Neutral Citation Number: [2026] EWHC 2100 (Fam)

Case No: WD25C50034

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16 April 2026

Before :

MR JUSTICE KEEHAN

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P (A CHILD) (INTERFERENCE WITH MEDICAL EQUIPMENT)

Between :

A LOCAL AUTHORITY	**Applicant**
- and -	
THE MOTHER	**First Respondent**
- and -	
THE FATHER	**Second Respondent**
- and -	
THE CHILD (***Through their children's guardian, Jane Holdsworth***)	**Third Respondent**

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Paula Diaz and Joanna Thom (instructed by Susan Billy of Hertfordshire County Council) for the **Applicant**
Cleo Perry KC and Tara Vindis and Kate Lamont (instructed by Tom Trim of Osbornes Law) for the **First Respondent**
Nicholas Goodwin KC and James Norman (instructed by Catriona Allan of Goodman Ray Solicitors) for the **Second Respondent**
Richard Jones KC and Samuel Marks (instructed by Sarah Ashby of Machins Solicitors) for the **Third Respondent**

Christopher Poole KC who attended the hearing on behalf of Great Ormond Street Hospital for Children NHS Foundation Trust on 12-19 March 2026

Hearing dates: 9 - 27 March and 13, 15 - 16 April 2026

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JUDGMENT

This judgment was handed down remotely at 10.30am on 21 April 2026 by circulation to the parties or their representatives by e-mail and by release to The National Archives.

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

Mr Justice Keehan :

Introduction

1. The local authority issued these public law proceedings in respect of P, who was born in 2024. His mother is the first respondent, and his father is the second respondent.

2. P has been diagnosed with a serious life limiting condition and has spent most of his young life in hospital. From 6th January 2025 he was an in-patient at a hospital forming part of the Great Ormond Street Hospital Trust, hereinafter referred to as the hospital. An incident which occurred on 29 January 2025 caused the hospital to make a safeguarding referral to the local authority and to the police. This led to the mother and the father being arrested on suspicion of the attempted murder of P and of child neglect in February: they were released on bail the following day.

3. The mother and the father were only permitted to have contact with P under supervision as agreed by the local authority and in the presence of nursing staff.

4. These proceedings were commenced by the local authority on 31 March 2025. P remains an in-patient at the same hospital and the mother's contact remains supervised. The father's contact continued to be supervised up until the point in this fact finding hearing when the local authority made the decision not to pursue findings against the father in relation to an incident at the hospital on 5 February 2025. I indicated that since the local authority no longer sought any adverse findings against the father there was no longer any reason for or purpose served by his contact with P to be supervised.

5. The local authority contend that the threshold criteria of s.31(2) of the Children Act 1989 are satisfied on the basis of actions of the mother toward P during his treatment in hospital which have caused or placed P at risk of suffering significant harm.

6. This hearing is listed as a fact-finding hearing to determine whether the local authority have proved the allegations it has made against the mother. The mother denies all of the allegations made against her.

Background

7. P was born in 2024. Shortly after birth he experienced significant medical issues requiring neonatal intensive care. He was transferred from the hospital where he was born to the hospital where he remains an inpatient the same day as a result of his complicated presentation. He was the subject of several medical investigations. P required prolonged inpatient treatment across several hospitals during the neonatal period and early infancy.

8. P was discharged home in early June 2024 but was readmitted to hospital on several occasions during the summer of 2024 due to several complications. In July 2024 he suffered an acute deterioration at his local hospital, requiring emergency resuscitation and transfer back to the hospital where he remains as an inpatient, where he was diagnosed with a severe life-limiting condition. From that point onwards P required prolonged intensive care, including treatment via a infusion line.

9. Throughout the second half of 2024 P remained medically fragile. He underwent repeated tests demonstrating poor function. Although there were periods of relative stability and brief discharges home, he required frequent readmission to hospital. His parents were closely involved in his care during this period and spent extensive time with him during inpatient admissions.

10. By January 2025, P had been readmitted to the hospital and remained an inpatient from 6 January 2025 onwards. He was dependent on continuous intravenous medication administered through an infusion line. His condition was regarded as life-threatening and he was under consideration for further significant medical intervention should further deterioration occur.

11. Between 29 January and 5 February 2025, a series of incidents occurred involving P's infusion line:

    a. On 29 January 2025, P's medication infusion line was found to have been cleanly cut. The mother alerted staff to the damage. P was not receiving medication until the line was replaced;

    b. On 4 February 2025, the infusion line was found disconnected and trailing on the floor shortly after the mother had left P's bedspace;

    c. On 5 February 2025, the infusion line was again found disconnected while neither parent was present.

    These incidents occurred while P remained critically dependent on continuous medication. Concerns were raised within the hospital that the damage and disconnections could not readily be explained by accidental causes.

12. Later, on 1 November 2025 there was a further incident of P's infusion line being found to be disconnected when the mother was having supervised contact with him.

13. On 30 January 2025, the hospital made a safeguarding referral to the local authority, raising concerns about possible tampering with medical equipment and potential

fabricated or induced illness. Strategy discussions were held involving the local authority and police, and section 47 enquiries were initiated.

14. On 3 February 2025, the mother submitted a formal complaint to the hospital, alleging that nursing staff may have damaged P's line. On 8 February 2025, the hospital issued both parents with a Stage 4 Safe and Respectful Behaviour warning. As a result, the parents were excluded from the hospital and existing supervised contact arrangements were temporarily suspended.

15. On 10 February 2025, both parents were arrested on suspicion of attempted murder and child neglect. P was placed under police protection the same day. Bail conditions were imposed, restricting parental contact to supervised arrangements only.

16. Following the arrests, P remained an inpatient at the hospital Contact between P and his parents resumed in March 2025 under strict supervision by two contact supervisors at all times.

17. Care proceedings were issued by the local authority on 31 March 2025, relying on allegations that P had suffered, or was at risk of suffering, significant harm arising from interference with his medical equipment, failures in feeding and monitoring, and concerns of fabricated or induced illness. An Interim Care Order was made on 23 April 2025. Parental responsibility was shared with the local authority.

18. During the spring of 2025, plans were developed for P's discharge into the interim care of his maternal grandmother, who underwent a positive viability assessment and commenced medical training. However, P's condition deteriorated again in late May 2025, requiring re-initiation of medication.

19. On 5 June 2025, P underwent surgery. From that point onwards he became hospital-dependent pending future significant medical intervention, with an anticipated waiting period of many months.

20. An internal investigation conducted by the hospital concluded in June 2025. The report found no evidence of intentional harm or negligence by hospital staff and noted that no further line incidents occurred once parental contact became supervised.

21. On 7 October 2025 P suffered further medical complications which had an adverse impact upon his already delayed fine and gross motor skills. An assessment of P's motor skills undertaken on 4 March 2026 found he was functioning at the level to be expected of a 7 month old baby.

22. Throughout the remainder of 2025, the proceedings were case-managed in the High Court. Extensive medical disclosure was obtained, including independent medical chronologies. Dr Kate Ward was instructed to provide a paediatric overview, though her report was delayed. Police disclosure continued to be sought, including forensic analysis of the cut infusion line.

23. By early 2026, P remained an inpatient at the hospital, medically stable but critically dependent on hospital care. The parents continued to deny any deliberate interference with medical equipment. A fact-finding hearing was listed to determine responsibility for the line incidents and associated threshold allegations.

Findings of Fact Sought

24. The findings of fact sought by the local authority were amended at the conclusion of the evidence from the treating clinicians and the nurses from the hospital. The revised findings may be summarised as follows:

    a. the mother has given exaggerated and/or false and/or misleading information about P's health and medical condition both directly to health professionals and others and on social media:
        i. she repeatedly referred to P as a patient with a particular treatment plan when this was not the case and at times when this was not clinically indicated;
        ii. being fixated on a particular treatment pathway for a significant period of time prior to clinical indication; and
        iii. stating that P was on a list to receive future significant medical intervention when he was not; and

    b. repeated incidents involving P's lines:
        i. 29 January 2025: the medication line was found to have been cut with a bladed implement. The local authority alleged the mother cut the line, exposing P to risk of infection, interruption of medication and clinical deterioration;
        ii. 4 February 2025: disconnection of the medication line, alleged against the mother; and
        iii. 1 November 2025: disconnection of a medication line, alleged against the mother.

    The local authority relied on the frequency, pattern and circumstances of these incidents to assert a real risk of significant harm.

The Law

25. In relation to the findings of fact sought, I remind myself that the burden of proof is on the local authority.

26. The standard of proof is the simple balance of probabilities: *Re B* [2008] UKHL 35.

27. In *Re A (Children)* [2018] EWCA Civ 1718, King LJ made the following observations in respect of the discharge of the burden of proof:

> "57. I accept that there may occasionally be cases where, at the conclusion of the evidence and submissions, the court will ultimately say that the local authority has not discharged the burden of proof to the requisite standard and thus decline to make the findings. That this is the case goes hand in hand with the well-established law that suspicion, or even strong suspicion, is not enough to discharge the burden of proof. The court must look at each possibility, both individually and together, factoring in all the evidence available including the medical evidence before deciding whether the "fact in issue more probably occurred than not" *(Re B: Lord Hoffman).*
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> 58. In my judgment what one draws from *Popi M* and *Nulty Deceased* is that:
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> i) Judges will decide a case on the burden of proof alone only when driven to it and where no other course is open to him given the unsatisfactory state of the evidence.
> ii) Consideration of such a case necessarily involves looking at the whole picture, including what gaps there are in the evidence, whether the individual factors relied upon are in themselves properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.
> iii) The court arrives at its conclusion by considering whether on an overall assessment of the evidence (i.e. on a preponderance of the evidence) the case for believing that the suggested event happened is more compelling than the case for not reaching that belief (which is not necessarily the same as believing positively that it did not happen) and not by reference to percentage possibilities or probabilities."

28. In *Re A (above)* King LJ considered legal guidance in relation to issues of credibility, demeanour, and memory in the context of a fact-finding process in private law children's proceedings, and legal guidance from family and wider jurisdictions. She observed that:

> "32. I have in mind the guidance given by Baker J (as he then was) in Gloucestershire CC v RH and others [2012] EWHC 1370 (Fam) and in particular at [42] his point 7:

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

33. The reasoning of Baker J in Gloucestershire CC v RH and others [2012] EWHC 1370 (Fam) was approved by the President in Re M (Fact-Finding Hearing: Injuries to Skull) [2013] 2 FLR 322, [2012] EWCA Civ 1710 at [30]. More recently, the courts have looked at the issue of what can, in broad terms, be identified as the fallibility of oral evidence. The issue of the extent to which a court should rely on the recollection of witnesses and the fallibility of human memory first arose in a commercial setting through observations made by Leggatt J (as he then was) in Gestmin SGPS SA v Credit Suisse (UK) Ltd and Another [2013] EWHC 3560 (Comm) ('Gestmin') at [15] – [22], and more recently in Blue v Ashley [2017] EWHC 1928 (Comm) at [68] – [69].

34. In the Gestmin case, at [22], Leggatt J expressed the view that the best approach for a judge to adopt in a commercial trial was to place little, if any, reliance on a witness's recollection of what was said in meetings and conversations; rather factual findings were to be based on inferences drawn from documentary evidence and known or probable facts. This was followed in Blue v Ashley, where Leggatt J at [70], having rehearsed his own earlier observations in Gestmin, approached evidence of a crucial conversation in a way that was "[m]indful of the weaknesses of evidence based on recollection".

35. The Court of Appeal considered both of these cases in Kogan v Martin and Others [2019] EWCA Civ 1645 ('Kogan'). This was a case where the judge at first instance had wrongly regarded Leggatt J's statements in Gestmin and Blue v Ashley as an "admonition" against placing any reliance at all on the recollections of witnesses.

36. The Court of Appeal in Kogan emphasised the need for a balanced approach to the significance of oral evidence regardless of jurisdiction. Although it was a copyright dispute between former partners, the judgment was a judgment of the court with wider implications.

37. In relation to the treatment of the evidence of the Claimant, the Court in Kogan said:

"88. … We start by recalling that the judge read Leggatt J's statements in Gestmin v Credit Suisse and Blue v Ashley as an "admonition" against placing any reliance at all on the recollections of witnesses. We consider that to have been a serious error in the present case for

> a number of reasons. First, as has very recently been noted by HHJ Gore QC in CBX v North West Anglia NHS Trust [2019] 7 WLUK 57, Gestmin is not to be taken as laying down any general principle for the assessment of evidence. It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed. Earlier statements of this kind are discussed by Lord Bingham in his well-known essay The Judge as Juror: The Judicial Determination of Factual Issues (from The Business of Judging, Oxford 2000). But a proper awareness of the fallibility of memory does not relieve judges of the task of making findings of fact based upon all of the evidence. Heuristics or mental short cuts are no substitute for this essential judicial function. In particular, where a party's sworn evidence is disbelieved, the court must say why that is; it cannot simply ignore the evidence.
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> […]
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> 41. The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of oral and contemporaneous evidence will vary from case to case. What is important, as was highlighted in Kogan, is that the court assesses all the evidence in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another."

29. In respect of the value of oral testimony and demeanour Peter Jackson LJ in the case of *Re B-M* [2021] EWCA Civ 1371 observed at paragraphs 25 & 28 the following:

> "No judge would consider it proper to reach a conclusion about a witness's credibility based solely on the way that he or she gives evidence, at least in any normal circumstances. The ordinary process of reasoning will draw the judge to consider a number of other matters, such as the consistency of the account with known facts, with previous accounts given by the witness, with other evidence, and with the overall probabilities. However, in a case where the facts are not likely to be primarily found in contemporaneous documents the assessment of credibility can quite properly include the impression made upon the court by the witness, with due allowance being made for the pressures that may arise from the process of giving evidence. Indeed in family cases, where the question is not only 'what happened in the past?' but also 'what may happen in the future?', a witness's demeanour may offer important information to the court about what sort of a person the witness truly is, and consequently whether an account of past events or future intentions is likely to be reliable.

> Of course in the present case, the issue concerned an alleged course of conduct spread across years. I do not accept that the Judge should have been driven by the dicta in the cases cited by the Appellants to exclude the impressions created by the manner in which B and C gave their evidence. In family cases at least, that would not only be unrealistic but, as I have said, may deprive a judge of valuable insights. There will be cases where the manner in which evidence is given about such personal matters will properly assume prominence. As Munby LJ said in Re A (A Child) (No. 2) [2011] EWCA Civ. 12 said at [104] in a passage described by the Judge as of considerable assistance in the present case: "Any judge who has had to conduct a fact-finding hearing such as this is likely to have had experience of a witness - as here a woman deposing to serious domestic violence and grave sexual abuse - whose evidence, although shot through with unreliability as to details, with gross exaggeration and even with lies, is nonetheless compelling and convincing as to the central core… Yet through all the lies, as experience teaches, one may nonetheless be left with a powerful conviction that on the essentials the witness is telling the truth, perhaps because of the way in which she gives her evidence, perhaps because of a number of small points which, although trivial in themselves, nonetheless suddenly illuminate the underlying realities."

30. I remind myself in relation to lies told by a witness that I should take account of a revised Lucas direction. Accordingly, I should only have regard to a lie told by a witness if I am satisfied that there is no innocent reason for the witness to have lied in his/her evidence.

31. The Court of Appeal considered the application of a Lucas direction *Re H-C* [2016] EWCA Civ 136. McFarlane LJ emphasised the following at paragraph 100:

> "One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim.L.R. 251.
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> In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt."

32. I have also had regard to the decision of the Court of Appeal in *Re H (Children: Uncertain Perpetrator: Lies)* [2024] EWCA Civ 1261. I accept that the mere fact

of a lie being told does not prove the primary case against the party or witness who has been found to have lied to the court.

33. Findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on mere suspicion, surmise, speculation or assertion: *Re A (A Child) (Fact Finding Hearing: Speculation)* [2011] 1 FLR 1817 and *Re A (Application for Care and Placement Orders: Local Authority Failings)* [2016] 1 FLR 1.

34. There is no obligation on a party to prove the truth of an alternative case put forward by way of defence and the failure by that party to establish the alternative case on the balance of probabilities does not of itself prove the local authority's case: *Re X (No.3)* [2015] EWHC 3651 (Fam) and *Re Y (No.3)* [2016] EWHC 503 (Fam).

35. In relation to propensity, I was referred to the case of *S (Children: Fact Finding)* [2023] EWCA Civ 1113 where at paragraph 30 Peter Jackson LJ said:

> "I also consider that the judge was in error in relation to the issues of propensity and hindsight bias. The question of propensity or similar fact evidence arises where an individual's behaviour in other circumstances makes it more likely that he will have behaved in the manner now alleged: see *R v P (Children: Similar Fact Evidence)* [2020] EWCA Civ 1088, [2020] 4 WLR 132 at [23]. In that case, the question was whether a man's behaviour towards one partner was admissible in relation to allegations made by another partner. Here, the court was concerned with a sequence of events within the same family. Self-evidently, one finding about a parent's behaviour towards a child might be relevant to another similar allegation and there was no need to resort to the concept of propensity or to erect artificial barriers around the assessment of evidence. Similarly, the well-known concept of hindsight bias cannot deflect the court from making a common-sense assessment of the evidence as a whole, and I do not understand the judge's apprehension that the local authority was asking him to do something unusual or impermissible."

36. I was helpfully referred to a number of other authorities by leading and junior counsel in their respective closing submissions which I have read and taken into account. The following cases appeared to be most pertinent in the circumstances of this case:

    a. *Re JS* [2012] EWHC 1370;

    b. *BR & Ors (Three Families: Fabricated or Induced Illness: Findings of Fact)* [2023] EWFC 326; and

    c. *Barrow & Ors v. Merrett & Anor* [2022] EWCA Civ 1241.

I respectfully agree with all of the above authorities and I have taken account of them in my consideration of the evidence and in my analysis of the same.

Expert Evidence

37. Dr. Ward is a consultant paediatrician who was instructed to prepare a report on P's diagnosis and treatment and to consider whether there was evidence of perplexing presentation and/or fabricated or induced illness on the facts of this case. Dr. Ward's main report of October 2025 was supplemented by two further reports of November 2025 and March 2026.

38. In her main report, Dr. Ward considered whether P could have initiated the line disconnections and whether there was evidence that the disconnections had been caused deliberately. In respect of the former, she concluded:

> "In my opinion, it is highly unlikely that the incidents described (clean cut of the [line], breakage/holes leading to leakage and disconnections) could have been caused by [P] who was not yet one year old. Use of scissors would not be possible for a child of that age. I cannot envisage any action by a child of this age which would cause a breakage or hole in the line. In an older child, disconnection is potentially feasible but, in my experience and opinion, it is unlikely that the incidents described on the 4th and 5th of February could have been child initiated as he was highly supervised and care had been taken to connect the components of the line and seal with parafilm. The mother alleged that he may have bitten through the line. The incident on 29 January 2025 was forensically identified as being related to a clean cut and not a bite and a bite would not account for the findings of 21 January 2025 and 4/5 February 2025.
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> Child related activity may result in kinks in tubes or disconnection from the insertion site if not correctly secured. There was no evidence of either of these scenarios. Thus, in my opinion, it is highly unlikely that any action by [P] was the cause of these incidents."

39. In respect of the latter, she concluded:

> "The parents were seen as attentive and interactive with [P]. They were described as anxious and keen to receive information with regard to the likely progression and treatment required – understandable in a child with a serious and potentially fatal condition. They were resident at the hospital and the mother in particular was involved in all aspects of his care. At times, it was reported that she showed controlling behaviour; something which has been described in reviews of parental behaviour under these circumstances. Maternal observations at times differed from that of medical staff. There was focus on invasive investigations and suggestions for interventions such as [X] which had not been suggested by medical staff. There were a number of parental complaints about the

> care which [P] had received at the hospital both by individual nurses and collectively by ward staff. Later, clinicians expressed concern that parents were interfering with monitoring equipment, intravenous fluids and medication and [a type of] feed. This had implications for the effectiveness of treatment for his condition, nutritional status, possible dehydration due to inadequate fluids and potential failure to observe deterioration as a result of lack of monitoring. As stated in the discussion above, the [line] incidents observed over a period of 15 days remain perplexing with evidence on one occasion of the line being cut and on two occasions disconnection of lines which is difficult to explain other than deliberate disconnection. However, there is no direct evidence of any one individual being responsible for all of the episodes.
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> I have used the RCPCH guidance as the basis for my discussion on perplexing presentations/FII and commented upon specific evidence which reflects a progression from anxiety and exaggeration of symptoms to a focus on invasive interventions and those representing major decisions such as a particular treatment and a future significant medical intervention. In this case, [P] has a very serious condition which is not fabricated but symptoms and need for specific interventions appeared to be exaggerated with the mother in particular placing pressure on professionals to carry out invasive procedures. The RCPCH guidelines emphasise the importance of establishing the state of the child. There is no doubt about the serious nature of [P]'s condition but, by January 2025, there was evidence that parental perception and actions stepped over the line from anxiety to interference with equipment, delivery of drugs and fluid and nutrition which was potentially harmful to the child."

40. In Dr. Ward's supplemental report of March 2026 she reviewed a number of further issues in respect of [P]'s lines which had occurred in November and December 2025. She was unable to identify any specific trend or evidence of interference with the lines in these reported episodes. In concluding her report she observed that:

> "Having reviewed the additional chronology and statements, I would not wish to overstep my responsibilities as an expert. I accept that determination of possible interference with lines and identification of person or persons responsible is a matter for the Court. However, I would not wish to change the opinions and conclusions reached in my first report."

Medical/Clinical Evidence

41. I had the benefit of witness statements from a large number of clinicians and nursing staff who were responsible for [P]'s care in the hospital and/or worked with and supported the parents. I heard evidence from nine witnesses from the hospital and from the two workers who supervised the mother's contact with [P] on 1 November 2025. I intend to focus on the key witnesses to the events of 29 January, 4 February and 1 November 2025.

42. Nurse 1 was one of the family liaison nurses at the hospital. He worked closely with the mother and the father from P's admission on 6 January 2025. He would see and speak with the mother and the father almost every day. His role was to support the family. Indeed, the mother was noted to say at one time that she could not have coped without the father's and Nurse 1's support which he recalled the mother saying.

43. Shortly after P's admission to the hospital Nurse 1 recalled the mother saying that P was coming to the hospital to get particular treatment. It was put to him in cross-examination that the mother had in fact said that she was really worried that P would need this particular treatment. Nurse 1 was clear that this was not what the mother had said. He recalled the mother asking a few days later for a pass to enter the ward because the parents of long-term patients get one. Nurse 1 explained that P was not long term and only been an in-patient for a few days. He said the mother replied that "the other [patients with this particular treatment] have one" to which he explained that P did not have this particular treatment.

44. It was put to Nurse 1 that he had told the mother that P needed this particular treatment and the clinicians would need to move quickly. He denied making any such comment.

45. In his witness statement Nurse 1 had said the mother was obsessed and fixated by this particular treatment. He was asked if he stood by the use of these words. He said he did and added that it was effectively the same conversation that he had had every day with the mother.

46. I note that on 21 January Nurse 2, a clinical nurse specialist spoke to the mother about having posted on social media that P was on the list for a future significant medical intervention when he was not and the decision to place him on the list had only just been made. The mother reacted badly in this conversation which was reflected in the explicit and forthright comments she made thereafter in her messages about being taken to task by Nurse 2.

47. Nurse 1 was involved in the investigation that followed the cut or break in the line on 29 January 2025. There are two important points to note. First, he recalled how after the event the mother changed her possible explanation for the cut in the line from being that P had chewed it. She said it could not have been chewed to break because she had tried to do so but could not do it. Second, he referred to the receipt of an email from the mother on 30 January which was headed "Accident or attempted murder", in which the mother had accused Nurse 3 of accidentally cutting P's line, albeit a few lines later she said "a deliberate cut line is attempted murder".

48. Nurse 3 was the staff nurse responsible for P's care on his ward on 29 January 2025. Just after she had returned from her lunch break she heard the mother call for help and heard her say 'the line was cut'. The nurse found the medication line was cut. She had expected to find blood around where the line was severed, but there was none and the area was dry. The mother had clamped the end of the infusion line connected to a second line. Nurse 3 said the mother had suggested P had bitten the line and said she had seen the end of the line in his mouth. Nurse 3 was clear that the line was too thick for P to have been able to bite through it and the end of the line was not long enough to have reached P's mouth: it had been severed about 5cm from the connection to the line.

49. Nurse 3 then replaced the damaged line and re-started the infusion of medication. She described how a short time later she was sorting out P's lead cords with the assistance of the mother when the mother cut a lead cord with a pair of scissors and made a comment to the effect of 'look now we are all frazzled'. The nurse did not know from where the mother had obtained the scissors.

50. It was put to Nurse 3 in cross-examination by Ms Perry KC, on behalf of the mother, that the mother had said that the line was broken when she had called for help. The nurse was clear that she had heard the mother say 'cut' not 'broken'. She accepted that her account in evidence that the mother had twice called for help was contrary to what she had said in her statement, but she confirmed that she had heard the mother call out for help twice

51. The nurse accepted that earlier in the day, well before this incident, she and the mother had each assisted to put gauze around the connector to protect P's skin as the mother preferred and that she had used scissors to cut the gauze. She described them being on either side of P's bed and the cut to the gauze had been made well away from the line. She then said that connector had been placed on P's arm and his baby grow was then done up.

52. Nurse 3 accepted she was very busy that day and been caring for another patient as well as P. She had not had time to complete the nursing shift plan for that day. Nevertheless, she denied being responsible for the cut to the line.

53. On the same afternoon the mother repeated the account that P had bitten through the infusion line to Nurse 4, a senior staff nurse, involved in the care of P.

54. Nurse 5 was one of the staff nurses responsible for P's care on his ward on 4 February 2025.

55. Nurse 5 said in evidence that she had checked the line at 6pm by physically handling it and all was well. Parafilm had not been used to secure the connector and the use of parafilm for this purpose was not standard practice. She said the mother then

returned to the ward. She looked visibly upset after taking part in a psychology session. She gave P a cuddle and then put him back in his cot and left the ward still upset. From CCTV it would appear the mother left at about 6.15pm.

56. At 6.20pm Nurse 5 noticed the line was dangling from the infusion pump and had become disconnected. She acted to remedy the position. The mother then returned to P's bedside. Nurse 5 said that the mother scoffed, smirked and then become tearful. She said she would be blamed and that she "didn't mean to disconnect it". She did not pursue this. She sought to de-escalate matters and was worried about the mental presentation of the mother.

57. The nurse confirmed that if the line was not connected correctly it would spring apart. The connector needed to be twisted to make and tighten the connection. She told the court that a line disconnection had never happened in her experience.

58. Nurse 6 was the senior staff nurse looking after P on 1 November 2025. She described the position of the two contact supervisors in the bay by P during the time the mother was having contact with P. The mother was sat on the floor on a playmat with P on the floor sitting or lying between or around her legs.

59. Nurse 6 explained that before the disconnection of the line the connector was on P's right forearm with one end of it sitting at or close to P's wrist. The contact began at about 2pm and the line was checked when P was placed on the floor with his mother and then again at about 2.15pm. The line had been re-positioned because one of the supervisors had seen the line in P's hand. The nurse was alerted to the disconnection by the mother at 2.50pm. The parafilm on the part of the connector closest to P's wrist was intact but the parafilm at the other end was unravelled and opened up.

60. The mother was distressed by the disconnection.

The Evidence of the Mother and the Father

61. The local authority had originally asserted that the mother or the father were responsible for an infusion line disconnection which took place in the evening of 5 February 2025. After hearing evidence from the member of staff responsible for P's care that evening, Senior Staff Nurse, Nurse 7, it was clear that the mother had not been at the hospital that afternoon or evening and the father had left the hospital at least one hour before the time the line had last been checked and when the disconnection was found. This allegation was not then pursued by the local authority.

62. This episode was the only event in respect of which findings of fact were sought against the father. Therefore, it was agreed between the parties that there was no

need for the father to give evidence or to be cross-examined.

63. During the course of the mother's evidence, I had well in mind her vulnerabilities and the enormous great stress of being a parent with a seriously ill baby who had been unwell for the whole of his life, as a set out in paragraph 83 below. The mother was provided with breaks in her evidence every 40 minutes or so for 5 or 10 minutes to enable her to collect her thoughts and to give her a short respite from the pressure of giving evidence in court.

64. At the outset of her evidence she described the journey P, she and the father had endured since his birth. Her love for and devotion to P was palpable and she spoke movingly of him as a baby and as a growing child. She said she had been upset at the idea of P having to undergo significant medical intervention. She knew the plan in the hospital was for P to be maintained on medication, to assist his functioning, for as long as possible and to enable him to put on weight which was an essential prerequisite for him to be placed on a particular treatment plan. She knew that the next stage, if the medication was not proving effective, was for P to receive a particular treatment pending a possible future significant medical intervention. She denied ever exaggerating P's condition.

65. The mother spoke about commencing psychology support sessions with a psychologist at the hospital in July 2024 when P was an in patient at the hospital. When P was re-admitted to the hospital in early January 2025 the psychologist at the hospital was off sick and unavailable. The mother did not resume her sessions with her until the end of January 2025.

66. In late December and early January 2025 the mother was becoming increasingly anxious about P's condition and wanted him to be transferred from a local hospital to the hospital to which he was subsequently admitted. When it appeared this was not going to happen imminently, the mother said she had telephoned that hospital, spoke with a receptionist and lied in order to be put through to a doctor with the intent of seeking to secure his transfer to that hospital.

67. In relation to her conversations with Nurse 1 about P and his need for a particular treatment, the mother initially said that she could not recall how these conversations had gone and then that he must have misunderstood what she was saying. However, when it came to the issue of her requesting a ward pass, the mother accepted she had asked him for one but that he had not responded to her. She then said he had lied in his evidence when he had said that the mother said the parents of the patients with a particular treatment had a pass. Shortly after this, when asked why she had posted a message on social media about P being placed on a list for a significant medical intervention when he had not been, the mother said that a play therapist at the hospital had told her that P was 'pipelined' for this particular treatment. The mother had never previously given this account in her police interview or in her

witness statements, although she did make reference to this in a message sent to a social worker on 4 February 2025.

68. In relation to her reaction to being taken to task by Nurse 2 about this social media post, the mother accepted she had sent explicit and forthright messages afterwards which conveyed her anger at being spoken to about her use of social media. The mother said she regretted her response.

69. When further cross-examined about her conversations with Nurse 1 about a particular treatment for P, the mother denied being fixated or obsessed about this but accepted that she was worried and anxious that if P deteriorated that particular treatment may not be available for him. When cross-examined on behalf of the guardian, the mother denied wanting P to receive that particular treatment or to be placed on the list for a future significant medical intervention, but she did comment that she was concerned that there were so many children ahead of P on the list.

70. In respect of the events of 29 January 2025 the mother agreed most of the chronology. She accepted the expert forensic evidence that P's line had been cut with a pair of scissors, she accepted that after the line had last been changed she was always at P's bedside, she accepted that no-one else had entered the bay area apart from Nurse 3 and on one occasion Nurse 4, who had checked the pump and passed parafilm to Nurse 3, and she accepted that she said she had seen P chewing the line. She denied calling for help by saying the line had been 'cut' and insisted she had said it was 'broken'. She disputed Nurse 3's evidence that the line had last been changed and the connector wrapped in gauze at about 12.40 and insisted this had happened no later than 10am. She accepted that she had clamped the end of the line to secure it.

71. It was the mother's case that Nurse 3 was clumsy and under pressure and that she must have cut the line when she was cutting the tape to secure the gauze around the connector, although she did not suggest that she had seen the line being cut. However, she accepted that the nurse had cut the tape to secure the gauze away from P's body.

72. There was an issue between the mother and Nurse 3 about whether or not the gauze was still wrapped around the connector when the line was found to be cut. I do not consider this issue to be of any great significance in determining the issue of who cut the line.

73. In respect of the events of 4 February 2025 the mother accepted that she felt low in mood when she had returned to the ward in the evening after a session with the psychologist at the hospital. The mother said she had felt she should not have sent the 'accident or attempted murder email' to the hospital on 30 January. The mother accepted she had had suicidal thoughts.

74. She accepted Nurse 5's account of events. She accepted that she had been upset when she returned to P's bedside after the psychology session at about 6pm and accepted that she had picked up P to cuddle him before placing him back in his bed and briefly leaving the ward at about 6.15pm. She accepted that when she returned some 5 or 10 minutes later after it had been discovered that the line was disconnected she had said to the nurse that she "had not meant to disconnect it".

75. Nevertheless, the mother denied she had disconnected the line, but she could not give any coherent or plausible explanation for making that comment other than to say that she did not know if she had done something. She did accept that she had asked the nurse about the twist lock action to secure the connector.

76. On 1 November 2025 the mother agreed she had supervised contact with P. She described playing with him on the floor and unwrapping presents for a celebration. She did not take issue with Nurse 6's account of the events of that afternoon in terms of her checking the line and then re-positioning the line after part of the connector was seen to be in P's hand. The mother accepted that it was her who discovered the line to be disconnected at about 14:50 and who called the nurse for help. The mother accepted in evidence that P had not disconnected the line.

77. Neither of the contact supervisors reported seeing anything untoward in the mother's interactions with P that afternoon and certainly no attempts or actions by the mother to interfere with the line.

Submissions

78. In their submissions on behalf of the father, Mr Goodwin KC and Mr Norman submitted that nothing new had emerged in the oral evidence concerning the events of the line disconnection on 5 February 2025 from that which had been known in February 2025. Therefore, the local authority should never have pleaded an adverse case against the father. The consequence of it doing so was that the father's contact with P had been restricted and supervised for the last 13 months.

79. I recognise the force in this submission and the father's wholly understandable frustration at the disruption of his contact with P who had been denied the opportunity of having a loving and caring parent as his primary carer over this period.

80. The local authority will need to reflect on the position it had taken prior to responding to these submissions. I will consider this issue at the welfare hearing.

81. I am enormously grateful to leading and junior counsel for their full and comprehensive closing submissions which each contain a thorough analysis of the

voluminous medical records and of the oral evidence given. I have read all of them with considerable care and intend no disrespect to their joint endeavours when I do not replicate their analyses in this judgment.

82. Ms Perry KC, Ms Vindis and Ms Lamont, on behalf of the mother, were keen to stress a number of important matters in the course of their closing submissions, namely:

    a. the court should be vigilant against the reversing of the burden of proof from the local authority to the mother;
    b. an examination of the mother's social media postings and phone records was imperative to appreciate what the mother did think and say about P's condition and treatment options in late 2024 and early 2025. These were not consistent with suggestions that the mother wanted P to have a particular treatment or, as it was called, 'doomscrolling' on the internet;
    c. the clear evidence of the mother's devoted and loving care of P;
    d. the lack of an obvious motive for her actions in cutting and/or disconnecting P's infusion lines; and
    e. the adverse impact of the mother's conditions and vulnerabilities on how she expresses herself and the perception of others about her comments and/or behaviours. It was submitted that the mother tended to catastrophise and to act impulsively in responding to challenges to her behaviour or conduct.

    I accept all of these submissions.

83. Mr Jones KC and Mr Marks, on behalf of the guardian, set out the reasons for and against the making of the findings sought by the local authority. In their analysis of the evidence they submitted that there were clear grounds for the court to make adverse findings against the mother in respect of views about P receiving a particular treatment and/or being on the list for a future significant medical intervention, the cutting of the infusion line on 29 January 2025 and the disconnection of the line on 4 February 2025. However, they did not support the making of an adverse finding in respect of the disconnection on 1 November 2025.

Analysis

84. There is clear and overwhelming evidence of the love, devotion and care which the mother and the father had and have given to P. The enormous great stress and pressure on the parent of a seriously ill child who has spent prolonged periods in hospital and whose condition has markedly fluctuated from day to day and week to

week cannot be overstated. I have well in mind the opinion of Dr. Ward on this issue.

85. When considering the mother's evidence I have kept in mind two key matters:
    a. her diagnosis of autism spectrum disorder and ADHD and the implications of both of these conditions on her ability to give evidence and to respond to questions; and
    b. the adverse impact on the mother of having a child with a very serious medical condition, whose symptoms and well-being has fluctuated on a regular basis and who has had to spend most of his life in hospital.

86. It is of considerable significance that the mother accepted that she had spoken with a receptionist and lied in order to be put through to a doctor with the intent of seeking to secure his transfer to the hospital. It is plain from the evidence, most particularly the mother's evidence, that she was under a great deal of emotional stress and pressure in January 2025. Although she may not have wanted P to be placed on a particular treatment pathway or to undergo a future significant medical intervention, she was clearly worried and occupied by the fear that if his condition deteriorated the particular treatment pathway would not be available for him.

87. The extent of her emotional turmoil and her ability to act impulsively or to catastrophise, is aptly demonstrated by her extreme and disproportionate response to (a) being spoken to by Nurse 2 about her social media posting about P being on the list for a future significant medical intervention, when he was not, and (b) the wholly intemperate email which was sent to staff at GOSH on 30 January 2025.

88. The mother left Nurse 2 and Nurse 1 in no doubt about her worries about and pre-occupation with P being a recipient of a particular treatment.

89. I found Nurse 1 to be measured and reasonable in his evidence. I gained no sense that he was recalling his discussions with the mother through the prism of subsequent events concerning the cutting and disconnection of lines; still less did I have any sense that he was embellishing his evidence or more starkly lying to the court. He believed, as the mother had contemporaneously accepted, that he had formed a good and supportive working relationship with the mother. The mother's account in evidence that she had felt Nurse 1 was avoiding her was in my judgement of recent invention. Where there is a dispute between accounts given by him and the mother, I have no hesitation in preferring and accepting the account of Nurse 1.

90. Likewise, I found Nurse 3 to be a frank and honest witness who readily accepted that she was working under pressure on 29 January 2025. She explained in some detail the changing of P's line at around 12.40pm and of the steps taken by her and

the mother to wrap gauze around the connector. I have no hesitation in accepting her evidence that she did not cut P's line whether deliberately or accidentally. On the mother's own account she was present with P at all relevant times on this date and did not see any action by the nurse which resulted in the cutting of the line.

91. It is agreed that the line was found to be severed at about 2.40pm. If Nurse 3 had been responsible for cutting the line when the line was changed and gauze was applied at about 10am, on the mother's account, or at about 12.40pm, on Nurse 3's account, it would have resulted in medication being pumped out of the line onto P and/or his bedding for a number of hours. The evidence of the nurse that upon attending to the severed line she found P, his clothes and bedding to be dry with no evidence of any leaking of medication was not challenged.

92. It is implausible in the extreme that P's line could have been severed for some hours without evidence of blood or a leakage of the drug and I reject this possible explanation.

93. I am satisfied on the balance of probabilities, indeed I am in no doubt, that the mother deliberately cut P's line.

94. It would be wholly inappropriate for me to speculate about her reasons or motivation for so doing. This is a matter I will have to consider at the welfare hearing.

95. The mother was in the same state of emotional turmoil on 4 February 2025 as she had been on 29 January, if not more so following her email of 30 January and her session with the psychologist at the hospital in the late afternoon of 4 February which had caused the mother some distress and upset. When last checked before the mother left P's bedside, the line was intact. Shortly after she had left it was found to be disconnected. On her return the mother accepted that she had said "I didn't mean to disconnect it" but cannot give any coherent or plausible explanation for her comment, other than she had disconnected the line which she denied.

96. I am well aware of and take full account that it is now agreed that the disconnection of the line on 5 February occurred without any intervention by either the mother or the father and remains an unexplained event.

97. It is agreed that the disconnection of lines is a rare and unusual event. I note an analysis of disconnected lines at the hospital between January 2024 and November 2025 recorded 59 events. The vast majority were found to have been the result of faulty equipment, a few others occurred when patients were being transferred on or between wards. Two occurred as a result of the actions of much older children. There was one episode for which there is no clear explanation but there is a benign working hypothesis. The other events all relate to P. The upshot is that lines can

disconnect, most likely because they have been incorrectly connected, but it is a very rare event.

98. In light of the disconnection of P's line on 5 February for which there is no explanation, is there a sound, safe and rational evidential basis for concluding that the mother was responsible for the disconnection on 4 February?

99. I regret to conclude that there is a sound, safe and rational evidential basis for finding on the balance of probabilities that the mother disconnected the line on 4 February. The mother was in a highly emotional state. She remained worried about P's condition and the fear that a particular treatment would not be available for him if he deteriorated. The disconnection was discovered just minutes after the mother had left P's bedside. There is only one plausible explanation for the mother's comment that she had not meant to disconnect the line and that is that she had disconnected it. I am wholly satisfied on the balance of probabilities that the mother deliberately disconnected P's line on 4 February 2025.

100. Once more, I will not speculate about the mother's reasons or motivation for so doing.

101. Given my findings about the events of 29 January and 4 February 2025 there must be a high degree of suspicion about the mother's role in the disconnection of P's line on 1 November 2025. The local authority submitted I should make that finding, whereas the mother, supported by the guardian, submitted that I should not.

102. I am greatly concerned about this event because of:

    a. my findings about 29 January and 4 February 2025;
    b. the clear evidence that P was not capable of doing anything to lead to the line being disconnected;
    c. the fact that the parafilm was unravelled at the end of the connector furthest from P's wrist; and
    d. it was the mother who noticed the disconnection.

103. However, I take account of the following factors:

    a. the mere fact that I have made two adverse findings about previous events are not of themselves probative about what occurred on this occasion;
    b. there had been a period of 9 months between the last disconnection on 4 February and this event;
    c. there was no evidence of the mother's well-being or behaviour at this time which was a cause of any concern;

d. P had by this time received a particular treatment in marked contrast to the circumstances of the two earlier events;
e. the mother was being supervised by two contact workers and whilst there may not have kept sight on the mother of every single interaction she had with P, they were both clear in their evidence that neither of them saw anything untoward in the mother's actions when both were well aware of the earlier events; and
f. the mother was clearly shocked and distressed when she discovered the line was disconnected as was observed by the contact supervisors and Nurse 6.

104. On the balance of probabilities I am not persuaded that it would be right or appropriate for me to find that the mother disconnected the line on 1 November 2025.

Findings of Fact

105. In late January and early February 2025 the mother was highly anxious about P's progress and future treatment. Her various comments to clinicians and nursing staff left them with the clear view that she was anxious and concerned about P receiving a particular treatment and being placed on the list for a future significant medical intervention.

106. On 29 January 2025 the mother cut P's line with a pair of scissors, she then clamped the end of the line connected to the infusion pump and called for help.

107. The mother sought to deflect blame for this incident from herself by suggesting that P had chewed through the line.

108. On 4 February 2025 the mother disconnected P's line which she did not then report to the nursing staff but left his bedside and left it to the nursing staff to discover and remedy the disconnection.

109. For the avoidance of any doubt, I do not find that the mother disconnected P's line on 1 November 2025.

Conclusion

110. There was compelling evidence to lead to the findings I have made against the mother. These stand in marked contrast to her otherwise devoted and loving care for P. The mother maintained her denial of any wrongdoing throughout this hearing. It would be wrong for me to speculate on the reasons why the mother acted as I have found. This will be an issue for the court to consider and determine at the welfare hearing.

111. The local authority did not pursue a finding that the father disconnected P's line on 5 February 2025. Accordingly, and for the avoidance of any doubt, the court has not made any adverse findings against the father.

112. The local authority will now undertake a risk assessment of the mother based on the findings set out in this judgment and on the mother's response to the same. I will consider and determine issues about the future care arrangements for P at the welfare hearing.

113. I repeat the gratitude I have already expressed for the assistance the court has been given in this difficult and complex matter by leading and junior counsel for the parties and I express my thanks to the legal teams for the considerable work undertaken to manage the huge volume of medical records and other documentary evidence and the witnesses warned to attend this hearing.

114. A large number of witnesses were clinical or medical staff from the hospital. I wish to express my gratitude to them attending to give evidence or preparing statements in anticipation of being called to give evidence. I am most grateful to the hospital for instructing counsel and solicitors to assist the court with managing the calling of witnesses from two key wards at the hospital whilst at the same time mitigating the potential adverse impact on the operation of those wards whose staff were required to give evidence.