Case No: XX19C02212

IN THE FAMILY COURT

IN THE MATTER OF THE CHILDREN ACT 1989

AND IN THE MATTER OF J (DOB 2017)
(A CHILD)

Date: 23 December 2020

Before :

Elizabeth Isaacs QC sitting as a deputy high court judge

- -

Between :

A LOCAL AUTHORITY

Applicant

- and -

(1) AB
(2) CD
(3) J
(by his guardian) **Respondents**

- and –

XYZ **Intervener**

- -

- -

Sarah Morgan QC and Steven Ashworth for the **Local Authority**
Clive Newton QC and Alexa Storey-Rae for the **First Respondent**
Penny Howe QC and Adam Clegg for the **Second Respondent**
Pamela Warner for the **Children's Guardian**
Elizabeth McGrath QC and Lydia Slee for the Intervener

Hearing dates: 2-6, 9-13, 16-20, 23-27 November and 9 December 2020

- -

JUDGMENT

INTRODUCTION

1. This is a complex and troubling case involving extensive documentary evidence. The extent of the evidence and the nature of the allegations which has required extensive forensic analysis, reflected unfortunately in the length of this judgment. I am concerned with a young boy, J (dob: 2017) who is now aged between 3 and 4 years. J has been placed in foster care since 2 October 2019, initially accommodated, but since 24 October 2019, subject to an interim care order.

2. J's parents are AB (aged 24) and CD (aged 25) to whom I shall refer to as M and F from now on. J is the first child for both parents.

3. M's current partner is XYZ who was joined as an intervener to these proceedings on 2 April 2020 on the basis that findings may be made against him in respect of some of the injuries caused to J in October 2019 and which the local authority asserts are inflicted injuries. I shall refer to him as XYZ.

4. This is a case in which, although there is a vast volume of documentary evidence which warrants detailed forensic scrutiny, ultimately it remains a case in which one of the central issues is credibility – the credibility of M, F and XYZ, as well as other lay and professional witnesses.

5. This court is not required to make findings on every issue in the case. The court is only required to make findings on the relevant issues and those which assist in the determination of the matters before it at that time.

6. I have therefore followed that practice in this judgment. I am very conscious that there may be other issues. I have endeavoured to remain focused in this hearing on determining only the facts necessary to properly resolve the issues before the court and to deal with the case justly.

THE FACT-FINDING HEARING

7. This fact-finding hearing took place before me over the course of 21 days on 2-6,9-13, 16-20, 23-27 November and 9 December 2020. It was heard entirely remotely with the agreement of all parties in light of the prevailing Covid-19 health crisis in the UK.

8. Throughout the hearing I have considered all the relevant evidence in the case available to me at that time. Failure to mention any specific part of the evidence should not be taken as an indication that I have failed to consider it.

9. During the fact-finding hearing I heard oral evidence from a number of lay, professional and expert witnesses, including –

- Dr L, consultant paediatric neurologist (treating clinician)
- Dr EP, paediatric specialist registrar (treating clinician)
- HV, health visitor
- Dr U, consultant paediatrician (treating clinician)
- EF, head of safeguarding children at the Hospital Trust
- GH, social worker
- Professor Peter Fleming, consultant paediatrician (expert)
- Dr SP, consultant paediatrician (treating clinician)
- IJ, deputy designated safeguarding lead
- KL, manager, teacher and designated safeguarding lead
- MN, early years practitioner
- BX, previous team manager
- Dr Gwen Adshead, consultant in forensic psychiatry (expert)
- Dr Anand Kumar Saggar, consultant in clinical genetics (expert)
- Dr Diana Birch, paediatrician (expert)
- Dr S, consultant paediatrician (treating clinician)
- M
- F
- Paternal grandmother (PGM)
- XYZ

10. I received and considered written submissions shortly after the conclusion of the oral evidence, and also heard short oral submissions on behalf of the LA, M and F at their request.

11. I am extremely grateful to all advocates for their assistance. I am also very grateful to the parents and XYZ for the dignified way in which they conducted themselves throughout the proceedings.

LEGAL FRAMEWORK

Burden of proof

12. In any fact-finding exercise the burden of proof of proving any allegation lies on the party seeking to prove the allegations. In this case it is the local authority that brings these proceedings and identifies the findings they invite the court to make. Therefore, the burden of proving the allegations rests with them. Those against whom allegations are made do not themselves have to provide an explanation or context for any disputed allegation or to prove that any allegation is false.

13. The burden of disproving a reasonable explanation put forward by the parents falls on the local authority (see **Re S (Children) [2014] EWCA Civ 1447** where Macur LJ said at paragraph [10] **–**

> *'… it was for the local authority (i) to disprove the possible explanations for injury, whether accidental or congenital and (ii) establish that, on the balance of probabilities, the whole of the evidence led to the conclusion that the injuries were non accidental rather than simply incapable of being explained otherwise.'*

14. The burden of proof should not be reversed. There is no obligation on a parent to provide an explanation. If an explanation or hypothesis is put forward by or on behalf of a parent which is not accepted by the court, the failure to do so does not establish the local authority case. In **Rhesa Shipping Co SA v Edmunds (HL(E)) [1985] 1 WLR 948** Lord Brandon said at pages 955G-956D –

> *'…the late Sir Arthur Conan Doyle…describes…Mr Sherlock Holmes as saying to…Dr Watson: "How often have I said to you that, when you have eliminated the impossible, whatever remains, however improbable, must be the truth?'…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…*

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 regards 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…

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.

15. In **Re BR (Proof of Facts) [2015] EWFC 41** Peter Jackson J, as he then was, said at [15]-[16] –

'[15] … It would of course be wrong to apply a hard and fast rule that the carer of a young child who suffers an injury must invariably be able to explain when and how it happened if they are not to be found responsible for it. This would indeed be to reverse the burden of proof. However, if the judge's observations are understood to mean that account should not be taken, to whatever extent is appropriate in the individual case, of the lack of a history of

injury from the carer of a young child, then I respectfully consider that they go too far.

[16] Doctors, social workers and courts are in my view fully entitled to take into account the nature of the history given by a carer. The absence of any history of a memorable event where such a history might be expected in the individual case may be very significant. Perpetrators of child abuse often seek to cover up what they have done. The reason why paediatricians may refer to the lack of a history is because individual and collective clinical experience teaches them that it is one of a number of indicators of how the injury may have occurred. Medical and other professionals are entitled to rely upon such knowledge and experience in forming an opinion about the likely response of the individual child to the particular injury, and the court should not deter them from doing so. The weight that is then given to any such opinion is of course a matter for the judge.'

16. The concept of the pool of perpetrators does not alter the general rule on the burden of proof – see **Re B (Children: Uncertain Perpetrator [2019] EWCA Civ 575**. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown.

Standard of proof

17. The appropriate standard of proof is the civil standard of the simple balance of probability as confirmed by the House of Lords in **Re B (Children) [2008] UKHR 35** per Lord Hoffman at paragraph [2] –

'If a legal rule requires a fact to be proved (a 'fact in issue'), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened.'

18. This means that if the local authority or another party proves an allegation to this standard, that fact must be treated as having been established and will bear on all future decisions concerning the children. Equally, it means that if allegations are not proved to that standard, then they must be disregarded completely. However, it does not follow that a rejection of evidence mandates a judge to find that it is false; see **Re M (Children) [2013] EWCA Civ 388**.

19. The inherent probability of an event remains a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. **Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2008] 2 FLR 131** In Lord Hoffman said at paragraph [15] –

> *'[15] Common sense, not law, requires that in deciding this question regard should be had, to whatever extent appropriate, to inherent probabilities.'*

20. However, it is not the case that the more serious the allegation, then the more cogent the evidence needs to be to prove it. In **Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2008] 2 FLR 131** Baroness Hale said at paragraph [70] –

> *'[70] My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under s 31(2) or the welfare considerations in s 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies.'*

21. There is therefore no logical or necessary connection between seriousness and probability. In **Re B (Children) [2008] UKHR 35 at [72-73]** Baroness Hale said –

> *'[72] As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability. Some seriously harmful behaviour, such as murder, is sufficiently rare to be inherently improbable in most circumstances. Even then there are circumstances, such as a body with its throat cut and no weapon to hand, where it is not at all improbable. Other*

seriously harmful behaviour, such as alcohol or drug abuse, is regrettably all too common and not at all improbable. Nor are serious allegations made in a vacuum. Consider the famous example of the animal seen in Regent's Park. If it is seen outside the zoo on a stretch of greensward regularly used for walking dogs, then of course it is more likely to be a dog than a lion. If it is seen in the zoo next to the lions' enclosure when the door is open, then it may well be more likely to be a lion than a dog.

[73] In the context of care proceedings, this point applies with particular force to the identification of the perpetrator. It may be unlikely that any person looking after a baby would take him by the wrist and swing him against the wall, causing multiple fractures and other injuries. But once the evidence is clear that that is indeed what has happened to the child, it ceases to be improbable. Some-one looking after the child at the relevant time must have done it. The inherent improbability of the event has no relevance to deciding who that was. The simple balance of probabilities test should be applied.'

Judicial approach to evidence

22. Findings of fact must be based on evidence not speculation; see **Re A (Fact Finding: Disputed findings) [2011] 1 FLR 1817 at [26]** Munby LJ (as he then was) said –

'It is an elementary position that findings of fact must be based on evidence, including inferences that can be properly drawn from evidence and not suspicion or speculation.'

23. In **Re B (Children) [2008] UKHR 35 at** Baroness Hale said at paragraphs [31-32]

'[31] … In this country we do not require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day, up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other, and their overall impression of the characters and motivations of the witnesses. The task is a difficult one. It must be performed

without prejudice and preconceived ideas. But it is the task which we are paid to perform to the best of our ability.

[32] In our legal system, if a judge finds it more likely than not that something did take place, then it is treated as having taken place. If he finds it more likely than not that it did not take place, then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other. Sometimes the burden of proof will come to his rescue: the party with the burden of showing that something took place will not have satisfied him that it did. But generally speaking a judge is able to make up his mind where the truth lies without needing to rely upon the burden of proof.'

24. The judge must decide if the facts in issue have happened or not applying the binary system made plain by Lord Hoffman in **Re B (Children) [2008] UKHR 35 at paragraph [2]**. This applies to the conclusion as to the fact in issue, not the value of individual pieces of evidence (which fall to be assessed in combination with each other).

25. The court must take into account all of the evidence and consider each piece of evidence in the context of all the other evidence and look at the overall canvas. Evidence should not be assessed in separate compartments. The judge must assess and evaluate the evidence in its totality; see **Re T [2004] 2 FLR 838** where Butler-Sloss P said at paragraph [33] –

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

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; see **Re W and another (Non-accidental injury) [2003] FCR 346**.

27. See also Ryder LJ in **Re M (Children) [2013] EWCA Civ 388 at paragraph [6]** –

> *'[6] When any fact-finding court is faced with the evidence of the parties and little or no corroborating or circumstantial material, it is required to make a decision based on its assessment of whose evidence it is going to place greater weight upon. The evidence either will or will not be sufficient to prove the facts in issue to the appropriate standard. As has been said many times in one form or another, the judge is uniquely placed to assess credibility, demeanour, themes in evidence, perceived cultural imperatives, family interactions and relationships.'*

28. However, in assessing and weighing the impression which the court forms of the parents, the court must also keep in mind the observations of Macur LJ in **Re M (Children) [2013] EWCA Civ 1147 at [12],** that –

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

29. That need for caution and the dangers of over-reliance on demeanour (and the research base to support that danger) was echoed by Leggat LJ in **Sri Lanka v The Secretary of State for the Home Department [2018] EWCA 1391 at paragraphs [40-41]** –

> *'40. This is not to say that judges (or jurors) lack the ability to tell whether witnesses are lying. Still less does it follow that there is no value in oral evidence. But research confirms that people do not in fact generally rely on demeanour to detect deception but on the fact that liars are more likely to tell stories that are illogical, implausible, internally inconsistent and contain fewer details than persons telling the truth: see Minzner, "Detecting Lies Using Demeanor, Bias and Context" (2008) 29 Cardozo LR 2557. One of the main potential benefits of cross-examination is that skilful questioning can expose inconsistencies in false stories.*
>
> *41. No doubt it is impossible, and perhaps undesirable, to ignore altogether the impression created by the demeanour of a witness giving evidence. But to*

attach any significant weight to such impressions in assessing credibility risks making judgments which at best have no rational basis and at worst reflect conscious or unconscious biases and prejudices. One of the most important qualities expected of a judge is that they will strive to avoid being influenced by personal biases and prejudices in their decision-making. That requires eschewing judgments based on the appearance of a witness or on their tone, manner or other aspects of their behaviour in answering questions. Rather than attempting to assess whether testimony is truthful from the manner in which it is given, the only objective and reliable approach is to focus on the content of the testimony and to consider whether it is consistent with other evidence (including evidence of what the witness has said on other occasions) and with known or probable facts.'

30. When considering the 'wide canvas' of evidence the following section of the speech of Lord Nicholls in **Re H and R (Child Sexual Abuse: Standard of Proof) [1996] 1 FLR 80** remains relevant –

'[101B] I must now put this into perspective by noting, and emphasising, the width of the range of facts which may be relevant when the court is considering the threshold conditions. The range of facts which may properly be taken into account is infinite. Facts including the history of members of the family, the state of relationships within a family, proposed changes within the membership family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child, and unsatisfactory parental responses to complaints or allegations. And facts, which are minor or even trivial if considered in isolation, taken together may suffice to satisfy the court of the likelihood of future harm. The court will attach to all the relevant facts the appropriate weight when coming to an overall conclusion on the crucial issue.'

31. In **Westminster City Council v M, F and H [2017] EWHC 518 (Fam)** Hayden J said at paragraph [25] –

'[25] The Local Authority must, ultimately, assess the manner in which it considers it can most efficiently, fairly and proportionately establish its case. The weight to be given to records, which may be disputed by the parents, will

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

Evidence arising since the commencement of proceedings

32. In **M (A Minor) (Care Order: Threshold Conditions) [1994] 2 AC 424 at 440** Lord Templeman clarified that even if the risk of significant harm has reduced or disappeared since protective measures were taken, this does not preclude the court from making a care order so long as the threshold was met at the time those protective measures were taken.

33. **In Re G (Children) (Care Order: Evidence) [2001] EWCA Civ 968 at paragraphs [9-15]** Hale LJ (as she then was) confirmed that although the time that threshold must be established is the time at which protective measures are taken, further developments or evidence which comes to light after that date may still be considered at the hearing.

Credibility, memory, recall and reconstruction

34. The evidence of witnesses and the explanations given by them are of the utmost importance and a clear assessment of their credibility and reliability must be made by the court. In the context of the consideration of a wide canvas of material in reaching the factual decisions in the case, investigations of fact should have regard to the wider context of social, emotional, ethical and moral factors. The assessment of credibility generally involves wider difficulties than mere 'demeanour', which is mostly concerned with whether the witness appears to be telling the truth as he or she now believes it to be. With every day that passes the memory becomes fainter and the

imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited. Therefore, contemporary documents are always of the utmost importance.

35. Every time a court has to assess 'memory' and 'credibility' it is faced with a difficult process and a sometimes almost impossibly difficult problem. In **Gestmin SGPS v Credit Suisse (UK) Ltd [2013] EWHC 3560 (Comm)** Leggatt J (as he then was), confirmed the importance of a proper approach to memory and eyewitness testimony –

> *'[16] While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.*
>
> *[17] Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flashbulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event. (The very description 'flashbulb' memory is in fact misleading, reflecting as it does the misconception that memory operates like a camera or other device that makes a fixed record of an experience.) External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which did not happen at all or which happened to someone else (referred to in the literature as a failure of source memory).*
>
> *[18] Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our*

present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.

[19] The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.

[20] Considerable interference with memory is also introduced in civil litigation by the procedure of preparing for trial. A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does nor does not say. The statement is made after the witness's memory has been "refreshed" by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall. The statement may go through several iterations before it is finalised. Then, usually months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.

[21] It is not uncommon (and the present case was no exception) for witnesses to be asked in cross-examination if they understand the difference

between recollection and reconstruction or whether their evidence is a genuine recollection or a reconstruction of events. Such questions are misguided in at least two ways. First, they erroneously presuppose that there is a clear distinction between recollection and reconstruction, when all remembering of distant events involves reconstructive processes. Second, such questions disregard the fact that such processes are largely unconscious and that the strength, vividness and apparent authenticity of memories is not a reliable measure of their truth.'

Hearsay evidence

36. Hearsay evidence which must be considered in the wider context. Proper caution must be exercised in view of the fact that hearsay evidence has not been the subject of formal challenge in cross-examination.

37. In **R v B County Council ex parte P [1991] 2 All ER 65 (at 72J), [1991] 1 FLR 470 at 478**, Butler-Sloss LJ observed that –

> *'A court presented with hearsay evidence has to look at it anxiously and consider carefully the extent to which it can properly be relied upon.'*

38. When assessing the weight to be placed on hearsay evidence the Court may have regard to the matters set out in section 4 of the Civil Evidence Act 1995 even in cases (such as this one) where the Civil Evidence Act does not strictly apply.

39. Section 4 of the Civil Evidence Act provides that –

(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.

(2) Regard may be had, in particular, to the following—

(a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;

(b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;

(c) whether the evidence involves multiple hearsay;

(d) whether any person involved had any motive to conceal or misrepresent matters;

(e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;

(f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight.

Expert evidence

40. In considering the evidence of an expert witness, the court must not confuse the functions of the expert and the judge whose roles are distinct. It is for the court to make the factual decisions based on all the available evidential material in the case, not just the scientific or medical evidence; and all that evidence must be considered in the wider social and emotional context; see **A County Council v X, Y and Z (by their Guardian) [2005] 2 FLR 129**.

41. If the court disagrees with an expert's conclusions or recommendations an explanation is required; see **Re B (Care: Expert Witnesses) [1996] 1 FLR 667 and Re D (A Child) [2010] EWCA 1000**.

42. In **Re B (Care: Expert Witnesses) [1996] 1 FLR 667** Ward LJ gave the following guidance as regards the evidence of expert witnesses –

> *'The expert advises but the Judge decides. The Judge decides on the evidence. If there is nothing before the court, no facts or no circumstances shown to the court which throw doubt on the expert evidence, then, if that is all with which the court is left, the court must accept it. There is, however, no rule that the Judge suspends judicial belief simply because the evidence is given by an expert.'*

43. Butler-Sloss LJ continued –

'An expert is not in any special position and there is no presumption of belief in a doctor however distinguished he or she may be. It is, however, necessary for the Judge to give reasons for disagreeing with experts' conclusions or recommendations. That, this Judge did. A Judge cannot substitute his own views for the views of the experts without some evidence to support what he concludes.'

44. In **A County Council v K, D and L [2005] EWHC 144 (Fam)** Charles J emphasised at paragraph [39] that the roles of the court and the expert are distinct, and that it is the court that is in the position to weight the expert evidence against its findings on the other evidence. A paragraph [44] he noted that in cases concerning alleged non-accidental injury to children, properly reasoned expert medical evidence carries considerable weight, but in assessing and applying it the judge must always remember that he or she is the person who makes the final decision.

45. At paragraph [49] Charles J went on to make the following observations about the judicial function –

'i) The court has to take into account and weigh the expertise and speciality of individual experts and is often assisted by an overview from, for example, a paediatrician.

ii) In a case where the medical evidence is to the effect that the likely cause is non accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof.

iii) The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury (or human agency) and the clinical observations of the child, although consistent with non accidental injury (or human agency) of the type asserted, is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that on the balance of probability there has been a non accidental injury (or human agency) as asserted and the threshold is established.

iv) Such findings have to be based on evidence and findings of fact to the civil standard and reasoning based thereon.

46. In assessing the expert evidence the court must bear in mind that in cases involving a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bring their own expertise to bear on the problem, and 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 (see the observations of Eleanor King J (as she then was) in **Re S [2009] EWHC 2115 (Fam))**.

Unknown and disputed cause

47. The court is not precluded from making a finding that the cause of harm is unknown. In **Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam)** Hedley J said at paragraph [10] –

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

48. The court must resist the temptation identified by the Court of Appeal in **R v Henderson and Others [2010] EWCA Crim 1219** to believe that it is always possible to identify the cause of injury to the child.

49. In **Re U (Serious Injury: Standard of Proof): Re B [2004] EWCA Civ 567,** Butler-Sloss P explained at paragraph [23] that –

'i) The cause of an injury or an episode that cannot be explained scientifically remains equivocal.

ii) Recurrence is not in itself probative.

iii) Particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.

iv) The Court must always be on guard against the over-dogmatic expert, the expert whose reputation or amour propre is at stake, or the expert who has developed a scientific prejudice.

v) The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.

Lies

50. The court should be cautious when evaluating the evidence of a dishonest witness; see **R v Lucas [1981] QB 720** –

'If a court concludes that a witness has lied about a matter, it does not follow that he has lied about everything. A witness may lie for many reasons. For example out of shame, humiliation, misplaced loyalty, panic, fear, distress, confusion and emotional pressure...The jury should in appropriate cases be reminded that people sometimes lie, for example, in an attempt to bolster up a just case, or out of shame or out of a wish to conceal disgraceful behaviour from their family.'

51. In **Re A (A Child) (No.2) [2011] EWCA Civ 12** Munby LJ, as he then was, observed –

'[104] Any judge who has had to conduct a fact-finding hearing such as this is likely to have had experience of a witness – as here a woman deposing to serious domestic violence and grave sexual abuse – whose evidence, although shot through with unreliability as to details, with gross exaggeration and even with lies, is nonetheless compelling and convincing as to the central core. It is trite that there are all kinds of reasons why witnesses lie, but where the issues relate, as here, to failed marital relationships and the strong emotions and passions

that the court process itself releases and brings into prominence in such a case, the reasons why someone in the mother's position may lie, even lie repeatedly, are more than usually difficult to decipher. Yet through all the lies, as experience teaches, one may nonetheless be left with a powerful conviction that on the essentials the witness is telling the truth, perhaps because of the way in which she gives her evidence, perhaps because of a number of small points which, although trivial in themselves, nonetheless suddenly illuminate the underlying realities.'

52. In **Re M (Children) [2013] EWCA Civ 388** Ryder LJ said at paragraphs [7-8] –

'[7] A Lucas direction is a criminal direction derived originally from a case on corroboration, R v Lucas [1981] QB 720. It is used to alert a fact-finding tribunal, that is a jury in a criminal trial, to the fact that a lie told by a defendant does not of itself necessarily indicate guilt because the defendant may have some other reason for lying; that is, he may lie for innocent reasons. A witness may lie because she lacks credibility, or because she has an innocent motive for lying. If she lies about the key fact in issue, that is one thing; if she lies about collateral facts, that may be quite another. A judge of fact may not be able to separate out every fine distinction, but may nevertheless conclude that an allegation is proved, despite the fact the witness has lied about other matters.

[8] This is often simplified in the circumstances of emotionally-charged allegations remembered through the fog of distress and relationship breakdown as a core of truth surrounded by sometimes exaggerated and sometimes badly recollected or hazy memory. There may also be an overlay of deliberate untruth arising out of the anger and distress of the breakdown and/or the nature of the application before the court…'

53. In **Re H-C (Children) [2016] EWCA Civ 136** the Court of Appeal confirmed that the Lucas approach applies in family cases. Thus, the court must first determine if the alleged perpetrator has deliberately lied, and then, if such a finding is made, consider why the party lied. McFarlane LJ stated –

'[98] The decision in R v Lucas has been the subject of a number of further decisions of the Court of Appeal Criminal Division over the years, however the

core conditions set out by Lord Lane remain authoritative. The approach in R v Lucas is not confined, as it was on the facts of Lucas itself, to a statement made out of court and can apply to a "lie" made in the course of the court proceedings and the approach is not limited solely to evidence concerning accomplices.

[99] In the Family Court in an appropriate case a judge will not infrequently directly refer to the authority of R v Lucas in giving a judicial self-direction as to the approach to be taken to an apparent lie. Where the "lie" has a prominent or central relevance to the case such a self-direction is plainly sensible and good practice.

[100] One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim. L.R. 251.

In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt.'

Repeated accounts and possible reported discrepancies

54. Peter Jackson J (as he then was) in **Lancashire County Council v. The Children and Others [2014] EWFC 3** stated that –

'[9] ... in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further

possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith.'

Identification of perpetrator

55. It is in the public interest that those who cause non-accidental injuries should be identified; see **Re K (Non-Accidental Injuries: Perpetrator: New Evidence) [2005] 1 FLR 285, CA**.

56. When seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator; see **North Yorkshire County Council v SA [2003] 2 FLR 849**.

57. The approach which should be adopted in relation to the identity of a perpetrator has been the subject of recent consideration by the Court of Appeal in **Re B (Children: Uncertain Perpetrator) [2019] EWCA Civ 575** where Jackson LJ reviewed the line of relevant authority and summarised the approach to be taken in 'uncertain perpetrator' cases as follows –

'[46] Drawing matters together, it can be seen that the concept of a pool of perpetrators seeks to strike a fair balance between the rights of the individual, including those of the child, and the importance of child protection. It is a means of satisfying the attributable threshold condition that only arises where the court is satisfied that there has been significant harm arising from (in shorthand) ill-treatment and where the only 'unknown' is which of a number of persons is responsible. So, to state the obvious, the concept of the pool does not arise at all in the normal run of cases where the relevant allegation can be proved to the civil standard against an individual or individuals in the normal way. Nor does it arise where only one person could possibly be responsible. In

that event, the allegation is either proved or it is not. There is no room for a finding of fact on the basis of 'real possibility', still less on the basis of suspicion. There is no such thing as a pool of one.

[47] It should also be emphasised that a decision to place a person within the pool of perpetrators is not a finding of fact in the conventional sense. As is made clear in ***Lancashire*** *at [19],* ***O and N*** *at [27-28] and* ***S-B*** *at [43], the person is not a proven perpetrator but a possible perpetrator. That conclusion is then carried forward to the welfare stage, when the court will, as was said in* ***S-B****, "consider the strength of the possibility" that the person was involved as part of the overall circumstances of the case. At the same time it will, as Lord Nicholls put it in* ***Lancashire****, "keep firmly in mind that the parents have not been shown to be responsible for the child's injuries." In saying this, he recognised that a conclusion of this kind presents the court with a particularly difficult problem. Experience bears this out, particularly where a child has suffered very grave harm from someone within a pool of perpetrators.*

[48] The concept of the pool of perpetrators should therefore, as was said in Lancashire, encroach only to the minimum extent necessary upon the general principles underpinning s.31(2). Centrally, it does not alter the general rule on the burden of proof. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see Re S-B at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof.

[49] To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472 at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.

[50] Likewise, it can be seen that the concept of a pool of perpetrators as a permissible means of satisfying the threshold was forged in cases concerning individuals who were 'carers'. In Lancashire, the condition was interpreted to include non-parent carers. It was somewhat widened in North Yorkshire at [26] to include 'people with access to the child' who might have caused injury. If that was an extension, it was a principled one. But at all events, the extension does not stretch to "anyone who had even a fleeting contact with the child in circumstances where there was the opportunity to cause injuries": North Yorkshire at [25]. Nor does it extend to harm caused by someone outside the home or family unless it would have been reasonable to expect a parent to have prevented it: S-B at [40].

[51] It should also be noted that in the leading cases there were two, three or four known individuals from whom any risk to the child must have come. The position of each individual was then investigated and compared. That is as it should be. To assess the likelihood of harm having been caused by A or B or C, one needs as much information as possible about each of them in order to make the decision about which if any of them should be placed in the pool. So, where there is an imbalance of information about some individuals in comparison to others, particular care may need to be taken to ensure that the imbalance does not distort the assessment of the possibilities. The same may be said where the list of individuals has been whittled down to a pool of one named individual alongside others who are not similarly identified. This may be unlikely, but the present case shows that it is not impossible. Here it must be shown that there genuinely is a pool of perpetrators and not just a pool of one by default.

[60] [The concept of a] *pool of perpetrators is a departure from the norm and every effort must be made to ensure that the departure operates in a principled way."*

58. In this case the issue of uncertain perpetrator arises in relation to the bruising to J seen on 2 October 2019. Therefore, the issue for the court must be to consider whether the actual perpetrator can be identified on the balance of probability and the court should seek, but not strain, to do so; see **Re D (Children) [2009] EWCA Civ 472**.

59. Only if the court cannot identify the perpetrator to the civil standard of proof, should the court go on to ask whether there is a likelihood or real possibility that any of the people on the list, was the perpetrator or a perpetrator. Only if there is, should those people be placed into the 'pool'.

Threshold

60. In **Re J (A Child) [2015] EWCA Civ 222** Aikens LJ set out the following fundamental principles at paragraph [56] –

> *'ii) If the local authority's case on a factual issue is challenged, the local authority must adduce proper evidence to establish the fact it seeks to prove. If a local authority asserts that a parent "does not admit, recognise or acknowledge" that a matter of concern to the authority is the case, then if that matter of concern is put in issue, it is for the local authority to prove it is the case and, furthermore, that the matter of concern "has the significance attributed to it by the local authority".*
>
> *iii) Hearsay evidence about issues that appear in reports produced on behalf of the local authority, although admissible, has strict limitations if a parent challenges that hearsay evidence by giving contrary oral evidence at a hearing. If the local authority is unwilling or unable to produce a witness who can speak to the relevant matter by first hand evidence, it may find itself in "great, or indeed insuperable" difficulties in proving the fact or matter alleged by the local authority but which is challenged.*
>
> *iv) The formulation of "Threshold" issues and proposed findings of fact must be done with the utmost care and precision. The distinction between a fact and evidence alleged to prove a fact is fundamental and must be recognised. The document must identify the relevant facts which are sought to be proved. It can be cross-referenced to evidence relied on to prove the facts asserted but should not contain mere allegations ("he appears to have lied" etc.).*
>
> *v) It is for the local authority to prove that there is the necessary link between the facts upon which it relies and its case on Threshold. The local authority must demonstrate **why** certain facts, if proved, "justify the conclusion that the*

child has suffered or is at the risk of suffering significant harm" of the type asserted by the local authority. "The local authority's evidence and submissions must set out the arguments and explain explicitly why it is said that, in the particular case, the conclusion [that the child has suffered or is at the risk of suffering significant harm] indeed follows from the facts [proved]".

vi) It is vital that local authorities, and, even more importantly, judges, bear in mind that nearly all parents will be imperfect in some way or other. The State will not take away the children of "those who commit crimes, abuse alcohol or drugs or suffer from physical or mental illness or disability, or who espouse antisocial, political or religious beliefs" simply because those facts are established. It must be demonstrated by the local authority, in the first place, that by reason of one or more of those facts, the child has suffered or is at risk of suffering significant harm. Even if that is demonstrated, adoption will not be ordered unless it is demonstrated by the local authority that "nothing else will do" when having regard to the overriding requirements of the child's welfare. The court must guard against "social engineering".

vii) When a judge considers the evidence, he must take all of it into account and consider each piece of evidence in the context of all the other evidence, and, to use a metaphor, examine the canvas overall..

The role of culpability in establishing the threshold criteria in s31 CA1989

61. In **Re D (A Child) (Care Order: Evidence) [2010] EWCA Civ 1000**, Hughes LJ (as he then was) highlighted the objective nature of the threshold test, noting that –

'…it is abundantly clear that a parent may unhappily fail to provide reasonable care, even though he is doing his incompetent best'.

62. In **Re B (A Child) Threshold Criteria) [2013] UKSC 33** Lord Wilson said at paragraphs [30] and [31] that, when establishing threshold, there is –

'no requisite mental element to accompany the actions, or inactions, which have caused or are likely to cause significant harm'.

63. In **Re S (Split Hearing) [2014] EWCA Civ 25**, Ryder LJ held at [19]-[21] –

> *'[19] The term 'non-accidental injury' may be a term of art used by clinicians as a shorthand and I make no criticism of its use but it is a 'catch-all' for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and / or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of section 31(2).*
>
> *[20] The court's function is to make the findings of fact that it is able on the evidence and then analyse those findings against the statutory formulation. The gloss imported by the use of unexplained legal, clinical or colloquial terms is not helpful to that exercise nor is it necessary for the purposes of section 31(2) to characterise the fact of what happened as negligence, recklessness or in any other way. Just as non-accidental injury is a tautology, 'accidental injury' is an oxymoron that is unhelpful as a description. If the term was used during the discussion after the judgment had been given as a description of one of the possibilities of how the harm had been caused, then it should not have been; it being a contradiction in terms. If, as is often the case when a clinical expert describes harm as being a 'non-accidental injury', there is a range of factual possibilities, those possibilities should be explored with the expert and the witnesses so that the court can understand which, if any, described mechanism is compatible with the presentation of harm.*
>
> *[21] The threshold is not concerned with intent or blame; it is concerned with whether the objective standard of care which it would be reasonable to expect for the child in question has not been provided so that the harm suffered is attributable to the care actually provided. The judge is not limited to the way the case is put by the local authority but if options are not adequately explored*

a judge may find a vital piece of the jigsaw missing when s/he comes to look at all the evidence in the round.'

RELEVANT BACKGROUND

64. Both M and F were subject to local authority involvement as children.

65. M was removed from her parents' care at the age of 10 and placed in foster care, after experiencing neglectful parenting, physical abuse from her father and exposure to domestic abuse and emotional abuse. It is also recorded that M experienced sexual abuse, although the identity of the perpetrator is not known. Throughout M's childhood in foster care, and since, she regularly reported being pregnant and experiencing miscarriages.

66. M has reported that her father was a violent drunk and that she looked after her brothers as her mother had nervous breakdowns. The police disclosure includes more recent allegations of aggressive and abusive behaviour by M's father towards her. It was reported that she obtained a non-molestation order against him in 2016 after he assaulted her.

67. F was known to social services since the age of 12 in 1997. There were four referrals made between 1997 and 2010, all of which related to an unsafe, unhygienic home environment and the appearance of the children. F reported to Dr Adshead that his mother had suffered from depression as a child and his father had been away a lot when he was growing up. He said he had very few memories of his childhood owing to a traumatic experience at the age of 9 when a school friend died.

68. In around late May 2012 M became pregnant at the age of 15 which was confirmed by a pregnancy test completed by the school nurse in June 2012. M saw her GP and attended a consultation/counselling session at the Marie Stopes clinic in Town A. Following discussions with her foster carer, M attended two appointments in July 2012 to terminate her pregnancy. However, M also maintained for many years a false account that she had a baby daughter called 'Lily Gower', whom she said was born in February 2011, and whom she claimed died of Sudden Infant Death Syndrome (SIDS) at the age of 6 months. This account was provided regularly to the doctors who treated J as well as social work professionals. M also maintained this false account to F and to XYZ, as well as to F's mother, PGM. M insisted her account was true, in the

face of professionals' assertions that there were no records to confirm the child's existence. This account was maintained to professionals until her response document shortly after these proceedings commenced in October 2019.

69. In early 2016, before she met and commenced her relationship with F, M obtained a tattoo on her back depicting 'Lily'.

History of the parents' relationships

70. M's relationship history with F and XYZ has been at times almost impossible to discern. However, what is clear is that her relationship with both men, as well as with other men, has been complicated, convoluted and often overlapping.

71. In around March 2016 M and F met and commenced a relationship. Two days after they met M reportedly moved into F's family home, and it is reported that the parents separated and reconciled on a number of occasions.

72. In about July 2016 M became pregnant.

73. M reported (subsequently) that on 1 January 2017 F raped her.

74. On 8 April 2017 J was born. Very shortly afterwards the parents separated and M returned to live in her own property with J.

75. On 20 April 2017 M presented at the hospital with PQ, her new partner.

76. On 25 May 2017 M told the health visitor that J was now having his care shared between her and F as they have now separated.

77. On 13 July 2017 PQ was seen as M's partner by the health visitor, and he was seen at subsequent home visits until March 2018.

78. On 24 July 2018 M told the SW that she and F had resumed their relationship. However, by mid-end September 2018 it appears that the relationship between M and F was finally ended.

79. On 30 August 2017 M reported to police that she had been sexually assaulted whilst in her home alone with J by an unknown stranger.

80. On 16 September 2018 M reported she was in a new relationship with a man called RS, and in October or November 2018 M began a relationship with a man called TU.

81. M reported (subsequently) that in mid-October 2018 F raped her.

82. On 30 October 2018 F described M to the police as his "girlfriend". In November 2018 M and XYZ began their relationship, were engaged in early December, then separated in mid-December 2018.

83. M has reported (subsequently) that in mid-November 2018 F raped her.

84. On 7 December 2018 M alleged to the police that F had raped her on three occasions. However, at her request, F was not arrested or interviewed.

85. In January 2019 M and XYZ were reconciled, but on 30 January 2019 M stated that they had separated again and that she had only got engaged because she was drunk.

86. On 6 February 2019 M was reported to be in a relationship with a man called TU.

87. On 7 March 2019 M and F resumed their relationship for a very short period, and later in March 2019 M and XYZ were reconciled. In April or May 2019 XYZ moved into M's home to live with her and J.

88. On 30 July 2019 M reported that XYZ had hit her and that she had been staying at her parents' house to get away from him. However, on 31 July 2019 M retracted her concerns and said they had been misinterpreted.

89. From that point M and XYZ have remained living together and have presented as a couple throughout this hearing.

Summary of relevant medical history

90. J was born in 2017 at which point his parents were still living together at the home of the paternal grandparents.

91. On 20 April 2017, at the age of 14 days, J was taken to the GP by his paternal grandmother (PGM), who reported that whilst on the bus and J was asleep she saw that one of his arms and one of his legs were making twitching

movements. The GP referred J to the on-call paediatrician at Hospital A, where he was admitted as an in-patient until he was discharged home on 28 April 2017. During that admission J was under the care of Dr U, consultant general paediatrician. In evidence she confirmed the accuracy of the entry dated 20 April 2017 taken by a junior doctor at 10:50. After he was seen by junior doctors, Dr U was asked to review him clinically herself due to his age and concern about his presentation with possible seizures. She confirmed in evidence that the history of the death of an earlier child and the jerky movements in J had been given to her by one of two junior doctors, and that it had been the combination of those two factors that made them come and seek her out as the more senior colleague. Those junior doctors had picked up that this was potentially very serious. She was clear that the SIDS was a significant and relevant factor for the hospital staff.

92. She said in evidence that she has a clear memory of this case. She and her colleagues are always concerned about a very young baby and she explained that, understandably, parents are usually naturally quite concerned about children at that age if they are having jerky movements. Upon her review, she noted that the history was that M had a history of non-epileptic attack disorder (NEAD) and depression. She also gathered there was a history that M had had a previous child who had died from SIDS at 6 months. She said for parents in those circumstances they are, in her experience, quite understandably even more anxious.

93. She noted the reported jerking had been seen by the paternal grandmother and said it was M who was questioning whether or J had been jerky because of the heat, but that M also said that she thought J might not have had this episode. Dr U explained to M that the history was worrying because J was a 12 day old baby with jerking episodes, and she told M that she wanted to make sure they didn't miss anything.

94. On examination Dr U noted he was normal, but she also considered that the history of abnormal episodes of movement in such a young child was concerning for infection and/or an underlying metabolic or neurological abnormality which could have been evolving. She considered this was also concerning in the context of a family there had also been a previous child's death from SIDS. She therefore made a clinic plan for him to be covered for infection with IV antibiotics and to have bloods taken, including for a metabolic screen. He had an ECG and was admitted to the ward and an MRI of his

brain was requested. A plan for an urgent EEG was made and to plan a lumbar puncture. A plan was also made to consider anticonvulsant treatment if there were further episodes of seizure.

95. That evening Dr U had had a long discussion with the family who wanted to self-discharge J. M felt that he was back to normal and that the episodes were due to heat. She discussed the case with M, M's partner (PQ) and PQ's mother. Dr U stated that M felt she wanted to discharge J because he now seemed well and also intimated that PGM had made up about the seizures to stop M going to City B. Dr U discussed her concerns about possible infection and seizures, and said she felt J needed to remain in hospital in case of further deterioration, offering a variety of options including babysitting by hospital staff. Dr U also explained to M that the results of the MRI report, which had suggested a possible microbleed/developmental venous anomaly, increased her clinical concern at the time. However, the family remained adamant they wanted to discharge J. In the end, Dr U explained the risks were unknown and she felt she would have to refer to the local authority if they did leave. Ultimately, M then agreed for J to stay overnight and there were no further issues. J was reviewed the following day during a ward round. There had been a documented episode of jerking, but otherwise he was stable. He continued on his antibiotics and a plan was made for a lumbar puncture and to discuss his case with the Hospital B neurology team.

96. In her oral evidence Dr U said she had felt there was some underlying tension to M not wanting to stay in hospital. She felt it was important to document in the records that M was not giving her the answers that she would necessarily expect. She said M was giving her slightly unusual answers. She confirmed that her notes are contemporaneous, namely that she writes rough notes during the clinic appointment or consultation while the child is in front of her, then later types those notes up into a letter. She was quite clear that the source of the information or history at this appointment was M. She made referrals for a sleep study and for a glaucoma check. She could not recall in evidence what the purpose of those referrals was, but thought it was because they were requested or required or recommended by Hospital B.

97. The nursing notes from this admission raised concerns regarding the parents' hygiene, sterilisation of bottles and possible lack of interaction with J. There were also concerns regarding the home environment, which delayed J's discharge.

98. On 21 April 2017 Hospital A contacted the paediatric neurology service at Hospital B with a request for advice about J. The referral stated that J had been admitted the day before aged 12 days old having been presented to have had 3 episodes of jerking/twitching of his arms, lasting for 1-2 minutes. He was also reported to have had some episodes with a change in his breathing pattern accompanied by some unusual leg movements. These episodes were reported to have occurred while he was in PGM's care. The report also stated that J's older sibling had died at the age of 6 months due to SIDS. M was noted to have a diagnosis of non epileptic dissociative seizures, and the PGM to have a diagnosis of epilepsy. J was documented to have a normal neurological examination, a normal EEG and an MRI scan reported as demonstrating a tiny hypodense region in the L cerebellar hemisphere. It was considered by Hospital B staff that it was unclear if these episodes were epileptic seizures, and that it was more likely they were more suggestive of a benign sleep myoclonus. It was therefore recommended that if further episodes were witnessed, samples should be taken for toxicology assessment.

99. On 23 April 2017 J was commenced on phenobarbitone pending outpatient review and follow up at Hospital B.

100. It was agreed that J should be followed up by Dr L in the Hospital B paediatric neurology clinic as he provides an outreach service to the East County area. Dr L is a consultant paediatric neurologist currently based at Hospital B. His scope of practice includes acute neurology, management of epilepsy in childhood, complex motor disorders and neurorehabilitation following acquired brain injury. He has been a consultant for four and a half years. Review appointments were fixed with Dr L for 5 June 2017, 3 July 2017 and 14 August 2017, all of which were missed.

101. However, on 19 July 2017 the parents did attend an outpatient appointment with Dr SP, consultant paediatrician at Hospital A. It was reported to him that J had not had any further seizures since being discharged from hospital in April 2017. Dr SP therefore proposed weaning J off the anti-epileptic medication over the next two weeks.

102. On 11 October 2017 M called for an ambulance and reported that J had stopped breathing following a coughing fit. J was admitted to hospital overnight, and an ECG was performed.

103. On 6 November 2017 J was finally seen and reviewed by Dr L in the Hospital B paediatric neurology clinic. M told Dr L that for two months after J was weaned off phenobarbitone she had observed no abnormal movements, but that one month before the clinic appointment J had experienced an episode which she thought was a seizure – describing J's eyes rolling up accompanied by jolting in the arms and legs – which she had not disclosed to the hospital staff during J's October 2017 admission. M attended that appointment with her parents. F did not attend. M told Dr L that the events of 11 October 2017 caused her a great deal of distress as she had a previous child who died of SIDS at the age of 6 months. Dr L's examination of J demonstrated no concerns and no signs of a neurological disorder. Dr L was not convinced that the episodes described were seizures. During that appointment Dr L reviewed the results of the MRI scan taken on 20 April 2018 with M and explained that it showed only a very small micro- haemorrhage in the L cerebellar region which he did not think was of any significance.

104. On 7 November 2017 J was reviewed by Dr U, noted to be well on examination with no abnormal findings. An EEG and sleep study were arranged, which took place on 15 December 2017 and 10 January 2018 respectively and raised no concerns.

105. On 8 January 2018 M reported to NHS 111 that she thought J had had a seizure. J was brought to hospital by ambulance and was seen by Dr S, consultant paediatrician, who commenced treatment with carbamazepine medication, an anticonvulsant. Dr S made arrangements for a further MRI head scan, blood testing, genetic testing and follow-up in clinic by him and also by Dr L.

106. On 11 January 2018 J was seen at an outpatient appointment by Dr L at his Outreach Neurology Clinic accompanied by M and F. Again, the neurological examination was unremarkable. Dr L expressed caution about labelling these episodes as definitive seizures. He suggested continuing the carbamazepine as a pragmatic treatment trial and asked M to try to capture video recordings of events witnessed by her in order for them to be reviewed in clinic.

107. On 22 February 2018 a further MRI scan was carried out under sedation, which was normal. The genetic CGH analysis identified duplication associated with chromosome 22q11.2 microduplication syndrome.

108. On 26 February 2018 the mother reported to NHS 111 that J had a three minute seizure and was now jolting, for a further three or four minutes. He was taken to hospital by ambulance but discharged home later the same day.

109. On 13 March 2018 J did not attend the next follow up clinic appointment with Dr U who subsequently wrote to the GP, the family and Dr S and discharged him from her care.

Subsequent actions of the local authority

110. On 30 May 2018 EF, Head of Safeguarding Children at the Hospital Foundation NHS Trust, compiled a chronology of J's health records and co-ordinated the analysis of concerns arising from the chronology with Dr L and Dr S. Dr L and Dr S concluded that there was sufficient evidence of concerns to warrant a diagnosis of FII in J at Level 1, 'Fabrication of signs and symptoms, including fabrication of past medical history'.

111. On 23-24 July 2018 J was admitted to the Ward R at Hospital C to trial weaning him off his carbamazepine medication.

112. On 29 November 2018 Dr S, EF and the allocated SW, VW, told M at a meeting about the diagnosis of FII (M was accompanied by the maternal grandmother). Dr S recorded –

> *'The main reason for this appointment was to inform mother that all investigations towards diagnosis of fabricated induced illness was finalised and J fulfilled the criteria of fabricated induced illness. It was a difficult conversation but in the end we have agreed that J will remain under my care and I will keep seeing him annually and if there are other concerns raised by the family or social services I will be ready to see him in extra appointments out of clinical hours.*

113. On 24 January 2019 the HV, and VW, SW, made a joint home visit to complete J's developmental assessment. There was a

noticeable deterioration in all areas of his development other than in his gross motor skills.

114. On 5 February 2019 a Child In Need (CIN) meeting was held. M and F reported that J was biting, hitting and throwing things. However, they reported no further seizures since the hospital admission. At this point, VW was the allocated SW, and WX was her team manager.

115. On 20 February 2019 WX chaired a strategy meeting which was also attended by VW, a representative from the Police and EF, Head of Safeguarding. At that meeting EF queried why it had taken so long to convene the strategy meeting given that the information/chronology from Dr S and Dr L had been sent in July 2018; it was confirmed that although the hospital had sent the health analysis (she means the chronology), the LA had not been copied into the letter of 3 December 2018. EF recorded her frustration about the lack of activity and said there were many concerns at that time. The minutes of the meeting also record **C53** –

> *'EF advised she had sent VW the chronology on 28 September 2018 (on checking documents received, the documents EF refers to which have been uploaded to the system contains the draft watermark and are not signed and therefore were not considered as finalised confirmed documents).'*

116. This failure to act is a matter of great concern in respect of the local authority's actions.

117. At that meeting **C52** the multi-agency participants decided that as there had been no further repeats of J being presented at hospital with claimed fits, and there was a robust Child in Need Plan in place, there were no additional known risks that met the threshold to convene an Initial Child Protection Conference at that time, or to initiate care proceedings. WX noted that this was not a case that the LA would have closed and ignored due to the concerns and that J was being supported under a robust CIN plan. She recorded that this strategy meeting was a formality under the guidance.

118. On 26 March 2019 the HV, completed J's developmental review during a home visit. M reported that J had returned from

staying with F in dirty, inappropriate clothes, with a heavy nappy and with scratches to his arm.

119. On 28 March 2019 there was a further Child In Need meeting at which he was observed to be interacting with M and F appropriately.

120. On 9 April 2019 M told the SW (VW) that J returned from F's care with a bruise. This bruise was seen by the SW, but it was also observed that D crawled under the sofa and hurt himself in the same place on a metal bar.

121. On 16 April 2019 the HV carried out a joint home visit with a community nursery nurse to carry out J's 2 year developmental review. However, as M was not present, the full review could not be carried out.

122. In April or May 2019 XYZ says that he moved in to live with M and J. He said that M was J's main carer, although he would help out.

123. On 26 April 2019 AZ became the allocated SW (until 25 October 2019); she was supervised by BX, team manager, during that period. BX also commenced as the team manager in April 2019.

124. On 8 May 2019 a further Child In Need meeting was held. I have not seen the minutes of that meeting. However, there are sufficient references in the minutes of the Strategy Discussion held on 15 May 2019 to provide a flavour of the escalating concerns by professionals at that stage, as well as in the report by AZ dated 31 May 2019. AZ is recorded as having described huge concerns at that CIN meeting regarding J's emotional wellbeing. It was reported that J had been exposed to his parents being unpleasant to each other, and that M had been unable to control her emotions in front of J, shouting and becoming very emotional towards professionals and F. She was described as crying and shouting, and getting up and walking in and out of the room. J was described as not being distressed by this which was regarded as being extremely worrying to the SW and indicating that at 2 years old he was already normalising this behaviour. HV is described as having reported that at the end of that meeting F having stated that if J bit M, then she would bite him back. BX did not attend this meeting. In evidence she said that after the meeting both the SW and CW told her of concerns about the CIN not being progressed. She therefore took the view that the case should now be dealt with via the Child Protection route.

125. On 15 May 2019 a further strategy meeting was held although it is recorded as having been an Initial Strategy Discussion Meeting. This meeting was chaired by BX and attended by AZ, a representative from the Police, Dr S, the HV, EF (Head of Safeguarding) and CW, a SW assistant. The purpose of the meeting is recorded as being held for two reasons – *'There is a diagnosis of Fabricated Induced Illness and the family have been under a Child In Need plan for over a year with a lack of progress and increasing concerns regarding M's mental health'*. At this meeting it was unanimously decided the case should be progressed to an Initial CPC to be held on 6 June 2019 and that the LA should commence a s47 investigation.

126. On 31 May 2019 AZ completed her report for the ICPC. Her concerns about M can be summarised as follows –

a. Concern that M's need to be loved had taken priority over J's needs for security, stability and identity.
b. M's fixation with J being unwell and the need for medical attention is extremely worrying to the point that M has caused deliberate harm to J which could be long lasting.
c. M denies that she fabricated having given birth and losing her baby, 'Lily', at the age of 6 months to cot death, even though the lack of records suggests this is untrue.
d. M's numerous reports of J returning from F's care with bruising which had not been identified by any professional is extremely concerning.
e. M's lack of insight into how her ability to control her emotions in J's presence represent concerns about her capacity to protect him from emotional harm and to promote positive wellbeing.
f. Concerns that M has had multiple relationships to which J has been exposed when in the very early stages.

127. Concerns about F were limited to his capacity to protect J from any harm inflicted by M, and his poor, unhygienic home conditions.

128. There were also concerns about the long term impact on J of having received unnecessary treatment.

129. Those concerns were shared by the HV in her report to the ICPC dated 6 June 2019. At the ICPC on that date both parents attended, as did a representative from the Police, EF, the HV, and BX. AZ did not attend, nor did XYZ. It was recorded that M has reported she is pregnant with XYZ's baby. It was unanimously agreed that J should be made subject to a Child Protection Plan under the category of physical abuse and the members of the Core Group were identified as the parents, AZ, the HV, EF and Dr S. It was agreed as part of the plan that Dr S would be the lead professional overseeing the management of the FII element of the case and that he would review J's status on 9 December 2019. It was also agreed that Dr L would review J on 3 October 2019. It was agreed as part of the plan that AZ, SW, would see J at least once every 2 weeks to check on his welfare and to make ongoing assessment of the quality of his relationships with M and F, as well as to assess the quality of his physical living environment. It was agreed as part of the plan that HV, the health visitor, should complete J's two year developmental check on 12 June 2019, and thereafter would visit him once every two months to check on his health and development and to offer any advice or support to M if required.

130. Critically, it was agreed as part of the plan that J should not be given any medication or be the subject of any medical procedure that was not based on an assessment and diagnosis made by a qualified health professional. It was also confirmed that if any member of the Core Group was of the view that the risks to J's welfare were not reducing or were actually increasing, then the LA should seek legal advice to establish if the threshold for significant harm had been met and if so, whether it should be acted upon.

131. Both parents expressed their views to the ICPC. M stated that she had not maintained that J has seizures. M had also apologised to F for reporting to VW that J returned home from a weekend at his house with bruises. It was noted by BX that the SW (VW) had visited the home the following day but had been unable to see any bruises on J. M told the meeting that she loses her temper and was completing an online anger management course. However, M was also adamant that she had a baby who died at 6 months. She said she understood that there were no records of the death. She said she took a pregnancy test at school which was positive, and said that no matter what people say, she was still saying this happened.

Injuries to J

132. On 12 June 2019 HV made a further home visit with the community nursery nurse to carry out the outstanding two year developmental review of J. She observed marks to J – bruising to his L thigh (not thought to be of concern), a graze to his L elbow and a red block mark above his L elbow. M did not have an explanation for these marks. HV told M that the marks were unusual and a concern, and she informed the SW of the bruising that day. I have no difficulty therefore in finding that these bruises occurred to J and were plainly of such concern to the HV that she felt it necessary to report them to the LA, but I cannot go beyond that in terms of when or how or by whom they were caused. In oral evidence BX said she was never made aware of this referral, and to her knowledge no response was made by the LA to the health visitor.

133. The outcome of the developmental check identified that J was behind in his social and emotional development. HV made a referral to the Integrated Children Therapy and Co-Ordinated Team (ITACC) to determine whether this was environmental or developmental in cause. She also noted that J had difficulties with eye contact.

134. Less than two weeks after the ICPC, AZ carried out a home visit on 19 June 2019 at 17:30. She recorded that as soon as she arrived, M informed her that F had been harassing her since Tuesday. M showed AZ messages which stated how he missed her, asking her not to ignore him and how he missed his best friend. M's replies were minimal and to the point. M also reported that she had received a telephone call from F stating that he had received a phone call from AZ on 11 June 2019 stating that if M failed the psychiatric assessment that J would be taken into temporary foster care. AZ told M that she had not had such a discussion with F, although she did explain to M that part of the psychiatric assessment would explore whether she is mentally well enough to be able to keep J safe. During this home visit M told AZ that F had been saying that J was arriving at his home with bruises, and that F had been accusing XYZ of causing them; M stated that XYZ had not harmed J, and said that J falls over and bumps into things a lot. M said that F had accused XYZ a few times. M took J's tee-shirt off to reveal four fingerprint bruises – one in the centre of his back, and three to the left. AZ's record states – *'The bruising suggests he has been grabbed or held tightly'*. AZ

also recorded – *'Throughout my observations J did not go to M for any of his needs, and I did not witness an affectionate and nurturing relationship from M.'*

135. The analysis of the information received at this home visit was recorded by AZ as follows –

> *'It is concerning that from my observations J did not go to his mum for his needs to be met. M's expectations of J suggests lack of understanding of what is appropriate at J's age. M requires direct work focusing on exploring her understanding of J's needs to be able to grow and be healthy as well as being able to reach his full potential as he gets older. It is a worry the bruising on J's back appear to be finger print marks and their* [sic] *is still self-reporting of J being harmed.'*

136. AZ recorded her plan of action as being to speak to F about the bruising, and to contact the health visitor. In oral evidence, BX confirmed that she had seen no evidence in the case records that the SW had in fact spoken to the health visitor as planned, other than a week later at the CGR meeting on 26 June 2019.

137. The bruises were of sufficient concern for her to referred to them as *'worrying'*. However, it is impossible to go beyond that and make any finding about when or how or by whom they were caused.

138. In her oral evidence BX accepted that AZ did <u>not</u> discuss the bruising, or the outcome of this home visit with her at the time.

139. Seven days after that home visit, on 26 June 2019, the first Core Group meeting took place. Neither BX or XYZ present at that meeting. The meeting was attended by both parents, the health visitor, AZ and EF (Head of Safeguarding). At the meeting the health visitor gave an update about J's two year developmental check.

140. At the CGR AZ informed of her observations at the home visit on 19 June 2019. It was stated that at the time M told AZ that she had made HV aware of the bruising. This is not recorded in the case note of 19 June 2019. In any event, HV denied that she had been made aware of the bruising. It

was agreed that the SW and the HV should communicate any marks and self-reporting health issues with each other from then on, rather than accepting M's word.

141. On 15 July 2019 AZ had supervision with BX. There is only a single reference to general allegations of bruising now being made by M in these notes, and no specific reference to the bruising observed by AZ during the home visit on 19 June 2019. BX confirmed in evidence that the SW did not mention the bruising she had seen to J on 19 June 2019 four weeks previously.

142. BX said in evidence that she eventually found out about the issue by chance on 25 July 2019 when she overheard the SW having a conversation about the case with CW, the SWA. However, BX's note of the 25 July 2019 supervision still deals with the matter only superficially. The reason for this supervision was stated explicitly as –

> *'Discussion with SW in relation to bruising seen to J during a home visit in June.'*

143. The detailed notes state that the SW advised she had seen fading bruises which she thought might be grab marks about 4 weeks ago. In her evidence, BX said she had no memory of the context in which the SW had been shown J's bruises. During their informal discussion on this day, the SW told BX that she had spoken to M about the bruising at the time and that M had advised that J may have fallen although this seems unlikely. The notes recorded –

> *'Due to the bruising no longer being present, J being non verbal and unable to offer an explanation and M already having given her view on how the injury may have occurred, the decision is made not to hold a strategy discussion. SW reminded of the importance of discussing concerning bruising etc with her manager at the time these are observed in order to ensure all children are safeguarded especially in FII cases where there is the possibility of a parent or carer inducing illness or injury.'*

144. Although in evidence BX said she thought the reason the SW had not told her about the bruising was because she did not want to expose J to further 'over-medicalisation' by a CP medical examination, this is not borne out in the supervision notes of 25 July 2019. Those notes begin by placing the discussion in the

context of wider concerns being raised by the SW about aspects of the case relating to CW. There is no reference to any concern about over-medicalisation at all at that stage.

145. Later that morning, at 12:00, a further CGR took place as planned. Neither EF or BX attended that CGR which was attended only by AZ, HV and the parents. At this meeting the SW reported that on 15 July 2019 (during a home visit), M had told her J had been self-harming by pinching himself on his arms which had been seen by DT (the parenting worker). The SW reported that DT had confirmed she had not seen J pinching himself or hurting himself in any other way. At the meeting M denied this, stated that DT had seen this, and said she had specifically asked DT to contact the SW which she had failed to do.

146. It is stated by the SW (in her report dated 23 August 2019) that on 30 July 2019 M reported (although to whom is not clear) that XYZ had physically assaulted her. In her oral evidence, however, BX could not remember having had any discussion with the SW about this important issue. BX said in evidence that she accepted there are gaps in the SW files. In relation to this issue I found her to be an unhelpful and unimpressive witness.

147. On 23 August 2019 the SW set out some information about the bruising she had observed during the home visit on 19 June 2019, and the matter was then discussed at the Review CPC on 29 August 2019. The SW and EF both attended that CPC, but BX did not attend. Both parents attended, but XYZ was not invited and did not attend. The minutes of the CPC recorded that M had said F caused the fingertip bruising seen on 19th June 2019. It was also noted that M had removed herself and J from the family home in July 2019 when she alleged there had been a domestic abuse incident. However, M is noted in the minutes to have denied there had been any domestic abuse between herself and XYZ – she said they were *'play fighting'* but that because at the time it had hurt, when she spoke to the SW she did not see it as playfighting.

148. The minutes also noted the Chair's concern about the LA's failure to have dealt properly with the 19 June 2019 bruising –

'The chair raised concern about what was done when the bruising on J's back was seen on 19.6.19. In the report it concluded it may be due to rough handling or being grabbed. Was a strategy meeting held, a body map completed, discussion with management and the process followed (ie: to see a paediatrician)? Very mindful that previously mum has said there are bruises on her son, but they have not been seen. However, this has been described as fingertip bruising in an unusual place and currently unexplained. Given the diagnosis of FII we also need to ensure the procedures around this are considered.

AZ said that the matter had been discussed with management, although not at the time of the incident. The bruising was observed to be fading. It was decided by Team Manager to monitor to see if any other bruises appear as he was already on a Child Protection Plan and they were mindful of FII. M had stated that it was done by F when in his care, then stated it could have been done on the door of his toy cupboard.'

149. It was agreed that the SW would ensure a full body map was completed, and also that the Chair would raise with the team manager. It was also confirmed that should something arise in the future, the appropriate steps are taken.

150. On 9 September 2019 BX carried out a further supervision with the SW. She noted that this was provided given the concern raised by the CPC chair in relation to the issue. BX recorded as follows –

'The social worker accepts completely that in any other situation she would have spoken to me immediately to request a strategy discussion. We explored the reasons why this did not happen and AZ felt that this process may have resulted in a medical for J and she did not want to subject him to any more intrusive medical interventions given the FII diagnoses and unnecessary procedures that he has experienced which is abusive and the very reason for him being considered to have suffered harm. We explored that this may have been the case but just because of the FII diagnosis he could experience other types of harm and the usual processes are not superseded by the diagnosis. AZ is clear around the need for observations as well as listening to parents and is clear around the thresholds for strats in any case.'

151. It was agreed at the supervision that the body map was to be recorded and to be sent to the safeguarding health for the bruises. The body map, such as it is, appears then to have been completed. It is signed by AZ but is undated. However, it had clearly still not been completed by 9 September 2019 – which was almost three months after the bruising had been seen by the SW. It shows a single faded bruise in the centre of J's back and there is a reference to *'tiny faded bruising'* although it is almost impossible to see where these marks are placed or indicated on J's body. To say this body map is unhelpful does not begin to explain how inadequate this course of action was. As EF said robustly in the review CPC, as this was abnormal bruising, these injuries should have been checked with a paediatrician.

152. In her oral evidence, BX said that no other bruising to J was brought to her attention in the period June – October 2019, other than the 19 June 2019 bruising referred to above. However, she then conceded that she remembered CW, the SWA, noticing a bruise to J's cheek but deciding that it was not significant and that M had said it had been caused by J banging into a tree. BX accepted she could not remember exactly how she had been informed about this bruising, accepted there was no decision making record confirming the decision not to proceed with any investigation, and accepted that they *'probably should have had him medically examined'*. There is a body map dated 17 September 2019 but it is signed by AZ, not CW. It shows a bruise marked on the L side of the face situated vaguely under the outer edge of the L eye. It is described by the SW as *'blue/grey with red round the sides'*. Again, the body map is worse than useless. There is also a photograph of the bruise which shows that a large dark mark on the L side of J's face but nowhere near his eye.

153. If this bruise was indeed seen by CW, there is no explanation as to how it came to be photographed or drawn (inaccurately) on a bodymap signed by AZ. The fact that the bodymap is signed by AZ makes it impossible to find that she was unaware of this injury. It is therefore impossible to understand how in the light of the discussions at the CPC on 29 August 2019 and in supervision with BX on 25 July 2019 and 9 September 2019, she did not consider it important to raise the issue with her team manager. It is also impossible to understand how BX, for whom the issue of bruising became high on her alert list after the 25 July 2019 discussion with the SW, could not have known anything at all about this injury to a child on the case load of one of her supervisee social workers.

154. The local authority seeks no finding about this bruise and there is insufficient evidence to support any finding. **However, the issue raises important questions to be considered by the local authority in terms of child protection and management procedures.**

155. J had been made subject of a Child Protection Plan on 6 June 2019 under the category of Physical Abuse. He was seen by the SW during statutory child protection visits on at least seven occasions following that decision.

156. However, by the time J began attending nursery the following day on 18 September 2019, he had sustained or appeared to have sustained three separate areas of bruising which had not been investigated at all by the local authority. **Again, this issue raises important questions to be considered by the local authority in terms of child protection and management procedures.**

157. There is no evidence that the nursery was made specifically aware of these three incidents. On 4 September 2019 IJ and KL from the nursery visited J at home as part of their standard preparations for new children about to start at the nursery. The purpose of the home visit was to enable them to meet him with M, see his home circumstances and generally help J get to know them before he started at nursery. XYZ was present during that home visit.

158. On 16 September 2019 the nursery staff had their first contact with AZ, and the nursery chronology noted – *'Child Pro. Physical: FII'*. Beyond that shortnote, there is no evidence of any detailed information being given to the nursery by AZ.

159. On 19 September 2019 the nursery noted unexplained bruises to J's back and rear of thighs. The safeguarding incident form was completed by MN, J's key worker, who recorded that she observed the bruises at 2:30pm. She completed a body map on which she noted three small bruises to the middle of the L side of J's back and one small bruise to the upper rear R thigh; she noted that all four bruises were no bigger than a 5p piece and yellow/brown in colour. MN spoke to M when she came to collect J that afternoon. She recorded that M told her the bruises had been reported. MN asked her to explain what happened anyway, and M told her they were unexplained, they had happened while he was at his dad's.

160. It was recorded that the nursery would closely monitor J for any new bruises during every session when changing his nappy. There is no evidence that the nursery reported these bruises to the LA. **This issue raises important questions to be considered by the local authority and the nursery in terms of child protection and management procedures**.

161. On 24 September 2019 MN completed a Prior Injury Form which was countersigned by M. This form was accompanied by a body map which described three small scratches to the bridge of J's nose and a small bump to the centre of his forehead. The note provided by F was that the accident had happened the previous Friday.

162. However, later that morning MN noticed three further bruises to J while she was changing his nappy, this time to his upper rear thighs and buttocks. Again MN completed a bodymap based on her observations at 10:40 and completed a safeguarding incident form. The bodymap shows three areas of bruising. One small red/purple bruise (about the size of a 5 pence piece) was seen on the L upper rear thigh, and a similar sized bruise (blue/purple in colour) seen on the R upper rear thigh. A third small (2-3mm), yellow/brown bruise was seen on the L upper buttock. MN spoke to F that afternoon when he came to collect J, but he said he was unsure about how the bruises had been caused as J had been with M the previous night. Again the action recorded was to continue to monitor each session and to keep recording. There is no evidence that the nursery reported these bruises to the LA. **Again, this issue raises important questions to be considered by the local authority and the nursery in terms of child protection and management procedures.**

163. On 1 October 2019 the SW visited J in nursery. There is no record of what she was told by the nursery of the two episodes of bruising observed by them, or what action she proposed to take. If she had been told, there is no evidence that BX was informed by her. KL said in evidence that she remembered speaking to the SW that day. She also confirmed that no bruising was noted to J by the nursery that day.

164. On 2 October 2019 the nursery staff noted further bruising to the backs of both J's forearms which was unexplained, looked like possible fingermarks and which

had not been present the previous day. The nursery notified the SW team appropriately. However, no action was taken before the end of the day and therefore M returned home with J after nursery. It was M herself who sent photographs of the bruising to the SW about an hour after returning home.

165. On 18 October 2019 the LA issued care proceedings.

166. On 24 October 2019 J was made subject of an interim care order which remains in place to date. He is in foster care and has sustained no injuries since being in placement.

POSITIONS OF THE PARTIES

The local authority

167. This is a highly unusual case in which M accepts having lied about a critically important matter (the existence of the child 'Lily'), but denies having lied about almost all other matters. Her acknowledgment of the lie about 'Lily' is qualified.

168. The local authority has summarised the lies told by M as falling into seven categories –

a. Lies about the termination of pregnancy;
b. Lies about 'Lily';
c. Lies about her history of pregnancy and miscarriage;
d. Lies about J's symptoms and medical history;
e. Lies about FS and the use of social media;
f. Lies about the bruising to J; and
g. Other lies.

169. The local authority invites the court to make ten substantive findings of fact, and two other findings that relate to risk posed by M and F (Allegation 5 and Allegation 11).

170. The substantive findings sought by the LA relate only to the parents and can be summarised as follows –

Allegation 1 – M has fabricated to healthcare professionals that J has had seizures.

Allegation 2 – M and F have exaggerated that J may have had a microbleed to his brain.

Allegation 3 – M has fabricated an account of having a daughter called 'Lily Gower' who died at the age of 6 months from SIDS.

Allegation 4 – M has reported a large number of pregnancies and miscarriages, at least some of which were fabricated.

Allegation 6 – as a result of M's false accounts of seizures and having a sibling who died of SIDS, J has been subjected to unnecessary testing and procedures.

Allegation 7 – in the longer term, J was likely to suffer significant emotional harm where his life would have been medicalised as being an unwell child and where he would have been raised with a narrative that he had an older sibling who died at the age of 6 months from SIDS.

Allegation 8 – the parents failed to attend important medical appointments.

Allegation 9 – J was likely to suffer significant emotional harm due to the volatile relationship between the parents, which includes allegations made by M against F regardless of the truth of such allegations.

Allegation 10 – J was likely significant emotional harm arising from the instability of M's various relationships which are likely to leave him confused, as well as being exposed to verbal and physical aggression.

171. The two findings that relate to risk are Allegation 5 and Allegation 10.

172. Allegation 5 relates to M. The LA invites the court to find that her behaviours fulfil the RCPCH criteria for FII and warrant also the paediatric diagnosis made of

J in June 2018 of fabricated and induced behaviour at level 1: fabrication of signs and symptoms including fabrication of past medical history.

173. Allegation 10 relates to F. The LA invites the court to find that he lacks insight into the concerns about FII in respect of M which mean that his capacity to protect J from this is limited.

174. The remaining Allegation 12 was initially related to M and XYZ, namely that on or shortly before 2 October 2019 M or XYZ inflicted bruising to J's arms. However, at the conclusion of the hearing the local authority submitted that it is now possible to identify that it is more likely than not that it was M who caused those bruises. The local authority therefore no longer invites a finding that they were caused by XYZ, or that this is a case in which the identification of a perpetrator would involve the court straining to such an extent (or indeed at all) to identify a perpetrator, such that the only safe finding would be that there is a pool of possible perpetrators.

M's position

175. M denies all allegations made against her, save to the extent that Allegations 3 ('Lily' deception) and Allegation 8 (failure to attend appointments) are admitted to a qualified or limited extent. In respect of Allegation 3 (about the SIDS deception, M accepts that her account concerning Lily is untrue, but maintains that her social worker at the time made her have a termination. In respect of Allegation 8 M's position is that she has explained the situation so far as she can recollect, and on the basis of her explanation it is submitted that the allegations relating to missed appointments have no probative value in respect of the issues of FII.

176. In respect of Allegation 12 (the bruising), it is not M's case that XYZ inflicted the bruising. She maintains that the bruising could have been caused at the nursery, including by nursery staff.

F's position

177. F's case in relation to Allegation 2 (the microbleed) is that he has not exaggerated the significance of the microbleed such as to cause significant harm to J or to expose him to such harm.

178. In relation to Allegation 8 (failure to attend appointments) F accepts that he cancelled (to the best of his recollection) two medical appointments at Hospital B for J, including the appointment on 14 August 2017. However, he says that he cancelled this with M's knowledge and consent and sought to rearrange any other appointments that he cancelled. His case is that he does not accept that this is sufficient to ground a threshold finding, but will respect any finding made by the court.

179. In relation to Allegation 9 (parents' volatile relationship) F accepts that there were occasions when he and M argued and shouted in J's presence, including at the CIN meeting on 8 May 2019, which he accepts was poor parenting and potentially harmful to J. Again, he questions whether the available evidence as to the extent and frequency of arguing is sufficient for a threshold finding of harm or risk of harm attributable to F's parenting of J.

180. In relation to Allegation 10 (lack of insight) F's case is that it is unclear what act or omission on his part is relied upon by the LA in asserting that he has demonstrated a lack of insight into the concerns of FII and limited capacity to protect. He invites the court to consider carefully whether he has yet had a real opportunity to develop insight and invites the court to reserve judgment as to his capacity to protect J.

181. F advances no positive case against M and awaits the court's determination of the allegations against her.

XYZ's position

182. In respect of Allegation 12 (bruising) XYZ accepts the medical evidence in this case in relation to the bruising, namely that the likely mechanism is forceful gripping or from very firm or vigorous handling of his arms by an older individual, but that it is not possible to date the bruising. He now accepts that the bruising is unlikely to have resulted from swinging J in the air, or from J banging his arms against a table.

183. XYZ invites the court to conclude that there is insufficient evidence to support a finding that there is a realistic possibility that he inflicted the bruises on J.

184. His stated position in closing submissions is that although he has never seen M behave in a way which he believes could cause injury to J, he accepts that if the court concludes that the injuries were deliberately inflicted, and that there is no realistic

possibility that he is responsible for them, then a finding that M inflicted the bruising is inevitable.

185. In particular, it is his case that rumours circulating in and around July 2019 to the effect that he had physically abused M and J were the catalyst for a regime in which thereafter he was never left alone with J. That position is accepted by M who states that it was strictly enforced. There is no evidence to counter this account by either M or XYZ, nor was this point challenged during the fact-finding hearing.

The guardian's position

186. It is submitted on behalf of the guardian that the court may find, given the totality of the evidence in this case, that there is sufficient evidence to find that M has fabricated to healthcare professionals that J has had seizures, that she fabricated an account of having a daughter called 'Lily' who died of SIDS at the age of 6 months, that M has reported a large number of pregnancies and miscarriages, and that shortly before 2 October 2019 she inflicted bruising to J's arms.

187. The guardian also submits that it is open to the court to find that M's behaviour fulfils the criteria for FII and warrants the diagnosis made in relation to J in June 2018.

THE EVIDENCE

188. Taking account of all the evidence as a whole, my findings on the balance of probability are as follows (summarised in the attached Schedule of Findings Made).

ALLEGATION 1 - Fabrication of symptoms

189. The LA has particularised 10 different episodes in which it is alleged M has fabricated symptoms of seizures which were not observed by any other family member or professional.

190. Professor Fleming, instructed as an expert in these proceedings following application by M, concluded that the most likely explanation for the episodes in April 2017 was benign sleep myoclonus of infancy. The local authority indicated in its preliminary observations within the schedule of allegations that, having regard to the

divergence of view between Dr Birch and Professor Fleming and the relevant standard of proof required for the court to find that those episodes were fabricated seizures, it did not seek a finding in respect of April 2017. At the experts' meeting convened on 7 October 2020, Dr Birch expressed agreement with the view of Professor Fleming concerning the April 2017 episodes.

EPISODE 1

6 September 2017 – M reported to HV that J was having seizures approx. 3 times per week

191. HV is a health visitor. She has made one statement dated 18 December 2019. She also prepared a report dated 6 June 2019 for a child protection conference. She gave evidence at the hearing and I found her to be a clear, articulate and careful witness. She has been a health visitor for six years. She made her statement from the electronic records. Those records were disclosed during the hearing and I accept them as an accurate account.

192. She described a home visit to M on 6 September 2017 for which her note clearly reads that M reported J was having seizures, approximately three per week. In her oral evidence she confirmed that account.

193. By contrast, M's account of what she said to the health visitor on this date has been variable, self-serving and at times confusing and inherently inconsistent. For example, in her schedule response she said she did not report seizures as she had only observed absences at this stage but that what she had reported to the health visitor was what F told her he had observed plus the absences that she and PQ (her then partner) had observed and that collectively she thought this amounted to approximately three times a week. However, in her latest statement dated 3rd November 2020 she said she told the health visitor that F had told her that J was having seizures although she and PQ had only seen approximately three absences a week.

194. What is notable about this incident is that just two months previously on 19 July 2017 at the outpatient appointment with Dr SP M had reported that J had had no seizures since April. In evidence Dr SP confirmed that he had not been told that there had been any further seizures since discharge from hospital in April 2017 and it was clear to him that J's development was in the normal range . He was clear in

evidence that as a direct result of what he was told by M, he suggested weaning down on the anti-epileptic medication with a plan to stop it. It is highly unlikely that Dr SP would have made such a recommendation or come to that conclusion have he had been told in any way that J was in fact still having seizures.

195. Where the evidence of HV and Dr SP differs on the facts from M, I prefer their evidence. **I find that M fabricated symptoms of seizures on 6 September 2017**.

EPISODE 2

11 October 2017 – M called for ambulance and reported J had stopped breathing followed by a coughing fit

196. The telephone recording of this 999 call was played twice during the hearing and I have also read the transcript of the call very carefully. I have also considered the ambulance records and the hospital records of the subsequent admission.

197. The ambulance records note that the ambulance was called at 21:53, was at the scene nine minutes later at 22:02, was at J's side by 22:04 and then left the scene at 22:51. The notes recorded that on arrival J was found supine in bed, crying and moving all four limbs. M is described as having reported him having a non-productive cough for a week, and he was afebrile. She said he was heard to be coughing when he then went silent. She is reported as describing his chest not rising or falling, with breath sounds said to be absent. J was also described as having pallor. The ambulance records also described him as having had a seizure three days prior, and a possible vacant seizure that day. The ambulance crew saw no signs of any abnormal observations. No account was given to them of a seizure involving any description of jolting.

198. In the hospital records at 23:46 there is no account of a preceding seizure in the initial assessment. At 00:35 there is no mention in the history of a preceding seizure. At 00:38 J was described as very well alert and happily playing with his rattle on examination. In the discharge notification it was stated that J had been well on admission with no record of M reporting a preceding seizure on the date of admission.

199. Again, M's account of this incident in her various responses is variable. In her threshold response she said her recollection was that the ambulance did not arrive for

approximately 45 to 60 minutes after her call to the emergency services. However, in her recent statement she accepted on reflection that the ambulance arrived much more quickly than she had thought but she said it just seemed longer to her.

200. She was asked about the 999 call in detail in cross-examination and gave a detailed account most of which was completely fresh evidence. She said she went into J's room to check on him and he was completely silent so went over to him and found him lying on his back. She said she noticed his chest wasn't moving up and down with no sound coming from him which was unusual. She said she leaned into the cot over the side to put her ear near to his mouth standing on the bottom bar of the cot. She said as soon as she couldn't hear anything she instantly ran out of the room to get her mobile and sent a message to F. Then she went straight back into his room and rang 999; at that point nothing seemed to have changed. During the telephone call she said F phoned her on her house phone which was on a little shelf just outside J's room. Indeed the transcript does show that just a moment or two into the call an external phone was ringing.

201. The transcript also shows that M spoke to F and told him that J wasn't breathing. She said that when she leaned into the cot she didn't think he was breathing. She said she picked him up for the first time during the 999 call by scooping him into the crook of her arm with her mobile on the loudspeaker before she picked him up, and she was asked why she hadn't picked him up at that stage. She described how she didn't know what to do but said she saw his chest rising and falling. However, a moment later when asked to describe the colour of his face, M then said – for the first time – that it was hard to see what was happening because the lights in the room had just blown and she could only see vaguely what she was doing. She gave this as the reason why she could not describe if there had been a change in his face. There is no reference to the quality of the light at all in the 999 call nor that she was having any difficulty seeing J. Nor was this account given in the first part of her evidence in the hearing about going into the room and leaning down into his cot.

202. She was also asked to describe the position of her hands but was unable to answer. She said that eventually took him out of the cot, put him on the play mat in his bedroom during the 999 call. She also said at some point she moved J onto her bed in the living room but she didn't remember him being on her bed when the ambulance crew arrived.

203. Her account about this incident was confusing contradictory and self-serving, and was also notably wholly lacking in empathy in the way in which she described J. It is unclear how much she could see J's face in a room which was in almost total darkness and there was no mention of the light not being good enough in the 999 call in which M sounds largely able to articulate herself. The evidence she gave about the poor light in the witness box had not been mentioned by her previously, nor was there any mention of her leaning down into the cot and putting her ear to J's mouth. Even if such a manoeuvre was possible (which seems inherently unlikely), she did not then give a coherent account about why she didn't lift him out of the cot immediately at that stage and take him into the living room where she could have comforted him, checked him and seen him properly.

204. The fact remains that there is no independent corroboration of M's account that J had stopped breathing. Professor Fleming was asked to listen to the 999 call (although he had read the transcript in any event) and in evidence stated that although M was clearly very upset, it was also very clear that whatever had happened to J at the start of the call, by the time of the first rescue breath he was breathing. Ultimately all the tape confirms is that J was making no noise for the early part of the call but then was heard to be gurgling . Professor Fleming also observed that for most of the tape the action was <u>after</u> J was breathing. In summary, he could say nothing more than this tape was consistent with the baby not making a noise but he certainly couldn't put it any higher than that. He said in evidence that he has dealt many times with children where parents cannot tell if the baby is breathing or not. But he said that what M has described in this case is not to be characterised as a seizure. He also said that although M had described an apnoea, he could not say that one had occurred. He said babies can have 10 to 12 second apnoea episodes very regularly and in most circumstances it is not correct to say they have stopped breathing.

205. In light of the ambulance notes which do not indicate that J was presenting in anyway abnormally and in light of the lack of independent corroboration of this episode, M's account lacks coherence and credibility. **I find that M has fabricated symptoms of seizures occurring on 11 October 2017**.

EPISODE 3

On 6 November 2017 M gave an account to Dr L of J having had 'absent episodes'

206. There is a second element to this incident whereby M describes J's eyes having rolled up and his arms and legs jolted for about 30 seconds in the period after J had stopped breathing but before the ambulance crew arrived on 11 October 2017.

207. She described this incident in the appointment with Dr L on 6 November 2017. M said this had happened during the evening of the 11th of October before J was brought to hospital by ambulance.

208. However there is no record in the ambulance notes or in the hospital admission notes or in the hospital discharge notes the following day of any account being given by M of such seizure activity. In cross-examination M explained she had not described this account to the 999 operator or to the hospital because it already happened earlier that evening and she had other things on her mind. She accepted in evidence that she had, by contrast, been at pains to repeat the lie about the SIDS episode with 'Lily' to the ambulance crew and the hospital but had omitted to mention a very recent seizure. However, when she was asked to explain the conundrum she was simply unable to do so.

209. Her lack of explanation is just as important in evaluating the credibility of what she says as much as any account that she has given, particularly when it is considered in the overall pattern of her reporting. I must consider the totality of the evidence as well as the forensic detail of each episode. Her evidence about this lacked any credibility.

210. In evidence she denied having used the word 'seizure' to Dr L although she said it was a 'labelling' issue, rather than someone saying something she didn't say. However, she agreed that his account is something she reported that she saw. She said she very rarely uses the word seizure. She was quite clear she did not see arms flapping and flailing (which she said F had told her that he had seen) but reported everything else that she saw. She said however that she herself did not call that episode a seizure.

211. In his clinic letter following the appointment with Dr L he reported M having told him that his eyes rolled up there was jolting in the arms and legs which was not synchronous on the episode had probably lasted only 30 seconds. He reported M saying that this episode preceded the later event of J coughing in bed and then being found reportedly floppy and unresponsive by M. Although there is no reference to the word seizure, in evidence Dr L was clear that his recollection of the appointment was that M said she was concerned that the episode was a seizure. In his clinic report dated 30th of November 2019 Dr L does use the word seizure. He said M was the main historian although at times there was some confirmation by the maternal grandparents who accompanied her to the appointment.

212. In his evidence Dr L said he could not recall any reference being made in this first appointment in November 2017 events having been witnessed by the F but not by M. His clinic letter is dated 15 November 2017 and clearly describes two episodes being reported by M, firstly the episode where his eyes rolled up and accompanying jolting in the arms and legs, followed by an incident later that night where M found J floppy and unresponsive in his cot. Dr L was asked who reported the incidents to him and he was clear in evidence that they were reported to him as being observed by M.

213. It is right that there is a discrepancy between Dr L's contemporaneous clinic letter and his report dated two years later in terms of M's use of the actual word 'seizure'. Although Dr L said he did not believe he made a mistake, he did confirm in evidence that an accurate history is absolutely essential to his working practice and said he would have stressed to M the importance of providing a clear picture during that consultation. He confirmed that his usual practice is to make brief handwritten or electronic notes during a consultation then to dictate his clinic letter at the end of the clinic on the same day. He said that as he does his letters in the clinic room they are predominantly based on his recollection. His clinic letter can therefore be taken as a contemporaneous letter, not least because it refers in the first sentence to him having reviewed J in the clinic that day. He agreed in evidence that his clinic letter and the account given by M of the description of the jerking movements therefore represents the best evidence of what she said. He was clear that he dictated it on the evening of the consultation appointment and that it included everything important to M's description.

214. He accepted in evidence that a layperson may give a different definition of a seizure and he agreed that the term seizure is often used to describe a number of different things. He said that benign sleep myoclonus is not uncommon and it is not uncommon for that particular movement to raise concerns in a parent about seizures. By contrast his report dated 30 November 2019, which includes a reference to M saying that J had experienced an episode she thought was a seizure, is dated over two years later. I accept therefore the clinic letter dated 15 November 2017 represents the best evidence of what Dr L was told by M and where it differs to the later report, I accept the earlier letter as the most accurate account. I therefore cannot find that M used the actual word 'seizure' to report this incident when talking to Dr L. However, I do find and accept that the account given by M as reported by Dr L in the clinic letter is accurate and represents the best evidence of her account at that time, and it is quite plain that her account included a description of seizure-like activity.

215. In respect of this aspect of the evidence, M was inconsistent and variable in the extreme. There is no consistent or coherent explanation about her failure to mention something to ambulance and hospital staff that was so obviously important, namely the 'seizure' preceding the 'apnoea' episode. Taken in the round, M's account of the whole episode that she said had occurred on 11 October 2017 simply does not stand scrutiny as a cogent or credible piece of evidence.

216. By M's own account, this must have been a terrifying evening where she thought her baby had stopped breathing, followed by a jolting seizure like activity which she agreed in evidence was the first full seizure that she had seen. It is unthinkable that she would not have thought to tell the hospital about this shortly after arrival, particularly as the initial assessment at the hospital was no more than an hour and a half or so after the ambulance crew arrived at J's side and particularly in light of the previous recorded history.

217. The only reasonable explanation is that she has lied. **I find that M has fabricated her account of symptoms of seizures or seizure-like activity occurring on 11 October 2017 in her discussion with Dr L on 6 November 2017**.

EPISODE 4

7 November 2017 – M reported to Dr U that J was having 'absent episodes' once or twice a week

218. On 7 November 2017 J was seen in the outpatient clinic by Dr U. She is a consultant general paediatrician based at Hospital D. She has provided a statement dated 14 January 2020 and she gave oral evidence.

219. In evidence she confirmed that her habit is to take rough notes during a clinic appointment as the child is actually in front of her which she then types up into a letter. I have seen her notes and I have also seen her clinic letter which she confirmed she wrote that evening after the clinic, although it is not dated until 19 November 2017. I accept that letter as a contemporaneous account of the clinic appointment.

220. In that letter she refers to the fact that J had already been seen by Dr L at Hospital B. She reports the history given to her by M in the clinic appointment as including a description of J seeming to have have some 'absent episodes', whereby he would be well in himself but then suddenly seem as though he is staring with his eyes rolled back. She reported M saying that on occasions he could fall back and become unresponsive for around a minute, but will then come round and look as though he is playing. In her clinic letter, Dr U commented that these episodes sounded possibly too long in duration to be simple absence episodes.

221. In evidence Dr U said that she could not remember who had accompanied M to that appointment; although she thought maybe a grandmother, she could not now say which one. All she could say was that she saw M with one other person. Both PGM and M accept that it was PGM who was also present at this appointment. However, in M's recent statement there is a shift in emphasis from her schedule response. She now claims that she thinks PGM told Dr U during that appointment that F had seen seizures. She also claims that she thought PGM had reported how J was with them and that he had apparently seen seizures in addition to M calling J to inform him about the absences.

222. In evidence Dr U was unable to recall anything other than she had documented in her letter. She does not remember anything else about the appointment, including whether or not F said he had seen seizures. However, in evidence she agreed

that if she had been given a history of another parent witnessing episodes, she felt sure she would have documented the fact because she takes such comprehensive notes at the time. There is no reference in her clinic letter to corroborate M's recent account. I accept her evidence in that regard.

223. Although PGM could not discount the possibility, she could not remember telling Dr U that F saw seizures. In cross-examination she said that if F had seen seizures and told her about them she would remember. She was clear that she did not remember any such thing . She also said that if she had seen seizures herself she would remember that very clearly, but she does not.

224. In F's evidence, he said he could not remember telling PGM that J was having seizures or even what label he was using to describe any behaviour by J. Where their evidence differs from M in this regard, I prefer the evidence of PGM and F. M's statement is hearsay evidence which is uncorroborated to the required standard and on which I place only limited weight, not least because it has not appeared until much later in M's written evidence. It is a self-serving account that can only have been introduced to bolster M's case.

225. I also accept Dr U's evidence in preference to that of M. There is absolutely no suggestion in Dr U's written material or her evidence to support M's recent account that PGM described F seeing seizures. In cross-examination Dr U said she suspected she would have recorded alleged comments by PGM about seizures as she keeps detailed notes for most parents, and she said she thought she probably would have documented it because she wrote a reasonable amount of detail so they were obviously talking about it. She went on to say it was the main focus of the consultation, so again that made her think she probably would have documented it although she conceded she could not now remember the exact word wording three years down.

226. The only reasonable reason for the absence of any record of PGM having reported to Dr U that F had told her that he had seen seizures is because no such thing was ever said. I find that M has introduced this theme of evidence in her most recent statement in a self-serving way to bolster her own case and has been untruthful in that account. **I find that M has lied in her account to Dr U on 7 November 2017 that J was having 'absent episodes' once or twice a week, and that she also lied in saying that PGM had told Dr U these were witnessed by F**.

EPISODE 5

8 January 2018 – J was brought to hospital by ambulance with M reporting that he had been having increasingly frequent absence seizures and two seizures in which his whole body was jerking with eyes closed

227. It is the LA's case that on 8 January 2018 M stated that J had two seizures, the second of which was prolonged for more than ten minutes, and that she presented J as having had an escalation in seizures over the last three to six months.

228. Once again M has given conflicting accounts of this incident.

229. In her schedule response M stated that J had been with F for the weekend and that on his return home F reported to M that J had had seizures at the weekend also seen by PGM. M said that F had not taken J to hospital but that he had been eating and drinking fine. In that response she made no mention of any seizure having been reported or observed on the bus on the way home to her.

230. However, in her oral evidence M said that J had been with F at the paternal grandparents home over the weekend. She said that he telephoned her on the bus at about 11:00 to say that J had been twitching and having movements on the bus. She said she was concerned so she asked him if he was taking J to the hospital but that he said no because he thought it would be better for him to be with her. She asked him she said if anyone else had seen anything or if anything had happened that weekend. And she described how F told her that over the weekend J had been having twitching and jolting. She said he told her that PGM had also seen those movements over the weekend.

231. PGM was clear in evidence that she has not seen anything that could be described as a seizure since she observed the twitching in April 2017. Where her evidence differs from that of M in respect of factual matters, I prefer the evidence of PGM.

232. M went on to say in evidence said that F arrived with J at about 12:00 and she said she tried to get more information out of him about what happened but he said he had to go. She said J was asleep, that he seemed fine and that F was gone by about 12:10. J woke up soon afterwards and she changed him. However, she said that at about 13:30 she was in the living room with him watching TV when he fell back

onto the sofa and his eyes seemed to roll up. She said she tried to get his attention and rouse him but could get no response from him. She said he was not crying and his eyes would not follow her. She said his head then flopped to the right which lasted about five minutes before he came round a little bit. However, she went on to say that a few minutes later a similar thing happened again but it only lasted one or two minutes on that occasion. She said she was concerned about this so then called an ambulance at 14:16.

233. She said at the time that the ambulance arrived J was propped up on the sofa and she described him as having returned to a normal state . She said she went to the hospital with J in the ambulance and PQ went there separately in his car. She telephoned F while the ambulance was getting ready to take J to hospital. When they arrived she and J went up to the ward and were put into a side room. At first just she, J and PQ were in the side room then Dr S came in and she had seen him by the time F came in. She was quite clear that F was not in the room when she saw Dr S for the first time because he was off 'dealing with his girlfriend'. She said that Dr S and his colleagues started asking her questions and she explained what she had seen and described what F had told her over the phone. She said F entered the room as she was discussing what F had told her while he was on the bus. She said Dr S asked F what he had seen himself and she said she remembered F going into more detail about what had happened over the weekend and he had with her this included the part about J flapping and flailing but other than that she couldn't fully remember.

234. I have considered the transcript of the 999 call, the ambulance records and the hospital notes.

235. In the NHS 111 notes J's reported condition was described as being under investigation for epilepsy, that M thinks he had a seizure, that J had a head injury in the last seven days, and a fit or seizure in the last twelve hours. Under the pathways assessment it is stated that a probable fit within the last or previous twelve hours was the main reason for the contact. That document was created at 14:21. There is no reference whatsoever to M having reported a history at this stage of F having thought that J had had seizures at the weekend while in his care.

236. The ambulance crew arrived at the home address by 14:45, and they left the scene at 15:08. The onset of symptoms was described on the ambulance form as being

within the last 24 hours at 14:00 hours. J had a Glasgow coma score of 15 indicating that he was alert, he had normal pupil reactions and he was observed to be calm.

237. In the paramedic notes the history given by M was stated as follows to be that at 14:00 J had a 2 minute seizure, followed by another one at around 14:10. He was said usually to have absent seizures but that day he had become vacant, floppy and unresponsive, and he was slow to recover on one occasion. The ambulance crew described J as sitting up playing appropriately and did not appear post-ictal (meaning post-seizure) . He was said to be engaging and orientated. On examination all his clinical observations were normal he had eaten and drunk normally and there was no change described in him prior to the seizures. He was taken by ambulance to hospital accompanied by M.

238. The hospital notes show that he arrived at the hospital at 15:36 and was admitted as an inpatient under the care of Dr S on the children's assessment unit. At 17:30 he was transferred to the Ward R. At 17:45 he was seen by Dr S and a nurse called HR. Dr S is a consultant paediatrician based at the Hospital Foundation Trust. He has provided a statement dated 26 November 2019 which includes an analysis of the past medical history. He is the local professional with expertise in paediatric epilepsy. He has worked as a consultant paediatrician in the UK since 2011 although he previously gained his medical qualifications in Czechoslovakia and the Czech Republic.

239. There are various sources of evidence in relation to this consultation. First in time is a handwritten note completed by HR. This record was the subject of detailed forensic analysis during the hearing. HR however was not required by any party for cross-examination I therefore accept the evidence of this handwritten note as unchallenged. Indeed M accepts that the account is accurate and invites me to accept it in full. This record notes that the history was taken with Dr S and that the source of history was 'mum and dad'. The history includes a record that for the past six months 'mum and dad feel as though seizures are returning'. It is submitted on behalf of M that this should be accepted as evidence that the history was taken throughout the consultation from both M and F. I shall return to this shortly.

240. The history gives an account of two periods of apparent seizure activity. The first lasted for about 5 minutes and is noted by HR as being that J

was sitting that day with M was floppy when his head fell back, his legs were twitchy and making small movements. M accepts that she said everything reported in HR's note as being what she herself described, except a part about J's arm flapping and flailing with strong movements which she says she did not see, but which F had told her about. The note then goes on to describe a second period of apparent seizure activity similar to the first, but lasting for about two minutes, with eyes having rolled back and J dribbling. Again M accepts she said this and she said it because this is what she saw for herself. M said in evidence that she saw Dr S for the first time in a side room on Ward P. She said she, PQ and J were there plus Dr S and his junior. She said F came into the room at the point that she was telling Dr S about what F had told her earlier that day. She said when she finished Dr S then asked F himself what he had seen and F answered. But she was clear however that apart from the arm flapping and flailing part which she attributed to F having told her he had seen she said she saw and described everything else herself.

241. Dr S gave evidence to me. He confirmed that the note to which I have just referred was written by HR who is an advanced nurse practitioner. He confirmed that he was present and asking questions while she was writing the handwritten record. He accepted that to have included the words 'mum and dad' as the source of history must have meant that both parents were present and were both answering the questions although he cannot now remember who told him that the seizures were returning. He thought however that the historical account was given by one person whom he thought was M, although he gave no reason for that.

242. The second source of evidence in relation to this consultation is found in the discharge notification which is a typed computerised form. That discharge summary includes a type section called *'Notes: 18:00 hours review by Dr S'*. Dr S confirmed in evidence that this was his plan and that he himself wrote those notes. This confirms that the consultation lasted for about 15 minutes, Dr S having written up his notes immediately after the clinic appointment ended. It was suggested to him that F did not see or report any account of spreading from limb to limb or the extremities. And he said that if F had said that he would have expected it to be in the notes. He described in evidence how he writes his notes. He says mainly he relies on his own recollections immediately after an appointment on this occasion he was quite clear that HR wrote her notes at 17:45 and he wrote his own notes after the consultation ended at 1800. He said that everything he recorded is part of what M told

him in that appointment. I accept that contemporaneous note as the best evidence of what he discussed and observed in the consultation that day.

243. Dr S's notes include a plan which included starting J on carbamazepine, carrying out an MRI head scan, and following him up in his clinic in three months. It was also part of the plan that J would attend a follow up appointment in the paediatric neurology clinic with Dr L. It was quite clear in evidence that he wrote that plan as is his working practice based on the history he was given. In this case he said he considered the case was important enough to include his own notes which is not what he typically does and he said this was to help in his further assessment. He said in evidence that this was a case where there was a history of a previous siblings death and history of seizures in the first three months of life. He said in evidence that all made him feel more vigilant in his considering his diagnosis.

244. Later that evening at 22:05 he emailed Dr L in order to alert him to the fact that he would be seeing J in a few days time in clinic. He set out the history and explained that J had started developing vacant spells which were now occurring daily. He then said that in the last several weeks J had also had focal seizures, the longest of which had lasted 10 minutes and that he had had two episodes that day. He set out the plan that he had devised and explained that he would arrange a follow up in his own epilepsy clinic.

245. It is plain and a matter of common sense that not every single word of every single medical consultation with a parent can be or will be recorded by medical professionals. Dr S explained, as indeed did Professor Fleming, that what is included in notes and letters very much depends on the purpose of the document; in other words, the person for whom the document is intended dictates to a greater degree the way in which the information is conveyed. Much was made in cross-examination on behalf of M of the fact that in Dr S's first email to Dr L that evening there is a reference to J having started a twitchy movement of his right leg and twitching spreading to all extremities. I find it likely on the balance of probabilities that this was information that was provided to Dr S and HR during the consultation attended by M and F. I find nothing necessarily sinister about the fact that some information was included in the email written a couple of hours later between from one doctor to another but not having been included in the handwritten notes by a

senior nurse practitioner nor included in Dr S's discharge summary note. I found Dr S a clear and frank witness, and I accept his evidence.

246. Dr S was also asked at length about differences in the length of time of seizures between the notes, namely that while in HR's handwritten note stated that the first seizure lasted up to five minutes, in his own note in the discharge summary he referred to it having lasted for ten minutes. He attributed this to a transcription error, but explained again that this is a matter of common sense that was most probably caused by being under work pressure that day. I accept his evidence. For these purposes, however, the critical point is that he confirmed that the exact length of time does not actually make any difference for diagnostic purposes. He went on to confirm that when all the notes are taken together and read as a whole they also do not make any difference to his clinical assessments. I found him a frank and helpful witness who was quite open about the less than optimum accuracy of some parts of the notes, but I place that in the realistic context in which busy medical professionals work every single day. The most important elements of this part of the evidence relates to the impact or the lack of impact on his overall diagnosis. Nothing critical turns on these differences and in the end it matters not.

247. He was also asked in detail about exactly who was present during the consultation and who said what. He described M saying she had seen absences on and off for a couple of months and then told him what had happened that day. She said there were two episodes very close in time. He was cross examined about the fact that in his later statement he describes a single event when plainly his contemporaneous notes refer to two events. Although he initially agreed in evidence that what he was told on the day was a combination of what M and F had seen, he then revised his opinion and confirmed that he really could not recall anything that F had said in addition to M. However, on reflection he thought when looking at the tone of the writing (by HR and his own notes) that it must have been M giving this account. He also accepted in cross-examination that if F had made a contribution of significance about the seizure behaviour he would have expected it to be noted.

248. However, it is clear that he does not now have a clear recollection of the meeting which is why he relies on his contemporaneous notes. He has no recollection about what F said additionally to M but he thought and considered that his use of the word *'today'* meant that it was M who told him.

249. In evidence F said that M would be the more sociable and outgoing of the two of them. He said that appointments with doctors and professionals make him nervous and so he tends not to do the majority of the speaking. He finds it particularly difficult if he is talking to professionals if he has not met them before. He described how a big part of the problem for him is if a strange person is asking him something seriously and quickly and it becomes even more inhibiting for him because he has no time to process the information. He was quite clear that unless somebody has specifically asked him a question then he will leave that to M.

250. I find it likely that this is what happened on this day during the appointment with Dr S when important and serious information was being obtained. The interview with the parents was relatively short at the end of the day. The presentation of both parents in the witness box confirmed that whereas M appears articulate and at times quite assertive, this is in marked contrast to F who appeared vulnerable and at times fragile and highly anxious. F described M as being the life and soul of the party and very sociable he agreed with that, whereas by contrast he is sensitive and quiet and M is much more confident. In addition F suffers from an extreme stammer which becomes significantly worse under stress. That was apparent at various points in his evidence.

251. I therefore find it much more likely on the balance of probabilities that it was M who took the lead role in explaining the history to Dr S on that day. F said that unless a professional was specifically asking him a question, in circumstances where he would try and interrupt, the professional would almost always cut ahead and leave him by the wayside. Those were his words. He gave the example of trying to leap in if something was said wrongly or mistakenly to the social worker and he described being cut off. To use his words, he was ‘discarded’. I don't think for a moment that if that's what happened with Dr S or nurse forward that there was any malign intent to make F feel discarded. But I do think it likely on the balance of probabilities that in a fairly quick consultation dealing with a highly stressful and upsetting event and where J had by then been at the hospital for several hours, it is most likely that it was M who provided the bulk if not all of the description of what had happened that day to Dr S.

252. In evidence F said that he was at this point seeing J most weekends. He agreed that J had been with him that weekend. He said he remembered taking him

back to City B on the bus. However in evidence he could not remember the details of phoning M on the bus or in fact whether he had phoned her at all or not. He thought it possible that he had phoned her. But he could not remember any detail of this. All he could really agree was that that he arrived at M's home then left shortly afterwards at about 12:10 on Sunday 7 January 2018.

253. Therefore by the time M telephoned for an ambulance the following day at about 14:16, J had been back in her care for almost 24 hours. F described how on 8 January he went to the hospital himself separately. Ultimately it matters not whether he was already in the room when the meeting with Dr S began. What is important is that F described M speaking to Dr S before he himself spoke and that she had already started to outline what I had told her over the weekend. He remembered Dr S then asking him about what he had seen but said he couldn't remember in full detail. He was taken to Dr S's first email to Dr L that evening to which I've already referred in which the word 'extremities' was used. He did not remember ever hearing or saying the word 'extremities' and said perhaps unsurprisingly that he would not have used a word he did not understand and has trouble pronouncing. In short he cannot remember the specific details of what he said to Dr S. I found his evidence in this regard somewhat confusing but ultimately frank. It is now two years later almost three years after this meeting and in that time F has been diagnosed with a condition that is considered possibly post traumatic stress disorder and he is on medication for extreme anxiety. In addition when I weigh in the balance his likely response to difficult or stressful situations in terms of his fluency I think it highly likely that he is genuine in that he can't remember what happened.

254. M was questioned about F's role in this consultation with Dr S. She said that F was just as worried as she was about the seizures. She agreed that what she had described was all a single episode that lasted up to five minutes. However she confirmed that the phrase arms flapping and flailing no twitching eyes closed were F's words not hers. She said in evidence that she believed that the her two reports of what she said and what F said have become intertwined into one, and she denied robustly that the entire history had come from her. Her position remained that the note of Dr S has conflated and mixed up parts of what she said and parts of what F said . But she also said both reports are wrong in any event . She denied that she said the phrase spreading to all extremities nor that she had said 10 minutes.

255. The local authority's case is that M gave almost all if not all of the history to Dr S on this occasion just as she had given the history to the ambulance crew and indeed to the 999 call before that. When I look at the totality of the evidence, where there is a factual dispute between M and F, then I prefer and accept F's evidence. Similarly, where there is a factual dispute between M and Dr S, then I prefer and accept the evidence of Dr S. The absence of any reference at all to previous events over the preceding weekend, whether reported by F or not, in the transcripts of the 999 call, the ambulance notes and the contemporaneous notes by HR, are highly relevant and supportive of the proposition that the only cogent reason for the absence of that material is because it was never said. The only reason the matter has been included in M'ss recent statement as a self-serving attempt to bolster her own case. The likelihood of F being able to give any sort of fluent account including using words such as extremities which he does not understand and cannot pronounce in light of his extreme stammer in times of stress during a short consultation at the end of an inevitably stressful stay in hospital is highly unlikely. It matters not whether F was there at the beginning of the appointment or came in after the appointment had started. What matters is that my observation of F in evidence throughout these proceedings including his obvious deterioration in fluency at times of stress make it inherently unlikely that he would have been able to interrupt the flow of discussion between unknown medical professionals and the more dominant character of M.

256. Taking account of the entirety of the written evidence in relation to this point, as well as the oral evidence of Dr S and F, I find that it is likely that the bulk of the history, if not the entirety, was given by M. I find that M fabricated reports on 8 January 2018 that J had been having increasingly frequent absence seizures and two seizures in which his whole body was jerking with eyes closed.

EPISODE 6

On 11 January 2018 M told Dr L that she had observed J having vacant episodes for a short period once or twice a day. She also described episodes during which J experienced behavioural arrest

257. In his clinic letter to Dr S dated 12 January 2018 he described the information given to him previous day by M at the appointment in the paediatric neurology outreach clinic. He reported that unfortunately since he had last seen J

there had been the emergence of some more events, including continuing to have perhaps one or two brief vacant spells on a daily basis. However he remained unconvinced that these were seizures. He also explained that M had told him perhaps more pressingly that J was experiencing episodes which generally started with a behavioural arrest before the development of initially intermittent and then more rhythmic jerking of the right leg which then spread up to the right arm and could also spread across to the left leg. He said he was told that typically these only lasted for one or two minutes although earlier in the week there had been an episode which lasted for 10 minutes and prompted attendance at the hospital.

258. Dr L was struck by the very striking difference between the two consultations in terms of the clarity of the account provided by M in describing reported episodes. In the second appointment on 11 January 2018 he said M gave him a very clear description of the events she saw J experiencing. He said in evidence that her description was much more suggestive of an epileptic seizure whereas before the second appointment his concern had been that M was misinterpreting J's movements as seizures which he thought would be very understandable given her accounts of a previous SIDS death.

259. So it was in that context that after this second appointment, having been given a much clearer description, he was then much more concerned that J may have been experiencing seizures because of the clarity of the account. However, he still continued to advise caution and felt that J should be admitted to hospital for observation. He said in evidence that he was quite clear at that second appointment the only basis on which to make a diagnosis of epilepsy was M's account of the events and he felt they needed more evidence before committing J to long term treatments. He had a concern that other professionals had not witnessed the episodes and felt that a period of observation would allow medical professionals to see them occur.

260. He was asked in evidence about what it was in M's description in the second appointment that he felt was clearer and he gave a very clear account; he said she used different words and told him that these were new and different events. She said they began with J stopping what he was doing jerking in an isolated way and then in a synchronised way. The jerking would then spread across one side of the body. She said his arms and legs were jerked together. He felt that such description was very suggestive

of a focal onset motor seizure. He asked her to clarify if J's arms and legs had been jerking together and she said yes.

261. Although he noted that he had discussions with both parents, he was quite clear that it was M who provided that description. His working practice is to make very brief handwritten notes during the consultation and then dictate his clinic letter within two hours of the appointment and certainly as soon after the appointment as possible. It was put to him that M had in fact told him that J was not having vacant spells on a daily basis, rather on a weekly basis. He agreed it was possible that he had made an error but his recollection was that she said daily and in any event he was clear that she gave him a more active description. I accept his contemporaneous clinic note as the best evidence of what happened in that appointment. Although he agreed in evidence that he had not written down explicitly that it was M who said it and he accepted in general terms that his memory could be faulty, he was also clear that he remembered it was M who gave the account and that she had directly witnessed events because he was struck by how much clearer her language was on this second occasion. He also confirmed that the vast majority of information came from M and did not remember F contributing much to the conversation. He said there were times when M looked to F for confirmation but that it was M who described the events as things she had herself witnessed. He said there was never a moment where he doubted that. He was asked about his impression as to who was the historian and he agreed that it was M who was effectively in the driving seat during the appointment.

262. He repeated that simple daydreams or absences in children are often in his experience over-interpreted by parents, but was quite clear that this is <u>not</u> what he was being told about in the second appointment. He said it was M's very clear description of jerking limbs and an event which sounded much more convincingly like it could be a seizure that he was being told about.

263. In her recent statement M confirmed that she did report vacant episodes to Dr L but at a frequency of one or two a week, not per day. She said the other seizures mentioned were those witnessed by F. She said she wasn't sure if it was F or her who reported those seizures but whoever it was certainly did not say that it was she who had witnessed them. In her evidence M said that Dr L was wrong when he said she had described having observed the seizures herself. She agreed that she gave part of the information described by Dr L in his clinic letter, including the

information about the vacant episodes. But although she agreed that it was she who had told Dr L about the episodes starting with it behavioural arrest which Dr L felt most likely to be focal onset seizures, she maintained in evidence that she said they typically only last one to two minutes.

264. In her evidence M described telling Dr L about what had happened on the day of J's hospital admission three days previously, and also what F had told her. She said she distinctly remembers looking at F for confirmation in case she got anything wrong. It was submitted on behalf of M that this should be taken as reliable evidence to support the credibility of her account. I disagree. All that can be said about this is that M was speaking and may or may not have looked across at F. It is not evidence of the inherent truth of what M was saying.

265. F agreed in evidence that he had been present but said that M did most of the talking about the incident on 8 January. This included saying what F told Dr S he had seen. He said M did most of the talking because it was easier due to his own limitations in talking out loud. However he was asked also if he described the episodes generally starting with the behavioural arrest as reported by Dr L. And he said he could not remember M saying that. He said that in any meeting involving him and M she would look to him for clarification and confirmation however this was not one of those sort of meetings.

266. It remains the case that M was describing another set of uncorroborated events. Where her evidence differs on the facts to F, I prefer his evidence. And where her evidence differs from that of Dr L, I prefer his evidence.

267. I find that on 11 January 2018 M lied when she told Dr L that she had observed J having vacant episodes for a short period once or twice a day, and when she described episodes during which J experienced behavioural arrest.

EPISODE 7

M falsely claimed she had ten recordings of J experiencing seizures (or similar episodes) on her phone

268. It remains the case that no recordings of J experiencing seizures or similar episodes have ever been produced by M or that fact being corroborated by any other

person. F said in evidence that he could not remember if he had sent M any videos of twitching or seizure like activity at all.

269. The simple issue arising from this allegation therefore is whether M has lied about having had such recordings. The local authority's case is that M has lied because there are no clips, M's account is uncorroborated and she raised the point about F having sent her video clips only very late in the proceedings.

270. M's evidence about the issue of the phone clips has been variable and inconsistent. In her threshold response M states that F sent her a number of recordings of J's reported seizures. She said she also took some video clips herself as requested by Dr S; however she dropped her telephone into the sink and the evidence was destroyed. She said she asked F for the clips again but he told her that he had upgraded his phone without backing it up and had also lost the video files. She denied that she had reported having the videos in an attempt to persuade medical professionals of their existence, and her case remains that she had some video evidence for them to consider as part of the investigation as she had been asked to do.

271. This remained her stated position in her most recent statement. In her oral evidence she said she didn't take very many photographs or video clips herself. She said she was sent video clips by F so she could show them to doctors at a medical appointment but her phone fell into the sink and she was not backed up. She could not recall if there were any further seizures after the phone fell into the sink although she did not think this was likely. It was put to her that this was an unfortunate coincidence and she agreed.

272. Dr S recorded on the evening of 8 January 2020 that he had been told by M that she had 10 recordings on her phone but that the phone had been damaged by liquids and she no longer had the recordings. Dr S's account of M having phone recordings is not disputed by M who confirmed this in her written evidence. She also said in oral evidence that her phone had been damaged and that the recordings were lost. It's unclear how many of the recordings were taken by her and how many by F. But what is important about this part of the evidence is that M does not dispute that she said this to Dr S.

273. However, within the bundle of evidence there is a note from the police logs of an evidential review carried out on 12 January 2018 in relation to a report of section of

the assault reported by M to have happened on 29 August 2017. That evidential review includes a reference to M's phone having been destroyed from acid damage. In evidence she denied that she said the phone had been damaged in this way. This is one of a multitude of examples of things reported by professionals in the papers that she says are wrong or only partially stated.

274. In evidence, M reiterated that she took video clips herself as requested by Dr S in 2018 but the evidence was destroyed. She couldn't remember when but felt it was early or mid 2018. However, she agreed in evidence that the reference by Dr S in his email to Dr L in the evening of 8 January 2018 to the fact that M had ten recordings on her phone must have meant that by that stage she had already taken the video clips or received them.

275. The discrepancy in her threshold response was put to her but she simply said she must have been mistaken in her threshold response. She said she took about three or four video clips which were relevant because they showed little movements by J of one of his legs (she thought the right leg) at a time when he was half-awake and half-asleep. She said there was one clip which looked like one of his eyes had gone a bit funny into a different direction but she since realised he's got a lazy eye. She could not say whether a doctor would think they were significant and she was unsure herself.

276. It remains the case that at the end of the fact-finding hearing the court is no clearer as to exactly what video clips M herself took, of what and when. It is also unclear why there is no backup copy which is difficult to understand in the modern age.

277. I have considered this part of the evidence very carefully which cannot be viewed in isolation from my earlier finding that M fabricated her account to Dr S on 8 January 2020. **I find that M falsely claimed she had ten recordings of J experiencing seizures (or similar episodes) on her phone in an attempt to persuade Dr S of the truth of her fabricated account that day.**

EPISODE 8

12 January 2018 - M gave account to SW of J having had two seizures on 8 January 2018 prior to being taken to hospital

278. The local authority's case is that despite the reassurance M had been given the previous day and Dr L's caution about not labelling a child of J's age with

a seizure disorder without appropriate confirmation, nonetheless M gave the social worker an account of him having had two seizures on 8 January 2018 prior to being taken to hospital.

279. I did not hear evidence from the social worker, AZ, and the only documentary evidence of this home visit is contained within in a broader chronology compiled by her within her written statement. It has therefore not been possible for this part of the evidence to be tested in cross-examination.

280. No contemporaneous case record of this note has been provided. Therefore, I only have available to me one side of the evidential picture in respect of this allegation and I consider it would be unsafe to proceed to make any finding based on only a partial picture of the evidence. **I make no finding in respect of this allegation.**

EPISODE 9

26 February 2018 - J was brought to hospital by ambulance due to M reporting he had experienced a seizure and jolting movements

281. The local authority's case is that there is a progression in M's case about this point between her schedule response in October 2019 and her witness statement in November 2020. The local authority submits that M's account raises questions about what time F came home and whether M sought medical attention at the time or only after what she claimed happened while watching a film with J.

282. In her threshold response M recalls that on this date J was again returned to her by F following a weekend visit. She said that F informed her that on his way to bring J home J had suffered a seizure. M asked him why he had not taken J straight to hospital and he told her that he thought it was better that he brought him home. M recalled being annoyed by this as she thought he just wanted to get away to be with his girlfriend which may have been the reason she did not take J to hospital.

283. In her recent statement she said that at some point after he was returned to her care, she was sitting on the sofa watching a film with J who was propped up, when his leg began to jolt and twitch. She said she tried to get his attention but there was no eye contact and then he went floppy. As a result she called 999 and an ambulance came.

She said J was not fully recovered by the time the ambulance crew arrived and because he was under two years old they said he needed to be checked over.

284. In her oral evidence she said she stood by that evidence. She was quite clear that F had told her that J's leg had been jerking and that he had been twitching, although she said that was all she could remember him saying. She also said that PGM would have witnessed this seizure. However, she accepted in evidence that F did not see the episode which led to her calling the ambulance and that she had mistakenly put this in her statement. She confirmed that it was she, not he, who saw it. She said it was a clear mistake for which she was very sorry but that she had made her statement without sight of the bundle and entirely from memory. She confirmed that when she called 111 for an ambulance she was reporting not what F said but what she had observed. She agreed that she told the ambulance a different account of what she had observed. She said she saw the seizure at about 13:10 and that J was still jolting when she made that call. She was advised to seek medical advice if it continued but said that he was coming round and she wasn't overly worried. However, she said that after she finished the 111 call at 13:25, J then had another seizure lasting about 3 minutes and he did not fully recover until the crew arrived.

285. The ambulance was called at 13:31, was on the scene by 13:36 and left the house at 14:03, arriving at hospital at 14:29. The record shows that M accompanied J. The Glasgow coma score is stated as 15 at the time of 13:40 meaning that J was fully alert and with no abnormal presentation symptoms just 15 minutes after the 111 call was made. The observations on examination by the paramedics were that there was no obvious injury, no vomiting and no active seizure. M was described as reporting that J had not returned to his normal self completely yet whereas normally he would have. The plan was made for him to be transported to hospital and M travelled with him.

286. I have considered the transcript of the 111 call, the ambulance records and the hospital records relating to this incident. There are obvious discrepancies and inconsistencies between M's account and the forensic evidence from the hospital and ambulance crew. In the ambulance records the presenting problem is described only in terms of J having been limp and floppy seizure for three minutes, followed by a period of jolting for a further three to four minutes. The outcome of the 111 call record states quite clearly that J's reported condition was a seizure for three minutes now

jolting. There is absolutely no reference to J having had an earlier seizure that day in either record.

287. I have also considered the initial assessment nursing notes which include a record by a nurse, LQ, at 14:48 hours. This was made less than 20 minutes after arriving at hospital. The account is stated as having been given by M of a three minute seizure at 13:00 when J went floppy, was not breathing for less than one minute and was slightly pale in colour. There is no mention in this account of any seizure being observed in F's care earlier that day.

288. On the following day, 27 February 2018, M called 111 again at 15:50. The presenting problem was this time described as being related to J being lethargic and thirsty with diarrhoea. The important aspect of this record is that the history of the previous day's events were stated as J having gone to hospital the previous day after a seizure. These notes therefore contain only a reference to a single seizure and no reference to an earlier seizure observed in F's care earlier on the previous day.

289. In evidence M said that both F and PGM returned J to her on 26 February 2018. She said that F had telephoned her on his way to say he was concerned because J was jerking in his pram on the bus and over the weekend, although she said she could not now remember the specifics of the conversation. She thought they had returned at about noon. However, she was adamant that F did tell her that J had had a seizure on the way home. She said it was the late morning or early afternoon. When she was asked about why she had not told either the 111 operator or the ambulance crew about the earlier seizure she said later that J had experienced in F's care, she simply said that she could not remember why she did not bring this up. She categorically denied that this was an occasion where she had fabricated a seizure.

290. In evidence F was asked about what he could remember of this day and said quite frankly that he could not remember much of that February due to having been on strong medication after an operation to remove his appendix. It was not put to him that he was lying or being untruthful about this episode.

291. Again this is an account where there is no independent corroboration of M’s account. F cannot remember anything about the incident, and PGM was not asked about the episode in terms. As already stated above, PGM’s evidence was quite clear that the only twitching or seizure-like activity she had ever witnessed was in April 2017.

292. The evidential picture is therefore quite clear. There is absolutely no reference to an earlier seizure incident asserted to have happened just an hour or two before M called the ambulance in her history to the hospital in the notes of the 111 call or the ambulance history taken from M at the house that day. There is no reference to J having suffered two seizures in the hospital review notes at 17:10 just before he was discharged. In the further 111 call the following day, M made no reference to an earlier seizure having happened on the previous day. There is no independent cooperative evidence to support J having either one or two fits as reported by M. **I find that on 26 February 2018 J was brought to hospital by ambulance due to M falsely reporting he had experienced a seizure and jolting movements.**

EPISODE 10

6 March 2018 - M falsely told HV that J had a seizure which was witnessed by staff during a recent stay in hospital

293. Again M's evidence about this point has been confusing and unclear. In her threshold response she denies having said this, yet in her recent witness statement she said this 'relates to a conversation she had with the health visitor' on this date. However her further answer is nonsensical and simply says there was one occasion which stands out in her mind when J was in hospital what might have been a seizure which staff may have witnessed was in April 2017 but that she is not sure that this is the context of this allegation. Frankly, her written evidence is incoherent and makes absolutely no sense at all.

294. In her oral evidence M denied that she said the hospital had witnessed a seizure, and changed her account to explain that she thought she said that J may possibly have had a seizure. She thought that this was another example of a recording by a professional that someone had got wrong.

295. By contrast, the health visitor, HV, gives a very full and detailed description of her attendance at the family home on 6 March 2018 for J's one year developmental review. She saw M at home with J. M told her that she had recently had to call an ambulance as she could not rouse him although when the ambulance arrived he woke up and set up. M told her that J had had a seizure during his stay in hospital that staff had witnessed. She also told her that J was under a paediatric

consultant, Dr S, who had prescribed carbamazepine as a temporary treatment for possible seizures. This medication was not started until the appointment with Dr S on 8 January 2018 and confirmed at the clinic appointment with Dr L on 11 January 2018. It must therefore follow, and M confirmed as such in cross examination, that any account or treatment referring to the administration of carbamazepine could not have any relevance to episodes in 2017, and could only relate to episodes witnessed after January 2018. As a matter of logic, M's proposition relating to April 2017 cannot be correct.

296. In cross examination on behalf of M it was put to the health visitor that M did not say that which is reported. It was also put to her that she was talking about the current context rather than any hospital admission in 2017. My impression of HV was that she was a clear articulate witness who made comprehensive notes about her contact with M. I have also seen her typed note relating to this visit which states that M reported that J did have a seizure in hospital which the staff observed. I accept her evidence. Where there is a factual dispute between M and HV, I therefore prefer the evidence of the health visitor. **I find that on 6 March 2018 M falsely told the health visitor that J had a seizure which was witnessed by staff during a recent stay in hospital.**

297. The following episodes relate to two other medical issues which it is alleged have been falsely reported.

EPISODE 11

10 July 2017 – M took J to hospital at 11pm complaining that he was screaming and inconsolable and concerned he had suffered bruising whilst staying with F

298. On Monday 10 July 2017 the hospital records report the reason for admission and the history of presenting complaint as being that M noticed unexplained bruising to J's torso, arm and leg after he returned from visiting F. It was also reported that although Calpol had been given J seemed to be in a lot of pain. M reported that J had gone to stay with F on Friday and returned at 13:00 that day (although the triage notes at 23:14 state that J had been with his biological father since Thursday). The notes stated M reported that since returning home that day J had been inconsolable and screaming, she had noticed marks to torso left side red and his leg looked blue. He was reported to be very unsettled and screaming in triage.

299. In her threshold response M stated that when F handed J over to her at about 13:00 he reported that J had been grizzly and crying that weekend and had got his arm/leg caught in the cot bars. M said she asked F if he had got J checked over but he said that he had not as he did not have the time or money to do so. She said that when J arrived back into her care she checked him and he did not present any concern save for some pinky red marks to the side of one of his thighs. Otherwise she said there did not appear to be anything to worry about and J was sleeping. M said her partner PQ returned home from work at about 17:00 or 18:00 and they discussed the incident. At that point M thought he looked the same as earlier in the day with no deterioration or progression in the marks noted but to be sure she called 111 who advised her that if J got worse or any information was observed then she should seek further advice.

300. M said that later that evening at around 20:00 or 21:00 J was unsettled and screaming and despite all her best efforts she could not pacify him. She and PQ took J to hospital by car. She also telephoned F to advise him that she was having J checked she accepted that the hospital did not observe any bruising. In her recent witness statement she adds nothing to this account.

301. In her oral evidence M accepted that the hospital report was correct in every aspect except that she denied she had said ‘inconsolable’ and wondered if that was something said by somebody else, She also denied having said that his leg had looked blue. She did however accept that there was no reason for J to have been taken to the hospital on that occasion. There is no evidence to support a finding that the notes were inaccurate in respect of these two points and where there is a factual dispute between M’s evidence and the hospital evidence, I prefer the evidence of the hospital notes.

302. It was put to her on behalf of F that she was trying to get him into trouble and that she had lied. She did not accept this but sought to characterise it as an example of a time when she had acted out of anxiety.

303. In his oral evidence the F agreed that he had handed J over to M and reported that J had been grisly and crying that weekend. He said after the handover he remembers having a telephone discussion with M about J getting his arms and

legs stuck in the cot bars. He agreed there was a genuine cause for concern by M on that weekend.

304. The clinical findings on admission were noted to be that there was no bruising or discoloration of note on examination. The registrar on call also reviewed J and could not identify any discoloration. The consultant on call advised that J should be discharged and referred to the health visitor for further review. The following morning at 07:27 he was examined and described as a healthy baby who was playful, pink and showing no sign of distress. Examination of his torso was normal with no bruising with the impression stated as being probable pressure marks.

305. I find that on 10 July 2017 M took J to hospital complaining that he was screaming and inconsolable and falsely concerned he had suffered bruising whilst staying with F. I make no finding about M's motivation in having done so. I do find that no bruising was seen.

EPISODE 12

11-12 October 2017 – M reported to hospital staff that J had been mimicking masturbatory behaviours and was upset that F had taught him how to do it. M has also reported this to SSD

306. During the hospital admission on 12 October 2017 at 00:35 a social history was taken from M. This stated that J lives with his mum and partner but sometimes goes to his F's house. The record continues *'mum today made mention that the child has recently been mimicking masturbatory behaviours and said that she is upset that his biological father has taught him how to do it'*. At this stage J was aged six months old. In the handwritten note completed by a consultant at about 10:40 the history is noted to include M stating that *'dad made joke while changing nappy'*. M conceded in evidence that this was a reference to a joke where PQ had said *'oh look J's tossing himself off'*.

307. In her oral evidence M stated that this record was wrongly recorded, and she denied saying anything like this. She said that it was said by PQ, her partner at the time. She said she does remember saying something to the effect that F could sometimes be rude but she didn't find it funny. She said it may have been the case that she mentioned it. She conceded that if she did say this then it might get someone into

trouble. I do find that the context of the comments namely made during a conversation about J having returned from his F was likely to have caused safeguarding concern to professionals hearing that information. I do not accept that M was telling the truth about her accounts that it was either wrongly recorded or that PQ said it, not her. This is another example of a self-serving and inaccurate account given by M in an attempt to bolster her own case. And it is yet more evidence of the fact that M will continually twist and turn in an attempt to conflate or confuse straightforward accounts.

308. In his evidence F said he was upset about the comment at the time in relation to why would somebody say it if it wasn't true. However he said after he had been reassured at a meeting by EF saying that J is not of an age to do it he felt better and he said now is not worried about it.

309. I found F's evidence worryingly minimalizing and missing the points about a comment that is clearly referred to as having been made by M during giving a history two medics at the hospital. It is hard to see what possible basis there could have been for anyone to say this such a comment.

310. I have not heard evidence from PQ.

311. The local authority submits that M's reporting of this behaviour by J during this hospital admission is yet another way in which M misreports and creates false stories about and around J. Not only did M report to staff that J had been mimicking masturbate re behaviour and that she was upset that the F had told him how to do it, but she also reported it to social services.

312. In and of itself, this incident might not satisfy the threshold but as I have previously stated, the court must consider the evidence in its totality. On 19 October 2017 the health visitor received a telephone call from the hospital safeguarding informing her of J's hospital admission which included a report that the staff reported concerns about M's behaviour with M discussing how J plays with his genitals and stating that he has been taught to masturbate by his father. The local authority's case is that this is all part of the way in which M reports something, then backs away from its attributes it to someone else before then reporting it again elsewhere.

313. I accept that analysis and find that this is another example of M seeking to evade responsibility for what she has said by attributing something reportedly said by her to

have been incorrectly stated or to have been stated by somebody else. The local authority's case is also that this is yet another example about J's wellbeing and safety being at risk as a direct result of M's fabrication and deceit. I accept that analysis. **I find that on 11-12 October 2017 M reported to hospital staff that J had been mimicking masturbatory behaviours and was upset that F had taught him how to do it, and that she has also reported this to the local authority.**

314. The local authority also submits that this is an important piece of evidence in relation to the F because it serves to underline the way in which F appears to have found it very difficult indeed to assert himself against the will of M. This was a good example as I have said of the F lacking proper insights into the malign intent of M. **However, this is a point more properly dealt with at the welfare stage and I make no specific findings about F in relation to this incident at this stage.**

ALLEGATION 2 - Elevating the microbleed

315. The local authority seeks a finding that M and F have each exaggerated the suggestion that a possible 'microbleed' was identified in J's brain (albeit subsequently not confirmed as a microbleed by Dr Stoodley), elevating this to a "significant bleed" and a "bleed on the brain" when there was no reasonable basis for them to believe this.

316. On 20 April 2017 J had an MRI scan which identified a tiny hypo intense focus which was considered may represent a microbleed or a small venous anomaly. Dr Stoodley, consultant paediatric neuroradiologist, was subsequently instructed as an expert in this case to comment on J's neuroimaging. He considered that the small area of low signal referred to in the clinical report in the left cerebella hemisphere is a slightly prominent vessel within the folial space over the cerebellum. He could see no abnormal vessels or any old bleeding related to this.

317. On 21 April 2017 Dr SP met the parents at hospital at 16:10 hours. It is clear that at that stage the MRI results had not yet been received because the MRI was only reported on the 20th of April 2017 at 5:03 PM (having been carried out at 12:27 pm that day). Indeed that is borne out by Dr SP's handwritten note in which he states that he and his team were awaiting further advice from the neuro team having discussed the matter with them. Dr SP is a consultant paediatrician at Hospital D and he wrote a report dated 15 January 2020 about his involvement with

J's care during that inpatient admission. There is no evidence in Dr SP's report of that initial meeting that he discussed with them the nature of the MRI scan results. His letter states that he told the parents or discussed with the parents that there were a few concerns with regards to his MRI which was linked to the neurology team at Hospital B and was not yet reviewed by the team. In the end the parents agreed to stay in hospital.

318. The following day, 22 April 2017, Dr SP reviewed J on the ward round and found that all appeared well. His antibiotics were stopped because his lumbar puncture test results were negative. He also started J on phenobarbitone. There is no reference in Dr SP's letter or reports of him having reassured the parents at that consultation that there was nothing to worry about with the MRI results because it appears that they were still not known at that time.

319. The hospital records handwritten records for 24 April 17 indicate that the plan was to continue to chase the review of the MRI results from Hospital B. It is clear that further attempts were made that afternoon to contact Hospital B to obtain the results.

320. On 24 April 2017 the health visitor, NP, telephoned M. M reported that J was still in hospital being investigated for fitting and said that she had been told that an MRI scan had shown that J had a cerebral bleed and that he was currently on anti-epilepsy medication. It is plain therefore that by that date the results of the MRI scan had been explained to M in some way although to what extent by whom and how and when is not clear.

321. The handwritten notes for the morning of 25 April 2017 state that it was explained to the parents that they were awaiting a plan from Hospital B's neuro department and again there is no further reference to the results of the MRI scan.

322. On 26 April 2017 at a ward round it is recorded that they were still awaiting a discharge planning meeting and that Hospital B had interest in reviewing J. However, on 27 April 2017 the plan still stated that Hospital B was to be chased and to plan a discharge planning meeting.

323. By the time of the discharge notification to the GP on 28 April 2017 it is clear that the MRI results had been notified to J's medical team because the results were transposed into the discharge summary. There is no indication in the discharge summary of any meaningful discussion with the parents about the meaning of those

MRI results. There is also no indication in the health visitor's records of any further discussion by her with the parents about the meaning of the MRI results following J's discharge from hospital before the full explanation subsequently given to M by Dr L on the 6th of November.

324. There was obviously some reference to the bleed at the 6 - 8 week review completed by NP on 25 May 2017 because it is reported that the ASQ (Ages and Stages Questionnaire) developmental assessment was completed due to a history of cerebral bleeds. However, although age appropriate development milestones were documented again it is not clear to what extent the parents were aware of the full and proper meaning of the MRI results at that stage.

325. Unfortunately medical appointments to review J at Hospital B were then missed for reasons that I will come on to shortly. The first review appointment was due to have been held on 5 June 17 but did not take place. The second review appointment was due to take place on 3 July 17 but again did not take place.

326. Although on 19 July 2017 the parents met Dr SP again with J in clinic appointment, in his letter dated 15 January 2020 he simply says that she noted J was not reported to have had any further seizures since discharged from hospital, that everything appeared normal and that as J had remained completely seizure free with normal development in examination he suggested weaning down on the phenobarbitone with a plan to stop the medication. Again there is no reference to Dr SP having sought to reassure the parents or indeed informed the parents of the MRI results at that clinic appointments. Although in Dr SP's letter to the GP dated 20 July 2017 the MRI results are described as showing a tiny hypo intensity in the left cerebellar hemisphere, there is no indication about how that was explained in a meaningful way for these parents.

327. On 13 July 2017 the health visitor, HV, completed a visit to M but once again there is no reference in her notes of any discussion about the results of the MRI scan on that occasion.

328. In the medical chronology provided by Dr Birch in her report dated 21 January 2020 there is a reference to a discussion between M and a social worker on 24 July 2017 at which Dr Birch reports M said the brain scan showed a cerebral bleed. Dr Birch's analysis within this chronology is that M exaggerated a possible microbleed

which was not significant. Later on in her report, Dr Birch relies on those reported comments by M to the social worker in July 2017 as well as M's comments to Dr L on 6 November 2017, in concluding that M was stating – wrongly – that J had been diagnosed as having had a large cerebral haemorrhage. Dr Birch's analysis is that M misrepresented what others had said falsely reporting or exaggerating diagnosis and test results.

329. However, I could find no record of the content of any social work discussion with M on 24 July 2017 to support such an analysis by Dr Birch. In any event, even if this meeting did take place, it fell in the period before the first full explanation was provided by Dr L to M on 6 November 2017. It follows that even if this is what M said to a social worker on 24 July 2017, and I am not satisfied that there is sufficient evidence to support such a finding, I do not consider this provides sufficient evidence to support a finding that M elevated or exaggerated a possible microbleed at that stage.

330. Furthermore Dr Birch makes absolutely no reference to F's involvement in any discussion that may have taken place on 24 July 2017, and so I consider there is also insufficient evidence to support a finding that F exaggerated or elevated the microbleed at that stage in any event. The local authority's references of the evidential basis to support this finding do not indicate any social work case record of this meeting on the 24 June 2017. There is no reference in the detailed chronology produced by EF of any social work contact with M on 24 July 2017. Neither is there any reference to a conversation by a social worker with M on 24 July 2017 in the initial social work chronology included within the witness statement of AZ.

331. The only reference to any event having taken place on 24 July 2017 is in the initial social work chronology in which it is stated that on that date J was admitted to Ward P after M reported jerking movements; it is said he was diagnosed with a bleed to the brain and was given a brain scan. Professor Fleming said in his report that he could find no reference in the medical notes too this admission or anything arising from this event. Neither can I. Nor is it referenced in the local authority's chronology.

332. It seems that there is therefore no evidence to support Dr Birch's assertion about what M said on this date and I therefore cannot find that a meeting took place on the balance of probabilities. At the start of the proceedings the local authority clarified that this reference was a typographical error and should have referred to the hospital admission on 24 April 2017.

333. On 14 August 2017 a third review appointment for J at the Hospital B paediatric neurology clinic was arranged but did not take place.

334. It was not until 6 November 2017 when the fourth review appointment at Hospital B finally took place and M was told by Dr L the full detail and meaning of the results of the MRI scan.

335. In the absence of proper evidence of exactly what the parents were told about the meaning of the MRI scan, I cannot find that they sought to misrepresent or exaggerate or elevates the meaning of the bleed in the period until that appointment with Dr L. There is insufficient evidence to support a finding that there was no reasonable basis for the parents to believe that this bleed was not significant until that stage. **I therefore do not find there is sufficient evidence to support a finding that M elevated and exaggerated the bleed by this stage or at this appointment with Dr L on 6 November 2017. Similarly, given that he was not present at this appointment, I do not find there is sufficient evidence to support a finding that F sought to elevate or had sought to elevate the bleeds by this stage.**

336. However, it is plain that M was reassured properly and appropriately by Dr L at that clinic appointment and I accept his evidence about what he said for the reasons already previously stated. Therefore any assertions made by the parents that this bleed was significant after the reassurance by Dr L on 6 November 2017 need to be considered very carefully.

337. At the appointment with Dr L M told him that she had been told by paediatric services at Hospital A that the MRI scan in April had demonstrated a quote significant bleed. I can find no reference to these words having been used or anything like that having been said by Hospital A. However, as already stated, neither can I find that there was any meaningful discussion documented with either parent to explain the outcome of the MRI examination.

338. In his interview with Dr Adshead in January 2020, F is reported to have given a similar account of J's difficulties to that of M, including emphasising to Dr Adshead on two occasions that J had had a bleed on the brain. Dr Adshead noted that this was despite F being told that the bleed was minimal and could not generate symptoms.

339. However, as already stated, F did not attend the first appointment with Dr L on 6 November 2017 at which the MRI scan results were described in detail by him to M and the maternal grandparents. It is also unclear whether F attended the follow up appointment with Dr U on 7 November 2017 because in her clinic letter she refers only to reports of the history given by M. In evidence Dr U confirmed that she had not documented who joined M at that appointment; she thought maybe a grandmother but could not say which one. All she could say is that she saw M and one other person and now has no recollection of the appointment other than as she documented in her clinic letter. I also accept F's evidence that after he and M separated earlier in 2017 he did not routinely receive medical letters in relation to J for some time. In any event there is no reference in Dr U's clinic letter of 7 November 2017 to suggest that the MRI results were discussed in detail on that date.

340. In Dr L's clinic letter following the 6 November 2017 appointment he made it clear that he reviewed the MRI scan and reported that M had had the impression that this demonstrated a significant bleed. He said he was able to show her the scan at the clinic appointments and explained that this had shown only a very small micro haemorrhage in the left cerebella hemisphere which he did not think was of any significance. I am in no doubt that Dr L's account in this clinic letter was accurate for all the reasons that already explained about the way in which he made his notes. He said in evidence that when he showed M the scan he told her it was an inconsequential bleed.

341. In his report dated 30 November 2019 he described the MRI scan as demonstrating a tiny hypodense region in the left cerebellar hemisphere. He said in this report that M reported having been told by the paediatricians at the hospital that the MRI scan in April had demonstrated a *'significant bleed'*. He said he explained to M that this was <u>not</u> the case and was <u>not</u> how the MRI scan had been reported by the radiology team at the hospital. He said in evidence that he placed the words *'significant bleed'* in his report in inverted commas and to denote that these were the words or words to that effect that were spoken to him by M; he said that this is effectively what he took M to be saying. He described how he accessed the scan during the appointment, showed M the area raised as a possible bleed and told her that it was not uncommon and there was nothing to worry about. He said in evidence that he thought she seemed quite relieved by that explanation and reassured by seeing the scan.

342. In her threshold response M said it was not factually incorrect to say that J had suffered a bleed on the brain, but in any event it was not her intention to elevate this; if she did so it was only in the use of her terminology as opposed to any intention to dramatise or cause harm.

343. In evidence M accepted that it had been Dr L who explained to her that the bleed was not as serious, said it was miniature and could go away on its own, and that he did not have any concerns. She said that after this appointment she was still concerned but not nearly as much as before then. She accepted that she did not really retain any concern after that that it might be having an effect on J.

344. She was then invited to consider the technician's report a month later on 14 December 2017 during J's EEG investigation which records that M said there was some bleeding on the brain due to birth. In evidence M said she believed that the microbleed was one of the reasons J had been referred for an EEG but said she could not remember the questions she was asked that produced that answer. She conceded in evidence that now she does not think that the microbleed is a neurologically significant thing for J.

345. I accept that at the EEG investigation on 14 December 2017 the record shows that M said J had some bleeding on the brain due to birth, but there is no evidence to support a finding that she elevated the microbleeds at this stage. It is indeed right to say that there was a micro bleed on the brain, therefore M was not in fact factually incorrect in stating this. I heard no oral evidence from the EEG technician and there is no other evidence in relation to what was actually said on this occasion. **I therefore do not consider there is sufficient evidence to support a finding that M sought to elevate or exaggerate the microbleed at this stage. It's also clear that F did not attend that appointment and I therefore also cannot make a finding that F sought to elevate or exaggerate the microbleed at that stage.**

346. The local authority submits that the microbleed is something which F has presented as serious and possibly linked to seizures. The local authority's case is that either F has not taken in or has rejected the medical evidence, or it may be that receiving it through the filter of M from the appointment with Dr L on 6 November 2017 he has received an unrealistic report of it.

347. F's case is that he was told at the hospital that J had suffered a micro bleed which he thought might explain his difficulties. F did attend with M at the second appointment with Dr L on 11 January 2018.

348. In evidence F said that they (meaning he and M) were told on 20 April 2017 that J had a bleed and that was why the hospital wanted to keep him in. He said they were told that it was a significant bleed that may have started the seizures and that the hospital wanted to do investigations to rule out any other cause for the seizures. He was clear in evidence that the words *'significant bleed'* what they were told by the treating clinician. He said he understood that meant a significant bleed and although he now accepts that there is no concern about this, he was very concerned until all the evidence was received from the experts. That includes the report from Dr Stoodley and Professor Fleming.

349. In evidence F confirmed that he did not have the scan explained to him by Dr L himself. He said that M told him what Dr L had said that the bleed was only a tiny bleed and not as bad as he thought.

350. However, he said he still wasn't told that it had disappeared or how serious it was or what damage it had caused. He also said M told him that Dr L still wasn't sure if this was the cause of the seizures. He said that at the end of his discussion with M he thought the bleed was still very concerning, and that he was not thinking that this was something he did not need to worry about. As already stated it is clear that Dr L did not say this to M. However, I do not think it unreasonable for F to have relied on what M told him about Dr L's interpretation of the MRI scan.

351. It was put to F in cross-examination that he had told Dr Adshead on 3 January 2020 that J had a bleed on the brain and that although the doctors had stopped J's medication they had treated him as if he had epilepsy and the bleed on the brain could have caused it through a kind of trauma. He confirmed that this in fact <u>is</u> what he believed at the time and he <u>did</u> think the bleed on the brain could have caused the epilepsy. He said it was something he was told during the hospital stay in April 2017 and after that he was not told anything different by any doctor. He was quite clear in cross-examination that he was never told that the bleed was minimal until these court proceedings. However, the definitive analysis of the bleed was not received until Dr Stoodley's report dated 25 June 2020.

352. In considering the entirety of the evidence in respect of this issue, I do not consider it unreasonable for either parent to have continued to maintain some degree of concern about the microbleed until receipt of all the expert evidence. That is after all why experts are instructed and invited to comment on issues in the case. The instruction of Dr Stoodley was not determined by the court as being necessary until 15 May 2020, and the fact remains that his definitive report (accepted by all parties) was not received until 25 June 2020. **I therefore do not consider there is sufficient evidence to support the finding sought by the local authority and I make no finding in this regard.**

ALLEGATION 3 - 'Lily' Gower

353. The local authority's case is that M fabricated an account of having given birth to a daughter, 'Lily Gower', on 24 February 2011, and who she claimed died of Sudden Infant Death Syndrome (SIDS) at the age of 6 months. M repeated the 'Lily' account to numerous professionals including doctors involved in J's care. M maintained this false account over several years, embellished it and persisted in it, in the face of professionals making it clear that no records could be found to substantiate 'Lily's' birth or death. After hospital records again confirmed that 'Lily' was not born, M protested that this was a *'cover up'* by Social Service, and reported that she had people who saw 'Lily' and could thus confirm that she was born. M falsely claimed that a previous social worker had told her that there were some records of 'Lily' being alive. M claimed that 'Lily' could have been verified by her previous foster carers but that the female carer had dementia and the male carer had died.

354. In her threshold response M accepts that her accounts concerning 'Lily' were not true, but she claimed that her then social worker *'made her'* have a termination. This remains her position.

355. Such an allegation against a professional is serious and warrants careful scrutiny.

356. The lie about 'Lily' is one of the most troubling aspects of this case. At face value it could be taken as a simple lie, told in a moment of panic by M who had experienced deep grief and emotional response to previous events in her life. In her oral evidence M sought to perpetuate an account that she was so far embedded in the lie that she could not now resile from it. However, the court does not necessarily need to concern itself with motivation or culpability, and the local authority's case is quite

properly limited in that regard. As the local authority puts it, at this stage it does not matter why M does what she does. The court can find that M told a lie, plain and simple, and let the matter rest there.

357. However, there are many concerning and significant matters arising from this part of the evidence that will have great relevance to the welfare stage, and I do consider it relevant to analyse this part of the evidence carefully and in some detail because the fact of the lie has a direct bearing on J's emotional and psychological wellbeing. I do find that the fact of the lie has caused J significant emotional harm. Firstly, because M has deployed the lie as part of his medical history which has created a false reality for him in medical terms. And secondly, because she has deployed the lie as part of creating a false actual or potential false emotional reality for J himself. Part of that lie has involved lying to J's wider family, including PGM, F and XYZ (the man to whom she is now engaged).

358. The lie has been robustly perpetuated for many years stretching back to at least November 2016 when M told a social worker that she had had a child die at the age of six months.

359. On 5 Jan 2017 she told her midwife who saw her memorial tattoo that there were no records of a birth, that it was a social services cover up. On 25 January 2017 she left a CIN meeting prematurely when professioanls were told of the lack of evidence about 'Lily's' existence.

360. It is of significance that all these accounts were given prior to J's birth. this means that J was himself born into a life where the false reality about his 'dead sister' was already established from the outset.

The false medical reality

361. The Oxford English Dictionary definition of *'lying'* includes *'to speak falsely, to be deceptive, and to convey a false impression'*. By the very nature of that definition, to lie requires an active state of knowledge on the part of the liar. If there is no active state of knowledge, then the person making the statement is operating under an honest belief and cannot be said to have lied. It follows that one cannot lie 'accidentally'.

362. In this case, M accepts she has lied about 'Lily'. I accept her evidence in that regard, and I have proceeded on the basis that she therefore had an active state of knowledge about her actions. I do not accept that she has lied 'accidentally'.

363. There are numerous examples emerging from the evidence of M having perpetuated the lie about 'Lily' to medical professionals. Having considered the evidence carefully, the only logical explanation for this is that M was indeed seeking to convey a false impression and to ensure that J was viewed as a child at higher medical risk by direct virtue of having had a sibling who had previously died of SIDS.

364. For example, on 20 April 2017 and 12 October 2017, both occasions when M gave a history of J's medical history to medical professionals, she included the history of having had a previous child die of SIDS as part of the history. In her evidence M said that when she went to the hospital with J, 'Lily' did exist and was very much alive in her own mind. She said it was something that she now deeply regrets saying but at that point that is what she believed and that is why she said it. She also said that on reflection at the time she had not considered the seriousness of what she was saying and what the consequences could be for J but now accepts that it clearly has had some sort of medical impact on him and that giving a false history has been unhelpful to J. These two propositions are inherently contradictory. If M truly believed in the truth of what she was saying about 'Lily', then she had no need to consider the consequences for J. If on the other hand she now recognises that she failed to consider the seriousness of what she was saying and the consequences for J, then that implies that she knew full well what she was doing.

365. M presents an intelligent, articulate and sentient adult. It is difficult to think of a more serious matter for a parent to tell doctors about than the death of a previous child. It is unthinkable that she could not have recognised in April 2017 the likely impact on treatment for her two week old baby of giving that account to medical professionals.

366. Although at various points in her evidence M sought to rely on her poor mental health, there is no evidence before the court to suggest that she was anything other than psychiatrically or psychologically normal at that stage or in some way acting as a result of not being in her right mind.

367. In evidence she said that somehow in her head she was saying what she needed to say to get the best help for J. However, and this is most telling, she did not accept in evidence that the impact of her false history about 'Lily' has in fact been as significant as people are alleging it to be.

368. She was asked in detail about that first visit to hospital with J on 20 April 2017 and in particular why she had included the SIDS as part of J's past history. She explained in evidence that everything she said had happened in her mind '*because of her mental health at that time'*. She said she gave the date of 2011 as being the date of the SIDS because that was the date she fell pregnant with *'her'*. It is important to record that at this point in the evidence M very clearly presented in was talking about 'Lily' as if she was a child who had actually existed and who was very real in her own mind.

369. On 12 October 2017 she repeated the SIDS account in the 111 call. On 6 November 2017 she saw Dr L for the first time, during which consultation she was still stating that J's incident caused her a great deal of distress because of the previous history of 'Lily'. I have already explained why I accept Dr L's contemporaneous note as the best evidence of what M told him during this consultation. He recorded in inverted commas that M informed him that this episode had caused her a great deal of distress as she had a previous child who died at six months of age due to sudden infant death syndrome (SIDS).

370. M's explanation for why she said this to Dr L was that she *'wasn't in the right headspace'*. In the absence of any medical or forensic evidence about what this actually means, I find that it is another example of M seeking to dissemble or confuse the detail of what happened. In evidence she denied that Dr L had written an accurate account of what she said. She said he hadn't used the exact words she used, rather that he was paraphrasing and making an assumption. In short, she denied that she had said it caused her great deal of distress because of the SIDS. She couldn't tell me that she remembered what she had said but she knew she hadn't said this. If M really believed in the truth of 'Lily' and the 'SIDS' at that stage, there is no logical reason for her to have denied feeling highly anxious about what that might mean for J. It would have been highly understandable for her to have told Dr L that she was distressed and there would be no reason for her to be so vociferous in her denial of his evidence about this. But she was at pains in her evidence to state that he had recorded this wrongly. The obvious and only logical inference to draw from this is

that she understands only too clearly what the impact of her having linked 'Lily' to J was for the doctor, and now seeks to distance herself from having sought to convey a false impression about that. In evidence she confirmed very clearly that she understood then, and understands now, that doctors do need a truthful account, and that without a truthful account there can be serious consequences for a child. She was able to give as an example a child being given the wrong medication as the result of an inaccurate medical history being provided.

371. Her evidence about her intention and motivation was confused and self-serving. For example, she said firstly that she did not tell Dr L about 'Lily' with any malicious intent and accepts she told lies, but not on purpose. As I have already outlined, the very nature of a lie requires active intent; it is not something one can do by accident. Later, she was clear that the doctors believed her and that she intended them to believe what she was saying about 'Lily'. She said she understood that for the doctors it did *'ratchet things up'* but denied that this was because she enjoyed the drama.

372. All the medical professionals who gave evidence shared the unsurprising view that the information about 'Lily' inevitably had a direct bearing on how J was then treated.

373. For example, Dr S confirmed that the fact of a sibling's death was relevant to his treatment of J because it was a significant consideration in establishing whether he might have inherited any gene or chromosome abnormality which could have caused the earlier child's death. Therefore the subsequent child in that situation is inevitably exposed to more testing so that medics can be sure that he or she does not have any chromosomal or genetic abnormalities.

374. Dr L described how in his first consultation with M she gave him the background history including the fact that she had had a previous child who had died at six months of SIDS. He clearly recalled that M expressed concern that J was now at the same age. So it was not simply the case in respect of reporting the matter to medical professionals that M was just conveying a false impression; it was also that she was attributing concern for J as a direct result of the false event. Dr L was in no doubt that M told him this, and he said he had no reason not to take it at face value. I accept his evidence completely. He is an experienced medical professional, but remembered this case particularly acutely because it was his first FII case. He said that

obtaining an accurate history from parents is absolutely essential to his working practice. He said the majority of care decisions and the choice of investigations is very much influenced by the information they receive from the family.

375. Likewise Dr U also said she had a clear memory of this case. She said doctors are always concerned about any very young baby reported to be having abnormal movements, but the additional history of a mother having lost a baby to SIDS at the age of six months would inevitably lead to more anxiety and scrutiny. She said this was one of the factors that made her junior doctors seek her out because they had quite appropriately picked up that this was potentially a very serious factor. She was in no doubt that the SIDS was an important factor.

376. Professor Fleming said in evidence that in fact it is extremely common for medical professionals to be provided with partially fabricated parts of a child's medical history. He rightly cautioned that it does not necessarily mean that such a parent will lie about other things and he was plainly experienced in having received information given in this sort of way. However, he said that in this case lying about something so serious does give him slightly more cause for concern. In evidence he explained that the context of the lie is relevant because when it is taken as part of a child's medical history it raises the level of concern on the part of medical professionals. Put bluntly, he said from a medical professional perspective it is well known that if there is a death from SIDS in an earlier child, there will be an increased chance of a subsequent child dying of cot death (whether due to socio-economic or medical factors). He was therefore unequivocal in his opinion that such a history would immediately and quite properly have raised concerns for the treating doctors. He explained the investigations in such a case would almost inevitably be more thorough and also that with a history of a previously unexpected death medical professionals would never just seek to send the child home it would immediately raise their cause for concern.

377. I accept those multiple opinions. It is abundantly clear that Professor Fleming's opinion was borne out in the medical reality for J.

False emotional reality

378. In evidence M was asked about the emotional the emotional consequences on J of growing up believing he had a dead sister . She said she had not thought about

this issue before she *'worked on her mental health'* but now was able to tell me that *'he would have been sad'* and that *'he would have been upset hypothetically speaking'*.

379. Although M purports to have now accepted the consequences of her lie about 'Lily', she continued to demonstrate a worrying tendency to dissemble or minimise or be overly literal in her evidence.

380. An example of this was when she was questioned about exactly what she had told PGM about the location of 'Lily's' grave. She denied that she had told PGM she could not remember where the grave was, and said it was instead that she didn't know. In the context of a purported full acknowledgement about the consequences of having told the lie about 'Lily' it is difficult to understand why she continues to dispute minor details relating to this line of evidence. I make it clear that where there is a factual dispute in any part of the evidence between PGM and M on this issue, I prefer PGM account.

381. Similarly, although M accepted in evidence that she had suggested that social workers had covered up 'Lily's death', she was simply unable to explain why she said that. All she was able to say was that she *'could not give an exact answer'*. Not only did she not give an exact answer, but she gave absolutely no answer at all.

382. She accepted that on 23 August 2019 she asserted she had people who saw 'Lily' but denied that she had said there were records of 'Lily' really being alive. This is another example so characteristic of the common tenor of M's evidence that she will only make partial acknowledgments about details of various allegations put to her.

383. Similarly, although she accepted that she had said there were people who saw 'Lily', she qualified this by saying that what she meant was that she was referring to the photographs of 'Lily's scan'. And she sought again to dissemble by saying in evidence that she hadn't said her previous foster carers could verify 'Lily', rather that they could verify the pregnancy. She denied that she heard used words like 'dementia' and 'death' about the previous foster carers to put professionals off and she denied having made up those matters. Yet again she failed to provide any coherent explanation about why she did say those matters.

384. While of course M is not required to provide any explanation, her inability to explain coherently the reasons for her actions is highly relevant in light of her own

account that she has now had extensive counselling, has now *'worked on her mental health'* and has come to accept that there was never any child called 'Lily'.

385. Not only was M unable to describe with any credibility her own actions, but she also denied or sought to minimise the full impact of her actions on those people close to her. For example, she denied telling PGM that 'Lily' had died of multi organ failure but explained that she said that SIDS means that a child's organs shut down on their own with no real reason. This is another example of M seeking to be overly literal and concrete, without demonstrating any obvious acknowledgement of the full emotional impact on PGM of such a significant lie. Again, I make it clear that on matters of factual dispute between M and PGM, I prefer the evidence of PGM.

386. The obvious and only cogent inference to be drawn is that M talked about things such as 'Lily's grave', SIDS, multi-organ failure, people 'seeing Lily', or a 'cover up' by social workers to seek to bolster her own case.

387. M's case continues to be that having been forced to have a termination by the social worker, GH, has had a direct impact on why she has lied about 'Lily'. In her recent statement, she said –

> *12….the termination of my pregnancy has been one of the most traumatic events of my life. It still haunts me. GH says in her witness statement that I wanted to have an abortion. I never wanted to have an abortion and I never told her I wanted to have an abortion. I wanted my child but she said if I have my child it would be taken away from me anyway. My foster carer at the time was a lovely lady but was a stranger to me when this matter arose. GH was not sympathetic to me and was of no support to me at all.*
>
> *I feel it was this event that significantly affected my mental health and led to me lying about the existence of my baby and, as I have already said, I did not know how to retract from things I had said previously and regrettably I kept up the pretence. However, I realised when these proceedings commenced I had to be truthful about this and I found it extremely uncomfortable confronting what I had done but I knew that I had to stop this pretence. I am not an untruthful person.*

388. Notwithstanding the fact that this account confirms the fact that M knew she was being untruthful before the proceedings began, she also makes serious and highly significant allegations about a professional social worker.

389. I have considered the case records of GH in relation to this issue and I heard oral evidence from her. She was an impressive, thoughtful and empathetic witness with no reason to fabricate any part of the evidence. The first case record is dated 18 July 2012. In that case record it's plain that GH discussed the pregnancy at length with M's foster carer who told her that she had taken M to the GP and that M had said she wanted to have a termination. The next case record is also dated 18 July 2012 and includes GH's account of collecting M from school and taking her to the Marie Stopes clinic at which point M had the first stage of her termination; after that GH returned M to her foster placement. The second appointment was noted as being the following day. The next case note is dated 19 July 2012 and states that GH received a telephone call from the foster carer to let her know that M had the second abortion pill that day and giving her an update on M's general wellbeing and progress.

390. M said in evidence that almost all of these entries were made up and that she stuck resolutely to her accounts of the social worker's actions. She maintained that it was true that a social worker made her have a termination and was clear that the social worker did not give her an option to keep her child. I reject her evidence because it is unsubstantiated, uncorroborated and inherently unlikely. I accept these records as accurate. I make it clear that where there is a dispute on the facts in relation to this incident between M and GH, then I prefer the evidence of GH.

391. In cross examination M was asked to confirm the false dates of birth and death of 'Lily'. She said the date of birth was 24 February 2011. Although the date of the termination was the 19th of July 2012 she said she meant 'Lily's' birth date to coincide with the prospective birth date for that pregnancy. M was asked about when she began believe that 'Lily' was real, and confirmed that it was around the time of the termination in 2012. However, she also said in evidence that she created 'Lily' in her mind when she found she was pregnant with J. She became pregnant in July or August 2016. This part of her evidence is completely contradicted by the fact that she had already confirmed that she obtained a tattoo as a memorial to 'Lily' at the start of 2016, and by F's evidence that M already had the tattoo when they started their relationship in March

2016. In evidence she agreed that the tattoo could be perceived as an outward sign of her having lost a child. She was quite clear that it is there to inform other people that she is a young mum who has lost a child.

392. She said that F and PGM were the first people she told about 'Lily' because she wanted to be completely open. She began her relationship with F in March 2016 and said that at the time 'Lily' was *'someone who was very real to me'*. F said he completely believed her and so did his family. Both M and F described in detail the actions that flowed from the lie about 'Lily' within her wider family. She said she would be in a low mood, would always light a candle, and they would watch movies to commemorate the relevant important dates. She said she was given a memorial teddy bear by MGM to help her and at times she wrote a note and stapled it to a balloon which she would then release. M she first used the candle in 2013 and then the memorial teddy and the balloon featured from about 2016 or 2017. However, she sought to minimise the impact of this behaviour on F by saying that although he F knew about it, he wasn't part of it. Where her evidence differs from F in this factual regard, I accept and prefer his evidence. She said in evidence that she planned to have a ceremony on 26 August 2019 with F but they didn't carry that out because they had other plans that day. If M is to be believed about this, it can only mean one of two things. Either M still believed as late as August 2019 (just under four months before she told Dr Adshead that she now knew 'Lily' was not real). Alternatively, she did know by that stage that 'Lily' was not real, but nonetheless was prepared to let F go ahead with the ceremony.

393. There is no cogent evidence to support the proposition that commemorative events were initiated by M as part of her finding herself trapped in a lie from which she could not escape. Rather, I find they are clear evidence of her persistent attempts to perpetuate the lie. The motivation for her behaviour will undoubtedly form the subject or further assessment, but for present purposes **I find that M continued to lie about 'Lily' persistently, deliberately and with full knowledge of the likely impact on others of those lies.**

394. It is also clear that M sought to involve both F and XYZ in the commemorative activities relating to 'Lily' on a regular basis.

395. M began her relationship with XYZ in November 2018 and said she last had the balloon ceremony on 24 February 2019 at which time she still believed 'Lily' was real. He confirmed in evidence that he participated in this ceremony. This is a particular

concern, given that she told Dr Adshead on 12 December 2019 that it was only since she had been with XYZ that she had been able to admit that 'Lily' was not real.

396. On M's evidence, this means that any counselling or therapeutic effect in terms of her belief system regarding 'Lily' must have occurred between the ceremony on 24 February 2019 and 12 December 2019 when she saw Dr Adshead.

397. However, M's account of the counselling work she has completed is minimal and uncorroborated by any independent source. She described having started in October 2019 with somebody called L at the Children Centre whom she saw for a maximum of six sessions (each about two hours) between October and the end of November. Although she said L was some sort of therapist she did not remember or know her discipline. She said L was helpful to her and then she understood that 'Lily' was dead. Although she said she had some more counselling in March 2020, she was clear that it was the first period of counselling that *'shifted her thinking'*. She described this counselling as having helped her see what was a figment of her imagination. She said there was no single event in the counselling that had transformed her thinking rather it was little by little through talking to the counsellor. It is clear that until M's oral evidence during this hearing the nature of this counselling was unknown.

398. She said after she had the counselling the first person she told was F at the beginning of these proceedings which began on 2 October 2019. She said there were times she tried to and wanted to tell XYZ but couldn't bring herself to. She said she felt really bad for him but just couldn't get the words out. During this part of the evidence in particular when M described XYZ giving her what I can only describe as a memorial necklace for 'Lily' at Christmas 2019, he appeared in genuine and palpable distress.

399. She was asked about how she felt having lied to PGM. She said in evidence that at the time 'Lily' was very much real to her and so she also wanted to find out where the grave was as well. She accepts that people believed her. She did not demonstrate any empathy for PGM during her account at this part of the evidence and I find her evidence confusing in this regard. Either she honestly believed that 'Lily' was alive at the point that she was pregnant with J in which case it is extraordinary that no mental health difficulty appears to have been identified by any health professional including her midwife. Or she was deliberately lying to PGM; for whatever reason matters not at this stage.

400. She was also questioned about her use of social media accounts and she agreed that J features on most of her accounts. She agreed that 'Lily' had been in her Facebook biography with references to her name and date of birth and two Angel symbols. She accepted that if anyone had read that biography they would believe that 'Lily' was a child who had died. Her evidence in respect of this part of the evidence was minimising and troubling in the extreme. It is plain that until at least the day that she was questioned about this during this hearing in November 2020 she had continued to assert either explicitly or by implication that she was a mother of two children one who had died, one who was still alive. It is difficult to reconcile this evidence with her earlier assertions that she now believed, with the help of 'extensive counselling', that 'Lily' was not real. Notwithstanding the 'extensive counselling', it is clear that as late just a few weeks ago she was still maintaining images and references to 'Lily' on her social media accounts which indicate and confirm her as the mother of a dead child.

401. Later when she was presented with evidence obtained overnight of screenshots of various social media accounts which showed that 'Lily's' name and the various angel symbols associated with her name had been deleted overnight, she denied categorically that it was she who had taken that action. This was an obvious example of M telling a lie even faced with what appeared to be incontrovertible evidence. I have considered whether there might be a benign cause for such a lie, for example because she was worried she would get into trouble. However, by this very late stage in her evidence she had no reason to maintain such an unnecessary lie. The only conceivable reason for her continuing to lie is simply to bolster her own case still further. At this stage in her evidence she was lying in the face of overwhelming evidence to the contrary. She gave evasive and highly defensive answers and she was reluctant and uncooperative. In a period of extraordinary evidence over several days this was probably the most extreme example of such dissembling behaviour. She maintained that she was not responsible for the changes to her Facebook and WhatsApp accounts and had no idea how those changes had been made.

402. In evidence she was asked about why she had told F first about 'Lily' in November 2019 before telling XYZ. She accepted that she was aware that F still had feelings for her at that time. She said by way of explanation two things. Firstly that she could not bring herself to tell XYZ. Secondly, because she had also deceived F and PGM the longest, she felt it was only right they should be the first people to know. She did not agree that she was being manipulative but she did accept that she was sharing a

major disclosure with F. Her answers to this part of the questioning were at times incomprehensible and her evidence was mainly self-serving and confusing.

403. In evidence she remained adamant that by February 2020 XYZ knew the truth. It was put to her that she did not tell him until March or April but she was absolutely clear that she had told him just after 14 February 2020. She described XYZ as being totally besotted by her and said he trusts her and that he accepted what she told him about 'Lily'. The fact that M knows this made her deception of him even more dismal.

404. F, XYZ and PGM all gave moving evidence about their absolute belief in the fact that M had had a previous child who'd died.

405. F said he first learned about 'Lily' when he and M met up on a day off and he noticed her tattoo. By the time she got pregnant with J he already knew about 'Lily'. He said M showed him a photo of 'Lily' in a frame which was a picture of a newborn baby in hospital . He said she kept the photo always by the side of her bed and it seemed to him that it was the only proof of 'Lily'. He described her getting very upset telling him about 'Lily', breaking down and found it obviously very difficult to talk about. He said the conversation was quite brief because they both got so upset and he said he was also crying. He said he fully believed her. He said there were a few occasions during their relationship when 'Lily' was brought up around the date of birth and the date of death and at Easter and Christmas. He said in between those times 'Lily' was also discussed at meetings with social workers. He said he believed in 'Lily's existence throughout. He was asked about how the date of death was marked. He described M as appearing to feel very low and quite emotional and said he would do his best to distract her and take her mind off the day. He had experience of setting off balloons, the memorial teddy bear and candles which they would light on special occasions. He believes that the memorial teddy bear some sort of special link to 'Lily'. He described the balloon as being normally a red helium balloon with a tag on it which included a special message to 'Lily'. He said he would be there at those times to give emotional support to M. He thought the last such event that he attended was in February 2019.

406. In this part of his evidence, F was impressively articulate and clear in these answers and I accept his evidence.

407. XYZ explained that in the family home there is a photograph of a child which he believed was 'Lily'. The child in the photograph was pictured with a blanket. It was put to him on behalf of M then at no time did she ever tell him that one of those photographs was 'Lily' but he adamantly refuted this. He said he was 100% sure that this is what M had said. He was adamant that he actually saw the blanket which is the same blanket as worn by the baby in the photograph. He said he was told by M that the blanket had belonged to 'Lily'. The photograph, a candle and some ornaments are all on a table in their front room. He described the items on the table which included some toys, some skulls and ornaments. He agreed that J would have been quite interested in that table. He confirmed that he thought J would have been aware of the photograph and knew it was a special thing and not to touch it because it was precious although he did not think J knew who it was. But he would point at the picture and say 'baby'. He said the photograph was definitely in their property on display until very shortly before she told him the truth about 'Lily' when she then removed it from the flat.

408. XYZ confirmed that he also took part in one or two of the memorial events for 'Lily', certainly at least one. He confident that this was on the 26 February 2020 because he knew that J was no longer living with them (having been removed on 2 October 2019). He attended an earlier memorial a year before on 26 February 2019 when J was out. He said he was quite happy to take parts in such events because he felt it would help M get closure and she was celebrating her daughter's birthday. He said he was just being a loving partner.

409. Perhaps the most moving part of his evidence was when he described having bought M a necklace to commemorate 'Lily' at Christmas 2019. It was clear that he had been trying to support M emotionally in an appropriate and loving way. On M's evidence, by that stage she believed 'Lily' was not real and she had already revealed as such to F in November 2019. M offered no explanation about why she allowed XYZ to go ahead with such a moving action.

410. He also gave evidence about how he found out that 'Lily' was a lie when M told him in March 2020. He described being angry and upset. J was accommodated by the local authority on the 2nd of October 2019 . He was told the truth about 'Lily' in the first period of Covid-19 lockdown in March 2020. He was adamant that M was incorrect when she said she had told him just before 14 February 2020.

411. I have reflected very carefully on whether it is necessary at this stage to consider whether M believed all of what she said in respect of 'Lily'. That matter requires careful consideration, in light of my findings, at the welfare stage. However it is an important part of the court's function at this stage to provide as detailed a factual matrix as possible having heard considerable and extensive evidence in this case which can provide a solid platform for future work with all members of the family including J himself. As I have set out above, there is significant evidence of persistent and continued calculation and deceit to support a finding that M lied about 'Lily' for a considerable period and to many people, including medical professionals.

412. I therefore make findings about the following factual matters that are relevant to ground any further assessment of the parties.

413. I find that M was not forced against her will by a social worker or a foster carer to undergo a termination in 2012.

414. I find that whatever M's reaction to having had a termination in 2012, by the time she met F four years later she was demonstrating no significant or discernible psychiatric or psychological disorder.

415. I find that before M became pregnant with J in July or August 2016 she had taken the considered decision to obtain a tattoo to commemorate 'Lily' with the intention of conveying to others that she was the mother of a dead child.

416. **I find that at the outset of her relationship with F in March 2016 she told him that she had had a child called 'Lily' who had died from SIDS**.

417. I find that M persisted in maintaining the lie about 'Lily' at least from late 2016 or early 2017 until October 2019 to medical professionals, to social work professionals, to F and to the PGM, and until March 2020 to XYZ.

418. I find that M did not tell XYZ the truth about 'Lily' until March 2020.

419. I find that M persisted in maintaining the lie about 'Lily' on her social media accounts until November 2020.

ALLEGATION 4 - False pregnancies

420. The local authority seeks a finding that M has reported a large number of pregnancies and miscarriages, at least some of which are fabricated. As part of its closing submissions the local authority has submitted a schedule of pregnancies and miscarriages reported by M. M does accept that she fabricated a pregnancy in February 2011, and that she had a termination in 2012.

421. In a very recent statement dated 17 November 2020 M said she admitted making up a pregnancy in February 2011 and accepts she has had a high number of miscarriages. However, she denies having lied about being pregnant or having miscarried.

422. Neither Dr Adshead nor the court has had access to M's full obstetric or medical records. It has therefore not been possible for Dr Adshead to confirm whether various reported pregnancies and miscarriages are supported by medical evidence. There is insufficient evidence to support a finding that any of the reported pregnancies and miscarriages were fabricated by M, other than as admitted by M.

423. However, in the absence of full medical evidence it is difficult to make findings about the veracity or otherwise of what M is said to have reported. Dr Adshead was appropriately wary of commenting any further and advised that an obstetric and gynaecological expert would need to review the notes to comment further. In any event, she confirmed that it is not possible for a psychiatrist to say that something is fabricated on the basis of notes alone.

424. Dr Adshead did not accept or agree that the case could be put as highly as M having fabricated her accounts of miscarriage and/or pregnancy because part of the difficulty and the reason for the lack of clarity is that the records are unclear and were not written for this purpose. The records are incomplete in that they did not have all the details of hospital treatments, do not include any accounts of labour or attendance at antenatal clinics, and only include letters and records from some hospitals.

425. On the basis of M's admissions, I find that M fabricated a pregnancy in February 2011 and had a termination in July 2012.

426. I do not consider that it is proportionate or necessary to order any further inquiry into this matter in light of the total picture of the evidence in relation to this case.

ALLEGATION 6 - Unnecessary medical testing

427. The local authority seeks a finding that as a result of M's false accounts that J was experiencing seizures (influenced also by her false report that she had a child who died of SIDS at the age of six months) J has been subjected to unnecessary medical testing (including an ECG, more than one EEG, MRI scan under sedation, participation in a sleep study and chromosome testing) and received medication which he did not require. M's evidence was that she does not consider her narrative about 'Lily' featured into the professionals' decision-making process, although she did not give a coherent explanation for why she believes this. I reject her evidence because it is overwhelmingly obvious that it did.

428. Professor Fleming, Dr U, Dr SP and Dr S all confirmed the importance of obtaining an accurate history from a parent when treating a very young baby. M's inclusion in J's medical history on 20 April 2017 about the death of a previous child from SIDS clearly did serve as a significant influence on the decision- making and treatment plan for J at that stage. Although the presenting problem was later considered to be consistent with benign sleep myoclonus, the history of SIDS directly influenced the decision to give J various tests, including an MRI scan under sedation, an EEG, a lumbar puncture, a sleep study and chromosome testing. The commencement of that passage of treatment in April 2017, combined with the further history given by M, also directly led to the commencement of carbamazepine in January 2018.

429. If M had not told the doctors about the history of SIDS at that first hospital admission then it is highly unlikely that J would have been required to stay in hospital. All of the treating doctors in this case agreed that benign sleep myoclonus is a relatively common phenomenon in very young children. It was the added history of SIDS that increased the concern of the treating doctors. Although Dr U confirmed that the key to J's treatment was the history of possible seizures (indicated by a history of jerking movements), she was also quite clear that the SIDS was also a key factor for her and her team in planning J's treatment.

430. Dr U described any EEG as not being terribly unpleasant for a baby and that might be right on a physical basis. But that early medical treatment is part of the created false physical and psychological reality for J. As such, it has just as much significance in my view as any direct physical harm. The treatment in hospital

inevitably also included the insertion of a cannula and the taking of bloods. He had an EEG at 8 months old during which he needed to be held very still and which Dr U described as being necessarily unpleasant for him. He had an MRI at ten months old for which he was given oral sedative drugs to keep him sleepy. He had a lumbar puncture at 12 days old whereby a needle was inserted into his spine while he was lying in a foetal position. Dr U described it as quick but unpleasant. He was commenced on phenobarbital in April 2017 as part of a treatment plan formulated as a result of the overall history provided by M.

431. Although it was reported to Dr SP in July 2017 that the seizures had ceased, the further history of seizures provided to Dr L on 6 November 2017, to Dr U on 7 November 2018, to Dr S on 8 January 2018 and to Dr L on 11 January 2018 played a significant causative role in the decision to commence J on carbamazepine in January 2018.

432. While it is troubling that M continues to assert that she does not consider that J has suffered significant harm, physical or otherwise, as a result of those investigations or treatments, that is not a relevant concern for this part of the proceedings; however, her attitude to this part of the evidence is something that will need to be evaluated at the welfare stage.

433. I find that as a result of M's false accounts that J was experiencing seizures (influenced also by her false report that she had a child who died of SIDS at the age of six months), J has been subjected to unnecessary medical testing (including an ECG, more than one EEG, MRI scan under sedation, participation in a sleep study and chromosome testing) and received medication which he did not require.

ALLEGATION 7 - Over-medicalisation effect on J

434. The local authority seeks a finding that in the longer term, J was likely to suffer significant emotional harm owing to living in an environment where his life has been medicalised and where he has been provided with M's narrative that he was unwell and that there was something wrong with him when this was not the case, which would have marked him out as different from his peers.

435. My earlier findings confirm that J was living in an environment where his life had been medicalized and in which he was provided with the narrative that he was unwell. It is beyond doubt that this inevitably would have marked him out at the time and in the future as being different from his peers.

436. The local authority also asserts that J was likely to suffer significant emotional harm from growing up in the false belief that he had an older sibling who died as an infant and with whom he therefore had lost the opportunity of a life-long sibling relationship.

437. It is clear on the evidence that J was aware at least of the importance of the photograph of the baby placed in a prominent position or significant position in Ms living room. XYZ confirmed in evidence that J knew it was important not to touch that photograph. M continued even in her oral evidence during this hearing to talk about 'Lily' as times as a real entity and used the words *'she'* and *'her'* when she talked about 'Lily'. It is still difficult to understand her rationale in waiting four months between telling F in November 2019 and March 2020 that 'Lily' did not exist at all, yet for a period during that time she wore the necklace given to her by XYZ at Christmas 2019 which included the word 'Lily' on it. It matters not at this stage what her motivation was for all this. What is relevant, however, is that October 2019 J was living in the family home with M who was perpetuating that emotional reality and after that time, M continued to have contact with J throughout. **I find it is likely that the narrative about 'Lily' would have continued.**

438. Doctor Birch stated in her report that anxiety and psychological issues are difficult to evaluate and she described how an anxiety state in an adult can lead to hypochondriasis and a focus on illness. She said in children and young people anxiety and emotional symptoms can be picked up from parents and carers and the child can be instilled with fear and anxiety over certain situations. Even if J was not physically present in the house at the times of the commemorative events relating to 'Lily', it was M's evidence, supported and corroborated by both F and XYZ, that her commemoration and consideration of 'Lily' as a real entity was not limited to those events and also extended to times such as Christmas and Easter.

439. XYZ described how M would become sad and low. Both F and XYZ said in evidence that they saw it as part of their role to lift M's spirits or cheer her up or support her at those difficult times. That inevitably means that they were unlikely to have been

as emotionally available as they might have been to J at those times. It also inevitably means that M was unlikely to have been as emotionally available to J as she might have been. It remains to be seen what M's current attitude to that is; this is another matter that will need to be evaluated most carefully at the welfare stage.

440. However, I am in no doubt that J was likely to suffer emotional harm as a result of M's actions. It does not matter whether or not M has explicitly told J he is unwell. By all accounts he is a bright and emotionally attuned child. For example, during a SW home visit on 17 July 2018 J was observed to become upset when M left the room and sought comfort from her. Equally, the health visitor's evidence about J's lack of reaction to what sounded like a disturbing and persistent argument between the parents at the CIN meeting on 8 May 2019 was concerning to her. I accept that evidence. It is unrealistic to suggest that a child a young child is not emotionally attuned to the reactions and actions as well as the inactions and omissions of the adults around him. From just a few weeks of age J was subjected to repeated medical appointments, invasive medical treatments and drugs that he ultimately did not need. It doesn't matter whether or not M told him that he was ill. It is unthinkable that he would not have realised in some way that he was unwell.

441. I find that, in the longer term, J was likely to suffer significant emotional harm owing to living in an environment where his life had been medicalised and he had been provided with M's narrative that he was unwell and that there was something wrong with him when this was not the case. I find that this would have been likely to have marked him out as different from his peers. I find that J was also likely to suffer significant emotional harm from growing up in the false belief that he had an older sibling who died as an infant and with whom he therefore had lost the opportunity of a life-long sibling relationship.

ALLEGATION 8 - Failure to attend medical appts

442. It is the local authority's case that M and F failed to attend important medical appointments with J.

443. In her initial threshold response M accepted this allegation but stated that many of the appointments that were missed were while J was in F's care. In her later response to the schedule of allegations M stated that she believed there had been approximately five missed appointments of which she accepts responsibility for two.

One when J was ill and another when she had no money or card to get there and she called the hospital asking to reschedule, although she says she never received an alternative appointment. M stated that some of the appointment letters had gone to F and so she was not aware of these appointments. Mother says she was not aware that F had missed some appointments and states that if he had told her that he could not take J then she would have done her best to take him herself.

444. In his initial response to interim threshold F did not reply at all, and stated this was an issue for M to answer. His later response to the schedule of allegations states that there were occasions when through no fault of his own he was unable to attend a medical appointment, either because he was unwell or because he did not have sufficient funds to travel to the appointments.

445. It is clear on the evidence that there were several significantly important medical appointments that were missed by the parents, although at times it is difficult to discern the actual reasons given for the appointments being missed.

446. Dr L refers to three review appointments in 2017 that were made for him to review J in the paediatric neurology outreach service. The first two of these were on 5 June 2017 and 3 July 2017. These appointments were cancelled but it is not clear from the hospital records who requested the cancellations. There is therefore insufficient evidence to support a finding that the parents deliberately missed these appointments. However a third appointment was booked for 14 August 2017. J was not brought to that appointment. It is beyond doubt that M knew about that appointment because the date of that appointment was recorded in the clinic letter copied to the parents that was sent following Dr SP's clinic letter on 19 July 2017. That letter was sent to the parents at M's home address. M said explicitly in her evidence that she lives in a one bedroomed flat on the ground floor, the post is delivered through the front door into the living room and she is in the habit of picking letters up straight away. It is therefore most unlikely that she did not receive letters from the hospital. However, F said in evidence that after he and M separated, he did not receive letters about medical appointments. It is correct that all the letters I have seen were addressed to the parents at M's home address.

447. The reason given by both parents in their evidence for missing the appointment with Dr L on 14 August 2017 was that F was very anxious about travelling to London after the recent bomb attack in the London Bridge and Borough Market area

on 3 June 2017. M says that F cancelled this appointment due to his anxiety. However, she gave no cogent reason why she herself did not attend that appointment. There was no evidence that M shared F's anxiety about travelling to London some two months after the bomb attack. I do not consider that a bomb attack two months previously represents a cogent reason for missing such an important review appointment for J. Furthermore the letter was received directly by M at her home address but F was aware of it. **I find that the important review appointment with Dr L on 14 August 2017 was missed intentionally and without good reason by both M or F.**

448. It is plain that M was aware of that appointment and indeed the earlier appointments because on 6 September 2017 she reported to the health visitor that J had now missed three consultant appointments. In the health visitor's note of that home visit to M, she described M as telling her that F cancelled the August appointment and that J has now missed three appointments. For reasons already stated, I accept the health visitor's evidence. On the basis of that evidence that it is safe to find that the parents were both aware of the two earlier appointments with Dr L on 5 June 2017 and 3 July 2017. The fact that F was aware of the third appointment makes it inherently unlikely that he was not also aware of the first and second appointments. **I find that the two appointments with Dr L on 5 June 2017 and 3 July 2017 were missed intentionally and without good reason by M and F.**

449. On 6 September 2017 the health visitor meeting explicitly advised M to call the hospital to rearrange. M told her that she could not contact the hospital as F had the details and she had the money ready to take him. Neither aspect of that explanation to the health visitor makes sense, particularly in the context of the now long overdue and important appointment with Dr L specifically to review J's health. In any event, M says in her second witness statement that she did call the hospital to reorganise an appointment on 31 August 2017 due to her then-partner, PQ, wanting to be at the appointment but being prevented by work. This lends further weight to the fact that M was misleading or lying in her conversation with the health visitor on 6 September 2017 when she said she did not have the details to contact the hospital. In any event, by this stage it would not have been difficult for M to have obtained the details for the paediatric neurology clinic at Hospital B.

450. A review appointment with Dr U on 13 March 2018 was also not attended by the parents. The letter to the GP confirming this and explaining that Dr U would therefore discharge J was also copied to the parents at M's home address. In her

second witness statement M says it was her fault that this appointment was missed because she was miscarrying and in a lot of pain as a result and she could not find the correct number to contact the hospital. She said that when she asked F if he could take J he did not have the funds. She also said she believed this appointment may have been cancelled internally. There is no indication that the appointment was cancelled internally. Again, it is most unlikely that this intelligent and articulate mother could not have either found the correct number to contact the hospital herself or that she could not have asked F to contact the appointments on her behalf. **I find that the appointment on 13 March 2018 with Dr U was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

451. A further appointment with Dr S was arranged for 5 April 2018 for the purpose of explaining to the parents the results of the chromosome study and to review J's seizure frequency following the hospital admission on 8 January 2018. Dr S had made it clear at that stage that part of his plan was to offer a follow up appointment in three or four months time in his clinic. Dr S wrote to the GP on 17 April 2018 explaining that he had tried to contact the parents on the mobile phone numbers recorded in the system but the call was not answered. He then asked his secretary to contact the family the following day and offer a further appointment on 10 April 2018 with a plan to stay for further observation if the seizures were still not settled. He was hopeful at that stage of making contact and communication with the family to carry out the suggestion for that further observation made by Dr L. That letter also was copied to the parents at M's home address. M's explanation for missing this appointment in her recent witness statement was that J was staying with F from 31 March until 6 April for the run up to his birthday. She said that she was not aware until after she had collected J that F had not attended due to lack of funds. That explanation lacks any credibility. It has never been presented as the case that these were parents who refused to attend appointments together. It should have been entirely foreseeable to M that it was necessary to take J to this important follow up appointment with Dr S.

452. In any event this is not consistent with what M told Dr S's secretary who later did manage to make contact with the family after the missed appointment on 5 April 2018. The secretary was told that M had mixed up the dates and thought the

appointment was the following week, although she had confirmed to the secretary beforehand that she understood when the appointment was. **I find that the appointment on 5 April 2018 with Dr S was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

453. On 20 April 2018 Dr S wrote to the GP copying in the parents again. In this letter he confirmed that J was not brought to the rearranged appointments on 10 April 2018. He said in his letter that he gave 24 hours to the family to contact him with an explanation and with a request for a further review but then nobody contacted him. He said he therefore tried again using the numbers in the system and one of those numbers was not working at all and the other number was attended by somebody who did not know J. Dr S remarked in his letter that this was all *'a little bit bizarre because his secretary managed to contact the family on those numbers'*. M says in her most recent witness statement that she did not know about the 10 April 2018 appointment as she did not receive a letter or any phone call. I do not accept her explanation in light of the fact that the letter making the rearranged appointment was sent to M's home address and furthermore indicates that she did have a conversation with Dr S's secretary. **I find that the appointment on 10 April 2018 with Dr S was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

454. As a result of that non-attendance and the previous non-attendance at Dr U's clinic, Dr S felt that there was a significant increase in concerns about J's wellbeing. He therefore sent a copy of the letter to the safeguarding team. As he said in his letter, which again I stress was made available to M at her home address, *'something must be stopping a family from coming to see me with J who suffers with epilepsy and they may require some support and help and unless we explore the situation we will not know'*.

455. On 6 September 2018 J had an appointment booked again with Dr L in the paediatric neurology outreach clinic in Town C. He was not brought to this appointment. Dr L's clinic letter dated 13 September 2018 documented that his secretarial staff had not been able to reach M the day before the appointment to

confirm her attendance. In her most recent witness statement M said she could not recall this appointment. The clinic letter dated 13 September 2018 was sent to Dr S, the GP and also to the parents at M's home address. **I find that the appointment on 6 September 2018 with Dr L was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

456. On 18 September 2019 J was due to have an eye appointment at Hospital E with Ms G, consultant opthalmologist. He was not brought to the appointment and there is no explanation provided by either parent for why this appointment was missed. The hospital notes for 18 September 2019 indicate that Ms G's team called the GP, obtained and confirmed that the family address was correct but that the mobile phone number was different and uncontactable. In her most recent statement M does not deal with the date of the appointment being 18 September 2019 and states that she did not receive any contact about an appointment on 27 September 2019. Her explanation for missing this appointment was that had she been aware of it she and J would not have gone on holiday that day. She gave no explanation in evidence as to the reason for missing an appointment nine days earlier on 18 September 2019. **I find that the appointment on 18 September 2019 with Ms G was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

457. In addition to these missed hospital appointments, the local authority also asserts that there were a number of missed home visits with the health visitor, including 3 October 2017. The heath visitor's records indicate that this was a pre-arranged visit agreed with M at the home visit on 6 September 2017 in light of her discussions and concerns about introducing solid foods, but that she was unable to contact M by phone. Once again M says in her witness statement that she cannot recall the appointment. This is highly unlikely because the appointment was arranged in the context of M herself raising concerns on 6 September 2017 about the level of solid food being introduced to J by F. **I find that the appointment on 3 October 2017 with the health visitor was missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.**

458. The local authority also seeks to rely on a missed home visit on 3 May 2018 where the health visitor says there was a *'no-access visit'*. M herself says she cannot recall this appointment. There is no record of this visit having been arranged and there is no evidence to support any finding in respect of this visit. It is unclear whether that this was a pre-arranged appointment missed by M rather than an unarranged or unannounced visit. **I make no finding in respect of any appointment on 3 May 2017.**

459. On 10 May 2018 OM, the epilepsy specialist nurse, made a home visit to deliver an appointment note but could gain no access. In her recent witness statement M said that J was under F's care on 10 May 2018 because she was due for or had just had a D&C (gynaecological) procedure. She said she phoned to explain and reschedule. It is correct that on 14 May 2018 M telephoned OM and explained that the appointment had been missed because F was caring for J on that day. OM's note states that M said J was no longer seeing his father and that she would definitely bring him to the appointment on 29 May 2018. However, the appointment on 29 May 2018 was also missed by M. In her statement M explained that she missed the appointment on 29 May 2018 because she was recovering from her D&C. She said she takes full responsibility for this but could not contact the hospital as the number that she had was not to hand as she was recovering at her parents' home.

460. However, there is no independent evidence to corroborate that M was having any sort of gynaecological procedure at this time. M told the health visitor HV on 20 March 2018 that she had recently lost a baby. On 26 March 2018 the health visitor contacted the midwife who confirmed that M had miscarried. In April 2018 M reported having a miscarriage with her then-partner, PQ. The next reference in the evidence to any gynaecological issue being reported by M was not until 4 September 2018 when she reported a suspected miscarriage.

461. It is therefore clear that M was aware of the appointment on 10 May 2018 and was also aware that a rearranged appointment with Dr S was made for 29 May 2018. Her explanations as to why she missed either appointment lack credibility and corroboration.

462. I find that the appointments with OM on 14 May 2018 and with Dr S on 29 May 2018 were missed intentionally and without good reason by M. I make no finding about F who by this stage was not living at the family home and was reliant on being informed by M about medical appointments.

ALLEGATION 9 - Volatility and conflict in relationship between M and F

463. The local authority seeks a finding that J was likely to suffer significant harm owing to high levels of volatility and conflict between M and F. This included M making repeated allegations regarding J's welfare and safety when cared for by F, conflict and shouting between the parents in J's presence at a CIN meeting on 8 May 2019, and M's allegations to the police in July 2018 that F had raped her several times. The local authority asserts that a likelihood of significant harm to J arose irrespective of whether M's allegations against F (or some of them) were true or false. If they were true, J was likely to suffer significant harm in the care of F. If they were false, J was likely to suffer significant emotional harm as a result of malicious allegations being made by one parent against the other.

464. F gave oral evidence and it was apparent almost immediately that he struggles with anxiety which partly manifests itself physically in his body. He is on a waiting list to see a CBT therapist following a suggestion from his GP that he may have post-traumatic stress disorder . He also has very rare episodes of NEAD, but said that he has worked hard to maintain and control the frequency of seizures by trying to level out his stress levels following his own research after diagnosis. He presented as a somewhat fragile, vulnerable individual but one who is highly intelligent and articulate and demonstrated a great deal of warmth and love for J. He also spoke warmly of M at times in his evidence saying that she had been by his side supporting him since he was diagnosed with a hernia last year, described her as only person to whom he can talk and said she is the only friend he has left.

465. This is notwithstanding the fact that M has made the three allegations of rape about him, and also alleged on 11 July 2017 that he had taught J to masturbate. As stated above, I have already made a finding that on 11-12 October 2017 M reported to hospital staff that J had been mimicking masturbatory behaviours and was upset that F had taught him how to do it, and that she had also reported this to the local authority.

466. The local authority's case is that this is another way in which M misreports and creates a false reality about and around J. At that time J was just a few months old. The local authority accepts that in a different sort of case this may well not have been a factor relied on to satisfy the threshold criteria and I agree. However it is of

importance and significance in this case because it is part of a body of lies and deceit committed by M and should be seen and placed in that context.

467. F accepts that to argue in front of J as he and M did was potentially harmful to J and he asserts that he tries now to take steps to ensure that J sees his parents cooperate with each other amicably.

468. In terms of the allegation that J was likely to suffer significant harm due to high levels of volatility and conflicts between the parents, I do not consider this is an insignificant issue. Section 31 defines the nature of the harm that may be suffered but does not indicate the necessary degree of that harm. When making a finding of harm it is important to distinguish between simple harm as opposed to significant harm. Minor shortcomings or deficits in physical, psychological or social development should not require compulsory intervention unless cumulatively they are having or are likely to have serious and lasting effects on the child. For J it is exactly the accumulation of harm arising from the sustained conflict between the parents that is of concern and that I find does satisfy the threshold criteria.

469. The level of culpability or insights by a parent matters not; it is the fact of the harm or the likely harm being caused that is important. I find that M's allegations of rape against F and the allegation about teaching J masturbatory behaviour to medical professionals can only have had the effect of causing J likely significant harm. It matters not whether M herself made the comments about the masturbation or whether it was her then-partner, PQ; the fact remains that M was present and was responsible for giving the history to the medical professionals. If M had doubts about the veracity about anything being said by PQ, then it was her responsibility as J's mother to correct the information. But she did not. It is not relevant at this stage to seek to understand why she said these things, or whether she believed they were true or not. But the fact of M having made these various allegations is sufficient to demonstrate actual or likely harm to J. **I find that a likelihood of significant harm to J arose irrespective of whether M's allegations against F (or some of them) were true or false.**

470. At the child in need meeting on 8 May 2019 it is reported that M spoke aggressively and in a hostile manner in front of several professionals and ultimately left the meeting. The record of this meeting indicates that both parents were hostile to each other. M shouted at F and at other professionals, became emotionally distressed and

walked out of the room, then returned to apologise for her behaviour and talked calmly, before the same pattern happened again. J was in the room throughout and it took professionals to remind both parents that he was present and that their behaviour was inappropriate. It is correct that both parents then adapted their behaviour accordingly; however, the fact remains that the behaviour occurred in J's presence.

471. In the health visitor's report dated 6 June 2019 she confirmed that, based on her own observations, the parents had been observed to be in frequent conflict with each other in front of J, their arguments had escalated to shouting and crying, and they had been observed to be struggle to calm down for his benefit, they could easily escalate after a short period of time, and both parents had been observed to demonstrate difficulty in managing their emotions around D. I accept her evidence for the reasons I have previously stated.

472. I find that J was likely to suffer significant harm owing to high levels of volatility and conflict between M and F.

ALLEGATION 10 - Instability in M's relationships

473. The local authority seeks a finding that J was likely to suffer significant harm arising from instability in M's relationships. It is asserted that she formed a succession of a relationships with different men, at least some of whom took on a caregiving role for J, which was likely to cause him confusion and instability. It is also asserted that J was exposed to verbal and physical aggression between M and her partners.

474. However, while it may well be the case that M had a number of partners since J's birth, there is insufficient evidence that either any significant harm occurred or was likely to occur as a result of those partners. It is submitted on behalf of M that whilst one stable partner may be deemed to be ideal, it is not necessarily the experience of vast numbers of the population, and the converse cannot of itself imply harm or likelihood of harm. I accept that analysis. **I make no finding in respect of this allegation.**

ALLEGATION 12 - the bruising

475. The local authority's case is now that it is possible to identify on the balance of probabilities a perpetrator of the bruises found on J on 2 October 2019. The local authority now invites the court to find that it is more likely than not that it was M who

caused those bruises, and no longer invites a finding that they were caused by XYZ. The local authority invites the court to find that this is a case in which identification of a perpetrator would not involve the court straining to such an extent (or at all) to identify a perpetrator, such that the only safe finding would be that there is a pool of possible perpetrators.

476. No party now asserts that XYZ caused the bruises. M's case in evidence was that J could not and did not cause the bruising himself by pinching or some form of self-harm. No party asserts that the bruises could have been caused by J himself. M's case in evidence was not any longer that the bruises were caused by J running into walls and doors the previous evening. No party asserts that the bruises could have been caused in that way. M also confirmed in evidence that there was no possibility that FS caused the bruises because she had no involvement in his care.

477. M's case in evidence was that neither she or XYZ had caused the bruises. She said in evidence that she had not seen the bruises before J went to nursery on the morning of 2 Ocotber and she does not know who or what inflicted the bruises. She denied having asked FS to lie for her.

478. I heard evidence from QL who is a social worker. She also prepared a written statement. I permitted that evidence to be adduced on the basis that it was admissible hearsay evidence which is relevant to the issues in this case, and I gave a short extempore ruling to that effect during the hearing. QL has no knowledge of the matters in this case and has had no involvement with any of the parties. She was contacted by FS on 31 October 2019 by email and telephoned her on 2 November. She has known FS since 9 November 2018 in her capacity as social worker involved with the family. In that time she has had limited contact about every three to six months before statutory reviews. Prior to her recent involvement during these proceedings, she last spoke to FS during the school summer holidays. She describes her as someone with complex needs who is very vulnerable; she said her partner, JK has disabilities and is also vulnerable. She said both of them are prone to exploitation by others. However, she said FS has always been transparent and open in working with her. FS told QL that she had been asked to lie to the police by M, but that she had not wanted to do this because she knew it would be a lie. QL made a contemporaneous note of their conversation in which she stated that FS said she used to be a neighbour of

M but has now moved. She told QL that she feels intimidated by M which negatively affects her mental health. QL described her as seeming very, very frightened of repercussions on this day, was becoming increasingly agitated and began to hyperventilate. QL was clear that FS has never said anything like this to her before. I accept QL's contemporaneous note as accurate and I accept her evidence about her experience of FS as accurate. QL presented as an open, clear and credible witness with absolutely no reason to lie or make up her account. Her note was written at the time of making and I accept it as an accurate account of what she was told by FS. **I find that FS was asked to make a statement by M to verify M's account of J being hard to settle on the night of 1 October 2019.**

479. There is no need to go any further in evaluating FS' evidence because both M and XYZ agree that J was hard to settle. In her oral evidence M agreed that she had had a difficult night with J due to him having a cough and a cold. That description is further corroborated by F who was telephoned by M. It matters not whether FS was there or not. M herself said in evidence that FS is not a spiteful person and she agreed with QL that she presents as very vulnerable.

480. M's oral evidence about the bruising was dissembling and lacked credibility. She appeared incapable of giving a straightforward answer throughout almost all of her evidence on this point, and appeared inexhaustible in her drive to distract by detail. Although I place limited weight on her demeanour during evidence, the way in which she described the bruises was in stark contrast with F and XYZ. They both described their abject shock at the sight of the bruises and expressed what appeared to be genuine concern that someone could have grabbed and hurt D, while M appeared to express no empathy or sympathy for J at all.

481. It is worth saying something here about the actual appearance of these bruises to the non-expert eye, for those reading this judgment in due course. It is difficult to know how to do justice to these marks shown so graphically in the photographs taken by M that afternoon on return from nursery. It is plain that J is crying in one of the photographs and both arms show dark reddish brown obviously linear marks. They are not minor marks, and would make any parent shocked. That is not the reaction that I observed at any time in M when giving evidence about these injuries. It is correct to

say that in evidence she agreed the bruises were shocking, but words do not necessarily equate emotional response. She was asked why she had not been the first one immediately to look at the bruises when they got home, and why she had gone first of all into the kitchen. She denied that it wasn't a priority for her. But then she said – *'let's face it, it would have made no difference to the bruises.'* Her tone when she said this was sarcastic, rude and hostile. She then became tearful at this point, but this appeared to be borne not out of empathy for J but out of concern for herself about the persistent and highly effective questioning by Miss McGrath. I take account of course of the inevitable stress on any lay party in giving oral evidence, not least over several days as happened in this case. But she was being questioned entirely appropriately and I found her tone extraordinary in terms of the issue she was being asked to describe, and by contrast with the obvious anger and pain and shock experienced by both XYZ who saw the bruises first hand, and by F who saw them in photographs.

482. M also said in evidence and this was not contradicted by XYZ, that at home in terms of J's discipline and routine she was the boss and she decided how things should be for J in her home. She said XYZ respected her and did what she said. She repeated clearly that she had never seen XYZ grab J hard enough to cause bruises or marks to cause him any pain.

483. Both M and XYZ were also clear that he was never left alone with J after the concerns raised by F in August 2019 about whether some bruises to J could have been caused by XYZ.

484. M constantly shifted position in evidence, leaving the impression that she was most concerned to say whatever she thought would be most expedient. For example, in cross-examination by the local authority she began by stating that by a process of elimination she thought J could have caused the bruises to himself, then pulled back from this. On 15 July 2019 she was described by the social worker (in her case record) as having said J had been self-harming by pinching himself on the arms and that DT saw this. DT has denied all knowledge of this according to the social worker's case note. There is no evidence to counter this account which I accept as accurate. However, M then demonstrated a clutching movement with all four fingers and thumb, and denied that she had ever said J was self-harming. She also then denied she had ever said the marks could have been caused by pinching.

485. She continued to state in cross-examination that she believed it was a possibility that someone at the nursery could have hurt J there on 2 October 2019 and when explicitly invited to confirm her position, she said she did invite the court to find that the marks could have been caused at the nursery on that date. However, she also agreed that if the bruises had been caused on 1 October 2019 she would have known about them that day if they had come out by then. She agreed that if XYZ had done something to cause the bruising at home, then she would have known.

486. She was similarly dissembling about whether she believed the 123 swinging game could have been a possible explanation for the bruises. At first she said she believed this could have caused the bruises, although she did not think this at the time. But she confirmed that the game was played very regularly, and it had never caused any marks previously. She and XYZ played it at least three or four times a week with J and she never saw any marks caused by it.

487. Her account of who had first remembered the account about the 123 game was also hazy and shifting. She said variously that she had reminded XYZ they had gone to the shop on 1 October 2019, then that XYZ had said there was one time when they were playing the game and she lost grip of J and that XYZ had caught him. She said she had asked XYZ if he meant it happened that day and he then said he did remember that. She agreed that XYZ told her he didn't have a clear recollection, but that he effectively deferred to her opinion. Later she said that if XYZ hadn't said anything about it, she most likely would not even have remembered the incident.

488. She agreed she and XYZ had the discussion before Dr Birch's evidence. However, the point was not put to Dr Birch in cross-examination, even though M does invite the court to consider it a real possibility that the 123 game caused the bruises on the arms.

489. XYZ said in evidence the bruises looked like grab marks to him at the time. He confirmed that he has never grabbed J in any other way to cause bruising on his arms, other than one time during the 123 swinging game when he grabbed him so he wouldn't fall on his face. He accepted in evidence that during the 123 game he held J's R arm and possibly caught him on the L bicep, but was unsure about how this could have caused bruises to both arms. He said he just wanted to put every possible explanation forward, but agreed that in his heart he doesn't really think that caused it.

He said J was wearing a coat and a jumper and it just seemed unlikely to him that the bruising could have been caused through those layers.

The mechanism of the bruising

490. The medical evidence is that these bruises were inflicted injuries.

491. Dr EP was the paediatric registrar on call at Hospital C in Town D on the evening of 2 October 2019. She was asked to perform a child protection medical examination of J and she saw him on the ward at 19:45. He was accompanied by M and XYZ, as well as the social worker (AZ) and two police officers. J was aged 2 years and 5 months at the time.

492. Dr EP took the following history from M who said that she first saw the bruises when she picked him up from nursery and the nursery staff had asked about them. She said she was unsure where they had come from and hadn't noticed them before. She queried whether they could have been caused by J running into the corner of the wall which is something he does when restless. She said he had done this the previous night when he was up all night with cough and cold symptoms. She had given him Calpol at midnight and 06:00. During the previous day he hadn't been eating as much, but was drinking well with no vomiting and fever. No marks had been noticed that morning when getting him dressed. M said XYZ and two friends were also there that morning and these bruises weren't noted. At 09:00 she walked him to nursery.

493. Dr EP also took a past medical history from M which included an explanation that J has a chromosome 22q anomaly of uncertain medical significance which runs in the family on the paternal side, and affects F and PGM. There were no concerns raised about his development.

494. On examination Dr EP noted him to be chatty and interacting positively with M and the others present. He had normal movements and tone and there was no evidence of head injury. His throat was red which she thought could be consistent with an upper respiratory tract infection, or cough or cold like illness. She noted some marks on his upper abdomen, R knee and R ankle which were consistent with a mobile child and not of concern. She also noted multiple blanching red spots around his mouth, each less than half a centimetre, which could be consistent with a viral infection such as described by M.

495. However, she also noted five circular bruises or marks on the outer aspect of the back of both arms below the elbow. Each mark was around 1.5 cm diameter and the marks were clustered together. The marks were not explained by the history and she considered them to be highly suspicious for fingertip bruises. She did not consider she could rule out a non-accidental cause in relation to those injuries.

496. Dr Saggar is a consultant in clinical genetics who was instructed as a joint expert in this case. He has produced two reports and also gave oral evidence. He has over twenty years' experience specifically in clinical genetics. He regularly sees patients, children and adults, with inherited or genetic conditions. He has been engaged as an expert witness in over 110 separate cases for child protection or criminal proceedings. His expert evidence is relevant to the issues of bruising and seizures.

497. J's genetic investigations showed a duplication on chromosome 22q11.21, maternally inherited ("the Chromosome 22Q duplication"). In lay language, this means that J has a small extra amount of chromosome 22. The features of people with the Chromosome 22Q duplication vary extremely widely, even among members of the same family. Some people can have developmental delay, intellectual disability, slow growth or weak muscle tone (hypotonia). Other people have no apparent physical or learning difficulties or disabilities. It is entirely possible for a person to have other chromosome conditions as well as the Chromosome 22Q duplication.

498. Dr Saggar reviewed J in clinic on 30 June 2020 when he was accompanied by his current foster carer in whose care he has been continuously since mid-October 2019. Dr Saggar noted the history taken from the foster care which described J as a rough and tumble boy who rarely shows any sign of bruising; the foster carer has not seen any bruising that has not obviously been related to a small knock or play. However, she did report that occasionally J may get some bruises on the palms of his hands, near the thumbs when he has been pressing or lifting himself against things. There has been no history of any bleeding or nosebleeds. However, the foster carer has noticed that J is quite hypermobile and seems to be able to bend a lot. She has also never observed J have any fits. There is no history of any falling over although he is a bit wobbly in his gait.

499. Dr Saggar concluded that J is obviously hypermobile and has a diagnosis of hypermobility spectrum disorder (HSD) which may explain bruising after lesser

force; however, he was clear that it does not explain or cause spontaneous bleeding or spontaneous fingertip bruising. His opinion is that the lack of any further history of easy bruising or fingertip bruising while in foster care supports the notion that the earlier bruising seen on J's arms, was after a force or forces that would be known to a carer to be an excessive force for such a small child.

500. Dr Saggar concluded that there are numerous supporting features for a diagnosis of HSD which is a milder version of the most severe form of hypermobile Ehlers-Danlos Syndrom (EDS) called hEDS. This risk may therefore predispose J to a greater degree of bruising and/or bleeding for any given force. However, because there are no known genes for hypermobile EDS, the diagnosis is a clinical one established through a combination of the symptoms, signs, family history, examination findings and exclusion of overlap EDS syndromes by genetic testing.

501. In his initial report, Dr Saggar concluded that there is a negligible risk that J has the vascular form of EDS as an explanation for any unexplained skin bruising. He explained that bleeding and easy bruising is seen in many forms of EDS and is well described in the literature. It is also well described that HSD is associated with easy bruising, which is frequently without obvious trauma or injury. However, in his opinion, HSD alone would not explain spontaneous and sudden onset of fingertip type bruising.

502. He said clearly in evidence that although in hypermobile forms of EDS you would expect to see a bruise after <u>some</u> force, the bruises to J's face and arms are <u>not</u> spontaneous bruises. He was quite clear in his opinion that the facial bruise <u>must</u> have been caused by some sort of force because it occurred in a very soft area. He was of the same opinion in relation to the bruising on the arms, explaining that these bruises could not have occurred spontaneously and in order for J to have caused them himself, he would have needed to have gripped himself by each arm. He described seeing many many children with EDS and holds about six clinics a month; in his expert experience the bruising to J's arms is unusual in his clinical experience. He said he would not expect to see this kind of localised bruising, in a discrete pattern, all very close together.

503. He also said that the lack of any further history of easy bruising or finger tip bruising while in foster carer supports the notion that the bruising to the arms was after a force that would be known to a carer to be an excessive force for such a small child.

he was quite clear that there would not be any resolution of easy bruising after just a few months. To use his exact words, *'these things don't just turn on and off overnight like a tap in the case of connective tissue disorders'*. He was quite clear that there is absolutely no scope for any kind of 'temporary' bruising disorder.

504. He explained that fingertip bruising can be seen in children who have hypermobile forms of EDS and is also seen in many of the overlap forms of EDS. He said that the way in which J was held and gripped may be sufficient to cause discrete bruising. However, fingertip bruising does not occur in such small children spontaneously ie: in the absence of any description of force, albeit lesser force. He confirmed that analysis of the forces and the mechanisms required is outside his area of expertise. However, he cautioned that bruising is nonetheless unusual in such very small children and could not exclude excessive force and/or inappropriate handling. He also took account of the lack of any history of continued bruising whilst in foster care which he described as a notable factor. He said that it would be very unlikely in a short time frame, that any tendency to easy bruising after normal or rough handling would resolve, if there was a true susceptibility to bruising.

505. He was asked in evidence whether it is possible to have a propensity to bruise in particular parts of the body. He agreed that, in theory, that is possible but it depends on the actual part of the body. For example, it is easier to bruise a bonier part of the body. However, he was unequivocal in stating that the force required, and the forensic analysis of the mechanism required to cause the bruising to J's face and arms was not within his area of expertise.

506. Professor Fleming was clear that it is incredibly difficult to interpret bruising from photographs or in isolation. He was clear in evidence that therefore the court must place heavy reliance on the treating clinician who saw the bruises. However, he observed that, in his professional opinion, the distribution of the marks to J's forearms was not suggestive of anything else other than an inflicted injury. He considered that the bruising as indicated in the photographs is consistent with a hand being placed around J's arm, and in the absence of any other explanation, it reflects inappropriate and vigorous handling. He was quite clear that whatever produced these bruises was more than normal and ordinary handling.

507. He explained that unexplained bruising in a small child is important and significant to a consultant paediatrician because in the absence of a history of any

protective action, any paediatrician would look and think carefully about the possible causes of such bruising. He was very clear that it was the location of the bruising that is important. He deferred to Dr Saggar in terms of the degree of lesser force that might be required to cause such bruising because this is outside his own area of expertise. However, the fact that this bruising to this type of area has not been repeated and therefore represents an isolated event, means in his opinion it is unlikely to have arisen due to normal, routine handling. He considered that the hypermobility would be unlikely to be a relevant factor and said that it's not a condition where a child bruises with relatively normal handling, although he accepted that one might need a bit less force than necessary.

508. He dismissed the possibility that the bruises could have been caused by running into a wall because the bruises are in a broadly linear appearance. He also dismissed the possibility of the marks having been caused by J pinching himself because of their appearance – linear marks across the arm.

509. He said in evidence that if an ordinary carer saw the marks, they would recognise that something untoward had happened. This was significant bruising in an unusual site for bruising on an area of a child's body that doesn't normally make much contact with surroundings.

510. I accept the combined medical evidence. I find that the bruising was caused non-accidentally by a force or forces that would be known to a carer to be excessive for such a small child. I find that these were inflicted injuries that could not have been caused accidentally or benignly or as a result of normal handling, even with a degree of lesser force. They were most likely to have been caused by inappropriate and vigorous gripping to both forearms. I find that the 1-2-3 swinging game incident could not have caused these marks because the mechanism described by M and XYZ does not account for the distribution, pattern and location of the bruising seen.

<u>The timing of the bruising</u>

511. On Tuesday 1 October 2019 AZ, the social worker, visited J in nursery. KL said in evidence that she remembered speaking to the social worker that day and confirmed that no bruising was noted to J by the nursery that day.

512. MN confirmed in evidence that her safeguarding incident form dated 2 October 2019 was correct in which she stated that she noticed bruising to the backs of both forearms which had not been there the previous day.

513. I find that the bruising was not caused during the period of J's attendance at nursery on Tuesday 1 October 2019 between 09:00 – 15:00. I find that J left nursery at about 15:00 on 1 October 2019 15:00 without any bruising having been noted to his forearms.

514. Both M and XYZ stated in evidence that they did not observe any marks to J that evening. XYZ described how he had last seen J's naked arms at about 23:00 when he was giving him some Calpol with a syringe. The next time he saw J's arms was when he undressed him after nursery at some point after 15:00 the following day.

515. In oral evidence M described how difficult it was to get J to nursery the next morning. She said he would sit on the ground and the pavement, would cry and would run back towards home a few times. At times she had to pick him up. She described getting down to his level and trying to reason with him, but in the end she picked him up and carried him to nursery. She denied having gripped him by the arms to pick him up, and denies manhandling him that morning. She denied she was angry that morning.

516. MN is a nursery nurse who was J's key worker. On 2 October 2019. She discovered the bruises to J's forearms when she was changing him at 10:45 on the morning of 2 October. She completed her safeguarding incident form certainly within the hour of discovering the marks (and quite possibly sooner) and recorded her findings on a contemporaneous body map. Her note states that she noticed bruising to the backs of both his forearms which had not been there the previous day, and appeared as though they were possibly finger marks. She also noted that when M had dropped J off that morning she had said she had to fight him all the way to nursery as he didn't want to go that day. She confirmed in evidence that she had included as much information on the form as possible, and was very clear that she used the bodymap to record what she actually saw, and that this is what she had seen for herself. In evidence she was shown the photographs of the bruises taken by M later that afternoon at home, and confirmed that these were the marks she herself had seen and drawn on the bodymap that morning.

517. She was very clear in evidence that M had not told her that she had had a difficult night with J, nor that he had been running against walls. She was clear she wrote down everything that M told her. Like KL, she explained that all the staff have been trained in how to hold children and that they know they need to hold them in a light grip by the finger and thumb. She was absolutely clear that there had been no occasion that morning between 09:00 and 10:45 when she had to restrain J, nor that anything stood out to her from the previous day. In fact, she said that she never had to control J in the time he was attending nursery because he was always a happy and good natured little boy. She presented as a cogent and straightforward witness, and I accept her evidence in its entirety.

518. KL gave evidence. She is the nursery manager and the designated safeguarding person. She confirmed that she and all the nursery staff were trained in safeguarding procedures. She also confirmed that their practice is to adhere to a ratio of usually 1 member of staff to 5 children aged under 3, but that they always make sure there are three staff actually available, 2 staff with the children eating lunch, and 1 staff member cleaning the bathrooms. She said in evidence that it would be very unlikely that a staff member would be under such pressure that they could have caused bruising to J without her knowing. She also said that if such a thing had happened, she would imagine that the child would have made a noise. She said they can always hear staff with all the children all the time, and that even when she is in the staff office, she can hear what's going on in the bathroom. She said her practice is always to leave her office door open. She said the playroom is about 4 metres square and can hold about 22 children, although they never usually have that many. On 2 October 2019 she did not hear any unusual noise or shouting or screaming in the period between 09:00-11:00.

519. Like IJ, KL confirmed that no bruising had been noted to J at nursery on 1 October, nor had none been reported to them by M. She confirmed in evidence that she has never had to investigate an incident of non accidental injury caused by a member of staff. I accept her evidence in its entirety.

520. IJ is the deputy manager of the nursery and she also acts as the deputy safeguarding officer. She confirmed in evidence that generally all the staff take notes about all the children, who attend nursery in one big room. On 2 October 2019 at 15:02 she spoke to M about the bruising; although she had not seen the bruising herself, she was reliant on MN's bodymap and half-completed safeguarding

incident form and was also reliant on what she had been told by staff. She told M that some bruising had been noticed. In evidence she said that the nursery routinely records any injury caused there, and that in those circumstances the parents would be shown a separate accident form and asked to sign it at the end of the day. There was no such form completed on 2 October 2019 which confirms that the bruising was not caused by a member of nursery staff during the day. I have seen an example of the nursery's use of such a form in respect of some marks to J's nose reported by M on 24 September 2019. She gave clear and cogent evidence demonstrating a good understanding of the importance of the nursery staff keeping accurate records. She was clear that the bruises had not been caused at nursery. I accept her evidence in its entirety.

521. She was cross-examined on behalf of M to the effect that the bruising had been caused at nursery. M's case in this respect has been evolving and confusing. In her initial threshold response she said it could only be that the bruising was caused at the nursery which is what she believed had happened. However, in her final threshold response she said that the bruises could have occurred at the nursery that morning given that they were not observed there until late morning.

522. In her contemporaneous note IJ described M interrupting her to ask whether the bruises noted had been on his arms, M then denied knowing how they had been caused, then said she should have said that morning but had forgotten. I accept IJ's evidence about this completely. She presented as a straightforward and credible witness, and where her evidence differs on the facts to M, I prefer her account. Her contemporaneous note confirms that M told the nursery that the bruises had already been present by the time J presented at nursery that morning.

523. KL explained in evidence that the nursery practice is never to hold or restrain a child by his or her forearms, and that if they do have to use any sort of restraint, then they automatically record it. She described the usual practice as being to take a child by the hand if they needed to control him or her. But she was clear that J was always an easy to manage child in the two weeks or so in which he had been attending the nursery. She said he wasn't difficult in any way, was a quiet child and was not at all disruptive.

524. I find that it is not likely that the bruising was caused at the nursery between 09:00-15:00 on 1 October 2019 or between 09:00-10:45 on 2 October 2019.

525. I therefore find that it was likely that the bruising was caused in the period between 15:00 on 1 October 2019 and 09:00 on 2 October 2019.

526. MN was very clear that when M came to collect J from nursery on 2 October 2019, M did not ask to see his arms or the bruises. She said clearly in evidence that at no stage did M mention the bruising to her, and when she saw M later that afternoon she did not in fact know whether M had actually seen the bruises by then. She was adamant she did not say words to the effect that she'd had enough and they all had homes to get to (as was put to her in cross-examination on behalf of M). She said if a parent asked to see marks on their child, she would never stop them. She agreed that if either M or XYZ had asked her if they could see the bruises, then she would have let them. She was adamant she did not chivvy them or hurry them out of the nursery. She also confirmed in evidence that there was plenty of opportunity for M and XYZ to have looked at the bruises within the nursery building if they had wanted to.

527. I found her to be a kindly, straightforward and cogent witness who is plainly very experienced and trained in safeguarding. I accept her evidence in its entirety, and I make it clear that where there is a dispute on the facts between her and M, I prefer her evidence.

528. When I consider the evidence of both XYZ and M, it is possible to narrow the window more tightly on the balance of probabilities to have been in the period between about 23:00 on Tuesday 1 October 2019 until he arrived at nursery at about 09:00 the following morning. I find that the window for the causation of the bruising must have been in that period for the following reasons.

529. I have already rejected the possibility of the bruising being caused by any '123 swinging game' after school on Tuesday 1 October 2019. F said in evidence that although M had told him she thought the 123 swinging game may have caused the bruises, he doubted this as he had played this game with J himself with M where they held J by his hands, not his forearms.

530. XYZ gave evidence. He said that in the afternoon of 1 October 2019 he remembered going to the shops and seeing M and J approach as he left the shop. He said he gave M some money to get J a chocolate bar, then hid it in his own pocket so J couldn't see it. He described J as seeming very excited, just his normal self. Although at first he said he thought it might be a possibility that the 123

swinging game could have caused the bruising, he said there was some doubt and confusion in his mind about the date.

531. In evidence, he described J that evening. He said he was very energetic and running about, then when he heard FS and JK come over he became even more energetic as a result. He said he tried himself to settle J in bed and went into the room while M was at the bedroom door. He said he picked him up then put him back in the bed, then left the room. He believed after that M had stayed to read him a story while he went back into the living room.

532. He said although J then appeared to settle, as soon as M had left his bedroom he was back up again. He agreed in evidence that although he had not seen M lose her temper with J, he then did not go back into J's room with her every time. He was quite clear that from the time he eventually went to bed that evening, he did not see his arms undressed again. He said in evidence that J was still awake at midnight, after FS and JK had left. He described M as still having to sort J out, and that J was still being very energetic at this stage. He described both he and M as being absolutely exhausted at this stage.

533. F said in evidence that M had phoned him between 23:00-midnight that night saying that J was unsettled which wasn't necessarily that uncommon.

534. XYZ said he didn't get cross with J. He agreed that he could not say what M did while he was asleep.

535. He woke up the next morning about 08:00, M got J dressed. He was very clear that he did very little with J that morning because FS and JK came back for coffee. He thought all he did was make J his breakfast and fetch his uniform (a polo shirt and jumper or sweatshirt) for M. He was clear in evidence that it was M who had dressed J. He didn't think J had a bath that morning and may have had a bath the night before, but he said M washed him that morning.

536. He said that later that day M suggested to him that he go with her to collect J from nursery for the first time. She raised it about 10-20 minutes before she was due to leave to collect him. He said this was very unusual as he didn't really like going out. He said he hates it with a passion, but if he has to go outside and it's important, then he will go. He thought M was aware of this. He said he didn't really want to go with M that day but changed his mind as he thought it would be nice for J to see them

both. In his interview with Professor Fox he confirmed how difficult things were for him at this time. On 26 September 2019 he is described as having had contact with his GP about longstanding mental health issues, including struggling to go out of the house with low mood and daily thoughts of self-harm. I accept his evidence about this.

537. He said when they got to nursery M had a conversation with MN and they both went into the room. He described M saying she wanted to see bruising on J's arms but MN saying *'it's time for you to leave now'.* MN did not describe this in evidence at all as I have already indicated. I find that where there is a dispute on the facts in respect of this matter between her and XYZ, I prefer her evidence. However, I bear in mind that this was the very first time XYZ had ever been to the nursery and he had not met MN before. Indeed, he later accepted it was IJ who told them they had found some bruising to J's arms.

538. He explained that the worker had asked M if she knew where the bruising had come from and M had said no. In evidence he described how they were ushered or shooed away from nursery that day, but agreed this was the only time he had ever been to the nursery. He agreed there was an opportunity for them to have looked at the bruising on the way home, but that it was cold and he just wanted to get J home and it was only a five minute walk home. He said M phoned F on the way home to tell him about the bruises, but to his knowledge at that stage M had still not seen them herself.

539. XYZ gave evidence about what happened when they got home. He said he was the first one to look at the bruises. He said they were going to look at the bruises together but that he was impatient and took off J's jumper himself while M went into the kitchen. He said he was a bit concerned to learn J had bruises to his arms because he knew children don't normally get bruises there. His shock in evidence when he was describing this was palpable and credible and genuine, and I completely accept his evidence in this regard. He said he said *'what the fuck is that'.* He described himself as being shocked, horrified, disgusted and angry. He said he felt like a rage had built up inside him and he felt really sick and was wondering where they'd come from. As he gave evidence it was plain this episode had greatly affected him. He was asked how he would have responded if he <u>had</u> seen M cause the bruises, and he was unhesitating in his answer that he would have phoned the police immediately because it was a crime.

He said he definitely would have done something about it if he'd seen anyone do this. He agreed that M would have a good idea that this is how he would be likely to respond.

540. XYZ presented as a cogent, articulate and coherent witness. In all regards, apart from the part of his evidence in relation to what he says he and M were told at the nursery by IJ for reasons I have already explained, I accept his evidence. He spoke movingly and warmly in evidence about J, and I watched him very carefully while he was giving evidence. He said he is quite experienced with young children as he has a nephew the same age and younger siblings and cousins. He described how important he considers it still to have contact with J so that their connection is not lost.

541. XYZ's evidence was therefore that he last saw J's uncovered arms at about 23:00 when he gave him some Calpol. He saw no bruises at that stage. I accept his evidence.

542. I find that the only person who had direct care of J in the period between 23:00 that night and 09:00 the next morning was M.

543. Both M and XYZ confirmed in evidence that all XYZ did the next morning was possibly give him his breakfast, at which point J was dressed. M was the person who had cared for J through the night, M was the person who got him washed and dressed in the morning, and M was the person who took him to school. It is not M's case that FS (who she says accompanied them to school) hurt J in any way. J was wearing a school coat and a sweatshirt that morning.

544. XYZ described what M said when she got back from nursery that morning – that it had been like hell trying to get J there and that he had thrown himself on the floor. He said M used the words *'it was a real mission'* to get him there. He said that was quite common, and that most times J wouldn't want to go to nursery at all. He also said that at those times J would throw himself on the floor, and said there had been quite a few occasions when he was a bit moody or grizzly. However, he agreed he had never seen bruises caused to him as a result at those times.

545. MN's note of safeguarding actions recorded for 2 October 2019 reads as follows – *'On arrival Mum told me: J had 2 hrs of sleep. Off his*

dinner/breakfast. Didn't want to come to preschool today, she had to fight him all the way here.'

546. In evidence M denied having grabbed J during the previous night, denied that she had ever used force on him or ever picked him up by his arms. She said she gave J a quick wash (not a bath) and confirmed that J had been very difficult to settle. She described a trying period when J was running around, pretending to be a racing car, and was wriggling a lot. She said that even after she and XYZ had settled him into bed, they had to go back into the room on at least two occasions. She agreed that she and XYZ were trying to relax and have some adult time with FS and JK, but that they could hear J wasn't asleep but was still running around and not settling in his room. She denied she found this frustrating.

547. In cross-examination she denied 'manhandling' J the next morning. She said that he had been awake before her and was crying. She agreed that she had got him dressed in the living room but agreed that she had had quite a difficult journey to nursery and said it had been a struggle pretty much all the way there. She described how at times J would sit on the pavement so that she had to pick him up by getting down to his level. She said this was a normal thing for him and denied that she had been angry with him at all.

548. In his evidence F confirmed that the first he knew about the bruising was after J got out of nursery that afternoon. He said M phoned him saying she had collected him from nursery with the bruises. Initially he imagined they would just be normal, little bruises caused by bumps. He said M sent him the photographs in the bundle, and he described how shocked and upset he'd been when he saw them thinking that someone had grabbed J by the forearms and upset at the very thought of him being upset. He said when he saw the photos he was crying because they were really upsetting. I found his evidence in this regard credible and moving. He was presented as genuinely emotional about this incident. He said as soon as he saw the photos, he immediately thought they looked like grab marks and that someone had grabbed him.

549. Taking account of all the relevant evidence in respect of this incident, although it is right that the nursery staff had an opportunity to cause the injuries to J in the period between 09:00 – 15:00 on 2 October 2019, I do not consider there is a likelihood or real possibility that any member of the nursery staff was the perpetrator.

550. I find that the only people in the pool of possible perpetrators were M and XYZ. I find it is likely M was the perpetrator and inflicted bruising injuries on J's forearms at some point in the period between 23:00 on Tuesday 1 October 2019 and 09:00 on Wednesday 2 October 2019. I find that the injuries were grab marks caused by M's very firm or vigorous handling of J's arms, most likely more than once. The force used was excessive and inappropriate and would have been painful for J. I find that M would have realised that J was being harmed.

ALLEGATION 5 – FII

551. The local authority seeks a finding that M's behaviours fulfil the RCPCH criteria for Factitious and Induced Illness (FII) and warrant also the paediatric diagnosis made of J in June 2018 of fabricated and induced behaviour at Level 1; fabrication of signs and symptoms including fabrication of past medical history.

552. However, the local authority also recognise that dependent upon such findings as may be made by the court, and having regard to Dr Adshead's own observations as to the appropriate timing for the instruction of an expert from her discipline, the court may wish to consider further this finding sought with benefit of Dr Adshead's view post fact-finding.

553. I accept this proposition. This issue is more appropriately dealt with at the welfare stage of these proceedings. **I make no finding in respect of this allegation at this stage.**

ALLEGATION 11 - F's lack of insight into FII concerns re M

554. The local authority also seeks a finding that F lacks insight into the concerns of FII in respect of M and that his capacity to protect J from this is limited.

555. It follows in light of my lack of finding in respect of Allegation 5, that I also consider this issue is more appropriately dealt with at the welfare stage of these proceedings. I agree. **I make no finding in respect of this allegation at this stage. I accept this is a more appropriate matter for the welfare stage of these proceedings, and that any judgment as to his capacity to protect is best reserved for that stage**

when a true measure of risk has been determined, and after he has been given an opportunity to absorb and reflect on any findings made.

556. That is my judgment.

POSTSCRIPT

557. On 6 June 2019 it was unanimously agreed at the Initial Child Protection Conference (ICPC) that J should be made subject to a Child Protection Plan under the category of physical abuse. Professionals attending that ICPC were the police, EF, the health visitor and BX. He remained subject to that Child Protection Plan until after these proceedings were issued on 2 October 2019.

558. Within this judgment I have highlighted the injuries sustained or apparently sustained by J in the period 12 June – 1 October 2019 while he was subject to a Child Protection Plan. This may raise important questions to be considered by the local authority and the nursery in terms of child protection and management procedures. I shall therefore direct in due course that this judgment (or a redacted version of it) shall be sent to the relevant senior managers at the local authority and at the nursery.

Elizabeth Isaacs QC
(sitting as a Deputy High Court Judge)

23 December 2020

SCHEDULE OF FINDINGS MADE – 23 December 2020

Fabrication of seizures

1. **M fabricated symptoms of seizures on 6 September 2017**.

2. **M fabricated symptoms of seizures occurring on 11 October 2017**.

3. **M fabricated her account of symptoms of seizures or seizure-like activity occurring on 11 October 2017 in her discussion with Dr L on 6 November 2017**.

4. **M lied in her account to Dr U on 7 November 2017 that J was having 'absent episodes' once or twice a week, and that she also lied in saying that PGM had told Dr U these were witnessed by F**.

5. **The bulk of the history, if not the entirety, was given by M on 8 January 2018. M fabricated reports on 8 January 2018 that J had been having increasingly frequent absence seizures and two seizures in which his whole body was jerking with eyes closed.**

6. **On 11 January 2018 M lied when she told Dr L that she had observed J having vacant episodes for a short period once or twice a day, and when she described episodes during which J experienced behavioural arrest.**

7. **M falsely claimed she had ten recordings of J experiencing seizures (or similar episodes) on her phone in an attempt to persuade Dr S of the truth of her fabricated account.**

8. **On 26 February 2018 J was brought to hospital by ambulance due to M falsely reporting he had experienced a seizure and jolting movements.**

9. **On 6 March 2018 M falsely told the health visitor that J had a seizure which was witnessed by staff during a recent stay in hospital.**

10. On 10 July 2017 M took J to hospital complaining that he was screaming and inconsolable and falsely concerned he had suffered bruising whilst staying with F. No bruising was seen.

Fabrication of other matters

11. On 11-12 October 2017 M reported to hospital staff that J had been mimicking masturbatory behaviours and was upset that F had taught him how to do it, and she also reported this to the local authority.

12. M was not forced against her will by a social worker or a foster carer to undergo a termination in 2012.

13. M fabricated a pregnancy in February 2011.

Fabrication about 'Lily'

14. Whatever M's reaction to having had a termination in 2012, by the time she met F four years later she was demonstrating no significant or discernible psychiatric or psychological disorder.

15. Before M became pregnant with J in July or August 2016 she had taken the considered decision to obtain a tattoo to commemorate 'Lily' with the intention of falsely conveying to others that she was the mother of a dead child.

16. At the outset of her relationship with F in March 2016 M falsely told him that she had had a child called 'Lily' who had died from SIDS.

17. M persisted in maintaining the lie about 'Lily' at least from late 2016 or early 2017 until October 2019 to medical professionals, to social work professionals, to F and to the PGM, and until March 2020 to XYZ.

18. M did not tell XYZ the truth about 'Lily' until March 2020.

19. M persisted in maintaining the lie about 'Lily' on her social media accounts until November 2020.

20. M continued to lie about 'Lily' persistently, deliberately and with full knowledge of the likely impact on others of those lies.

21. It is likely that the narrative about 'Lily' would have continued.

Unnecessary medical testing

22. As a result of M's false accounts that J was experiencing seizures (influenced also by her false report that she had a child who died of SIDS at the age of six months), J has been subjected to unnecessary medical testing (including an ECG, more than one EEG, MRI scan under sedation, participation in a sleep study and chromosome testing) and received medication which he did not require.

Likely emotional harm

23. In the longer term, J was likely to suffer significant emotional harm owing to living in an environment where his life had been medicalised and where he had been provided with M's narrative that he was unwell and that there was something wrong with him when this was not the case. This would have been likely to have marked him out as different from his peers. J was also likely to suffer significant emotional harm from growing up in the false belief that he had an older sibling who died as an infant and with whom he therefore had lost the opportunity of a life-long sibling relationship.

24. J was likely to suffer significant harm owing to high levels of volatility and conflict between M and F.

25. A likelihood of significant harm to J arose irrespective of whether M's allegations against F (or some of them) were true or false.

Missed appointments

26. The appointments with Dr L on 5 June 2017, 3 July 2017 and 14 August 2017 were missed intentionally and without good reason by M and F.

27. The appointment on 13 March 2018 with Dr U was missed intentionally and without good reason by M.

28. The appointments on 5 April 2018, 10 April 2018 and 29 May 2018 with Dr S were missed intentionally and without good reason by M.

29. The appointment on 6 September 2018 with Dr L was missed intentionally and without good reason by M.

30. The appointment on 18 September 2019 with Ms G was missed intentionally and without good reason by M.

31. The appointment on 3 October 2017 with the health visitor was missed intentionally and without good reason by M.

32. The appointment with OM on 14 May 2018 was missed intentionally and without good reason by M.

Bruising

33. M asked FS to make a statement to verify M's account of J being hard to settle on the night of 1 October 2019.

34. The bruising was not caused during the period of J's attendance at nursery on Tuesday 1 October 2019 between 09:00 – 15:00.

35. J left nursery on 1 October 2019 at about 15:00 without any bruising having been noted to his forearms.

36. It is likely that the bruising was caused in the period between 15:00 on 1 October 2019 and 09:00 on 2 October 2019.

37. It is not likely that the bruising was caused at the nursery on 2 October 2019 between 09:00-10:45.

38. These were inflicted injuries that could not have been caused accidentally or benignly or as a result of normal handling, even with a degree of lesser force. They were most likely to have been caused non-accidentally by inappropriate and vigorous gripping to both forearms, most likely more than once.

39. The 1-2-3 swinging game incident could not have caused these marks because the mechanism described by M and XYZ does not account for the distribution, pattern and location of the bruising seen.

40. The only person who had direct care of J in the period between 23:00 on 1 October 2019 and 09:00 on 2 October 2019 was M.

41. It is likely M was the perpetrator and inflicted bruising injuries on J's forearms at some point in the period between 23:00 on 1 October 2019 and 09:00 on 2 October 2019.

42. The force used was excessive and inappropriate and would have been painful for J. M would have realised that J was being harmed.