OUTER HOUSE, COURT OF SESSION

[2024] CSOH 72

A12/20

OPINION OF LORD BRAID

In the cause

(FIRST) Y, AS LEGAL REPRESENTATIVE OF B; (SECOND) X;

(THIRD) Y; AND (FOURTH) Z

Pursuers

against

NHS GRAMPIAN

Defender

Pursuers: Scott KC, D Anderson; Drummond Miller LLP
Defender: Reid KC, Scott; NHS Scotland Central Legal Office

18 July 2024

Introduction

B's medical history – a brief outline

[1] B, by all accounts a delightful and now healthy little girl, much loved by her family, was born in January 2016. From birth, she lived in the family home in Orkney with her parents (her mother, X, and her father, Y) and her siblings (collectively, Z). Until 2 February 2018, X was her primary caregiver, while Y worked in London most of the time.

[2] On any view, the first two years of B's life were blighted by a complex and unusual medical history which included numerous short hospital stays for various different conditions, for which she received several invasive treatments and investigations. At the

age of about four months, she was prescribed Levetiracetam (brand name Keppra), to treat suspected epilepsy, the dose gradually being increased over the following 18 months as her weight increased. In May 2017, aged 16 months, B was fitted with a nasogastric (NG) tube, passed from her nose to her stomach to aid feeding, problems in that department having been reported by X. In July 2017, the NG tube was replaced by a nasojejunal (NJ) tube, passed from her nose to her jejunum (the middle part of the small intestine). In October 2017 that in turn was replaced by a percutaneous endoscopic transgastric jejunostomy (PEG-J) tube, inserted through her abdominal wall and through her stomach into her jejunum to aid artificial feeding. Following that procedure, carried out under general anaesthetic, B was fed through the PEG-J tube.

[3] Against that background, B was admitted to Royal Aberdeen Children's Hospital (RACH) on 2 February 2018, severely ill with profuse watery diarrhoea: in particular, her sodium levels were dangerously high to the point of being potentially fatal. She remained there for more than seven weeks. During that time, when X ceased to be involved in her care, B very quickly recovered from the illness which had caused her admission; and within a matter of days she had also successfully been taken off Keppra; and was able to eat normally without resort to the PEG-J tube. Her entire medical history coupled with the unusual nature of the diarrhoeal illness led to an initial suspicion on the part of Dr Elma Stephen, the paediatric consultant in charge of B's case, and Dr Marianne Cochrane, the lead child protection consultant paediatrician in Grampian, that B was the victim of fabricated or induced illness (FII). That suspicion was conveyed to Orkney Islands Council (OIC), setting in train the events which have led to this action against the defender, which is admittedly responsible for the acts and omissions of Drs Cochrane and Stephen.

The child protection order, and subsequent procedure

[4] By the end of March 2018, B had fully recovered. On 29 March 2018, she was discharged from hospital to the care of foster parents pursuant to a child protection order (CPO) granted by the sheriff in Kirkwall on 28 March 2018 on the application of OIC, on the basis that there were reasonable grounds to believe that B was likely to suffer significant harm if not removed to, and kept in, a place of safety, and that a CPO was necessary to protect her from such harm, all in terms of section 39(2) of the Children's Hearings (Scotland) Act 2011. One item of evidence relied on by the council in making the application was an email dated 26 March 2018 from Dr Cochrane, in which she expressed her opinion that B's medical history, including the severe illness which led to her hospital admission in February 2018, and her rapid recovery from all the conditions for which she had previously been treated, was consistent with a diagnosis of FII at the hands of X.

[5] Sundry procedure followed. The statutory child protection regime under the 2011 Act kicked into action. The Children's Reporter referred B to the children's hearing as being in need of compulsory measures of care, on the grounds that she was likely to suffer unnecessarily or her health or development was likely to be seriously impaired, due to a lack of parental care; and that a schedule 1 offence[1] had been committed in respect of her. Those grounds were not accepted by X and Y, and were referred to the sheriff for determination. While the referral was ongoing, a series of Children's Hearings took place, at which interim compulsory supervision orders (ICSOs) were made and varied (and in some instances, appealed to the sheriff). These required B to remain with foster carers until mid-July 2018, when she was allowed to return to the care of Y, who by this time had given up

[1] That is, an offence specified in schedule 1 to the Criminal Procedure (Scotland) Act 1995

his employment in London and returned to Orkney full time in order to care for B in temporary accommodation paid for by OIC. The ICSOs made from time to time also allowed, and regulated, contact between B, and X and Z respectively.

[6] The sheriff never had the opportunity of making a determination as to whether the grounds of referral were established. By 29 January 2019, the Reporter had decided, in light of expert opinion evidence obtained by solicitors acting for X and Y, that the referral could not be established, and he abandoned it on that date, following which B and Y were able to, and did, return to the family home to resume family life with X and Z a short time later. It is fair to record that in the five or so years since then, not only have there been no further concerns for B's safety, but, happily, she has thrived. There has been no recurrence of the illness which led to her final hospital admission, nor has she required Keppra or to be fed through a tube since both were stopped during her hospital stay in February/March 2018.

The orders sought

[7] B, X, Y and Z seek declarator that in consequence of the actions of Dr Cochrane and Dr Stephen, there has been a violation of their right to respect for private and family life under article 8(1) of the European Convention on Human Rights (ECHR, or the Convention). They also seek damages in respect of that alleged violation. The defender denies there has been any infringement of the pursuers' article 8 rights for which the defender, through Dr Cochrane and Dr Stephen, is responsible and resists the orders sought.

The proof

[8] The action called before me for proof. The parties, by joint minute, have agreed the damages which fall to be paid to each pursuer in the event it is held (a) that the defender is

responsible for an unlawful infringement of the pursuers' article 8 rights, and (b) that just satisfaction for such infringement requires the payment of damages. Accordingly the principal issue for me to determine is that of liability, with a secondary issue, if liability is established, as to whether just satisfaction for any infringement requires damages to be awarded to one or more of the pursuers.

[9] The pursuers advance four propositions: (i) that B's separation from her family was an interference with her family life, and that of the other pursuers; (ii) that the separation was caused by the allegation of FII made by Drs Cochrane and Stephen; (iii) that it is for those doctors to show that there were "relevant and sufficient reasons" for the allegation, in other words, that their belief that there had been FII was reasonably held; and (iv) that the evidence led at proof demonstrates that their belief that there had been FII was not merely mistaken but vitiated by error.

[10] The defender accepts that there was an interference with the pursuers' family life, but argues that it was effected by the sheriff in accordance with the regime set up by the 2011 Act, and was both in accordance with law in pursuance of a legitimate aim and necessary, the suspicion of FII being reasonably held by Drs Cochrane and Stephen.

[11] Much of the factual evidence for the pursuers was given in the form of affidavits of: X, Y, and some of Z; police officers DC James Sutherland and Sergeant Jill Walker; and James Henry, Peter McAndrew and Jane Alexander, social workers with Orkney Islands Council at the material time. X, Y and Ms Alexander also gave oral evidence (in the course of which X adopted four police statements as part of her evidence). The pursuers also led evidence from a Consultant Paediatrician, Dr Gerard O'Hare, who had provided a report dated 25 July 2022; Mary MacKinnon, former social worker and children's reporter, who had provided a report dated 28 July 2022; Gordon Henderson, the children's reporter who

latterly dealt with the referral and who formed the view that the referral proceedings should be abandoned; and Dr Malcolm Coulthard, Consultant Paediatric Nephrologist, who had provided a report dated 22 January 2019. The pursuers also relied upon reports by Professor Peter Milla, Professor of Paediatric Gastroenterology and Nutrition, and Professor Sameer Zuberi, Consultant Paediatric Neurologist, respectively dated 17 November 2018 and 31 December 2018. For the defender, Dr Cochrane and Dr Stephen both gave evidence, as did Dr Nelly Ninis, Consultant Paediatrician, who had provided a report dated November 2023. By a further joint minute, the parties also agreed much non-controversial evidence.

[12] Finally by way of introduction, it is important to record what this case is *not* about: it is not about determining judicially whether B was a victim of FII at the hands of X: it is no part of the defender's case that X ever fabricated B's symptoms or administered any substance to her. All that the defender offers to prove is that it was reasonable for Dr Stephen and Dr Cochrane to have a concern that there may have been a degree of FII in at least some of B's presentations. That is the key factual issue which I have to resolve, but before considering the evidence, it is helpful, first to explain what FII is, and then to set out the applicable law, in relation both to Convention rights, and to child protection.

What is FII?

[13] FII is explained in a guidance document "Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians", issued by the Royal College of Paediatrics and Child Health (RCPCH), in October 2009. It can cause significant harm to children. It suffices to note for present purposes that FII involves a well child being presented by a carer as ill, or an ill child being presented with a more significant problem than exists in reality, and

suffering harm as a consequence, namely that unnecessary medical treatment is provided. It includes cases where a carer actively promotes the sick role by exaggeration, fabrication (lying) or falsification of signs, and/or induction of illness. (Although Dr O'Hare's evidence was that one rarely finds that a parent who fabricates also induces illness, the guidance expressly embraces the possibility that both may be present in any given case.) Other behaviours by a carer that may result in harm include: deliberately inducing symptoms by administering medication or other substances; claiming the child has symptoms which are unverifiable unless observed directly, such as pain, vomiting or fits, or exaggerating symptoms, in either case resulting in unnecessary investigations and treatments. Its incidence is rare, only about 45 per 100,000. The modern terminology where a child is suspected of being a victim of FII is that the child has a perplexing presentation. Dr O'Hare explained that the role of the paediatrician, when faced with such a case, is to distinguish between cases where the perplexing presentation has a genuine medical cause, and those which do not. FII is a clinical diagnosis, which must be based on a full consideration of the child's clinical features including past and present medical history, examination findings and all available test results. The diagnosis is not usually made on a single finding or a single event but often on a series of different events over a period of time (section 5.7). A paediatrician who suspects FII should discuss the case at the earliest opportunity with a colleague who has expertise in child protection and with other relevant nursing and medical staff. The key tool in the diagnosis of FII is the chronology which the paediatrician must prepare (section 5.14). The process of preparing a chronology should start with a review of the records available to the responsible paediatric consultant and should be expanded to include all of the child's health records (that is, including the GP records). In the present

case, Dr Cochrane did prepare a chronology, a key issue being whether she did so with sufficient care and accuracy.

[14] I would add two comments of my own. First, it is apparent from the foregoing that FII, by its very nature, is likely to be difficult to prove, at least where an allegation of induced illness is made. There is unlikely to be a "smoking gun" in the form of direct, eye witness evidence and proof is likely to require an inference to be drawn from such circumstantial evidence as there may be. Second, the risk to the child posed by fabricated illness, and the steps necessary to manage that risk, will be different from the risk posed by induced illness, since in the former case it may be sufficient for medical professionals simply to stop treating the child; whereas in the case of induced illness, where the carer is actually making the child ill, more drastic action, in the form of removing the child from their carer, is more likely to be required.

The law

Human Rights Act 1998

[15] Section 6(1) of the Human Rights Act 1998 (HRA) makes it unlawful for a public authority to act in a way which is incompatible with a Convention right. By virtue of section 6(3), each of the defender, the social work department, the Reporter and the sheriff was a public authority. Convention rights are specific articles of the ECHR mentioned in the HRA: section 1(1). Those articles are set out in schedule 1 to the HRA. Section 8(1) and 8(6) read together provide that an award of damages may be made against a public authority which has committed an act which is unlawful by virtue of section 6(1). Section 8(3) provides that no award of damages is to be made unless, taking account of all the

circumstances of the case, the court is satisfied that the award is necessary to afford just satisfaction to the person in whose favour it is to be made.

[16] Article 8 of the Convention sets out a Convention right. It provides:

> "**Right to respect for private and family life**
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

[17] Mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life which can be lawfully interfered with, but only if the conditions specified in article 8(2) are fulfilled: the interference must be (a) in accordance with law; (b) necessary in a democratic society; and (c) to secure a legitimate aim. The defender accepts that there was an interference with the article 8 right of each pursuer, and the pursuers accept that the interference was in accordance with law and pursued a legitimate aim (namely, for the protection of the rights and freedoms of others). Whether the interference was lawful turns, therefore, on whether the interference was necessary in a democratic society. As to the test for that, we must turn to the Strasbourg jurisprudence.

Strasbourg jurisprudence

[18] Consideration of necessity involves a consideration of proportionality, the structured approach to which was considered in *Bank Mellat* v *HM Treasury* [2014] AC 700 at paragraph 74, by Lord Reed; but in cases where a child has been removed from his or her family in response to ultimately unfounded concerns about a risk, both parties accept that

the test comes to be whether the reasons given were 'relevant and sufficient'; or, as senior counsel for the defender put it, whether in terms of the fourth criterion expressed by Lord Reed, the impact of the rights infringement is disproportionate to the likely benefit of the impugned measure. The phrase 'relevant and sufficient' has been used in a string of cases before the European Court of Human Rights, not confined to article 8 but in a range of circumstances: *Handyside* v *United Kingdom* (1979-80) 1 EHRR 737 at para.48-50); *Sunday Times* v *United Kingdom* (1979-80) 2 EHRR 245 at para.62; *Barthold* v *Germany* (1985) 7 EHRR 383 at para.55; *Lingens* v *Austria* (1986) 8 EHRR 407 at para.40. Those cases were concerned with whether a measure taken by a contracting state was necessary and whether there could be said to be a pressing social need for the measure in question, which in turn gave rise to consideration of whether the reasons given by the state were relevant and sufficient. In a child protection context, the phrase has been used as a shorthand means of describing whether the necessity test is met. As it was put in *Olsson* v *Sweeden* (1989) 11 EHRR 259 at paragraph 68, the court must look at the impugned decision in the light of the case as a whole and must determine whether the reasons adduced to justify the interferences at issue are 'relevant and sufficient'; see, too, *Strand Lobben* v *Norway* (2020) 70 EHRR 14 at paras 202 and 203 to similar effect, although in that case the court went on to say that the notion of necessity further implies that the interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued, regard being had to the fair balance which has to be struck between the relevant competing interests.

[19] In *Venema* v *Netherlands* (2004) 39 EHRR 5, a child had been detained in hospital and then placed with foster carers on the grounds of FII (then called Munchausen syndrome by proxy). As here, it was not disputed that the detention and placement were in accordance with domestic law and pursued the legitimate aim of protecting the child's rights; and the

issue before the court was whether the measure could properly be described as necessary in a democratic society; that turned on whether the reasons adduced to justify the measure were relevant and sufficient: paragraph 90. The essence of the applicants' case was that they had not been consulted about the concerns being expressed about them, nor offered the opportunity to contest the reliability, relevance or sufficiency of the information being compiled on them: paragraph 89. The court held that the decision-making process had not been fair: the parents had not been able to participate effectively in that process, but were presented with a *fait accompli*: paras 91, 92 and 99.

[20] *MAK* v *United Kingdom* (2010) 51 EHRR 14 concerned a child whose father had taken her to her GP, concerned about what appeared to be bruising on her legs. She was seen by a paediatrician at the local hospital where photographs and blood samples were taken in the absence of either parent. The paediatrician concluded that the child had been sexually abused and informed social services. The parents were prevented from seeing their daughter. Subsequent tests, commissioned by the parents, led to a diagnosis of a rare skin disease which explained the bruising. The paediatrician who had raised the concern subsequently wrote a letter stating that there was insufficient evidence to consider that the girl had been abused. Infringements of article 8 were found in three respects: (a) the taking of photographs and blood in the absence of the parents (para 79); (b) the initial decision to prevent the parents from visiting the girl (the Government accepted this lacked a legal basis and so was not "in accordance with law": para 65); and (c) the delay in obtaining an opinion from a dermatologist, which could have resulted in an accurate diagnosis a few days earlier: paragraph 72. The court, having reiterated at paragraph 68 that the question of whether an interference was necessary in a democratic society required consideration of whether in the light of the case as a whole the reasons adduced to justify the measures were 'relevant and

sufficient', said at paragraph 69 that mistaken judgments or assessments by professionals do not *per se* render childcare measures incompatible with the requirements of article 8:

> "The authorities, both medical and social, have duties to protect children and cannot be held liable every time genuine and reasonably held concerns about the safety of children vis-à-vis members of their family are proved, retrospectively, to have been misguided."

Given the nature of the allegation, and the fact that the parents were under suspicion, the court was not critical of the authorities for treating their explanations with caution (paragraph 70), nor was the court critical of the decision not to interview the child (the second applicant) (paragraph 71). However, the court did find that the delay in consulting a dermatologist, who, when consulted, diagnosed a clinical cause of the child's bruising, extended the interference with the applicants' right to respect for their family life, and was not proportionate to the legitimate aim of protecting the child from harm. Consequently, there had been a violation of the applicants' article 8 rights.

[21] In *RK and AK* v *United Kingdom* (2009) 48 EHRR 29 the same principles were enunciated, but no violation of article 8 found. The child was a small baby who had suffered a serious and unexplained fracture of her femur. Later, when she suffered a subsequent fracture while in the care of an aunt, she was found to have *osteogenesis imperfecta* (brittle bone disease). The court acknowledged that it was a very rare condition and declined to fault the authorities for having failed to diagnose it immediately. Again, the court held that mistaken assessments by professionals did not as such make child-care measures incompatible with article 8, and there had been relevant and sufficient reasons for the authorities to take protective measures. There had been no lack of appropriate expedition. At paragraph 34 of its judgment, the court said:

> "As to whether the interference was 'necessary in a democratic society', the Court's case law interprets this phrase as requiring consideration in particular of whether, in

> the light of the case as a whole, the reasons adduced to justify the measures were 'relevant and sufficient', and whether the decision-making process involved in measures of interference were fair and afforded due respect to the interests safeguarded by art.8."

Then at paragraph 37:

> "The applicants' complaints very much amount to criticising the way in which the professionals, medical and legal, were prepared to suspect the worst on the information available to them and failed immediately to perceive their innocence or give them the benefit of any doubt. Nonetheless, it must also be noted that, while an interim care order was issued with a view to protecting [the child], steps were also taken to place the baby within her extended family and in close proximity to the applicants' own home so that they could easily and frequently visit. And crucially, as soon as a further fracture occurred outwith the applicants' care, further tests were quickly pursued and within weeks [the child] was returned home.

[22] *AD* v *United Kingdom* (2010) 51 EHRR 8 was also a case involving brittle bone disease which went undiagnosed at first. The child suffered a number of broken ribs, which clinicians initially attributed to a non-accidental cause. Care proceedings were initiated which resulted initially in the family being placed in a family assessment centre and, latterly, in the child being placed with foster parents. The court held there were relevant and sufficient reasons to investigate the child's injuries and assess the risk posed to him by his parents. At paragraph 83 the court observed that:

> "the [domestic] authorities enjoy a wide margin of appreciation when assessing the necessity of taking a child into care. A stricter scrutiny is called for, however, in respect of any further limitations, such as restrictions placed by those authorities on parental rights of access."

The court did not fault the social or medical experts for not reaching an earlier diagnosis of brittle bone disease, or, in the absence of a diagnosis, acting on the basis that the injury could have been caused by the child's parents; nor did it fault them for not conducting further investigations. The court did however hold that fundamental errors were made in conducting investigations and assessments; in particular, by failing to carry out a risk assessment while the family was at the assessment centre, it being significant that when a

risk assessment was eventually produced, it recommended the speedy return of the child to his parents. The local authority was also at fault for not giving proper consideration to the possibility of placing the child with a family member. Finally, the lapse of time between the final risk assessment and the child's return to his parents was unreasonable. For those reasons, the court found that there had been a violation of article 8 and awarded non-pecuniary damages of €15,000.

[23] In *TP and KM* v *United Kingdom* (2002) 34 EHRR 2, the local authority suspected that a child was being sexually abused. In a video recorded-interview the child disclosed that she had been abused by "X", who shared the same first name as the child's mother's partner. The child was taken into care, and contact between her and her mother was severely restricted. The mother was denied access to the interview, or a transcript. The court found that the use of emergency procedures to take the child into care was a proportionate measure and necessary in a democratic society for protecting the child's rights. The competent national authorities enjoyed a wide margin of appreciation, in particular when assessing the necessity of taking a child into care, although a stricter scrutiny was called for in respect of any further limitations, such as restrictions placed by the authorities on parental rights of access and of any legal safeguard designed to secure an effective protection of the right of parents and children to respect for their family life (paragraph 71). However, the mother had been deprived of adequate involvement in the decision-making process by the failure of the local authority to disclose the video and the transcript of the interview, or to submit that issue to the court to determine. That was held to amount to a breach of article 8 (paragraph 83).

[24] Finally, it is important to note that at the level of the Strasbourg Court, liability rests upon the State, and nothing turns on which of its emanations is responsible for an

infringement of the right. At domestic law, such a distinction does arise. At that level, it is necessary to establish not unlawfulness by the State but unlawfulness by the public authority which has been convened as a defender. The distinction is noticed and explained by LCJ Morgan in *Jordan* v *The Police Service of Northern Ireland* [2021] NI 149 at para.21:

> "Whereas under the Convention liability rests upon the state, the HRA has devised a procedure broadly similar to that in tort claims where liability falls directly upon the public authority which the court finds has acted unlawfully. In a claim based on delay that can lead to a circumstance where two public authorities are each responsible for the same period of delay or alternatively each is responsible for separate periods of delay."

Remedy

[25] As noted above, section 8(3) of the HRA allows damages to be awarded where (but only where) such an award is considered necessary to afford just satisfaction. An award of damages for a breach of a Convention right is a matter of discretion: *R (Sturnham)* v *Parole Board (Nos 1 and 2)* [2013] 2 AC 254, paragraph 29 by Lord Reed. While the court must take into account principles applied by the Strasbourg Court under Article 41 of the Convention (section 8(4) HRA), it is not strictly bound to follow such principles*: R (Greenfield)* v *Secretary of State for the Home Department* [2005] 1 WLR 673, paragraph 6. That paragraph in *Greenfield* also explains that there are three preconditions to an award of damages as just satisfaction under article 41 of the Convention: (a) that the court should have found a violation; (b) that the domestic law of the member state should allow only partial reparation to be made; and (c) that it should be necessary to afford just satisfaction; there are four pre-conditions to an award of damages as just satisfaction by a domestic court: (a) that a finding of unlawfulness should be made based on a breach by a public authority of a Convention right; (b) that the court should have power to award damages in civil proceedings; (c) that the court should be satisfied, taking account of all the circumstances of the particular case, that an award of

damages is necessary to afford just satisfaction to the person in whose favour it is made; and (d) that the court should consider an award of damages to be just and appropriate. It is implicit in the negative structure of section 8(3) that awards of damages are the exception rather than the rule, which reflects the focus of the Convention being on the protection of human rights and not the award of compensation: *Greenfield*, paragraph 9. The focus of the HRA is to ensure the United Kingdom's compliance with its obligations under the Convention and not compensating a pursuer for any loss: *DSD* v *Commissioner of Police of the Metropolis* [2016] QB 161 at paras.65-66. Declaratory relief should not be underestimated as a remedy: *D* v *Commissioner of Police of the Metropolis* [2015] 1 WLR 1833 at paragraph 18.

Common law duties of a doctor

[26] For completeness, at common law a doctor's duty is to their patient (not the patient's parents) and the common law recognises that a doctor must be able to act single-mindedly in the patient's interests where something does not feel "quite right": *D* v *East Berkshire Community Health NHS Trust and others* [2005] 2 AC 373, Lord Nicholls at paragraph 85. It was held by the House of Lords (Lord Bingham dissenting) that no duty of care was owed by healthcare professionals to the parents of young children arising out of false and negligent statements that there may have been child abuse. It was this case which gave rise to both *RK and AK* v *United Kingdom* and *MAK* v *United Kingdom*, above. The parties in the present case were at odds over whether *D* remained good law in light of these two cases, the defender asserting that it did, the pursuer that it did not. Both are correct to an extent: *D* has not been overturned, and so it continues to be the law that no delictual claim, or claim based in tort, will be available to a parent falsely and carelessly accused by a doctor of child abuse; but a claim under the HRA may be available if an infringement of article 8 can be established

and if the doctor was employed by a public authority. What can be said is that a "feeling" that something is "not quite right" is not sufficient to defeat an HRA claim.

The child protection regime

[27] In order to understand the legal process by which B was removed from her family, it is important to note the structure of the 2011 Act under which the CPO was sought and granted. The scheme of the Act is to impose duties and confer powers on different bodies, principally, the local authority, the Reporter and the sheriff. The effect of this is to create a unitary jurisdiction that is to be exercised collaboratively by a number of different actors in different ways, the overall purpose of the scheme being to safeguard and promote the welfare of the child throughout childhood: *Principal Reporter* v *LZ* 2017 S.L.T 961, para. 51.

[28] When a child is in need of protection, it is generally for the local authority (through its social work department) to commence the statutory procedure. If it considers that it might be necessary for a compulsory supervision order (CSO) (and not, as the defender submitted, a CPO) to be made, it has a statutory duty to make all necessary inquiries into the child's circumstances, and to give any information it has about the child to the Reporter: section 60 of the 2011 Act. Note that a CSO may, but need not, result in the child being taken into care.

[29] Upon receipt of information from the local authority under section 60 (or information *via* a variety of other routes), and after making any further investigation that is considered necessary, it is then for the Reporter to determine whether a section 67 ground applies; and if so, whether the Reporter considers that it is necessary for a CSO to be made: section 66(1) to (3). If so, section 69(1) and (2) require the Reporter to arrange a children's hearing, to determine whether a CSO should be made on one or more of the grounds listed in

section 67(2). These grounds include: that the child is likely to suffer unnecessarily, or her health or development is likely to be seriously impaired due to a lack of parental care; and that an offence mentioned in schedule 1 to the Criminal Procedure (Scotland) Act 1995 has been committed in respect of her. The Reporter prepares a statement of grounds which sets out which of the section 67 grounds the Reporter believes applies, and the facts on which that belief is based: section 89 of the 2011 Act. It is then for the children's hearing to decide if a CSO should be made or not. If the section 67 grounds are not accepted by the child and relevant persons (at a so-called grounds hearing), the children's hearing must either discharge the referral, or direct the Reporter to make an application to the sheriff for a determination on whether each ground that is not accepted is established: section 93(2)(a) and (b). If the grounds are established, the sheriff must direct the Reporter to arrange a children's hearing to decide if a CSO should be made: section 108(2). If in the meantime the children's hearing considers that the nature of the child's circumstances is such that for the protection of the child it is necessary as a matter of urgency that an interim compulsory supervision order (ICSO) should be made, the grounds hearing may make such an order: section 93(5); and the sheriff subsequently has the power to make or extend or vary an ICSO: sections 98 to 100.

[30] Separately, if, prior to all of that, the local authority considers that the circumstances are such that protective measures must be taken as a matter of urgency, it may apply to the sheriff for a CPO in respect of a child under section 37(1) of the 2011 Act. Section 39 then applies. Section 39(2) entitles the sheriff to make a CPO if satisfied (*inter alia*) (a) that there are reasonable grounds to believe that the child has been or is being treated in such a way that the child is suffering or is likely to suffer significant harm, or the child is likely to suffer significant harm if the child is not removed to and kept in a place of safety, *and* (b) that the

order is necessary to protect the child from that harm or from further harm. In considering that, the sheriff must be mindful that the court is also a "public authority" by virtue of section 6(3)(a) of HRA. The sheriff must therefore consider whether the granting of the CPO, and if so, the terms of that order, is proportionate. In making that assessment, the court must have regard to the need to safeguard and promote the welfare of the child throughout the child's childhood as the paramount consideration: section 25(2) of the 2011 Act. This includes both the need to protect the child from the immediate circumstances prompting the application for a CPO and the potential impact the granting of the order may have on the child. Finally, when considering an application for a CPO, the sheriff, having considered the grounds and the supporting evidence, must grant or refuse it: rule 3.31 of Act of Sederunt (Child Care and Maintenance Rules) 1997. Where a CPO is made, the Reporter must be notified as soon as practicable: section 43(1)(e), which triggers the section 66 procedure set out above. The Reporter must also arrange a children's hearing to take place on the second working day after the day on which the child is taken to the place of safety: sections 45 and 46. That children's hearing may continue, vary or terminate the CPO: section 47. Finally, in simple terms, a CPO will terminate after eight working days unless a children's hearing under section 69 has taken place by then: section 54.

[31] Ten points arising out of the foregoing are worth highlighting. First, not only the court but also the local authority and the Reporter are public authorities for the purposes of the HRA, and as such, must act at all times, including when they are making decisions, in a manner consistent with the Convention. Second, if the local authority comes by information which suggests that a child may be in need of protection, it has a duty to investigate and, if appropriate, to inform the Reporter. Third, it is for the Reporter, in turn, to investigate and, if appropriate, to refer the child to the children's hearing, whose role it is, ultimately, to

decide if the child does need compulsory measures of care and if so what they should be. Fourth, where, before that procedure is under way, the child is believed to be in need of urgent measures of care the local authority may apply to the sheriff for a CPO. Fifth, as section 39(2) makes clear, the sheriff, to grant a CPO, need only be satisfied that there are reasonable grounds to believe certain matters, as opposed to whether the matters actually exist: *Application for a Child Protection Order* 2015 SLT (Sh Ct) 9, at paragraph 9. Indeed, sixth, it is implicit in the scheme that temporary measures for the care of the child – be that a CPO or an ICSO – may require to be taken before it has been judicially determined whether the grounds on which the referral to the children's hearing has been made are established or not. Nonetheless, seventh, such measures may be taken only where necessary. Eighth, a sheriff's decision to grant a CPO lasts for a maximum of eight working days; thereafter the children's hearing takes over the judicial role (except insofar as further ICSOs may require to be made). Ninth, the regime established by the 2011 Act is therefore laden with safeguards designed to ensure that any measures taken in relation to a child, including removal from his or her parents, are proportionate, necessary and time-limited. Tenth, and finally, those raising concerns about the welfare of a child (such as medical professionals) may input information into the scheme, but they are not part of it.

B's medical history before 2 February 2018

[32] Before the fateful admission on 2 February 2018, B was admitted to RACH seven times. I have derived the following history, describing those admissions and other material events, from the medical records and the joint minute.

22 to 26 April 2016 (seizure activity)

[33] B was admitted to RACH twice during this period following a referral by her GP, Dr Simon Kemp, who had seen a video of B taken by X, showing what appeared to be spasms. X reported that B had been having "episodes of unusual movements which wakes her up from sleep, with arms flexing and drawing up legs" and that B's sibling had epilepsy from 3 to 7 years. The view of RACH paediatric neurologist, Dr Tyagi, was that the video showed what appeared to be infantile spasms. During B's first admission, from 23 to 24 April, medical staff did not observe any spasms and B was discharged with a plan to return the following day. On 25 April X told Dr Tyagi that B had "whole body jerks for last 10 days (happening in clusters). Gets upset after every jerk. Happens in sleep as well. Happening daily and getting frequent now". B was again admitted to RACH from 25 to 26 April 2016. At 12.45, staff recorded that "Mum states that [B] had a few 'shaking' episodes overnight but none since around 2am this morning". Then, at 15.45: "Mum stated B had an episode of the spasms when upset but that it did not last long. Not witnessed by nursing staff", this latter entry apparently referring to an episode on the ward since 12.45. Six episodes of seizure activity overnight on 25/26 April 2016 were recorded, noting that X had been present and attending to care most of the night. On 26 April, five further episodes of seizure activity were recorded. On that day, B underwent an EEG which was normal. A repeat EEG was to be carried out in 10 to 14 days. The hospital records do not make clear how many of the episodes of seizure activity were witnessed by staff.

[34] During that admission, X was keen to have B's urine checked to ensure she did not have a urine infection upsetting her. This was carried out despite X being aware that a urine infection was not likely.

3 to 6 May 2016 (seizure activity)

[35] This was a further referral by Dr Simon Kemp, on 3 May 2016 (exactly one week after B had been discharged from RACH), due to increasing episodes of infantile spasms, resulting in B being readmitted from 4 to 6 May 2016. X had reported a "3-4 week history of rigidity and screaming lasting seconds or minutes. Increasing frequency to 20 times per day, also occurring at night". The referral did not record whether such incidents had been witnessed by Dr Kemp: the hospital notes, somewhat ambiguously, say: "Seen by GP to have a more prolonged cluster of flexing attacks lasting around 10 mins (was there about older daughter) @ referred back in." X had described increasing frequency of events in the past few days and had videos on her phone of flexor attacks. During the initial assessment on 4 May 2016, staff at RACH did not see any abnormal movements, but they subsequently recorded three episodes of spasms each lasting approximately two minutes, one causing B to be upset but the other two not appearing to bother her. The hospital notes show that during B's admission, a number of episodes were reported: five overnight on 4/5 May; 14 clusters, maximum three minutes, over the last 24 hours (which may have included the overnight ones); eight episodes on 5 May; further episodes overnight on 5/6 May. X was present throughout. It is unclear from the hospital records how many of the recorded episodes were witnessed by staff; certainly, some were not, as the notes for 5 May make clear: "Mum recording episodes of infantile spasms as sleeping by cot holding on to B's hand". However, at least some of the videos taken by X were reviewed by Dr Stephen, who reported to Dr Kemp that the episodes "appeared to resemble infantile spasms with some atypical features...." She diagnosed "probable benign myoclonic epilepsy of infancy", together with congenital hydronephrosis secondary to vesico-ureteic reflux, and prescribed regular anti-epileptic medication, namely Keppra, increasing incrementally to 90mg twice per day.

Dr Stephen told Dr Kemp that the side effects of Keppra had been discussed. On B's discharge, Dr Dale Gracie noted: "On assessment [B] looked very well and was developmentally appropriate ... There were no focal neurological abnormalities, and the medical staff did not witness any convulsions. However she continued to have multiple clusters of seizures throughout her stay which didn't really vary in morphology".

June 2016 to April 2017 (seizure activity)

[36] During this period, the Keppra dose was further increased. On 13 June 2016 X told Children's Epilepsy Specialist Nurse, Jo Campbell, that there was a slight improvement in B's seizure control, but that there was on-going seizure activity, resulting in Ms Campbell increasing the dose to 100mg, and thereafter to 120mg, twice daily. Tests for genetic abnormalities (which might have shown a link to epilepsy) in June and September proved negative. On 21 September, in view of B's increasing weight, Dr Tyagi increased B's dose of Keppra to 150mg twice daily, following confirmation that she had not had any seizures since going on her dose of 120mg (except for one occasion when she had a tummy bug and was sick). On 13 March, Children's Specialist Epilepsy Nurse, Ena Cromar, increased B's dose of Keppra to 200mg twice daily following X having expressed concern that the dose may need to increase, as B's doses of other medication had been increased after she gained weight. X reported that B was still having some jerks especially after episodes of vomiting.

November 2016 to April 2017 (feeding difficulties)

[37] On 29 November 2016, X told GP Dr Catriona Kemp of feeding difficulties. Dr Kemp recorded that "mum has tried to wean [B] since 6 months now 11 months. Can't manage even 2 teaspoons dilute baby rice without vomiting. Exclusively breastfed. On 75th centile

for weight". On 9 March 2017 Dr Catriona Kemp recorded "Infant feeding problem ...ongoing problems with difficulty weaning. Not tolerating follow on milk or solids – tends to gag. reflux?" On 28 March, Dr Simon Kemp recorded, again under the heading "Infant feeding problem", that "Omeprazole improving vomiting after feeding but still some present: mum keen to try further increase from 10mg daily"; and on 18 April, under that same heading, Dr Kemp recorded "Ongoing problem with weight; seeing dietician ...current weight 11.4kgs". On 24 April, GP Dr McAdam recorded: "Dietician has requested referral for Ba Swallow. Child has lost a kg. Mum says she is not having so many wet nappies, sometimes only one a day. Still breast feeding twice a day but Mum feels she does not take much, can drink from bottle but will only take a couple of oz, prev was 7 oz, has tried drinking cups, spoons, syringe, but often child gags, not taking any solids, only managing fluids. Have tried soft foods, food play, whole family involved but gags on things and vomits".

28 April to 5 May 2017 (seizures and feeding difficulties)

[38] On 28 April, GP Dr McAdam referred B to Balfour Hospital, Kirkwall, reporting that she had increasing difficulty in swallowing solid foods, was having difficulty feeding with limited fluid intake and was now losing weight. (She also reported that B's myoclonic epilepsy was reasonably controlled but that her seizure activity had increased in the past week.) The referral recorded that B weighed 10.1kg and that X reported that B's weight had been 12.4kg three weeks ago. B was admitted to Balfour Hospital overnight. At 20.00 she was sick in bed. At 03.30 she was given 70mls of water, which was followed by 70mls of vomit. On 29 April she was transferred to RACH. On admission there, her weight was

recorded as 10.92kgs (which plotted above the 75th centile on the growth chart). It was noted that B had lost 600g of weight over the last four weeks. X reported that B:

- Had 20 seizures in quick succession on 6 April 2017.
- Was unable to tolerate liquids, had swallowing difficulties and would choke and/or vomit immediately after intake.
- Was vomiting all the time.
- Does not have solids as she will choke afterwards
- Only passed stools twice in the last 23 days with the last bowel motion on 20 April 2017, loose and pale with no blood
- Had very dry nappies with one nappy potentially lasting up to 36 hours.

At 20:00 B had still not passed urine and had vomited anything she had tried orally. There was no urine output by midnight and IV fluids were commenced.

[39] On 30 April 2017 a staff nurse recorded: "Mum resident in room. ? for NG tube today and close observation when feeding. Nursing staff have not witnessed [B] taking anything orally, Mum reports she gags and then is sick. Perhaps a bay environment would be more suited to gain a better insight into feeding/drinking habits." The notes described B's presentation as a "very unusual story": lifelong effortless vomiting, feed refusal, myoclonic epilepsy and V-U [vesico-ureteric] reflux. B was duly transferred to the ward bay area so that "nursing staff can observe breast feeding and possible vomiting episodes" which X had been reporting. X said that she was "uncomfortable being transferred to the bay due to 'inappropriate comments' made to her whilst breastfeeding in the bay on [B]'s last admission by a male nurse". It was noted that all care was given by X; B took some milk but became very distressed afterward until she vomited most of the feed up, crying a lot of the afternoon.

[40] On 1 May 2017, nurses recorded that B slept well, had no vomits overnight and that X arrived on the ward at 5am. Subsequently, it was noted that B "continues to have vomits.

Had 5 small-moderate vomits". On 2 May, nursing notes recorded no vomits overnight. X reported gagging but that was not observed by nurses. At 09.25 a naso-gastric tube was passed into B's right nostril. She took "quite readily" 25mls of pediasure orally and the balance of an 80ml feed via the naso-gastric tube, with no retching or vomiting. Staff suggested that some finger foods should be tried, which X was reluctant to do. In the afternoon a barium meal was administered to B, the preliminary report of which was of a severe gastroesophageal reflux. On 3 May B was reported to be tolerating the naso-gastric tube well and was no longer vomiting. On 4 May, the dietician treating B recorded a vomit "due to feed and meds being at the same time". On 5 May B was recorded as tolerating feeds without issues, and she was discharged from RACH.

22 to 25 May 2017

[41] Just over two weeks later, on 22 May 2017, B was re-admitted to RACH following a report by X that for the past week she had not been tolerating more than 40mls of NG feeds. The notes on admission, under the heading "nutritional requirements", state: "? Unsafe swallow – No oral food". X said that "B has pain (screams and arches back) during feed and on occasion vomits". B was admitted to a medical ward and moved to a bay. X reported that B had become distressed during a feed, so she had switched off the pump after 17 mls. On the night of 22/23 May, B was noted to be tolerating feeds. At 11.10 am on 23 May staff at RACH noted: "Written in retrospect: 80mls bolus given at 08:30am, Mum stated she stopped at 80mls as [B] was wretching [*sic*], this was not noted by nursing staff that was present in bay at the time. Mum then took [B] to the play area and returned around 10:30am and stated [B] had vomited in hallway. Mum stated a domestic had cleaned it up and it was roughly a plate size vomit. Not witnessed by any staff. Domestic staff asked but none of the

domestic staff present had cleaned it up". A summary by Dr Mayo includes: "still no oral intake/solids intake. Mum says multiple approaches tried. Not willing to attempt here at RACH – 'would rather do at home' ... Dr Mayo explained, to get a baseline, important to observe feeds. If looking sick, discomfort, to call over nurses so they can document. Mum unhappy, feels has abnormal stomach, or some neurological cause underlying. Doesn't want her suffering as much discomfort every day. Frustrated." The plan included "1. Closely observe all feeds please. 2. Document witnessed vomits or episodes of discomfort. 3. Dietitian/SALT assessment. 4 Liaise with team at Balfour to orientate strategy/progress/concerns. 5. Urine sample." Also on 23 May, B was noted not to be tolerating a full amount of bolus feed via her nasogastric tube. The notes recorded "2 x large vomits today following feeds witnessed by nursing staff and doctors. To continue to monitor." B's 17.30 feed was discontinued after 58 mls due to her "wretching (*sic*) and having a mouthful of vomit". The notes then record that at 22.55 an auxiliary nurse was checking B's drawer and came across a syringe of a 6ml aspirate wrapped up in a paper towel. The nurse was unsure why it was there. No vomits were noted overnight.

[42] On 24 May, nurses recorded a large vomit. X was in attendance all day doing all feeds and care. Overnight, B tolerated feeds and no vomits were noted. On 25 May nurses noted that X reported wretching (*sic*) but none was observed by nursing staff, although a large vomit was recorded. Nurses noted that X had stopped a feed as B was retching, which was unwitnessed by nursing staff. B was tolerating feeds well. She was discharged that day.

11 to 17 July 2017

[43] B was admitted electively to RACH for investigation of vomiting. On 11/12 July 2017 X was attending to her care in RACH. No vomiting occurred overnight. On 12 July, Dr Tyagi reviewed B and noted: "Since April this year her reflux has been getting worse. Prior to that she has had symptoms which could be a marker of GORD [gastroesophageal reflux disease] but things were never this bad. Right now she is on continuous gastric feeds and plan is to go for NJ feeds. She doesn't eat semi solid/solid foods. Doesn't swallow. Spits it out…. Although a degree of GORD is expected in kids with central hypotonia but [B's] reflux appears to be quite severe to be explained by it…" On 12/13 July, it was recorded that B [note: not X as per the joint minute] tolerated an overnight feed. On 13 July an upper GI endoscopy was carried out with a nasogastric tube passed down her left nostril: "massive regurgitation + laryngospasm" was noted as was "delayed gastric emptying". Biopsies taken at the time showed mild reflux oesophagitis (inflammation of the oesophagus), mild chronic inflammation of the stomach and a normal duodenum. On 14 July B had a NJ tube inserted. On 15 July X reported to staff that B had four vomits but was unable to say how much exactly. Nurses recorded vomiting and retching. On 19 July B was reviewed before discharge. Her notes recorded "Mum concerned over lack of bowel movements. Retches when feed rate ◎ past 35 ml/hr. Plan Dr Oxley to r/v – for Peg-J insertion."

16 to 19 October 2017

[44] B was admitted to RACH from 16 to 19 October 2017 for insertion of a PEG tube, which occurred on 17 October 2017.

31 December 2017 to 4 January 2018

[45] On 31 December 2017, B was seen at Balfour Hospital appearing to be in pain and ill. She was described as "like a kid with a viral illness but had no focus of infection and no temperature. Her history is complex." She presented as "generally unwell" with tachycardia. It was recorded that she had "[n]il obvious infective symptoms: no cough/noisy breathing/vomiting". The reason for her attendance was noted as tachycardia with an increased respiratory rate. The notes say: "Discussed [with] Dr Oxley who knows her well. She is complex and he has safeguarding concerns". She was referred to RACH where she was admitted on 1 January 2018. At 5am it was recorded that X felt that B was uncomfortable when volume above 20ml/h even with diarolyte; and that B had 3 x vomits in the air ambulance; and, at 12.45, that B had vomited four times at home, then 2-3 times in hospital/ambulance. It was noted she might have gastroenteritis, similar to siblings. Later it was noted that she tolerated dioralyte at 40ml/hr with no vomiting; and that she was retching after glucojuice, but no vomiting. No vomits were recorded overnight on 1/2 January. On 3 January, a nurse recorded "Due to ward workload I have had limited time to supervise mum. I have taken away 2 wet nappies. Mum reported that a member of staff took away another nappy – green loose stool. I have been unable to identify who took away this nappy." On 4 January, B had a settled night. One large vomit was recorded at about 21.00. B was discharged on 5 January 2018.

[46] On 1 February 2018 X took B to GP Dr Catriona Kemp, who noted: "not been well since hospital discharge over Christmas period. Listless. Vomited in waiting room (no diarrhoea). Vomiting is a daily feature with peg tube. Mum concerned that blood sugars may be low at times as seems to be twitchy…..suggested she acquire a BG machine and monitor". B's temperature was 38.7. Her random blood sugar was noted to be 12.8 mmol/l.

Chronology of material extracts from medical records from 2 February 2018

[47] On 2 February 2018, X took B to GP Dr Simon Kemp. He recorded the history as "vomiting plus diarrhoea over the past 1-2 days; getting worse". B's temperature was 37.4. Dr Kemp made a provisional diagnosis of "?gastroenteritis?" underlying infection. B was referred to Balfour Hospital, where she was seen by Dr Neil Shepherd, who noted that B "presented to us this morning with around 36 hours of vomiting, diarrhoea and lethargy" looking pale and withdrawn. During her time on ward she "spiked a temperature to 38 degrees". Dr Shepherd diagnosed possible sepsis and referred her to RACH. His provisional diagnosis on referral was "?gastroenteritis ? underlying infection". The A&E diagnosis at Balfour Hospital was noted to be a bacterial infection with "36 hour history of D&V". B was transferred by air ambulance to RACH. When admitted there, a one-day history of diarrhoea and vomiting and a two-day history of her being withdrawn was noted. A separate note records "2/7 [two-day] history of vomiting, diarrhoea and lethargy". The medical record also notes that since presentation to OOH on the evening of 1 February 2018 B "had profuse watery diarrhoea (12 nappies full)". Dioralyte at 35 ml/h had been administered to B. The doctor at RACH admitting B noted "Significant hypernatremia dehydration - suspected sepsis, possible gastroenteritis". B's sodium was recorded as being 170mmol/l with a lactate of 5.4mmol/l. Dr Tyagi, who was the resident consultant paediatrician on call, noted "profuse watery diarrhoea (no blood) for last 2 days".

[48] At 4 am on 3 February, B continued to have diarrhoea and had passed almost 300ml of purely watery stool in the previous four hours despite her feeds being stopped the evening before. The records noted that "this is unusual in viral osmotic diarrhoea which stops after stopping feeds". The stool was watery with no faecal matter. B looked dry with

sunken dry eyes and mucous membranes, but normal skin turgour. At 6.30am B was noted to have PEWS (Paediatric Early Warning Score) 1 – 2 due to pyrexia and tachycardia. She was "Pyrexic, 37.7 – 38.8". Antipyretics were given with little effect. She continued to have profuse watery diarrhoea. Her urea and creatinine were normal. Her sodium was recorded as having increased to 175mmol/l with a lactate of 4.3mmol. Staff were to "keep a close eye on mum and [B] and if her gas is no better and she continues to pass watery stools and still look dry, then to transfer her to bay area for close observation". At 9am a sample of B's stool was taken to be sent for analysis. Nursing notes record that there was insufficient stool in her nappy to obtain a second stool sample. At Dr Stephen's ward round, B was noted to have "severe hyponatraemic dehydration likely secondary to acute gastroenteritis. Differential include metabolic and other possibilities including FII". B had a temperature of 38.2 – 38.6 and a CRP substantially elevated at 4. (CRP is C-reactive protein, which, where raised, is indicative of inflammation.) As part of B's treatment plan, it was noted that stool samples should be sent to bacteriology, virology, and for certain other tests including toxicology (to be tested for lactulose). Dr Stephen recorded: "Whilst many results are pending and may indicate infectious cause/metabolic cause, to keep in mind the possibility of FII; as this is a vulnerable child with a PEG in situ with repeated hospital presentation; she remains developmentally normal; need to discuss with child protection next week …". It was recorded at 16.55 that a second stool sample and urine sample had been obtained and sent. B was apyrexic with a temperature of 37.5 but her CRP remained at 4. The sodium concentration in her blood had fallen to 158 mmol/l.

[49] By 4 February, B was "improving fast". Her PEWS at 07.00am were 0-1 "due to temp", but dropped to PEWS 0 at 9.45am. On 5 February it was recorded that there was an "unclear cause of current event." Urine testing for laxatives was being performed. B's stool

was sent for chromatography. X was happy with a plan to reduce Keppra. On 6 February it was noted at 10.00am that the biochemist was "unable to do stool electrolytes & chromatography, will look into reference labs. Suggests urine laxative screen". There was a further note at 15.30 that stool sugar chromatography was sent to Alderhey Hospital, Liverpool with a turnaround time of four weeks. A urine laxative screen was sent to City Hospital, Birmingham with a turnaround time of two to three weeks. It was also recorded that no vomiting or seizure activity had been noted that day and that "[X] doesn't give lactulose at home unless B needs it. [X] reckons she gives lactulose about twice a month at home". On 7 February Dr Stephen met with X and Nurse Easson and explained that B had many unexplained symptoms to date. Dr Stephen's view was that B did not have epilepsy. X agreed. Dr Stephen said that the medical staff had to keep all possibilities in mind, including the possibility of an intravenously administered substance, and that it was in B's best interests to have all possibilities investigated. The plan was to discharge B at a medically appropriate time, pending the results of investigations.

[50] On 8 February 2018, Dr Cochrane and others met with X. The notes show that Dr Cochrane said, in agreement with Dr Stephen, that "we needed to consider that [B] had been given something that she shouldn't have". X said: "We've given her nothing, but she has had Keppra + tubes that she didn't need. ... I'd be very interested to see the results of the stool". Dr Cochrane explained that:

> "regardless of the results I was suspicious that she had been given something...I tried to clarify the history again, stating it was very unusual for [B] to have become so unwell so quickly. X said 'she had been having vomiting and diarrhoea for Wednesday, Thursday, and Friday'. THIS IS CONTRARY TO HER INITIAL HISTORY OF ONLY GETTING DIARRHOEA ON FRIDAY (day of admission), AND THE GP CONFIRMED DIARRHOEA WAS NOT MENTIONED AT THE APPOINTMENT ON THURSDAY 1/2/18 ... I asked X about testing for low blood sugars. She answered that she was concerned from B's previous admission that her blood sugar was low and that at the child's plan meeting it was suggested she

> attend the GP. She attended (1/2/18). The GP Dr Kemp tested her sugar and it was "high" so she was given a blood glucose machine and told if it went into the teens to go to A&E. I asked why she had been testing the sugars before then and she said 'I have never tested it before now'. THE CHILD'S PLAN MEETING MINUTE 31/1/18 RECORDS "MUM IS CONCERNED ABOUT HYPOGLYCAEMIA AND HAS TESTED THIS, IT IS READING 2.8".

[51] Also on 8 February, there was a plan to move from jejunal to gastric feeding, to see how B coped. On 9 February, on a break from continuous feed, B was offered toast and seemed keen to take the plate. She was also offered custard, which she was very keen to be fed but became distressed when some landed on her hand and asked for it to be cleaned off (tending to give the lie to X's assertion that she was comfortable playing with food). Later she managed soup, jelly and ice cream from spoon. In the evening, she ate toast and drank juice. On 10 February B was eating a normal diet with no vomiting.

Child protection investigation

[52] As the hospital records show, Dr Stephen had suspicions of FII from an early stage of B's admission on 2 February 2018 and she shared those concerns on 5 February with Dr Cochrane, as the lead child protection consultant paediatrician, describing the case as perplexing due to the high sodium levels. As is also evident from the above extracts from the hospital records for 7 February 2018 Dr Cochrane, too, suspected FII and that day she passed her suspicions on to social work. That initiated the involvement of the Orkney Child Protection Committee, which consisted of a number of representatives of different agencies with responsibilities in respect of child protection. No issue is taken by the pursuers with the suspicions or actions of either Dr Stephen or Dr Cochrane at this early stage: it is accepted that having regard to the RCPCH guidance, they were entitled, indeed bound, to act as they did. The pursuers' challenge is directed at, as they would have it, the doctors'

subsequent lack of appropriate investigation and the conclusions which were ultimately drawn.

[53] On 8 February 2018 the Orkney Child Protection Committee conducted an Initial Referral Discussion Meeting involving representatives of the defender, NHS Orkney, the local authority and Police Scotland. Dr Cochrane attended by telephone. Among other things, she told the meeting that, in her view, the decision to initiate PEG feeding (in response to X's reports of reflux, vomiting and intolerance of oral feeding) may have been precipitate; and that during the present hospital admission, the hospital would try to feed B orally and to take her off anti-reflux medication. X said that B vomited every day, but she had not done so since admission on 2 February. An action plan was agreed upon, which included that B would remain at RACH for at least two weeks, and that there would be strict nurse surveillance so that X would not be alone with B.

[54] The Committee held a Review and Planning Discussion on 19 February 2018. Dr Cochrane was unable to attend. However, she had reported that B had been eating a normal toddler diet and drinking well, with no retching, gagging or vomiting; all medication had been stopped with no repercussions; and it was intended to remove B's PEG tube in theatre and then to devise a discharge plan.

[55] The Child Protection Committee arranged an initial child protection conference on 5 March 2018. It was attended by X, Y, representatives of the defender (including Dr Cochrane by video conference), NHS Orkney, the local authority and Police Scotland. The decision of that meeting was that B required a child protection plan and that she be placed on the child protection register. Dr Cochrane reiterated her concern that B had received significant levels of medical interventions in the past, but had no structural abnormality in her brain and it was unusual to see an inability to eat in a developmentally

normal child. X and Y said that a possible cause of B's eating problems was the Keppra she had been prescribed, and pointed out that when the Keppra was stopped, she started taking food again without difficulty; that explanation was discounted by Dr Cochrane.

[56] Between 5 and 22 March 2018 Dr Cochrane communicated about B's case with Dr Malcolm Coulthard, Honorary Consultant Nephrologist at the Great Northern Children's Hospital, Newcastle upon Tyne. Dr Coulthard's overall conclusion, based upon the information provided to him by Dr Cochrane, was that B's hypernatremia was entirely compatible with a pathophysiological sequence that can be predicted to happen if a child is suddenly exposed to a very severe episode of osmotic diarrhoea. He noted that such severe acute bouts of osmotic diarrhoea are not seen in clinical practice in the developed world.

[57] On 26 March 2018 at 9am the Orkney Child Protection Committee held a 'Core Group/Discharge Planning Meeting', attended by X and Y (the latter by telephone), representatives of the defender (including Dr Cochrane by telephone), the local authority and Police Scotland. The Chair of the meeting (James Henry) recorded at the outset that:

> "conclusion of medical opinion as to why B had such high sodium levels was needed in order to inform her discharge plan from RACH. Dr Marianne Cochrane stated that she had done as much medical analysis as she could (including review of B's stool samples), had looked at the primary and secondary care chronologies and had taken account of what the parents said had gone through B's PEG feeding tube. From this information Dr Cochrane had come to the conclusion that something had been administered through the PEG tube to cause B's severe osmotic diarrhoea".

Mr Henry observed that the assessment continued to be significant, wide-ranging and on-going with information still being gathered. DC James Sutherland said that once all the information had been gathered a decision would then be made about whether a report should be submitted to the Procurator Fiscal. Dr Su Bunn told the meeting that the PEG feeding tube had been removed from the inside. The usual procedure would be to increase

food intake by mouth but the tube had not had to be used at all in hospital. A button (gastrostomy) which is held in by a water filled balloon could be removed from the outside and the opening would normally close up within 24 hours. Dr Bunn said that the button could be left in for 2-6 weeks and then taken out. She spoke about the balance of risk, in that the chances of B needing the tube again in the future were small but the chance that something could be put through the tube was a higher risk. She advised that the button should be taken out for her safety. If B were to be in a foster placement Dr B reiterated that the button could be taken out after 2-6 weeks. X asked if the button was removed whether there was the potential for B to come back to her home environment, but Dr Bunn expressed her view that it was not safe for B to go home with the gastrostomy in place. After further discussion Mr Henry stated that whilst all agencies had responsibilities in the assessment and decision making, there was heavy reliance on the assessment and opinion of the medical team in Aberdeen. The outcome of the meeting (among other things) was that it was agreed that an application was to be made for a CPO; and that Dr Cochrane would complete and finalise her report. Mr Henry concluded by saying that the application for a CPO, scrutiny and decision making of the sheriff would be helpful in the assessment and planning for B.

[58] Later that day, at 13.03 Dr Cochrane sent an email to Mr Henry in which she summarised B's medical history, which she described as complex. The email concluded with the following (bold emphasis in original):

> **"This is a very perplexing presentation of a neurodevelopmentally normal little girl with an unusual collection of symptoms (seizures, feed aversion, hypoglycaemia, twitching) that are not explained by a known medical condition. They have not responded well to the treatments instigated. All the symptoms reported are now NOT evident for the last 7 weeks when mother has not been unsupervised with B. This presentation clearly fits with the one of Fabricated and Induced Illness as described by the RCPCH.**

B has been subject to significant iatrogenic (medically induced) harm due to the symptoms reported. She has had unnecessary treatments, investigations and procedures and has had many hospital admissions. She has recently required a prolonged hospital stay. She has also been presented in her community as being a child who has complex medical illnesses and has been treated as such.

I am in agreement that placing B home at this point poses significant risk of harm to her health and wellbeing in the contest of the above AND the lack of acknowledgement from the family in relation to these concerns."

[59] On 28 March 2018 the local authority applied to the sheriff for a CPO, producing that email, and the CPO was granted in terms of section 39 of the 2011 Act. The Reporter arranged a two-day children's hearing under section 46, and on 2 April 2018 the children's hearing continued the CPO, being satisfied that there was clear professional opinion to support that B had been subject to treatment that had or was likely to have caused significant harm (medically induced) and that at that stage her safety and wellbeing could not be guaranteed if she were to be removed from the place of safety and returned to the care of her parents. A referral having been made by the Reporter under section 69, at a hearing on 10 April 2018, the children's hearing made the first of a number of ICSOs, including a requirement that the child reside with foster carers, the reasons given being:

"Decision 3: The panel all agreed that as the [CPO] ended as of today, with no clear conclusion as to how and why [B] suffered from potentially fabricated and/or induced illness to a life threatening stage, there was an urgent requirement for [B]'s protection and safety that an interim compulsory supervision order was required.
Decision 4: Given the clear professional opinion that [B] had suffered from fabricated and/or induced illness, the panel all agreed that it was necessary for [B]'s protection, safety and continued wellbeing, for [her] to remain in foster care."

[60] On 1 May 2018 the children's hearing continued the ICSO, the reason given being:

"Until ongoing investigations are completed there are still many unanswered questions regarding the care [B] has received at home. The panel still believes there is a possible risk to [B]'s health and welfare."

[61] It seems that decision was appealed to the sheriff by Y (the interlocutor states that the male foster carer was the appellant, but that is clearly an error), the appeal being determined

on 10 May 2018. For reasons which, regrettably, do not appear on the face of the interlocutor, or in the sheriff's note, the appeal was conceded by the reporter, but a fresh ICSO was made by the sheriff, it being agreed by all parties (including, therefore, Y) that one was necessary. It further appears that the sole bone of contention at the appeal was where B should reside, Y's position being that she should reside with him. The sheriff was not prepared to order that, his note of reasons stating that this was because the proposed address had not previously been provided to social work and they had not had the opportunity to assess whether the accommodation was suitable or not. As to his reasoning, the sheriff said this:

> "I reminded myself and all present that the child became very seriously ill while in the family home and environment; it is not known how that came to be; medical opinion is, amongst other things, that there is a lack of acknowledgment from the family in relation to the concerns in relation to the child; while in hospital for a long period the child became well; while with carers she has remained well."

[62] Subsequently, the sheriff made further ICSOs from time to time. From July 2018, these required that B reside with Y, subject to contact with X and Z.

The joint report dictated 26 March 2018 (signed 6 April 2018)

[63] It is convenient to refer to the March/April report at this stage, since, although not relied on at the outset of the child protection proceedings, its terms reflected the opinion already offered, and contained the chronology on which that opinion was based. The report was written by Dr Cochrane jointly with Dr Stephen, and in evidence both stood by its terms. It narrated events around B's hospital admission on 2 February 2018 and her prior medical history in some detail. Four possible causes of the high sodium levels were noted: (i) kidney disease or kidney problems; (ii) severe dehydration (hypernatremia dehydration); (iii) salt poisoning; and (iv) severe osmotic diarrhoea. The first three of these were

discounted for reasons which are not challenged. As regards severe osmotic diarrhoea, it occurred when a substance with a high osmotic load of non-absorbable material entered the gut, resulting in large amounts of fluid being drawn into the bowel and excreted leaving the body water deplete and resulting in a relative high sodium. Such a substance could be lactulose or other substance with laxative effect, or a high molecular load feed if there was also accompanying bacteria breaking down the feed. The conclusion of Drs Cochrane and Stephen was that severe osmotic diarrhoea was the most likely cause of B's high sodium level and resulting acutely unwell presentation. The report went on to note that a stool was tested for the presence of laxatives but was negative, but this was not done until after the stool had normalised somewhat. The treatment of this type of diarrhoea is not 0.9% saline and it was likely that administration of this fluid had further increased B's sodium level in hospital. B's sodium level started to drop once 0.45% saline was administered, further evidencing this mechanism of severe osmotic diarrhoea. The report also stated that:

> "It is important to acknowledge that some of B's presentations have had a genuine medical reason. For example her renal ultrasound did show hydronephrosis and there was evidence of vesicoureteric reflux, which has now resolved. B has never had a proven urinary tract infection. In addition her presentation to hospital in January 2018 did show raised inflammatory markers indicating a likely infection."

[64] The report ended with four conclusions/opinions. First, that the presentation of significant hypernatremia secondary to severe osmotic diarrhoea in a child with a PEG jejunostomy was highly suspicious of a substance being administered through her PEG. There was no explanation from X to account for this. (In this regard, the report went beyond the opinion expressed in Dr Cochrane's email of 26 March.) Second, that B's numerous unusual presentations of seizures, vomiting, gagging and retching with feeds, twitching and hypoglycaemia were not accounted for by medical diagnosis. A prolonged period of hospital admission (from 2 February to 26 March 2018) had evidenced that she did not have

seizures or a gut condition requiring a PEG and could eat normally. No twitching and hypoglycaemia had been noted during that admission. Third, that B had suffered considerable iatrogenic harm in the form of unnecessary investigations, surgical procedures, general anaesthetics, prolonged hospital admissions, as a result of repeated, sustained presentations and reporting by X of symptoms. Fourth, that B's presentation was consistent with FII as described by the Royal College of Paediatrics.

[65] Dr Cochrane was asked by the Reporter to prepare a further report, which she did on 4 July 2018. It largely repeated the terms of the April report and expressed the same opinion, that B's presentation on 2 February 2018 was suspicious of her having been administered a substance via her PEG which had caused a severe osmotic diarrhoea and subsequent dangerously high sodium levels. The report went on:

> "It is important to acknowledge that B at times has had vomiting which is common in babies and toddlers and that some investigations have evidenced reflux. However the extent of reporting of intolerance of feeds, including nasogastric and nasojejunal feeds, and chronic vomiting and retching has led to surgical interventions that were unnecessary."

The evidence

X

[66] X's position was that she had done nothing to harm B, had not fabricated or exaggerated her symptoms and that B's vomiting and eating problems all emanated from her being prescribed Keppra, but that the doctors had paid no attention to her concerns about that. She had not been told much about the side effects of Keppra, but had read the leaflet herself and the many side effects included vomiting, stomach complaints and nausea. The movements which she had videoed in April 2016 had worried her. She had wanted B to have her urine checked in case she had a urine infection which was perhaps hurting her or

causing discomfort. The seizures referred to in the hospital records had been witnessed by nurses. It was not that B did not like the idea of food; simply that everything she was given seemed to come back up. She remembered B being sick on 23 May 2017, while at the play area. A member of staff who was there at the time came and cleaned it up. B vomited a lot, often large vomits which made a mess, including of the car seat. She did not have a clear recollection of the week beginning 1 February 2018, because that had been a traumatic time. Being separated from B had been very difficult. Even though she was allowed to have contact, it had to be supervised. The separation had also left its mark on B. When B was still in hospital, parcels and letters had been sent to her, which had not been passed on. Dr Cochrane had all the letters in a binder.

[67] In cross-examination, X accepted that not all of the seizures in hospital had necessarily been witnessed by staff: it depended how busy they were at the time, but they were always around. She could not explain the discrepancy between the medical records to the effect that there had been no seizures since B went on to Keppra, and her evidence that the more Keppra B was given, the more she was sick. She did not know why there were occasions when she had spoken to medical professionals but had not mentioned the increase in seizures. As to why she had not wanted B to try out food in hospital, her thinking had been that B was quite agitated and stressed, and X wanted to keep food a positive experience for her. She thought the dietician had said she would come round to watch B eat. As for the syringe in a drawer, she could explain that: she had to draw back aspirate when using the tube, then test the aspirate on a pH strip to check whether it was acidic or not; that was done over and over again; she was not surprised that she had managed to drop a syringe into the drawer. Contrary to the GP notes, she had not told the GP on 1 February

that B was not having diarrhoea. She had said that B was having diarrhoea because B did have diarrhoea for more than one day prior to her admission to hospital on 2 February.

Dr Stephen

[68] Dr Stephen spoke to, and elaborated upon, the hospital records of which she had first-hand knowledge. When B was admitted on 2 February 2018, she was very ill and the priority had been to make her well. The appearance of B's stools was extremely unusual, so much so that the nurses had retained them for Dr Stephen to look at: she had never before seen stool of such appearance. It comprised clear gelatinous material. Dr Oxley, too, had said he had never seen stool like it. The ward round on 3 February was also memorable because of B's high sodium levels, the highest Dr Stephen had ever seen at 172 and 175. The priority was to get those down. She had recorded several atypical features about B's case. The first was that she had been diagnosed as having epilepsy but there was no real EEG evidence to date. Second, she had been diagnosed as having gastro-oesophageal reflux and was being fed via a peg into her stomach. Third, X had asked to administer B's medication, which was unusual, and Dr Stephen had said at the time (and recorded) that this must be done under supervision. B looked very ill, more ill than Dr Stephen would have expected had she had an infection. Dr Stephen instructed nurses to shift B from a cubicle (where she had been with X, mainly unobserved other than when nurses entered to do observations, probably hourly) to a bay, for more one-to-one supervision. She discussed her safeguarding concerns with Dr Cochrane. As regards stopping Keppra, she thought she had consulted with Dr Jollands (Consultant Paediatric Neurologist), but by this time in any event she was increasingly suspicious that B did not suffer from epilepsy. Given the extent of B's vomiting, Keppra was unlikely to be the cause. When the Keppra was stopped, there was

no return of the seizures. B also very quickly embarked upon a feeding diet which was normal for a child of her age. That was all consistent with a diagnosis of FII. Dr Stephen remained content with the report prepared jointly with Dr Cochrane, and with its conclusions. She had not since come by any information which would cause her to qualify the opinions expressed in the report. She had never seen such a quick resolution of symptoms as with this child.

[69] In cross-examination, Dr Stephen acknowledged the importance of the chronology. When she signed the report of March/April 2018, she was satisfied that it was accurate. Insofar as the hospital records recorded seizures and vomiting, she was prepared to concede no more than that was what was recorded, observing that the records did not make clear (or did not always make clear) whether the nurses themselves had witnessed what was recorded, or whether it had simply been reported by X. In relation to whether B had been given a general anaesthetic when sent for a brain scan, it was her understanding that she had been but she accepted that B might have been "fed and bundled". It was correct that Keppra could in theory cause side effects, including headaches, nausea, vomiting and increased risk of infection, but in practice she had never seen that and it was highly unlikely that it had caused B's vomiting, because the pattern of vomiting did not fit. She refused to rule out the possibility that X had administered a substance to B, through the tube, when she was in the hospital. She agreed that if the suspicion of fabrication fell away, that undermined the thesis of the more serious allegation of induction.

Dr Cochrane

[70] Dr Cochrane has been the lead paediatrician in Grampian since 2013, having practised paediatrics since 1998. She has had a child protection role for 18 years. She

remembered Dr Stephen raising B's case with her at a Monday hand-over. Although she saw hundreds of cases each year, B's case stood out because it was so complicated and had proved difficult to manage. She had never seen similar sodium readings to B's, which had been dangerously high to begin with, rose still further then plummeted and normalised. It was normal to rehydrate a child whose sodium was very high with a solution of 0.9% saline. She had contacted Dr Coulthard because he had been recommended to her as someone who could advise on the possibility of salt poisoning, which was initially suspected. She sent him various data which had been collated on B. He advised that he did not think it was salt poisoning. The other possible diagnosis suggested by Drs Oxley and Stephen was osmotic diarrhoea; Dr Coulthard had agreed that this was a possible diagnosis. She asked him to confirm his views in writing (which confirmed her views and those of the team in Aberdeen), because she wanted a written audit trail. She did not want the report for medico-legal purposes, but to enable her to write her own child protection report. She had not discussed the possible administration of a substance with Dr Coulthard before she wrote her report. Her concern was that X had had the opportunity to administer a substance when B was first admitted to hospital. That could be done by inserting a syringe into the hole of the PEG. The most common cause of osmotic diarrhoea was the administration of a substance, such as a laxative. The 0.9% saline solution was confounding the sodium level because B was not dehydrated but pouring out lots of liquid osmotically. The increase in sodium level from 156 to 175 was very concerning, the biggest risk being that B might suffer brain swelling leading to a seizure or coma. She (Dr Cochrane) had attended the child protection meeting on 26 March 2018. The minute correctly recorded the views she had expressed. The email of later that day simply set out the views she had already expressed. She had not reached her opinion about FII lightly. It was a very difficult conclusion to reach.

As regards B's other reported symptoms, it was significant that she was neuro-developmentally normal. It was particularly unusual for a neuro-developmentally normal child to require duodenal feeding. She had written the report of 6 April 2018, which Dr Stephen also signed because she had raised the initial concerns. The chronology and background were very important in arriving at a conclusion of FII. The last admission period where B recovered from all of her illnesses was also very important from a child protection standpoint. Her seemingly spontaneous recovery was highly unusual. The reports of B's vomiting in hospital had not been witnessed by hospital staff. The finding of a syringe in a drawer was unusual; that was why it had been recorded by the nurse. While it was not unusual for a parent to have to aspirate their child in the manner described by X, it was not usual to then put the syringe in a drawer beside a bed. It was significant that B had been assessed as having a normal swallow, which meant that she did not have a mechanical swallowing difficulty. Within a week of her admission to hospital, B had been eating normally – items such as toast, a banana, rice crispies and juice. That was entirely incongruous for a child being fed by a PEG jejunostomy, which meant that the child was unable to eat. The transition would normally be far slower, with ups and downs and variability in the ability to eat. The clinicians had formed the view that B was unable to eat because that was what had been reported by X, who had also declined the opportunity to try B out with food in hospital. Even without the acute presentation on 2 February 2018, that alone would be a reason for suspecting FII. Another factor which gave rise to concern was that X had given a different history to different medical staff on a number of occasions, for example, that the diarrhoea had been going on longer than she had initially said. For a substantial part of the time that B was in hospital in February and March 2018, X was not present. Dr Cochrane did not have, in her office, a pile of parcels sent by X for B.

[71] Dr Cochrane also spoke to the terms of her July 2018 report, which she had written at the request of the Reporter. She had not been involved in B's care since her discharge from hospital, but she had no information which caused her to revisit her earlier opinion of FII. She acknowledged that ideally a stool test should have been carried out earlier (than 5 February 2018) but it had been very difficult to capture, when there was so little stool content. The rapid progression from oral feeding to PEG-J tube was highly unusual in a child who was neuro-developmentally normal. There was no reason to depart from the terms, or conclusions, of the July report.

[72] In cross-examination, Dr Cochrane accepted that by the time of the meeting on 26 March 2018, she considered she had enough information to enable her to reach a conclusion. Her email confirmed the views already expressed and she was aware it was to be one of the documents used in the application for a CPO. In her opinion, placing B at home on her discharge from hospital carried severe risks. She acknowledged that the chronology was important. Various passages in the medical records were put to Dr Cochrane, designed to show up inaccuracies in her chronology. Whereas she had recorded that B did not have a temperature on admission, she accepted that the records showed that B did at times have a temperature, which could have been indicative of fever (although also indicative of salt poisoning). That did not change her overall opinion. A slightly raised CRP was another infection marker which she accepted she did not mention. It was put to Dr Cochrane that the medical records showed vomiting and diarrhoea from 1 February 2018: she considered that was still a very short history, not one that would cause hypernatremia. The email did not require to include every detail; it was not a medical report. It had not been possible to carry out stool electrolyte tests, which would have identified whether there was osmotic or secretory diarrhoea, as it had not been possible to

obtain a sample of stool. B did not have a clinical picture of infective diarrhoea, an opinion shared by countless medical staff.

[73] As regards whether B's seizures had been seen by nurses, Dr Cochrane maintained that the medical records showed no more than that the nurses had recorded seizures; that did not mean that the seizures had been observed. She understood that they had not been. She had assumed that B's MRI scan had been done under general anaesthetic. As for the vomits and the insertion of the tubes, Dr Cochrane acknowledged that the records referred to many vomits, and that on the face of the records, X had not done anything wrong: it was the fact that it was a neuro-developmentally normal child who had all these symptoms that was perplexing. She did not have a view on whether the Reporter was correct to abandon the referral but she was still of the view that she had done the right thing.

[74] Although the case does not ultimately turn on credibility and reliability, insofar as they spoke to factual matters, I found the evidence of Dr Cochrane and Dr Stephen to be credible and reliable, (so that, where it differed from X's evidence on matters of fact, I prefer their evidence: for example, in relation to whether or not Dr Cochrane failed to pass on parcels from X to B).

Dr O'Hare

[75] Dr O'Hare has been a Consultant Paediatrician for about 16 years, currently at Leeds Children's Hospital and Leeds Teaching Hospital. He was the Named Doctor in children's safeguarding between 2014 and 2018. He spoke to and adopted the terms of his report. His approach had been to prepare the chronology which he would have prepared had he been the paediatrician presented with the case, and to compare it with that prepared by Dr Cochrane. He considered it necessary to present full information in any opinion he wrote

for the multi-agency team in such a manner that his conclusion might be challenged. He was of the view that Dr Cochrane had made it very difficult for her opinion to be challenged. She had too quickly come to the conclusion that something had been administered by X to B and had not presented her views to the multi-agency team in a transparent manner. He had available to him the NHS Grampian Records (but not the GP records); and the expert reports of Professor Milla, Professor Zuberi and Dr Coulthard (all prepared for the purposes of the children's referral hearing and none of which were available to Dr Cochrane).

[76] Without meaning any disrespect to Dr O'Hare, his report is not an easy read, partly because it is at times unnecessarily repetitive (for example, section 2 replicates most of what is in section 1, word for word, and features again in section 9), and partly because the language is, in places, opaque (for example, in paragraph 3.1.17.7.2:

> "Might it be that the weight of 11.8kg...does not reflect the actual weight in Aberdeen, following this diarrhoea – although speculative, very possibly – perhaps probably")

but there is no doubting Dr O'Hare's expertise. He was critical of the failure to test for stool electrolytes and stool osmolality. Had such tests been done, they could have confirmed whether or not B had been suffering from secretory or osmotic diarrhoea. Osmotic diarrhoea stopped when intake of the substance causing it stopped. Secretory diarrhoea persisted (as B's had). It was very speculative to conclude that B's diarrhoea had continued because a substance was continuing to be administered. He found it unusual that a speedy decision to change the clinical management of B's suspected epilepsy and perceived feeding difficulties was taken, when the use of neither the Keppra nor the PEG-J were driven by X. His interpretation of the medical records was that there was no evidence of illness fabrication and that all the concerns expressed by X were valid. Equally, the building undercurrent of mistrust which was evident from the records was not sustainable.

Dr O'Hare's conclusion was that "on balance, and awaiting both challenge and further information from my multiagency colleagues, I do not find evidence supportive either of previous episodes of fabricated illness, nor of illness induction in this case." Insofar as B's rapid recovery was concerned, Dr O'Hare did not find this surprising. It appeared that the neurologist consensus before February 2018 was that Keppra was not required. As for the feeding, the records disclosed a plan to return to normal feeds in February, the advice from the gastroenterology expert being that the reflux from which B suffered was very likely to be outgrown. He was not surprised that B fed well and had no further seizures.

[77] In cross-examination, Dr O'Hare accepted that the "paediatric duty" was owed to the child rather than the parent. A broad range of behaviours fell within the term "fabricated or induced illness". Regarding the GP records, he had neither received nor asked for them but he was not aware of their having any useful information; however, ultimately, he was constrained to accept that he could not say whether they contained any relevant information or not. On reflection, he acknowledged that he should have drawn the court's attention to the fact that he had not seen the GP records, but his opinions were unlikely to have been changed had he seen them. He could not explain why paragraph 5.16 of the RCPCH guidance (which states that the health chronology should include information from primary, secondary and tertiary care, and that it was crucial to liaise with the GP) had not made it into section 20 of his report, which summarised the guidance. He had based his opinion in part on the reports obtained from Professor Milla and Professor Zuberi. It made no difference that in this case they had been obtained by the parents. He would have asked the consultants the same questions. He had not been aware, when writing his report, that the report of April 2018 had not been founded upon when the CPO was sought. Looking at Dr Cochrane's email of 26 March 2018, he disagreed that the symptoms were not explained

by a known medical condition. The feeding aversion was explained by reflux; the seizures had been seen by the paediatric team who determined to commence treatment, suggesting that the seizures might represent myoclonic epilepsy. He did not find it concerning that X had declined the opportunity to try B on solids in hospital. The best way for testing a child for aversion was in the home setting, where the child was more likely to accept food. He did not criticise Dr Stephen for having shared her concerns with Dr Cochrane, nor Dr Cochrane for having shared her concerns with social work.

Dr Ninis

[78] Dr Ninis is a Consultant in Acute General Paediatrics in a London Teaching Hospital. She has over 30 years of experience in paediatrics and is part of the on-call Child Protection Team. She spoke to and adopted the terms of her report. She, too, had prepared a chronology, albeit briefer than she would have done had B been her patient (and in that respect her approach was different from Dr O'Hare's). She had seen the GP records, which contained useful information, but they had not caused her to revisit her opinion. Unlike Dr O'Hare, she did not criticise the paediatricians for not having tested for stool electrolytes or any other specialist tests (other than virology or microbiology, which were done), as initially there was no reason to suspect that anything unusual was going on. The tests would not have been straightforward in any event, and would not necessarily have differentiated the reason for the stool losses. The fact that stool losses continued despite enteric food/fluids being stopped suggested a secretory diarrhoea but could have resulted from a substance such as an osmotic laxative before the diarrhoea started and after the feed was stopped. In her opinion, B's excellent and rapid recovery and the manner in which she

started to eat normal foods without problems in eating, swallowing and retaining food fully justified the team's child protection concerns.

[79] Dr Ninis acknowledged that there was evidence of gastroesophageal reflux on barium study, and mild reflux oesophagitis on endoscopy, but she noted an increasing discord between what was observed on the ward, B's development and what was reported by X. Despite the reported problems, B had continued to gain weight well. There had been instances when X had not wished to comply with the medical plan to try to feed B in hospital. The one criticism Dr Ninis had of B's treatment was that, in her view, the move to NG and then PEG feeding occurred too quickly instead of observing B for longer and referring her to the speech and language therapist. It was exceptional that B had started eating normally so quickly after the tube was removed. The suspicion of FII was reasonable and consideration of a possible diagnosis to that effect could have been made earlier.

[80] As far as B's vomiting was concerned, Dr Ninis' position was that the hospital records showed that some episodes of vomiting had been witnessed and some not. It was not significant that B had vomited: all children vomit. That was not material to her overall conclusion. The real question was whether the vomiting was a problem or not. B was thriving and putting on weight. There was evidence of reflux, but that was different from oral aversion – where a child refuses to take food in their mouth and swallow it – which was what B was being presented as having. The test was to feed the child under the observation of a trained speech and language therapist but X would not allow that to be attempted in hospital; in fact, she had refused three times. If it was true that B had never enjoyed solid food as was being claimed, she would not have been able to eat normally as she did when the PEG was removed in February 2018. Dr Ninis had never before seen a normally developed chid have a naso-jejunal tube. As far as Keppra was concerned, she had never

experienced it causing severe gastro-intestinal problems. The presentation on 2 February 2018 was most unusual: the diarrhoea had been so prominent, the sodium had shot up and the urea didn't change – she had never seen that before. B could have had secretory diarrhoea but the problem with that was that where diarrhoea was caused by a pathogen, it usually lasted for longer, whereas B's had started to settle by lunchtime. The diarrhoeal episode alone would not have justified a diagnosis of FII, but here there was one odd thing in the history on top of another.

[81] In cross-examination, Dr Ninis said that it was unusual that feeding difficulties would be raised only at 11 months; if a baby was unable to feed, difficulties would become apparent much sooner. X had repeated in April 2017 that B was unable to take solids; she had initially agreed that an attempt be made in hospital, but then changed her mind. The picture of fabrication was building by that time. Even if B had severe reflux that would not have prevented her from eating. Eating solids was part of the treatment for reflux. Dr Ninis disagreed that the barium test had necessarily shown that there was delayed gastric emptying as had been reported at the time. That assumed that B had been fasted appropriately, but another explanation was that there had been water in her stomach: one did not know. It was highly unlikely, as Dr O'Hare had suggested, that stopping Keppra had resulted in B being able to eat normally. Even if Keppra had been the cause of B's aversion to food, that aversion would have continued after the Keppra had been stopped. She disagreed with Professor Milla's opinion that fundoplication (an operation to control gastroesophageal reflux) would have been appropriate. The reference in the GP records to fundoplication made no medical sense, since one would never perform a fundoplication in a case of delayed gastric emptying. Although that was presented in the GP notes as having

come from RACH, it could not have done; there was nothing in the RACH records which supported that comment (which had come from X).

Dr Malcolm Coulthard

[82] Dr Coulthard spoke to the terms of his report, which he had prepared for the Children's Reporter, and also to his communications with Dr Cochrane in 2018. In his report (from which, for some reason, someone had deemed it appropriate to redact references to X which on any view were relevant to the matters in issue at the proof), he concluded that B's severe hypernatremia was not due to either hypernatremia dehydration or salt poisoning but was almost certainly caused by a diarrhoeal illness which caused her to lose water in excess of salt from her body, resulting in her tissues and blood becoming excessively concentrated with sodium. Because the osmotic diarrhoea lasted for many hours it could not have been caused by the single administration of an osmotically active substance, and must have been caused by an infective enteritis. The only other theoretical possibility, which Dr Coulthard described as "very unlikely", would be that an osmotically active substance was repeatedly, deliberately and covertly administered, for example through B's PEG-J tube throughout her first day in hospital. He said that when Dr Cochrane had contacted him in March 2018, she had not conveyed the full extent of the large volumes of watery stool; he also considered that the statement in the report of 6 April 2018, that prior to B's admission to hospital she was not having profuse diarrhoea, was a mis-statement of the position. He disagreed with Professor Milla's conclusion that the mechanism of B's hypernatremia was due to dehydration. In his evidence, Dr Coulthard elaborated upon his report; in particular, he disclosed what had been redacted. As regards his discussions with Dr Cochrane in 2018, he had made it clear to her that his opinion then was based upon the

data she had provided to him. He had not known of the extent of the diarrhoea. While a laxative could have caused watery diarrhoea, it would have stopped when administration of the laxative stopped, whereas here B's diarrhoea had continued, and her sodium continued to rise. It was very difficult to distinguish between an enteric infection and diarrhoea caused by administration of substance, since there would be a lot of watery diarrhoea either way. However, there would have to have been ongoing administration, which left an infection as the only likely cause of the diarrhoea. Although unusual, that could happen, in infections such as cholera. A test of the stool on the morning of 3 February 2018 could have disclosed whether laxative was present but he did not criticise the doctors for not having done that, which he would not normally recommend.

Professor Peter Milla

[83] Professor Milla is Emeritus Professor of Paediatric Gastroenterology and Nutrition at the UCL Institute of Child Health, University College London. He had reviewed B's hospital and GP records and the reports of Dr Cochrane and Dr Stephen. B had gastroesophageal reflux. When pathological, that was called gastroesophageal reflux disease (GORD). In his opinion, B's abnormal movements at three months were not seizures but an example of Sandifer's syndrome (a disorder of the upper gastrointestinal tract with neurological manifestations) which was not recognised. That syndrome may induce reflux episodes such as B experienced and had possibly led to B's feeding disorder. As for B's diarrhoea, its cause (and whether it was secretory or osmotic) could have been determined by simple clinical testing which was not done. The reported history given by X regarding B's tolerance of solid foods and vomiting together with the abnormal movement that she reported in April 2016 were consistent with GOR and Sandifer's syndrome. In many

children reflux will have ceased by 18 months of age so that the apparent cessation of symptoms in February 2018 could, at least in part, have been a consequence of the natural resolution of GOR. There was no evidence of a substance being administered and the commonest cause of B's symptoms would be a diarrhoeal and vomiting illness such as an enteric infection. The conclusions the medical team reached were not supported by the tests that were done which were inadequate, incomplete and not done at the appropriate time.

Professor Sameer Zuberi

[84] Professor Zuberi is a Consultant Paediatric Neurologist at the Royal Hospital for Children, Glasgow. Having reviewed the medical records and a panoply of other information, he did not think that B had epilepsy. She could have had Sandifer's syndrome, which would be consistent with her gastroesophageal reflux and jerky movements. It was possible that the Keppra she was prescribed had caused irritability and behaviour change. It was likely that B suffered from both reflux and the adverse behavioural effects of Keppra.

Mary MacKinnon

[85] Mary MacKinnon, now retired, formerly worked as a social worker, then as a solicitor, including spells as a children's reporter. She has over thirty years of experience in child protection and was led as a social work expert. I do not doubt her experience and skill in that field but her evidence largely consisted of an explanation of how the statutory child protection procedures work in practice, and of the respective roles performed by the various participants in those procedures; much of her report involved no more than a narration of either what had happened in the present case, or of the provisions of the 2011 Act; and to all of that extent Ms MacKinnon's evidence did not add a great deal to my understanding of the

case. She said that she had twice been involved in cases involving an allegation of FII, and her experience was that they were more complex than other child abuse cases in that the available supporting evidence tended to be less robust. It had been wholly reasonable for OIC, and thereafter the Reporter, to accept in good faith the validity of Dr Cochrane's concerns. Non-medical agencies, such as social workers and police officers, would have found it very difficult to challenge Dr Cochrane, given that her view was presented in such a direct and definite way. In performing the section 66 duty to investigate, the Children's Reporter would rely on all available evidence on the child held by the referrer and partner agencies. The Reporter may call for additional reports but did not usually do so; it was most likely in complex cases where there were conflicting views being expressed by professionals, usually in the field of paediatric medicine, psychology or psychiatry. OIC had followed its own Child Protection Procedures in 2018, when they received the child protection referral from Dr Cochrane. It was evident that the Dr Cochrane view that B was a victim of FII and the detailed health chronology were the significant factors which influenced proceedings and decision-making. Social workers did not have the professional curiosity, knowledge or expertise to question the diagnosis of FII. She would have been surprised if any sheriff would not have granted a CPO when faced with such serious concerns about a very young vulnerable child such as B was, having regard to the concerns coming from Dr Cochrane. The Reporter, too, lacked the clinical knowledge and curiosity to effectively challenge Dr Cochrane's clinical diagnosis. Any challenge would require to have come from another physician. She concluded that it was not reasonable to expect a social worker to do anything other than take the actions that were taken in this case to protect and safeguard B; in the absence of any information challenging or confronting Dr Cochrane's diagnosis of FII and her warnings about B's safety, neither social work nor the Reporter had discretion in

instigating and following their child protection procedures. In those circumstances seeking a CPO was reasonable, justified and unavoidable. Having explained why in her view no blame could be attached to any of social work, the Reporter or the sheriff, her overall conclusion was that had it not been for Dr Cochrane's clinical diagnosis of FII and suspicion of X, B would not have been removed from her family for eleven months.

[86] In cross-examination, Ms MacKinnon acknowledged that the decisions to remove B from the care of X and thereafter to require her to live apart from X were all taken by a judicial body, and that she did not know precisely what was said by Dr Cochrane at the Child Protection Committee meeting on 26 March 2018. She also accepted that others had contributed to the discussion at that meeting.

[87] I accept most of the foregoing. It is uncontroversial that in an application for a CPO based upon suspected abuse of a child, a sheriff will attach weight to a medical opinion, and that social workers, Children's Reporters and the sheriff all themselves lack medical knowledge. I do not agree, however, that such lack of knowledge precludes a critical approach being taken to such evidence, or that it necessarily follows that the opinion being expressed is the only valid opinion (or that the other agencies would, or should, assume that it is necessarily correct). It would have been open to the Reporter, in particular, to have sought an independent opinion, as Ms Mackinnon said happened in complex cases: the present case, after all, was nothing if not complex. Finally, it might have been surprising if the sheriff had not granted a CPO but that does not mean that he was bound to do so.

Gordon Henderson

[88] Mr Henderson's evidence was relevant inasmuch as it was he who (with the agreement of his line manager) took the decision that the allegation of FII could not be

proved and that the referral should be abandoned. He first became directly involved in the referral proceedings in October 2018. Subject to a few minor alterations, he adopted as his evidence the terms of a file note he had written shortly after the conclusion of the proceedings. It emerged that he was unaware of any amendment of the grounds of referral (as the parties had agreed by joint minute); he was unaware even of the existence of amended grounds of referral amongst the Reporter's papers. He had identified three issues arising from the grounds, namely (i) whether seizures had been mis-reported by X; (ii) whether feeding issues had been mis-reported by X; and (iii) the hospital admission on 2 February 2018. Insofar as the possible need for expert evidence at the proof was concerned, his approach was to await sight of expert reports instructed by agents acting for X and Y. Eventually four reports were disclosed, including the reports by Professor Milla and Professor Zabeeri. He took the view that these called into question the opinions of the Reporter's "experts" – by which he meant the clinicians, including Dr Cochrane, who had been involved in B's care or had formed a suspicion of FII; but they were not independent expert witnesses – and, as he put it in his file note, "it could not in any way be said that B's [issues with seizures and feeding] had in any way been contributed to by anything [X] had said or done". He placed some weight on Professor Milla's opinion that B had not had osmotic diarrhoea in February 2018 but had been severely dehydrated; but also on Dr Coulthard's opinion, in his report of 22 January 2019, that the overwhelming likelihood was that the diarrhoea had been caused by an enteric infection. As regards the first two of the identified issues – the misreporting of symptoms – he considered that this was not a case where it was clear that medical issues had been fabricated; on the contrary the medical records showed that these issues did exist to a certain extent. As for the third issue, Dr Cochrane's opinion was undermined by that of Dr Coulthard. In cross-examination, he

disagreed that the Reporter had a duty proactively to investigate cases by obtaining independent expert evidence, maintaining that the Reporter was entitled to conduct a case solely on the basis of information provided to it by the local authority; he was under no duty to undertake a root and branch investigation but it was reasonable to rely on the existing medical reports and not to look behind those.

[89] Mr Henderson was not the most impressive of witnesses. It emerged from the opening few questions that he had attended court reluctantly and I was informed by counsel that SCRA had been unhelpful in providing information in the course of preparations for the case. It was surprising that he was unware of the existence of amended grounds of referral. In light of that, and his assertion that the grounds of referral had not been amended, some discussion took place at the proof as to the status of paragraph 7 of the joint minute, in terms of which the parties agreed that the Reporter amended the grounds of referral on or about 24 July 2018. Reference was made to *Brown* v *North Lanarkshire Council* 2011 SLT 150 and *B* v *Authority Reporter for Edinburgh* 2012 SC 23, where, in each case, evidence had been led which was at variance with what had been agreed in a joint minute. The principle which emerges from those cases is that an admission in a joint minute will normally be conclusive, such as to preclude evidence being led in relation to the matter in question; but that where evidence is in fact led, without objection, the court may have regard to it if the evidence shows that the true position was otherwise than agreed (see *B* paras [15] to [16]).
Mr Henderson's evidence falls some way short of showing that the joint minute was wrong, but in combination with the absence of any court interlocutor amending the grounds of referral, it does at the very least cast a question mark over the accuracy of the joint minute. However, it makes no difference whether in fact the grounds of referral were amended. The fact is that, whether the court formally allowed them or not, amended grounds of referral

clearly were drafted and in existence, since they are in process. They must have been in the Reporter's file and there was a prospective reference in the sheriff court interlocutor of 24 July 2018 to the fact that the grounds were to be amended. Mr Henderson's ignorance of their existence does not inspire confidence in his mastery of his brief. As it was, he appears to have conducted the case throughout on the basis of the original grounds of referral. It also emerged that a somewhat *laissez faire* approach had been taken towards preparation for the referral proof, the Reporter's office being content to await the medical reports being obtained by the parents, rather than instructing expert evidence of their own, other than from Dr Coulthard.

[90] That all said, I do not criticise the Reporter's decision to abandon the referral proceedings. I simply observe that Mr Henderson's opinion that he would be unable to prove FII in the light of the evidence which he had does not amount to a discrediting of the allegation of FII, as senior counsel for the pursuers maintained. Had he had Dr Ninis' evidence available to him, it is possible, although I put it no higher than that, that a different view might have been taken as to the prospects of success.

Jane Alexander

[91] Jane Alexander was a children and families social worker at the material time, and became B's allocated social worker although she had no involvement in the initial stages. Her evidence was less than ideal, inasmuch as it was given remotely *via* a poor connection, such that those in court could not always see and hear her, which was far from conducive to understanding, let alone assessing, her evidence. Her memory of events was poor and her evidence did not add a great deal. In her police statement, given in 2018, she spoke of social work involvement in February and March 2018, but she could not now remember what she

had said. Had it not been for the medical concerns, there would have been no social work involvement. The difficulty in taking her evidence highlighted that where the technology does not work well, remote evidence falls some way short of evidence in person in court, where a witness can be seen and heard simultaneously at all times.

Y

[92] Much of Y's evidence was directed towards his claim for damages and he had little to contribute to the merits of the action. He gave evidence about having seen B vomit a lot, and said that the PEG tube had made a difference. He had also seen B's jerky movements. He was closely cross-examined about the extent to which he was in Orkney and involved in parenting B, since other witnesses, including some of Z, had suggested that he was there a lot less than he would have it. Senior counsel for the defender urged me to find him not to be a credible and reliable witness. Had the issue before me been whether B was in fact the victim of FII, then Y's evidence would have been material, and the extent of his presence in (or absence from) Orkney would have been critical. However, in relation to whether the doctors' opinion of FII was reasonably reached or not, Y's evidence in relation to the merits is of peripheral significance and I do not propose to discuss it further. Insofar as his evidence bears upon his claim for damages, and the impact which separation of B from her family had, I generally accept it; but given that *quantum* has been agreed in the event that I find that just satisfaction of any article 8 infringement requires damages to be awarded, that evidence, too, is of limited value except insofar as it has a bearing on whether damages should be awarded were liability to be established.

Assessment of the expert medical evidence

[93] Although senior counsel for the pursuers submitted that the case did not involve a battle of the experts, and was not a professional negligence action, I nonetheless need to resolve the difference between the evidence of Dr O'Hare and that of Dr Ninis, whose views differed on the core question of whether it was reasonable for Dr Stephen and Dr Cochrane to continue to suspect FII by the end of March 2018. Both have impressive CVs, both are undoubtedly expert in the field of paediatrics and child protection, and both are eminently qualified to give expert evidence to the court. However, in this case I found Dr Ninis to be the more persuasive witness. Not only was her report clearer and more concise, she had an impressive, almost photographic, grasp of all of the medical records, and was willing to engage with the questioner, and to make concessions in a manner which Dr O'Hare was not. She had also seen all of the medical records, in contrast to Dr O'Hare who had not only not viewed the GP records but was reluctant to concede that they could have contained any relevant information, when clearly they did. I also found Dr O'Hare's criticism that the team in Aberdeen had been too quick to stop Keppra and PEG feeding a somewhat curious one, when those actions turned out to be entirely justified. The other factor that must be borne in mind when considering Dr O'Hare's evidence, which is in no way a criticism of him, is that when he prepared his chronology, he had available to him reports which X and Y had commissioned many months after March 2018, when Dr Cochrane had to prepare hers. While part of Dr O'Hare's criticism of Dr Cochrane was that she had not obtained similar reports, it cannot be assumed, as he did, that had she done so, the same views would have been expressed by whichever experts she consulted: apart from anything else, there is clear room for an opposing view to be taken to that of Professor Milla, with whom Dr Coulthard, and for that matter, Dr Ninis, disagreed. Dr O'Hare's evidence that he would

have written a different chronology therefore takes the pursuers nowhere: it does not follow that Dr Cochrane's chronology was necessarily flawed, because it has not been shown that the views expressed by Professors Milla and Zuberi were the only views which could have been expressed. So, although I cannot, and do not, criticise Dr O'Hare's opinion that he would not have concluded that B was the victim of FII on the basis of the information which he had, it does not follow that Dr Stephen and Dr Cochrane unreasonably maintained the suspicion of FII beyond March 2018.

[94] Dr Coulthard was also an impressive opinion witness, whose ultimate conclusion – that B was suffering from osmotic diarrhoea in February 2018 – was not challenged by the defender; that was also Dr Cochrane's conclusion. That was, of course, at odds with Professor Milla's opinion that B was suffering from hypernatremia dehydration, although in fairness to him, he did not have the opportunity of justifying his view in court. At the very least, this difference of opinion highlights one feature of the case (which, in part, serves to differentiate it from many of the Strasbourg authorities): there is no consensus of opinion among the medical experts as to what caused B's presentation on 2 February 2018. The pursuers sought to make much of the fact, which Mr Henderson had considered significant, that Dr Coulthard had made clear that his opinion in March 2018 was not to be used for medico-legal purposes, and that Dr Cochrane had not told him of the full extent of the diarrhoea. As to the first of these, as Dr Cochrane pointed out she did not use his opinion for medico-legal purposes, but to inform her own views. As to the second, it was clear from the evidence that the extent of the diarrhoea did not affect Dr Coulthard's ultimate conclusion that B was suffering from osmotic diarrhoea; rather it altered his view as to whether it could have been caused by administration of a substance or not, which had more

to do with his perception of how easy or difficult it would have been for X to have done that, rather than with any medical considerations.

[95] Turning to B's other issues prior to February 2018, there is no conclusive medical opinion as to the cause of these, other than that all the doctors agree that she did not suffer from epilepsy and did not in fact require Keppra. Professor Milla is of the opinion that B may have had Sandifer's syndrome, with which Professor Zuberi agrees; but they never saw B. As for whether Keppra could have been the cause of B's feeding difficulties, or vomiting, Dr Stephen was clear that she had never known Keppra to cause vomiting to the extent suffered by B, and she was supported in that by Dr Ninis. Professor Milla expressed the opinion in his report that the Keppra could have caused an aversion to food and that the cessation of Keppra might have contributed to B's thereafter being able to eat normally, but I prefer the evidence of Doctor Ninis that even if Keppra had been the cause of B's aversion to food, itself unlikely, the cessation of Keppra would not then have led to the aversion immediately disappearing; her learned behaviour of not eating would not have transformed into a love of food as quickly and dramatically as it did.

[96] The final point to make about the medical evidence is that to the extent that the experts expressed an opinion on the likelihood of a substance being administered while B was in hospital, that is not something about which they have any direct (or expert) knowledge: they were not present, and they cannot know whether X had that opportunity.

Submissions

[97] As should be evident, I have dealt with many of the submissions made by the parties in other sections of this opinion. In this section, I record the parties' principal arguments. For the avoidance of doubt, I have taken all the submissions, written and oral, into account.

Argument for the pursuers

[98] The fundamental argument for the pursuers was that it was the advice of doctors Cochrane and Stephen which was the basis for the local authority applying for a CPO, but that that advice was incorrect; had it been correct, the local authority would not have made the application. Standing the nature of the advice, the local authority and the sheriff were in practice bound to act as they did: *Surrey CC* v *M*, founded on by the defender, below, turned on its own facts, and in any event involved English law, which was different. There were no relevant and sufficient reasons for the doctors' concerns about B, and they proceeded on the basis of unjustified suspicions. Each of the children's hearing, the Reporter and the sheriff would have been considered perverse had they not acted as they did. The original error was repeated in the July 2018 report, which led to the referral continuing. It was the reports by the doctors which instigated the child protection investigation and which brought about an interference with the pursuers' family life. The defective nature of the doctors' advice was responsible for that interference. They had failed to read the medical notes in full and there was no objective support for their allegations. There had been no cross-checking by carrying out tests, or seeking expert opinion. The steps taken by the local authority and the sheriff were the natural and direct consequence of that defective advice and no other agency was able to challenge Dr Cochrane's conclusion because they were not medically qualified, and because of the manner in which it had been presented.

Argument for the defender

[99] Before February 2018, B was a young child with a complex medical history, about whom some clinicians had begun to have concerns re FII. On 2 February 2018 she was

admitted to hospital having become acutely unwell at home and in the care of her mother. The cause of that illness was not clear but was consistent with the continuing administration of a substance. In the initial period after her admission to hospital, there was an opportunity for covert administration of a substance but following transfer to a more open bay, where there was no real such opportunity, B's condition improved. Following an extended stay in hospital, B recovered so that the interventions which had been in place could be withdrawn. In those circumstances, Dr Stephen and Dr Cochrane could not be criticised for raising their concerns (which was not the provision of advice) with the appropriate authorities about the possibility of FII. A referral having been made, it was for those authorities in honour of their statutory duty to investigate those concerns. Deferring to the judgment of clinicians is not permissible and would be an abdication of duty by the local authority: *Surrey CC* v *M* [2014] 1 FCR 429 at paras. 55-56. Any interference caused by placing B with foster carers or otherwise interfering with family life, was caused not by either doctor but by the authority which sought the order. Whilst clinicians in the position of Dr Stephen and Dr Cochrane may input information into the child protection system, they were not part of the system. It could not be said that they were wrong; at best, there was a difference of opinion between clinicians who had viewed the records.

Decision

Introduction

[100] As already observed earlier, this case is not about whether B was the victim of FII, and nothing which follows is to be taken as indicating that I think that she was. Rather, in summary, a suspicion held by Dr Cochrane and Dr Stephen that B was a victim of FII, which they communicated to the local authority, started a chain of events which resulted in B being

removed from her mother's care for a year, only for the allegation that there had been FII not ultimately to be proceeded with. To that extent, B was removed from her family for what transpired, with the benefit of hindsight, to be no good reason, which was an interference with the pursuers' collective family life. The questions which arise are whether these circumstances amounted to an infringement of the pursuers' article 8 rights, and, if so, whether the defender, as the public authority which, through Dr Stephen and Dr Cochrane, articulated the suspicion of FII, should be held responsible for the infringement.

[101] As a further preliminary comment, it is noteworthy that in those Strasbourg cases where article 8 claims were upheld, the infringement of article 8 consisted not of the original removal of the child from his or her family, but the unnecessary prolongation of the separation and/or a procedure which was held to be unfair in some way – in *Venema*, a failure to allow the parents to participate effectively in the decision-making process; in *MAK*, the taking of photographs and blood in the absence of the parents, and a delay in obtaining an expert opinion; in *AD*, the failure to carry out a timeous risk assessment, which when it was eventually done, recommended the speedy return of the child to his parents; and a failure to give proper consideration to the placing of the child with a family member. Those sorts of complaint are not made in the present case (other than in relation to the medical records, which I deal with below), but instead, in particular, sterling efforts *were* made to enable B to be looked after by her father, and to continue extensive contact between B and her other family members, and for that the local authority is to be commended.

Which organ of the state caused the interference with the pursuers' family life?

[102] Logically, this is the first issue which must be grappled with. As senior counsel for the defender submitted, this is not an issue which arises in Strasbourg, where the court is

merely concerned with whether there has been an interference at state level rather than which organ of state should be held responsible. However, a number of the cases discuss whether the social *and medical* (emphasis added) authorities were entitled to take the steps they did, which suggests that, at least in some cases, it has been recognised that the medical authorities *could* interfere with family life in an article 8 sense.

[103] The defender argues that because it did not apply for, far less grant, the CPO, it cannot be said to have interfered with the pursuers' family life, and that to argue otherwise runs contrary to the pursuers' concession that the CPO was granted in accordance with the law. However, that argument overlooks that, as article 8(2) recognises, an interference might be in accordance with law but nonetheless not necessary in a democratic society (as was the case in *Venema*, above). Further, it misrepresents the interference complained of. The defender's causation argument is that the separation of B from her family was brought about by a mixture of the local authority (which applied for the CPO), the sheriff (who granted the CPO and thereafter a series of ICSOs), the Reporter (who perpetuated the separation, by instituting proceedings under the 2011 Act), and the children's hearing (which continued the CPO and also granted ICSOs). It is one or more of those bodies, so argues the defender, that is responsible for any unlawful infringement of the pursuers' article 8 rights, and not the defender and its employees, who had no role in the child protection process, all of which was carried out in accordance with law. That is correct, insofar as it goes. However, although I agree with the submission for the defender that the local authority was bound not to abdicate responsibility to the doctors (*cf Surrey CC* v *M*, above), it would be difficult to hold on the facts of this case, standing the procedure which occurred before the CPO was applied for, that it did that. Clearly, it was entitled to have regard to the opinion provided by the doctors in deciding what action to take.

[104] However, the defender's causation argument does not meet head-on the case made by the pursuers, which is that it was the provision of the opinion that X had harmed B, not the application for the CPO itself, which was the interference by the defender with the pursuers' family life. In my view, that was an interference: the provision by an organ of the state of an opinion that a parent is abusing her child, in the knowledge that the matter will be investigated, which will inevitably intrude upon the life of the family and might lead to child protection measures being taken, is nothing if not an interference. Even had the local authority not applied for a CPO, but left it to the Reporter to make a section 69 referral, there would nonetheless have been an interference by the defender with the pursuers' article 8 rights. One can test the argument by asking what the position would be if such an opinion were provided by a doctor, employed by a health board, which had no factual or medical basis whatsoever: assuming that all of the local authority, the Reporter, the children's hearing and the sheriff exercised their respective roles appropriately, which organ of the state should bear responsibility for the infringement, if not the health board? Senior counsel for the defender submitted that in that scenario, the pursuers would require to go to Strasbourg for a remedy, but as senior counsel for the pursuers not unreasonably retorted, she has no desire, nor need to go there, given that the Human Rights Act provides for a remedy at domestic level. Nor is it relevant that the opinion might have been provided by a doctor in the private sector; that was not the case here, where it is accepted that the defender is a public authority. When one understands that the interference is the provision of the opinion (or, phrased differently, the communication of the suspicion of FII), that provides the answer to one point made by senior counsel for the defender, namely, that the doctors could not be expected to know about the details of the pursuers' family life, nor was it for them to carry out subsequent investigations; that is true, but is nothing to the point.

[105] The doctors' opinion was provided at several stages: in February 2018, when the suspicions first arose; later, on 26 March 2018, when there had been an opportunity to carry out further investigations; and later still in July 2018 when an updated report was provided. The pursuers do not challenge the first, but their challenge is directed at the second and third stages, which led to B's initial removal from X, and the subsequent prolonging of her being kept in a place of safety. As senior counsel for the defender submitted, the true complaint is therefore that Dr Cochrane and Dr Stephen did not change their opinion; or, expressed slightly differently, that Dr Cochrane and Dr Stephen, having had the opportunity to carry out further investigations, had insufficient material by 26 March 2018 to confirm their initial suspicions, and that, by then, they should no longer reasonably have suspected FII. It is at that stage that the pursuers say that the interference was not necessary. So, the pursuers do not challenge the fact that B was kept in hospital for seven weeks from 2 February 2018, in consequence of the original suspicion; but they do complain of the interference from 26 March 2018 and its consequences.

[106] In particular, they argue that everything that happened subsequent to the communication of the suspicion on 26 March 2018 can be laid at the door of the defender, being the natural and inevitable consequence of what Dr Cochrane and Dr Stephen did; in other words, that their interference led to the further state-sanctioned interference whereby B was actually removed from her family. I do not consider that the pursuers require to go as far as they offer to do, namely to prove that the local authority and sheriff were *bound* to act as they did. Apart from anything else, that is to ignore and diminish to the point of extinction the important role of the sheriff, whose function it was to give judicial consideration to the application for a child protection order and to be satisfied that it was indeed necessary that it be granted; and if either the local authority or the sheriff had

considered themselves bound to apply for, or to grant, a CPO, simply because of the medical opinion, so rendering the unitary jurisdiction created by the 2011 Act of no substance, then B's removal could not be said to have been in accordance with law. For example, although no criticism whatsoever is implied of the sheriff in this case, he might plausibly have reached the view that, although satisfied that there were reasonable grounds for believing that the pursuer had induced or fabricated illness in the past, nonetheless, a CPO was not necessary to safeguard B from future harm (for example, if the button had been removed, or other protective measures put in place, because there was no suggestion that X had harmed B other than by administering a substance through her PEG; nor was there any suggestion that any of Z were at risk of harm). An insight to the sheriff's reasoning is contained in the note to the interlocutor of 10 May 2018, in which he specifically stated that it was not known how B came to be seriously ill (which was true); and that there was a lack of acknowledgment by the family in relation to concerns (also true); that while in hospital B became well (also true); and that while with carers she had remained well (also true). All of those factors, bar the last were also present when the CPO was granted. It is difficult, in these circumstances, to hold that what happened was inevitable, or was based solely on an assertion that X had administered a substance to B, when plainly it was not. In essence the sheriff had picked up on a point also made by Dr Ninis in her evidence, which was that the concerns arose not only from the hospital admission on 2 February 2018, but from the prior medical history. Going back a stage in the process, nor can it be said that Dr Cochrane's opinion was the sole factor which led to the child protection committee's decision that a CPO should be applied for, although Dr Cochrane was present at the meeting of 26 March 2018 which took that decision. Other options were considered, including the possibility of removing the button, which Dr Bunn counselled against.

[107] Nonetheless, on the evidence, the opinion of Dr Cochrane and Dr Stephen that B's presentation was consistent with FII undoubtedly played *a* causative role both in the decision to apply for, and the subsequent decision to grant, the CPO. The very purpose of the email was for the local authority to present it to the sheriff in support of its application. If I were to find that the provision of the medical opinion was a contravention of the pursuers' article 8 rights, then, on the facts of this case, I would find the defender was at least partially responsible for all that followed. (For completeness, just as *Jordan* v *The Police Service of Northern Ireland* illustrates that two authorities can be responsible for the same period of delay in an article 6 claim, equally, two authorities might be responsible for the same interference with family life in an article 8 one. It follows that the defender need not have been exclusively responsible for everything that happened subsequently to the provision of the medical opinion; for example, if there had been a delay in obtaining supporting medical evidence which led to the case being prolonged unnecessarily; or if an unduly restrictive approach had been taken by the local authority to contact between X and B, it might have been unjust for the defender to bear the consequences of that. However, that is not argued in this case, and in any event, would most likely have been relevant only if the court had to assess the quantum of damages, which in light of the parties' agreement, is unnecessary.)

Was the interference necessary?

[108] Having decided that the communication on 26 March 2018 of a suspicion of FII was an interference with the pursuers' family life, it is next necessary to consider whether that interference was necessary or not. For all that it argues that it did not interfere with the pursuers' family life at all, the defender submits that the touchstone, when assessing the

acceptability of an interference with article 8 which arises from concerns about harm caused by a child's parents, is whether the concerns held are genuine and reasonably held, whether those concerns were reasonably investigated and whether those concerns can be seen, with the benefit of hindsight, to have been misguided. This is the nub of this case: are the criticisms of the doctors' opinion well founded, and were the concerns which they communicated to the local authority reasonably held (it not being maintained that they were not genuinely held)? The pursuers argue that the doctors' belief that there had been FII was vitiated by error, but in considering that question the Strasbourg guidance in *MAK*, above, must be borne in mind, namely, that doctors are permitted to be wrong, provided their concerns are genuine and reasonably held; the question is therefore whether the doctors' assessment was not only wrong, but undermined by an underlying inexcusable error (such as misunderstanding the hospital records, or failing to conduct enquiries which ought to have been made).

The criticisms advanced against Doctor Stephen and Dr Cochrane

[109] Before looking at what may be said in support of the opinion that Dr Stephen and Dr Cochrane reached, I will examine the main criticisms advanced against them.

Failure to carry out tests

[110] Professor Milla and Dr O'Hare were critical of the failure to obtain stools for analysis, which might have shown whether a laxative was indeed present and could definitively have differentiated between osmotic and secretory diarrhoea. Dr Coulthard by contrast said that, at the time, it was reasonable not to carry out such tests, and Dr Ninis said that the differential tests would have been difficult, and may have yielded no definitive answer. The

priority was to make B well – which undoubtedly it was; she was a very ill little girl when admitted – and in any event, the content of her stools was such that even obtaining faecal matter would not have been straightforward. The fact is, for better or worse, that the tests were not done and by the time B had recovered, the opportunity had been lost. Dr Stephen and Dr Cochrane cannot be criticised for having failed to instruct further tests, nor is their opinion vitiated by the fact they did not. In this regard, they were in no better position by the end of March 2018 to reach a conclusion than they had been in early February, and there was no further investigation which could have been carried out. Their opinion had necessarily to be formed on the basis of such material as they did have.

Incomplete or misleading chronology

[111] The main criticism here is that the doctors either misinterpreted or paid insufficient regard to the hospital records in founding their opinion, in part, on assertions that reports of vomiting and seizures by X had not been witnessed by hospital staff or other medical professionals, when, plainly (it was said) they had. To an extent this criticism misses the point, perhaps overlooked also by Mr Henderson, that FII includes not only fabrication but exaggeration of symptoms. That said, there are two distinct strands to the criticism. The first is that where an entry of (say) vomiting was made by a nurse, it meant (and should have been assumed) that the nurse had witnessed the vomiting. Both Dr Stephen and Dr Cochrane disagreed with that proposition, and maintained their position that the entries showed no more than that vomiting had been reported to the nurses. Under reference to *McEleney* v *Ohri* 2008 SCLR 245, and a comment by Lord Emslie at paragraph [7] (to the effect that resolution of certain apparent inconsistencies in the records might have been easier had their author given evidence), the defender submitted that it was unfortunate that

the pursuers had not called the authors of the records. The pursuers' retort was that if the defender wished to show that there was a reasonable basis for what the doctors were asserting, it was for it to show what the records meant. I do not see that either party would have benefited from calling the author(s) of the records. The matter in issue was, what were the doctors entitled to take from the records as they were written, rather than the accuracy of what was written; in any event, not even X maintained in her evidence that all of the vomits had necessarily been witnessed; rather, she said that the nurses had been around. The second strand of the criticism was that on any view, the records showed that some of the seizures and vomits had been witnessed and it was misleading to say that none of them had been. It is undoubtedly true that some of the vomits and seizures were witnessed but as Dr Ninis said: children vomit. Bearing in mind that FII includes exaggeration of symptoms, and that there was undoubtedly a dissonance, on occasion, between what X was telling different health professionals, in my view any mistakes, or loose expression, in the email and subsequent reports are not sufficient in themselves to vitiate the opinion reached. Insofar as the doctors formed their view on the basis that not every seizure and vomit which was reported had been witnessed by medical staff, they cannot be criticised for having done so. The point might also be made that there were instances – for example, the vomit reportedly cleaned up by a member of staff who could not be identified – where there was a legitimate basis for, at least, querying the veracity of X's accounts of vomiting. In short, it has not been shown by the pursuers that the chronology prepared by Dr Cochrane was flawed to any material extent.

Failure to make the medical records available to X and Y

[112] This criticism was made by senior counsel, in reliance on *TP and AK*, above. After submitting their opinion in March 2018, neither Dr Stephen nor Dr Cochrane had any on-going role to play other than that of being potential witnesses in the referral. It was not for them, but for the local authority, the Reporter or the court, to ensure that the records were made available, and any complaint in this regard should have been made against the local authority, as it was in *TP and AK*. In any event, this criticism is not made in the pleadings, and it has no merit.

Failure to obtain further expert reports/give Dr Coulthard complete information

[113] Insofar as Dr O'Hare criticised Dr Cochrane for not having obtained the full range of expert reports such as he had, it cannot be assumed, as I have pointed out in paragraph [93], that had she done so, the views expressed would necessarily have been the same.

[114] Dr Cochrane did, of course, consult Dr Coulthard where she perceived a gap in her expertise, but it is said that she gave him incomplete and misleading information. The first point to make here is that X had given conflicting information about when B's diarrhoea had started and it was uncertain when it had begun. However, allowing that Dr Coulthard was unaware that there had been 12 profuse stools prior to admission, that does not undermine the opinion he gave throughout, that the diarrhoea was likely to be osmotic rather than secretory, and that it was not caused by salt poisoning. He said that it was very difficult to distinguish between an enteric infection and diarrhoea caused by administration of substance, and he also conceded that it was theoretically possible for X to have administered a substance covertly and repeatedly. He also said that osmotic diarrhoea caused by infection, such as happened with cholera, was unlikely. Much was made by Dr Coulthard of

the fact that he had not given permission for his initial opinion to be used for medico-legal purposes, but it was not so used. I do not agree that Dr Cochrane not having conveyed full information about the extent of the diarrhoea to Dr Coulthard had the effect of vitiating the opinion he provided at that time as to the possible causes of B's illness, or that Dr Cochrane's reliance on the initial opinion which he gave vitiated her own suspicions.

Failure to ascribe B's feeding difficulties to Keppra

[115] X maintained in her evidence that B's vomiting and feeding difficulty could all be ascribed to Keppra, but on the basis of the evidence of Dr Stephen, Dr Cochrane and Dr Ninis, I am satisfied that the side-effects of Keppra do not extend to a feeding difficulty of the type which B was said to have. Certainly, no inference falls to be drawn from the fact that the withdrawal of Keppra coincided with B's being able to eat normally, for the reasons explained by Dr Ninis in her evidence.

Factors which supported the medical opinion of FII

[116] Perhaps the most significant, and striking, aspect of B's presentation in February and March 2018 was the speed with which, once removed from X's care, she made a full recovery from the conditions for which she had been receiving treatment. Most significant was her managing to eat and swallow normally within days of stopping feeding *via* her PEG-J tube, something which Dr Ninis found unprecedented for a child who had previously had an aversion to food. When that is viewed in the context of X having refused to allow attempts to be made to feed B in hospital, Dr Cochrane and Dr Stephen were entitled to form the view that the recovery tended to confirm rather than confound their suspicions of FII. In that respect this case falls to be distinguished from cases such as *RK and AK* v *United*

Kingdom, above, in which a subsequent injury while the child was in foster care did confound the original suspicions.

[117] Mr Henderson, for one, and Dr O'Hare for another, tended to dismiss the significance of B's recovery. Mr Henderson, for example, said in his file note that he had been concerned that the doctors appeared to be looking at this "back to front" and that he found it hard to get them to appreciate that, while that was an important piece of evidence, it was not probative of the case in itself. That much is true, but the present case is not concerned with whether FII can be proved, but whether the doctors' suspicions were reasonably held; and the concession that it was an important piece of evidence does tend to support that they were. Moreover, it was not just the recovery, but the speed of that recovery which was startling, particularly in relation to the feeding difficulties which had been reported.

[118] At the very least, then, in relation to B's reported difficulty with eating, on the basis of Dr Ninis' evidence which I accept, Dr Cochrane and Dr Stephen were entitled to form the view that X had either fabricated or exaggerated B's symptoms, leading to medical harm. Further, in relation to her seizures, they were entitled to form the view that here, too, the symptoms had been exaggerated, given that, per the medical records, many of the seizures had not been witnessed by medical staff, bearing in mind the guidance issued by the Royal College of Paediatricians, that FII includes the reporting of symptoms which are unverifiable unless observed directly, such as vomiting or fits. There is also the point made by a number of witnesses, that B was neurodevelopmentally normal, which made her presentation all the more perplexing.

[119] Then there was the matter of B's unexplained and sudden illness on 2 February 2018. For all that the pursuers' experts considered it unlikely that X had the opportunity to

administer a substance to B in the hospital, that was a possibility which Dr Cochrane and Dr Stephen were entitled, indeed bound, to consider given the nature of diarrhoea (the likes of which none of the doctors or nurses had ever seen), the fact that B was being fed through a tube and the fact that X was in fact alone with B and unobserved for periods of time.

[120] When all of the foregoing is considered in the context of several other unusual aspects of the case – X's refusal, documented in the records, to allow B to attempt to eat in the hospital; the finding of the syringe in a drawer; the occasional disconnect between what was said to different medical professionals; and for that matter the highly unusual nature of the diarrhoea in February 2018 – I find, on the basis of their evidence and that of Dr Ninis, that the suspicions of Dr Cochrane and Dr Stephen were reasonably held, notwithstanding that the view was subsequently taken by others that they could not be proved. Applying the test laid down by the Strasbourg jurisprudence, the reasons adduced for the suspicions were relevant and sufficient, and proportionate to the aim of protecting B's health and well-being. The views were appropriately passed on to the local authority. Since nothing happened between February and March 2018 giving cause for the doctors to change their views, and B's complete recovery from all reported conditions tended to confirm rather than confound their original suspicions, it was reasonable for the doctors to maintain their suspicions as at the end of March 2018 and for Dr Cochrane to express her opinion in the way that she did. Their interference with the pursuers' article 8 rights was, therefore, necessary. As regards the criticism made by Dr O'Hare and Ms MacKinnon that the opinion was not expressed by Dr Cochrane in a manner which made it amenable to challenge, that falls away with my conclusion that the opinion, as expressed was a reasonable one for Dr Cochrane to hold.

[121] It follows that even if the opinion held by the doctors was wrong, as is the view of at least some other doctors, there was no infringement by them of the pursuers' article 8 rights,

and the action must fail. That is not to underplay the enormity of the process visited on the pursuers, ultimately to no purpose, when their family was fractured for the best part of a year: what happened to them must be every parent's worst nightmare. Nonetheless, the process was, as a whole, fair and in accordance with their article 8 rights. X and Y were given notice of, and were represented at, the CPO hearing. All of the decisions were taken by a judicial body, be that the sheriff or the children's hearing. The child protection order was properly made in terms of section 39 of the 2011 Act. It is not maintained that the process took too long (and any such complaint could not have been directed against the defender). Moreover, steps were taken to ameliorate the harm to B by being removed from her family, inasmuch as she was returned to the care of Y within a reasonable period of her removal from X and measures were put in place to maintain contact with X; and the pursuers of course were all able to resume their family life within a year of B having been removed. Although in that regard, the story has a happy ending, I do not underestimate the trauma experienced by the pursuers, and X in particular, during the year in question.

Remedy

[122] If I had found that the defender's interference with the pursuers' article 8 rights was not necessary, and that there had been an article 8 infringement, I would have drawn a distinction between the pursuers on the question of remedy. Insofar as X is concerned, one can scarcely imagine a more devastating infringement of a mother's article 8 right than being separated from the daughter, of whom she had been the principal care-giver, for a period of a year. In her case, applying the principles in *Greenfield*, above, I would have found that an award of damages was necessary to afford just satisfaction; and that it was both just and appropriate to make an award. The position of Y is not quite so clear cut, since he was not

only not the primary care-giver but was often absent from the family home; and ironically his involvement in B's upbringing was significantly increased by her removal from X. Nonetheless, he had to give up his employment due to the child protection procedures, and I would also have been satisfied in his case that an award of damages was necessary to afford just satisfaction, the bulk of the agreed sum in his case being to reflect his pecuniary loss. To each of X and Y I would have awarded the sums agreed in the joint minute. However, insofar as Z are concerned, they did maintain contact with B. For them, I would have concluded that a declarator was sufficient, and I would not have awarded damages to them.

Disposal

[123] I have repelled the pursuers' pleas-in-law, sustained the defender's second and third pleas-in-law, and granted decree of absolvitor in respect of the first to fifth conclusions of the summons, reserving meantime all questions of expenses.