Neutral Citation Number: [2023] EWHC 1767 (Fam)

Case No: NG22C50102

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/06/2023

Before :

MRS JUSTICE LIEVEN

- -

Between :

X CITY COUNCIL

Applicant

and

M (The Mother)

First Respondent

and

F (The Father)

Second Respondent

and

A, B and C
(children represented through the Children's Guardian)

Third Respondents

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Matiss Krumins and Samantha Smith (instructed by **X City Council**) for the **Applicant**
Rachel Langdale KC and Hannah Simpson (instructed by **Smith Partnership**) for the **First Respondent**
Nkumbe Ekaney KC and Christopher Rank (instructed by **Bhatia Best**) for the **Second Respondent**
Vickie Hodges (instructed by **Hawley and Rodgers**) for the **Third Respondents**

Hearing dates: **5-12 June 2023**

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Approved Judgment

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MRS JUSTICE LIEVEN

This judgment was handed down in private on 12 June 2023. It consists of 87 paragraphs. The judge gives leave for it to be reported in this anonymised form. Pseudonyms have been used for all of the relevant names of people, places and companies.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by his or her true name or actual location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Mrs Justice Lieven DBE :

1. This case concerns three children, A a boy aged 6, B a girl aged 2 and C a girl aged 18 months. The First Respondent is the Mother and the Second Respondent is the Father. The Local Authority ("LA") allege that the Mother, between March and April 2022, deliberately poisoned C with excessive amounts of salt causing her significant harm. The Mother denies this allegation and suggests that the excessive salt may have been as a consequence of one of the medicines C was prescribed (omeprazole).

2. The LA was represented by Matiss Krumins and Samantha Smith, the Mother was represented by Rachel Langdale KC and Hannah Simpson, the Father was represented by Nkumbe Ekaney KC and Christopher Rank, and the children were represented through the Children's Guardian by Vickie Hodges.

3. C was born in December 2021 at 34 weeks gestation and weighed 2.7kg at birth. She had difficulty feeding when first born, as is quite common with premature babies, and a Nasogastric Tube ("NGT") was fitted. The Mother was trained to use it.

4. C was discharged home when about a week old where she lived with her parents and siblings and other members of the Mother's large extended family. The Mother, Father, A and C all slept in one room. The maternal grandmother ("MGM") and the (step) maternal grandfather ("MGF") slept downstairs. The evidence was that C was quite a sickly baby who was slow to feed and became constipated easily. The Mother tried to express breastmilk until late January but found this very hard.

5. On 3 January 2022 C was taken to hospital as the NGT was pulled out. It was refitted and she was discharged home. On 14 January she was prescribed lactulose by the GP. On 19 January she was also prescribed sodium picosulfate for constipation. On 31 January she was prescribed Gaviscon for reflux.

6. On 3 February C returned to A&E due to the Mother's concerns about her abdomen being distended, poor feeding, constipation and breathing problems. Her dose of lactulose was increased.

7. On 4 March she was taken to the GP because of a lower respiratory tract infection and was prescribed Amoxicillin. She was also prescribed omeprazole (a proton pump inhibitor PPI) for reflux.

8. It cannot have helped the Mother's anxiety that by this point C was on four different medications and they may all have been having different effects on her digestion.

9. On 14 March C went to A&E with similar issues. On examination she was recorded as appearing well.

10. On 16 March she was taken to A&E with the Mother reporting vomiting over the previous days and that she was less alert than normal. She had a sunken fontanelle. She was recorded as having high sodium and chloride levels. The records show 159, 160 and 152 mmol plasma sodium on that day. The normal range is 135-145 mmol. The evidence I refer to below shows that these were levels of real concern. She was observed to feed well and pass urine in hospital.

11. She was admitted to a paediatric ward where she stayed until 22 March. During her time on the ward she was again recorded as having high sodium levels in her plasma. On 17 March the readings were 144 at 8.20am and then 165 at 11.45pm. She was noted to have a sunken fontanelle. She was treated for dehydration and given antibiotics and her sodium levels normalised. On 18 April at 4.44am there was a sodium reading of 158 mmol.

12. On 24 March the Mother took C to A&E reporting that she had been shaking at home with eyes rolling and arched back. The Mother said this had lasted about a minute and she then went floppy and sleepy. C was admitted to hospital, fed well and there were no concerns on observations or examination. There was no evidence of infection. She was given an MRI scan under general anaesthetic, but this revealed no issues. She was discharged on 31 March. The sodium levels through this admission were normal.

13. She was taken back to A&E on 2 April with the Mother reporting that C had had three seizures during the day, but she had only seen the third one herself. Again at hospital the observations were normal and she fed well. Her dosage of omeprazole was increased. She was discharged on 7 April.

14. C went back to A&E on 15 April with the Mother concerned that she was not eating, had reduced wet nappies and was vomiting. Her fontanelle was observed to be slightly sunken. The blood tests showed high sodium and chloride levels, which normalised within 12 hours. She was not tolerating feeds and the NGT was used.

15. She was taken again to hospital on the health visitor recommendation on 21 April because the Mother said she was not feeding well. The blood tests showed she had raised sodium levels. She was discharged on 23 April.

16. On 2 May C was again in A&E on the Mother's report of her having had seizures, which seemed to be related to her feeds. The observations were normal, but blood tests showed raised sodium and chloride levels. The plasma sodium level was 160 at 3.336am, 150 at 5.09am and 152 at 6.40 pm. It then dropped the next day to 139.

17. At this point the treating paediatrician, raised safeguarding concerns and on 7 May the police arrested all the adults residing in the family home.

18. The two older children were placed with family friends, D and E, pursuant to s.20 Children Act 1989 and on 17 May C was discharged to live with them. An Interim Care Order ("ICO") was made on 31 May 2022 and the children were moved to foster care in September 2022.

19. Since C has lived away from the parents there have been no more admissions to hospital, no reported seizures and she has been well. There was a suggestion that one of the family carers had seen a seizure, but D made a statement that he was not aware of C having had a seizure in their care, and he was called to give oral evidence and confirmed this. The incident that was referred to may have been a symptom of reflux with C arching her back.

20. C was discharged with a prescription for omeprazole and continued to take this for about 10 days when the prescription ran out. She appeared to be more settled without it so the GP stopped the prescription. She has not had omeprazole since late May.

21. I heard evidence from the Consultant treating paediatrician. A number of experts were appointed; Dr Coulthard, consultant paediatric nephrologist; Professor Ng, consultant endocrinologist; Dr Hogarth, consultant neuroradiologist; Dr Saggar, consultant in clinical genetics and Dr Robinson, consultant paediatrician.

22. The treating paediatrician gave evidence as to the tests that had been carried out on C and referred to hospital notes, both for the results of the tests and the prescribed drugs that had been given to C. She was the treating consultant in May when the safeguarding issues had been raised.

23. She accepted that during the earlier admissions the assumption had been made at the Hospital that C had suffered from dehydration as a result of the Mother's reports of vomiting and diarrhoea. She accepted that the safeguarding concerns had only arisen when the blood tests results came back on the 2 May admission.

24. She said the sunken fontanelle was a sign of dehydration but alone it was not a good indicator. The other signs of dehydration were not present such as raised urea levels, or actual evidence of vomiting or diarrhoea. She confirmed that C had been prescribed omeprazole because she suffered from reflux.

25. I heard evidence from the health visitor who was the health visitor from March 2022. She had met the Mother on a number of occasions but never the Father. She said she had a good relationship with the Mother who accepted medical advice, asked appropriate questions and showed good emotional warmth with C. The records refer to the Mother having very good support from her family. Neither this health visitor nor the first health visitor had any concerns about the parents or the care that C was receiving.

26. The Mother had been concerned that C was allergic to cow's milk. There had been concerns raised about C suffering from constipation, vomiting and reflux.

27. Dr Coulthard is a consultant paediatric nephrologist, and he gave oral evidence. He explained that hypernatremia is a plasma sodium concentration above the normal range of 135-145, although sometimes it was accepted that it could go up to 147mmol. Values above 150 would be considered clinically significant hypernatremia. He had treated many children with hypernatremia.

28. The body maintains sodium strictly, and if there is excessive sodium the body acts quickly to excrete it, generally within a range of 1-4 hours.

29. Dr Coulthard was clear that in his view the only explanation for C's presentation was that she had been given excess salt. He said that she did not appear to be dehydrated. A sunken fontanelle was not on its own a good indicator of dehydration. Her weight pattern did not support a finding of dehydration as one would have expected her weight to fall when dehydrated and then to go up when rehydrated. However, there was no evidence of this pattern occurring. Further there was no evidence from hospital of her having gastroenteritis, or severe diarrhoea, which are the normal causes of dehydration in small infants.

30. It was his view that C had been given salt during the hospital admissions of 16-17 March and 2-3 May. This was because he would have expected her sodium levels to

fall rapidly once she was fed with uncontaminated milk. However, on 17 March her level went back up, and on 2 May it plateaued rather than fell. It was not possible to tell precisely what happened because the hospital did not take plasma readings at regular points across the entry, but he thought it highly likely that her sodium level on 2 May had fallen and then risen again when she was given salt.

31. He pointed to the fractional sodium excretion rate found on 2 May. This was some 10 times what would have been expected and was another strong indicator of salt poisoning rather than dehydration.

32. The evidence showed that there was no problem with her kidney functioning. Her creatinine levels were normal, and this is a very reliable test for kidney functioning.

33. He did not think that omeprazole could have been responsible for the high sodium levels. He had seen many infants prescribed with omeprazole and had never seen this effect. The article on Electrolyte Disturbance relied upon by Ms Langdale did not support a case for omeprazole increasing sodium levels – it was focused on magnesium levels; it actually showed a fall in sodium not an increase, and there was no broader review of studies which would support such a finding.

34. Professor Ng is a consultant endocrinologist. Her evidence largely accorded with that of Dr Coulthard. She explained that salt poisoning increases plasma volume due to increased osmotic pressure. Salt poisoning is associated with increased urinary salt excretion and usually with stable or increased weight. Like Dr Coulthard she relied on the very high fractional excretion level recorded on 2 May.

35. The only area where there was any suggestion of disagreement between Professor Ng and Dr Coulthard was that she did not initially think that the sodium plasma levels suggested that C had been given excess salt in hospital because she said that an increase of 2mmol was not itself significant. However, later in her oral evidence she agreed that she would have expected C's levels to drop to the normal range if she had been fed uncontaminated milk. Therefore, it followed from her evidence that Dr Coulthard's conclusions were justified on the readings on 16-17 March and 2-3 May.

36. Professor Ng said she had seen hundreds of children and infants on omeprazole and she had never come across any linkage with high sodium levels. The paper produced by Ms Langdale did not support any such linkage.

37. Dr Hogarth is a consultant neuroradiologist who produced a report but did not give oral evidence. He concluded that there were no findings that would affect the evidence in the case. He did say that there was some possible widening of the fluid spaces around the brain which might indicate dehydration. However, it fell within the range that some neuroradiologists would consider normal and he did not think the finding was of any material significance.

38. Dr Saggar is a consultant in clinical genetics who produced a report but did not give oral evidence. He found no genetic mutation that would explain the high plasma sodium levels or the fractional excretion of salt.

39. Dr Robinson is a consultant paediatrician who is frequently instructed in cases concerning allegations of Fabricated or Induced Illness ("FII"). He produced written

reports and gave oral evidence. His evidence followed on from that of the other experts. He thought there was no explanation for C's high sodium levels other than that she had been given excessive levels of salt. His evidence as to the likelihood of any other cause was essentially the same as that of Dr Coulthard and Professor Ng.

40. He said that it was possible that the Mother had misinterpreted C's symptoms of reflux as being her having seizures.

41. The Father gave oral evidence and was cross examined. He was not a forthcoming witness and gave the impression of being rather passive and perhaps somewhat uninterested in what had been happening. His evidence was that he worked as a security guard on Saturday and Sunday nights, and largely slept during those days. He said during the week he did help by taking the older children to school and was with them in the house.

42. He said that the Mother largely looked after C although he would give her bottles when asked. He said the Mother changed her nappies. On all occasions it was the Mother who took her to hospital and who met the health visitor and GP.

43. He seemed to have very limited understanding of the worries and anxiety of the Mother, or of her mental health issues. This may have been from a wish not to emphasise these parts of the Mother's presentation, or he may genuinely not have noticed.

44. The Mother gave her evidence in a calm and measured way. There were points when she got upset, which was wholly understandable. I formed the impression of someone who really loved her children and was absolutely trying to do her best, but who was under an enormous amount of pressure during the relevant period for a variety of reasons.

45. It was unfortunate that there had been no proper disclosure of the Mother's medical records and so much of her evidence in this regard could not be checked and came as something of a surprise.

46. She said she had suffered from anxiety for many years, in part as a consequence of traumatic events during her childhood. She described how C was not a planned baby, but she and the Father had been in Pakistan and had to stay much longer than planned which meant her contraception had run out. They were initially told the pregnancy was not viable and I suspect the early pregnancy was difficult. Although unplanned I did not get the impression that she or the Father were unhappy she was pregnant again.

47. She said that in 2020 she had had gastric surgery which led to major weight loss, including 20kg in the first three months of the pregnancy. It was also very hot in Pakistan whilst she was there. All of this probably led to a somewhat difficult pregnancy.

48. C was born at 34 weeks gestation and after the Mother had only been in hospital for about 10 minutes. She was then left very much on her own in hospital, in part because she had Covid at the time.

49. She plainly found it very worrying, understandably, to have a premature baby who only weighed 2.7kg and was being fed through an NGT. My very strong impression was that the Mother had limited help and support when she and C got home and the Mother was quite isolated. The Father left the primary care of the baby to the Mother, and the MGM required caring for. There are some texts from the Mother to a friend in February suggesting that the other family members did not give her much support, or at least that is how she felt. I note the Mother's sisters are teenagers and doubtless had their own lives to lead. But the impression of the household is one that in general was loving, but in practical and emotional terms left the Mother largely feeling isolated and unsupported.

50. The Mother said that in February she knew she was becoming very anxious, she could not enjoy "small things" and she was often crying. The Mother is someone who sees herself as a coper, but the evidence suggests that she was by this stage suffering from depression. She was prescribed sertraline by the GP.

51. She said that she did not speak to the Father about how she was feeling. She said very movingly that she did not know how to do so. She did open up more to her mother (the MGM), but the MGM could give only limited help

52. It was clear both from the records and the Mother's oral evidence that she was very anxious about C's feeding. She said that C frequently had diarrhoea or was vomiting, although that is not really borne out by the hospital notes. I note that the Father said that they did not speak about C's problems feeding.

53. Two oddities are that the weight chart shows that C actually put on weight throughout the relevant period in a reasonably appropriate way. This does not appear to have given the Mother much reassurance. Secondly, the Mother seemed much less concerned about C's seizures than one might have expected. She said this was because various adult members of the family have seizures and the doctors did not seem very concerned. This was her explanation for only taking C to hospital on 2 April when she was said to have had three seizures.

54. It may also be relevant that throughout the relevant period the Mother, MGM and MGF were all under investigation for fraud. The CPS were making a charging decision in early 2022 (and ultimately did charge them). Although the Mother denied that this issue was making her anxious, it can only have been another source of anxiety for her.

55. The Mother said that she had never knowingly given C excess levels of salt. She accepted that she was the person who largely fed C at home. But she said that in hospital the nurses had normally made up the bottles (or they were pre-prepared). She also said that nurses and staff came in and out of the room so she would have not been able to put anything into C's feed.

The Law

56. There is no dispute between the parties on the legal principles and the case law that should be applied in this case. The following represents a distillation of those principles and the considerable volume of applicable case law. I consider that the

summary set out below is an appropriate analysis of the relevant caselaw, and it is not necessary to set out the various cases that lie behind this summary.

57. The burden of proof is on the LA. There is no obligation on the parents to provide explanations for any matters or 'memorable events' although the court is entitled to weigh the absence of such explanation alongside all the other evidence in the case. The civil standard of proof applies, namely the balance of probabilities. If the LA proves that it is more probable than not that something occurred, then it becomes an established fact for the purposes of these proceedings. If the event in question is not proved, it is treated as having not occurred. That is the binary system that operates in the Family Court.

58. The court must reach decisions in relation to disputed allegations on evidence, not speculation or rumour. It may, however, draw logical inferences from evidence that it has accepted.

59. The court must reach a conclusion in respect of each separate allegation but must also take care not to compartmentalise its analysis – the entire canvas of evidence must be surveyed and each piece of evidence must be considered in the context of the other evidence.

60. The role of the judge and the expert are very different. The responsibility for making decisions always rests with the judge and not the expert - the expert advises, and the court decides. It is important that the expert evidence in this case is considered as part of the overall evidence in the case and not analysed in isolation.

61. When considering the expert evidence, the court must keep the following firmly in mind. The answer to the issues or an allegation in this case cannot be provided by the expert opinion alone. The expert medical evidence must always be combined with the factual evidence before a proper conclusion can be reached by the court and inevitably the parents' accounts will be an important part of its analysis.

62. The court should recognise that medical science, knowledge and understanding are always developing. Things which are routinely advanced as a matter of accepted medical understanding today may be shown, in subsequent years, to be unfounded or inaccurate.

63. Ms Langdale referred to *Kennedy v Coaria Services LLP* [2016] UKSC 6 and the reference to *Davie v Magistrates of Edinburgh* [1953] SC 34 and the importance of remembering that the decision is one for the Court.

64. Mr Ekaney referred to the decision of Hedley J in *R (Care Proceedings: Causation)* [2011] EWHC 1715 where he considered the importance of acknowledging the possibility of an unknown cause.

65. It is important that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others.

66. If the court disagrees with an expert's conclusions or recommendations an explanation from the court is always required to explain its reasons.

The parties' positions

67. The LA rely on their threshold and submit that the Mother gave C excessive quantities of salt. They rely on the medical evidence that I have summarised above. They do not seek to establish any findings in respect of C's seizures.

68. The Mother denies giving C excessive salt. Ms Langdale points to the fact that the Royal College of Paediatrics and Child Health Guidance on *Differential Diagnosis of Hypernatremia in Children, with Particular Reference to Salt Poisoning* (2009) makes it clear that salt poisoning is a very rare event and that further research is recommended.

69. She criticised Dr Coulthard for being too dogmatic and having strayed into the realm of the facts rather than remaining within the area of expertise. She referred to the study produced by Professor Ng on Electrolyte Disturbance which raised the possibility that omeprazole might lead to low sodium values.

70. However, despite these criticisms, Ms Langdale did not, because she could not, challenge the various sodium readings, or the very high fractional excretion rate.

71. She did argue that it would have been exceedingly difficult for the Mother to give C salt when she was in hospital given that staff were coming in and out of the room that C was in.

72. Mr Ekaney, on behalf of the Father, did not challenge any of the medical evidence. The Father was clear that he did not administer excess salt and he was not aware of the Mother doing so, and did not believe she had. He pointed to the fact that she had not done so with the other children.

73. The Guardian accepted the medical evidence and that it indicated that C had been given excessive quantities of salt. Ms Hodges set out a helpful balance of evidence for and against the findings sought by the LA.

Conclusion

74. I need to look at the broad canvas of the evidence and reach conclusions on the balance of probabilities.

75. The medical evidence is unequivocal and all points to the conclusion that C was given excessive levels of salt. She was found to have sodium plasma levels outside the normal range on at least six occasions. She was also found to have very significantly high fractional excretion levels of salt on 2 May.

76. The treating paediatrician, Dr Coulthard and Professor Ng all say that this was very unlikely to be caused by dehydration. C's sunken fontanelle is not on its own a good indicator of dehydration. Her weight movements, not going down and then up on rehydration, strongly indicate against dehydration.

77. There is no other medical explanation advanced and her kidney functioning was shown to be good by the measurements of her creatinine levels.

78. Dr Saggar confirms there is no genetic explanation for the sodium levels.

79. There is no medical evidence to link the sodium levels with omeprazole. Ms Langdale relies on the development of medical science, and effectively on the "unknown unknowns". But for a court to disagree with an expert medical view there has to be some evidence for the court to proceed upon. In this case all the medical experts say that the omeprazole is highly unlikely to be the cause of the sodium levels, and there are no research papers which establish such a link.

80. I accept Dr Coulthard's evidence that the changes in the sodium levels on 16/17 March and 2/3 May do suggest that C was given excess salt whilst in hospital.

81. It is also, in my view, important that once C moved from the parents' care there were no further episodes of ill health. The only reference to a seizure is the Mother's interpretation of what one of the carers said, but D said he had no knowledge of a seizure and in any event it might well have been a misinterpretation of a reaction to reflux.

82. Therefore, the clinical evidence overwhelmingly suggests salt poisoning.

83. I turn to the broader canvas of evidence. There is no evidence that would provide a motivation or explanation for the Mother giving C excessive salt. However, the evidence does show that the Mother was under extreme stress during the early months of C's life and was receiving very little support. She was at home with a premature baby who was not feeding well. She had two other young children, one of whom A, was plainly a challenging child. She had very limited support with the Father seemingly rather disengaged both from the Mother but also from the care of the baby.

84. All of this was happening in a very crowded household. I appreciate that many families, including often those from South Asian communities, live in extended multi-generational families in small dwellings. However, on any basis, this was a very crowded household which provided minimal support for a mother struggling with a tiny baby and her own mental health.

85. It is not possible or necessary for me to try to determine what the Mother was thinking. However, the broad canvas in terms of the family background and the Mother's history certainly does not point against the Mother giving C excess salt, whatever the motivation.

86. The Mother was C's primary carer, and generally fed her. I accept that in hospital there may have been limited opportunity to give her salt given the staff movements and that the nurses often made up the bottles. However, the incidents seem to have been relatively limited and the evidence does not suggest that it would have been very difficult to slip salt into a feed if the Mother so wished.

87. Looking at the broad canvas, I find on the balance of probabilities that the Mother did give C excessive salt as pleaded in the LA threshold.