Neutral Citation Number: [2025] EWFC 83 (B)

Case No: SA24C50125

In the Family Court at Swansea

This judgment was given in private. The judge gives permission for this version of the judgment to be published on condition that (irrespective of what is contained in the judgement) in any published version of this judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Before:

His Honour Judge Philip Harris-Jenkins

Re X and Y (Children) (FII: Midazolam: Safeguarding)

BETWEEN:

Neath Port Talbot CBC, the Local Authority

Applicant

and

Mrs AA

First Respondent

And

Mr AA

Second Respondent

and

X and Y, the children by their Children's Guardian, Ms Jones

Third Respondents

Representation:

The Applicant Local Authority, **Kate Hughes KC** and **Kay Waldron**, Counsel

The First Respondent Mother- **Owen Thomas KC** and **William Seagrim**, Counsel

The Second Respondent Father- **James Tillyard KC** and **Rhys Jones**, Counsel

The Children- via their Children's Guardian Ms Jones, and represented by **Vici Clarke**, Solicitor for the Child, and by **Simon Stephenson**, Counsel.

APPROVED JUDGMENT

1. I am concerned with two young children, X, now 12 years and Y, now 8 years. These are public law proceedings, in which the Applicant Local Authority seeks Care Orders for both children.

2. The Respondent parents are Mrs AA [mother, henceforward "M"] and Mr AA [father, henceforward "F"]. They are married but have separated during these proceedings and divorce proceedings have been issued.

3. This composite final hearing was to firstly, determine the main issue around whether Y was subjected to Factitious or Induced Illness at the hands of his mother and F's role within this alleged behaviour. Secondly, the Court had to determine the best welfare outcome for these children.

4. The hearing commenced on the 3rd March 2025, with live evidence heard between the 3th March -7th March 2025 and then on the 18th March -21st March. The hiatus in the evidence was caused by M's suicide attempts on the nights of the 7th and 8Th March 2025, necessitating admission to a psychiatric wing, where she remains to date. She was able to give live evidence remotely, on the 18th and 19th March 2025, from a private room on the wing. I received written submissions on the 24th March 2025, with oral submissions the next day. This Judgement is handed down on the 28th March 2025.

Background

5. From the time of Y's birth until March 2024, Y was believed to be a very unwell little boy. He was believed to suffer regular episodes of ataxia, respiratory issues and sleep problems, which was felt may be linked to a very rare genetic mutation. He was also assessed for cardiac issues. At the time he was removed from his parents' care, further invasive testing was being planned. He was using a wheelchair, hospital bed and specialist equipment daily. He was regularly being fed through a gastrostomy tube [Gtube]. His education was sparse and normal social interactions were few. He was

attending a palliative care centre for respite care. It was felt that he may have a short life expectancy.

6. However, since April 2024, when Y was removed from the care of his parents, he was gradually weaned from his medication without ill-effects. Fortunately, he now presents as a perfectly healthy and well-functioning 8-year-old boy, able to do all the things a boy of his age is expected to do.

7. From the outset, it was the Local Authority's case that the sudden change in X's presentation can only be explained by the nefarious actions of his parents, or one of them. Initially, the Local Authority contended that the illnesses described were induced, fabricated and exaggerated by the mother and that the father was either complicit or was so negligent in his understanding and involvement of X's care needs, that he failed to protect X.

8. M made only limited concessions to the Threshold document, conceding that she had exaggerated some symptoms. She indicated at the IRH that she did not challenge the medical evidence and understood that the Court was likely to make the findings against her in any event. However, she denied that she had ever feigned or induced Y's illness. F always denied that he was complicit or negligent and was merely going along with the information given by M.

9. This final hearing is to determine those Threshold issues around whether this is a case of FII by M, and whether F is complicit or negligent in what happened or whether he was ignorant and taken in by M. The welfare route for these children was agreed by all parties at the close of the evidence. In short, it was agreed that a rehabilitation into the care of F should take place under Care Orders. However, I have been careful not to agree that position simply because it was agreed by the parties. I have carefully scrutinised the welfare element in this case, as I must, based on the evidence, the findings I have made and the submissions of the parties and then my own analysis of what is best welfare outcome for these children.

Background.

10. In December 2016, an ambulance was called to the house because of reports that X had been found unresponsive. It appears that M was alone in the home at the time and performed CPR. F arrived during the episode. When the ambulance crew arrived, Y was described as happy and alert. He was admitted and remained well during his inpatient stay. It was felt that he had aspirated because of reflux and had suffered a life-threatening event (ALTE). No other investigation was carried out and this incident did not feature in this hearing as a factual issue to be determined.

11. However, by March 2017, the parents were reporting episodes of Y shaking. (M suggests that these episodes began in the first three days of life). Y was admitted to hospital on the 15th March and diagnosed with possible benign sleep myoclonus and a referral was made to Dr Thomas, a paediatric neurologist, who became the main treating clinician. Tests undertaken included an EEG, an MRI and a video fluoroscopy to determine safe swallow. All were normal but the shaking episodes were said by the parents to be continuing every two days and included unresponsive periods.

12. At the same time, Y was seen by community paediatricians and was noted to have mild left sided weakness which had almost completely resolved by January 2018. He was developmentally age appropriate in all areas.

13. In January 2018, the shaking episodes were reported by the parents to be still continuing. In addition, the parents were reporting poor sleeping and regular chest infections. A referral to respiratory clinic was made.

14. Despite the positive response from the community paediatricians to Y's developmental progress, in March 2018, the parents made an application for Disability Living Allowance [Z101]. Y was described by his parents as needing '*constant supervision during day and night due to constant threat and volume of seizures…. as he can stop breathing during naps*.' Further, he was noted by his parents to "*only shout scream and head butt, only has two words, communicated by pointing*." It was suggested that he "*has to be placed in his highchair for constant support, needs constant supervision due to constant seizure risk. He will scream constantly, push food away, spit it out. Head butt the highchair*." It is clear that this description did not accord with the child who

presented at clinics and other professional appointments, and I find that the application was based on exaggeration or fabrications by M, who completed the application.

15. Y was seen in the respiratory clinic on 10th April 2018. M provided a history of Y having required 9 courses of antibiotics and several courses of steroids in the past three months. I find that this history was exaggerated and false. Chest x-rays and other tests were undertaken and considered normal. However, because of the history provided by the parents, anti-biotics were prescribed on the theory that the alleged chest infections might be the result of aspiration. Y remained open to the respiratory clinic and continued to attend every three to six months. I find that this claim was exaggerated or fabricated by M.

16. Shortly after this, the parents withdrew Y from creche, expressing concern that staff were not actively reporting Y's episodes.

17. In May 2018, Y was admitted to hospital for three days because of reports that he had had four 'episodes' at home over a day. On the second day after admission, M suggested that he had had a seizure overnight but had not told staff about it at the time. M had made a video of the episodes which they said had occurred at home. Neither of the neurologists who saw it considered that the 'episodes' looked like seizures. M sought a second opinion and reported that he had had further 'absences' during the day while on the ward. All tests undertaken were normal, but M reported 'dystonic' movements overnight, though the nursing entries did not support those reports. However, Y was discharged with a prescription of Midazolam, which was to be used in the event of a seizure, despite no independent witnessing of any specific episode while he was an inpatient. I find that these claims were exaggerated or fabricated by M. Sadly, the prescription of Midazolam escalated M's behaviour into inducement of symptoms in Y.

18. From 24th May 2018, Midazolam became part of the monthly repeat prescriptions prepared for Y. From this point, the nature of the alleged 'seizures', changed from shaking and jerky movements to unsteadiness, unresponsiveness and floppiness. He was seen in the paediatric unit on two occasions in June 2018 with reports of this sort of 'episode'. In August 2018, Dr Hayman, Community paediatrician, reviewed some footage of an 'episode' videoed by M and she asked whether he could have ingested

any medication but was reassured by M that this was impossible. That was a lie by M, who I find had by now started to induce the episodes by injecting Y with Midazolam.

19. Y was seen by Dr Thomas and by Dr Hayman, separately. It was agreed that the Midazolam script would be stopped because the medical professionals did not consider that he was having seizures. At this point, M suggested the use of a naso-gastric tube [NGT] to help with feeding, but Dr Hayman considered that this would be a last resort. F was recorded as opposing this step. As a result of this consultation, the use of Midazolam was stopped from the clinician's perspective. Indeed, the parents received a letter from clinic confirming the advice provided.

20. It is a worrying feature of this case that Midazolam continued to be wrongly prescribed on a repeat basis and M ensured that it continued to be delivered to the home and stockpiled.

21. By February 2019, M prepared a document for Y's Multi-Disciplinary Meeting on the 15th February, requesting genome testing, and additional drugs. The parents described episodic ataxia, which could last between 30 minutes and 2 weeks. In early March, they submitted a further DLA application [Z144], drafted by M, in which it was suggested that Y hits himself until he bleeds and has 'constant seizures". These were exaggerations or fabrications put forwards by M. Y's list of medications, appended to that form includes Midazolam, which had in fact been stopped three months before.

22. In April 2019, at a meeting attended by both parents, it was reiterated that the Midazolam script had been terminated. Shockingly, it appears to have continued being prescribed until February 2022, at which point it was removed from Y's prescription (but only for a short while). Dr Thomas provided a working diagnosis of episodic ataxia, and it was reiterated that this would have no cognitive impact on Y.

23. By June 2019, Y had begun attending nursery and the parents were seeking an assessment by an educational psychologist. On the day that the psychologist was due to attend the nursery, Y attended in an alleged 'episode,' which was described by the staff as Y having 'a drunken gait' [AAi150]. This 'episode' was more likely than not induced by M injecting Y for the purposes of swaying the assessment.

24. Despite the health visitor reiterating to the parents that Y had no developmental delay [AAvii15], the 'parental view' document provided to the psychologist described a child who was 'developmentally delayed'. It also described episodes at least once a week lasting between 1 hour and 2 weeks in which Y would stumble, dribble and slur his speech, was unable to sit lost muscle tone and could not eat or drink. These claims were exaggerated or fabricated or otherwise induced by M.

25. Y continued to be reviewed by community paediatrician, neurologist and respiratory consultant on a 3 – 6 month basis. Each of the professionals relied significantly on the reports provided by the parents, mainly from M but frequently in the father's presence. From the evidence, it seems that F was very quiet in these meetings, letting M do the talking.

26. In July 2020, Y arrived at a paediatric clinic in an episode. He was noted to be slurring, off balance and with unclear speech. However, a SaLT assessment was undertaken and confirmed that he had safe swallow. Again, this was likely induced by M via Midazolam for the purposes of influencing the assessment. Despite this, M later reported that SaLT had told her that Y should have no food when in an episode, and she was syringe feeding him fluids for up to 3 days at a time. This whole situation of necessitating tube feeding was based on M's exaggeration or fabrication of events and the inducement of symptoms, via Midazolam.

27. In 2021, genome testing returned a negative result. The parents however reported continued attacks, occurring almost weekly.

28. On the 30th November 2021, during a pre-arranged visit to the home by an SaLT worker, Y suffered an episode after eating a bowl of cereal and milk (the 'milk incident'). He was noted to lose head control, and his speech became slurred but quickly recovered. In my judgment, this was induced by M injecting Midazolam for the purposes of influencing the assessment.

29. Two days later, on 2nd December 2021, he was admitted to hospital with facial swelling following a dental procedure. M reported that he had an unsafe swallow and had not eaten or drunk for the previous two days. He was seen on the ward by SaLT, who

clarified that refusing to feed him and the suggestion of an unsafe swallow was inconsistent with their advice and that he should continue to have an oral diet. M was noted to be upset by this advice. These accounts were exaggerated or fabricated by M.

30. During this period an educational psychologist report was completed and concluded that Y's cognitive functioning was above average and in the high range [AAi43]. The parents contested Y's statement and by March 2022 were enquiring about a place in the learning support unit at school.

31. On the 10th January 2022, Y was fitted with a nasogastric tube [NGT], as a result of the concerns of feeding during an 'episode' which the parents were reporting could continue for up to two weeks. These incidents were exaggerated or fabricated by M, to ensure that a NGT was provided (as she had earlier suggested). Sadly, concerns were soon raised that the tube feeding was being overused, despite advice to use only when Y was in an episode.

32. Y was placed on a reduced timetable at school, because the school were unable to administer feeds and M suggested that he required feeds on a daily basis. M said that this advice had come from Dr Thomas [[Vi1447]. This was a lie by M and Dr Thomas' advice had been clear- apart from when he was in an episode, Y should be fed normally. When the headteacher requested Dr Thomas' contact details the mother failed to provide them. Dr Thomas has later confirmed that he did not give such advice [C661].

33. Concerns around the feeding issues led to a professionals meeting in June 2022, in which fabricated or induced illness was considered for the first time. However, the meeting concluded that this was not a concern. Dr Thomas believed that the parents were genuinely worried and concerned parents who were doing their best for Y, in trying circumstances.

34. The family accepted support from family support workers who attended the home two or three times a week during the summer of 2022. That support continued until Y was removed from their care. The workers never witnessed an episode when caring for Y.

35. From September 2022, Y's school attendance dropped dramatically. A further education psychologist report had concluded that his cognitive functioning was above average,

but the parents were still seeking a place in the Learning Support Centre, suggesting that he required a quieter learning environment and additional support for learning.

36. In October 2022, Y had a Gtube surgically fitted to replace the NGT and was off school for recovery. In the same month, M wrote to the pharmacy asking why his Midazolam (which had been removed from his script in February 2022 but had not actually been required since December 2018) had been removed from Y's prescription. I find that Midazolam was returned to the script because of that email. That email was sent to ensure that M had sufficient Midazolam to inject Y and keep up the appearances of episodic ataxia.

37. In December 2022, M brought Y into school in pyjamas and a pull up nappy in a wheelchair, stating that he was in an episode. Y told teaching staff that he had no idea why M had brought him directly from bed, without any breakfast. He was able to change into clothes himself and participate fully in the school day, without the need for a wheelchair. I find that this episode was fabricated by M.

38. He stopped attending school on 9th December, with his parents citing ill- health and holiday commitments.

39. On 23rd January 2023, the parents served notice and expressed their intention to homeschool Y. M now suggests that it was because Y returned home from school having been left in his wheelchair with urinary incontinence after an episode. The Head Teacher was clear in her evidence that school have never witnessed an episode and that Y's presentation had always been normal. However, it was noted that he always arrived in a wheelchair and was collected in one, most often by M. However, he did not require the wheelchair once in school. She denied that he was ever sent home 'wet'. In my judgment, the picture provided by the school was accurate and M was not telling the truth.

40. Indeed, the school always took the parents' concern seriously and made every attempt to accommodate the parents' concerns. X continued to attend school though his attendance record was poor, often because of his brother's poor health.

41. In February 2023, F resigned from his job to care for the family (he had worked part - time from January). M was reporting that she was suffering from seizures and fibromyalgia and was struggling to care. From that time, F did not work and was seeing and caring for Y daily.

42. Both parents attended Dr Thomas' July 2023 clinic, F having been at home consistently since February. M reported that Y was having 7-8 episodes a week lasting 30 minutes to twelve hours. [X53]. In fact, F had, by that time had some periods of caring alone for the boys, M having been admitted to hospital for mental health issues in May 2023. I find that these accounts were fabricated or exaggerated by M and not corrected by F, who gave a completely different picture in his oral evidence. It was a failure by him to protect Y.

43. In the September clinic, which both parents attended, they reported Y having a few episodes a week [X27]. Again, this was fabricated or exaggerated by M and not corrected by F.

44. By October 2023, both parents were reporting that Y was having episodes of blue lips and breathlessness, and he was referred for cardiology investigations. Those concerns were not substantiated, and no such issues have been raised since he left his parents' care. In my judgment, that any such event was more likely than not induced by M.

45. In November and December 2023, both parents were reporting that Y's episodes were daily, and he had deteriorated in the past few weeks [Vi899, X35], Again, the oral reports came from M, but were not corrected by F, despite his being aware of the truth of the number and duration of alleged episodes.

46. Y was transitioned back to school in January 2024, attending two mornings a week. On the first day, he arrived in a wheelchair and with a feed, though he was not suffering an 'episode'. The parents had been repeatedly told that he was to maintain oral feeding and not to use tube feeding unless he was in an episode.

47. At the same time, M made a referral to obtain a hoist for Y. She stated, 'We have been discussing with his OT and it's been decided that we need to start the process of hoisting him." [J7]. In fact, the Occupational Therapist, C Williams, had been told by the

mother that Ty Hafan had wanted to begin using a hoist [K8]. In fact, Ty Hafan had never undertaken any assessment to use a hoist. It was another lie by M to obtain what she wished.

48. On 27th January 2024, Y and M attended a clinic with Dr Thomas and Y was seen to be suffering an episode while in the waiting area. Dr Thomas saw the episode and noted that he was acutely ataxic. A further MRI was planned. In my judgment, this was another example of M inducing an episode by injecting Midazolam, more probable than not, into Y's Gtube. The purpose was likely to show Dr Thomas an episode, to keep up the concept that Y was a very sick boy and for further medical treatment and investigation to continue.

49. Y had begun attending a local children's hospice for respite care because of a referral by M. This is a local hospice for dying children, offering palliative care. In Y's time there, it is of note, that they did not witness a single 'episode', nor had they any concerns about Y's eating or sleeping during his several inpatient visits.

50. However, Y was reported to have been in an episode when a nurse attended a pre-arranged home visit in December 2021, to assess him for his eligibility to attend. The nurse noted a child who was unable to hold his head up, was dribbling and had slurred speech on her attendance at the prearranged appointment. M reported that he had not eaten for 48 hours. Again, this is on the balance of probability, an induced episode caused by M injecting Y with Midazolam, in an attempt to get him into the local children's hospice.

51. The children's hospice were informed by M, of a regime which involved three periods of tube feeding Y whether or not he was in ataxic state. That was deliberately incorrect information provided by her. Staff followed that instruction, whilst Y was an inpatient. Sadly, Y attended regularly to enable the parents to have some respite from his alleged regular episodes and his failure to settle to sleep.

52. On 6th March 2024, there was a critical incident to the understanding of this case. During an attendance a nurse witnessed M injecting a syringe of clear fluid into his

GTube tube at 12:30pm. M said that it was Sytron (an iron supplement). The evidence strongly supports the conclusion that M gave Midazolam to Y for the following reasons:

(i) Y went downhill very quickly. By 12:50pm he was slurring his words and was unable to hold himself up. By 1:50pm he was bright and alert and wanted to play and run around. This was consistent with the live evidence of Dr Thomas in relation to the likely symptoms and how Midazolam acted very quickly (but 10-15 minutes slower when administered through gastrostomy) and that the effects would start to wear off after a reasonably short period of time (approximately 30 minutes).

(ii) When challenged M said that it was drawn up from an old bottle which was a clear liquid. No clear form of Sytron exists [C 137, pdf 331].

(iii) M later asserted that she must have given another medication by mistake. However, M was giving Sytron to Y three times each day for over three years. This meant that she gave him Sytron approximately 3,000 times. It is highly unlikely that she would have confused Sytron for a clear liquid in March 2024.

(iv) M's dishonesty was because she had been caught out, she was aware of her guilt, and she lied to try to cover up her actions.

53. It was only after this point that the true horror of what had been happening to Y, began to show. I say that with the important caveat, that this realisation was not immediate. Even after this incident, when FII was raised as a suspicion in the next two multi-disciplinary meetings Dr Thomas still rejected the notion, even with his experience of involvement in other cases of FII, so adept was M at persuading professionals that she was a genuine, loving and concerned M.

54. However, enquiries were made of pharmacists, as to whether the medication she suggested she had administered could indeed be clear and it was clarified that iron medication was always a red or brown colour. There was also professional concern as to why M would have drawn up a single syringe of medicine from home, when she had brought the medication into the hospital in readiness for Y's stay.

55. On 20th March 2024, she was once again challenged about this incident, and this time, she suggested that she must have mixed up the bottles and given him the wrong

medication. That was a clear inconsistency, which was underlined the dishonesty of M's account.

56. There followed several professionals' meetings, at which the professionals began discussing several concerns, including the overuse of the Gtube and the over-use of medical equipment.

57. On 4th April 2024, C Williams, the astute OT, attended the home to find X unrousable. Both parents were present in the home and unconcerned about his state, saying he had been in bed for two days. She made a referral to social services.

58. On 15th April 2024, the police and social services attended the home and seized Y's medication. This included several boxes of Midazolam (which should not have been supplied). M commented that it was there 'in case he needs it" [Ji27]. She had previously told Dr Thomas that he had not had Midazolam for years, which was another blatant lie. She continued to assert that she has not used it except on two occasions in 2018. This was another lie. She has given a variety of reasons why she has kept it and where the shortfall of medication might be. Dr Thomas considered that medicating a child with Midazolam unnecessarily could lead to the symptoms he observed in January 2024. In his oral evidence, he stated that all the symptoms which were described over the years could have occurred from this source. He also provided clear evidence of how quick acting the drug was because by nature it was an anti-epileptic drug. If inserted directly into the Gtube and flushed, it would take around 15 minutes to take effect but would be cleared from the system in 45 minutes to an hour. That explains why these alleged episodes occurred shortly before or just after an attendance at a setting, e.g. Dr Thomas' waiting room, or upon delivery at school, or were taking place before a SaLT attendance or by the children's hospice's attendance at the home but always dissipated quickly.

59. Y was removed to hospital and into the care of his maternal uncle and partner, where he remains and has enjoyed his full and full recovery.

60. At this stage, the parents had no access to medication, the police having removed all medication in the home before Y was admitted. However, M's friend reported overhearing a phone call between M and the pharmacy on 24th April, in which M

requested all medication and specifically confirmed that she required buccal Midazolam [C694]. That witness evidence was not challenged. M's explanation in her live evidence was to say that she was unsure whether her brother and his partner had all the medication for Y and wanted to ensure a supply. That raises the concern, why she specifically wanted this drug, given that she knew it was not needed by Y? In her oral evidence, she also said that she was taking the drug herself, to assist with sleep. That claim did not ring true, and I find it to be another lie to cover up her actions.

61. Since Y has been in the care of his maternal uncle, he has had no episodes and no unusual presentation. He attends school, eats well and is described as energetic. He is functioning without medication as a healthy young lad. That fact is key to understanding how Y was made to look unwell by the direct and egregious actions of his mother.

62. On 3rd May 2024, a hair sample was taken from Y to test for Midazolam. Three sections corresponding to time periods between January 2024 and late April 2024 were tested. Midazolam was not identified in any of the samples. A report from Professor Coulson, Clinical Pharmacologist and Toxicologist [E276 onward] concluded that the test results do not preclude the misuse of Midazolam. Professor Coulson refers to a report from Alveraz et all, in 2018, which found that Midazolam was not found in the hair of children who had been receiving it therapeutically for periods between 1-13 days. Additional questions were asked of him [E719] but he did not alter his opinion. Therefore, the absence of the drug, does not preclude it being injected into Y either directly or via his tube, over this lengthy period. Having considered all the evidence, I find that is precisely what M was doing- providing her well son with Midazolam to induce the symptoms which were similar to an ataxic episode.

63. As to X, he has been significantly impacted by the household in which he lived. He has been described as exhibiting anxious behaviour, constantly angry, smashing his room and threatening to cut himself in 2019 [V8]. He was referred to CAMHS because of his anger. In April 2021, he alleged that F was hitting and kicking him [Vi959]. In March 2022, the parents were reporting that he was threatening to kill a teacher and had a knife and a screwdriver. He was clearly emotionally impacted by the thought that his brother was seriously unwell and believed that he would die [Vi1195].

64. In addition to support for his mental health, his parents were suggesting that he had traits of ADHD and ADD and were seeking assessments to obtain those diagnoses. On two occasions in May 2024, X has made detailed allegations to professionals of incidents where Y has been physically hurt by F, though Y himself has not made direct allegations, save in 2021. As a result of those concerns, and the growing realisation that the extent of the harm done to Y was substantial, he was removed to his uncle's care in May 2024. That placement broke down and he now lives on a temporary basis between his maternal grandfather and a family friend, an arrangement which is not long term. M has provided a text exchange in which she suggests to F that he needs to find an alternative method of discipline, suggesting that there was a strong element of conflict between X and F. It was part of an emerging pattern of a narrative provided by M to undermine F.

65. Following the removal of the children from their care, the parents separated, though there have been periods of sustained friendship, daily home visits and phone calls, and they had physical relations in June and October 2024. They also spent three days together at Christmas. Worryingly, until very recently, F has been unable to accept the role that M appears to have played in Y's presentation. The sexual activity and the companionship, continued despite the receipt of the expert evidence, which was overwhelming against M. Indeed, F only started to speak more negatively of M at the end of February 2025, following a statement she had filed where she had been critical of him and making allegations of his being abusive towards her and X, and coercive and controlling towards her.

66. In June 2024, F was at the home when M attempted suicide. She left a note in which she made concessions of fabricating and inducing Y's illness. She refers to F being unaware of what "I have been doing." She also says that Dr Thomas only acted on what she had told him. [Aii 19-22, pdf 66-69]. The only plausible explanation for this is that M has been fabricating and inducing illness in Y and that this was to be her last confession. That is the only time that she has fully acknowledge what she has done.

67. Sadly, she now claims that F had tried to persuade her to change that letter, so that her concessions were removed. That suggestion was non-sensical, because F had already

informed the social worker of the contents of that note. It would not have been in his interest to remove the concession made by M, because that cleared him of active participation. In her evidence, M stated that he probably wanted to produce the original note later in the day, to show that she was dishonest. Again, that was another lie. Having considered that suicide note, I believe that the confession made by M as to wrongdoing was, on balance, genuine. This was to be her final words on earth, after all. They stand in stark contrast to the more recent Facebook suicide notes which were written in the middle of this hearing and were wholly self-exculpatory and an attempt to place F in a bad light.

68. Despite that June 2024 suicide note, F has maintained an emotional relationship with the mother. He continued to have joint contact with her. He says that they wanted an outward showing of solidarity for the boys.

Experts within Proceedings

69. During proceedings, three expert reports have been commissioned. Dr Andrew Curran, Consultant Paediatric Neurologist, considered Y's neurological history in the context of his earlier symptoms. [E238]. Reporting in November 2024, he concluded that despite extensive and detailed investigations, no abnormality has been found to explain Y's symptoms. Most of the diagnoses were based on maternal history with sparse professional observation to support them. On balance, he concluded that Y's neurological presentation was likely to be factitious. His evidence was not challenged, and I accept his opinion.

70. Dr Parbary, Consultant in Paediatric Respiratory Medicine, reported on Y's respiratory history [E256]. He suggested that the symptoms seen in early infancy, were likely accurate but that by April 2018, when prophylactic anti-biotics were being prescribed there was a reduction in objective signs of illness, although parental reporting remained high. From January 2019, he concluded that there was minimal evidence of respiratory illness and no objective evidence of aspiration. He concluded: "*There is no objective evidence from the notes or imaging that I have reviewed that would have led me to remotely consider the possibility that Y should stop feeding orally.*" His evidence was not challenged, and I accept the same.

71. Dr Ward, Consultant Paediatrician, provided two reports- a short preliminary document [E82] and a longer more detailed report [E484]. She provided a detailed history of Y's symptoms and treatment and a full medical chronology. She concluded that none of Y's symptoms has been explained clinically, despite extensive testing. Early diagnoses of reflux, milk intolerance and bronchitis were plausible, but the history of respiratory issues and ataxia could have ben precipitated by the administration of drugs. The medical chronology is supportive of prolonged, repeated exaggeration and fabrication of symptoms causing a perplexing presentation to clinicians, which resulted in multiple unnecessary investigations, treatments, procedures and limitations of daily activities. Dr Ward gave evidence, and I shall deal with her oral evidence later in this Judgment. Needless to say, I found her evidence reliable, and I accept the same.

72. Despite detailed investigation by neurology, cardiology, paediatricians, geneticists and the Specialist Sheffield Attaxia service, no medical diagnosis or explanation for the symptoms has been found. It is accepted that no stone has been left unturned to find an organic explanation for what befell Y and how he made such a striking and swift recovery, once removed from the care of his parents. In short, the expert evidence was overwhelming in this case and most of it was not challenged. Indeed, M even accepted that the evidence against her was overwhelming, and that the Court was likely to make the findings. The ultimate conclusions of the court appointed experts was that M has fabricated and/or induced significant illness in Y.

Position of the Parties

73. At the outset, the Local Authority filed care plans, which enable the children to return to F's care, subject to the findings the court makes. Should the court determine that F had colluded with M, then rehabilitation would not be possible and foster care is indicated. However, if F's role was one of negligent ignorance or the court found that he could not reasonably have been expected to suspect M's actions, then the plan was for rehabilitation, following work to be done with him and the children. The Local Authority considers that the rehabilitation could only be supported by a Care Order for each child.

74. At the conclusion of the evidence, the Local Authority indicated that it was not seeking a finding that F induced illness or was complicit. They maintained that his actions were

negligent. The Care Plan was amended to take on board the recommendations of the Guardian but remained one of rehabilitation to F's care.

75. M accepted that she has exaggerated some elements of Y's condition, but only insofar as they relate to the frequency of episodes; not the symptoms themselves. She accepts that she exaggerated the extent of Y's food aversion and the seriousness of his sleep disorder. She made no concessions regarding inducing or fabricating Y's symptoms. However, she accepted the enormity of the case against her and said that she did not seek to challenge the evidence. A letter from her psychiatrist suggested that her anxiety about giving evidence was not so significant as to lead him to recommend that she should not do so.

76. A parenting assessment was undertaken within proceedings, in respect of M and concluded negatively. She did not seek to challenge that assessment and does not seek the return of the boys to her care. She supported them being returned to F's care under Care Orders.

77. F made no concessions on threshold, as far as it pertains to him. He took no responsibility for his part in the harm suffered by his sons and that remained the case until he provided his evidence, where he accepted several failings on his part. Notwithstanding his concessions, his case has remained that since the medical professionals were taken in, it is also reasonable for him to have been taken in. The Local Authority and the Guardian submitted that the role of the medical professionals is quite different from that of a parent. The medical professionals in this case saw Y for review clinics, for at most a few hours every 3 to 6 months. They relied heavily on reports from the parents, as is expected. F's relationship within that household was quite different. He was present daily, and, in the latter 14 months, he was the main carer of the children, having given up work to be there full-time. He would have had an intimate knowledge of Y's sleeping pattern and eating regime, as well as his presentation day to day, especially in the months after January 2023, when he stopped working.

78. He also attended the medical appointments and would have heard his wife's false explanations of Y's presentations, sleep patterns and eating, even if he did not participate in the exaggeration himself. He had heard and received the advice about

using medical equipment and use of the nasogastric tube and yet he would have been aware of the significant reliance placed on equipment and the feeding tube in day-to-day life at home.

79. The Local Authority submits that it is not enough to simply say, he left things to his wife. I concur that as an equal parent, he had a duty to involve himself in the medication prescribed to Y and its use and in all aspects of Y's health. Further, his failure to do so, and his failure to question M's worrying behaviour, which should have been obvious to him, is a failure to protect the children from harm. It is submitted that his inability to see this, suggests a worrying lack of insight into the part that he played, in the harm caused to the children and how he might manage the children's relationship with M in the future. He should have been the voice for Y but was concerningly silent.

80. F seeks the return of the children to his sole care. Initially, he did not see the need for a care order, suggesting that a supervision order is sufficient to support his care of the children. However, prior to the Guardian's evidence it was indicated by Mr Tillyard KC that his client accepted that a Care Order was necessary in this case.

81. It may seem strange at first blush, that in a case of this nature that a parent living within the home should be considered as a carer, given the extent and length of the FII involved in this case. Despite his current lack of insight, with work, the Local Authority is to use its own phrase 'optimistic that rehabilitation can be successful in this case'. They rely on his parenting assessment being broadly positive, and he clearly can meet their basic needs. However, the complex nature of the dynamic between the adults and between the father and X, as well as X's emerging anger about his situation are all problematic factors and will require significant support.

82. The Children's Guardian expressed initial caution about the rehabilitation plan. She had greater concerns about F's insight, his ability to divorce himself from M on an emotional basis and questions his realistic understanding of the task he is suggesting taking on, practically and emotionally. She was unable to provide a firm recommendation for the court until she has heard all the evidence.

83. However, her position following the evidence was to support the rehabilitation with strong recommendations for work required and support needed for this to work. She was the opinion that this could only be safely achieved under Care Orders.

The Law

84. The legal framework for hearing such as this has more recently being considered by MacDonald J in the reported decision of Re A Local Authority v W and others [2020] EWFC 68. I summarise the core principles as follows:

(I) The burden of proof lies on the local authority that brings the proceedings and identifies the findings they invite the court to make. There is no obligation on a respondent to provide or proven alternative explanation.

(II) The standard of proof is the balance of probabilities.

(III) there is no burden on the parent to produce an alternative explanation and when alternative explanation for an injury or course of conduct is offered, its rejection by the court does not establish the applicant's case.

(IV) The inherent probability or in probability of an event should be weighed when deciding whether on balance the event occurred but regard to inherent probabilities does not mean that very serious allegation is an issue the standard of proof required is higher.

(V) Findings of fact must be based on evidence, not suspicion or speculation. The court must consider all the evidence and consider each piece of evidence in the context of all the other evidence.

(VI) The opinions of medical experts need to be considered in the context of all the other evidence. it is important to remember that the roles of the court and the expert are distinct, and it is the court that is in the position to weigh up the expert evidence against its findings or the other evidence. The judge must always remember that he or she is the person who makes the final decision.

(VII) The evidence of the parents and any other carers is of that most importance. they must have the fullest opportunity to take part in the hearings in the court must form a clear assessment of their credibility and reliability.

(VIII) It is not uncommon for witnesses in these cases to tell lies during the investigation and the hearing. The court must be careful to bear in mind that a witness my life for various reasons, such as shame, misplaced loyalty, panic, fear, distress, and the fact that the witness has lied about some matters does not

mean that he or she has lied about everything. It is good practice for the Court to consider the suggested questions set out by Macur J in A, B and C Children [2021] EWCA 451, para 57. Caution should also be exercised in relation to responded giving unsatisfactory explanations or failing to give any explanation for the allegations made against the. The fact that they are unsatisfactory or missing may not be probative of the truth of the allegations or the culpability of the respondent.

(IX) Caution is also advised regarding today's medical certainty may be discarded by the next generation of experts or that scientific research may throw a light into corners that are present at dark- see Re U, Re B [2004] EWCA civ 567.

(X) The test for identifying a perpetrator of harm to a child is the balance of probabilities nothing more nothing less. There are many potential advantages in identifying the perpetrator of non-accidental injuries, but the court should not strain to find the perpetrator and sometimes the task is impossible. in an appropriate case the court should identify the pool of potential perpetrators of significant harm applying the test of 'real possibility'.

85. Both parents gave evidence at this hearing and were cross examined by Leading Counsel. In particular M, who became most vulnerable prior to giving evidence and subsequently, after a week's hiatus, provided her evidence from a Psychiatric ward, and required obvious participation directions. In any event, I have warned myself to guard against an assessment solely by virtue of the behaviour of the parents or any other witness in the witness box.

86. I have also reminded myself of the warning given by Ryder J in A County Council v A Mother and others [2005] EWHC 31 fam at [175] to [178], as it applies to this case.

87. As to Fabricated or Induced Illness, in February 2021, the RCPCH published guidance, Perplexing Presentations (PP) / Fabricated or Induced Illness in Children, which I have found considerable assistance. The guidance clearly distinguishes FII from "medically unexplained symptoms", and "perplexing presentations", in a clear and concise manner. It sets out clear guidelines for professionals and how to manage any investigation into FII. It sets out key flags to watch out in respect of FII behaviour. Because of the length of M's behaviour towards Y, we straddle the period of this guidance and its predecessor.

Helpfully, Dr Ward, in her report, sets out a comprehensive review of the 2021 Guidance and its application to the current case, which I accept in full.

88. In terms of welfare, the Court's paramount consideration is the child's welfare, section 1 Children Act 1989. The Court needs to have regard to the welfare checklist contained with section 1 (3) of the Children Act 1989, when making any determination on welfare.

Evidence

89. In advance of the hearing, I had the advantage of having read the digital files and viewed the police interviews of the parents. I also heard live evidence from 13 witnesses and their evidence has been summarised below.

90. Lydia Jones, a SaLT worker, told me that she had no direct involvement with Y but had been asked to prepare a chronology of work undertaken by SaLT. She confirmed that predominantly M had been the contact and had shared the information. F was present at just one home visit and attended three multi -disciplinary meetings.

91. It was pointed out that initially F was resistant to the NG tube and only gave consent later, when it was discussed directly with Dr Thomas, who agreed it was necessary.

92. Dr A Proctor, Consultant Paediatrician and Safeguarding Lead, had also prepared chronologies and summaries for the purposes of the FII investigation. She accepted that it was not always clear to ascertain whether both parents were present or whether it was just M present from the records. She accepted the main contact was with M.

93. She was concerned as to the way in which Midazolam was being continually prescribed on repeat prescription despite it being stopped in 2018 by Dr Thomas, there being no epilepsy found after investigation. The records show that requests were being made for it to be continued by M, long after that.

94. Dr G Thomas, Consultant Paediatric Neurologist and main treating clinician. He accepted that he had been taken in by M. He told me that he had been satisfied that the parents and M were loving, caring and responsible parents and were genuinely concerned with Y. He had very little dealing with F and his contact in the main, was with M.

95. He felt throughout that Y had a serious underlying condition, which may have been life threatening. He took me through the large volume of tests that were undertaken from epilepsy, genetic, cardiology and neurological issues. He described that on some occasions he observed Y looking very disabled, when having a purported episode.

96. He saw one incident in his surgery waiting room, but did not see the start. He confirmed that administering Midazolam to a well child could lead to the child exhibiting all the symptoms that were observed in Y. He accepted that M must have injected Y shortly before his presentation in his clinic. He had also seen Y on other occasions, where he was listing to one side, could not stand etc and he felt that time, that this was a genuine case of ataxia. However, when all neurological tests and genetic tests were undertaken and revealed nothing, he informed me that he was concerned that this was a very rare genetic issue and hence, the referral to the lead genetic hospital in Sheffield for further tests.

97. He told me that he was initially of the view this was not FII because of his view of the parents. However, when it came to the point that he was concerned that Y was being given Midazolam, M confirmed to him that she had not been receiving that medication for years, which was a lie. In fact, Midazolam was subsequently found in the home and repeat scripts for the drug was being requested from 2017 onwards until even after Y was removed from parental care.

98. He told me that if Midazolam was injected into the inside of the mouth, as was its normal application, then it was a very fast acting drug - around 5 minutes and the effect on a well child would have lasted around 30 minutes. Had the Midazolam been injected into the NGT or GTube, then the drug would have gone straight into the stomach and therefore a delay in response would be expected of around 15 minutes and potentially a longer reaction period of around 45 minutes to an hour.

99. He also stated that this was treated as an episodic condition, where Y often appeared as a healthy, normal child. He felt that explained why these episodes were not being seen by other independent persons, such as the school or OT. He confirmed that he never advised M that he required feeding by tube when he was well.

100. Dr Moynihan, Consultant Paediatrician, produced several safeguarding reports in this case. She had met Y but not treated him. She told me that one of her concerns was evidence of a pharmacist that a new prescription request was received for Midazolam in April 2024.

101. At the main meeting where it was raised with the parents that they were concerned that Midazolam was being administered, when it should not have been, she agreed that F seemed removed from what was going on in terms of the medication being prescribed. F stated that M dealt with the medication and understood what they were being given for.

102. At the meeting on the 27th June 2024, F handed a list of questions to the witness and Dr Thomas. F, by now understood that the drug was being given to Y and that he should not have received and that was being prescribed when they should not have been, the questions were entirely appropriate, they were not answered immediately. Dr Thomas responded subsequently to those questions.

103. She confirmed that most of the references in her safeguarding chronologies that most of the information provided to professionals came from M. F attended some meeting but did not say much. However, there were recordings where both parents were in meeting, and each contributed and there was never a sign of dissent from the other parent regarding information shared.

104. C Williams, an Occupational Therapist, made a referral on 4th April 2024 because of her concern following a home visit. She stated she had visited the home with both parents present. Initially, she stated that neither seemed concerned with the fact that Y was very sleepy, and they stated he had been in bed all day. In context, this was following the local children's hospice's observation and heightened concerns because it seemed that this presentation was taken to be normal by the parents. She felt that F was present in the house but not in the bedroom. In any event, he was not spoken to. She confirmed that neither said he was having an episode; just that he was unwell. He was more than just sleepy, and his presentation was worrying.

105. She dealt with issues that were raised in her chronology regarding what M had told another OT, about a purported genetic condition and then a discussion with school

where M had informed an OT technician, that school had refused access for a visit. Both were said to be a misreport from M. She also recalled a discussion with M, where she said that she wanted equipment to home school Y and she also felt that school was not picking up on episodes and she decided to remove him from formal schooling. The school had a different view about Y suffering episodes and that was where the witnesses' concerns started. They denied he was leaving school wet, and there was never an ataxic event, and he was running around and interacting with his peers in a normal way.

106. At one meeting, both parents were told not to use wheelchair unless there was an episode and not to tube feed unless there was an ongoing episode. She recalled that most of the discussions were with M.

107. She was taken to an annual progress review document where both parents were in attendance (19th April 2023). She had been concerned to read that Y continued to move around with his wheelchair supporting him in his daily routine. After this meeting, she requested a meeting with Dr Thomas with the parents to try and support them to get Y back into school. At that time M wanted Y in a day unit because school was allegedly not meeting his needs.

108. She agreed that almost all the information provided to her emanated from M. F was sometimes present on visits but in the background and limited to niceties. M took the lead on all conversations. F attended some very limited number of meetings.

109. She spoke to Dr Thomas about her concerns; namely, that she had never seen an ataxic episode, despite numerous observations of Y, in the home and school. On one day (December 2023), she visited, because M said he was at the start or end of an episode, so she went to observe. His presentation was not as M had suggested. Y was pale, difficult to understand when distressed/ crying; he wanted food but was prevented from eating and the witness was told he would be peg-fed in an hour. He seemed distressed after that being refused. However, he was not unsteady on his feet (as M had reported) and was not in her view, ataxic. The witness denied that she had to catch Y as he walked by her, as was suggested by M. In my judgment, this was an event where M had induced illness in Y.

110. On this occasion, M also requested that she be provided with a hoist to lift him. The need for a hoist was not supported by the witness and she denied that she had initially suggested this was required. It was raised on other occasions by M, that the children's hospice had suggested that one was needed, and also that Dr Thomas had advised that. This was not the case. The witness emailed Dr Thomas about her concerns. In my judgment, these were all examples of M's ability to play professionals off against the other and to mislead them.

111. She was also concerned that M was saying that Y's episodes were becoming more frequent, but they were never witnessed by anybody such a school or the witness. Yet, M was requesting more and more equipment and the more issues they resolved, the more M made further requests. Her main concern was about the discrepancy in the child that was being presented on observation versus the child that M describing.

112. This witness was professional and reliable. She is commended for being what was a sole voice in questioning the genuineness of Y's symptoms. She drew her concerns repeatedly to other professionals. Unfortunately, her concerns were not shared.

113. The head teacher at Y's school told me that the school witnessed no ataxic episodes and X presented as engaged, and popular with his peers. He was full of energy, and he commanded a room. He was very good at eating with his peers. He would often come to school every day in a wheelchair and sometimes with a helmet.

114. Frequently, M said he was asleep, because he was supposedly in an episode; but as soon as he was in nursery, he was alert. M would provide that information that he was in an episode on these occasions.

115. She could not comment on whether F said that. Predominantly, it was M who came to the school. Only on one day, she recalled Y saying he felt wobbly and that was the only incident she recalled. His attendance dropped over the years, going down as low as 14% and the witness was told by M at the same time that the episodes were worsening. By that time, he was falling behind his peers.

116. The school did not use the wheelchair, as it was not necessary, as he was not episodic. However, he was always produced in one and at the end of the day he was taken home in one.

117. In 2021, M informed her that he had now been diagnosed with periodic episodic ataxia and 'possibly something else'. There was never a definitive diagnosis, it was a working diagnosis, which M liked to state erroneously, as fact.

118. In Spring 2022, he was fitted with NGT and there were issues with his coming to school. M said that he had difficulty with swallowing and had been told that by Dr Thomas. Training was provided to staff, but the staff were shocked with the invasive nature of the NGT. Her understanding was that Y would be required feeding through NGT whilst in an episode. The school never saw him in an episode. The Local Authority decided that staff could not undertake this task.

119. The feeding plan changed a lot. M said at the start, he needed feeding and medicine through the tube. It was changing almost daily. The parents felt that he was different from other children. They wanted him in the special educational need unit, but he did not fit the criteria. Many reasonable adjustments were made but his attendance still dropped consistently.

120. The school supported the expedited gastrostomy surgery to get him back into school. Again, staff were trained around October 2022, when he had his surgery. In January 2023, he was taken out of school. In that intervening period, his attendance did not markedly improve.

121. She denied that the school was not meeting his needs or allowing him to go home when wet, nor that they were not noting episodes, which were the reasons given by M for removing Y from school. These concerns had never been brought up by M during the almost daily discussions with the school.

122. I found this witness to be credible and reliable.

123. Elizabeth Walton, Independent Social Worker, provided parenting assessments for both parents. Her live evidence did not assist me with the critical issues, save to say

that the parents were not wholly open about their relationship troubles and that they have has sexual relations following separation.

124. Dr L Hayman, retired specialist community paediatrician, was asked questions by Mr Tillyard KC, about her involvement with Y, as the main treating clinician for three years prior to her retirement. She also had much experience of safeguarding.

125. She told me that there were explanations for Y's presentation and a potential diagnosis and therefore, it was not obviously a case of fabricated illness at the time. She was concerned at the levels of anxiety exhibited by M. Most of the contact was with M but when they were together, they seemed a 'quite a together team'. However, F was not keen on the idea of NGT at the first meeting and against M's view, which was the only notable departure from that. However, most meetings and telephone calls were with M. The talking was predominantly done by M, at any joint meeting.

126. Dr K Ward, Independent Consultant Paediatrician, and a jointly instructed expert. She confirmed that there was no medical cause for ataxia at any time. There were two reasons: the nature of ataxia was very specific: distinctive history of episodes of ataxia and in between attacks he was normal and could function as a normal child. It is a very complex area. where genetic causes may be behind this type of condition. However, Y was tested for all genetic variants and had none. Even if he had one, it would not suddenly improve, as it did when he was removed from the care of his parents. The second point: one would not expect this to suddenly stop with a developmental issue, either.

127. She opined that there was nothing left to be done medically before determination in this case. Periodic ataxia is very rare condition, and she could not think of one case in her experience, with symptoms such as this.

128. A limited number of reports of ataxia had been seen by any of the medical professionals- one with OT in community (Milk incident) and secondly, what was seen by Dr Thomas in the waiting room, and then the episode in the children's hospice (after M was seen administering the drug), as an example. There were 4 episodes where the child presented as ataxic in her view, 'whatever the cause of those', a medical cause is ruled out. She ruled out fabrication for these events because each was witnessed by

professionals and therefore, we are left with drug administration, alone- either drugs given on prescription or combination of them caused ataxia (which Dr Coulson rules that out) accidentally or not; or he was likely administered Midazolam, when well. In my judgment, it is the administration of the drug which causes these alleged episodes.

129. The witness had not seen cases of misadministration of this drug, but had seen adverse reactions to the drug, given therapeutically. The results are the same, as reported with Y. The reaction of the drug is very quick, within minutes and effects will persist for maybe a few hours. It will be a decreasing curve over time. The witness stated that if more than one administration at the same time was given or regularly, it was more likely that it would cause greater severity and greater increases in ataxia and the child could stop breathing.

130. She agreed that M was having the majority of interaction with medical staff/ and other professionals in this case. She accepted that it was invariably difficult to diagnose FII. The parent may believe it – the gain may be emotional as well as financial. Also, the parents may have a strong belief that there is something wrong with the child. That may be down to the psychology of the parent or neurodiversity. It is not always malicious. Medical professionals as well as family members are often taken in by the parents acting in this way.

131. This was an impressive witness with vast experience of FII cases both in practice, as well as a court appointed expert reporting on FII. I accept her evidence, but I also bear in mind that based on her vast experience of these cases, it had taught her that parents in M's position sometimes believe in illnesses which are not objectively verifiable. It is not always the case that a parent who has fabricated and/or even induced illness in a child has simply done so maliciously. That is also the learning from the 2021 Guidance.

132. L Davies, the Social Worker, had prepared the final care plans and transition plans. She told me that Y is a delightful boy, fit, active, well, and happy. There is no indication of the symptoms he had suffered with whilst at home. The extent of the emotional harm is now coming out, for example, he shows anger at medical professionals, and he is only now asking questions. X has struggled with going into care

and he was angry at first with Y going into care. He now understands that Y is well but that has also been traumatising and difficult for him to understand, given the history of believing his brother was extremely ill. He is really struggling with the experiences and shows anger in school.

133. She explained why a Care Order was necessary in this case if the children are placed with F (The Local Authority needed to assess F's reaction to the Judgment and caring full-time and also issues around contact). She also explained why M's contact should not be altered to match M's one session with both boys together and then the next session (bi-weekly) would be separate, especially not on every occasion, but that could be reviewed as part of the LAC process. She felt that would confuse the boys and would also impact on the boys by having to wait around knowing the sibling was having time alone with M and that held sway over X's dislike of sharing contact.

134. She is also concerned about any indirect contact being managed by F, given their history of enmeshment, ditto F supervising direct contact. All matters will be reviewed in any event in the normal LAC review process. Mr Tillyard KC voiced that F now accepted the necessity of a Care Order if the boys returned to live with his client, their father.

135. She accepted that contact with F was positive, and he has a lovely relationship with the boys. Both wish to return to his care. She confirmed that F now accepts that M administered the drug to Y and though that has been slow for him to acknowledge given the background of a 17-year relationship, he is now "angry" about what M has done. She accepted that he is now saying that he would not contemplate a resumption of the relationship with M, despite their reconvening at Christmas.

136. The next witness was the pharmacy manager, from which Y's repeat prescriptions were provided. She told me that she only recalled speaking to a woman about Y, never a man. She prescribed for Midazolam for Y three times in 2024, the last being 14th March 2024.

137. In this case, the monthly prescription was delivered to the home, each month. She would speak to M, to see what she wanted each month for Y and then that would

be dropped off at the GP surgery, it was always the precise prescription requested. She did not recall M ever saying she did not required Midazolam.

138. She did not recall speaking to M in April 2024, but there was a request for Midazolam and that would have been sent to the GP. However, she believed that someone contacted the pharmacy to prevent the delivery going out.

Update on M's Participation

139. On the 10th March 2025, M was due to commence her evidence. However, we could not proceed because M had attempted suicide on the previous Friday and Saturday. She had also put on Facebook a series of 6 messages which stated that she was driven to this point by F having sided with the Local Authority. She alleged that F had caused her mental health to disintegrate over the course of the marriage, by coercive, controlling behaviours and domestic violence. (This was denied by F). She maintained that she did not harm their child and was alarmed at the accusation that she had 'poisoned' him and that care should be taken in promoting supervised contact (both were part of the cross-examination of the social worker by Mr Tillyard KC on behalf of F on the previous Friday).

140. The week of the 10th March 2025 was taken up with a review of M's mental health situation at the hospital and her ability to provide evidence. There was no issue that she had capacity, and the hospital were of the view she could possibly providing evidence from the hospital, which would lower the risks of further harm being attempted.

141. On the 17th March 2025, a hearing was convened to discuss the ground rules around her oral evidence. It was confirmed that M was willing and able to participate from the hospital and to give her oral evidence from that location. A private room had been secured for her, and it was agreed that her solicitor would be present to assist M with access to the electronic bundle. It was agreed that regular breaks in the evidence should be scheduled. A nurse was also present in the room to support her.

142. Another aspect which required discussion was around M's position to the allegations of domestic abuse / violence she had made against F. Mr Thomas KC explained in his position document that "M does not ask the court to determine any of

the allegations she has made against F which are denied by him. She does not suggest, given the way that the overall and ultimate issues in the case are joined, that it is necessary or proportionate for the court to do so. Despite the significant and sustained level of violence M has alleged that F showed her, she remains convinced that it does not give rise to any risk of violence by him to his children in his care. Neither does she believe that any past behaviours shown by him to the children put them at any risk of physical harm in his care".

143. No other party sought findings in respect of those allegations. On that basis, M's evidence commenced remotely on the 18th March 2025.

M's Evidence

144. She confirmed that the recent two suicide attempts were genuine attempts to take her life. She confirmed that the children would be happiest in the care of F, despite the allegations she has made against him.

145. She was cross-examined by Ms Hughes KC firstly, about F and his role in the household. From March 2020, whilst in lockdown, F was at home and had not worked until the end of that year. He helped care for the children in this period but not with the administration of Y's medication. F was present in some of the video appointments during this period. After he returned to work, he was at home on weekends and evenings and had later starts on a Tuesday and Thursday. She would fill out any medical/ SEN/DLA forms, but she would read them back to F and ask him for feedback. He never challenged the truth of what she put in the forms until the end of 2023.

146. One such form, on the 6th February 2023, said that parents were reporting that during an episode Y is, "unable to sit stand and hold his head up talk. Swallow triggers include sudden noise, illnesses, changes in body temperature, fatigue, busy. Episodes last from 2 minutes to two weeks." She and F had agreed that was correct.

147. Later that month, F stopped work altogether. He had been working part-time hours prior to that, because she was struggling with the children. When he was home with the boys, he would play fight and play computer games and help with bedtime routine. He would not deal with any of the medication for Y, save that sometimes she would draw it up for him to give it to Y- not the larger amounts of medication (limited

to Calpol and Melatonin). Most of the time he was present when she administered Y with his medication. F would ask now and again what the medication was for. He was fearful of giving the children medication.

148. F attended many of the appointments with Dr Thomas. The night before, they would discuss what they were going to raise. She made notes and they exaggerated some of the symptoms in the early days when he was around a year old. F was aware of that. They were afraid that there was something wrong with him, so they decided to say they were happening more frequently or lasted longer, so that they would be taken seriously and Y would receive the treatment available.

149. The decision to remove Y from school was a joint decision, F felt strongly about the school were not meeting his needs and took the lead.

150. The repeat prescriptions were dropped off at the home by the pharmacy in bags. F would be present when he was at home. F would unpack the medication.

151. F's behaviour towards X was discussed. Occasionally, F hit X and the smacks got harder over time. F would acknowledge that he had hit him too hard sometimes. Usually, it was a slap but sometimes there was a punch with a clenched fist, which left X with a dead leg or arm. Sometimes he would hit him across the head in a slap. She was taken to a text exchange around the 4th March 2024, after F hit his son, X, in a rage, and F was fearful he turning into his own father. She confirmed that when he was in a rage, he can get quite angry and struggle to control himself and he will lash out, but it would not be very often. She saw marks on X around 7-8 times. There seemed to be a 'clash of personalities' between F and X, even though his son was just 9 years of age at the time. She confirmed that the incident that X reported to the headteacher in 2021, occurred and F slapped his arm on that occasion.

152. The couple separated in April 2024 but lived in the same house. The day that X moved out, F moved out the same day. They kept in touch with regular daily multiple calls and messages, and F would visit her most evenings. In June 2024, she made an attempt on her life and left a note saying she accepted the blame for Y's illnesses. After she came home from hospital, F said that she needed to change the note (He had already told the social services about the note). He was trying to get her to change it, so that he

could say that this was not the note and produce the original one. She thought he was double-crossing her. In that same month, they had sex. After this suicide attempt F slept on the sofa until end July, maybe into August. It felt like they were couple but not and she suggested that he should move out. He went to stay with his friend. They occasionally had sex when he was at the home- once or twice. They knew they should not have been together but knew there was no future for them.

153. Most of the reports were filed in June/July of causing the injuries to X- this was discussed, and things became tense. She felt that she had to disconnect from the reports to remain civil.

154. In or around October 2024, they had sex again. He had been visiting her home daily at that time. He stayed the night twice, sleeping on the sofa. This arrangement ended shortly after Christmas, when he stayed for a few days. She felt that her mental health was lowering, and she asked him to go. It was playing with her head, whether they and a future and whether he believed her or not. After that, there was a brief period of no contact and then he started phoning for the purposes of contact. She confirmed the Guardian's suspicions that in February 2025 they were still in daily contact and multiple times. M said that F did not have the school apps, so they discussed what was happening school.

155. F refused to discuss things face to face about what had happened to Y. He does not know what to think, was what he said.

156. Y and his illnesses were discussed, and she accepted that he is now perfectly well, with no episodes since he left their care. M was unable to explain that difference. It was suggested that she caused or fabricated these illnesses. Midazolam was discussed in detail. She accepted that in 2018 she was told that he was not epileptic and did not need the drug. However, it was still claimed on the script. In April 2019, the parents were told again that he was not epileptic and did not need the medication. On both occasions, letters were sent to reinforce that. However, the script continued until January /February 2022. She accepted that they had a significant store of Midazolam which was unneeded. M did not raise the issue of the drug remaining on the script and that it was being delivered. It was laziness she said, she tried a couple of times but got

sick of just repeating herself. It was suggested she did not say that to the pharmacist, and this was the first time she mentioned that.

157. By February 2022, she had 2 years and 10 months' worth of Midazolam that she did not need. In October 2022, she emailed the surgery asking if it was an error that it had been stopped. She stated that not all items were kept and there was a clear out from time to time. Also on occasions, she used it on herself (2-3 times). When it was cleared out, it was squirted down the sink. Both parents did that.

158. It was suggested that she asked for the Midazolam to give to Y so that he would go into an episode. In October 2022, Midazolam started again and continued until August 2023. It was suggested that she had a large amount stockpiled.

159. In January 2024, it started to be delivered again. The police found 3 boxes in April 2024. She was asking for additional medication even when Y was out of her care and had moved in with her brother. She felt that this was assist her brother and was given to him.

160. She denied using Midazolam to induce an episode. In the children's hospice, on the 5th March 2024, it was suggested she did this and was observed. She denied that she did this. She stated it was an iron supplement (Sytron) that she administered. He had been taking that for 3 years, daily. It was red/brown medication not clear like Midazolam. She was on her own in the room when she started, and a nurse came in halfway through. She accepted that the medication provided was clear. The nurse challenged her at the time that it was clear. M denied the colour was discussed. The nurse says M told her that it was drawn from a bottle of Sytron at her home, which was clear. M could not answer why she said this. It was suggested she was covering up, which she denied that and maintained that she had given the wrong medication accidentally.

161. It was pointed out that she changed her story on this incident. By 13th March 2024, she said to a social worker that she could not recall what she provided. On the 20th March 2024, she showed a social worker bottle in her cupboard, which she said she must have drawn the liquid from the wrong bottle and did not notice the wrong colour.

162. She denied lying to Dr Thomas, by responding to his question whether she had the drug? She said she did not have any. She said we haven't used it in years. These were lies. In January 2024, suggested that she induced an episode by providing him medication in Dr Thomas' waiting room, which she denied. She also denied doing so for the educational psychologist appointment in the Summer.

163. She was taken to exaggeration where she claimed that the events lasted between 1 hour and 2 weeks. She accepted only that she exaggerated the frequency. She stated that there was one episode which lasted on and off for two weeks- unable to sit, losing muscle tone, not eat /drink. The medics said it was tonsillitis, but she did not feel comfortable that was the case and felt something wasn't right.

164. She was asked about a joint appointment at Dr Thomas's clinic [X63] 26th October 2023, she said large number of episodes and one lasted for 4 full days. She exaggerated the duration on this occasion.

165. At another joint appointment with F at Dr Thomas' 7-8 episodes a week, for a few minutes to an hour. She stated Y was self-reporting episodes- that he felt dizzy, and the parents thought these were linked to his episodes.

166. In an appointment in September 2023, she told the doctor that there are few times a week when all symptoms were present. She then stated that he never had all the symptoms together. That was a remarkable admission, because she failed to clarify that to any medical professional. He was treated on the basis that these were significant symptoms occurring regularly in pattern.

167. In January 2024, M described episodes lasted for 2 -3 days at a time, and were no longer short. She accepted that she exaggerated that they lasted for days. They both decided to lie for the professionals to find out what was wrong. She denied making it up, they exaggerated.

168. She insisted that the procedures were necessary to find out what was going on. She could not see that he is a healthy child, she then said F could provide an explanation for what was going on. It was suggested that she was making it up and inducing it. She denied inducing any episodes.

169. The issue of safe swallow was raised since he was a very young baby. On the 16th June 2017, he had his first assessment for safe swallow. He was almost a year old. There was no issue around his swallow. It was pointed out that she insisted that the professionals re-consider that. It was then pointed out that immediately following the June appointment, M lied to the Health Visitor in a text about what SALT had found, suggesting that an issue had been identified. M explained she must have had a different take on what was said and misunderstood.

170. She accepted that she was exaggerating the amount of time he had an unsafe swallow, which led to her insistence to the insertion of a NGT. On the 15th July 2020, she said he was in an episode and SALT were able to test his swallow. The professionals found there was not an issue, in fact he had a 'a reassuringly safe swallow'. M said in evidence, that it was not one of the major episodes. On 21st July 2020, she reiterated he had an unsafe swallow. In April 2021, she said he had a problem with swallowing, despite no evidence of that.

171. On the 30th November 2021, she called SaLT to the house to see him having an episode (milk incident) and further assess him. They, again, had no concern about his swallow and was eating different foods without problem. M stated once more that it was another minor episode, despite her description at the time being serious. Two days later, on the 1st December 2021, she took him to hospital and maintained he had an unsafe swallow and had not eaten for 2 days. She maintained that she felt he was not swallowing properly in an episode. She told medical staff that he had been in an episode for two days and had been unable to swallow. She did not inform the hospital of the SALT assessment. In my judgment, it was another example of her exaggerating and fabricating an issue- this time around his swallow, all because she wanted NGT inserted.

172. On 28th January 2022, Dr Thomas agreed to the insertion of a feeding tube for 6 weeks. Despite that, she was told he should eat normally when not in an episode, because he was able to do that without difficulty. However, she told school that he had to be fed and receive his medication every day through a tube, which was another lie. [C75]. He did not attend school for most of that year because he needed feeding through the tube, and they could not use the tube in school. M said that if the tube had come out,

they did not know what to do with it. That was also not correct, and the school evidence was clear. She then stated that he was receiving his medicine daily through the tube and said he wanted to be fed also (for hydration) through the tube. She argued with the school for months because he needed to be fed every day through the tube. She was taken to a description she gave at the time that he needed tube feeding to build him up.

173. By April 2022, she was feeding him via the tube every 2 hours, despite her assertion that she only did so during an episode [687]. The context was that she was seeking a unit placement who would be able to feed him through a tube. The dietitian told her that if he was not in an episode, that he should eat and drink normally. M attempted to say that the plans between the nurse and the dietician were in conflict. She was giving different information to different professionals about the need to feed him through a tube, when both parents would have known he did not need to be fed through an NGT when well. All this meant he lost 6 months of school and led to his getting a GTube, as the only way he could go to school and be tube fed. None of this was needed.

174. Further, she told the children's hospice that he needed to be fed through a tube three times a day [C80] in March 2024. It was incorrect information. M stated this was the dietician's feeding plan. She was told that he needed to be tube fed as well as normal feeding. That was not true. The hospice records show that M was lying.

175. With sleep disturbance she exaggerated that quite significantly because she wanted to get some sleep herself meaning he received melatonin and then another drug. Those drugs were not required. She accepted had they been truthful about his sleep, they would have stopped the drugs. In the hospice, he slept through each night without issue. She could not explain that. It was suggested he was perfectly fine, and she had been fabricating and exaggerating.

176. The OT said that in April 2024 she visited, and Y could not be roused, but M denied she had given him extra melatonin that day to keep him drowsy through the day. M gave an account that there was no real attempt to wake him. That is not the case.

177. On the 28th January 2021 [C212], she was inaccurate in a medical appointment about the number of courses of antibiotics needed by Y in recent months. She felt they all ran into one and she always said 'approximately' and assumed the professionals had

all the information in front of them. She stated that he did not use a nebulizer at home, save once, even though it is within the recording. It was another example of incorrect information being provided by her.

178. Finally, she was asked about use of equipment. Y was using a wheelchair every day. She denied that he was placed in it but jumped into it. That was another lie. He did not require a wheelchair she accepted, unless he was in an ataxic episode. She accepted this was no longer necessary.

179. The same with the matter of the hoist, she told the hospice that she needed a hoist. She said this was the issue 'really frustrated her- it had been bounced around and nobody took responsibility.' This was a strange comment given what had happened to Y. Again, M's evidence was unreliable. It was clear that she misled people as to professionals were suggesting a hoist was needed, whether school or OT or the hospice. It was an example of how M raised the issue of a hoist and then tried to throw that suggestion back on the person to whom she had had raised the issue and misinformed the others involved. [K17/18]. In any event, there was no need for a hoist.

180. M had been telling people in 2021 that Y suffered with alternating hemiplegia of childhood and continued to do so until 2023, despite being told he did not have the genetic condition. M maintained that was what he was being treated for and if the doctors did not believe he had that condition, then they would not have given him that medication. By October 2020, it was clear, he did not have that genetic mutation / disease. That did not prevent M from persisting to tell people that he did.

181. M was then cross-examined by Mr Tillyard KC, and she admitted that she was 'very good at getting her opinion over' to others. She was taken through her medical records which undermined her allegations that F was violent towards her and caused her injuries.

182. She was challenged as to her honesty, and it was suggested that she recently told mental health professionals that Y was having less frequent episodes in the care of her brother. That was a lie. She also told them that there was no evidence of wrongdoing or FII by her. This is another lie.

183. It was pointed out that she claims that she could not recall many key events in this case, but she was recently referred to as a good historian by her treating mental health clinician. In my judgment, she was lying to put herself in a good light and so that she would be viewed as a victim.

184. She was asked why she was making allegations against F but wanted them to be returned to his care. Her explanation was that she wanted them to have the correct support to ensure these things would not keep happening. It was suggested that she was lying about these allegations. She accepted that there may be a chance that it would be less likely that the children would be returned to him given her allegations. She said she wanted to consider all angles and did not trust her own judgment at the time. In her recent statement of the 14th March 2025, she wanted people to know what he was really like, that he was not always a nice person and was not always what he seems. He was an abusive person who abused her and his child. She said she was acting out of hurt and anger at the whole situation and specifically aimed towards F. There was no thought how that might have impacted on her children. She felt her suicide note was her last opportunity to tell the truth.

185. During the parenting assessment, she told the assessor that F did not have her back and blamed her for what had happened. She also said that F just needed time, and she did not want the marriage to end and wanted him back. She also told her that there was no violent in the marriage, which undermines her current allegations. M said that it was mentioned but it did not feature in the assessment. It was pointed out that she had also said that [E448] F was her 'first and primary sources support …. he supported her every day with everything. That they had been married for 17 years and have two children together and that she was heartbroken, and marriage had ended'. That did not accord with her current allegations.

186. She said that she had never blamed him for anything that happened to Y. In the suicide note on the 8th March 2025, [C862], it was pointed out that her sending this to her friends and family meant that they were not going to support him and would blame him. She added in evidence, "He is to blame for me never getting them back because of the amount of lying and exaggeration in his statement". It was put to her that this was another attempt to manipulate the family and friends to her view, which she denied.

She accepted she was lashing out and wanted everyone including the court to know what he was like, from her perspective.

187. She was asked what "endless lies" he had told about her. She responded that he was never been involved in Y's care and it was all down to her, lied about sending note to X (he had not), disagreeing about what to do with first suicide note. She was asked about what she told the treating clinicians at the hospital that on the 7th March 2025, F had lied in court (F did not give evidence that day. When that was pointed out that M said it was what he had told the social worker). She could not recall what those lies were. She told her doctors 'I have not done what he is accusing me of.' It was pointed out that the accusations come from the Local Authority. She also said, 'he has convinced me that there is something wrong with my mental health to cover his lies'. That was also incorrect.

188. She also said in the note, "I would never harm a hair on the head of my children". It was put that she gave Y medication to make him appear unwell for 7 years. She denied that she had done so. She tried to say that he had got better. It was put to her that there was nothing wrong with him in the first place. The fault for that lies with M, but she would not take responsibility for that.

189. She also said that F "has destroyed me" in that message. Asked about that, she explained that she meant that he 'destroyed her character, and he made out she was awful to live with because of her mental health and he had to give up everything to look after their children'. It was pointed out that he did not say that. He has also told friends and family that she has done all this from early on, not that she was accused of it. It was pointed out that she filed a statement prior to the hearing saying she accepted the evidence was overwhelming and that everyone would think she did this, so much is she did not want a hearing. It was pointed out that it was the evidence that was destroying her, not F. She said, 'he did not need to make it worst by telling everyone', before the reports had been filed. She also pointed to his having been concerned about her being the cause for Y stopping breathing when a baby.

190. Shown [C864], where she said he would tell the boys lies about her. The lies she could not articulate but he was free to say whatever he wanted about her. She was

concerned that he would say she was a monster, as he had told everyone else. It was pointed out that had said that she hoped the boys remembered what really happened and not the lies.

191. She was asked about her comment that he had dragged her dead mother's name who supposedly had 'Munchausen by Proxy', when in fact, it was her brother who had said that he was put in a wheelchair, when it was not needed. The information came from her brother and F was asked about it who said that he knew nothing about it and said a neighbour had mentioned it. It was another example of how she sought to blame F for things without just cause.

192. The message continued to say [865], 'that there are people out there know the real truth', by which she meant about his controlling behaviour. It was also put that she had written that, 'it was far from the truth that she hurt the boys, and it was F that was making her out to be a liar'. It was pointed out that the case was put by the Local Authority based on the medical evidence. She was asked why she just blamed him, and she said her anger in the message was directed towards him 'for the last 17 years'.

193. The cross-examination continued in the same vein, drawing out that the messages were intended to deflect blame from M and point a finger of blame towards F, whilst failing to accept her own actions. Much of what came out in the messages were not included in her several statements filed within these proceedings, nor had she told the assessor (despite her assertion that she did so) nor to the Guardian.

194. She was asked to compare those suicide notes to that the suicide not that she has prepared on the 23rd June 2024 [C120]. She said she was 'sorry for all the pain and suffering she caused'. She explained that she was referring to emotional pain she caused by her suicide and what she was accused of doing to Y. She commented that 'she was taking full responsibility for everything'. The note said that F 'has nothing to do with what had happened to Y and his ill-health and F is unaware of what I have been doing'. She denied that this was a genuine acceptance that she had hurt Y. She said she wanted the boys to live with a parent and felt this would help. On her version, she wanted the boys to think she had hurt Y, when she had not. In my judgment, which was preposterous suggestion. It is in stark contrast to what she now says was the motive for

the most recent suicide notes, which was to tell the truth in her last message on earth (by exculpating herself and painting F in a bad light and to blame him for her mental health issues).

195. She claimed that they had discussed exaggerating Y's symptoms for the first year and a half of his life and after that it was an understanding between them that this would continue. In her statement of the 21st February 2025, she stated they did that from around 4 years of age. This was an inconsistency. It was put that this was made up and F knew nothing about the exaggeration. She claimed not to understand how 'only she was being questioned when F played such a big part in their lives during Covid and recently'. F claims that he knew nothing but lived in the same house and she found that 'frustrating'. In fact, she had not mentioned his role until the 21st February 2025, when her statement was filed and therefore this was a late narrative. She said that she had kept his name out of things to ensure the boys went to live with a parent. Again, I find that she lacks credibility and was merely trying to spread the blame.

196. In the June 2024 [120] note, she also stated that 'F and my family have only ever supported me and followed any advice and guidance.' She confirmed that was true, even though it contradicts her current assertion as to his part. It went on to say, 'whatever she told F that needed to be done he tried to do it.'

197. She also added, Dr Thomas has only ever acted on what she had said. In oral evidence, she agreed that she deliberately misled Dr Thomas. She also mentioned that F 'is a fantastic dad and only has the boy's best interests at heart'. She accepted that was true. It was another contradiction to the person that she was now calling 'a manipulator, a bully, a thug, an abuser.' Again, it undermined her credibility.

198. M said she was trying in that suicide note to say what we all wanted to hear, to ensure that the boys lived with F. In my judgment, this note was the only time that M has accepted responsibility for what she had done. It is a stark contrast to the Facebook messages around the 8th March 2025, which were also meant to be her final word. In my judgment, the former, on balance, is likely to be more dependable than the latter.

199. She was asked about how much F knew about Y's condition and the deceit. It was suggested that he knew nothing and took her word for things. She accepted that he did not say much in any meeting. He was also shown YouTube videos of how bad the condition was by M. In my judgment, this was stage management by M, to show F how bad Y was. However, this was all because of an induced state. What it reflects is that F was not mindful of M's cruelty and deceit.

200. She was challenged as to the quantity of sexual contact there had been since their separation. She maintained her position that there were several occasions. She accepted that she wanted to get back with him and he did not, and she tried to use sex as a way of getting him to return to their relationship. His initial case was that they had sex once in October 2024, however in his live evidence he accepted on earlier occasion.

201. She was also challenged on her account that F had squirted Midazolam down the sink. She maintained he did. In my judgment, I preferred the evidence of F that this never happened and all he was tasked to do was take out the black bags that had been filled by her. This was likely an attempt by her to drag him into sharing blame.

202. She accepted that she did everything for the children and when he gave up work in February -April 2023, it was after that she expressed that she felt that she needed exclusive care of the children. In her statement July 2024, she says that F was doing more after Summer 2023, even administering medication which gave her relief. These are more inconsistent accounts. M tried to say it was that state of doing everything led to her mental stress. The mental health assessment professionals were told at this time, that she had not even asked him to take on more responsibility but would welcome the same. It was put that she was so negative about him in the assessment that the professionals invited him into the meeting, because it was felt that he was not doing anything and that there were communication difficulties. The assessors felt that he resented care of the children being forced upon him by her suicidal behaviour. Again, the content of her statement is a lie to place more blame on F.

203. In 2023, when she was having seizures, she claimed that F stepped up to look after the children for a day or two. M said, there were periods of weeks when she remained in bed for much of the time. He would give the evening medication, but only

when directed by her. It was put to her that she remained the main carer for Y throughout and she accepted that she did most of the night care and throughout most of the days. Again, it was an inconsistent account.

204. She was taken to her July 2024, statement [C128], where she had stated that F suggested that she re-wrote her suicide note to remove those parts where she accepted responsibility. This was inconsistent to what she told the parenting assessor which was that she could not recall what he asked her to re-write her note. It was suggested that this was all a lie, and it was pointed out that F had already told the social worker about the original note and that M had properly taken full responsibility and had since tried to resile. In my judgment, M lied about this event of F trying to get her to change the note. It was an attempt to try and distance herself from what was her written confession to the wrongdoing which is central to these proceedings. Her suggestion that he wanted to double-cross her and produce an amended suicide note to show she was a liar, made no sense and was a clear lie of significance. It shows how she is prepared to manufacture accounts to manipulate a more favourable outcome.

205. Mr Stephenson cross-examined her about the marital relationship and roles within the marriage and the fact there were 7-8 separations and reconciliations. There was a lack of clarity over the number and degree of these separations. M has not been consistent in providing the history of these separations. The point made on behalf of the Guardian that neither parent told the parenting assessor about the recent separations or about the sex they had at the end of last year. She denied that they had spoken about what to omit to the assessor.

206. There was also discussion as to situations where M accepted providing Y with Midazolam (only twice, when he was having an alleged seizure). I find this to be another lie. The evidence overwhelmingly shows that M was using the drug to induce symptoms which mimicked episodic ataxia, whenever it suited her. She was asked about Y telling the school that she had provided him with an orange medicine and rubbed it into his mouth? The only medicine which was given in this way was Midazolam. The colour of the injection of the drug at both ends is orange. In my judgment, it is safe to infer that Y was describing being provided with Midazolam by his mother. This does not accord with her evidence that she administered the drug only

twice during seizures and therefore when Y would have been unaware of the same and undermines her account, which I find wholly lacking in credibility.

207. She denied that when Y was seen in very few instances by professionals in an alleged episode that she had provided him with Midazolam. She denied that she had sought for respite in a children's hospice to make it look like he was near death. She denied that she insisted on a Gtube to make it look like Y's condition as worse. In my judgment, all these assertions have a solid evidential foundation and are on balance, true.

Father

208. F denied that he was complicit in what was happening to Y. He accepted that M was administering Midazolam to Y to induce symptoms (which was unknown to him at the time) and was misreporting and exaggerating other symptoms to professionals. He denied that he was part of any discussion around the latter. He believed that Y had a serious condition because that was what was being told by M and the doctors. He always felt that she was doing her best. He felt angry and upset at being informed that his boy was sick for 7 years, when there was nothing wrong with him.

209. He said he saw the episodes sometimes, but he was well otherwise- 'he was just like any normal child'. He was not present in the videos, save for one. Those would be shown to him prior to any appointment. When he looked after the children alone, e.g. when M had surgery, he provided only the night medication and Y was always fine.

210. He denied being violent towards M and had no intention of resuming a relationship with M.

211. At the meeting on the 26th April 2023, [R164] he was called into a meeting between M and mental health practitioners. He was not resentful of being asked to look after the children and did not say that. He said it felt like it was an ambush, and he was being attacked for being the cause of M's mental health issues.

212. He agreed they separated many times in their 17 years, mostly these were short breaks and the longest was a month.

213. He agreed that he felt that Y was falling behind his peers and he felt that it was best that Y taken out of mainstream schooling. M had shown him other things his peers were doing, and Y could not. He required extra help, and he felt that he was not in the right educational environment at the time.

214. He accepted smacking X a few times, but did not believe he ever left marks. He denied he ever smacked him in the way M described.

215. When he and M separated in 2024, he returned to the home regularly, but did not have sex with her, as she alleges, save twice, the last time in October. He returned to the home to wash himself in privacy and clean his clothes and see to the dogs. His living environment was very poor at this time, he had been effectively homeless and was living in a shelter at one point. She would often ask him to resume the relationship which he turned down.

216. When he was cross-examined by Ms Hughes KC, he stated that he did not see an 'episode', until he stopped work in February 2023, unless it was pointed out to him or was shown a video. Most weeks she would point out him having an episode- whether he was wobbly, slurring or hands had a tremor, these were minor. In his initial statement [C109], he claimed that in the earlier years before 2020, "I worked a lot, and I didn't see the episodes. I only saw what M pointed out to me. So, he had a tremor in his hand, or he was having a bad day". He did not say to the doctors, that apart from these occasions, he had seen nothing wrong with Y until 2023. He accepted that was a significant failing. What was of note was that there was no explanation for the failure, merely an acknowledgement of failure.

217. When he was at home at lockdown in 2020 (11 weeks), he accepted he saw nothing untoward with Y but of significance, he again, failed to mention that to any professionals and he did not challenge M's accounts of regular episodes. There was no particular reason why he said nothing about that period when he saw nothing wrong with Y, which would have been good news to impart but also would have assisted the clinicians. In my judgment, it is also likely that this salient information from a parent, combined with the evidence of the school and OT that they did not see the 'episodes' may have led to a far swifter determination that this was a case of FII. F's actions in

remaining silent about matters of import of this nature, were acts of negligence on his part.

218. Taken to a DLA form [Z144], he was asked whether that had been read to him in advance of its sending, which he denied. This was in March 2019, a year before lockdown: “my son needs constant supervision night and day due to his condition and the volume of the seizures needs constant monitoring. He stops breathing and it's a constant battle with himself and he draws blood when he hits himself in the face.” F admitted he saw none of these behaviours. He accepted that he knew M was applying for DLA. He did not know what she was putting down and he trusted her to be accurate. He confirmed that Y did not need constant supervision. Fron his evidence, and based on his experience, until 2023 he was a perfectly normal boy from what he saw. He accepted that the DLA application was ‘a complete pack of lies’. Of course, the 2021 Guidance makes it clear that one of the motivations for FII in a parent may be to obtain benefit. In this case, the deceitful application by M for benefits for Y were in part the motivation for her actions, but not all. I accept F’s evidence that he left the form filling to M and it was on balance unlikely that he was unaware of what was written.

219. After lockdown, he returned to work in mid-July 2020, working 9-5pm and weekends. He saw no episodes from then onwards unless they were pointed out to him. If M was unwell, he would from end of 2022, work school hours. In 2022, Y had his NGT inserted and that led to the issue about that being used in school by staff. His understanding was that he was only to be fed during episodes via tube. This was not the information passed to the school by M, who had insisted that they used the tube to feed him and provide medication, daily. F accepted that he knew tube feeding was only required when Y was in an episode. He was unable to explain why he did not correct the school’s understanding, he simply said, it did not cross his mind.

220. He accepted that there was no reason why he could not have intervened and sent Y to school when he was well, and thus, when he did not need feeding via tube. He responded that, he ‘did not know why he did not say anything. Y lost much schooling as a result. It was a big failing in his parenting, he accepted. He also accepted it was not because he felt unable to challenge his wife. In my judgement, this feeds into the

overarching finding that F was negligent in his acts and/ or omissions and that let to failures to protect Y from more significant harm.

221. In January 2023, it was agreed by the parents that he should come out of school, because he was falling behind. He accepted that he did not make the connection that Y had missed most of the previous year's schooling and that probably explained why he was falling behind. He accepted that was another failing. He could not answer properly the question, why he did not challenge M? He said that he had difficulty in challenging M, after he expressed initial challenge to the insertion of the NGT, which was ultimately supported by the doctors, and he felt that he had made Y's situation worse. In my judgment that was not a reasonable explanation. His decision to challenge the NGT at that time was supported by the treating clinician. If anything, his resistance meant that Y was free from the tube for a longer period. It is more likely than not, that he found challenging M difficult because of the dynamics of the relationship, where she is clearly forceful in her opinions and was more clued into what Y needed from a medical perspective, because she was in complete charge of that situation.

222. It was suggested that he must have known as time passed, that M was exaggerating the situation, by not telling the school the truth about his not needing feeding via the NGT every day. F accepted that with hindsight that was correct but again offered no explanation as to why he said nothing, other than 'he felt that he might undermine her'. This last response may give a likely explanation for his weak position – M's mental health issues must have been difficult to handle, let alone juggling work commitments and caring for two boys, one of whom on the face of it was very sick.

223. In January 2023, he worked part time before giving up work entirely in February 2023. In his statement [C109] he says: "It was after I gave up work…. that I started to see more. He would have wobbly days, would slur his speech and the colour would drain from his face." He confirmed that Y came out of school soaking on 'a few occasions' but these were what M mentioned to him, and only once did he collect him from school himself, when he was wet. He could not say whether that he had an episode, nor was he clear when this occurred.

224. He accepted that he had never seen a two-week episode, as M suggested occurred, nor a 4-day episode. These were raised often in the meetings, but he never informed the meeting he had never seen that. He had no explanation why he did not impart that information.

225. In December 2018, there was a meeting with Dr Hayman in which M first mentioned NGT and the response was that this was a last resort. He told the meeting he wasn't happy either. The next time it was raised, was when the SaLT Team attended the home, to assess safe swallow during an episode and found no issue. He said he was unaware of that and was reliant on what M had told him. He claimed that he never opened a letter or read a letter from the professionals. It is another failing on his part but is indicative of his general lack of interest in fully understanding Y's situation.

226. There was a text exchange [C852]- about the NGT at the end of 2021, where he acquiesced to the tube based on what was Dr Thomas' changed view towards application of the tube.

227. He accepted that that he was at home in lockdown or else had the evenings and weekends around the home and on his account, Y seemed perfectly fine. M says to F in that text: 'sorry to be the bearer of bad news'. F responded they 'should really expect these things'. M said, she 'feels that you're blaming me' and his response was: 'I'm not blaming anyone…'. He went on to refer to the appointment in December 2018, when M raised tube insertion for the first time. F confirmed that her suggestion had come out of the blue, in that meeting. He resisted at the time, and they had words later about it, and the text explain 'it felt like he was being pushed into it at that time'. He explained that he did not feel Y needed the tube in 2018 and it was suggested to F that it must have been obvious that M was pushing for some medicalization of their child that was unnecessary. F responded that he did not think M had agenda, he was just recalling how he felt. He was asked whether this text exchange mean that he had felt that she was pushing it again and that he was manipulated by her. That led ultimately to his acceptance of the NGT, on the basis that it was supported this time by the medics. However, F failed to put into the equation for Dr Thomas, what he knew about Y and his lack of 'episodes' as described by M. In his statement, F had claimed that because of him, he had put the break on the tube being inserted for 6 months. He accepted that

this text message was the only conversation they had about the NGT. That was the extent of his challenge and there is no evidence that he 'put a break' on this issue. In my judgment, F was negligent in not providing Dr Thomas with the evidence and information he knew, so that a balanced decision could be made.

228. In 2023, M was struggling with her health and mental health. She stayed in bed some days, every couple of weeks. He was the main carer for the boys, even though he was working part-time in January. There would be 'wobbly days' and 'slurring'. Of note, he said that these were always when both were caring and there were no issues when he was caring alone for the boys.

229. In July 2023, there was a meeting with Dr Thomas [Q2694], where F was present, and the letter sent to the parents afterwards, records that Y was having 7 to 8 episodes a week. F denied the accuracy of that frequency but was unable to say how many with any clarity. He accepted that he did not step in to inform the doctor of the truth and that he allowed the exaggeration to taint the treatment. He agreed that M was difficult to challenge at that time through her own issues. It is another example of the negligent way that F allowed fabricated an exaggerated symptomology to be aired by M without challenge.

230. He clarified that the incidents he saw were mostly in the morning, 'possibly' after Y's morning medication was provided and would last around a few minutes to 45 minutes but not 2 hours, he would then sleep and after he awoke and was fine. This accords with the evidence of Dr Thomas.

231. Y could eat normally when not in an episode and in F's care, he was fed normally, with solids. In M's care, he was fed through the tube, 'possibly' when not necessary. Therefore, a different picture was seen between the care of M and F. Needless to say, this was not brought to the attention of professionals.

232. The children's hospice was told Y had to be fed through his tube 3 times a day. F claimed that did not realise that was being done. He thought it had been part of his plan only when he was unwell. He was unaware that M was over-using the peg. He had always thought that she was trying to help Y, even though she was feeding him through

a tube when he was not in an episode. He never challenged her on this obvious discrepancy in the plan, of which he was fully aware, and this was another extraordinary failing, especially when he was feeding Y differently. It encapsulates how much M dominated these tasks and decisions.

233. He was taken to [X27] a meeting on the 20th September 2023, where exaggerated description of degree and frequency were stated by M and not challenged by F. He was unable to say why he stayed silent, but accepted he failed Y.

234. He accepted that he may have hit X on the arm, as he told the school. He accepted that his text after one incident, showed that he lost his temper and smacked him 'probably in a rage'. He denied he did more than smack him on the bottom. He accepted that he requires work on how to manage boys of this age. After another incident, he sent a note to X telling him that he had accepted smacking him once. M had said they felt paranoid that the police were bugging the home, F refuted that he felt that initially but agreed that the police officer left a personal phone in X's room. He accepted that he thought the phone had been planted to video them. He then accepted that he and M were both very paranoid after a second police phone was left at the property. He denied that was the context of his sending a note to X and asking him to destroy the same. He was asked why he sent the note surreptitiously, if all the note had said was for him to tell the truth. He denied that he wanted X to minimise how often he had been struck by F. I did not find F's evidence credible on this point. In my judgment, he was lying, and the note was clearly sent to minimise the regularity and degree of chastisement. Clearly, F tried to influence X with the note, which adds to his dishonesty over this issue.

235. Between the 17th June and 10th July 2024, he now accepted they had sex once and therefore, the report of the Guardian was likely to be accurate. The sex in October 2024 was due to 'temptation only'. He accepted that he spent Christmas at the family home. To place this in context, these latter events were after the experts reports provided overwhelming evidence of what had likely happened to Y at the hands of M. Therefore, it was suggested that M and F were enmeshed. He accepted that he did not see the risk that M posed at the time, and he said he was struggling and was still awaiting Dr Ward's final report. However, even after that was received, he continued to phone M daily.

236. He agreed to the suggestion that he was in the very early stages of understanding the risk M posed and being able to challenging her and therefore, it was necessary for the Local Authority to have a Care Order and help through the months and possible years to follow.

237. Mr Thomas KC cross-examined about two matters. The first, was about discussions the night before every appointment in the early days, where it was suggested that they discussed what they were going to tell the doctors. He agreed M kept a note of what they discussed but denied they had conspired to exaggerate. He had no concerns then, about what M had been saying was being a fair representation of what they had seen, or he assumed she had seen. He did not feel there was any exaggeration of symptoms to ensure Y got the care he needed at the time. Again, I do not believe F is being entirely truthful about this topic. Whilst I can accept that there was a discussion and notes were taken, it is likely these fell short of an agreement to fabricate or exaggerate. However, as time went on and more and more fabrication and exaggeration was taking place to influence medical responses, it must in my judgment, have been obvious to him, that M was stating things that were just not accurate and he failed to correct her. This was a large failing on his part to protect his son.

238. The second matter was about throwing out medicines after stockpiling, which he accepted occurred on occasion. He said he assisted M occasionally, but he never saw any surplus Midazolam decanted into the sink and did not do so himself and he never saw her doing that. I accept his account.

239. Mr Stephenson cross-examined, and F accepted that he did not tell the Guardian that he had sex with M in June and October 2024. He denied speaking to M and colluding with her to keep these events secret. He accepted that he never confronted her about what the experts were saying had happened in their reports and that M was to blame for FII. He felt that M would not tell him the truth, in any event.

240. He denied that he had any suspicion of anything malign happening to Y.

<u>The Guardian</u>

241. On the morning of the final day of evidence 9 21st March 2025) the Guardian produced a Position Statement setting out her current view, having heard the evidence.

242. The Guardian indicated in her final analysis that in principle she would support rehabilitation of the children to F, and she expressed concerns in respect of the proposed transition plan [para 4.15 E755]. F's evidence had not alleviated the concerns, and in some respects has heightened them, which is a view that I share.

243. Nevertheless, the Guardian continued to support a plan of rehabilitation to F but maintains that this is not without risk. She felt that a Care Order is necessary and proportionate in this case. That was on the basis that the Local Authority will need to be actively assessing and managing the plan and they will need to be supervising Mother's contact. They will need to continue to assess F's ability to safely parent the children, his ability to remain separate from Mother and both parents' acceptance of any findings made by the Court.

244. In order to seek to ameliorate the risks, the Guardian suggests the following is necessary:

a) Work with F to include anger management and NVR training – this will need to have been completed ahead of the children being in his full time care;

b) PACE parenting work be undertaken with Father to ensure he is fully equipped to parent the children and help them recover from the harm they have suffered;

c) The current transition plan sets out that contact will remain at the same level for week 1 and that the focus will be on working with the family and the children to understand the outcome of the proceedings and any findings. The Guardian agreed with this and recommended that the plan will need to set out how contact will be increased thereafter in terms of days and times;

d) Supervision should remain in place initially as contact is increased so that Father's parenting can be further assessed. As the plan progresses, contact can move from supported to unsupervised but there needs to be supervision in the early weeks. A parenting worker has already been put in place, and they can provide support if any difficulties arise;

e) The plan should be reviewed on a weekly basis;

f) All steps and support must be provided to assist F in securing suitable accommodation;

g) Whilst it is difficult to predict how long the transition plan will take, as it will be dependent on the work with F – the Guardian envisaged a 6-8 week plan. The Guardian understands from the Social Worker that F has a holiday planned around Easter but clearly the focus needs to be on making this transition plan work;

h) The Guardian agrees with the other work and recommendations of the Local Authority; however, she would suggest that the assessment of the parents' (and the wider family's) understanding of and acceptance of the findings of the Court will need to be an ongoing process.

245. She then dealt separately with the plan for contact and those recommendations were agreed by the Local Authority.

246. Following receipt of that Position document it transpired that no party wished to cross-examine the Guardian. The Local Authority were prepared to amend their final care plan accordingly.

Submissions

247. Following the close of evidence on the 21st March 2025, I received written submissions by all parties on the 24th March 2025 and heard oral submissions on the 25th March 2025. Judgment was reserved and handed down on the 28th March 2025.

248. The main thrust of the submissions from each party were as follows:

(a) Ms Hughes KC on behalf of the Local Authority submitted that the Court safely make the findings against M contained in the Amended Threshold document. As for F, the whilst the Local Authority do not assert that he was aware that M was inducing illness by giving drugs, they continue to assert that he was aware that she was exaggerating and over a long period of time consistently failed to speak up, making him grossly negligent in his duty of care to Y. In respect of the over chastisement of X, it is submitted that F has not been entirely open and honest and minimised the extent and nature of the chastisement. As to welfare, it was

maintained that a Care Order was necessary in this case, given the history and dynamics and likely future issues around contact.

(b) Mr Thomas KC on behalf of M, accepted the Amended Threshold document reflects the evidential landscape upon which the court will make its determinations. Whilst M denies most of the allegations made against her, and all of the more serious ones, particularly inducement of illness, there is little she challenges in terms of the factual basis in which the Local Authority grounds its (challenged) threshold conclusions. M does not join issue with any welfare (as opposed to threshold) aspects of these care proceedings. She is realistic about the likely shape of the contact her sons will have with her for the foreseeable future. M does not seek to challenge the making of care orders nor the care plans. M accepts some elements of exaggeration, but she continues to believe that Y experienced genuine ataxic episodes and that these were witnessed by her, his father (F) and sometimes the professionals. M acknowledges fully the sheer weight of the case the Local Authority brings against her. She is acutely aware that the court is likely to make all the threshold findings sought.

(c) On behalf of F it was submitted that the Court the court cannot rely upon anything M says in relation to F being aware that she exaggerated Y's symptoms, and as such was complicit in what she was doing. In fact, it cannot rely on anything she has recently said about him at all unless it is corroborated from other source. Further, the court was invited to consider that M is a master manipulator, and F is gullible and accepted what his wife told him without much analysis, thus the failure to contradict her exaggerations of symptoms at meetings.

(d) Mr Stephenson on behalf of the Children's Guardian submitted that the Court could make the findings sought by the Local Authority.

My Assessment of the Parents

249. I take into account that M was a vulnerable witness, who gave her evidence from a psychiatric hospital following her recent suicide attempts. However, she gave her evidence in a calm and articulate manner, showing emotion only once or twice during. There were regular breaks to assist her participation, and she was supported by her solicitor. I have had the benefit of the recent psychiatric records and reports and bear those in mind when assessing M as a witness of truth.

250. I have been careful not to attach weight to her two recent suicide attempts. It cannot be said confidently that the only explanation for doing would be the guilt inevitable felt at behaving in the abusive manner alleged. There is a long and complex mental health history and previous attempts at her life.

251. That said, her evidence taken was wholly unreliable and, on many occasions, preposterous in face of the overwhelming evidence, as even she acknowledged it to be. Yet, she stood steadfast by her case that other than some exaggeration, she had not done anything to harm her son. She maintained that his symptoms were genuine and had no explanation for his rapid recovery.

252. The genesis of M's behaviour in this case, has on balance, a psychiatric component. There is some evidence which supports this to an extent, at least in the early days Y was unwell, as was set out in the unchallenged report of Dr Pabary. And that it was during this period M of low mental health that she began to view him as an unwell child.

253. There were also some signs which lead to the conclusion that M genuinely (but wrongly) believed had indicated that Y had some underlying condition and hence she exaggerated symptoms earlier on his presentation, to Dr Thomas and Dr Hayman. However, I do not accept the submission made by Mr Thomas KC that she came to believe that she (and others) were seeing ataxic symptoms. Those symptoms were only present because of her inducing them by injecting her son with Midazolam, when it was needed and no longer prescribed. It was a deliberate act to continue to seek that prescription and to inject him with it with the regularity that she did. She did so to convince professionals that he was genuinely ill and had a limited life span. All that must have been known to her and was, on the balance of probability, a mendacious act, repeatedly undertaken.

254. On M's own case, there were limited concessions to having made exaggerations, albeit borne of her belief that doing so would secure for Y better medical care/attention. That may have been the case in the very early days, but it cannot have been after she began to induce the illness and make ever more exaggerations and distortions of his

symptoms and needs. There was a financial benefit as a result of her actions, which was likely part her behaviour.

255. It was obvious that M was lying in her account of having not induced her son's illness by injecting him with Midazolam. There is no other explanation for what happened to this little boy over a period of 7 years. Doubtless, as I have stated, the reasons behind her actions have a psychiatric element. She has a long history of mental health issues and suicidal ideation and physical ill-health. It was obvious that she was struggling to care for her children. At some point, very early on in Y's life she started to fabricate and induce illness. She managed to hoodwink all the medical professionals for several years. As she stated in her evidence, she misled Dr Thomas by claiming that symptoms were far more regular and of greater duration. She clearly misled him that she had been inducing the illness in the first place, so that it was believed he had episodic ataxia. It led to the insertion of an NGT and then surgery to place a Gtube into his stomach. There were also a battery of invasive scans and tests over the 7 years. All for a healthy little boy, who has been deprived of a normal upbring and by dint of that his older brother who was told that his sibling would die young, has been significantly impacted on an emotional level.

256. Not content with all that, M pretended to the school and to OT and to anyone who would listen that he required greater care and accessories, such as wheelchairs and hoists, when none were needed. She provided false accounts of his needs to the school and to OT. To the school, she insisted that he required feeding and medicines to be administered via NGT. When they were unable to provide that she removed him from school and pushed for the insertion of a GTube. He was delivered and collected from school in a wheelchair, when none was required. The school saw Y as a normal energetic normal boy in school. They saw no episodes. M maintained that they were not meeting his needs, not noting episodes, all to justify her stance of keeping him away from school. This mean that he fell way behind his peers in his development. It also meant that an important safeguard was missing to challenge her narrative. I am satisfied that was the real reason behind her decision to remove him from school. All whilst claiming that he needed a specialist unit to meet his needs.

257. What is most troubling about M's actions over this lengthy period and the way in which she has run her case within these proceedings, is the unusual way in which she had done so. There is no insight or acknowledgment of the horrific acts that she pursued to make her child ill and make everyone believe that he was so sick, and he would likely have a short life expectancy. As an example of her behaviour to push for Y to be treated as a seriously unwell child, the day after the NG tube was fitted, M requested a gastrostomy tube [Q 437, pdf 442]. M described this as a "long-term situation" in her police interview [T 92; Supp pdf 296]. I agree with Mr Stephenson's submission, that this supports a contention that M wanted Y to be seen to have a long-term illness. There was no thought of the devastating impact this would have on Y, or his brother X.

258. The first sign of emotion in the courtroom was the Friday before her double suicide attempts. It was only at the point of Mr Tillyard KC's cross-examination of the social worker as to necessity for reduced contact, professional supervision and a cut in indirect contact, that she began to cry. Anyone reading the Facebook suicide notes, will see that she refers to F lying on that Friday about her and making things worse for her, so that she should be the only one blamed. It was then that she made additional allegations against F and his behaviour towards and her X. All this, despite her case remaining that she wished him to care for the boys.

259. In my judgment, this was another tactic seen to be used by M, which was one of deflection and falsely creating a narrative that she was the victim and had done nothing wrong. She could not see that in making these allegations against F, she increased the risk of the Court finding that the boys would not be safe in his care. It is another example of how she cannot prioritise these boys. She was more interested in creating the idea in the mind of her family and friends and ultimately the boys that she was a martyr, who was wrongly accused of these acts and that F should be blamed for her mental health troubles and suicide. Again, there was no thought on how that would impact on the children and their relationship with their father or the support that could be offered by the maternal family. M has shown that she is only able to think of her own needs and image.

260. Instead of owning up to what she has done, she deflected blame onto F. In her oral evidence, she was tested as to those claims that he was abusive and controlling

towards her. In my judgment, the court could not believe a word that came from her mouth. It was entirely self-serving evidence. She failed to see that what was best for the boys was for her to admit to what she did. Rather than that, she tried to call into question F's behaviour towards her. The cross-examination by Mr Tillyard KC, showed that the medical records undermined her allegations and that she had more likely than not lied about events for her own warped reasons.

261. What was striking was that M's oral evidence was mostly delivered in a matter-of-fact way. As she commented, 'she is very good at getting her opinion across'. That much is obvious from the way in which she misled the treating clinicians for so long. It was also observed in the way that she coolly denied all the assertions made against her by the Local Authority, despite the expert evidence, coupled with Y's immediate return to good health and active lifestyle. She simply commented that she could not explain that change in Y's presentation.

262. The very limited concessions she made as to the exaggeration of symptoms were the tip of the iceberg in terms of her culpability, and it merely highlighted how much of her decision making in these proceedings has been to save her own neck, rather think what would be best for the boys; namely, that they deserved a full explanation from her as to what she did and why these things occurred.

263. Even Mr Thomas KC, had to accept that 'M is on the back-foot in terms of her credibility with the court. On her own case, she lied in this fundamental way while trying to kill herself. On her own case (said itself to be a lie by others) she falsely sought a repeat prescription of Midazolam for Y, while wanting it to take herself (and did so). This claim rang untrue and was another lie. She admits various (albeit limited) exaggerations. She has no explanation for the various things she said about the clear liquid she administered to Y at the hospice. It is rightly pointed out by others, that on M's instructions no challenge was put to Kirsty Gibbs nor any other nurse required to give evidence about the conversation, in which it is alleged that M said she had a clear version of Sytron at home. M was asked in detail about what she had said about this wrongly administered medication (whatever it was) and had to admit that she simply had no explanation about why she had said different things at different times about her error'.

264. The inconsistent accounts about administering the drug to Y at the hospice, is a significant point to remember about the levels of deviousness in her behaviour. She was inconsistent in her statements and her evidence about the wrong medicine being given. The only conclusion that this court can come to is that these were an attempt to cover-up by her for drugging him to induce an 'episode', when under the care of professional staff, thus supporting her claims that the 'episodes' were genuine. It was not the first time she had done so, as I have indicated.

265. Ultimately, she was unable to offer any explanation for the significantly different presentation of Y from the time he left her care. She was unable explain what it is that accounts for Y going from where he was to where he is now (and has soon after leaving his parents' care). I agree with the submission made by the Local Authority, that the answer lies in the fact that M has thereby been successfully prevented from making false statements about his presentations and from causing episodes by drugging him from time to time with Midazolam. Whilst absolutely denying this as being the explanation, M has no alternative to offer the court. And as Mr Thomas KC, accepts on her behalf, 'she knows how that leaves her in an impossible position'.

266. There is one sad example that Y became aware of what was happening to him. Y's own comment to his teachers in January 2023, that M had given him some orange medicine in his mouth, which she had rubbed into his cheek. This is also only explained by the fact that she was giving him Buccol Midazolam [Q38]. In short, no other prescribed medication was administered in that way. It is safe to infer from this comment that her misuse of Midazolam had been a long-term issue. His comment also coincided with a day when he was complaining of being 'wobbly' for a short period of time – a symptom that accords with misuse of Midazolam.

267. Further, she controlled the narrative between the professionals. Symptoms of both seizure and ataxia were predominantly seen by her alone and reported as fact. She clearly misinformed and fabricated information to some professionals despite being given wholly different information by other professionals, sometimes just days or hours before. I agree with the submissions made by Ms Hughes KC that "M's misinformation fed an entire narrative between professionals. School was told that the children's

hospice had seen episodes. The OT had understood that the school were experiencing episodes. Dr Thomas was being told that episodes were extremely frequent or extended. Since the mother was the cog which fed the information, it seems that the professionals believed that other professionals had experienced the episodes which they had not seen. Of course there were times, such as in January 2024 in Dr Thomas' surgery and in March 2024 in the hospice, when the mother medicated Y to induce an episode to bolster the narrative".

268. This all shows the difficulties for any professional or other person in dealing with M in the future, and especially around contact. Everything she claims will have to be robustly challenged and independently verified. She cannot be believed implicitly, on anything.

269. As to F, he was a more straightforward witness. He was calm and measured in his demeanour and in my judgment seemed shattered by what has occurred to his family and very much wanted to put thigs right for the children. He was accepting of the need for a work to assist him being able to parent to a more attuned standard and was welcoming of the support that was part of the care planning under the Care Orders.

270. I have been careful in my approach to the evidence to avoid hindsight bias, when considering the evidence against each parent, perhaps even more so, with the issues around F's role and state of knowledge.

271. As to the main concept around F of his state of knowledge about M's inducement of illness and exaggeration or fabrications of illness or symptoms, in my judgment, on the balance of probabilities, it is unlikely that he was aware that M was inducing the ataxia-like symptoms by injecting Midazolam. Indeed, if he saw symptoms at the home, then in my judgment, these were likely induced without his knowledge to deceive him. Hence, why he noted that these episodes were in the morning and 'possibly' after M had given Y his medication.

272. However, not every episode reported by the parents could have been induced by Midazolam, there was simply not enough of it to induce the extent of episodes the mother was reporting, and the father was not challenging. Since Y has not had any episodes since being removed from his parents care the only realistic conclusion is that

many of these ‘episodes’ were simply fabricated. What, if any, was F’s role in that fabrication?

273. On this point, one must consider the factual backdrop and context of what was occurring and the roles at play. There is some modicum of merit in Mr Tillyard KC’s submissions, that all the advice being referred to was given to mother. That is not to say that father wasn’t there on some of the occasions when this advice was discussed but the doctors, and professionals, all agree they spoke to M. That was very much a common theme from all witnesses. Their understanding was that she was the parent who was taking responsibility for Y’s care. It is true that not one of them ever contacted him for anything or discussed any treatment or gave him, rather than M, advice.

274. The incontrovertible evidence is that he never dealt with the NG tube, or Gtube, nor was he involved with feeding him during episodes of ataxia.

275. However, what he failed to do, was to offer any challenge to M’s descriptions of frequency and degree of episodes over many years. He failed to tell the clinicians about his very different experience of caring for Y, in which there was no medication being provided in the morning and there was no negative impact, that he always fed him solid food, where M was not doing so. He did not see episodes lasting for days or weeks, all as described by M to the experts in his company. He sat silently.

276. It was submitted that he was a ‘gullible male’, but in my judgment, he could not have been a completely blind to what was occurring within the home. In my judgment, he knew at the very least, that symptoms were being exaggerated, even if he was taken in by the seriousness of the underlying cause. He had ample opportunity to observe, he was even the primary care for periods, and he knew there was a different presentation in his care and even in M’s primary care, but when he was present, to the picture being portrayed to the experts. Short of setting himself at odds with M, he also had important evidence that he could and should have provided to the clinicians and failed to do so. Subsequently, that impacted on the way that Y was treated. In my judgment, that is not malevolent behaviour, he was not out to harm Y, rather it is an act of negligence. These are acts of omission not commission on his part.

277. Further, F allowed Y to miss school for large tracts of time, without questioning M about her false reasoning and knowing, as he accepted, that feeding via tube was not a daily requirement. He failed to join the dots that Y was falling behind his peers because of lack of attendance rather than any cognitive issue or environmental issue. He also knew that Y did not need the wheelchair daily.

278. In my judgment, F cannot hide behind the fact that M was able to manipulate all the clinicians, and he falls into the same bracket. He does not. He was a present parent, on occasion primary carer. He was prepared to make judgments calls, such as not giving Y his morning medicine. The latter meant logically that either he knew it was not needed, or he was utterly negligent in believing that he needed it but decided against giving the same, because it was not something he liked doing. It is more likely that F was aware that Y did not need the medication.

279. It does fit with a pattern identified in his evidence that when he was caring for Y, he did not feed him via tube, he did not put him in a wheelchair, he did not medicate him. He must have noted there were no ill-effects. The only time that he chose to voice an objection was when an NG tube and an operation to fit a Gtube were proposed, F expressed his unease about those procedures. As Mr Stephenson submitted: 'In other words, when the proposed intervention for Y got serious, F became more uncomfortable. One interpretation of this is that F knew that they were not necessary procedures for Y'.

280. It is for these reasons that I did not find F an entirely credible witness on the key component of the case. He has more likely than not minimised his state of knowledge or at the very least not been honest about his suspicions which any reasonable parent would have had given the dichotomy between what he was observing, M's claims and Y's general presentation. In my judgment, it is on the balance of probabilities the case that F had some awareness of M's fabrication and exaggeration, but was unable or unwilling to challenge , and it would in all likelihood have been very difficult to challenge her, given her prolonged mental health issues and assertiveness over Y's illness and needs and her levels of deception and manipulation. Unfortunately, he took the easier path of acquiescing by silence, which was a failure to protect Y and would

not have been the actions of a reasonable parent, particularly given the length of time this was occurring.

281. To F's credit, in his live evidence he accepted his failings, as each was pointed out to him. However, it was a nonsense to have suggested that he struggled to see what more he could have done. When all the failings he admitted to, are added up, it amounts to grossly negligent behaviour on his part, in respect of his duty of care to Y, over many years, and which fell way outside the actions that would have been expected from the reasonable parent in his position.

282. As to the findings in respect of his alleged over-chastisement of X, F made limited admissions about having on times, smacked X on his bottom, when he had been naughty. He accepts that there have been occasions when he has done that having lost his temper. He does not accept that in so doing he has ever left a mark on X and there is no evidence that he has other than from mother in her very recent statements. There is the reference to X having complained to school that F smacked him on the leg in April 2022, but it is safe to infer that had a mark been present, the school would have recorded it. Further, the recording indicates that they accepted M's explanation that X was difficult to manage and let her address the issue at home, rather than make any formal referral. Again, one can safely infer, if the school felt this was serious concern, then formal safeguarding routes would have been taken. F says, that on this occasion in smacking his bottom he may have hit his leg.

283. Therefore, the Court is left with the very little evidence about the degree of chastisement, other than F's admissions. The main source of detail is M, and as I have discussed, these came later in the day and at a time when M was attempting to deflect some blame onto F. On that basis, the Court must be cautious about accepting her evidence alone. Mr Tillyard KC submitted that any finding against F under this heading to be limited to the extent of his admissions while his evidence. I am of the view that this is the correct approach, based on the evidence.

284. That leads to the next issue of F's secret note to X and what it contained and the reasoning behind it. The Local Authority submits that it was an attempt by F to limit any allegation by X around chastisement. X was never asked about it. The note no

longer exists. Therefore, we are left with M and F's evidence. Mr Tillyard KC submitted that both M and F said the same thing regarding the note, that it was not an attempt to close down X's allegations, it was a way of letting him know that he was free to tell professionals about the chastisement. In fact, M said in her evidence and had earlier stated to the Guardian, that the note made reference to F having admitted to smacking X 'once', ergo, the message to X would have been to follow that narrative, rather than provide a possibly more expansive account.

285. The court is left with scant evidence on this issue. The Local Authority must prove the allegations against F. They could have asked X about it, but they did not. I cannot rely on M's recent and inconsistent account. Indeed, earlier in proceedings, she had been saying that she never witnessed F harming the children [E349]. Her live evidence was that she saw him or heard him doing so several times.

286. I must also consider that when X was asked about chastisement generally, he stated to the social worker, that he has never been purposely hurt by F. He also felt very safe at home with his parents. Of course, that is contrary to his report to the school of that one smack. That discussion resulted from Y saying he recalled that F threw X into the fridge. It is of note, that X, M and F when questioned about this stated there was only play fighting and Y must have misinterpreted events.

287. At the very least, whatever the motive behind it, it was secretive communication at a time when F knew that all communication should go through social services. It is more likely than not sent with the intended message that F had accepted one occasion of smacking him and he should follow. The mischief in that note is that by encouraging X to be part of the secrecy, by telling him to say nothing and to dispose of the note may have done untold damage to X's perception of and relationship with the Local Authority.

288. In my judgment, the allegations of over-chastisement must on the available evidence, also be limited as outlined to F's admissions in his evidence.

289. Finally, the Local Authority also alleges that F has suffered periods of poor mental health which negatively impacted on his ability to meet the children's needs or recognise the mother's inappropriate behaviour in respect of Y's medical needs. They

rely on one reference in F's GP records {20th February 2023), where there is a phone triage, and he is complaining of mental health issues for 2 or 3 months. "He is getting angry quickly. He cuts everyone off. Thoughts of self-harm. Feeling alone and can't talk to anybody. Better off dead and his wife and children better off without him... Thoughts about the wife and her ex-partner and feeling paranoid about their relationship. Stressed and anxious and his mind is somewhere else".

290. There was no cross-examination on this issue and no other mention was made of the same. Mr Tillyard KC submits that the Local Authority has no tried to make a connection between the entry in the GP records and his ability to meet the children's needs. That said, it is submitted, that may well explain why, in 2023, when it is now being argued that he was not working and he was at home and so he should have been more aware of mother's deceit, that as a matter of fact he wasn't. It passed him by, which is rather the case that he presents.

291. Again, this was not an issue raised at the final hearing. There is no evidence linking that one incident to any failure to meet the needs of the children. Therefore, that allegation is not made out.

Threshold Determination.

292. I find that Threshold has been met in this case on the following basis:

1. The relevant date for consideration of the threshold criteria in respect of X is 30th May 2024, the date upon which protective measures were Implemented. Protective measures have been continuously in place since that date.

2. The relevant date for consideration of the threshold criteria in respect of Y is 26th April 2024, the date upon which protective measures were implemented. Protective measures have been continuously in place since that date.

3. On the relevant date, X and Y had suffered and were likely to suffer significant harm attributable to the care given to them by their parents not being what it was reasonable to expect a parent to give.

4. The harm suffered and likely to be suffered by X was physical harm, emotional harm and neglect.

5. The harm suffered and likely to be suffered by Y was physical harm, emotional harm, neglect and impairment of his health and development.

   In particular:

6. The mother induced illness in Y by administering medication to him with the intention of causing episodes of ataxia, slurred speech and altered behaviour on several occasions including 5th March 2024.

7. The mother fabricated and exaggerated illness in Y in that she:
   a) Fabricated or exaggerated symptoms of seizure in Y
   b) Fabricated, exaggerated or distorted symptoms of ataxia in Y
   c) Fabricated exaggerated or distorted symptoms of aspiration (the inhalation of food/ liquid into his airways) in Y
   d) Fabricated exaggerated or distorted symptoms of unsafe swallow in Y [Core PDF 336]
   e) Fabricated or exaggerated symptoms of selective or aversive eating in Y
   f) Fabricated or exaggerated symptoms of sleep disturbance in Y [Bundle 2 PDF 57]
   g) Fabricated or exaggerated symptoms of behavioural disturbance and developmental delay in Y. [Bundle 2 PDF165]
   h) Falsely informed professionals that he had a diagnosis of alternating hemiplegia [Core pdf 428, 666, 830]
   i) Falsely overreported to health professionals the prescribed use of antibiotics for Y. [E536]

8. The father was aware of the exaggeration, and he failed to correct them, or he was negligent in his understanding of and involvement with Y's health needs resulting in a failure to protect Y.

9. As a result of the matters set out in para 6-8 above, Y was subjected to:

a) Unnecessary and invasive medical treatments including
   (i) The use of a naso-gastric tube
   (ii) The insertion of a gastrostomy tube
   (iii) Exposure to Xray
   (iv) Investigations for safe swallow – video fluoroscopy.
   (v) Removal of gastrostomy tube
b) The unnecessary request for/ use of medical and mobility aids which were obtained under false pretences including but not limited to
   (i) Wheelchair [Bundle 2 PDF 207]
   (ii) Hospital bed with rails [Bundle 2 PDF162]
   (iii) Specialist buggy [Bundle 2 pdf 203]
   (iv) Hoist/sling [Bundle 2 PDF 171]
   (v) Outdoor covers for buggy
   (vi) Electric car [Bundle 2 pdf153]
   (vii) Helmet [Bundle pdf 2 207]
c) Unnecessary medication [E712]
d) Unnecessary periods of inpatient treatment and respite care at a palliative care hospice
e) Prolonged periods of school absence
f) Repeated unnecessary medical appointments.
g) Limited daily activity.

10. The parents have failed to follow medical advice consistently:
    a) They did not follow advice relating to the use of feeding plans.
    b) They failed to follow advice that Y should be provided with food during episodes of ataxia, resulting in him being denied food orally. [Core pdf178]
    c) They failed to follow medical advice about the restricted use of Y's naso-gastric tube and gastrostomy tube.
    d) The mother has administered medication against medical advice
    e) The mother continued to request and administer Midazolam to Y despite having been informed in December 2018 and April 2018 that the drug was not needed, and its prescription should be halted.

11. As a result of the matters set out above, X was likely to suffer physical and emotional harm.

12. X and Y have suffered emotional harm as a result of believing that Y had serious and complex health difficulties which required significant medical intervention.

13. X has suffered physical harm at the hands of his father by over chastisement, but that is confined to the admissions made by F that he smacked X on occasion, to the bottom or top of the leg, but without marking the child. These occasions were limited and only when X had been naughty, and F accepts there were occasions he did so when he was angry.

14. The mother has suffered period of poor mental health and suicidal ideation which rendered her unable to provide consistent care to the children.

293. With Threshold satisfied, the gateway to making public law order is open to the court. The Court must consider all powers available and only make orders which are necessary and proportionate and the least interventionist. The Court must consider the principle of No Order.

Welfare Determination

294. All parties agree that there should be a rehabilitation of the children into the care of F under Care Orders. Each party agrees that this case is exceptional and therefore Care Orders to a parent are necessary and proportionate. It is acknowledged by all that this is an unusual order when a child is placed at home, but I agree that this is an exceptional case (principles of Re JW (Child at Home under Care Order) [2023] EWCA Civ 944 applied) for the reasons I shall amplify.

295. Firstly, I agree with Ms Hughes KC's submissions that: "The manipulation shown by the mother throughout Y's life and seen at close quarters throughout these proceedings is at a level which is rarely seen. F has shown himself to be vulnerable to manipulation and pressure for the mother. He has also struggled to accept the seriousness of the allegations and the mother's part in them". Further, F has not always been entirely open about the nature and extent of his relationship with the mother and

there was enmeshment in evidence until fairly recently, when things turned sour at the end of February 2025, when M began to make allegations against F.

296. In fairness, he has moved on since then and is angry at what M did to Y for so long and the impact it has had on the boys. However, it is a real risk that once M is discharged from hospital that she will try and push her own narrative, as she did in the recent suicide note/ Facebook messages. That was orchestrated to manipulate a picture of her as an innocent, wrongly accused and to ensure that her family did not support F. There is no other familial support available to him. That would leave him and the boys vulnerable to future manipulation by M. He has also shown that he is easily manipulated by her, and he has shown a weakness to whistleblowing and has even acted in a secretive manner against the protective framework (the note to X). This is why Care Orders are necessary in this case.

297. The welfare decision in this case is not easy. It has troubled me to think that the boys are returned to the care of F, who failed for so long to be an advocate for them and who has struggled in caring for the boys, when that was thrust upon him. Further, there is the issue around the control of his anger and how that leads to chastisement.

298. However, I accept the submission made on behalf of the Children's Guardian, that the alternative welfare outcome for the children is bleak. The children, X in particular, are unlikely to accept a foster placement posing a real risk of placement breakdown, instability and potentially separation of siblings (depending on subsequent placement options).

299. Although the court has made very serious findings against both parents, I agree with the Guardian's analysis on welfare that there are essential factors that form part of the welfare evaluation and which when considered against the welfare checklist in section 1 (3) of the Children Act 1989, leads to the conclusion that the best welfare interest for the children is to be rehabilitated to F's care under a Care Order.

300. The key evaluation is that although I have been critical of F's failure to voice what he was seeing and simply acquiescing to the exaggeration and fabrication or 'going along with M', whether for an easier life or whatever may have been his reasons,

there is little doubt that M was the instigator for the fabrication and induced illness. It is highly unlikely that Father would seek to pursue any similar conduct on his own.

301. The parenting assessment upon F showed positive indicators in his capacity to care. The identified concerns and weaknesses, which have been heightened to a degree by the live evidence, as the Guardian suggest, can be ameliorated by the raft of work and support which is set out in the care plan and the transition plan. This return to the care of a parent will also accord with the wishes and feeling of the boys. However, I acknowledge that this is not without risk. These boys have been emotionally damaged by these events, and they may manifest that through difficult behaviour, which F has historically struggled to manage appropriately on a consistent basis. There is also the continued risk that stems from M's manipulative and egocentric behaviour and her attempts to influence the narrative and potentially try an inveigle herself back into the family. Contact will need to be carefully managed and that cannot be done by F alone.

302. The transition plan provides for rehabilitation to Father's care over 6-8 weeks with careful review and ongoing assessment. As part of the rehabilitation plan the Local Authority will need to review and assess how well it is going and be prepared to apply the brakes if there are issues, and F will be expected to take the lead of the Local Authority.

303. The proposals for contact between the children and Mother are a gradual reduction to once per fortnight with no indirect contact permitted. These will be professionally supervised. In my judgment, contact between the children and M will need to be very carefully managed for the foreseeable future. It is likely that she will not accept the court's findings and will seek to provide her own narrative to the children. She may seek to undermine the placement and/or any therapeutic progress the children make. She may seek to influence her family, has she had done already, not to support F, because she is driven by the concept that she has been wronged by this process and by F. That is wholly erroneous as a concept, but it is one M will likely continue to push, so desperate is she to cast herself in a good light. I hope that M can work out her mental health issues and that she can be prevented from any further attempts at suicide. The boys will need to be insulated as best they can be, from any actions of that nature.

304. There is no issue as to the work required by F as part of the transition plan, nor of the support that is required. Contact is agreed by all parties, in accordance with the amended final care plans.

305. I am, on balance, satisfied that the care plans/ transition plans and contact provisions best meet the welfare interest of the children.

Wider Safeguarding Concerns

306. During her evidence, I asked Dr Hayman how so many professionals could have been taken in for so long. I was concerned that there had been a breakdown in communication systems, so that those professionals who saw Y as a fit and well child, were manipulated into thinking that other professionals had a genuine experience of him being a very unwell child. Also, that contrary views expressed by school and OT in particular, were not given due weight. Further, there is an issue as to how M was able to obtain repeat medication for years after it should have been stopped.

307. I have already indicated that the Occupational Therapist should be commended for her professionalism and tenacity in raising her concerns and, despite being told by a senior consultant that she was mistaken, continued to pursue her unease for Y's safety.

308. It is even more concerning that after M was seen administering the wrong medication in a children's hospice, M's explanations could well have been accepted, so strong was Dr Thomas' view that she was entirely genuine. FII was rejected at two subsequent MDT's, despite that incident based on Dr Thomas' strong support of the parents. The occupational therapist pursued her concerns with her seniors and at an MDT which ultimately led to the sharing of pertinent information about Y's day-to-day presentation. Above anyone, she saved Y from more probably years more of significant harm from ongoing FII.

309. Having considered my concerns, the Local Authority and the Children's Guardian invite me to invite at the very least an audit/ review of processes to prevent this scenario from recurring and to encourage dialogue between the various bodies who might see a child in these circumstances.

310. To my mind, it is essential to prevent further cases of this nature occurring in the future that an even more robust approach must be considered and that is a formal review undertaken with the oversight of the Local Safeguarding Board. I am aware that this may not be a case which would fall into an automatic SUSR (Single Unified Safeguarding Review). To do so, the Safeguarding Board would need to be satisfied that the child has sustained serious and permanent impairment of health or development. I make this point, we have already seen X's reaction to the knowledge that he had been led to believe that his sibling was terminally ill, on a wholly false basis. What more will be the emotional reaction of Y, when he finds out the full details of what happened to him at the hands of his mother?

311. Further, this case consists of FII of some significance, over a long period of 7 years, with serious unneeded medical interventions, including surgery were occasioned. Experienced clinicians were hoodwinked into believing this was likely a rare genetic mutation, maybe not even seen before. There was a failure to ask the simple question, why was this not being seen by school or OT? Even when the latter was maintaining a challenge to the accepted medical position, with some force and with good cause.

312. In my judgment, there also appears in this case to have been some very significant and serious failings including repeatedly dispensing medication that was supposed to be stopped, for some reason no review structures identified this as an issue either within the GP, the pharmacy or with the treating Consultants.

313. There was a lack of critical analysis and inability to cross reference what other professionals, such as the school and OT may have been saying and indeed, rejecting or closing down safeguarding concerns, when they were properly raised on two particular occasions, even after what had been witnessed to happen on the 5th of March 2024 at the hospice.

314. This safeguarding process badly let down this little boy. He should not be further let down by a decision not to fully investigate what went wrong and why it went on for so long.

315. I therefore direct the Local Authority to invite the Local Safeguarding Board to conduct a review on the basis that the facts fall into the criteria to consider an SUSR.

The benefits of this system over an internal audit are that all partners would be involved and would have input. An action plan, if one is considered appropriate after the review, would have statutory force in that it would be submitted to Welsh Government to consider policy change. That is how seriously I consider this prolonged failure in an essential safeguarding mechanism and the risks to other children who may face a similar fate.

Conclusion

316. I am satisfied that a rehabilitation of the boys into the care of their father is in their best welfare interest, which is my paramount consideration. I am satisfied that Care Orders are necessary and proportionate in this case, given the background, the work and supported needed and also the likely issues which may arise around contact. This is an exceptional case, which necessitates Care Orders being in place to ensure the stability and safety of the children.

317. I therefore make the Care Orders in respect of both boys and endorse the Transition Plans and Amended Final Care Plans.

318. I direct the Local Authority to invite the Local Safeguarding Board to conduct a review on the basis that the facts fall into the criteria to consider an SUSR.

319. Because of the serious issues raised within this judgement I took the view that it is in the public interest that it should be published. This was canvassed with the advocates in advance of the handing down of the judgement. No objection was taken by any party, to its publication.

His Honour Judge Philip Harris-Jenkins.
Dated: 28th March 2025.