for just under 9 months. There had been developmental progress but he was still showing significant development delay with overall functioning at around 2 1/2 years of age.

iii) There is therefore no clear evidence that X has shown significant developmental catch up [later revised in light of Portage Developmental Assessment]. His developmental progress is commensurate with his increase in age but he still does show significant developmental delay of around 12 months. This argues that X does have an underlying undiagnosed developmental problem causing his developmental delay which is likely to continue.

iv) There is evidence that X has shown physical catch up in that his height and weight centiles have improved. The implication is that X was not receiving sufficient nutrition for him to maintain his natural centiles until he was in foster care. ii. The multiple developmental assessments have indicated that X continues to have developmental delay at a similar level in early and mid 2021. iii. There is therefore no clear evidence that a component in X's developmental delay is neglect.

59. Dr Rose gave oral evidence over the course of a day. In the course of that evidence he confirmed the accuracy of his reports and of the schedule of agreement/disagreement with Dr Salvestrini. The overall effect of his oral evidence and its impact on his previous written evidence seem to me to be as follows and as incorporated into the Schedule above.

i) The 2009 RCPCH guidance on FII has been supplemented by the 2020 guidance. He said in his clinical practice the issue is a difficult one and an uncomfortable one. It represented an end of a spectrum of behaviour which did not involve a hard jump but rather a continuum from acceptable anxiety to unacceptable anxiety. He emphasised that in his clinical practice it would be he who was ultimately reaching a decision on whether FII or perplexing symptoms were present and he of course would take into account a bigger picture than a purely medical picture. He emphasised that in his role as a medical expert it was ultimately for the court to determine what the conclusion was, taking into account all of the evidence and that his report should be read on the basis that his expressions of opinion were those which he could draw from the medical evidence. The evidence in relation to V's alleged hypermobility and the request for a specialist buggy and boots when he appeared to have hypermobility within the normal parameters for a child and where one would expect him to be rushing around developing his physical skills might be an example of unacceptable anxiety becoming exaggeration or possible fabrication.

ii) Paediatricians will always approach the history given on the basis that it is true; they may ask questions to clarify. The range of responses of a medical professional to a presenting complaint will also vary and it is not possible to say

one response is necessarily right and the other necessarily wrong in cases where there is a range of acceptable responses.

iii) Although ultimately the expertise on gut function lay with Dr Salvestrini the overall picture which emerged from the medical evidence (notwithstanding Dr B's concern about gut dysmotility) was that there was no underlying condition affecting X's ability to absorb nutrition. His periods of weight gain and weight loss were not consistent with any known condition but were consistent with variation in the amount of calories provided to him. His apparent vitamin B12 deficiency was also most likely due to insufficient supply of B12 rather than an inability to absorb it. Although the intrinsic factor which attached itself to B12 was produced in the stomach and the resultant product was processed in the jejunum there was no reason why the intrinsic factor should not pass from the stomach to the jejunum and attached to the B12 there.

iv) The medication X received: Ranitidine and Omeprazole were to limit or stop the production of gastric acid and were linked to vomiting and would not affect nutrient absorption. Alimemazine was to counteract possible gut dysmotility and so should not have affected nutrient absorption. Antibiotics would not affect calorie absorption either although the underlying illness might require the body to use more calories and so one would expect weight loss with an infection even in a Peg J fed child.

v) Babies and infants are known to vomit for no physiological or pathological reason and can do so effortlessly and without obvious distress, but they tend to grow out of it; usually by 12 months certainly by 18 months to 2 years.

vi) If the Mother was inducing vomiting and not giving calories the faltering weight gain outside the Mother's care and in particular in the hospital environment where, whilst the Mother was not supervised or observed constantly, no evidence of her failing to feed or inducing vomiting has been seen and this has also to be taken into account. There is no suggestion from the blood analysis that salt, or another mineral was being introduced to X to cause the vomiting nor is there evidence of dehydration. The introduction of significant amounts of water into his stomach might cause vomiting and the difference between 20 ml and 10 ml is not such as to give rise to X vomiting.

vii) Some care has to be taken in interpreting recorded weight. Different scales in different locations may give highly variable weights and the circumstances of the weighing will also have a potential impact. Weighing the baby with the Mother or weighing a baby clothed, when in a nappy or naked may all affect the reliability of the recorded figures. Children might be expected to gain somewhere in the order of 25g weight per day at the relevant age but this is variable. If he wasn't eating at all, a loss of 50-120g might be the expected range. We do not know what X's natural centile position is and this also influences our interpretation of his weight gain and loss. An apparent weight loss over time is compounded by the fact that a child should be gaining weight. The weight chart could suggest that there had been periods of time whilst X was in hospital in September 2020 and since his discharge when he has lost weight or failed to gain the weight that would be expected of him. There are a variety of factors which might be relevant to this including variations in the reliability of the

recorded figures, changes in the way in which he was being fed and the amounts he was being fed and the medication he was on (in particular steroids).

viii) X showed significant global developmental delay up until his admission to hospital. His developmental assessment after he left his Mother's care showed progress but by summer 2020, he was still recorded as having significant delay. The most recent developmental charts prepared by the portage service suggest that X is continuing to catch up in terms of his development. However, he is not yet at a developmental stage commensurate with his chronological age. He may have an underlying undiagnosed developmental disorder, or he may yet catch up. It is entirely possible that if he had an underlying condition (which might include myelination as noted by one paediatric radiologist) that this would contribute to developmental delay and that environmental factors including lack of nutrition or lack of stimulation may have added a further layer of developmental delay. In relation to early gross motor skills, neglect or lack of nutrition is a less likely explanation because they are linked to the making of neurological connections rather than stimulation although it is possible that a lack of nutrition could contribute to delayed development even in these fields as the body would prioritise other functions. In relation to other aspects of development, in particular more sophisticated motor skills and communication and interaction, these could be affected by lack of nutrition as well as lack of stimulation. However, unless one reaches the level of severe malnutrition the lack of calories is unlikely to impact on brain development itself, but fatigue which prevented a child undertaking tasks or hunger would impact on ability to engage and thus gain developmentally. The fact that X has caught up suggests that environmental factors are a significant part of the causation rather than an underlying neurological condition being mainly responsible. His sudden improvement must be linked to some change in his situation; including more stimulation. Neglect may explain some of his developmental delay; this represented a change in opinion since his report which he explained by reference to the most recent evidence which supported a great catch up than he had earlier understood to be the case.

ix) In relation to V's asthma, he remained of the view that he had been over treated for this including the admission to Hospital C. He said this because V had never been seen in acute distress or admitted to a paediatric ward in relation to an asthma-related event and so the extensive investigations were not founded in his medical history but arose from the Mother's reports. He himself would not have undertaken those investigations without a firmer medical evidence base. He accepted that the use of the word 'significant' in a letter from Dr O might have been interpreted by the Mother as meaning severe; he was himself concerned about the amount of medication he was taking and the lack of observable symptoms which was why he was referred to Hospital C. There was some limited evidence from Hospital C of reduced lung function. It is not possible to say at present whether V's complaints are learned behaviour or because he genuinely has asthma still. Overall it was not asthma at the level which he was being prescribed medication for.

x) In relation to V's hypermobility if a medical professional such as a physiotherapist said he had it, the Mother could be expected to rely on that and its reported severity. The community paediatricians thought differently.

xi) In relation to W, the cow's milk intolerance was diagnosed by medical professional and she was put on a different diet as a result. Her asthma was based on the Mother's reporting. The resolution of those issues since W was in the care of her maternal grandparents' points to her never having had asthma (or at most very mild) or a cow's milk intolerance. The development of her being prescribed salbutamol was inappropriate, but it was prescribed by doctors on the Mother's reports. It moved from being prescribed as an acute treatment for a viral wheeze through to regular prescription without a proper basis. The last prescription sought was in July 2020. It may be as she grew older that her immune system became more robust and so her wheezing or coughing was less noted.

xii) In relation to Y, all of his issues resolved on moving to the care of his grandparents and there is no physiological reason for his feeding difficulties. He had enlarged tonsils and they were removed and although there is no link between choking and enlarged tonsils one could understand why a parent might think there was. The housing situation that the children lived in if there were mould spores would tend to exacerbate asthma.

xiii) All of the children had various documented childhood illnesses which are observed by GPs and other medical professionals such as upper respiratory tract infections, chest infections, enlarged tonsils and similar.

60. The overall composite effect of his evidence seems to me to be to confirm:

i) That each of the children had various normal childhood ailments for which appropriate medical treatment was sought and given.

ii) That each of the children also had symptoms of commonly encountered childhood ailments which, based on the Mother's reports, led to them being over investigated and over medicated. In relation to V this was most obviously in relation to his constipation for which he received extensive investigations and medications which were unlikely to have been given as prescribed and which prolonged the fact of and treatment of the problem but also in relation to the extent of his investigation and treatment for asthma which probably existed but was mild. In relation to W this took the form most obviously of the over medication in relation to asthma which at worst was mild. In relation to Y this was in relation to his feeding and swallowing.

iii) The cause of X's initially reported poor weight gain and subsequent vomiting is not established. What is clear is that despite extensive dietician and paediatric input he did not gain weight, and this was not due to any underlying physical condition. The only explanation is a failure to deliver the calories which were being prescribed and this must lie at the Mother's door. The evidence suggests that he was not vomiting his feeds and thus it should have been available to his body to absorb. This is illustrated by his subsequent progress after he left her care. In addition, this development was significantly delayed whilst in her care

which could have been as a result of an underlying issue, lack of nutrition and lack of stimulation. His progress developmentally since suggests environmental factors relating to the Mother's care were a significant component. The medical treatment that he experienced including nasogastric and naso-jejunal feeding, his extensive inpatient stays and his PEG- J were unnecessary and essentially a product of the Mother's failure to provide him with the nutrition he required.

61. Dr Salvestrini, consultant in paediatric gastroenterology and nutrition provided a report dated 23 July 2021 and an addendum report dated 23 September 2021. She attended the experts' meeting and approved the transcript and the schedule. She gave oral evidence on 24 November over the course of about one day. Her CV makes clear the degree of expertise that she holds in this area and she has extensive clinical practice, leading the regional specialist unit serving a population of 1 million. Her oral evidence was detailed and precise and delivered in an accessible way. She made clear that she recognised the limits of her role or ability to offer an opinion on various aspects of the case, both those outside her area of medical expertise but also those areas which were the responsibility of the court rather than the expert. In particular, she was careful to make clear where she was identifying a possible explanation which could only be determined by findings of the court and I thought she was particularly careful to identify that the medical records contained nothing (save for September 2020) which suggested medical staff had noted matters which pointed to abusive behaviour by the Mother.

62. In her first report she undertook a detailed examination of the medical records and reached the following conclusions.

i) X has been the subject of numerous investigations and interventions to deal with reported symptoms of persistent and treatment resistant vomiting and FTT. It is my opinion that he was excessively medicated without robust assessment prior to escalation of treatment. As a result, he became feeding tube dependant, did not learn to eat at the right time, developed significant developmental delay. After 3 years of being significantly medicalised, he made rapid progress towards normalisation of his feeding and hence growth and developmental delay. This coincided with him being removed from his mother's care. I believe his mother was responsible for exaggerating/over-reporting/inducing his symptoms.

ii) V's constipation management involved an extraordinarily high dose of medications without the expected results. He also was prescribed multiple asthma treatments at a young age and needed several medications to be used at the same time. V was also treated for Gastro-oesophageal Reflux Disease (GORD) without typical symptoms and relying only on one test, which findings I believe are controversial. V was a young boy with the burden of needing to take a significant number of medications for 3 different conditions. He failed to attend school and was reported to have behavioural difficulties. Since he was placed with his grandmother and removed from maternal care, he stopped needing medications for GORD or constipation and had no further asthma exacerbations. I believe his mother was responsible for exaggerating/over-reporting his symptoms.

iii) W was brought to her GPs very often (14 times in the first 3 months of life) and had been diagnosed with URTIs and prescribed numerous courses of antibiotics, sometimes without a physical examination or convincing findings. She was

feeding less well when poorly which is common. Her issues with cow's milk allergy resolved promptly once she was placed with her grandmother. I believe his mother was responsible for exaggerating/over-reporting her symptoms.

iv) Y did not suffer from sustained feeding difficulties. He struggled to feed only when unwell with an acute infection. This presentation is common and self-resolving as reflected in his steady growth. I believe his mother was responsible for exaggerating/over-reporting his symptoms.

63. In her addendum report she examined the x-rays of V's abdomen in order to opine on the issue of constipation. Her impressions are contained within the detailed chronology in relation to the dated x-rays.

64. The overall effect of her reports and her oral evidence seem to me to be as follows.

i) The advantage she has as an expert looking back over the entire history and with the benefit of knowing what has happened to X and V since September 2020 enables her to approach the case in a different way to that which she would have had to approach it as a clinician treating the children. In particular, knowing how X has responded since September 2020 enables various potential causes of his vomiting and failure to thrive to be ruled out. His situation since September allows one to exclude chronic conditions such as metabolic disease, and anatomical abnormality or other underlying condition. What has changed since September is the Mother is no longer involved in his care. The change to gastric feeding from jejunal feeding is of course a change but the evidence suggests that had it been attempted earlier he would always have been able to tolerate gastric feeding. While she was alive to the possibility of an unknown medical cause she could not formulate any possibility, which had existed for three years and which resolved within days and simultaneously with the Mother's removal from his care.

ii) The use of a Peg J at such an early stage without a robust period of observation and nurse led feeding was not something that doctors should have supported. In particular she identified the absence of specialist paediatric gastroenterological input as a flaw in how she would have approached it. She also considered that the significant decisions on escalating the complexity of devices and changing feeding regimes were not supported by a robust period of observation and that the treating clinicians at the time plainly thought it was appropriate. She also noted that the Mother had failed to bring X to a number of paediatric gastroenterological appointments and X had been discharged in summer 2019.

iii) When Peg J feeding is undertaken, in order to ensure the child receives the appropriate level of nutrition, one has to ensure that the pump is running so as to deliver the required amount. The Mother was noted to have stopped the pump at times during X's inpatient admissions and whilst it may have been understandable for her to stop it on a couple of occasions, if she was concerned about him vomiting she would have had it explained to her how important it was that the pump continued to run and that it was not linked to his vomiting.

iv) X does not have any underlying condition which prevented him being able to absorb calories provided to him. The periods of his life when he has gained

weight demonstrate that physically his body is able to absorb calories provided to it. During those periods there were no other significant changes in respect of medication, presence or absence of vomiting, illnesses and his ability to gain weight since September 2020 all support the probable conclusion that it was the amount of nutrition rather than the ability to absorb nutrition provided. In particular the trajectory after September 2020 and a period of weight gain in 2018/19 point away from his having any significant gut condition either then or now. Gut dysmotility is often linked to a neurological condition which is not X. The issue therefore is whether he was provided with sufficient calories or whether he retained them in his body. The same was true in respect of his ability to absorb vitamin B12 where she considered the only explanation for his low levels was a lack of nutrition being provided.

v) None of the medications provided to X, either individually or in combination, would have an impact on his body's ability to absorb nutrition.

vi) His vomiting appeared unconnected with his failure to thrive. Throughout the period summer 2018 to summer 2019 he was reported to be regularly vomiting but was putting on significant weight both in real terms and in his progression through the centiles.

vii) The decision to reduce X's weight gain was not one which Dr Salvestrini would have implemented in the way it was. She considered that the appropriate course of action was to maintain feeding at a level (rather than increasing it) which would reduce the Kcal/kg bodyweight ratio and thus X would have come down through the centiles. She considered that the plan which was implemented which was actually to reduce his feeds and to reduce his weight was potentially harmful particularly given his weight instability history and that it would have led to him in effect being starved whilst his weight reduced. However, although she was critical of that approach, she ruled out the change having any physiological consequences in terms of X's ability to absorb nutrients thereafter.

viii) All of the medical records suggest that X was not vomiting feed and thus his body would appear to have been retaining the feed that was provided to it, in particular by the time it was provided either by the naso-jejunal tube or by the Peg J tube. The delivery of feed directly into the jejunum is the ultimate treatment for vomiting as the food is delivered into the jejunum which is beyond the stomach and the ileum. Although feed can return back into the stomach it is rare and this is not what was reported for X in any event. It is a relatively simple process to interfere with the feeding pump whether at home or in hospital in such a way as to prevent the feeds being delivered. It can be done in such a way that the pump would record the feed being delivered in terms of volume but if the tube was disconnected from the port and the feed delivered into a bottle the pump would provide a misleading figure of the total feed delivered.

ix) A clinician would distinguish between a posset, regurgitation and vomiting. It is possible a parent might describe them differently. The videos recorded by the speech and language therapist do not show vomiting, but he does have mucus in his mouth always seems to be straining to produce something. The reasons for X's vomiting needed to be looked at according to different stages of his life. As an infant of a few weeks old, young children will often swallow mucus and

saliva and together with secretions in the stomach they may vomit them in particular when they are ill with viral infections or upper respiratory tract infections and are producing and swallowing more. Typically, they may vomit in the morning after they have been recumbent and may then vomit when there is sufficient build-up in the stomach again. However, these are unusual and usually not significant in volume. However, this would tend to come and go with the illness causing the increase in mucus et cetera. X was on omeprazole which is intended to reduce acidic stomach secretions and so it should reduce the volume. Vomiting can be induced by the introduction of fluid into the stomach; a large amount of cold water might prompt a vomit due to the mechanical distension of the stomach being beyond its capacity. As an infant of a few weeks old the oesophageal sphincter may not be fully developed, and this will often be the cause of young babies regurgitating or vomiting their feed; it is physiological not pathological and usually resolves within a few months as the sphincter matures. Some babies overfeed (happy spitters) but they put on weight and it is hard to overfeed a baby in any event. However, they should put on weight. If Mother was feeding X as much as she reported (which was 1 ½ times the amount recommended for him) how could he be vomiting it all up and not growing? Overfeeding is not compatible with his dropping through the centiles and it becomes irrelevant to the issue of vomiting when jejunal feeding was introduced. Illness can cause children to vomit. Young children will often swallow mucus and saliva and together with secretions in the stomach they may vomit them in particular when they are ill with viral infections or upper respiratory tract infections and are producing and swallowing more. A medication mixed with water might irritate the stomach but the stomach is a relatively hostile environment being accustomed to a strongly acidic content. No one observed anything being done of this nature and it would be in the territory of an assumption for me. Cow's milk protein allergy is also ruled out in respect of his vomiting as he was both given the formulas which are prescribed in CMPA cases without any alteration in symptoms and since September 2020 he has tolerated dairy. Gastro oesophageal reflux disease is also not indicated; it is irrelevant after the jejunal feeding was introduced in any event. When he was having nasogastric feeding in late 2017 there was no reported significant vomiting which is not consistent with GORD. His tolerance of gastric feeding after September 2020 also points against GORD. After lockdown most of the symptoms were reported rather than observed and it appeared to be a story of chronic ongoing mucus.

x) Some of the medications X was on could be linked to vomiting. Omeprazole can cause vomiting and lactulose can cause bloating and discomfort. The antibiotics are unlikely to be linked as vomiting was reported when he was not on antibiotics.

xi) Bleach is a highly dangerous substance to ingest. If it is ingested orally it can burn the mouth and oesophagus which can cause narrowing and long-term feeding problems. In X's case its introduction to the stomach which is accustomed to chemical aggression probably resulted in less damage to the stomach as it was mixed with stomach contents as well as diluted and vomited. It is standard protocol to undertake an urgent endoscopy when bleach is consumed. For an infant this involves a general anaesthetic. No damage was

detected to the mucosal lining of X's stomach. Had bleach been administered on a regular basis it seems likely the mucosal lining would have shown signs of inflammation or other damage.

xii) There is nothing in the medical notes to suggest that any medical professional connected any of X's vomiting with a smell of bleach and chlorine is a noticeable smell.

xiii) The evidence, including the x-rays does not suggest that V had chronic constipation. The Mother never reported soiling which is common in chronic constipation where liquid faeces will be ejected involuntarily. When he was admitted to hospital for disimpaction it was the enema which resulted in emptying rather than the Movicol which takes 24 to 48 hours to have any impact. The amount of Movicol that was being prescribed is unlikely to have been consumable by a child of his age. If he had been consuming that amount it is unlikely, he would have wanted to consume any other food or drink. It seems likely that he was not consuming the amount of Movicol that he was prescribed. The medical notes do not suggest that the Mother was telling the treating clinicians that he was not consuming the amounts prescribed but allowed them to believe (at best) that he was consuming his prescribed medication. It is certainly understandable that a child would struggle to consume those amounts and would seek to avoid consuming those amounts but the onus is on the parent to report accurately to the clinicians what the child is doing and to oversee them to ensure that they are consuming their prescribed medications.

xiv) In looking at weight gain, one should focus more on the centiles rather than the absolute weight as it can vary so significantly depending on the time of day, whether the child has urinated or defecated, whether the feed has recently been ingested et cetera. Weighing is usually done twice a week in identical circumstances in order to give a consistent picture. The trajectory in late August/early September suggest some weight was being gained at home and in hospital. When the bleach was administered X was not fed for up to 36 or 48 hours. When his feeding regime resumed it was quickly changed to try gastric feeding and the process began with dye or a light and then a small amount of feed which explains the dip in his weight around 24 September and then the regaining of weight thereafter. It is significant that, prior to the Mother's departure from his care, X was consistently below the 0.4th centile but thereafter he began to climb through the centiles. This was not a dramatic change in weight; one would not want him to put on weight too quickly as that would become fat rather than muscle. What it shows is that he had a functioning gut which quickly adapted to gastric feeding despite being nil by mouth for nearly 2 years.

65. Overall I draw from her evidence:

i) There was no underlying physiological or pathological condition responsible for X's failure to gain weight. The cause was a lack of nutrition. The absence of vomiting feed, on balance, rules out X vomiting his feed as a cause of that lack of nutrition. The logical consequence is that X was not being given the amount of nutrition that the dietician and others were recommending. That lies at the Mother's door.

ii) In terms of his vomiting, Dr Salvestrini seems fairly clear that at various times there would be probable explanations for vomiting, including deposits, regurgitation as a baby and more frank vomiting as an older child which would be linked to identifiable issues such as a lax oesophageal-sphincter, to childhood illnesses including viral infections and upper respiratory tract infections which would cause a build-up of mucus, saliva and stomach secretions which would be vomited.

iii) However, the reported history of constant vomiting is not explicable by these known causes. Nor was he vomiting in any way linked to the failure to thrive as X gained weight from June 2018 to June 2019 during which time the various professionals involved in his care were regularly reporting observing him vomit.

iv) A possible explanation for some of the observed vomits particularly those which were noted to be unusual would be the Mother having taken some action to introduce something into the gastric port either water or some other fluid which caused X to vomit copiously or frequently.

v) The absence of a logical explanation for the reports of vomiting throughout X's life implies that the Mother was to some degree exaggerating how frequently he was vomiting and that this contributed to the implementation of the naso-jejunal and ultimately Peg J feeding and X being nil by mouth for nearly 2 years. Had the concerns over vomiting not existed a move towards gastric feeding would have commenced much earlier. It was largely Mother's resistance to this and the continued reports of vomiting which contributed to X being fed by Peg J for so long.

vi) In relation to V, it seems unlikely that he did experience chronic constipation; the x-rays and the maternal grandparents' reports do not suggest this nor do reports of the school or other factors such as the absence of reported soiling. What does appear more likely to be the case is that the Mother maintained that she was giving V the medication, in particular the Movicol and was reporting continued constipation when in fact V was not as constipated as he was and the doctors were misled as to the impact the medication was having because the Mother was not frank about the extent to which she was not giving the medication.

Clinical and Social Work Witnesses

66. Dr Q is a consultant paediatrician based at an NHS trust. She has been X's paediatric consultant since she first saw him on the Hedgehog Ward back in December 2017 when he was only a few weeks old and had bronchiolitis. She has been involved in his care since and most recently conducted a review on 8 October 2021. She produced a joint report dated 14 January 2021 with the consultant Paediatrician with special interest in gastroenterology, Dr T and a statement dated 28 October 2021. She gave oral evidence. The overall effect of her evidence seems to me to be as follows.

i) Over the period of her involvement with X there were ongoing concerns in particular about his failure to thrive with poor weight gain and periods of weight loss. The Mother reported frequent vomiting, and this was on occasion seen by clinicians.

ii) His weight chart showed a deterioration in his weight from birth to under the 0.4th centile within a few weeks of birth and that this had been the main long-term concern. His weight chart showed a period of time where he appeared to thrive but was then followed by a deterioration back to under the 0.4th centile. The fluctuation in his weight and his failure to thrive also incorporated a period of inpatient treatment; although during these periods the Mother would have been present almost continuously.

iii) He progressed from bottle feeding through to nasogastric feeds to naso-jejunal feeds through to a gastrostomy and then a jejunostomy. The purpose of feeding into the jejunum was to minimise the possibility of X vomiting food from the stomach. Whilst feeding into the jejunum does not eradicate the possibility of vomiting, it reduces it significantly and is intended to allow the body to absorb the nutrition.

iv) Despite the placement of a PEG-J feeding tube X continued to fail to thrive. Investigations had ruled out any physical condition which prevented the absorption of the nutrition and the period of time when X had thrived and put on weight was inconsistent with it being due to a physical condition preventing absorption of nutrients. The other alternatives were non-delivery of the prescribed amounts of nutrients or vomiting up of sufficient of the nutrients to prevent absorption and deliver weight gain.

v) No cause of X's vomiting had been discovered.

vi) After the Mother was removed from his care, following the incident in September 2020 X's weight gain had been relatively consistent whilst placed with foster carers and when seen most recently had progressed to between the 9th-25th centile. He moved from continuous jejunostomy feeds to bolus gastrostomy feeds which he tolerated successfully, and no further vomiting was noted. Very soon after his placement in foster care his need to be fed by the PEG had reduced significantly and he had begun taking food orally. At the most recent review it was noted that the PEG-J had only been used twice in recent months in order to ensure X remained hydrated when he was poorly. Whereas the Mother reported vomiting several times a day whilst X was in her care, the foster carers had not experienced any significant vomiting save in association with an illness or food poisoning. His anti-sickness medication had been discontinued in December 2020.

vii) During the period of Dr Q's care there had also been concerns about X's developmental progress. In September 2020 his developmental level was around one when his chronological age was three. When he was seen in the care of the foster carer some six weeks later, he had made significant progress; both the paediatrician and the neurologist were very surprised by his rapid progress.

viii) X had had multiple referrals for chest infections and had been on antibiotics in over 40 occasions. Chest x-rays were unremarkable. Although the medical notes demonstrate occasions when the GP diagnosed tonsillitis and prescribed antibiotics and although a child of his age in a household might expect to be seen up to 6 times a year for viral or other infections, the number of times X was seen was significantly more than would be expected. Since he had been in foster

care, he had not had any particular chesty symptoms or reported chest infections although remained on prophylactic antibiotics at the direction of the paediatric respiratory consultant at Hospital B but is awaiting further review.

ix) Dr Q said that X's failure to thrive was most concerning in that during lockdown she had advised that he be admitted to hospital to monitor, observe and document his feeding. His descent across three centile boundaries was very worrying and she believed she had made it clear to the Mother how concerned she was and how important it was that he was admitted. Initially the Mother had agreed to his admission in July 2020 but subsequently withdrew saying that it was not convenient because she was due to move house. The overall effect of Dr Q's evidence was that there were occasions when the Mother was resistant to advice or failed to attend appointments or referrals which had been made.

x) Eventually the Mother had agreed to X being admitted on 7 September but then discharged him against medical advice when it was proposed to give him a gastrostomy feed but later on the advice of the social worker (Dr Q considered that X was at risk of significant harm if not admitted and by implication care proceedings might have ensued) brought him back to the hospital where his feeds were administered by the staff. The Mother asked for his care to be transferred to Hospital B, but they refused to take him.

xi) Overall, she was of the opinion that X was likely to have been subjected to fabricated and induced illness with a possible combination of neglect and reporting of exaggerated symptoms; the possibility of interference in his treatments (feeding regimes) and possible deliberate induction of symptoms on occasions other than the injection of bleach. Whilst she considered various facets (other than the observed injection of bleach) were only possible and she could not be sure, the overall combination she considered enabled her to conclude it was likely that FII was the problem.

xii) In giving her evidence she was measured and, I thought, careful. She certainly not did not appear to be hostile to the Mother in any way and was able to acknowledge aspects of the case which were consistent with the Mother providing good care and there being areas of X's care where it was clear that doctors had considered his problems were genuine and had treated him accordingly. The evidence from the safeguarding meetings suggest that she did not take on X's care with any preconceived notion of FII, I accept that her evidence was genuine when she said that at the outset she would listen to the Mother and seek to find an underlying organic cause. She said that "when there are signs and symptoms for which no underlying diagnosis can be found it is reasonable to have FII in your list of differential diagnoses.".

xiii) Although her evidence was given as one of X's treating team, she is of course an expert in her field. Albeit her evidence was not given under the mantle of duties to the court that encompasses, I am satisfied that in so far as a treating doctor can deliver a balanced and objective appraisal that she did so. What she returned to was that the overall constellation in relation to X ultimately pointed in her opinion to FII whilst accepting that there were aspects of X's care which either showed genuine illness or which could not definitively be identified as a discrete event of fabrication, inducing or neglect.

67. Dr G was X's community paediatrician. The results of her reviews are recorded in the Chronology. Overall she was reluctant to draw much from her reviews preferring to rely on the contents as speaking from themselves although she did say that X had made very good progress from October 2020 to June 2021 and that from where he was as a 3 year old to where he was a 3years and 8 months was significant in terms of his development in mobility, in feeding (from bottle to beaker and to spoon feeding himself as well as from PEG to bottle and solids) as well as his weight gain and language.

68. Ms M is the lead safeguarding nurse of the NHS Trust. She compiled a very detailed chronology from the hospital's own records and from chronologies provided by third parties. She had some involvement with X's case as the safeguarding lead from shortly after X's birth but was clearly substantially more involved between the period of 2018 to 2020 although by chance was absent on leave during the events of 19 September 2020 and the immediate aftermath. Her report set out the following conclusions.

    i) X presented over a 3 year period with the following - Persistent and incessant chest infections with no obvious cause; had multiple antibiotics (40+ prescriptions) which did not appear to relieve symptoms; CXR not performed until October 2019 Chesty cough - persistent and unresponsive to asthma medications - unclear why Perplexing fluctuating weight - birth weight was normal (50th centile) but he had lost weight at Day 10. This pattern of weight loss and gain was a feature of the first 3 years of his life. He did not respond in an expected way to treatment and importantly did not respond to high calorie feeds; it is recognised that some children will require a high calorie intake [for any number of reasons] but there is always the assumption that they will put on weight; this did not happen with X. No explanation as to why. Consideration must be given to the theory that either he was not given the correct feeds, or his equipment was tampered with. Developmental delay - he presented as a child with gross developmental delay in all areas. All assessments showed this. No cause for this was ever found. The progress that he has made since going into foster care has been remarkable. There must be an assumption that his home environment was so neglectful and under stimulating that he was never given the opportunity to progress. Consideration should also be given to whether his carer 'enjoyed' the status of looking after a very sick child and was unable to allow X to progress as she would lose her 'heroic mother' status (and possible funding). Feeding and vomiting - X was noted to have started vomiting by day 10. He was prescribed a variety of anti-reflux medications and milk. No treatment plan appeared to have been effective and vomiting was a feature of his day to day life. This must be contrasted with his foster carers reporting minimal or no vomiting. Consideration must be given to whether his Mother was inducing the vomiting. There is no evidence except for the 'bleach' incident but professionals may wish to surmise that this was not a one off incident.

    ii) Carer engagement with professionals - evidence that Mother actively sought to sabotage health advice and admissions; she declined to have X admitted to Hospital A or Hospital B.

69. In her oral evidence, she confirmed various matters of fact which are incorporated within the chronology. She accepted that she was not in a position to comment on matters outside her expertise and her conclusions should not be read as doubting or challenging the conclusions of other medical professionals; in particular in relation to

X's chest infections and his cough. She also accepted that the Mother had engaged extensively with medical services over the years, faced many obstacles in the care of the children and that even during hospital admissions X had experienced perplexing symptoms of weight gain and loss. In her evidence she was in the main measured and matter of fact although under cross examination was occasionally defensive. Inevitably her report which was written in January 2021 was tinged in how it was expressed, in its emphasis and in its focus more on matters of concern about the Mother's care than on any qualities observed by the fact of 19 September 2020. The contemporaneous records created during the course of X's life certainly do not suggest that the professionals and in particular Ms M were approaching the case with a predisposition to fabricated or induced illness; indeed they were clearly ruling it out early on but it is also clear that as time passed and as no underlying condition or other explanation was found for X's ongoing difficulties, Ms M and others began to consider FII as a possible explanation. The growing concern which seems to have moved from a background possibility, through stages of suspicion, through to belief, through ultimately to confirmation by the events of 19 September undoubtedly has played its role in the tone of Ms M's report. As the safeguarding lead and with the statutory responsibilities that she holds, it seems to me to be entirely appropriate for her to raise the concerns she has in that report and to draw professionals' attention to possible behaviours of the Mother. She is not an independent expert instructed by the court but undertakes a statutory role in the field of safeguarding and given the factual matrix that existed by January 2021, the contents of her report reflect the concerns which existed within that body at that time.

70. Dr A was X's treating consultant paediatrician for his first week of admission in September 2020. He gave a clear but detailed explanation of the purpose which was to be served by the admission and in particular how they planned to progress X's ability to feed moving from continuous 24 hour feeding into the jejunal port of his PEG-J which involved him being permanently attached to the feed pump, through to higher calorie feeds at 1 hourly, then 2 hourly then 4 hourly intervals, moving the delivery from the jejunum to the stomach which, if tolerated, would have allowed X periods of time when he would be free of the pump and able to engage in other activities. He also explained that the process was to be closely monitored, was supported by nurses to reduce the burden on the Mother and that play therapists were to be involved in order to support X's development, alongside the feeding support. Dr A said his abiding thought relating to the period he was involved for, was that he would spend time discussing the situation with the Mother, would gain her consent to a course of action and then the next day it would not have been implemented as the Mother would have raised objections. I mention his explanation of the process to me in particular because I thought the clarity with which he explained it and his calm and positive demeanour would likely have been deployed with the Mother and would have maximised the prospects of her understanding exactly what was proposed and the potential benefits. He also confirmed that the rationale was repeatedly gone over and it was clear he would have given considerable time to ensuring the Mother was on board. He was a careful witness, he did not shy away from accepting limitations in record keeping or accepting the possibility for misunderstandings but overall he was an impressive, balanced and clearly expert physician who had no animus against the Mother and was matter of fact and, I thought, conscientious. The evidence of his actions is incorporated into the Chronology. For me, the most significant aspect of his evidence was that the impact on X of his preceding feeding regime was not only that it was not working in terms of promoting his growth but also that it had a huge impact on his ability to lead any sort

of normal life for a 3 year old. It was also significant that a change in his feeding regime would not only have had obvious health and developmental benefits for X but also for the Mother who would have been relieved of the burden of his being tied to a feeding pump and needing her attention and the need for her to be more taken up with monitoring and changing feeds. A change for X to fewer feeds by bolus to his stomach by day and the removal of overnight feeds seemed to be a win-win situation. He was clear that the Mother's suggestion that X had had a water feed into his stomach during his time caring for X which had led to vomiting (and hence provided a reason for the Mother to object to a gastric feed) was not his recollection and that not only would that have had to be at his instigation but it would have been recorded.

71. Dr T is a consultant paediatrician with specialism and training in gastroenterology. He provided gastroenterology specialist advice to Dr Q prior to X's admission in September 2020. The intention had been that Dr T would be the lead paediatrician because of his gastroenterology specialism during week two of X's admission. He was the joint author of the report with Dr Q and also provided statements to the police and within these proceedings. He was on duty on 19 September. His evidence in relation to what occurred on 19 September and what he did in relation to X's treatment is recorded within the main chronology. He appeared to be well versed in his field and gave detailed answers to the questions. He sought to exercise care when he was unable to recall matters beyond the notes; I see no reason to doubt the accuracy of his evidence most of which is supported by the notes in any event and it was clear that the unusual nature of the case had left its own imprint. He did not appear to have approached the case with any preconceived idea of what was happening with X and made clear that the events of 19 September were most unusual and worrying and that when they began to consider that FII might be involved they took care to observe the guidance given by the RCPCH. He said that the reason for X's admission was that there was no clarity as to why X wasn't putting on weight despite the amount of feeds, the calorie input and their being fed into his jejunum. They wanted to admit X in order to observe him, in particular the vomiting and to get an objective view of the symptoms in order to understand why he was not gaining weight. He said that were X vomiting his feeds it would be obviously different in colour and consistency to X vomiting stomach secretions and bile would be clearer or greener accordingly That would have informed the next steps in his management. He said in his experience the inability to identify an underlying cause was one of the most worrying situations for parents. At the point of his readmission the plan was for the Mother to observe and notify the nurses of his reaction to trial feeds into his stomach. Extensive assessments and investigations were planned throughout his admission including speech and language therapy assessment of his swallowing, play therapy and explore whether there was any neurological component linked to his apparent inability to feed. He said that during the first part of the admission and indeed into his week they had not got answers to the questions that needed to be addressed and so they were considering an extension of the stay. Following the removal of the Mother from his care following the bleach incident X was unable to be fed either orally or by his Peg J for upwards of two days although he received intravenous fluids which included electrolytes. He said that the need for an endoscopy with paediatric surgery on standby could not be conducted at his hospital hence the referral to Hospital B. That was carried out under general anaesthetic and a cannula was inserted to deliver intravenous feeds and medicine to protect the stomach from the effects of bleach.

72. He emphasised that following the removal of the Mother from the care of X, vomiting did not continue to be an issue and X tolerated into the stomach remarkably quickly, showed interest in oral feeding (Colin the Caterpillar seems to have assisted but neither provided a statement or attended to give oral evidence) and rapidly moved from continuous jejunal feeding to gastric feeding (initially half dioralyte/1/2 milk) and then to bolus feeds at intervals of a few hours. He said that in his experience this was markedly quicker than they had expected and that X's ability to tolerate gastric and oral feeds without vomiting and his weight gain were very positive. He said that it was, in part, the rapid progress that X made in tolerating gastric and oral feeds, his weight gain, and the absence of vomiting that led them to consider FII a possibility. X's interest in oral feeding and his subsequent progress to oral feeding were also notable given the fact that many children who have been fed by Peg J for prolonged periods develop aversions to oral feeding. He was also pleased by the fact that they had been able to cease the administration of three medications which had been given to X to improve his gut motility and to reduce the prospect of vomiting.

73. Dr D was both V's and X's community paediatrician. Most of her evidence is incorporated within the chronology. In relation to V she was involved with him in 2012 and 2015 when she considered her examination and that of a colleague showed him to be neurologically unremarkable, including in relation to hypermobility, and that there was no reason for him to be referred to the wheelchair service for any particular provision. In 2015 she was clearly concerned about the issues concerning his constipation but ultimately deferred to the consultant with gastroenterology specialism whose care V was under. She confirmed that one of the medications V was on had cardiac contra indications that he should not be on it unless it was essential. In relation to X she saw him as part of a multiagency assessment in March 2019 because his presentation was complex and confusing and they wanted to draw together all of those involved in X's care so they could get a fuller picture of his health needs and decide on a plan, including whether a referral should be made to children's services. When she saw him he vomited four times in an hour and was clearly exhausted by this which impeded her ability to undertake the Griffiths developmental assessment. However, with input from a number of X's carers and the Mother who was present, she undertook the assessment which demonstrated that at a chronological age of 18 months X's development ranged between five and eight months. Assessment was valid given the combination of her observations and reports from health professionals as well as the Mother. She said in her experience children who were fed via a Peg J were able in many ways to develop normally. She described X vomiting apparently effortlessly by which she described not retching or coughing before and that the Mother came prepared with a towel to mop him up. She said that witnessing his vomiting in that way over the course of an hour was quite shocking to see and how it affected him physically. The discussion recorded about his vomiting was principally focused on him vomiting secretions and the possible need for a drain to reduce his vomiting of secretions. She said she was unable to explain how he was at that time gaining weight (he was at the 25th centile) but was vomiting so frequently.

74. Ms H was (and remains for the time being) X's occupational therapist. Her involvement with X spanned the period when he was in the care of the Mother and his period of care with the foster carers. Much of her evidence is incorporated within the chronology. The evidence she gave was that, whilst X was in the Mother's care, he was making very poor progress but that since he had been in foster care he had made significant progress

in relation to his global development. She recounted several occasions when X vomited many times during the assessment she was conducting and that she usually expected X to be tired and listless as she viewed him as a poorly child. Since he had been in foster care he had not been vomiting and now appeared to be an active and energetic child. She had made arrangements for the Mother to have a hospital cot for X in order to assist the Mother in getting X in and out particularly during the night in order to change his bedclothes following frequent vomiting. She had arranged for a bath support chair and a specialist buggy to support X's posture. Since he had been in foster care neither the cot or buggy had been used at all and the bath support had been dispensed with soon after his arrival as he was able to sit unaided in the bath. She said that the Mother was plainly busy caring for the children and that in general she responded to texts and calls; there was no suggestion from Ms H that she had found the Mother to be obstructive or neglectful in complying with appointments. She expressed no view on the reason for the change in X's presentation and his development since he went into foster care.

75. Ms JK is a specialist paediatric dietician who was involved in X's care from approximately August 2019 to date. She said that over the course of her involvement they were trying to establish why X wasn't consistently gaining weight but his weight change was erratic going through periods of weight gain, weight loss and static weight (which in effect moved him down the centiles as he grew older). The overall effect of her evidence was that she and her team tried various strategies within their expertise to deliver consistent weight gain but they were unable to do so. She said she was unable to understand why they had not been able to achieve that and her experience of jejunally fed children markedly differed to her experience with X. Many of her cohort had underlying conditions which required the jejunal feeding whereas no underlying condition had been identified in X and yet despite an apparently high calorific intake of hydrolysed (partially digested) feed by jejunal feeding, both of which should reduce significantly the possibility of vomiting, he continued not to make consistent weight gain and was reported to and was observed vomiting copiously. She said he was unusual in her experience in terms of the frequency and volume of vomiting reported and observed. During her period of involvement, despite several changes to his feeding regime including changes to the calorific content of his feed (both in total and per millilitre), whether it was preprepared or powdered, whether it was delivered over 20 hours or continuously, no sustained weight gain had resulted. The calorific content of the feeds that were to be given to X were in excess of the standard calorific need of children of his age and at times the calorific content was increased significantly by the addition of Calogen or by increasing the calorific content per millilitre of feed delivered. She acknowledged that there were periods when he had gained weight and indeed a period in June and July 2019 when he had put on so much weight at hospital that his calorific intake was reduced but the overall pattern for X was failing to thrive. She acknowledged that various factors could affect weight gain including X being ill or taking medication and that it was important to be accurate in the information from which conclusions were drawn but ultimately the effect of her evidence was clear from the dietician perspective his failure to put on weight and to thrive was inexplicable; if the calories were going in he should have been putting on weight. Her explanation of the equipment made it clear that it would not be difficult to interfere with the delivery of feeds. There were periods when he was able to put on weight in 2018, 2019 and 2020 which pointed not to an underlying condition but some other issue. This I suppose begs the question either of whether the calories were going in or whether they were all being expelled through vomit. She said that the process essentially placed the

responsibility for mixing the feeds and delivering the feeds, maintaining the equipment and setting alarms were that of the parent. She was clear that the Mother was well aware of how to use the equipment and indeed was well aware of the feeds that X was to receive; she said that the Mother was able to recall precisely when asked the particular requirements of feeds at particular times. She therefore did not consider that there was any issue of the Mother misunderstanding what the expectations were of her. By the summer of 2020 she considered that it was essential that X be admitted for observation and monitoring so that they could understand what his reaction was to the delivery of his feeds when they were provided by nursing staff.

76. Following the Mother's removal from his care she considered his weight gain in hospital and in foster care and his rapid move from 24-hour jejunal feeding on a hydrolysed high-calorie feed through to a non-hydrolysed feed, to gastric feeding at four hourly intervals through to his calorie intake being taken mainly orally suggested to her that he had no underlying condition but some other factor was at play. She did not consider the change in proportions of his feeds which occurred at hospital to be any explanation of the significant change. It was clear that she considered his to be an unusual case and that it was inexplicable within her frame of reference. She was clearly knowledgeable in her field and appeared not to bear any hostility to the Mother and gave her evidence in an objective and measured way.

77. Dr U was and remains the family GP, including the Mother's, who has recently sought a referral to the community psychiatric team and who continues to take medication relating to her mental health. Dr U emphasised in her evidence that in relation to many aspects of the children's medical problems that the history given by the Mother was either a very important or the most important component. In particular she emphasised this in relation to asthma, constipation, cow's milk intolerance, and vomiting. She said there were clearly occasions when the Mother attended with the children and she heard wheezing, creps or other objective signs consistent with viral illness, swollen tonsils, chest infection or asthma but on other occasions she found no objective signs on examination but was entirely reliant on the Mother's report, and that they worked on the assumption that a parent had the child's best interests at heart and that when reporting illness detecting inconsistency or some other flag which might cause them to challenge or question a parent's account was much more difficult than when dealing with an injury. One particular example she did refer to was when the Mother sought a referral to the wheelchair service for a specialist buggy for V which she thought was unsupported by any condition (his hypermobility was within normal limits) whilst the Mother was suggesting it was necessary. She said that throughout her dealings with the children they appeared to have illnesses which since they had been removed from the Mother's care had not been present. She accepted that childhood asthma could resolve and the same was true of cow's milk intolerance although she thought the intolerance was unusual in a breastfed baby as W was and that if it resolved it would usually resolve earlier than it had appeared to with W. Ongoing medication for asthma was based on his own report of symptoms during fast walking and sports which were typically triggers for asthma. Unfortunately they had not been able to carry out objective assessments because the use of peak flow testing and Spiro metres was still prohibited under COVID regulations. She said that V's constipation medicine was at a very high level in terms of the volume of Movicol he was taking and that picosulfate not commonly used and that the levels of medication that V was supposed to be taking might be seen deployed for a short period with impaction seen on a maintenance regime.

When they were living with the Mother Dr U said she saw them far more frequently than was usual and that the Mother presented as an anxious mother who needed reassurance in relation to minor ailments and that since their transferring to the maternal grandparents' care she had not seen W for 11 months, and had seen Y on 9 June with a minor ear infection and V had been seen for his asthma review by the nurse in December 2020. She said the Mother made appropriate use of GP services in terms of seeking and attending appointments, although she also noticed that there was a pattern of the Mother not collecting prescriptions which they having been prescribed by consultants she would have expected to be collected.

78. Mr K works in the field of supporting child development. He said the portage service was brought in if a child was demonstrating more than six months developmental delay in more than two domains of development. Over the course of his involvement with X he noted that X had demonstrated very poor development despite attempts to deliver weekly sessions. He said that X's vomiting and his tiredness together with missed sessions limited his ability to develop and that targets which had been set were extended because it was clear X was unable to derive the maximum benefit from the sessions because of his tiredness and vomiting. Mr K described regular, frequent vomiting of clear and/or mucusy fluids. He said he had never seen X vomit a substance which appeared to be his feed. He said throughout their sessions X was attached to his feeding pump and so Mr K was well aware what his feeds looked like and whether what was being vomited was the feed or not. He said that when X was not vomiting and thus tired or distressed, he demonstrated considerable potential to benefit in developmental terms from the service. His evidence overall did not suggest that there was a pattern of X only vomiting shortly after Mr K's arrival but rather X's condition on his arrival was sometimes such that he concluded X had been vomiting frequently before his arrival and was already exhausted. On occasions X would not vomit for 20 minutes and progress would be made in the developmental exercises but then X would be overtaken by vomiting and on occasions was so poorly that he was unable to participate at all. Mr K did not consider that the Mother was seeking to hide X from view or take X away from him in a way which would suggest some malign activity was being undertaken although there were many sessions which were cancelled or where the Mother was simply not home to the extent that two letters were sent to her seeking to establish whether she wished to continue with the portage service. He said that during his time with X the developmental charts showed that at one year of age X was not able to undertake tasks which were well within the expected development of a one year old and that by the age of two he was completing very few of the developmental milestones to be expected of a two year old and certainly not edging into the three-year bracket which would be expected of a two year old. The charts demonstrated X completing one-year old milestones in his second or third year and two year old milestones in his third year. He said that he had made a recommendation for X to attend a special nursery in order to be supported more consistently in his development. His evidence was the most colourful in relation to the change in X after he went into foster care. He said *"From moving into care his development was nothing short of miraculous – went from not being to sit up without support to running around – nil by mouth but he went on to feed himself full meals in the end recognising images, shapes, colours, characters, engaging for full hour sessions, making social connections when he struggled before to even stay awake for more than 20 minutes"* which seems quite significant coming from an individual who had quite extensive involvement with X over a period of three years. He said that X had now been discharged from the portage service because he did not

meet their criteria (see above) and was now attending mainstream nursery. He acknowledged that the Mother faced challenges in extracting the maximum benefit for X from the service given her commitments to the other children, the intervention of Covid and the strains that must have brought to bear in her looking after four children at home and X's sickness itself. He said the Mother always appeared to be keen to help X in his development and he was not critical of her engagement but explained the need to maximise the time X spent out of his pushchair to help in his gross motor skills.

79. Ms LM was the social worker for the family for the period of time that the children were on child protection or child in need plans. She clearly knew the family well and said that she had found it a challenging case. She was frank in describing how the relationship between her and the Mother had been difficult and that, as she was the principal point of contact over concerns, she often bore the brunt of the Mother's dissatisfaction even though the messages she was delivering where the product of others' opinions rather than her own. However she did not appear to bear any grudge towards the Mother but rather accepted this as part of her job, notwithstanding that the Mother had complained about her and that a social work assistant had also been allocated to ensure that there were two social work professionals at meetings with the Mother. Much of her factual evidence appears in the chronology. The principal points which emerged from her evidence seem to me to be as follows

i) The Mother appeared to be well aware of the risks to the children that exposure to domestic abuse posed and was able to articulate this. She struggled to implement advice whether it was engagement with the Freedom Project, domestic abuse support work, applying for orders or otherwise taking precautions to avoid CD. The level of threat from CD appeared to be quite significant. However, she did ultimately obtain an order and did undertake work and notified police of concerns.

ii) V appeared to have been exposed to at least emotional abuse from witnessing arguments between the Mother and CD. He had also been exposed to abusive behaviour by the maternal aunt's boyfriend towards the maternal aunt. It did not appear that he had been exposed to any physical or sexual abuse of the Mother by CD.

iii) V's behaviour at home with the Mother could be challenging. The Mother seem to struggle to implement boundaries in relation to V and described him in quite extreme terms; saying she thought he was mental and that he had tried to strangle her. Neither the school nor the maternal grandmother who cared for V for extended periods of time had any difficulties with his behaviour. He was described by them in positive terms behaviourally and generally.

iv) Social services became involved initially due to concerns about exposure of the children to domestic abuse but when they became involved, they also had concerns about the Mother's mental health and over medication in relation to V. Over time, the issues relating to domestic abuse receded as the Mother took some steps but the concerns about the Mother's mental health and her engagement with the children in particular remained. V was a particular concern in this regard but when younger children arrived, or the Mother's mental health fluctuated her ability to continue to be engaged with the older children was a source of real concern. V ended up living with the maternal grandparents due to

concerns about the Mother's attitude to him. At times the Mother was attentive and loving; at other times she was withdrawn from the children.

v) The maternal grandparents, in particular the maternal grandmother were a source of huge support and showed considerable commitment to the children. The maternal grandmother moved into the Mother's home on occasions to support the Mother which resulted in significant improvements in the situation including school attendance. V lived with the maternal grandparents for a considerable period of time because the Mother's attitude to him was concerning. He experienced significant distress about this as well as other issues related to his parentage; the maternal grandmother showed insight into these.

vi) The Mother's engagement was sporadic. The times she appeared to be receptive to advice and expressed a desire to access support but then did not follow up on it. At times she was defensive and hostile to social work involvement.

vii) In relation to the concerns about the levels of V's medication and other medical concerns in relation to X social services were led by the advice received from the health professionals. I got the impression that social services retained some concerns about the medical issues even when the family were stepped down from a child protection plan to a child in need plan and ultimately to Early Help.

80. Ms N was X's physiotherapist and had some involvement with Y. Much of her factual evidence is incorporated in the chronology. The overall effect of her evidence was as follows

i) Prior to X's admission to hospital in September 2020 her experience of him was that during physiotherapy appointments he was more often than not unwell, tired and disinterested as a result. Progress in implementing physiotherapy was therefore very limited. He was often seen to vomit including on one occasion what appeared to be feed. When he was not unwell, he appeared to have much potential and sessions could be far more productive.

ii) During his admission to hospital the notes record him being able to demonstrate gross motor skills which she had not seen him demonstrate whilst at home albeit she had not visited him at home since the spring of 2020. During the hospital sessions he was recorded as active, interested and clearly not in the same condition as he was when she saw him at home.

iii) After his discharge into foster care she continued to be involved with him and he made significant and rapid progress in his gross motor skills. This to her head appeared more rapid than was actually the case because she had not seen the hospital records of his abilities demonstrated whilst he was in hospital.

iv) In relation to Y she had referred him for stiffer boots, and she considered that the Mother's interest in a BEAM class was warranted given his scoring on the Beighton test. In this respect her evidence appears to confirm some concerns in relation to Y's hypermobility

81. Ms L is a highly specialist speech and language therapist who had worked with X and the Mother since 2 January 2018. X remains her patient. Her particular area of

specialisation is the physiological aspects of feeding and dysphagia. What seem to me to be the relevant aspects of her factual evidence is recorded within the chronology. The important points which appear to me to emerge from her evidence are as follows.

i) Throughout her involvement with X the predominant problem with his feeding was vomiting. In most of her visits (all by appointment) X vomited or was otherwise unwell and she was unable to implement much in the way of feeding regimes because of his continued problems with vomiting. She said that at times he was assessed as having an unsafe swallow but at other times he was able to feed from a bottle. During his admission to Hospital A in March to May 2018 she said she considered he was so unwell that she considered end of life care at a hospice might be required. She had been involved with children who had been unable to feed and had subsequently died.

ii) She described seeing him vomit having seen it happen many times herself and having seen many videos of it. She said it was usually saliva or gastric juices or secretions in mucus and was obviously vomiting of bodily fluids. It had occurred in the absence of the Mother as well as in her presence. His vomiting was not usually preceded by coughing or retching. When he was in discomfort, he would throw himself around. On one occasion when it occurred at the meeting on 16 January 2020, she said it was obviously different, did not appear to be stomach contents but a clear fluid and she was sufficiently concerned that she wrote to the safeguarding lead Ms M about it. The suction machine was recommended; that is very rare and is usually only done in hospitals. They are quite complex to operate.

iii) The only period of time when she observed X to be significantly better was after his return from Hospital B in May 2018 when she described his recovery as having been dramatic. After his return from Hospital B the plan (advised by the team there and supported by her) was to introduce messy play to encourage X to feed. However, the Mother reported that his vomiting had resumed and so this fell by the wayside. At that time, they thought he had turned the corner, his medication was reduced. His skills had improved, and he was gaining weight indeed again so much it had to be addressed. She said the same was true when she saw him on 28 September 2020. She expected progress in relation to his feeding to be very cautious and to move slowly and this was the advice she gave. However he progressed from jejunal to gastric feeding and subsequently to oral feeding far more rapidly than she had ever experienced with any other child she had been involved with and in particular he showed little or no aversion to oral feeding which is usually a significant barrier. She described herself as having been shocked by how rapidly he progressed. She gave a very vivid description of her observation of him in October 2020

> *He loved having the plate – when I saw him in October 2020 – he wanted to have food and a taster plate in front of him – he wanted to have some solid food in front of him – he wanted to have it before him – he might put it to his mouth – he'd put it to his mouth and look for a response. He wanted to be part of the family eating*
> *It was a truly amazing recovery That is the same now. He continues to eat normally – with the skills he has, he has come on so fast and I would be looking for him not using the PEG at all and to be orally fed which he is*

achieving. He is just amazing – he has improved beyond my wildest dreams – it is so fantastic.

82. Ms P was X's social worker at the time the proceedings were initiated. She began working with the family in the summer of 2020 and her involvement ended in October 2020. Relevant aspects of her factual evidence are recorded in the chronology. The following appear to me to be important aspects of her evidence.

i) Her involvement with the Mother and the children began when she was conducting a child and family assessment which was concluded in August 2020. Much of the information available to her was taken from the files and she met the Mother and children on a couple of occasions.

ii) In the course of her assessment she found the Mother to be cooperative but rather negative in her outlook. She noted many positive aspects of the Mother's interaction with the children and her care for them in the CFA; particularly in relation to W and Y but also in various aspects in relation to V and X. Her latest social work statement concentrated on the negative aspects and she accepted that it was unbalanced as a result. She accepted that the concerns about domestic abuse (save for CD's occasional re-emergence) and the Mother's mental health had largely abated and that it was X's weight gain and feeding and developmental issues that were at the forefront of the CFA. Her initial assessment was of an individual who was having to cope with multiple stressors with little support. Hence Ms P went above and beyond in terms of the support she offered the Mother in particular around the time when X was due to go into Hospital A for further observation and tests. The text messages demonstrate the extent to which Ms P was offering support and taking on aspects of childcare, including completing school entry forms and offering to take the children to school and collect them from school.

iii) It was clear that she felt the Mother had not been frank about the extent to which she could rely on the maternal grandparents for support; in the CFA she had suggested they were limited in what they could offer but when it came to X's admission to hospital they demonstrated that they were prepared to do anything that was needed in order to support the children. She said she was not surprised that the grandparents knew so little about V's condition as she felt that the Mother had been selective in information provided to her and thought the same would be true of her provision of information to the family. It seems also that V had been reluctant to speak to the social workers when in the care of the Mother. He became more open when he was in the grandparents' care.

iv) Most importantly, I think the Mother's conduct in relation to the administration of bleach to X in hospital caused Ms P to completely re-evaluate her interactions with the Mother and inevitably when she has looked back she has framed her evaluation of the Mother within the cloud of concern the bleach incident gives rise to.

v) Whilst X was in the Mother's care, she observed that he was usually in his pushchair or sat on a tablet. When she saw him in hospital after the removal of the Mother from his care was sat on the floor playing and she described the change in him as being quite overwhelming. She accepted that the play therapy

initiated by the hospital had been occurring whilst the Mother was involved in his care but it was clear that she regarded the change in X as being really significant.

vi) It came across to me fairly clearly that Ms P felt somewhat duped or let down by the Mother given her initial evaluation was of someone who was trying but needed support (which she had offered in full) but this had changed both as it dawned on her that the Mother was creating barriers to X remaining in hospital but most importantly with the knowledge of the administration of bleach and she said that when she saw X after that she wondered what they could have done differently and if they had known that earlier how X's position could have been different

83. A psychological and a psychiatric assessment of the Mother had both been ordered by the court in the autumn of 2020.

Psychological Assessment of Mother by Dr Conning

i) The Mother's estimated Full Scale IQ score of 88 lies in the Low Average range, and at the 21% percentile. Her Verbal Comprehension Index score of 76 lies in the Borderline range, and at the 5th percentile. Her Perceptual Reasoning Index score of 88 lies in the Low Average range, at the 21% percentile. Her Working Memory Index score of 114 lies in the High Average range and at the 82nd percentile.

ii) Comparison of the Mother's Index scores indicated that her Verbal Comprehension Index score of 76 was statistically significantly lower than her Perceptual Reasoning and Working Memory Index scores; and that her Working Memory Index score of 114 was statistically significantly higher than her Perceptual Reasoning Index score by 26 points.

iii) Her area of relative cognitive weakness lies in Verbal Comprehension, that is, verbal abilities that require reasoning, comprehension, and conceptualization. Her area of relative cognitive strength lies in Working Memory, that is, verbal abilities that require reasoning, comprehension, and conceptualization. [I think there must be an error in one of these two as they appear to be mutually contradictory and are unexplained].

iv) The Mother has an unusual cognitive profile. There are statistically significant and unusual differences between her Index scores. There is considerable scatter in the scaled scores she obtained on the individual subtests: her scores range from 4 (Picture Completion) to 17 (Digit Span).

v) Having a cognitive profile in which there are considerable differences between different areas of functioning can be a disadvantage to people because their ability to perform in some areas of cognitive functioning is not in accordance with their ability in other areas. The Mother has a very strong ability to recall lists of numbers and to manipulate the numbers, that is, very good rote learning, but she is less able to use information she recalls, particularly if this is verbal information.

Psychiatric Assessment by Dr Adshead

vi) The Mother does not currently present as mentally unwell. She is currently experiencing a degree of anxiety and depression, but this is not at a clinical level. It is possible that she meets the criteria for a mild-moderate degree of personality dysfunction, based on her history (see below). But without the current adult notes it is not possible to provide a firm opinion,

vii) In my view, there is historical evidence that the Mother was diagnosed with a moderately severe psychiatric condition and psychological difficulty as a teenager. In her late teens, she was diagnosed with somatisation disorder in which she presented with multiple physical symptoms without any medical explanation. These symptoms were thought to be physical expressions of psychological distress. The medical investigations showed that the Mother had no organic disorder or disease that would account for her symptoms; which did improve somewhat after psychosocial treatment in Unit D.

viii) I am not able to say with certainty whether the Mother could now be diagnosed with somatisation disorder. This would depend on how she has related to medical services in adulthood. It is not unusual for young people to "grow out of" somatising disorder as they age; however, it is also not uncommon for women who were somatisers as young people to stop somatising as they get older but then have children who somatise and who have medically unexplained symptoms. There is a strong relationship between mothers with somatization disorder and children with somatising disorders, such that researchers have referred to the 'transgenerational transmission' of somatising behaviour.

ix) I think there is evidence that the Mother's psychological disfunction has had a significant impact on her ability to make and maintain enduring relationships in adulthood, especially friendships and emotional partnerships. Any individual who struggles with interpersonal function is likely to struggle in their relationships with their children. This does not mean that they do not love them; only that they may struggle with the emotional demands of parent-child relationships…..People with insecure attachment (and somatising disorder and personality disorder) may often struggle with being vulnerable and accepting help from others. I note that in the past the Mother has repeatedly insisted that she does not need help from anybody and she needs to rely on herself and this inability to make use of other people's help when she is vulnerable is another aspect of impaired personal functioning.

x) In the three years prior to September 2020, there are no references in the GP notes to the Mother presenting with any major mental health concerns; nor any evidence of the resumption of the abnormal illness behaviour that had been a feature of the Mother's teenage years and early adulthood. It is notable that her mental health does NOT appear to have suffered during all her pregnancies, although she did develop postnatal depression in April 2008; and remained on antidepressants for it for years. I also note her own reports of feeling stress in the maternal role. However, neither the Mother’s stress nor mild mood disorder appears to have manifested itself as abnormal illness behaviour or further eating problems or any other physical expression of distress.

i) I conclude from a review of these notes that the Mother's abnormal illness behaviour ceased when she left her family home and became a mother herself. It may be relevant that the first reappearance of the 'collapsing' behaviour took place in September 2020, when the Mother was taken to the police station to be interviewed in relation to possible child abuse

84. The Mother gave evidence over the course of 2 and ½ days. She had filed written statements in February 2021 and 26 October 2021. She had also filed a Response to the Threshold on 14 October. In addition, she was interviewed on 3 occasions by the police; 19 September 2020, 20 September 2020 and 16 April 2021. The psychological assessment by Dr Conning had confirmed that the Mother did not require an intermediary for the purposes of giving evidence but identified an unusual cognitive profile with considerable differences between areas of function and noted that she would benefit from the use of non-technical language and from being given information in small chunks. The advocates questioning seemed to me to appropriately take these into account and we took hourly breaks in order to allow the Mother to maintain concentration. Consideration had also been given to ground rules in relation to the Mother in relation to the evidence of the grandparents and AB and how she would give her evidence in relation to them. The principal focus of domestic abuse was on CD who was neither present or represented and although the Mother's allegations against CD developed to the extent that she asserted that the conceptions of both Y and Z were a result of rape, the substance of her allegations were not explored or tested in any detail but were in the main limited to an outline of the allegation. It was therefore not considered that screens or other ground rules as to the form and content of questions in relation to domestic abuse were necessary.

85. The Mother in her evidence demonstrated a degree of cognitive functioning which overall I think was broadly consistent with the psychological assessment. She had clearly read and assimilated a lot of the paperwork and she appeared to understand both medical terminology and the basis of the factual case against her. In particular she was adept at reading the underlying thrust of a question or line of questions and very frequently seemed to me having understood what was coming, responded by saying "I can't remember, that was so long ago" which led to her being taken to the documents and if the document appeared to establish a point against her, to the Mother by the repeating that she couldn't remember that or asserting that she must have said that because somebody else had said something to her which led her to believe it. On some occasions where the approach of the question was more nuanced the Mother was induced into giving a narrative answer which was then demonstrated to be false. On uncontroversial matters she was able to describe events or medical processes (the operation of X's equipment etc) clearly. After listening to her for two and half days I was left with the impression of the nimble boxer who was able to dodge and weave avoiding most of the punches thrown with only occasional blows landing but delivering almost no punches herself. However, whilst that may work in the boxing ring it created a powerful impression of an evasive witness and the points mounted against her without her gaining many in support of her own case.

86. After her examination in chief and the initial stages of her cross examination when she was very softly spoken, the Mother gave evidence quite confidently and indeed assertively. I considered it more important that she be able to give her evidence naturally rather than having to concentrate constantly on raising her voice but after she

got into her stride apart from occasional phases when she seemed less confident she was well able to engage with Counsel and to make her voice heard; both literally and metaphorically. At times she was combative telling counsel that if they had done their job properly, they would have read all the papers. Unfortunately, she proved to be an almost entirely unsatisfactory, indeed dishonest and evasive witness.

87. Given that the allegations against the Mother date back many years it is entirely understandable that the Mother would be unable to recall precise details, or even general details about the host of appointments or medical issues that the children have experienced down the years. However, when documents were brought to the Mother's attention which recorded what she had said at the time, she was very frequently unwilling to either seek to refresh her memory or to accept the contents of what was recorded as her position. I entirely accept that the Mother would be unable to remember innocuous or routine events even when given the opportunity to refresh her memory but her asserting that she was unable to remember whether she had sought to contact the press in 2018, and why she had a contact number for the press on her telephone was entirely unconvincing. Equally her inability to remember why she had recorded various conversations with doctors. On the other hand she was able to recall matters which were favourable to her very clearly; for instance the evidence of Doctors Rose and Salvestrini to the effect that there was no evidence in the medical records which demonstrated that she had done anything wrong or her recall of the timings of X's vomits during the portage worker's visits.

88. The Mother's overarching position in relation to the allegations that she had over medicalised the children was that she had only ever followed the advice of the medical and other professionals and thus that she was not responsible for appointments, investigations, medications, operations or any other aspect of their medical treatment. This inability to accept responsibility for her role was evidenced in many other domains; most obviously in relation to her administering bleach to X but also in other areas. Thus although she maintained that the poor state of her accommodation was responsible for aspects of the children's ill-health (asthma in V, W and Y) when given the keys to an alternative property she did not move for six months because the Local Authority failed to make arrangements to fund the removal and went on holiday to Hastings for the whole of the summer holidays rather than action in her move. Thus the move took place just after the start of the new school term and on the very day that X was due to be admitted to hospital. She said that the Local Authority had failed to offer her the sort of support that X's foster carers had received and when it was pointed out the huge array of professionals who had been assisting her, she changed tack and said she was a single parent and there were two foster carers. She appeared unable to accept that her choices in life in any way contributed to her situation. In relation to the resumption of the relationship with CD after his release from prison in early 2020 she said she was doing it for her children whilst at the same time maintaining that she distanced herself from AB because Social Services warned her of his track record. She said she blamed her mum for failing to provide sufficient support as she had said she was there from day one and she wasn't and that they only helped up to a point; this despite her mother dropping everything and moving in with her on several occasions.

89. Although the Mother's primary case was that she had only ever acted on medical advice and she asserted this repeatedly on any issue relating to over medicalisation, the reality was demonstrated to be quite different. An obvious example was in relation to the

advice that X be admitted to hospital for observation and testing from November 2019 onwards. In her evidence the Mother said *I wasn't doing anything wrong with him – I have never said I didn't want him to go into hospital*. *I have only gone by what professionals have advised*. However, the records demonstrated quite plainly that the Mother refuse to admit him at this stage, citing concerns about childcare which were unsubstantiated given the availability of her family and the offers of the hospital to care for X in the absence of the Mother. When being questioned about V and asserting that she had always followed medical advice, it was pointed out to her that she had not done so in relation to X's admission and she then became argumentative accusing counsel of changing the subject. Another lesser example was to be found in the Mother's request for a disabled buggy for V arising from his alleged hypermobility and difficulty with mobility. The Mother made a request to her GP for such a buggy the day after an assessment by a consultant paediatrician which had identified no issue with V's mobility. In relation to X's discharge against medical advice in September 2020 she suggested that she had in fact been acting on advice as she had taken the social worker's opinion as a "second opinion" and she relied on this to suggest that in fact the discharge was with the support of another professional's opinion. The obvious illogicality of her seeking to rely on the opinion of a social worker against the opinion of a consultant paediatrician did not trouble her. It also became clear that although she said one had to trust the professionals and go by what they advised, she did not adopt this in substance. She said that one had to accept the opinion of the experts but then said that they were just guessing from the papers and that they had not lived with child all their life so they did not know. Her messages with her sister and others which refer to medical professionals in derogatory terms point to the reality that the Mr may say she accepts their view, but ultimately that is simply window dressing and that she does what she believes to be right. There are many examples down the years of the mother apparently agreeing with a proposal and then backtracking on it. This was most obviously the case in relation to X's admission when the doctors said that in conversations with the Mother she would indicate agreement with trialling a change in feed and then on the next ward round he would discover that she had changed her mind and not implemented what had been agreed.

90. Examples of the Mother's inconsistency, illogicality, dishonesty or evasion were legion. The most obvious is in relation to the bleach incident. Firstly, she repeatedly asserted in her evidence that she had never given X anything which might have caused him to vomit and yet at the same time did not deny that she had injected bleach into his gastrostomy tube on 19 September. However, as I conclude elsewhere, this apparent inconsistency is because at heart I do not think that she genuinely accepts that she did inject bleach into his port. Her evidence to me was that she has no recollection of what she did or why. However, in her police interview she gave a detailed account of the sequence of events and of her actions in filling a syringe with dirty water, of the nurse returning and seeing her inject it and of X vomiting. She also recalled what she did afterwards. In her evidence she was pressed as to how she had been able to recall these events in September 2020 and again in April 2021 but was now unable to recall them. She refused to engage with the process of refreshing her memory or seeking to identify her last memory in any meaningful way, taking refuge in saying she could not remember. Her assertion that she had bought the bleach to undertake cleaning in the hospital was unsupported by any evidence from the documentation and she was unable to describe how she had undertaken the cleaning or to explain why she had told the police in interview that she had only ever undertaken cleaning with wipes. She

confidently asserted that one could not dispose of the syringe and bleach bottle in a normal bin within a hospital hence her reason for disposing of them in Costa coffee or the external bin. Other examples of her unreliability include her repeated assertion that she had only ever complained of Y choking on food once and in evidence she seemed to characterise it as the sort of event which anyone might experience when food goes down the wrong way. She said something similar in relation to drink. Quite why these would have been reported to the doctor she did not explain. The entries from the medical notes however demonstrated that over a period of time she made repeated complaints about Y choking on food or drink which she linked to his enlarged tonsils. It thus became an issue for the doctors. When being asked about activities in the summer of 2020 she identified a range of things including kids club which the children were doing on holiday. When Counsel pointed out that this showed that Covid was not any bar to the children being looked after by another, the Mother went into reverse asserting that these were activities that they would usually do and denied that she had said that they had actually undertaken them in the summer of 2020. When I pointed out that she had taken an affirmation to tell the truth and had directly contradicted herself, the Mother's response was completely unapologetic, and she maintained this position even in the face of my obvious disbelief and irritation. She asserted she had never been offered nursing care to look after X overnight, but this also was convincingly demonstrated to be untrue. The number of times that this sort of exchange occurred has caused me to question whether the Mother is actually able to discern the difference between objective truth and what she wishes to be the truth. The Mother constantly referred to the fact that she was only going by the papers but when they were contrary to her case she plainly did not wish to be bound by their contents.

91. The medical records demonstrate that whilst in Hospital B she would say that she wished to go to Hospital A, but when she was unhappy with Hospital A she would seek a transfer to Hospital B, her position changing only according to how she perceived she was being treated by the hospitals rather than what was best for X. In relation to W's cow's milk protein intolerance she asserted within the same passage not only that she bought free from items (so as not to expose W to dairy products) but also that she was giving her dairy products on a little and often basis. The school noted her inconsistency in telling them that W had a dairy allergy but packing dairy items in her picnics.

92. Her attitude to CD was one which I found almost impossible to understand. At one stage in her evidence she said that the only physically abusive behaviour by CD had been when he tried to kick down her door and was threatening and abusive outside. However elsewhere in the evidence she is recorded as having said he had physically pushed her to the floor. In her oral evidence she said that he had raped her on several occasions both in 2015 and again in 2020 when Z was conceived. She said she allowed CD back into her life and that of the children in early 2020 shortly after his release from prison because she thought he was a changed man and the children should know their father but was unable to identify anything about him which illustrated a change. Given on her own account this was a man who had terrified V, been responsible for grossly abusive and threatening behaviour (including to beat a child out of her and to throw acid on her), had raped her on several occasions and had just spent a lengthy period in prison and given that she was in a relationship with another individual and in regular contact with social services, her position is impossible to fathom. When pressed on this and how she came to be alone with CD in order to conceive Z if CD was only visiting to see his children, she was unable to offer any explanation other than in effect you

don't know what he's like. In relation to Z's conception by non-consensual sex she said she told neither her partner, her parents, the police or perhaps most importantly and most obviously her sister with whom, on her account, X was with for a short period whilst Z was conceived. Subsequent to this, the messages from CD suggest an ongoing dialogue between the two. Given that the Mother said that by this time she was well aware of the risks of abusive relationships from her Freedom Programmes and from social services' advice to her in relation to AB, her behaviour is even more inexplicable. In evidence she was unable to articulate in any meaningful way anything she had learnt from the Freedom Programme. Perhaps of more significance in relation to her dishonesty is her failure to identify CD as the possible father of Z. In the early part of the proceedings the Mother asserted that GH was Z's likely father. After DNA testing excluded him, the Mother was directed by my order to file evidence about who might be Z's father. She made no mention of CD. When I directed DNA testing of Z and the other children so that other alternatives including national database enquiries might be made, it transpired that Z was W and Y's full sibling and so CD was Z's father. In evidence the Mother said she had not had sexual intercourse with any man other than GH or CD at the relevant time and the Mother's explanation in evidence for her failure to identify CD as Z's probable father was that "*Maybe I blocked it out. I maybe was in denial about CD and didn't know how to say things*." I reject this explanation; she knew full well the other alternative and did not wish to disclose it because she was well aware that it opened the door to further criticism of her for resuming a relationship with CD.

93. The Mother's tendency to evasiveness was illustrated in a simple exchange between herself and counsel over whether the Mother accepted that the maternal grandmother was fundamentally honest. The Mother's answer was "*yes she can be fundamentally honest*", "*yes she is saying she has told the truth*", "*she is telling a lie about [witnessing Y choking]*". Thus, at no stage did the Mother actually answer the question. This was a frequently occurring event where the Mother would answer a slightly different question to that which had been asked. I wondered whether this was due to a lack of understanding on her part but as her evidence progressed it became clear that it was a habit which enabled her to appear to be answering or agreeing to something whilst not actually doing so. It appears that the professionals engaged with her also experienced this (see the example relating to the Mother's apparent agreement to changes in X's feeding given above). When asked about what was the last thing she could recall before she injected bleach into X, she said how could she be expected to remember any particular day and when it was pointed out this was a special day she said a special day was a birthday or something like that.

94. Throughout her evidence the Mother's focus was almost entirely self-centred and self-pitying focusing on how she felt, or the stressful situation she was in rarely referring to how the children were feeling physically or emotionally despite the majority of the focus being on their health. A constant theme throughout her evidence from her opening words was how demanding she found her situation and how overwhelmed she was by caring for her children and all the other stressors in her life and when criticised she repeatedly referred to the stress she was suffering and how it impacted on her mental health. The Mother herself did not seek any medical or other support for her mental health between 2017-2020 and when she was assessed in autumn 2020 no psychiatric diagnosis was made. When asked whether she would do anything differently in relation to her children the only thing she said was to look after her mental health better. The

Mother rarely showed any obvious emotion but when she did become tearful it was related to her situation rather than that of the children, for instance because she thought Counsel for the Guardian was suggesting that she was 'a slag' or the impact of CD's behaviour on her and the children. Even when the subject of X being critically ill on the high dependency unit with some of his team considering end-of-life palliative care she was matter-of-fact. When pressed over how she felt about having administered bleach to X she paused as if she had not really considered it before and eventually said rather blandly that it was disgusting; the words used by both her mother and father when they gave evidence. She seemed entirely detached from the physical or emotional consequences for X. She spoke of how she felt trapped when she was arrested and what was going to happen to her but made no reference to how X might have been. This may of course be because, whilst acknowledging that the evidence demonstrates she must have done it, in no way does she actually accept that she did it. She emphasised repeatedly that there was no way she would deliberately harm her kids and her case now is that she cannot remember anything about it. That lack of acceptance may lie at the root of her inability to engage with the reality of the consequences for X and for herself. I note that Dr Conning identified limitations in her ability to understand abstract or theoretical concepts and I wonder whether this extends to the ability to put herself in the position of any of her children or to empathise with their experiences. Both the maternal grandmother and grandfather when they spoke of the children were able to describe them in ways that brought them to life whereas the Mother's seemed more detached. When the Mother spoke of X's unsafe swallow she didn't refer to consequences for X but said "*I thought I will never be able to do anything normal with my son*"; this focus on herself rather than on the children was present throughout her evidence.

95. I am conscious of the considerable stress that the Mother is under within these proceedings where her actions have been subjected to the most intense analysis and where the stakes are so high for her both in terms of her reputation but more importantly in terms of her ability to resume care of any of her children. Giving evidence over 2 ½ days, with robust cross-examination by 4 Queen's Counsel must inevitably have been extremely stressful and will have impacted on the Mother in the quality of her evidence and her demeanour. However, giving every allowance that I can for the impact on the Mother's evidence that all of this would have had cannot get close to explaining or excusing her inconsistency, evasiveness, manipulation or frank dishonesty. Aspects of her evidence frankly defied belief. Her lack of credibility as a witness does not however establish the Local Authority's case. It does though mean that the weight that I am able to attribute to her evidence on any point is limited and I'm not prepared to accept her word alone on any contentious issue where the evaluation involves a weighing of her account as against a documentary record or an appropriately reasoned expert opinion but would require supporting material in some shape or form.

96. However, having said that, however unsatisfactory she was as a witness she clearly has qualities as a mother as well as obvious flaws. Over the years many social work and health professionals have endorsed her ability to provide good physical care for the children, to provide a safe physical environment and to meet at least in part the emotional and educational needs. It seems fairly clear that at times the Mother's mental health has deteriorated and she has been both less able to manage the children and to meet their varied needs and has needed extensive support from her family and from external agencies. During these periods in particular she has been emotionally detached

from the children and Ms LM referred to how worried she was for V about this trait in the Mother. The focus of this case and the nature of the allegations have placed the Mother's attitudes to medical issues under a microscope such that other aspects of her character and her capability as a Mother or her qualities as an individual are buried under the avalanche of medical detail.

97. The MGM and MGF filed witness statements (including in relation to the criminal investigation) and gave evidence. As the parents of the Mother they were in an unenviable position. Since September 2020 the maternal grandmother has lived in the Mother's home providing care for V, W and Y. Until very recently, the maternal grandfather has lived in the family home together with the Mother. Each day the maternal grandfather (who retired as a builder about six years ago) drives over to help the maternal grandmother with the school runs and the childcare. He remains there until fairly late in the evening before returning to his own home and his own bed. Those simple facts illustrate the depth of commitment that the maternal grandmother but also the maternal grandfather has to these children. However, the evidence down the years demonstrates the extent to which the maternal grandparents and the grandmother in particular have been prepared to put their lives on hold and support the Mother and their grandchildren. At an hour's notice the maternal grandmother would move in with the Mother on several occasions to support the family when the Mother was struggling. V lived with the maternal grandparents for several months. Even when they were not living with her the maternal grandmother was visiting on almost daily basis to support the Mother and help her; this only being displaced when Covid required the family to go into bubbles. It is clear that the grandparents concerns over Covid led to some reduction in their level of willingness to undertake care of the children but it is clear that, had they understood quite how concerned the medical professionals were about X's health, they would have taken on the care of the children to enable the Mother and X to go into hospital whether that was in late 2019, spring 2020 or summer 2020. The Mother's assertion that she would struggle with childcare as a reason for delaying X's admission was simply not supported by the grandparents' words and actions over the years. The grandmother said that the Mother told her she was reluctant to go into hospital because of her fears over Covid; a clear example of the Mother saying different things to different people.

98. Perhaps not surprisingly given the maternal grandfather has been living with the Mother, his attitude was markedly more defensive of her than the maternal grandmother's. Both of them accepted that she had injected bleach into X's feeding tube and said that her actions were dangerous and disgusting and that they simply could not understand why she would have done it. But the maternal grandfather was far more prepared to distance the Mother from responsibility for those actions. It appears his attitude has been significantly coloured by the many father/daughter conversations that have taken place since September 2020 and he has accepted the Mother's account uncritically. He therefore asks why the nurse did not stop the Mother doing what she did as she was present throughout but for a moment's absence? He asks what responsibility WHSmith bears the selling bleach in the first place at a hospital? He says the Mother was under great pressure because social workers and medics were always on her back. He says the social services have provided every possible support to X's foster carers, but they did not offer that support to the Mother. I have no doubt that these are the product of what the Mother has told him in the discussions they have had. Most of them are demonstrably untrue or illogical. However, whilst the grandfather is a rather

uncritical parent, I did not consider him to be dishonest in his recollection or seeking to fabricate material to somehow exonerate or lessen the Mother's responsibility for what he believes she did. When he said he thought the Mother was in many ways a good and caring mother I have no doubt he was sincere. I thought he was in general a straightforward witness. He was somewhat confused I think by certain lines of questions but in general was seeking to tell the truth as he recalled it. The grandmother seemed somewhat in awe of the experience and was clearly anxious about giving evidence that the content of her hesitantly delivered evidence was essentially true and delivered from the heart.

99. Aspects of their factual evidence are contained within the chronology. Significant points which emerge from it seemed to me to be as follows

i) When V was in their care prior to September 2020 he never seemed to have a problem with constipation. The Mother occasionally gave the medication for him but sometimes did not send it when he was with them, he did not need it. They put it down to them providing him with a healthier diet than the Mother. The grandmother's level of knowledge of V from a young boy into a teenager seem to be genuine and I see no reason not to accept her evidence in relation to his constipation. Since September 2020 he has had no problems in this domain and has no medication. He has used his asthma inhalers to a limited extent. He has a tendency to exaggerate symptoms if he is ill; recent examples include him hurting his wrist and complaining to such an extent that the doctors considered he had soft tissue injuries which might take weeks to recover but in fact he was better within three days; another was when they thought he might have Covid but he said he had no symptoms until a PCR test showed positive. He also misses his Mother and would like to reconstitute the family unit. He has had some issues at school with being teased about what the Mother is alleged to have done and are not sure that he knows the truth. He does not appear to have spoken to the other children about it. He has had some behavioural issues as a result but nothing serious. His school attendance is good, and he is coping academically. He has had no problems with hypermobility and she had been unaware that it was considered he had any issues with it.

ii) W's medication when she began living with them included omeprazole, montelukast and to asthma inhalers. They only found out about W having been prescribed omeprazole sometime after she went into their care. She has shown no signs of reflux or asthma in their care. Nor has she shown any problem with milk intolerance. When they used to cook for the children or when they bought them ice cream, she did not appear to have a problem with dairy although she would say she wasn't allowed to have dairy. She is quite sensitive and lacks confidence but is physically well. She misses her mother.

iii) Y is on no medication and has no medical issues. The only problem he had was in relation to recurrent tonsillitis and he has now had his tonsils removed. He is an active and confident little boy who loves wrestling. He also misses his mum.

iv) They had less to do with X than with the other grandchildren because they were unable to deal with his feeding pump and so the Mother had pretty much full-time care of him. Occasionally they witnessed him vomiting. When they were on holiday with the Mother in Hastings in 2019 and 2020, they witnessed him

vomiting. They never had any suspicions that it was anything other than sick. They believed that he was genuinely ill and that was why he required the feed pump. She felt guilty for a while because she has IBS and the Mother suggested that perhaps X had inherited something from her. She said in evidence that that had made her feel bad and that when she realised having heard all of the evidence that X probably did not have stomach issue she seemed upset that the Mother had allowed her to feel guilty about something which was not her fault. A suction machine was provided for X, but she did not remember ever seeing the Mother use it. The Mother had not explained to them how important X's admission to hospital was considered to be in 2019 /2020 and had given them the impression that the hospital were fine when she discharged him on 11 September. It was only later that it became clear to them that the hospital wanted him back in there and then they offered to care for the children. Had the Mother asked she would have stayed in hospital with X herself to enable the Mother to continue to care for the children. The Mother did have a lot on her plate in summer 2020 with the move but she did spend the summer in Hastings at the family caravan. She had no knowledge of AB and had never met him.

v) The Mother told the grandmother that she had put water in the gastronomy; she has never said that it was bleach. She told the grandfather that she bought the bleach in order to clean the hospital room because she considered it to be dirty. Since then, when she has asked the Mother why she did it, she has just said she doesn't know. The grandfather says he had had the Mother in tears pressing her as to why she did it but she still maintains she does not know.

vi) Although they were aware that the children had various health issues they seemed to be okay when they were cared for by the grandmother. The house whilst it was damp did not seem to be the cause of the illnesses; they put the children being ill when cared for by the Mother down to her being out and about with them more.

vii) The Mother herself suffered a lot of mental health issues as a teenager which were a conversion or somatoform disorder. The Mother was unable to walk and had to use a wheelchair, but the doctors could find nothing wrong. She was reluctant to accept help for her mental health and did not accept treatment when she was discharged from hospital when she was 16.

viii) They were aware of CD's reputation and had personal experience of him to some degree. The grandmother said that he would say that he was not the person they thought he was and yet she had seen him shouting and banging on the Mother's door and had to tell him to back off herself.

ix) Having heard the evidence she herself now believes that the Mother had injected bleach into X, had not fed him and had exaggerated the children's symptoms and illnesses.

100. AB has filed statements in these proceedings and in the public and private law proceedings relating to his four other children. His position is that he wishes to take on X's care full time along with that of his other three children. Currently he lives at home with his parents and works full-time as a delivery driver. He would propose to get rental accommodation from the council to care for the children. Currently he is having remote

contact with his three older children; those proceedings are awaiting the outcome of these. In the course of his evidence he demonstrated a tendency to maintain he could not remember matters which might be contrary to his interests and quite frankly denied the truth even of his convictions. He said he took the rap for one of his friends on one matter and that in respect of the breach of the non-molestation order had been unaware of the injunction and had been invited round by the applicant who then reported him to the police. His attitude to the findings made by her Honour Judge Davis in the public law proceedings was also essentially one in which he denied the truth of them. In respect of the finding that he was in the pool of perpetrators for the bruising injury, he is of course entitled to say that it was not him; that is not in conflict with a pool of perpetrators finding. It seems to me that the following are relevant aspects of his evidence.

i) Although in his response to threshold he said that he had not been aware of X's existence until the commencement of these proceedings the evidence that was put to him and his responses made it quite apparent that whilst on a very literal interpretation that might be true it was very far removed from reality. Of course he could only know for sure he was X's father when a DNA test was carried out but it is quite clear that he was aware that the Mother was pregnant very early in the pregnancy as she sent him a copy of a positive pregnancy test and a text message saying "it's yours". Thereafter it is clear from his evidence that there were periodic communications over X either from the Mother or from her sister and that he on occasions responded. The relationship was clearly something more than a one-night stand albeit was also hardly a relationship in the commonly understood meaning of that expression. The friendship may have lasted a few weeks at most and I doubt that he was involved in antenatal appointments with the Mother. In particular in early 2020 there were exchanges in which the Mother told him that X was in ill health and he proposed that they meet to discuss the situation. It seems that the Mother did not pursue it and neither did AB. He also acknowledged that he had received a telephone call from a social worker, and I do not accept that his claimed inability to remember what had happened was true. It is demonstrably clear that as a minimum he suspected or more probably believed that the Mother was pregnant with his child and in due course had given birth to his child however he expressed no interest in getting involved. Whilst he may be right that at times the Mother denied that X was his child had he really been interested in X at that time he could have pursued a course which would have enabled him to establish the truth and be there for X. Ultimately whilst he bears some blame for this, the principal responsibility lies at the door of the Mother for not confirming his fatherhood and encouraging his involvement.

ii) The father's evidence in relation to allegations of harassment or stalking of the Mother was that on the two occasions he had simply been at the school or in the street at the same time as the Mother. The contents of the police report show that they saw her complaints as being innocuous. Given the father was in a relationship with another woman whose child was at the same school as V (this fact appears to be corroborated by the hostile messages sent by the Mother's sister) and prepared to accept that the father's presence at the school and in the street were coincidence.

iii) The father's evidence in relation to other complaints of controlling or abusive behaviour was less satisfactory. Whilst he was able to say that domestic abuse can take many forms, his explanation of the "don't do" list written out by AB's former partner and the "What [AB] likes" list rang hollow. I have little doubt that he had made clear his likes and dislikes and that AB's former partner had felt it important enough to write them down. His denial of the finding that he had been overbearing or controlling was consistent with his denial of what appeared in black-and-white. I am therefore satisfied that AB does have an element to his personality which is overbearing and is capable of some degree of controlling behaviour. He appeared to be a man who likes to get his way and did not like being contradicted.

iv) Having said, that I thought his assertion that he had been "a bit of a twat" not becoming involved earlier and his upset at what had happened to X were genuine.

Evaluation

101. In seeking to reach a conclusion on whether the Local Authority have proven their allegations on the balance of probabilities the court is required in a case like this to undertake a highly detailed examination of the medical records relevant to the allegations but in doing so the court must not lose sight of the bigger picture which the broad non-compartmentalised panoramic survey enjoined by the fact finding authorities mandates. The intense focus in time and energy on the detailed medical evidence informs but is also informed by the bigger picture. That bigger picture includes also the detailed medical evidence, which is not the subject of the allegations, for to lose sight of that would be to exclude from the panoramic survey an important component.

102. In a case such as this the analysis of the medical evidence may provide the first layer of paint in the broad landscape the court is surveying. On its own it may depict some very prominent peaks representing the height of the allegations made. Without more layers being added, those peaks might seem to answer the question of whether the allegations are proven on the balance of probabilities. However the addition of further layers by the inclusion of other evidence whether medical or otherwise, the introduction of motive or lack thereof, the application of common sense and inference will result in alterations to that initial view of the landscape and may lead to the softening or erosion of those prominent peaks; equally even after the addition of all of those additional layers the final landscape may still depict some very prominent peaks nonetheless.

103. Despite the amount of time that has been spent delving into the detail of the medical evidence it is neither possible nor proportionate to reach a conclusion on exactly what did or did not occur on any particular interaction between the Mother and a health professional. There is a danger in immersing oneself in the detail so much that one loses sight of the bigger picture. On the other hand, one cannot go by impression alone. Seeking to achieve the correct balance between an appropriately deep dive into the detail such that one is not simply judging by impression and an overly deep dive which prevents one standing back and seeing the totality of the picture is quintessentially an evaluative exercise for this court. As with the approach increasingly adopted in the field of domestic abuse where the court is seeking to identify patterns of coercion or control which the court is satisfied on the balance of probabilities are made out on the evidence rather than seeking to focus on individual incidents which may when viewed in isolation

give a misleading impression, so in a case such as this it seems to me to be entirely appropriate that the court should look at the pattern which is demonstrated as well where possible and proportionate looking for some hard instances which are demonstrably proven on the balance of probabilities.

104. Furthermore in a case such as this where there is present in the landscape a 'Matterhorn-like' peak of a shocking and certain event which is central to the allegations some care must be taken to ensure that it does not dominate the evaluation of the wider allegations and lead to an acceptance of them by thinking 'well if she did that, she must have done X too'. The undoubted and shocking fact that the Mother administered bleach (seemingly diluted in water) into X's feeding port on 19 September 2020 is potentially relevant to the proof of other allegations but it is not proof in itself. I am very much alive to this and accept Mr Woodward-Carlton's invitation to seek to evaluate the case not simply through the lens of the bleach incident but rather to approach it from different perspectives and to seek to integrate into the evaluation the entirety of the picture. I thought there was evidence of this sort of thinking in the approach of a number of the clinical witnesses who had been involved with the Mother. It perhaps seemed most intense in those who had most trusted the Mother prior to 19 September 2020. Ms P, Ms M and Ms L but also several others expressed the thought either expressly or implicitly that the Mother's subsequent action explained the earlier perplexing presentation (my expression not theirs) that they had experienced in their dealings with the Mother and the children. The Local Authority's case is that the evidence demonstrates an escalation of behaviour which is represented by the apogee of the bleach incident. Of itself that approach reminds me that at the commencement of the chronological trail the Mother's behaviour may be of a very different quality to that which it may have reached by the end. Furthermore the RCPCH guidance clearly identifies a continuum of behaviour which may be present in a PP/FII landscape which ranges from innocent anxiety which barely makes it onto the continuum at one end through to deliberate and seriously abusive behaviour at the other which at its worst may result in serious harm or death to a child. I have sought in my evaluation to incorporate these ways of thinking.

105. In undertaking my evaluation, I have therefore sought to take into account all of the evidence, not just that summarised within this judgment and within the detailed chronology. The chronology also contains some of the reasoning which has contributed to this evaluation and should be read together with this; although it will not be published.

106. Where the focus of the evidence has been dominated by the analysis of the medical records that intense focus on the medical records tends to lead to a somewhat compartmentalised evaluation. In this case there was very little evidence about the bigger picture of the lives of the Mother and the children which might have shed some light on what was happening to the family away from the medical front. What might have motivated the Mother to behave in the way alleged? Ms M had referred to a possible financial motive; she identified the possibility that the Mother was receiving disability living allowance or other benefits linked to X or V's medical conditions. The RCPCH guidance identifies a range of possible reasons why a parent might act in this way and whilst it is undoubtedly the case that psychiatric or psychological factors may play a role in the reasons why a parent might induce or fabricate or mis-report symptoms those are not the only factors which are relevant even to frank FII cases.

Given this ranged from possible financial incentive to create a disabled child through to an underlying psychological or psychiatric condition the parking of 'motive' in the expectation that it fell within the remit of a psychological or psychiatric evaluation seems to me to pre-empt the outcome and to deprive both the Local Authority and the Guardian of a line of enquiry which might have benefited the understanding of the case. Although I appreciate that given the Mother's denial of any aspect of FII it is unlikely that her answers would have yielded much direct evidence, that is to overlook the forensic benefits of testing her evidence. Given that it was unlikely that she would accept any aspect of FII in her evidence if one were not to test evidence simply because it was likely to result in a denial, following that line of logic one would have adopted the same course for the FII. Where one is considering a continuum from benign anxiety-related GP visits through to administering poison it would have been helpful to have had some greater exploration of what else was happening in the lives of the Mother and children which form the backdrop against which the medical issues could be placed in context. Whilst proof of motive is not an essential component of proving abusive behaviour and whilst absence of motive does not demonstrate an absence of abuse it can be a useful indicator. I appreciate it is hard enough for the Mother to deal with the evidence arrayed against her let alone to give her family's life story in order to contextualise it better.

107. I have referred in my recitation of the law relating to fact finding the potential for evidence creep when looking at the evidence of witnesses long after the event. The memory may play us false as time passes; this may be an entirely innocent and subconscious phenomena. Of course, individuals may also choose not to recall events (or say they cannot recall events) or may lie about their memory. It emerges from the chronology that the maternal grandmother for instance was present at appointments with V in relation to his asthma and appeared to confirm the Mother's history when the impression one would have got from her written and oral evidence was that her experience of the children's alleged health problems was very limited indeed. That is not a criticism of the grandmother but a reflection of the caution that may be needed in relation to memory and historic evidence.

108. It is clear from evidence which emanates from a number of different sources that the Mother has experienced episodes of diagnosed mental illness. When she was a teenager in 2001, she was admitted as an inpatient and diagnosed as suffering from a somatoform disorder, one aspect of which caused her to require the use of a wheelchair. Other observations identified her as being dissociated and detached. In 2002 the psychiatric assessment identified a link between the Mother's emotional state and her functional capacity. The maternal grandparents both considered that the mental health problems that the Mother had experienced in her teens had led to a change in her. However thereafter although they identified there were times when her mental health suffered, she was resistant to seeking help. The medical and social work records document that when children's services were first involved with the Mother, a significant component in this was concerns over the Mother's mental health and the impact that was having on her capacity to parent the children. Both the grandparents and the records show that the Mother declined antidepressants prescribed by the GP and did not follow up referrals to the community mental health resource to which she was referred. However, concerns about the Mother's mental health abated and there is no evidence save that of the Mother's that by September 2020 she was experiencing some sort of mental health crisis. Indeed, the psychological and psychiatric reports commissioned in October and

December 2020 did not support a diagnosis that the Mother was then suffering from mental ill-health. Both identified issues with the Mother's psychological functioning and well-being but not at clinical levels. Mr Woodward-Carlton on behalf of the Mother submitted that the Mother's anxiety and the life stressors that she had to contend with which reached a peak in September 2020 were relevant to the court understanding of what had occurred throughout the period under consideration. There is an element of truth to this and which must be borne in mind in the evaluation particularly because the RCPCH guidance identifies the severity of FII including within the severity of the parent's actions a continuum starting with anxiety and belief related erroneous reports. It also may be of note that Dr Adshead identifies that mothers who have themselves experienced a somatoform disorder then have children who somatise and who have medically unexplained symptoms. The RCPCH guidance does not identify parental mental ill health as a prerequisite for FII but says that if present it may help to explain the motivations and behaviours of some parents as well as indicating prognosis for change. Whilst I accept that the Mother's mental health is potentially relevant, I do not consider that it bears the weight that the Mother seeks to put on it; particularly in respect of the anxiety and depression which she says really hold the key to her approach to the children's health and medical care down the years in which she was not provided with adequate support for. I say this because the report of Dr Adshead and the information that the medical and social work records contain suggest that the Mother herself did not consider herself to be suffering significantly from depression or anxiety for long periods of time and she was resistant to taking antidepressants and did not pursue referrals to the support resources that were offered. What I am prepared to accept is that the Mother's psychological or psychiatric profile has played some role in influencing the Mother's behaviour.

109. I observed in my observations on the Mother's evidence that she tended to deny responsibility and to place responsibility for events on others. The maternal grandparents also made submissions to the effect that the Mother tended to externalise responsibility. The most dramatic example of the Mother's tendency to do this came not from her lips but from the maternal grandfather's; but the source was plainly the Mother. In his evidence he queried why the nurse who had been present throughout had not intervened to stop the Mother injecting the bleach/water solution and even further suggested that WHSmith were to blame for selling bleach in a hospital. Whilst he had obviously taken these criticisms on board, I have no doubt that the source was indeed the Mother and that these had emerged during their conversations. That tendency to blame others or to absolve herself of responsibility is potentially relevant in a number of ways. First of all, an individual who is able to absolve themselves of responsibility may be more likely to undertake acts which an individual accepting responsibility for their own actions would not. Secondly an individual unable to take responsibility would be less likely to give an accurate account of their own failings and would be more likely to seek to provide an account which diverted attention from their own failings. This of course is relevant to issues relating to exaggeration or fabrication.

110. As I have observed elsewhere the broader panorama of the Mother's life is far less detailed in the evidence than is her involvement with social services and the medical professions in relation to the children. Thus, in charting the history of the Mother and children I am alive to the fact that the panorama contains much that is in shadow in this regard.

111. At the time that V was born, the Mother was living at home with the maternal grandparents. The Mother was on maternity leave for 8 to 9 months during which in her own words she found having a new baby very demanding. The records suggest that there were tensions within the home and some observations by the family that the Mother was somewhat detached from V. However, the medical chronology does not disclose anything unusual of concern in the first year of his life. On the Mother's account she must have returned to work in or about August or September during the winter of 2008 2009. V was seen by his GP and at accident and emergency who considered that he had widespread expiratory wheeze and was prescribed courses of antibiotics and steroids for mild asthma. The records for 2009 show some consultations for wheezing and constipation but they are relatively infrequent. In the course of 2010, a higher level of concern about constipation and asthma emerges and by May 2010 the Mother was reporting concern over V's breathing. At that time his chest examination was normal, and no respiratory distress was noted. It was during 2010 that the issue of constipation and a high level of medication for it based on the Mother's reports become more evident. He was also seen for other common childhood conditions in particular recurrent ear infections which were observed at A&E.

112. It is not clear when the Mother moved out of the family home; she remained there in May 2010 but had clearly moved out by April 2011 when it seemed she had problems with dampness in her flat due to flooding. By this time V had been admitted to hospital for chronic constipation and was recorded as being on 10 sachets of Movicol a day which was contrary to what Dr O had prescribed. The evidence of the x-rays taken in December 2010, and the results of the inpatient admission were not consistent with V having chronic constipation nor with him taking the full dose of Movicol. However it is clear that the Mother was assuring Dr O that he was taking the entirety of his Movicol medication (for instance 6th April 2011) and Dr Salvestrini's interpretation of the x-ray at this time was that it was consistent with him being on a high dose of Movicol. It seems probable that what had begun as a relatively commonly encountered condition of constipation had begun to assume greater significance both in the Mother's mind and in that of the doctors. Why it assumed more prominence in the Mother's mind is not clear to me but it seems clear that it came to be interpreted as a more significant problem for those treating V because the Mother continued to tell them that he had chronic constipation and that she was administering the entirety of the Movicol and subsequently sodium picosulfate and other laxative medications.

113. A similar picture emerges in relation to his asthma. It seems relatively clear from the evidence that V had been found to have wheezing which was consistent with asthma which continued to be detected over an extended period from its inception in December 2008, through April 2011, through the bronchoscopy undertaken by Hospital C in October 2012 and their subsequent lung function tests in June 2014. However, the Mother's reports of the extent of his problems with asthma did not correlate with the findings of medical professionals when they saw V. Nor as Dr Rose observed did the apparent severity of his asthma lead to the sort of emergency admission which one would expect with reports of that extent. As Dr O noted at the time there was evidence of a genuine problem but of a more modest extent than the Mother's exaggerated accounts.

114. There is at this time a clear example of the Mother's interpretation of V's condition being very significantly out of step with the views of the paediatricians and the GP.

This lies in the request for the specialist buggy for V. On 1 August 2012 Dr O had completed a form which appears to have been linked to an application for disability benefits in relation to V. In that, he said that V had no problems with his mobility. However, on the following day the Mother made a request of the GP for a specialist buggy. The Mother followed this up on 17 October 2012 with her GP who also noted that V seemed to walk normally. Dr F had noted him to be very well coordinated in September and following an enquiry from the GP, Dr D said the registrar had found that V's neurological and locomotor development was normal. Although the Mother said in evidence that she would not have known what to ask for unless somebody had told her, it is absolutely clear that at this stage V was considered to have no mobility problems. However, the Mother was not only saying that he had pain on walking but seeking a specialist buggy for him. Given that she was his primary carer it must have been self-evident to her that in reality he was able to walk and run normally and that there was no substantial issue with this. Even assuming V had occasionally complained of pain it would have been evident to the Mother that in all essential respects his mobility was normal, and he did not need a specialist buggy.

115. The picture which is therefore apparent by 2012/2013 is that a level of anxiety in the Mother about wheezing and constipation had developed into the misreporting of the extent to which she is giving the medication prescribed, is overreporting his asthmatic symptoms albeit in relation to a genuine underlying condition but has moved into generating complaints about V's mobility which are wholly unsubstantiated and indeed rejected by the medical practitioners involved with him. Thus what started in 2009 as perhaps over anxiousness on the part of the Mother, whilst living at home with the maternal grandparents has moved along the continuum well into the bracket of over anxiety leading to unnecessary medical examinations, investigations (including bronchoscopy, immunological and other investigations) and medication onto gross exaggeration or fabrication of a complaint in relation to V's mobility. By this stage that discrepancy between the Mother's reports and objective observations had become apparent to those most involved in V's care in particular Dr O. What was going on in the Mother's life at this stage is not clear but by early 2013 it was noted that V's school attendance was at 33.6% and when he was at school they were expressing concerns about the disparity between his presentation and Mother's reports. At that point the Mother appears to have told the nursery that his immune system was shot to pieces (29.1.2013) when four days earlier the immunological testing had showed his immunoglobin was within normal ranges. It is not clear if she had the results of those tests at the time but to describe his immune system as shot to pieces without any real basis illustrates the extent to which she exaggerates or over dramatises without any objective basis.

116. The pattern of overreporting V's difficulties and misreporting the extent to which he was taking his medication continues as the years pass. The Mother's description in May 2013 that if his medication is reduced, he goes blue and gasps for breath would appear to be a florid exaggeration. However, there are also times when the Mother is reporting improvements in V's asthma which the Mother linked with moving from a damp flat and at times his medication reduced but would then be increased again. His constipation medication continued at a high level and Dr Salvestrini said she found it hard to believe that he could take such extensive quantities and still eat normally.

117. In late 2013 or early 2014 the Mother became pregnant with W. She told social services that this was a result of a consensual relationship. V's visibility in medical terms declined and W began to come to the attention of the GP in particular because of her being said to have a rash after feeds which led to consideration of her having a cow's milk allergy and to advice being given as to her feeds and medication. In November when W was about 10 weeks old the health visitor reported very good progress. The Mother herself seem to be struggling in various respects but appears to have been caring for W well. However, across 2015 issues relating to W's feeding began to emerge more clearly along with concerns expressed by the Mother about shortness of breath and wheezing. CD was clearly on the scene at this time although the extent of the Mother's involvement with him is unclear. By September the Mother was reporting serious threats, she said that he raped her in the summer of 2015. However, despite this, when seen by her health visitor W appeared to be thriving.

118. The evidence from the PNC check, the Mother's own reports, the evidence of the maternal grandmother and the content of text messages make clear that CD is a highly abusive and potentially very dangerous man both physically and emotionally for the Mother and the children. The Mother received support from the domestic abuse volunteer support services as well as referrals to more formal programs such as the Freedom Programme. Although the Mother had reported concerns about V's behaviour before more serious concerns were reported by her around this time (3.11.15) and his school attendance became very poor. Concerns began to be expressed by various professionals about the Mother's emotional state and its impact on the children both in terms of her inability to respond to the children and her meeting their other needs including getting to school. By this time the Mother was pregnant with Y by CD which given the support she had been receiving in relation to the threat he presented was something of a surprise. The Mother at that time reported physical abuse as well as emotional abuse but not sexual violence.

119. This led in December 2015 to the maternal grandmother moving in with the Mother for the first time. V's school attendance immediately improved, and the maternal grandmother's evidence was that she did not experience health problems with the children during the eight weeks that she spent with them. This included constipation with V although she also wondered whether this was in part because she provided a better diet including fresh fruit and vegetables for the children. It was of course at this time that children's services first became formally involved with the family because of concerns about the Mother's mental health and its impact on the children and domestic abuse.

120. The Mother during this period of time was provided with considerable support to deal with the issues of domestic abuse (with which she did not engage well initially) as well as practical support from her family; including the maternal grandmother moving back in for a few days in March 2016. CD was sentenced to a term of imprisonment albeit suspended in February 2016 and whether this caused him to moderate his behaviour with consequent benefits for the Mother is unclear.

121. By the summer of 2016 the situation had improved to a degree. V went to live with the maternal grandparents for a period of time and on 29 July 2016 Y was born. CD continued to send threatening and abusive messages to the Mother who, with support, applied for a non-molestation order. W and Y experienced various ailments for which

they saw the GP and Y was admitted to hospital with a diagnosis of bronchiolitis in November 2016.

122. The picture over the subsequent 10 months until X arrived is of all of the children continuing to be presented in relation to asthma or wheezing, V continuing to present with constipation and W continuing to present periodically in relation to cow's milk intolerance or allergy. V returned home at some point around Christmas 2016 and his school attendance began to fall off again early in the New Year. The Mother was offered support with getting V to school but declined it on the basis that it was too early in the morning for her to have somebody come round to help her. Quite why it would be too early when she would presumably have been up in order to get V to school, I could not make sense. The Mother asserted that it was difficult getting V to school when she had all of the others to get to school when it was pointed out that none of them were at school at the relevant time she was unable to give any explanation.

123. At this point AB appeared on the scene and the Mother became pregnant with X and child protection concerns were heightened given the concerns about AB and the Mother's lack of proactive engagement with domestic abuse services or dealing with her underlying mental health issues.

124. After X was born the picture is dominated by concerns relating to his failure to thrive and I will turn to consider that. However, the Mother's behaviour in relation to V, W and Y continued. Clear examples of her exaggerating or misreporting conditions continue to be found in particular in relation to W's cow's milk intolerance or dairy allergy where the Mother gave W dairy products whilst maintaining that she had an allergy to them. In relation to Y she continually complained that he was choking on food and drink although she told me that he had only choked on mashed potato once and she had never considered he had a problem in this regard. The medical records tell a different story and it is clear that it was not connected to his enlarged tonsils. What motivated the Mother to exaggerate in these ways I'm unable to discern but it is clear that she did. In other respects, Y did have genuine conditions in his enlarged tonsils which were eventually removed. He was diagnosed as needing some supportive boots by physiotherapy and so the Mother's concerns in this regard were substantiated by professionals. However, the period between September 2017 and September 2020 was dominated by X's care. During this period of time CD reappeared on the scene and the Mother became pregnant by him again in uncertain circumstances and of course the Covid pandemic also intervened. However, for the purposes of this case the dominant feature has been X's failure to thrive in terms of his weight and his developmental delay.

<u>X: Feeding and Weight Gain</u>

125. As the experts made clear in interpreting weight charts one should have an eye to the bigger picture rather than focusing on short-term weight variations and should focus more on the centile than the absolute weight. The Weight Chart prior to September 2020 shows an erratic and dramatic fluctuation in X's weight. From October 2020 onwards it shows a steady upward pattern. The Weight chart shows that following his birth X's weight rapidly dropped to below the 0.4^{th} centile and remained there. During his admission for a week at the beginning of December 2017 and with the placement of a nasogastric tube he gained weight and was discharged on 8 December without the NG tube. Thereafter he lost weight and was readmitted on 28 December where a nasogastric tube was reinserted, and he began to put on weight again. Over the first three months

of 2018 he put on weight in absolute terms but remained under 0.4th centile until he was admitted to hospital again on 19 March 2018. Whilst in hospital an NJ tube was inserted on 22 March 2018 and his absolute weight fluctuated. During his admission to Hospital B his absolute weight appears to have reduced by about 100g, but the professionals involved in his care noted a significant change in his general well-being during that period. Following his discharge from Hospital B back to Hospital A he continued to put on some weight in absolute terms but at discharge on 7 June 2018 appears to have remained under the 0.4th centile. He was discharged with a nasojejunal tube in place and was being fed on infatrini peptisorb. From June 2018 his weight improved and by 29 June he was between the 0.4th and 2nd centile, moving over the 2nd centile by 11 July 2018 (7.41kg) to the ninth centile by 22 August 2018 (8.09kg). Between September and October, he increased to the 25th centile (8.76kg) and on 24 October 2018 had the Peg J inserted. Thereafter he remained on the 25th centile, moving to between the 25th to the 50th centile on 22 November 2018 (9.64 KG), coming back down to the 25th centile in late 2018 to March 2019. His feed had changed to Nutrini Peptisorb Energy by 9 January 2019 and by 1 May 2019 was recorded on the 75th centile (11.9kg). His weight continued to increase, and he moved into the 80th centile by 30 May 2019 having gained 2.36 kg in absolute terms from 1 March 2019 until 30 May 2019. His Peg J was replaced, and he remained at Hospital B between 28 May 2019 and 4 June 2019. At that point he was on the 75th centile weighing 12 kg. Thereafter the plan to reduce his weight was implemented. He changed feed to Neocate junior and on 12 June was recorded at the 62nd centile (11.9 kg) on 19 June at the 50th centile (11.36 kg) and by 12 August was on the 2nd centile (9.5 kg). By 18 September he was on the first centile (9.4/9.5 kg) and thereafter fell to beneath the 0.4th centile by second of October 2019 (9.1 kg). He was then below the 2nd centile from 17 October 2019 (9.2 kg), at the 1st centile (9.7kg) on 15 January 2020 by 24 April 2020 had fallen to under the0.4th centile (9.85 kg) and he remained under the 0.4th centile until his admission to hospital on 8 September 2020 when his weight was recorded as 10.3 kg.

126. During the first three days of X's stay from the 8th to 11 September his weight was recorded as dropping in absolute terms from 10.3 kg to 9.7 kg, despite being on Infatrini Peptisorb. On his readmission on 13 September his weight was recorded as 10.25 kg; an increase apparently of 550 g in two days which was questioned by both the dietician and Dr Rose.

127. During his admission from 13 September his weight was recorded as having increased to 10.6 kg by 18 September before falling to 10.1 kg on 21 September 2020; this of course covering the period when the bleach was administered, and his feeding was suspended for a period of time. From 21 September a trial of gastric feeding began with additional peg J feeding. On 21.09.20 a gastric intake of water via gastronomy commenced, which was well tolerated with no vomits (L572/ZB119). On 22.09.20 he was tolerating medication via PEG-G, tolerating 10ml Dioralyte via PEG-G well, Infatrini Peptisorb running via PEG-J at 45mls/hour. Trial of messy play with cake on SALT advice (L572-L575/ZB119) On 23.09.20 he tolerated feeds well including bolus PEG-G feeds every 3 hours (L578, L582/ZB119). On 25.09.20 he tolerated 3 hourly feeds well (L655/ZB120). By 28.09.20 he was tolerating 180mls of milk into PEG, almost constant communication with single words, lots of variety (Y2869-Y2870/ZB120) and they were no longer using jejunal port, possibly will be changing to gastric only button (Y2497/ZB121). On 29.09.20 he was recorded as continuing to gain weight on bolus feeds; discharged to foster care (L181-L182, L662, ZB121). By

the end of September his weight appeared to be stabilising and on 28 September it was recorded at 10.8 kg, on the 29th as either 10.2 or 10.4 kg before being recorded again on 29 September and 5 October as being 10.8 kg. These latter weights placed him on the 0.4th to the 2nd centile. During this period the hospital had trialled gastric feeding and by the time of his discharge he was being fed by the gastric port rather than the jejunal port and was not experiencing any vomiting.

128. Thereafter following discharge on 12 October he was between the 0.4th and 2nd centile (10.9kg), by 9 November 2020 under the 2nd centile (11.6kg), on 4 January 2021 was between the 0.4th – 2nd centile (11.7 KG, at the end of February was under 2nd centile (11.8kg) , 14 May at the 9th centile (13.3 kg), 21 June 2021 at the 9th centile 13.2kg), remaining on the 9th centile at 27 July 2021 (13.2 kg) and by 8 October had moved into the 9-20th centile (14.45 kg). His period in foster care has involved a transition from gastric feeds through to oral feeding entirely. The foster carers have not experienced vomiting as a problem; when it has occurred, it has been linked to some specific event. The foster carers, the paediatricians and the dieticians and others have all commented on how quickly he has been able to move from PEG-J feeding to gastric-tube feeding and thereafter to oral feeding. They have also observed that his tolerance of feeding orally has been remarkable and the oral aversion which was expected to be present and to be problematic and time-consuming to overcome did not materialise and he proved far more capable of transitioning to oral feeding and solids than they could have imagined possible. It seems to me to be probable that X was actually feeding himself on occasions with solid foods and liquids. The photographs that the Mother provided showed X with Pringles in his hands and a tray of fairy cakes in front of him and with a bottle of water she seems to be holding. This would potentially provide some explanation for his rapid transition to oral feeding and the lack of oral aversion.

129. Although it was submitted on behalf of the Mother that the weight charts showed that following his discharge from hospital into the care of foster carers that he had stuttering weight gain and that his progress could be seen as a re-establishment of the gain that could be detected in late August early September I do not accept that this is so. Prior to 7 September 2020 it is right that the weight chart suggests an increase in weight over the summer from 9.05 kg on 13 July 2022 10.3 kg on 8 September 2020; this was when X was being fed solely by peg J and was in the period when the Mother was under pressure to have X admitted to hospital. After 19 September X's feeding regimes change dramatically and rapidly with both the content of his diet and its means of delivery changing significantly as the team sought to promote his ability to move from jejunal to gastric port feeding to oral feeding. As Ms L said the calorie content of his feed was managed carefully to ensure that any weight gain was managed and reflected true growth and development rather than simply putting on fat. Whilst X's weight appears to have remained largely static from early November (11.6kg) until March (11.8kg) this was a period of considerable change for X in terms of how he was being fed and what he was being fed. This, in my view, adequately explains what might have been a cause for concern had X been in the Mother's care and remained on a stable PEG-J diet. Having remained consistently no higher than the second centile and frequently below the 0.4th centile in the 14 months prior to his admission to hospital in September 2020 his trajectory in the 14 months since has been upwards and for the last six months has been above the 9th centile. As Dr Rose said where his natural positioning on the centile charts is remains to be seen but it may be that he will eventually fall somewhere between the 9th to 20th centile.

130. Dr Rose and Dr Salvestrini both reached the clear conclusion that X's failure to thrive and his erratic weight gain and loss can only be explained by the level of calories provided to him. The evidence leads me to the same conclusion.

i) X's ability to gain weight from May 2018 through to the summer of 2019 demonstrates that physiologically he was able to absorb nutrition. There is therefore no underlying condition which prevents his being able to absorb nutrition delivered to him. The fact that he has been able to absorb nutrition since September 2020 also supports this. Dr Salvestrini could think of no physiological condition which would explain being able to absorb nutrition during one period of time, thereafter, losing that capability before regaining it. She was clear that X's progress since September 2020 rules out any condition which was previously considered as potentially relevant such as gut dysmotility.

ii) The evidence from X's infancy also demonstrates that when he was being fed regularly in hospital that he was able to gain weight as a young baby which also points away from any underlying condition. The other evidence at the time suggests that there were some problems feeding with a bottle but not that he was unable to feed with a bottle; see the entries 23 and 28 February 2018. It thus seems that his failure to gain weight at that time was more connected with how he was being fed although illnesses such as bronchiolitis also intervened.

iii) Both experts were clear that no combination of medication could have had the effect of rendering X in capable of absorbing nutrition delivered to him

iv) The evidence of the mother and of the professionals involved with X were clear that whilst he was either reported to have been vomiting or observed to have been vomiting, he was not vomiting feeds. The Hospital B records from spring 2018 record some vomiting of milk and this was part of the reasoning for transferring from gastric to jejunal feeding. Thus, one can rule out feeds being delivered but not being absorbed because they were vomited out. Given the whole purpose of jejunal feeding is to minimise the possibility of vomiting because the physiology of the body makes it much harder (albeit perhaps not impossible) to vomit jejunal feeds this does not explain X's failure to gain weight.

v) The changes in feeds do not explain the failure to gain weight either. During times of poor weight gain feeds which should have been easier to absorb (they being hydrolysed to a greater extent) were provided.

vi) Although Dr Salvestrini was critical of the process that was adopted in the summer of 2019 to manage X's excessive weight gain she was clear that whilst it was undesirable and potentially harmful in that it would have left X feeling relatively starved it could not have any impact on his ability to absorb nutrition.

vii) I accept that the vitamin B12 deficiency noted in the autumn of 2019 is indicative of the failure to provide the advised level of feeds. The content of the feeds should have provided in excess of 1000% of the recommended requirement and the evidence of Drs Rose and Salvestrini was that whilst intrinsic factor is produced in the stomach and would usually join with B12 to

be absorbed in the intestines there was no reason why the delivery of B12 to the jejunum would not have joined with intrinsic factor there and been absorbed.

viii) There is some evidence that the Mother stopped feeds to X when he was reported to be vomiting. I do not consider this to be of much assistance in this regard. What is clear is that the Mother was fully informed as to the operation of the pump and how the feeds were to be delivered, that she was solely responsible for delivering his feeds when he was at home and for significant periods of time whilst he was in hospital, but it would be relatively easy not to deliver the feeds either by simply not running the pump overnight or even to interfere with the delivery of feeds in hospital by running the feeds into another container rather than the jejunal feeding port and at the Mother's suggestion that she was at all times in the presence of others who would have observed that X was not being fed is unsustainable. For very considerable periods of time both during the day and in particular at night no one would have been either present or awake or in a position to monitor the delivery of feeds.

131. The decision to insert the PEG-J find its origins as long ago as April 2018 because of reports of continued vomiting with some milk being present. At that time the evidence suggests (See 16.4.2018) that the professionals agreed that X had an unsafe swallow and he could not be fed orally. The assessment on 22 March 2018 (Y2554) had concluded that it was not appropriate to start oral weaning because there was an aspiration risk due to poor oral and pharyngeal coordination. During his admission at Hospital A and at Hospital B he was subject to extensive observation. There is independent evidence of him vomiting at the hospital identified as being cough induced and some for no reason. Whilst at Hospital B the notes make clear that the intention was that all of X's feeds would be delivered by nursing staff in order to ensure objective observation and monitoring. There is no evidence of the Mother interfering with the feeds or acting in a way which raised any suspicion about her inducing vomiting. It is equally clear though that she was very unhappy about being excluded from X's feeding regime and felt that she was under suspicion. It seems unlikely that during a three-month stay in hospital both in Kent and in London that the two teams of treating professionals were not satisfied by what they observed as well as what they had reported to them that the insertion of a PEG-J was the appropriate course. During the admission to Hospital B there are documented records of X vomiting although there is a disparity between what is recorded and what mum reports which suggests either misinterpretation or exaggeration on the Mother's part and it is clear (25.5.2018) that feeding regimes even at Hospital B are adjusted based in part at least on the Mother's reports rather than pure observation. It is clear that after his discharge from hospital that X made progress in terms of weight gain through nasojejunal feeding and that the decision to progress the PEG-J was based on the fact that at that stage the professionals were satisfied that he could not progress to oral feeding but would have to remain on either nasojejunal or PEG-J and it was the decision of Dr NP and Dr Q that if jejunal feeding was to continue that the PEG-J should be inserted. Dr Salvestrini considered that a more robust evidence base should have been established before the PEG-J decision was implemented and she clearly considered that the decision in respect of X had been premature and inadequately evidenced. Thus whilst there may have been a degree of exaggeration by the Mother at that time particularly in relation to the frequency of X's vomiting, there is independent evidence from a number of sources that support the conclusion that X was experiencing some difficulty in oral feeding at the

time and that gastric feeding was resulting in more vomiting than jejunal feeding. I also note that Dr Rose considered that there was a pattern even whilst X was an inpatient at hospital.

132. However, whilst the Mother's role in the factors which influenced the decision-making to insert the Peg J may have been limited, her role in X's erratic history of weight gain and loss and his overall failure to thrive is more extensive. Her precise role in the difficulties experienced between birth and his admission to Hospital A/Hospital B in Spring 2018 is difficult to discern. There is a suggestion from the evidence of Dr Salvestrini and from Ms L's visit on 2 January 2018 that in fact the Mother was overfeeding him and that this was causing him to vomit. However as Dr Salvestrini said if he were being overfed he should have gained weight as 'happy spitters' do and so it seems more likely that over the period of time a combination of X being ill and being a difficult baby to feed led to his being underfed by the Mother. Subsequently on his discharge from hospital when he had gained some weight and when his general health and development seem to have improved, he returned to the full-time care of the Mother. Thereafter although he gained weight moving up through the centiles this was not accompanied by a significant improvement in his development. The inevitable conclusion in relation to his weight gain is that during this period of time the Mother was delivering his feeds. Ms L made clear that the calorific content of his feeds was in excess of that which would normally be provided to a child at that age and this would seem to explain why he progressed up the centiles until he reached the 75th centile at the beginning of May 2019. I have insufficient information available to me about what was happening in the Mother's life at this time. The evidence suggests that CD was in custody possibly from early 2018 and his absence from the scene may have been a factor in the Mother appearing to be able to comply with X's feeding regime from the summer of 2018 onwards but on the other hand the evidence suggests that it was in the autumn of 2018 that the maternal grandmother was seriously ill. Whatever it was that motivated the Mother she was able to comply with X's feeding regime during this period.

133. However, following the period of adjustment when X put on too much weight (this peaking in May and June 2019) he began a rapid decline falling under the 0.4th centile by early October 2019 which persisted until late November 2019. Around the time that Dr Q and others were seeking his readmission which the Mother was refusing he began to put on some weight which suggests that the Mother was again incentivised to comply more closely to his feeding regime but the modest improvement was not sustained. On the Mother's case and having regard to CD's criminal record it seems likely that he was released in late 2019 and on the Mother's case she allowed him back into the lives of herself and the children are such that by Spring 2020 she was pregnant by CD. The circumstances in which Z was conceived are incapable of determination on the evidence before me. The Mother maintains that she was raped by CD in the same way that she now says she was raped (albeit on 30.11.2015 she said it was consensual sex) resulting in Y's conception. The Local Authority and Guardian are sceptical given that on her account the older children were at school and X was with her sister at the time Z was said to have been conceived. Whatever the true nature of Z's conception and indeed the relationship between the Mother and CD which appears to have coincided with or overlapped with the Mother's relationship with GH who believed he was the father of Z, the reappearance of CD on the scene and the deterioration in X's condition may not be coincidental. I'm satisfied on the balance of probabilities that X's failure to thrive

from the summer of 2019 through to the admission to Hospital A on 7 September 2020 was due to the Mother failing to comply with his feeding regime. Apart from brief periods of improvement which appear to be linked to the Mother feeling under pressure from X's clinicians to have him admitted to hospital his failure to thrive over that period is obvious.

134. The Mother was the only individual who was trained in the use of the feeding pump for X. Neither the maternal grandmother or the maternal aunt were trained and so the Mother had sole responsibility for administering X's feeds. For significant periods of time X was being fed via the pump 24 hours a day the theory being that the more slowly the feed was delivered to him the less likelihood there would be that he could vomit it. The feeds were also adjusted to increase the calorific value per millilitre delivered in order to minimise the volume delivered and maximise the calorific content to reduce the vomiting risk and to maximise the prospect of calories contained in it. The pump could be set to deliver the feed at the set rate (e.g. 45 ml per hour) and the feed could be used for four hours after it was removed from the fridge and attached. When each feed was changed a process of priming the feeding tube with the new feed had to be undertaken so that air was not pumped into X's jejunum before the feed was pumped through. Self-evidently this would involve the Mother in a labour-intensive process where she would have to rise in the middle of the night and early in the morning in order to change the feed and re-prime the pump in accordance with the regime required. Dr Salvestrini said that the pump would record the volume of feed delivered that day and so one could see from the pump itself how much feed had been given. However, she identified that even within a monitored setting the feeding tube could be disconnected from the port so that the feed went into a bottle rather than the stomach and thus the pump volume monitor could be fooled. However, whilst at home the amounts of feed delivered by the pump were not recorded by any memory and the display simply showed the amount delivered that day. The experts concluded that the only explanation for X's failure to thrive was a failure on the Mother's part to deliver the feeds required. The Mother maintained that she had always delivered the feeds as required by the dieticians or other professionals and that had she not done so people would have known. By this she explained that the children were with her all the time and that she was at her sister's every day all day except for the evenings and that they should have been asked whether she was delivering X's feeds. This was another unsupported exaggeration as there was no evidence that she was at her sister's all day every day; rather the contrary. It is of course self-evident that even if the Mother were delivering the feeds during normal waking hours, during the night when she was at home and the children were asleep it would have been open to her to simply disconnect the pump and let X sleep throughout the night without any feed being delivered. His feed could then be reattached the following day, the pump reset, and a four hourly routine resumed. Any spare feed (particularly if it was preprepared in packs) could be disposed of if the Mother so wished. The amounts delivered to her were not the exact amount required each week as the dietician explained that they provided for a surplus in case there were any difficulties with deliveries or other unforeseen difficulties. Thus, even if a professional noted an apparent surplus of feeds there would be an explanation for it in any event. Thus, the system, hardly surprisingly, relied entirely on the fact that a parent would deliver the feed according to the regime set by the professionals. It did not provide a mechanism which would reveal if a parent were not complying with the regime. The only way of knowing that the feed had not been delivered was in the ultimate outcome for X which was whether he gained weight in accordance with the

expected trajectory that the calorie content of the feeds was projected to result in. In this case the failure to gain weight from 2019 through to 2020 is the ultimate proof of the pudding being in the eating if one will pardon the expression.

I am also satisfied that the Mother did place obstacles in the way of X's admission to hospital from November 2019 onwards. The Mother's assertion that she has always followed medical advice is most starkly demonstrated to be a lie by her failure to cooperate with his admission at a time when his failure to thrive was particularly serious. He had lost 16% of his body weight. It must have been obvious to the Mother, as it was to the professionals, that this needed to be addressed. The Mother of course would have been aware herself that the reasons for it were that she was failing to deliver his feed but rather than confess to this and to address it in a sustained and meaningful way she continued to maintain that she was complying with his feeding regime and to divert attention from the real cause. I'm satisfied on the balance of probabilities that the range of excuses she put up in order to avoid his admission were because she knew the real reason for his failure to thrive and feared that this would be exposed on his admission. These excuses shifted or were repeated over the following months whilst the concerns of the professionals and their desire to have X endured even when the Covid pandemic intervened. I accept that the maternal grandmother in particular was available and willing to help with childcare, that the hospital and social services were willing to support the Mother and that none of the reasons put forward by the Mother for deferring his admission had any real substance to them. Most parents in the position the Mother found herself in would have moved heaven and earth to ensure that X could be admitted if they had genuine concerns over his medical condition. The Mother's failure to do so lends further support to the conclusion that she was aware that his failure to thrive was due to her failing to comply with his feeding regime and that there was no underlying condition. That she continued to encourage the professionals to believe that there was some unidentifiable condition led to considerable anxiety amongst those treating X but also amongst those family members around him.

Development

135. The evidence relating to X's delayed development can be found in a variety of sources. The charts produced by the portage service provide a relatively accessible visual depiction of his level of development at various points in time.

i) Aug 2018 (age 11m) this shows significant deficits in physical development, health and self-care, and personal social skills as well as more modest deficits in other domains

ii) Aug 2019 (age 22 months) this shows that much of what he should have been able to do at one year of age in the field of gross motor and health and self-care has only be achieved at age 2 and there remain significant deficits in gross motor and fine motor skills that should have been achieved by age 2 as well as significant deficits in expected development in health and self-care at age 2 and in communication and language. However, in literacy and expressive art he was achieving goals in the 2-3 year range.

iii) November 2020: (aged 37 months): he was only then reaching goals in gross motor skills which she ought to have reached in his first year and his second year, was reaching goals in fine motor skills which she should have attained in

his second year as well as goals in health and personal care which he should have been meeting in his first and second years as well as significant communication and language goals that he should have met in his second year.

iv) Assessments in Jan 2021 and 30 April 2021 together with the evidence of Mr K demonstrated him filling in the gaps in his earlier milestones that he should have achieved in his second and third years and beginning to achieve some of the expected levels of development in his fourth year

136. The developmental assessments conducted by the community paediatric team and others which are recorded in the Chronology showed prior to September 2020 he was significantly delayed. In March 2019 at a chronological age of 18 months (and when his weight was above the 25th centile) that X's skills ranged between 6 to 8 months. His delay was attributed to his recurrent vomiting.

137. Whilst in hospital in September 2020 his developmental skills were observed by play therapists and recorded. Ms N acknowledged that these demonstrated a greater degree of developmental progress than she had seen prior to his admission; her last physical observation having been in February 2020. She thus acknowledged that her evaluation of his very considerable progress when she saw him in October 2020 could not all be attributed to the period after he left his mother's care. However, I accept the point that what is observed in hospital when X is neither compromised by vomiting, is being engaged by play therapists and is receiving full nutrition is likely to maximise his abilities to the observer. A number of professionals had noted that when he was well, he was able to demonstrate considerably better skills than they were usually able to observe. In her observations in October she noted that his energy levels and motivation had improved dramatically, and he was making much more rapid progress with skill development. Dr G made similar observations on 15 October 2020 although in June 2021 described it as 'quite good progress' and in January 2021with Ms H identifying huge developmental gains in last month and fantastic progress in March 2021, with Dr Q noting exceptional developmental progress in March 2021.

138. All those involved in his development identified significant progress in the months following September 2020 in contrast to the very limited progress he had made during their previous periods of involvement which for some, such as Mr K spanned in excess of two years. The combined effect of the evidence of the portage worker, the physiotherapist, the occupational therapist and a community paediatrician is that X was a very different little boy after September 2020 in terms of his developmental progress to that which he had been prior to September 2020. The developmental progress that X has made since 19 September 2020 has been variously described as astonishing, rapid, a different child, very pleasing. Whilst I am conscious of the possible risk of subconscious exaggeration of his progress in the shadow of the bleach incident and also the relative evidence deficit for the period when the covid lockdown limited the ability of professionals to witness X's development, the fact that these professionals all independently witnessed the lack of progress prior to September 2020 and the significant change thereafter leads me to conclude that the contrast between X's relative lack of development whilst in the care of his Mother and his rapid transition into significant progress afterwards is striking.

139. It seems likely that his relative lack of progress prior to September 2020 was attributable to a combination of factors. Firstly, was the ongoing issue with vomiting. Secondly was

the issue with the level of nutrition he was receiving. Thirdly was the impact on him of the manner by which he was being fed either through the NJ tube or for a longer period the peg J tubes with associated pump. Fourthly was a relative lack of stimulation; the frequency with which professionals observed X to be in his buggy and the issues that are documented in encouraging the Mother to maximise his opportunities to get out of his buggy and away from his tablet are strong pointers to the Mother's relative lack of stimulation for physical stimulation of X. Perhaps his relatively better development in creative/imaginative skills might be a product of his focus on the tablet. Of course, the existence of her other children and the demands placed on her by them together with other issues that may have preoccupied her or caused her to be emotionally detached would also have played their role in contributing to a relative lack of stimulation. Some of these factors are plainly attributable to the Mother's care of X.

140. The evidence in relation to the bleach incident on 19 September 2020 is essentially unchallenged by the Mother. The inferences that one can draw from it mean that I'm satisfied well beyond the balance of probabilities that the following occurred:

i) The Mother was told at around 10am when Dr T did his ward round that they would be trialling 10 ml of water into X's gastrostomy port.

ii) The Mother had previously purchased a bottle of bleach on 15 September which she had kept in X's buggy. I do not accept that the bleach was purchased in order to undertake cleaning; there is no evidence from the records that the Mother complained about the state of the hospital or that she was seen cleaning and she was unable to describe how she cleaned and indeed in her police interview maintained that she had not cleaned using bleach; although that point may be of dubious reliability given her dishonesty in the rest of the interview. The bleach was likely purchased in order to demonstrate vomiting. Given that the bottle was empty when found by the police it would seem that the Mother must have disposed of a significant amount of the bleach at some point probably after the vomiting had been induced and prior to her leaving the ward. Neither cleaning or using it to induce vomiting would explain the use of a whole bottle of bleach in the three and ½ days since it was purchased

iii) At some point during the course of the morning the Mother prepared a syringe into which she squirted bleach from the bottle that she had bought four days earlier from WH Smith together with water, probably from the open bottle of sterile water which was in X's room. A dry syringe was found in the bin in the room which suggests Mother had not used the syringe she was given by the nurse and replaced it with a syringe she had already prepared which had bleach in it.

iv) When Nurse J told her that the trial was to take place the Mother produced the syringe which she had previously prepared and attached it to the gastrostomy port. The amount of time the nurse was out of the room for and the possibility that the nurse might not have left at all immediately prior to trialling the water persuades me on balance that the Mother had prepared the bleach solution in the syringe at some point earlier that morning. On the basis of the accounts given both by the Mother in interview and by Nurse J I do not think it was possible for the Mother to have acted on the spur of the moment in getting the syringe, in squirting some bleach into it and then hiding the bleach bottle, in adding water

and in attaching the syringe to the gastrostomy port all in a matter of moments. It was thus very much a deliberate act involving preparation.

v) When nurse J returned the syringe was attached and ready to be delivered. In plain sight and in the presence of a nurse the Mother deployed the syringe and injected the bleach water mixture into X's stomach. This I consider took considerable bravado on the Mother's part. Had the syringe been prepared on the spur of the moment with the intention being to inject the mixture prior to nurse J's return I doubt very much that the Mother would have had the boldness to then administer the mixture. The facts thus point to the Mother feeling confident in deploying the mixture into X's stomach such that she was able with confidence to say to nurse J 'look I've done it'. Apart from the odd appearance of the contents of the syringe Nurse J does not make any observation of the Mother appearing to be nervous or hesitant or in any way demonstrating some sense of guilt. I'm satisfied that the Mother could only have felt such confidence that she was able to administer a bleach water mix to X in full sight of a nursing professional if she had both administered a bleach water mixture to X before but also on balance that she had done it within the hospital environment and within potential eyesight of health professionals.

vi) Thereafter X rapidly vomited almost immediately, and the Mother was matter-of-fact in cleaning him up. Thereafter she took such steps as she could to ensure that what she had done could not be detected. She refused the offer of nurse J to take the baby gro to wash it and thereafter the Mother left the ward with X.

vii) The CCTV evidence of her both outside the hospital and in Costa coffee show her disposing of the bleach bottle and the syringe in separate bins. She interacts with staff in Costa coffee. There is nothing in her demeanour which suggests random, anxious or unconsidered actions. On the contrary the disposal of the syringe and bottle in separate bins suggest a clear and planned course of action to dispose of the evidence of her actions.

viii) This together with her apparent lack of anxiety over X and his removal from the ward where medical support would be immediately on hand were he to experience an adverse reaction to the administration of the bleach water mixture clearly point on the balance of probabilities to the Mother having administered such a mixture on other occasions such that she was confident that he having vomited that he would thereafter not suffer further adverse consequences.

141. The Mother says that she was under huge stress whilst she was at the hospital with X leading up to 19 September and that this accounts for her mental state being such that she came to inject bleach into X's gastrostomy tube. Whilst I do not doubt that there were pressures on the Mother the other evidence as to the Mother's state of mind at the time does not suggest that she was having some sort of psychological crisis. The text exchanges with her sister and mother are innocuous on the 18th and 19th and are entirely in control of how she was thinking or acting and provide no support for the suggestion that the Mother was in such a stressed state that she was thinking irrationally. Her subsequent actions in disposing of the evidence and in her police interview provide support for the conclusion that she was well aware of what she was doing and in control of her actions.

142. The conclusions I reached in relation to the administration of the bleach water mixture are therefore of obvious relevance to aspects of the other allegations made against the Mother. This is not relevant purely because it is an act of intentional abuse of X because the content of her actions support the conclusion, and in my view well beyond the balance of probabilities, that she had administered a bleach/water mixture to X on other occasions. I'm satisfied that it extends to more than one other occasion because the confidence with which it was administered, the confidence in the lack of medium to long-term consequences and the planned disposal of the evidence point more to a pattern than to one or two isolated incidents.

143. I am also satisfied that the lies that the Mother told during the interview with police and in her witness statement in these proceedings satisfy the modified Lucas test but more importantly that she is now lying about her lack of recollection of events and that this more importantly satisfies the modified Lucas test in relation to the broader allegation that the Mother has induced vomiting on other occasions. She clearly is lying about not recalling the events of 19 September; it is deliberate, it relates to a material issue, and is motivated by a realisation of guilt and a fear of the truth. I'm satisfied that the Mother realised what could be inferred from her actions on the 19th and the account she gave in interview on the 19th and their relevance to her having injected bleach on other occasions and that this is why she now claims not to be able to recall anything about that day. I do not accept that the evidence relating to her demeanour on that day in any way supports the conclusion that either then or subsequently she is unable to recall what she did that day.

144. I'm also satisfied that the probable reasons for the injection of the bleach water mixture was because she wished to induce vomiting in order to persuade Dr T and the other treating professionals that X could not tolerate any feed into his stomach. If the doctors had accepted this, further trials of either water or feeds into the gastrostomy port would have ended and she would have been able to return home on Monday as she hoped. She would thus have left hospital with X being fed via the PEG-J; the same condition as he had been in when he entered. I am unable to discern any other explanation for the Mother injecting the bleach water mixture into X. An alternative theory might be that the Mother wished to prove that she was right and that the doctors were wrong but this ultimately leads back to the same conclusion which was that the Mother wished X to continue to be fed by PEG-J rather than progressing to normal feeding.

145. Given the Mother's complete denial of any memory of this and her denial of any other occasion when she has induced vomiting and her denial of any desire to keep X fed by PEG-J seeking to scratch beneath the surface of that motive is problematic and maybe no more than speculation rather than legitimate inference. The Mother's life would surely have been easier were X to have been feeding normally like his brothers and sister. The Mother would not have had the burden of changing his feeds every four hours, monitoring his pump, caring for his gastrostomy site, and managing all the paraphernalia and additional tasks that his condition required of her. She would have been able to leave X with others to care for for more prolonged periods of time, his progress to nursery and school would have been far easier. The list of benefits to the Mother are extensive and thus understanding the reasons for wishing to keep him on a PEG-J are for me as remote as understanding how she could have injected her apparently adorable son with a bleach water mixture in the first place. That I have concluded that she did it on various occasions makes it even less accessible.

146. However having concluded that the evidence supports the conclusion that the Mother had injected such a mixture on previous occasions and that her motive in injecting it on this occasion was to maintain X on PEG-J feeding does have direct relevance to when those other occasions of deliberate inducing vomiting occurred. Thus it seems to me to be a reasonable inference and one which I'm prepared to draw on the balance of probabilities that when the Mother considered that there was a need to demonstrate to professionals that X continued to have significant problems with vomiting which would present an ongoing bar to reconsideration of gastric feeding or reconsideration of PEG-J feeding that would be the probable occasions on which the Mother would have induced vomiting. Those would include:

    i) 15 September 2020 when X was reported by the Mother to her sister to have been 'megasick' by 13:48 hours which was subsequently noted in the nursing notes. That this was within 38 minutes of the Mother having purchased bleach in WHSmith provides further support for the Mother having bought that bleach specifically with the intention of administering it in a bleach water mix she having been told that morning by Dr T that they intended to trial water through the gastrostomy port.

    ii) 16 January 2020 when X effortlessly vomited a considerable amount of clear fluid which had an unusual smell. This was within five minutes of the Mother joining the multidisciplinary team meeting which was attended by Dr Q, Ms L, and a variety of other professionals and where the plan in relation to X including admission to hospital both Hospital B and Hospital A were under consideration.

147. Beyond saying that where the description of the vomiting is of copious amounts of clear fluid I do not consider it possible to identify other specific occasions although on balance I do not consider that three incidents of induced vomiting represents the totality of the Mother's behaviour in this regard. On balance of probability I accept that bleach was used on at least two occasions in order to induce the vomiting and that the most likely explanation for other induced vomits is either a bleach water mix or more probably or at least more frequently the introduction of a significant amount of water into X's gastric feeding port.

148. However, having made those findings I reject the allegation that almost the entirety of X's vomiting save where it is identified to have been linked to some identifiable illness or other event was induced. The totality of the evidence relating to X's vomiting does not depict a consistent pattern which would be consistent with induced vomiting. The evidence of Dr Rose and Dr Salvestrini is that there are no signs from blood or tests which would point to the introduction of an absorbable substance which could have caused vomiting, nor is there evidence of damage to the stomach which would be consistent with the use of bleach. Although Dr Salvestrini said that it was not possible to know what if any damage the introduction of diluted bleach on a regular basis would cause to the stomach the absence of any other evidence which links vomiting and the smell of bleach seems to me to lead to the conclusion that on balance bleach was not an agent regularly deployed by the mother to cause X to vomit. I do not think that the possible background smell of bleach or cleaning products either in the home or in a hospital environment would have gone entirely unnoticed over the three years had bleach regularly been deployed. If it was induced the likelihood would appear to be that it was caused either by the occasional administration of a bleach water mix or by the administration of a significant volume of water.

149. However, the descriptions of X's vomiting are not consistent with them being largely induced and induced by this method. No other potential cause of induced vomiting is identified by Dr Salvestrini or by Dr Rose. Having said that they have been unable to identify a medical explanation for much of the vomiting either. They are clear that some of it would be explicable by illnesses such as viral infections, tonsillitis, chest infections and similar which may have caused accumulations of saliva, mucus and stomach secretions to be vomited. However, it seems to me that there is an element of a known unknown in this area. Whilst the paediatricians are able to say that the combinations of medication do not establish a cause (and at least one was specifically prescribed to reduce secretions and thus the risk of vomiting) and that the whole reason for a PEG-J is to reduce the likelihood of vomiting by limiting the contents of the stomach, and Dr Salvestrini could think of no physiological explanation for aspects such as clustered vomiting or even of some condition of unknown aetiology which would account for the vomiting that still leaves areas of uncertainty; although they are linked to the what was happening to X in the care of the Mother but were not directed at inducing vomiting. Of course, it is possible that the Mother had developed a technique to induce vomiting in a variety of different volumes, types, patterns and occasions but this seems to me to be improbable. I also accept the point made by Mr Woodward-Carlton on behalf of the Mother that the terminology used has been rather loose at times. What is recorded as vomiting and indeed was described by Ms L as vomiting was not to my mind vomiting but was either regurgitation of some small amounts of fluids or on other occasions a difficulty swallowing saliva or mucus, which could be consistent with the difficulties that X had been diagnosed as having with swallowing. Thus, where it is recorded in the records that the Mother has reported vomiting may in fact reflect no more than regurgitation of secretions, mucus or saliva. It is clear from the descriptions of various of the professionals who have witnessed 'vomiting' that in many cases it would be better described as either a posset or regurgitation or possibly even a collection with difficulty swallowing. The fact that X's 'vomiting' disappeared from the scene apparently almost immediately he departed the Mother's care is undoubtedly a feature which points strongly towards the Mother being the cause. However I conclude that the likely explanation is that part of the reason for the Mother inducing vomiting before professionals which the evidence would suggest was something which emerged later in 2019 was in part because X was already 'vomiting' less frequently and that from March 2020 when lockdown was introduced that his vomiting from non-induced/genuine causes continued to abate and so the references to it from the Mother are exaggerated or false. I am not clear from the foster carer's account that vomiting is not a feature whether they would describe regurgitating, gagging, retching etc as vomiting; that they specifically refer to travel sickness and food suggest a more classically defined vomit.

150. It has been established that at times the Mother was not delivering X's full nutrition to him and it seems likely that this was largely because the Mother was not able to maintain the level of organisation or commitment required to keep it going. It has also been established that she was not ensuring that V was given all of his Movicol. It is also established that she exaggerated symptoms, initially that being a product of her personality and later it moving into a pattern which was more deliberate. I also have concluded that on balance X was probably consuming at least the occasional item of solid food. Thus, the reports of the Mother of his regular vomits were likely on many occasions to be either exaggerations or on occasions fabrications. What was actually observed by his supporting professionals would appear on many occasions to be genuine examples of X gagging, choking, regurgitating or vomiting for genuine reasons

some of them explicable by illness or accumulations of secretions and some of them genuine but of an unascertainable cause perhaps linked with issues arising from the failure by the Mother to actually maintain the regimes of feeding and medication that was prescribed for X. Whilst that is still culpable failure on her part both in exaggerating his symptoms and failing to maintain his regimes, it is a lower level of culpability than the deliberate inducement of vomiting to by the introduction of irritating agents such as bleach or large volumes of water.

151. The progress that all of the children have made since September 2020 provides further support for the conclusion that each of them have in different ways experienced over-medicalisation as a consequence of misreporting, exaggeration or inducing illness. X's progress in relation to his weight and his development has resulted in a transformation in him from a sick quasi-infant to a near normal active child. V has shed his need for medicines and has no problems with asthma or constipation. W experiences no issues with dairy intolerance, asthma or reflux. Y experiences no problems with asthma or choking and needs no medication. These changes are not only evident to the health professionals around them but also to the maternal grandparents and to the foster carer and indeed it would seem to the children themselves. The experts in these proceedings have endorsed those conclusions. Dr Rose concludes that Y and W are healthy robust children. V may have mild asthma. X's health and in particular his development will take longer to become clear given the extent to which his health and development have been compromised.

Conclusions

152. Thus, the outcome of my evaluation is that the Local Authority have substantially proved on the balance of probabilities the allegations set out in the threshold. That they are established, as summarised below, will have profound consequences for the future. As I have referred to before in this judgment, in a fact-finding case, particularly one of this nature, which focuses on aspects of the Mother's parenting which have caused harm or created a risk of harm to the children, inevitably means there is far less focus on the positive aspects of the Mother's parenting. In some cases, the positive parenting might come into much greater focus because it might be relevant to the determination of whether **that** parent was likely to have committed **that act/s**. When one knows at the outset of the hearing that a parent has committed at least one act of significant abuse as this Mother has, that argument is significantly undermined. However, I am conscious that since V was born the Mother has demonstrated the capability to provide at least good enough parenting in many different ways and over lengthy periods of time. What she has done in relation to fabricated and induced illness, exposing her children to the risk of domestic abuse and neglecting aspects of their care means she is a badly flawed parent and presents a significant risk to her children but she is not all bad. Various professionals over the years have commented on positive aspects of her parenting and the nature of her relationship with her children and her interactions with them have attracted praise as well as criticism. She is thus a complex character and presents a serious and complex risk, but the children clearly love her and in her own flawed way she loves them. What their views of her will be when they come to understand what she has done may in part depend on how she responds to the findings. She clearly has an awful lot of apologies to make to them. V has already experienced bullying in relation to the 'allegations' against his mum. The maternal grandmother does not think he has an understanding that they are true and how he will cope psychologically and in his

dealings with the outside world when he knows they are true I cannot imagine. He and the other children are likely to need a lot of help to understand and process what the Mother has done.

153. My findings on the threshold allegations are as follows. This

i) In respect of V, the Mother has exaggerated, over-reported and/or fabricated-

a) The extent of his asthma, both in severity and frequency.

b) The extent of any mobility problems, in particular in relation to his need for a special buggy which was not clinically required.

c) The extent and severity of his constipation and in particular in failing to ensure at times that his medication was taken and in mis-reporting the extent to which he was taking his medication.

d) Although Dr Salvestrini considered he did not have GORD its diagnosis by RBH leads me to conclude the Mother is not responsible for that.

ii) In respect of W, the Mother has exaggerated, over-reported and/or fabricated-

a) Her symptoms of cow's milk protein intolerance.

b) Her symptoms of asthma.

iii) In respect of Y, the Mother has exaggerated, over-reported and/or fabricated:

a) His difficulties in swallowing and choking/gagging on food.

b) His symptoms of wheezing/suspected asthma for which she reported that she was regularly giving him Ventolin.

iv) In respect of X the Mother has

a) Prior to his admission to hospital in March 2018 and since approximately July 2019 failed to provide X with adequate food and nutrition

v) Exaggerated and overreported the extent of his vomiting.

vi) Induced his vomiting by introducing bleach water mix into his gastrostomy tube on at least two occasions 15th and 19th September 2020 and induced his vomiting by introducing water or water mixed with other substances into his gastrostomy tube on other occasions including 16 January 2020.

vii) In consequence the children have suffered significant harm and/or been placed at risk of suffering significant harm from

a) undergoing repeated unnecessary medical appointments, examinations, investigations, procedures and treatments in particular for X which were particularly invasive.

b) The children have taken medications which they did not require, and which had the risk of side effects.

c) X's growth was hindered by the lack of nutrition.

d) X's gastrointestinal system was placed at risk of significant harm through the introduction of bleach water into his gastrostomy tube.

e) X's development was hindered by the combined effect of his lack of nutrition and lack of stimulation and by the Mother's care which was a significant factor in his experiencing vomiting throughout the time he was in her care.

f) V's school attendance hindered his educational progress.

g) The children were worried about the health of X and their relationships in particular with X did not develop to the extent that they ought.

h) V in particular has a false view that he is more unwell than he is.

i) I do not consider it necessary or proportionate to make findings in relation to allegations nine and 10 which relates largely to the failure to attend appointments save in one respect which relates to the Mother's failure to ensure that X was admitted to hospital in late 2019.

j) V, W and Y were exposed to domestic abuse in the relationship between the Mother and the father of W, Y and Z, CD, perpetrated by CD. The Mother resumed a relationship with CD knowing of his propensity to violent or abusive behaviour both in 2015/16 and in later 2019 despite the risks she was aware that he posed to her and the children.

k) V, W and Y were exposed to a risk of domestic abuse in the relationship between the Mother and AB. Although the relationship was short-lived and AB only saw the children in a public place he has a history of abusive behaviour to partners including behaviour amounting to controlling and emotionally abusive behaviour as found by HHJ Davies, by his convictions and by his behaviour to another partner in seeking to dictate how she behaved towards him (the lists).

l) The Mother has a significant history of mental ill health in her teenage years and has continued to suffer with variable psychological or psychiatric health as an adult. She has failed to take adequate steps to access help for these problems; whether psychological or psychiatric. At times these have impacted upon her ability to provide good enough care for the children and in particular have caused her to be emotionally detached from them.

154. Whilst I find that AB was aware that the Mother was pregnant with X and that X might be his and that his state of belief became firmer as more information was provided to him about X until it reached the stage where he came to believe that X probably was his child, I do not accept that his failure to seek to be involved in X's life had any material effect on X's well-being in relation to FII. At best had he become involved in

X's life he may have provided some emotional benefit to X and a chance that his medical trajectory may have been altered. AB clearly is a more complex character than at first meets the eye. There are plainly elements of him which are capable of behaving abusively towards his partner; these may emerge from his self-centredness and need to have his needs met and a potential lack of empathy for a partner. The findings made against him by HHJ Davies taken together with the other risk factors arising from domestic abuse clearly create a risk to any child in his care. However, the dark cloud created by the numerous police records and which are not convictions is not one which rules him out of the picture in respect of a role in X's life. It seems to me that further assessment will need to be undertaken in relation to AB bearing in mind the conclusions reached by the Cafcass officer in the Private Law proceedings relating to his older three children and the findings made herein.

155. Thus, each of the children have experienced a degree of over medicalisation or Fabricated or Induced Illness at the hands of the Mother. It has moved beyond perplexing presentation into a conclusion of FII based on my findings. The extent of it has varied. Although the youngest of those cared for by the Mother - X - has clearly experienced the most extensive exposure to abnormal behaviour by the Mother. In contrast V being the eldest has experienced a lower level of over medicalisation but over far more years. W and Y have experienced a far lower level of over medicalisation than either X or V. Given that W and Y are CD's children and that Mother's case is that Y is said to be the result of non-consensual intercourse one might have expected if the over medicalisation was underpinned by some animus towards the children and/or their father that they would have been more of a focus for the Mother. However, the converse is true. This lends support to the conclusion that each of the children experienced some genuine medical conditions and/or symptoms on which the Mother's over medicalisation of them was constructed. The degree of over medicalisation each of them experienced in my view bears some relation to the relative extent of the genuine medical conditions that they experienced although the relationship is not directly proportionate. It is self-evident in relation to X that the extent of the exaggeration, misreporting and ultimately inducing of illness was grossly out of proportion to any underlying genuine conditions that he experienced and this would seem to reflect to a degree the Mother having initiated a sequence of events which spiralled out of control in comparison to V, Y and W and became a runaway train which she could not get off but had to continue which ultimately led to her undertaking the shocking and dangerous steps of injecting X with bleach/water in order to maintain the fiction that he could only be fed by PEG-J and to prevent his doctors discovering that in truth there was little wrong with him save that his Mother was failing to feed him properly, was exaggerating his symptoms, perpetuating his inability to feed normally and was in various ways undermining his development. The Mother's behaviour in respect of X reached the most serious end of the continuum particularly because it was calculated but it is clear that over the years and in respect of different children her behaviour can be seen at different positions along that continuum. In the early years in relation to V and it seems to me at times in respect of both Y and W in some respects it fell at the anxious end of the spectrum but developed over time and in respect of different conditions into over anxiousness, exaggeration, misreporting before culminating in the inducing of vomiting in X in order to support the continuation of his diagnosis as requiring PEG- J feeding.

156. Plainly the Mother's underlying psychological and/or psychiatric health has played a part in this but that does not appear to me to be a complete explanation. We have not

really scraped the surface of the possible explanations for the Mother's behaviour in this hearing and some aspects will now not be likely to be capable of consideration. I have rejected the suggestion that anxiety and stress were the complete answers to her behaviour and to her claimed lack of memory of the events of 19 September 2020. That is not to say that various stresses in her life were not present and did not have some impact on the situation. The Mother's decision to continue extending her family seems unwise in hindsight in terms of the additional demands placed upon her already stretched capacities but the family now have five wonderful children. Her refusal of help with her mental health was unwise. Finalisation of the psychiatric assessment of the Mother in the light of my findings may be required but absent an acceptance by the Mother of what she has done over the years and in respect of each of her children the path ahead for her in relation to these children seems fraught with difficulty. The Mother has had over a year to reflect upon her actions in relation to X but has retreated into a bunker where she now maintains she cannot actually recall what she did. That is so far from an acceptance of her actions - indeed in some respects in terms of the prognosis for the future it seems worse than a straightforward denial - it is difficult to see how it would be possible for her to now reach an acceptance of her behaviour which would gain any traction. The Mother has a lot of reflecting to do.

157. As matters stand the Mother present a serious risk to her children. The prospect of her caring for any of them in the short to medium term is remote. The risk that the Mother would not present the children to medical practitioners for fear that she would come under suspicion for over medicalisation them would represent a serious threat to their health. The risk that health professionals would doubt the genuineness of any history provided by the Mother in relation to any presentation would represent a serious limitation on their ability to undertake a proper consideration of a child's health needs with a consequent risk that genuine complaints would be dismissed or overlooked. The risk that the Mother would resume the pattern of exaggeration, misreporting or inducing illness will present a risk both of considerable magnitude and possibly extensive harm particularly if the introduction of poisonous substances such as bleach occurred.

158. That is my judgment.