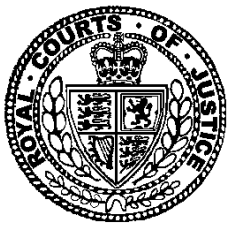

Neutral Citation Number: **[2024] EWCOP 13**

Case No: 12975950

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/02/2024

Before:

THE HONORABLE MR JUSTICE HAYDEN

- -

Between:

AN ICB **Applicant**

- and –

(1) G (BY HER LITIGATION FRIEND, THE OFFICIAL SOLICITOR)
(2) LF
(3) A LEAD OPERATING GROUP
(4) GR
(5) CJ

Respondents

- -
- -

Miss Nageena Khalique KC and Miss Olivia Kirkbride (instructed by **Hill Dickinson LLP**) for the **Applicant and Third Respondent**
Miss Sophia Roper KC and Mr Benjamin Harrison (instructed by **the Official Solicitor**) for the **First Respondent**
Mr Parishil Patel KC and Miss Francesca Gardner (instructed by **Irwin Mitchell LLP**) for the **Second Respondent**
Mr Joseph O'Brien KC and Ms Nicola Kohn (instructed by **Simpson Millar**) for the **Fourth Respondent**
Mrs CJ (appearing as a **Litigant in Person**)

Hearing dates: 17th – 31st July 2023, 6th, 9th, 16th-18th October 2023 and 13th – 15th November 2023

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN
The judge has given leave for this version of the judgment to be published.

MR JUSTICE HAYDEN:

1. This case concerns G, who is a 29-year-old woman, suffering from a profound, degenerative neurological condition. G lacks capacity to take decisions in relation to any aspect of her life and welfare. I have heard several applications in this case, the first of which started on 6th December 2021. Protracted litigation of this kind is extremely unusual in the Court of Protection. When G's circumstances first came to be considered before me, I was alarmed to discover that she had spent all her adult life in a children's hospital. Efforts to provide alternative care arrangements had been met with resistance, chiefly from G's father (LF), who did not consider the alternatives to be satisfactory. The relationship between the family, G's treating clinicians and many of the nurses was poor. The root of those difficulties lay in LF's attitude to his daughter's medical treatment. He had been repeatedly critical of the staff and of the senior clinicians. Living in accommodation in the hospital grounds for ten years, visiting his daughter daily, his own life absorbed in a hospital environment, fired in LF an intense interest in his daughter's medical condition and generated in him, a zealous desire to understand her treatment and the medical knowledge that informed it. His language is fretted with medical terminology. The ease and facility with which he uses the medical lexicon draws great admiration from his mother, CJ. She is in no doubt, and told me directly, that LF *"knows more about G's medical condition than anyone in this court room"*. As my previous judgments in this case reveal, LF has repeatedly challenged medical opinions and pressed for a Court determination.

2. In my judgment on the 13th December 2021, reported: [2021] EWCOP 69, when LF was still at the Children's Hospital, I made the following observation, at para. 16:

> *"[16] The Hospital is no longer an appropriate place for G, a 27-year-old woman. I agree with Miss Debra Powell QC, acting on behalf of the Clinical Commissioning Group (CCG), that at some point, G's continued placement there became irreconcilable with her dignity. I would go further, in these circumstances where the parameters of her personal autonomy are circumscribed by her condition, the continued placement at the Hospital limits, unnecessarily, the small sphere of autonomy that remains available to her i.e., to be treated as the young woman she now is and not as the child she was upon admission. It is important to record that nobody, including G's parents, has suggested that the Hospital is now the right place for her. In my judgement it is axiomatic that this children's hospital, however great its resources and skills, is ill-equipped to meet the emotional, medical and physical needs of this young woman."*

3. G's family were eager that she should, upon her discharge from hospital, live with them, supported by an intensive, bespoke domiciliary care package. The CCG was not prepared to fund it. Ms Powell, acting for both the Hospital Trust and CCG, politely but firmly, submitted that I should not use the powers of this Court to put pressure on the CCG to allocate its funds in a particular way: ***Holmes-Moorhouse v Richmond upon Thames London Borough Council* [2009] UKHL 7; [2009] 1 WLR 413**. Whilst I saw the force of Ms Powell's submission, I was of the view that G might, at

least arguably, fall within the category of those "rare cases" identified by Lady Hale as engaging Convention rights: ***N v ACCG and others*** **[2017] UKSC 22.**

4. The consensus of medical opinion is that G is at the end-stage of her life. It is impossible to say how long that will be. I do not think that LF or the family share this view and I make no criticism of them for that. However, my instinctive view was that even if it involved some detriment to her medical welfare, the desirability of affording G the opportunity to spend the end of her days in a family home and not an institution, might outweigh some compromise to her medical wellbeing: ***Re LBH (A Local Authority) v KJ & Others*** **[2007] EWHC 2798 (Fam).** The family did not see the decision in these terms but as they have repeatedly told me, both through Counsel and directly in the witness box, they recognised that the Court was resolved to get their daughter home, if that was possible and as soon as possible. I emphasise this because I consider it to be an important backdrop for all that has happened subsequently.

5. Ultimately, I was satisfied, on what I considered to be a compelling body of evidence, that a direct transfer home risked "*overwhelming"* G, given the extent to which she had become institutionalised. I was clear that the CCG and Trust were correct to identify *"a step down"* interim placement. Additionally, it had not been possible to identify a sufficiently robust care package. Care Home A (CH) had been identified. I made the following observations:

> *"[72] There must be a recognition that the timescales contemplated for the future plan must be driven wholly and entirely, by a clear identification of G's needs: it is necessary for her to readjust to life outside the hospital environment; it is important to stabilise her medically; it is essential that the relationship between the treating clinicians and the family (LF in particular) becomes fully functional; allied to this last point is the need for clear and unambiguous planning which all understand and are committed to; it must be understood, at all times, that G's relationship with her parents is of paramount importance to her as well as to them; notwithstanding this extensive period of hospitalisation, G has enjoyed a high quality of family life which must be preserved in her new environment, recognising that this will involve significant changes for her."*

6. At the hearing in December 2021, Dr D, Consultant in Respiratory and Intensive Care Medicine, emphasised the importance of what he termed greater *"functionality"* in the relationship between professionals and the family. I made these observations at para. 68:

> *"[68] Dr D was entirely of the same view. He expressed himself in clear terms. He referred to 'the jeopardy of [G's] discharge' and to the 'extremely complex' breadth of her medical needs. He also, properly in my view, identified the importance of achieving what he called greater 'functionality' in the relationship between professionals and family. This said, he emphasised that the love and commitment of these parents*

> *requires to be kept sight of. In simple terms, in a phrase which he repeated on a number of occasions, Dr D considered that G was likely to be 'overwhelmed if she were discharged straight home'. He told me in evidence that* ***it was important that G's team have full autonomy to deliver her care package, whilst respecting LF's practical contribution and insight. Though, I did not sense the parents were absorbing what he said, Dr D was also emphasising that G's family need to 'gain confidence in the team' in order fully to unlock their own role at home as a family. In order that both parents hear it clearly and unequivocally, I consider this perhaps more than anything else is the gateway to G's return to them. Ultimately, the decision to walk through it is theirs. I am confident that all involved with G would encourage them to do so."***

7. I do not think that this message could have been any clearer. It provided a road map to follow and to provide G with what was then a realistic prospect of being able to live at home. As I found, the dysfunctionality of the parents' relationship with the clinical team compromised G's safety and exposed her to avoidable harm. For too long, the clinical team yielded to LF's opposition and failed to protect their patient. As I noted, this could have had very significant and harmful consequences for her. The clinical team seemed somehow to have assumed that these parents had determinative rights in respect of their daughter's treatment. They did not. G was then, already an adult woman in her twenties. Her parents' views are, at least potentially, an important conduit by which her wishes and feelings might be communicated. That, however, will, in most cases, be the limit of them. The parents' role is to facilitate G's rights not to assert their own. This is the primary way by which the parents are most likely to make a significant contribution to identifying G's best interests. It was this misunderstanding that lay at the core of the dysfunctionality. Its danger was illustrated very clearly in the entirely unsatisfactory document that had become the CPR plan. Again, it is necessary to set out my earlier observations:

> *"[63] Up until this week the plan in relation to CPR as set out in the ReSPECT form was an unsatisfactory compromise, expressed in language which set out the views of the parents and the views of the hospital.* ***It was a study in confusion. It provided no clarity for the treating clinicians and served to stifle G's voice****. Indeed, I was told that notwithstanding the fact that the form was intended to communicate to the treating clinicians that CPR should not be attempted, it was more likely that the exact opposite would have occurred. It is a mark of Dr B's integrity that she should express herself with such candour, but she identifies a wholly unsatisfactory scenario.* ***She considered that if LF had been present at cardiac arrest, he would have pressed this ambiguous document upon the treating clinicians in order to encourage CPR****. That would have been painful and wholly contrary to G's interests as LF now recognises. Dr B had little doubt that LF would have persuaded the clinical team of the correctness of his view. There can be no further ambiguity in the documentation.*

> ***Treatment plans are not compromise agreements; they require clarity."***

8. The situation in relation to G's central venous line (CVL) is a further illustration of the harm presented by the dysfunctional relationship between the parents and clinicians. By the time of the December 2021 hearing, the CVL created a clinical risk, was not compatible with G's care in the community, offered no benefit and generated a real risk of sepsis. There was no coherent contrary view. The continuation of the CVL was not in G's best interests. It had remained there entirely because of LF's opposition.

9. The aspiration was to facilitate G's transition back into the community and reset boundaries. Dr Bentley described the care home, which is now subject to vituperative criticism from the family, as *"having a robust staffing structure"*, *"creating a most appropriate environment"* and *"providing highly qualified specialist nursing staff"*. I also heard (December 2021) from Dr D, also a Consultant in Respiratory Medicine and Clinical Lead for Ventilation. Dr D did not hear the parents give evidence but had, in my view, insightfully, identified that their obligation was to focus on their role as a family, to *"unlock",* as he put it, their own role at home.

10. Sadly, the resetting of the family/professional relationship did not occur. In June 2022, i.e., 6 months later, the case returned to me with G still living in the children's hospital. At the time of my judgment in December, I had anticipated a move being only weeks away. Moreover, the ceiling of care plan had still not been put in place, though there appeared to be consensus as to its content in December. The Trust and the CCG identified LF's intransigence as the cause for this and sought injunctive orders to implement and secure the placement at the care home. Ms Powell contended that LF was fundamentally opposed to the move and had conducted a campaign of resistance to it. Though LF insisted that he was only *'seeking answers to reasonable questions'*, he eventually yielded in cross-examination and accepted that he was fundamentally opposed to the placement. Again, I have worked through the history here to understand the present. It is significant that long before G was transferred to the care home, LF had a deeply entrenched opposition to it. The following extracts from my June 2022 judgment require to be set out:

> *"[19] LF's communication with the care home and its broader organisation were selective in the information disclosed, combative and directly opposed to my conclusions in the December judgment. LF's concession was only made when the compelling evidence of his opposition to the placement made his continuing denials of it risible. Thus, the abandoned move to the care home, planned to have taken place on the 8th March 2022, can only be attributed to LF's tactical strategy designed to sabotage it. The strategy was very nearly successful. The senior management wavered in their commitment to offer G a place. They became concerned as to how LF's behaviour might undermine their own ability to care for G and the wider impact on other residents."*

11. It is informative to identify what Ms Powell had distilled in relation to the concerns, at that time, regarding LF's behaviour. She expressed it thus:

> *"a. speaking to clinical staff at the Trust in a hostile and intimidating way and questioning their competence;*
>
> *b. questioning the competence of [the nursing home] staff when they visited [G] at the Hospital;*
>
> *c. writing to [the nursing home] and repeatedly to the Chief Executive of the [lead group] raising numerous alleged criticisms of [the nursing home] and its staff's competence to care for [G]."*

12. Additionally, a further feature was identified at that point:

> *"d. causing journalists and a "public relations consultant" to contact the [lead group] to discuss the family's ongoing opposition to the move to [the nursing home]."*

13. At the June 2022 hearing, Ms Powell skilfully highlighted some key aspects of LF's evidence, which bear review:

> *"[43] ... He admitted that he had deliberately taken [G] out of the ward on three occasions in August 2020 when he had been expressly told not to for reasons of Covid safety, and that he had returned to the ward when he was excluded.*
>
> *He admitted that he had sought to persuade [the CEO] to withdraw the offer of a place for [G], knowing that that was completely contrary to what the Court had determined was in [G]'s best interests. He admitted that the sending of numerous emails was designed to put further pressure on her to withdraw the place. He was driven, ultimately, to admit that he had lied in his witness statement when he claimed that he had accepted the Court's decision that [G] should move to [the care home].*
>
> *Finally, he admitted that, if he wasn't prevented from doing so, he would continue to do whatever he could to prevent the move taking place."*

14. What is, of course, obvious is how strikingly similar these allegations are to many of those now being considered. LF conceded his implacable opposition to the care home only when Ms Powell had carefully worked through the details of his behaviour, which really permitted of no other explanation. The reasoning LF proffers for the striking similarity of the present allegations is that the staff of the care home copied *"an algorithm that worked"* (at the Hospital), to use his exact phrase, and falsely reworked it, deliberately to undermine the family. I will return to this below. The language now used by LF and his family, at this hearing, permits of no possibility of a constructive working relationship with the care home. LF considers the regime of his daughter's care to be *"abusive", "incompetent", "frightening", "dangerous"*. He has also raised a spectre of 'sexual abuse' for which he identifies no evidence at all. GR

(G's mother) repeatedly uses the word *"disgusting"* to describe the quality of her daughter's care. She characterises the care home as *"a prison… worse than a prison"*. CJ (the paternal grandmother) describes the regime as *"torture"*. Unmistakably, the relationship is broken.

15. It is not necessary for me to review the complaints from the nurses at the children's hospital in detail, save to say, that they reported the following:

    i. to have frequently felt anxious when required to speak with LF;
    ii. perceived a hostile demeanour from him; generally feeling uneasy;
    iii. unusual things happening, such as disconnection from the ventilator, profile settings on the monitors changing, staff feeling as if they were *"being tested constantly"*;
    iv. *"feeling a sense of fear and dread as to what the day would bring"*. LF was described as "*physically intimidating"*. [A nurse] said she *felt fearful of her job*, *constantly assessed and questioned.*
    v. *"passive aggressive and intimidating"*.

16. These complaints require no amplification. They are set out in the judgment in detail. I would, however, record that there was a consistent complaint that LF's intimidating behaviour and demeanour had escalated since the court hearing in December.

17. I granted the injunctions sought by the Trust against each of the adults. The parents' appeal failed. The maternal grandmother's appeal succeeded; the Court of Appeal having concluded that she had not been given proper notice of the case against her. No comments were made as to the merits of the substantive allegations against her. An application was filed by the Integrated Care Board (ICB) on 2nd December 2022, for the court to list a hearing to consider directions relating to G's advanced care plan (ACP), with which the family did not agree. This was filed along with the witness statement of Ms L, Associate Director of Quality & Patient Safety, dated 2nd December 2022, which set out several allegations and incidents of concern involving G's family, in the period following the grant of the injunction, including concerns that the family had tampered with G's medical equipment.

18. On 19th December 2022, the court directed the ICB to file and serve further witness evidence and a Scott Schedule particularising all allegations upon which it intended to rely. I emphasised at that hearing and at subsequent hearings, that if these issues were to be litigated, the evidence would have to be clearly identified and properly marshalled. I also directed a statement to be provided by the local authority in respect of their safeguarding concerns. The local authority filed a witness statement on behalf of Ms Edmondson, dated 18th January 2023, and the ICB filed and served a statement from Ms L, dated 3rd February 2023, attaching a schedule of allegations and supported by witness statements from fifteen members of staff from the Care Home and one member of staff from the Hospital.

19. On 28th February 2023, I approved the ACP as being in G's best interests, pursuant to section 16 of the Mental Capacity Act 2005. By the same order, I directed the family to confirm, given the nature of the allegations being ventilated, whether they sought any findings of fact in respect of their allegations against the Care Home and, if so, to particularise those within a Scott Schedule. I make it clear, if it be needed, that there

is no jurisdiction in the Court of Protection to review the competence and professionalism of those commissioned by the ICB; however LF's case is that what is being alleged against him is in fact attributable to the incompetence or malice of the staff at the care home. LF served a narrative statement and a Scott Schedule on 31st March 2023. A response to that Scott Schedule was filed on behalf of the Lead Group on 28th April 2023, supported by a further 13 witness statements from staff at the Care Home.

20. By 30th March 2023, it had become clear that LF had been covertly recording his interactions with the staff of the care home. The court directed LF, GR and CJ to file and serve a statement setting out all dates on which they made any audio and/or video recordings at the Care Home and made an order for disclosure of audio and/or video recordings and text messages. I have been told that there were hundreds of hours of recordings. Some of them have been transcribed. Additionally, I granted leave to the Lead Group to be joined as a party and permission to the ICB to obtain a report from Dr Marc Beale, BSc. D.Phil., an expert in Assistive Technology, to comment on the cause of the damage to an oxygen valve (referred to in the statement of Nurse SJ). I renewed the injunctive orders, dated 13th June 2022, which were due to expire on 13th June 2023, until the conclusion of the fact-finding hearing.

21. This fact-finding hearing was listed for two weeks to commence on 17th July 2023. It has been beset by problems. Leading Counsel for the ICB contracted Covid at a key stage in the case and an adjournment was unavoidable. The time estimate for the hearing was itself overly ambitious. The nature of the case requires extensive reference to material and inevitably moves slowly. The allegations against LF, in particular, are of the upmost gravity. I have, accordingly, thought it appropriate to permit Mr Patel KC, Counsel on behalf of LF, extensive latitude in respect of his time estimates. CJ has also taken the opportunity to cross-examine witnesses which she has done skilfully and succinctly.

Fact-findings, the legal framework.

22. Fact-finding hearings at Tier 3 in the Court of Protection are extremely rare. Junior Counsel in this case tell me that they are conducted more frequently at Tier 1 and 2, especially at Tier 2. I have been surprised to hear that. I can see no obvious reason why this should be the case. For my part, I do not think that in this sphere of law, they have quite the same practical utility that they can have in the Family Court. In the Court of Protection, the range of welfare options for P is frequently very limited and unlikely to vary very much in response to a shifting factual matrix. In determining whether a fact-finding hearing should be convened, Judges must consider, rigorously, what real purpose it is likely to serve i.e., from the perspective of informing decisions relating to P's welfare. Such hearings are inevitably adversarial and invariably generate further hostility. This is inherently undesirable. Delay in reaching conclusions is inimical to P's best interests. In a very pressing and literal way, time is often not on P's side. Delay can only be justified if it is identifiably purposeful. Even in this case, given that G is moving towards the end of her life and has had a positive relationship with her parents from which she has and probably still does derive benefit, I wondered whether a fact-finding hearing was necessary. However, I am satisfied that the gravity of the allegations here and the nature of the family's responses has made such a hearing unavoidable. It has clear resonance for the central welfare issues i.e., as to where G will live and whether or to what extent it will be in

her best interests further to promote her relationship with her family. This disagreeable truth, I very much regret to say, must be confronted.

23. As I have intimated above, fact-finding hearings in the Court of Protection, as in the Family Court, require tight judicial control and an unswerving focus both on their scope and ambit as well as on purpose. The framework of such hearings is, as Baker J (as he then was) stated in ***A Local Authority v M & Ors*** **[2014] EWCOP 33** *"broadly the same"* in both jurisdictions. At para. 82:

> *"First, the burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings that they invite the court to make. Therefore, the burden of proving the allegations rests with them.*
>
> *Secondly, the standard of proof is the balance of probabilities: Re B (Children) [2008] UKHR 35. If the local authority proves a fact on the balance of probabilities, this court will treat that fact as established and all future decisions concerning M's future will be based on that finding. Equally, if the local authority fails to prove any allegation, the court will disregard that allegation completely…*
>
> *In my judgment, the same approach must surely apply in the Court of Protection where the court is carrying out a similar exercise in determining the facts upon which to base decisions as to the best interests of an incapacitated adult.*
>
> *Thirdly, findings of fact in these cases must be based on evidence. As Munby J (as he then was) observed in Re A (A Child : Fact-finding hearing: speculation) [2011] EWCA Civ 12:*
>
> *"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence, and not on suspicion or speculation."*
>
> *Fourth, the court must take into account all the evidence and, furthermore, consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss, President, observed in Re T [2004] EWCA Civ 458, [2005] 2 FLR 838, at paragraph 33:*
>
> *"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to the other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."*

> *Fifth, whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the experts are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence: A County Council v. K, D and L [2005] EWHC 144 Fam, [2005] 1 FLR 851 per Charles J.*
>
> *Sixth, in assessing the expert evidence, which involves a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem, one important consideration - and of particular relevance in this case - is that the court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers where appropriate to the expertise of others - see the observations of Eleanor King J in Re S [2009] EWHC 2115 Fam*
>
> *Seventh, the evidence of the parents 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 impressions it forms of them - see Re W and another (Non-accidental injury) [2003] FCR 346.*
>
> *Eighth, it is not uncommon for witnesses in these cases to tell lies, both before and during the hearing. The court must be careful to bear in mind that a witness may lie for many reasons - such as shame, misplaced loyalty, panic, fear and distress - and the fact that a witness has lied about some matters does not mean that he or she has lied about everything - see R v. Lucas [1981] QB 720. The assessment of the truthfulness is an important part of my function in this case."*

24. Neither the seriousness of allegations, nor the consequences of those allegations being established has anything at all to do with the standard of proof required to establish them. The inherent probabilities are merely to be factored in when deciding where the truth lies. Lord Hoffman in ***Re B*** **[2008] UKHL 35; [2009] [1 AC 11] at [70]** put it thus:

> *"…Common sense not law requires that in deciding this question, regard should be had to whatever extent appropriate, to inherent probabilities. If a child alleges sexual abuse by a parent, it is common sense to start with the assumption that most parents do not abuse their children. But this assumption may be swiftly dispelled by other compelling evidence of the relationship between parent and child or parent and other children. It would be absurd to suggest that the tribunal must in all cases assume that serious conduct is unlikely to have*

> *occurred. In many cases, the other evidence will show that it was all too likely.*"

25. In the context of the case I am hearing, the observations of Peter Jackson J (as he then was) are particularly apposite, in ***Lancashire County Council v C, M and F*** **[2014] EWHC 3 (Fam):**

> *"[9.] … one possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith."*

26. When evaluating human memory and demeanour, both its strengths and fallibility, Leggatt J's observations (as he then was) are helpful: ***Gestmin v Credit Suisse*** [2013] EWHC 3560 (Comm) at [16]:

> *"While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate."*

27. Of course, Leggatt J was not saying that the confident witness is unlikely to be accurate. The evaluation of accuracy is a far more multi-faceted exercise, which inevitably involves testing veracity by reference to objective facts, proved independently of their testimony by documentation, motives and overall probabilities. Consistency of account, from first recollection and over time is also not to be discounted where it can be evaluated in the above way. Where a witness's account is verified by this kind of external support, it matters not whether it is delivered confidently or diffidently.

28. As will be clear from the prefacing passages above, one of the issues that arises here is how similar fact evidence should be treated. This came to be considered in ***R v P***

(Children: Similar Fact Evidence) **[2020] EWCA Civ 1088** at [23-26]. Peter Jackson LJ's observations require to be set out in full:

> *"23. In O'Brien v Chief Constable of South Wales Police [2005] UKHL 26; [2005] 2 AC 534 the House of Lords considered the issue of similar fact evidence in civil cases, where it is contended that an individual's behaviour in other circumstances makes it more likely that he will have behaved in the manner now alleged because it is evidence of a propensity to behave in that way. Lord Bingham stated the position in this way;*
>
> *3. Any evidence, to be admissible, must be relevant. Contested trials last long enough as it is without spending time on evidence which is irrelevant and cannot affect the outcome. Relevance must, and can only, be judged by reference to the issue which the court (whether judge or jury) is called upon to decide. As Lord Simon of Glaisdale observed in Director of Public Prosecutions v Kilbourne [1973] AC 729, 756, "Evidence is relevant if it is logically probative or disprobative of some matter which requires proof .... relevant (ie. logically probative or disprobative) evidence is evidence which makes the matter which requires proof more or less probable".*
>
> *4. That evidence of what happened on an earlier occasion may make the occurrence of what happened on the occasion in question more or less probable can scarcely be denied. ... To regard evidence of such earlier events as potentially probative is a process of thought which an entirely rational, objective and fair-minded person might, depending on the facts, follow. If such a person would, or might, attach importance to evidence such as this, it would require good reasons to deny a judicial decision-maker the opportunity to consider it. For while there is a need for some special rules to protect the integrity of judicial decision-making on matters of fact, such as the burden and standard of proof, it is on the whole undesirable that the process of judicial decision-making on issues of fact should diverge more than it need from the process followed by rational, objective and fair-minded people called upon to decide questions of fact in other contexts where reaching the right answer matters. Thus in a civil case such as this the question of admissibility turns, and turns only, on whether the evidence which it is sought to adduce, assuming it (provisionally) to be true, is in Lord Simon's sense probative. If so, the evidence is legally admissible. That is the first stage of the enquiry.*
>
> *5. The second stage of the enquiry requires the case management judge or the trial judge to make what will often be a very difficult and sometimes a finely balanced judgment:*

whether evidence or some of it (and if so which parts of it), which ex hypothesi is legally admissible, should be admitted. For the party seeking admission, the argument will always be that justice requires the evidence to be admitted; if it is excluded, a wrong result may be reached. In some cases, as in the present, the argument will be fortified by reference to wider considerations: the public interest in exposing official misfeasance and protecting the integrity of the criminal trial process; vindication of reputation; the public righting of public wrongs. These are important considerations to which weight must be given. But even without them, the importance of doing justice in the particular case is a factor the judge will always respect. The strength of the argument for admitting the evidence will always depend primarily on the judge's assessment of the potential significance of the evidence, assuming it to be true, in the context of the case as a whole.

6. While the argument against admitting evidence found to be legally admissible will necessarily depend on the particular case, some objections are likely to recur. First, it is likely to be said that admission of the evidence will distort the trial and distract the attention of the decision-maker by focusing attention on issues collateral to the issue to be decided. This… is often a potent argument, particularly where trial is by jury. Secondly, and again particularly when the trial is by jury, it will be necessary to weigh the potential probative value of the evidence against its potential for causing unfair prejudice: unless the former is judged to outweigh the latter by a considerable margin, the evidence is likely to be excluded. Thirdly, stress will be laid on the burden which admission would lay on the resisting party: the burden in time, cost and personnel resources, very considerable in a case such as this, of giving disclosure; the lengthening of the trial, with the increased cost and stress inevitably involved; the potential prejudice to witnesses called upon to recall matters long closed, or thought to be closed; the loss of documentation; the fading of recollections. … In deciding whether evidence in a given case should be admitted the judge's overriding purpose will be to promote the ends of justice. But the judge must always bear in mind that justice requires not only that the right answer be given but also that it be achieved by a trial process which is fair to all parties."

24. This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible. Secondly, is it in the interests of justice for the evidence to be admitted? This calls

for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.

25. Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established? That question was considered by the Supreme Court in the criminal case of R v Mitchell [2016] UKSC 55 [2017] AC 571, where it was said that the defendant, who was charged with murder by stabbing, had used knives on a number of other occasions, none of which had led to a conviction but which on the prosecution's case showed propensity. Lord Kerr addressed this issue in the following way:

"Propensity - the correct question/what requires to be proved?

39. A distinction must be recognised between, on the one hand, proof of a propensity and, on the other, the individual underlying facts said to establish that a propensity exists. In a case where there are several incidents which are relied on by the prosecution to show a propensity on the part of the defendant, is it necessary to prove beyond reasonable doubt that each incident happened in precisely the way that it is alleged to have occurred? Must the facts of each individual incident be considered by the jury in isolation from each other? In my view, the answer to both these questions is "No".

43. The proper issue for the jury on the question of propensity… is whether they are sure that the propensity has been proved. … That does not mean that in cases where there are several instances of misconduct, all tending to show a propensity, the jury has to be convinced of the truth and accuracy of all aspects of each of those. The jury is entitled to - and should - consider the evidence about propensity in the round. There are two interrelated reasons for this. First the improbability of a number of similar incidents alleged against a defendant being false is a consideration which should naturally inform a jury's deliberations on whether propensity has been proved. Secondly, obvious similarities in various incidents may constitute mutual corroboration of those incidents. Each incident may thus inform another. The question … is whether, overall, propensity has been proved.

44. … the jury should be directed that, if they are to take propensity into account, they should be sure that it has been proved. This does not require that each individual item of evidence said to show propensity must be proved beyond

> *reasonable doubt. It means that all the material touching on the issue should be considered with a view to reaching a conclusion as to whether they are sure that the existence of a propensity has been established."*
>
> *26. Again, this analysis is applicable to civil and family cases, with appropriate adjustment to the standard of proof. In summary, the court must be satisfied on the basis of proven facts that propensity has been proven, in each case to the civil standard. The proven facts must form a sufficient basis to sustain a finding of propensity but each individual item of evidence does not have to be proved."*

Covert recordings

29. LF has made a very large number of covert audio recordings of the staff at the care home, *"hundreds of hours"*, according to his solicitors. Both GR and CJ are aware of this and heavily implicated in it. These recordings are, in my judgement, a violation of the personal and professional privacy that each member of staff is entitled to. It also requires to be said that it is a violation of G's privacy. I emphasise, once again, that G's right to privacy is precisely that, i.e., her own right. It is not a gift to be bestowed or withdrawn by her family. To treat it as such, as has been the case here, is to fail to respect her adult autonomy. Perhaps more than anyone else G is entitled to look to her family to protect her privacy. In these secret recordings, they have failed to do that. She, of course, is silent throughout but her presence in the hostile encounters that swirl around her is keenly felt by any listener who is motivated to protect her.

30. When it was realised what had been going on, the ICB sought disclosure of all the recordings. Ultimately, 10 recordings have been disclosed from 2022 and 26 from 2023. I have listened to a relatively limited number of them nor have I been referred to them, at any length, by the advocates. The recordings range between a few minutes and 2 hours. The Official Solicitor has listened to all of them at least once. Some have been transcribed. I am also told *"all parties have spent a significant amount of time checking their accuracy and amending them"*.

31. Miss Khalique KC, on behalf of the ICB, opposed the admission of both the recordings and the transcripts, at the start of this fact-finding hearing. The Court had not been asked for permission for them to be included and no party has an automatic right to rely on them as evidence. The relevant Court of Protection rules are:

> *"14.4. Written evidence – general rule*
>
> *A party may not rely on written evidence unless—*
> *(a) it has been filed in accordance with these Rules or a practice direction;*
> *(b) it is expressly permitted by these Rules or a practice direction; or*
> *(c) the court gives permission."*

32. The more general powers of the Court to control evidence are found in r.14.2:

> *14.2. Power of court to control evidence*
>
> *The court may—*
> *(a) control the evidence by giving directions as to—*
> *(i) the issues on which it requires evidence;*
> *(ii) the nature of the evidence which it requires to decide those issues; and*
> *(iii) the way in which the evidence is to be placed before the court;*
> *(b) use its power under this rule to exclude evidence that would otherwise be admissible;*
> *(c) allow or limit cross-examination;*
> *(d) admit such evidence, whether written or oral, as it thinks fit; and*
> *(e) admit, accept and act upon such information, whether oral or written, from P, any protected party or any person who lacks competence to give evidence, as the court considers sufficient, although not given on oath and whether or not it would be admissible in a court of law part from this rule.*

33. In ***Jones v. University of Warwick*** **[2003] EWCA 151, [2003] 1 WLR 954**, the Court of Appeal considered the ambit of the court's discretion in relation to identical provisions to the COPR under the CPR in respect of video surveillance evidence obtained covertly, involving a trespass and a breach of the right to privacy under article 8(1) of the ECHR. The Court of Appeal concluded that it was *"not possible to reconcile perfectly the conflicting public interests that arose, namely on the one hand, that in litigation the truth should be revealed and, on the other hand, that the courts should not acquiesce in, let alone encourage, a party to use unlawful means to obtain evidence"*. At para. 28, Lord Woolf, LCJ, concluded:

> *"The court must try to give effect to what are here two conflicting public interests. The weight to be attached to each will vary according to the circumstances. The significance of the evidence will differ as will the gravity of the breach of article 8, according to the facts of the particular case. The decision will depend on all the circumstances. Here, the court cannot ignore the reality of the situation. This is not a case where the conduct of defendant's insurers is so outrageous that the defence should be struck out. The case, therefore, has to be tried. It would be artificial and undesirable for the actual evidence, which is relevant and admissible, not to be placed before the judge who has the task of trying the case."*

34. The approach of the civil and criminal law in England and Wales is broadly to regard evidence as 'admissible' if it can be established as 'relevant' to the matters in issue. The United States doctrine of "fruit from the poisonous tree" (*if the source, the 'tree', of the evidence or evidence itself is tainted, then anything gained, the 'fruit', from it is tainted as well*), has never gained significant traction in our domestic law. The approach here has been to link admissibility with relevance and not how the evidence

was obtained (***Ras Al Khaimah Investment Authority v Azima*** **[2021] EWCA Civ 349**). Whether this approach will hold in a GDPR framework remains to be seen but the approach outlined above reflects the existing law, which I apply. Albeit in a pre-Human Rights Act 1998 era, the force of the approach is demonstrated in ***Helliwell v Piggott-Sims*** **[1980] FSR 356**, per Lord Denning:

> *"I know that in criminal cases the judge may have a discretion. That is shown in Kuruma v the Queen. But so far as civil cases are concerned, it seems to me that the judge has no discretion. The evidence is relevant and admissible. The judge cannot refuse it on the ground that it may have been unlawfully obtained… But, even if it was unlawfully obtained, nevertheless the judge is right to admit it into evidence and to go on with the case as he proposes to do."*

35. Whilst I deprecate the serious breach of G's privacy and that of those caring for her, those rights have, in my judgement, to be balanced against G's interests in ensuring that this Court reaches the correct results on all of the available evidence. In ***Re F*** **[2016] EWHC 2149 (Fam) [2017] 1 FLR 1304**, I admitted verbatim transcripts of recordings made by a mother of her interview with a Court appointed expert. The recordings were made covertly and without the expert's consent. Ultimately, I found them to be relevant, in the context of a broader canvas of evidence to support my conclusion that the expert had manipulated material in a way which was wholly unacceptable and far below the standard required by his duties to the Court.

36. The interpersonal relationships between G's carers and the family are, as is already apparent, central to the conflict in this case. The recordings purport to be an illustration of that. LF has sought to rely on them as establishing his moderate and reasonable behaviour. As such, they are clearly relevant and thus admissible. Ultimately, it is a question for the Court as to what weight may be placed upon them. I would observe, however, that it is, I strongly suspect, the experience of many Judges and seasoned practitioners that covertly recorded material frequently redounds adversely to the interests of those who do the recording. Certainly, for reasons I address below, that was the case here.

<u>The allegations</u>

37. The allegations against the family are set out in a 17-page Scott Schedule, dating from February 2022 until May 2023. It would overburden this judgment to set them all out. There is, as mentioned above, a counter-Scott Schedule, prepared by LF's team (9 pages). It is not necessary for me to reach factual findings in respect of each allegation on either side. It is only necessary to do justice to the evidence; to identify where risk lies, if risk there be, where harm has occurred to G, if it has, and, if so, the perpetrators of that harm.

38. The court is not bound by the cases put forward by the parties but may adopt an alternative solution of its own**:** ***Re S (A Child)*** **[2015] UKSC 20; [2015] 1 WLR 1631** at [20]. Judges are entitled, where the evidence justifies it, to make findings of fact which have not been sought by the parties, but they should be cautious when

considering doing so: ***Re G and B (Fact-Finding Hearing)*** **[2009] EWCA Civ 10; [2009] 1 FLR 1145**, where Wall LJ said this at [15]-[16]:

> "*I am the first to acknowledge that a judge … is entitled to take a proactive, quasi-investigative role in care proceedings. Equally, she will make findings of fact on all the evidence available to her, including her assessment of the parents' credibility; she is not limited to the expert evidence. I am also content to decide the question in this appeal on the basis that a judge … is not required slavishly to adhere to a schedule of proposed findings placed before her by a local authority. To take an obvious example: care proceedings are frequently dynamic and issues emerge in the oral evidence which had not hitherto been known to exist. It would be absurd if such matters had to be ignored. All that said, however, the following propositions seem to me to be equally valid. Where, as here, the local authority had prepared its Schedule of proposed findings with some care, and where the fact-finding hearing had itself been the subject of a directions appointment at which the parents had agreed not to apply for various witnesses to attend for cross-examination, it requires very good reasons, in my judgment, for the judge to depart from the schedule of proposed findings. Furthermore, if the judge is, as it were, to go "off piste", and to make findings of fact which are not sought by the local authority or not contained in its Schedule, then he or she must be astute to ensure; (a) that any additional or different findings made are securely founded in the evidence; and (b) that the fairness of the fact finding process is not compromised."*

Similar fact evidence

39. As will become obvious below, many of the allegations made by the staff of CH, have a striking similarity to the findings made in my earlier judgments, most particularly, in my June 2022 judgment. I have already set out the principles to be applied in approaching evidence of this kind in para. 28 (above), see ***R v P (Children: Similar Fact Evidence)*** **[2020] EWCA Civ 1088.** I propose to look separately at the allegations made at this hearing and then to consider whether my earlier findings are relevant to this investigative process and, if so, to evaluate the weight to be afforded to them.

The Scott Schedules

40. In ***Re H-N And Others (Children) (Domestic Abuse: Finding of Fact Hearings)*** **(Rev 2) [2021] EWCA Civ 448**, the Court of Appeal heard extensive submissions from a range of parties considering whether, *"where domestic abuse is alleged in proceedings affecting the welfare of children, the focus should in some cases be on a pattern of behaviour as opposed to specific incidents. We also address the issue of the extent to which it is appropriate for a Family Court to have regard to concepts which are applicable in criminal proceedings. We consider the consequence of these issues for the way such cases are conducted in applications made for private law children*

orders ('private law orders') made under the Children Act 1989 ('CA 1989')", per Sir Andrew McFarlane P.

41. What is clear from the Court of Appeal judgment in *Re H-N* is the clear concern that Scott Schedules, particularly in cases which involve a pattern of behaviour, may not provide a framework that properly captures the gravity of the behaviour alleged. Indeed, the Court was plainly troubled by the detailed submissions which contended that these Schedules could operate in a way that served, inadvertently, to erect a barrier to fairness and sound process rather than to facilitate it. The President identified some of the shortcomings inherent in reducing allegations to schedule format:

> *"[44] Concern about the utility of Scott Schedules was raised on two different bases: one of principle and the other more pragmatic. The principled concern arose from an asserted need for the court to focus on the wider context of whether there has been a pattern of coercive and controlling behaviour, as opposed to a list of specific factual incidents that are tied to a particular date and time. Abusive, coercive and controlling behaviour is likely to have a cumulative impact upon its victims which would not be identified simply by separate and isolated consideration of individual incidents.*
>
> *[46] For our part, we see the force of these criticisms and consider that serious thought is now needed to develop a different way of summarising and organising the matters that are to be tried at a fact-finding hearing so that the case that a respondent has to meet is clearly spelled out, but the process of organisation and summary does not so distort the focus of the court proceedings that the question of whether there has been a pattern of behaviour or a course of abusive conduct is not before the court when it should be. This is an important point. Everyone agrees.*
>
> *[47] The Harm Panel has expressed a similar view and noted that 'reducing a long and complicated history of abuse into neat and discrete descriptions is challenging and can itself result in minimisation of the abuse' (Chapter 5.4), and that by limiting the number of allegations the court is not exposed to 'more subtle and persistent patterns of behaviour' (Chapter 7.5.1). So too did Hayden J in F v M in his Post Script."*

42. Scott Schedules have been prepared in this case because they were considered to be the appropriate framework by which to attempt to marshal a very large body of evidence, requiring scrutiny of human behaviour as well as extensive documentation. However, I consider that the reservations expressed about Scott Schedules, in the Court of Appeal, have clear resonance in this case. What I find myself evaluating is an alleged course of behaviour, manifested in different ways and contested to varying degrees. A great deal of the behaviour in focus relates to interactions between the staff and the family but some of it concerns specified allegations of covert tampering with

G's ventilation equipment. Additionally, as I have mentioned, there is a schedule, prepared on behalf of LF, setting out allegations of general negligence against the care home (CH).

43. The Court of Appeal recognised that specific pleading of individual incidents in Scott Schedules, in family cases, might too easily divert the focus from the important broader picture and serve, paradoxically, to minimise the seriousness of the allegations by severing them from a course of conduct. The alternative options, however, are elusive. One of the suggestions made involved creating "narrative statements" which it was submitted, would allow there to be consideration of the overall nature of the relationships in focus. It was advanced that such an approach would allow the court to identify the real character of the allegations before then going on to look at the *"granular detail"*. I recognise that the structure of the allegations here is steeped in *'granular detail'* and also runs the risk of occluding the significance of the totality of the alleged behaviours and their impact, on both sides. Ms Roper KC, on behalf of the Official Solicitor, suggests that the Court should approach its judgement by "narrative" findings based on an adaptation of the model discussed above. I am not sure whether my judgment reflects Ms Roper's aspiration but I have endeavoured to address the overall picture emerging from the broad evidential canvas as well as its individual parts.

44. The first tranche of the applicant's Scott Schedule, dated 26th May 2023, is not, in the conventional sense, a Scott Schedule at all. It is a document particularising how it is said that the behaviour of LF, GR and CJ, breaches the Injunctive Orders made by me on 13th June 2022. Thus, it focuses on breaches and not on patterns of behaviour. Ultimately, I have not found the structure of the schedule to have been an entirely satisfactory framework by which to navigate this highly contentious case. When I asked Miss Khalique at the outset of the hearing if there was to be an application to commit for these alleged breaches, I was told, after some deliberation, that there was not. I have taken the central allegations and themes and constructed this judgment around them. A narrative summary of my findings can be found below (paras 201-211).

45. The central feature of concern here has been the behaviour of the family, particularly, though by no means exclusively, LF, towards the staff of CH. It is said to have been repeatedly intimidating, threatening, challenging and insidiously rude. It is asserted that this behaviour was deliberate, intending to weaken the placement to the point where it was no longer viable. Its impact is said to have been deeply corrosive of morale. It is contended that the family's behaviour was orchestrated to undermine the professional confidence of the staff and to portray them as incompetent and unsuitable to care for G. This is the real nature of the first tranche of allegations. As the President suggested, it is helpful to recognise and establish the true complexion of the allegations and then consider the granular detail.

46. Approached in this way, it strikes me that, despite a great deal of evidence focusing on the family's relationship with the staff, it became increasingly difficult to see what, ultimately, was in dispute on this central allegation. As the hearing progressed, the family's criticisms of CH became increasingly florid. GR describes the care home as *"like a prison but even worse than a prison"*. She repeatedly describes CH as *"disgusting"*. CJ said that G was being *"tortured"* by the staff. Both LF and GR told

me explicitly that they remain 100% committed to G being removed from CH. I have been struck by the number of times the parents have described themselves as *'terrified'* by what they see as the poor quality of G's care. It is LF who uses that word most. I also note that when he does so, he becomes visibly distressed. This is in contrast with his rather more overbearing manner when talking, often in challenging terms, about G's medical needs.

47. As the hearing evolved, LF has made dark, unspecified insinuations about G having been sexually abused at her care home. I should emphasise that there is not a scintilla of evidence in support of this. Mr Patel has advanced no case in respect of it. If these insinuations have any evidential relevance, it is only as yet further illustration of LF's determination to terminate the placement. This has further resonance in an issue that arose at the very end of the hearing. At Mr Patel's request, I agreed to look at a recent photograph of G with what is being suggested is a 'black eye', inflicted abusively by an unknown carer or nurse. I emphasise that whatever Counsel's perorations on this, there was no doubt at all that this was being advanced by LF as an abusive injury. I was asked to listen to a covert recording of the nurse's response when this complaint was made to her. I have been told that LF reported this alleged assault to the police (Mr Patel confirmed that those were his instructions). There is no doubt at all that LF considered the nurse's response to his complaint to be some kind of admission of fault. There has been no medical opinion, as yet, but an explanation was proffered by the nurse (a burst vessel whilst cleaning G's eyes) which, to the lay person, seems, at the very least, as viable as that proffered by LF. The point here is that LF rushed immediately to a hostile interpretation and is resistant to any benign explanation. As to the nurse making any admission, the recording reveals nothing of the kind. The interpretation LF places upon it requires a distortion of perspective. The nurse, who was plainly offended, eventually stated *"well… alright, you know what, maybe we've smashed her in the face"*. This was a nurse, who at that particular point, had simply had enough and wasn't going to let an allegation of physical abuse of this nature go by unchallenged. In different circumstances, her response might be seen as unprofessional. On some level, it is; however, placed in the context of LF's corrosive behaviour, I do not consider it attracts criticism. She was, in my judgement, indicating to LF, in plain, albeit ironic language, what she regarded as an absurd and manipulative allegation.

48. CJ is very clear that the earlier judgments are all wrongly decided. It is important that I emphasise that she expresses this view cordially and politely. Despite the compelling professional consensus as to its danger, she continues, for example, to believe that it was wrong to have removed G's central venous line. I find her position on this both unsustainable and alarming. CJ allies herself entirely with her son. Her respect for his medical knowledge and opinion is boundless. As I have already alluded to, with no hesitation and with absolute confidence, she told me that LF knew more about G's condition than *"anybody else in the court room"*. She asserts that each of the family members is *"trained"* and *"expert"* in G's care. She has appeared in person and cross examined the care staff. She was courteous, thorough, and well-versed with the documentation. She presented as confident; indeed, I sense she was relishing her opportunity to question the staff in a public forum. They were in the witness box; she was at the front of Counsel's row. They, in her mind, were on trial. Of course, there is inevitably a highly adversarial complexion to this case but it is important not to lose sight of the fact that the overarching ethos of this hearing is

investigative, non-adversarial and driven by the statutory obligation to promote the best interests of G.

49. The parents' position regarding the ICB and CH's allegations surrounding their attitude to staff is rather more fluid. LF suggests that the staff have read and digested my findings relating to the family's behaviour at the children's hospital and adopted it as *"an algorithm that works"* to construct a false narrative against the family. The phrase, coined by LF has, in my judgement, been carefully thought out. It was not a spontaneous concept conceived in the witness box. What LF means by it, as I understand it, is that the allegations which contend that he has been threatening and challenging have found favour in earlier judgments and the care and nursing staff have, dishonestly, copied them. It is suggested that this is motivated by a plan to conceal the depths and breadth of their own negligence. Inevitably, that has led to assertions that documentation has also been used dishonestly with the intention of discrediting the family. For this reason, LF tells me he felt justified in covertly recording the care home staff for many months.

50. I heard evidence from 18 witnesses, working variously as nurses, managers, and carers at CH. It is important that before I consider the detail of their evidence, I record the impact that they had on me as a group. They left a marked and lasting impression. I have never seen a group of professionals so deeply demoralised, profoundly distressed, devitalised and dispirited. They had been reluctant to come to Court, they yielded with disheartened resignation to many points put to them in cross examination, seemingly at times, prepared to agree to anything to get their ordeal over. Some felt unsupported by their senior management (not in my view without some justification), almost all of them felt that they were on trial. Some, and it is unnecessary for me to name them, were profoundly unnerved by the experience of coming to Court and having to give evidence. One witness was visibly shaking, at least two of them were suffering from depression. Each of them, without exception, was acutely conscious of the family in the courtroom and although they, mostly, retained their professional composure, I was left with no doubt that their experience was painful and for some, traumatising.

51. My recollection is that requests had been made, at earlier hearings which must have been before Miss Khalique was instructed, requesting that the statements stand as evidence, with the attendance of their authors dispensed with (LF interprets this as the witnesses' wish to retract their evidence). Given the very serious nature of the allegations made, it was impossible to grant such a wide-scale request. Miss Khalique requested that the witnesses be permitted to give evidence on video-conferencing platform. I declined that. I did that because in my view, the complexion of the evidence, involving allegations and counter allegations, required parity of participation for both sides. Thus, if the parents were required to give evidence in the witness box, so too were those making the allegations against them. This, in my view, was essential to the fairness of the process. I am bound to say that even the trauma caused to the witnesses does not cause me to regret the correctness of the decision. Moreover, the hearing simply could not have been conducted fairly without, at least some oral evidence being heard and challenged. Only in this way could the voluminous written evidence in other statements and documents be properly evaluated. This is, for example, the approach I took to the evidence of Nurse CB i.e., by evaluating its reliability in the light of the wider canvas and examining its own

internal consistency. This witness did not give oral evidence. Ultimately, I accepted that given a relatively recent diagnosis of a serious neurological condition, which was symptomatic, it would be unreasonable to expect her to attend, either in person or remotely. Whilst I of course bear in mind that her evidence could therefore not be put to the assay by way of cross examination, that does not render it valueless. I was able to listen to extensive recordings of her, taken covertly and thus entirely without her own knowledge. This material, which involved her interactions with LF, helped me to assess the general demeanour of both. Though at risk of emphasising that which might be regarded as obvious, assessing individuals in audio recordings, in real time situations, may, as here, have qualitative advantages. Assessing people in the stressful artificiality of a witness box in a busy courtroom may carry inevitable disadvantages. The former has, in many ways, greater authenticity and most obviously so in the case of the individuals who do not know they are being recorded.

52. When IW, the Home Manager at CH, was asked, by me, how he would assess the morale of his staff, he responded bleakly, *"rock bottom"*. He paused and then volunteered *"below rock bottom"*. Nobody watching these people give evidence in this courtroom could fail to see the impact that contact with this family had upon them. I agree with IW. I have found watching their evidence a disturbing experience. Their position had not been helped by the way the lawyers for the ICB had prepared their case. I am afraid this criticism requires to be levelled and must be faced. The initial statements of many of the witnesses had been taken by way of free flow narrative, from recollection, some months after events, with no or scant reference to the relevant forms and documentation. This is simply poor practice. It resulted in inevitable revisions when the exercise was properly completed and revealed, predictably, that statements taken entirely by way of memory test are unlikely to be accurate. This opened obvious forensic opportunity which Mr Patel exploited, both in detail and at length, as he was bound to do. Moreover, all this occurred in the face of my entreaties to the ICB, at several directions' hearings, to ensure that the evidence was presented with tight forensic care. Allegations of this kind, raising safeguarding issues of this complexion, is unfamiliar territory for lawyers acting for health bodies in the Court of Protection. It was for this reason that I tried to signal, in advance, the forensic discipline required.

53. In addition to the above, the lawyers for LF have obtained extensive transcripts of many hours of their client's covert telephone recordings. In the end, very few of the transcripts or recordings have been referred to. Most of those that have been considered, I should record, have tended to weaken LF's own case rather than enhance it. As I have already commented but I consider to bear repetition, it is quite extraordinary how frequently that occurs in cases where lay parties compile covert recordings. For reasons that I will look at below, some of the most cogent evidence against the family is provided from this source. I raise the question of the recordings here, however, because it is important to identify the fundamental attack they represent on the professional privacy of those working at the care home. The recordings took place over many months. Moreover, it seems that IW knew they were continuing some considerable time before they were finally stopped. He appears to have accepted LF's assertion that his actions were legal, they were not. The destructive impact of this fundamental breach of trust between the professionals and the family cannot be underestimated.

54. Accordingly, each of the CH witnesses faced material, in cross-examination, emanating from three different sources, one of which involved their own conversations, recorded without their permission in circumstances where they had a reasonable expectation of privacy. Whilst I deprecate the circumstances in which these recordings were obtained, I have set out my reasons for admitting them into these proceedings in para. 34 et seq.

55. The following are illustrations of what the ICB contends are examples of what has been described as *"passively aggressive"* and *"intimidating behaviour"*.

> *"Whilst we were transferring [G], [LF] was making comments to [G]'s Mother, GR such as,* ***"for a clinical lead she doesn't care very much"*** *referring to [Nurse C] and also things like "when [Nurse K] didn't turn on the oxygen this morning".* ***I felt as though [LF] wanted a reaction out of us and specifically out of [Nurse C]. [Nurse C] didn't rise to this and continued caring for [G] and told [LF] that she did not wish to discuss this in front of [G] and had to repeat herself several times".*** (3rd October 2022)

56. The parents are said to have revisited this when they returned with G later that evening:

> *"Parents and [G] arrived back at [CH] at 17:20pm. They asked for [G] to be hoisted back into bed which staff attended to. During the transfer parents were asking [Nurse C] about the situation that happened earlier with the oxygen, [Nurse C] said that the situation had been discussed with [IW] and that we weren't going to discuss it now as we are caring for [G].* ***Her parents continued to ask questions and [G] repeated what she had just said****".*

57. It is to be noted that the above record in the nursing notes is generally supportive of the account of the parents' behaviour earlier that day. It shows a persistent pursuit of their criticism of a staff member. As a document, it is, in my view, sparse but firm. If it were a falsification, designed deliberately to discredit the parents, as they have at times appeared to suggest, it is, at best, half-hearted.

58. Nurse C completed the observation chart for the same period:

> *"…[G] arrived back from social leave and family requested for her to be hoisted to bed. X2 nurses on duty: DOC and SHCA assisted to bed. DOC asked family to leave [but] mum and dad both refused. Staff hoisted [G] to bed with no issues. All checks complete. Dad started to [ask] DOC about O2 cylinder when hoisting out. DOC respectfully said she was aware of the issue they had raised but was not going to discuss anything at [G]'s bedside.* ***Dad said he was shocked at the lack of concern she had and again DOC said she would not discuss this at [G]'s bedside****…."*

59. Finally, I have listened to LF's own covert recording of this and read the transcript. This requires to be set out in some length:

> NURSE C *Yeah, but what I'm saying is -- I'm not talking about the clunk, I'm talking about -- if you hear oxygen coming through, the oxygen is on. It cannot come through without it –*
> *FEMALE STAFF: Yeah, yeah. Yeah.*
> *NURSE C: -- the valve being on is what we're saying.*
> *FEMALE STAFF: No. Yeah, I know.*
> *NURSE C: The clunk's irrelevant. That's irrelevant.*
> *GR: But when the girls (Several inaudible words).*
> *LF: No, I'm sorry, the clunk is very relevant because you have to clunk it on with the first opening (Overspeaking)*
> *NURSE C: What I'm saying is –*
> *FEMALE STAFF: When we tested on –*
> *LF: Super relevant.*
> *FEMALE STAFF: When we tested on one of the ones that are waiting to be picked up, it made that clunking noise. So, I know obviously you said –*
> *(Overspeaking)*
> *LF: Well, that's it when it's been full. But initially, that's the first time you open it when it's (Inaudible).*
> *FEMALE STAFF: Yeah, but they were the ones that are empty that are going and it made the clunking sound.*
> *LF: If you turn that one off now and try and close it again –*
> *NURSE C:* ***Let's just -- right, I'm not -- we've got a young lady here that*** *–*
> *GR: The main thing (Several inaudible words).*
> *NURSE C: --* ***we're all disputing over her head. I don't think it's relevant. We've looked into it. The oxygen is 100 per cent on. If I turn that valve off and switch this off, you wouldn't hear a hiss at all.*** *It will not (Overspeaking)*
> *LF: I'd like you to do it and see if it clunks.*
> *NURSE C: I'm not bothered about the clunk; I'm bothered about oxygen coming through. It will not come through without the valve being on. And that's all I'm saying about it. Do you want me to turn it off?*
> *LF: Was that the same when it was at 22 minutes the other day?*
> *NURSE C: Well, I'm not in involved in that incident at all. Obviously, that's gone to safeguarding so I'm not discussing that.*
> *LF: You weren't involved in this one either, but …*
> *NURSE C: I'm not involved in any of it. But as a manager I have to look into it.*
> *GR: (Overspeaking)*
> *NURSE C: So obviously if it's gone to safeguarding, then I am involved and I have to look into it.*

> ***LF: It's just I'm a little bit disappointed as clinical lead you seem very disinterested and dismissive of our concerns, Nurse C.***
> ***NURSE C: I'm not going to argue with you, [LF].***
> ***LF: Nobody's arguing, Nurse C.***
> ***NURSE C: I'm very interested and I'm going through the process. That's all I'm saying is I'm going through a process.***
> ***LF: Nobody's arguing, just raising a point.***
> [Emphasis added.]

60. Despite the clear consistency of the evidence, from each of the available sources, LF denied that he was behaving in an intimidating manner. When it was put to him that staff members were pressured and undermined by this personal and professional criticism, LF told me that the staff were *"shocked by the extent to which they had struggled with G's care"*. He told me that *"they found that troubling, but incidents have to be raised"*.

61. In cross examination, LF denied that there was a *"dispute",* he characterised it as a *"conversation" ... "the only thing we do is raise legitimate concerns about the very poor care"*.

62. As I have said above, it is sometimes difficult to glean quite what is in dispute. LF's own transcript reveals that he is calling the clinical lead *"disinterested and dismissive of our concerns"*. The transcript itself reveals him to be argumentative and not *"just raising a point"*. The nurse's concerns about this conflict taking place above G's head are completely ignored by LF, again, demonstrated by the recording. Notably, this same concern has been raised in earlier observations and on the same date.

63. In many ways the events of the 3rd October 2022, are paradigmatic of the frequent disputes and confrontations which have characterised the evidence. Here, they involve, as so frequently they do, two completely different and essentially irreconcilable versions of the same incident and, commonly, with high level of agreement as to the language that was used. It is 'a parallel universe', a phrase which has been used with some regularity during the course of the evidence. The incident also provides a characteristic example of LF's attitude to these confrontations taking place in G's presence. Though it was twice pointed out to him that the *"heated disputes over her head"* were entirely inappropriate, he simply was not prepared to acknowledge any substance in that at all. This attitude is reflected in his approach to the covert recordings. He simply does not recognise that G's right to privacy is also engaged. When GR was asked about this on a different occasion, she said that *"[G] does a little shake"* when she *"hears raised voices"*. She went on to say that G liked the fact that her parents were arguing on her behalf. There remains no consensus as to what G can absorb of her surroundings but the proposition that she is understanding, let alone excited by arguments concerning the circumstances of her care, is vanishingly unlikely. Moreover, if it were the case that she understood what was going on, it is deeply concerning that her mother interprets G's 'shaking' (if that does occur) as reflective of her pleasure in the conflict rather than the far more obvious interpretation i.e., that she might be distressed.

64. This family is entirely enmeshed in their thinking about G's welfare. There is no difference, at all, in their perspectives. Neither is there any light and shade in their views, they are simply all of one voice when it comes to G. I think, they would say this themselves. I have no doubt that, in his own mind, LF regards himself as a warrior on his daughter's behalf. This would of course fit with GR's belief that G is excited by LF's persistent criticisms of the staff. I by no means discount the possibility that both LF and CJ share this distorted perspective on G's response to conflict. What is, however, notable is the recognition by GR that G is indeed subject to *"raised voices"* and not the mere *"conversations"* LF had described.

65. It must be remembered that the family had the advantage of knowing that they were being recorded. The nursing and care staff did not. In the end, 50 hours of recordings, have been retrieved. No example has been pointed out to me that shows anything other than the staff holding a professional line against softly spoken but persistent and withering criticism. Virtually all of this has occurred in the presence of G. Alongside all this, the family has launched a barrage of professional complaints. Though I have repeatedly asked, I have not been able to obtain the precise number. This is in part because they continue to grow. All I can say is that there have been over 100. These complaints sap time, energy and are caustic to professional morale.

66. I turn now to an allegation arising from events on 8th November 2022, which I have already briefly touched upon. This incident occurred on a wet, cold, and miserable late autumn evening. G had been out with her parents for most of the day. Having regard to G's overall health, I am concerned as to whether these kinds of arrangements are truly in her best interests. I have expressed my concern and I have not received any satisfactory answer. It strikes me that the question must be asked, as it would be in any care plan, what is the purpose of contact and how should the arrangements for contact facilitate that identified purpose.

67. Ms Roper has described this episode as *"appalling"* for G. In the context of the parents' attitude to the staff, I agree with her description. However, I have no idea at all what impact this has on G. The whole episode has been recorded and transcribed. I have at the request of each the advocates, listened to the recordings. I have also listened to it again when preparing this judgment. It was Mr Patel, on his client's instructions, who was most insistent on it being played. It is perplexing to me that LF considers that the recording and the transcripts redound favourably to his case. They do not.

68. The recording begins with the parents pushing G in her wheelchair towards the front door of the care home. The first few seconds, record their interaction with G. I should observe that their engagement with her is, in content and tone, that of an adult interacting with either a very small child or a baby. Though this jars with me, I do not say it to be critical of the parents. I can understand why G might always be seen as their little girl. I observed in my earlier judgments that one of the many reasons that children's hospital had become unsuitable for G was that she was infantilised by her surroundings. In a case where I am disappointed to be unable to identify very many positives, one has been obvious. The staff of CH treat G as a woman in her late twenties. I have noticed this on a number of occasions throughout the evidence. Nurse K told me that she was very conscious that she and G are the same age. She told me that when planning for G's day, she asked herself what she would want to do and then

tried to transpose that into G's world. She told me that she liked meeting up with her friends and so she would ensure that G had some opportunity for socialising. She had formed no real impression of G's capacity to connect with the world but worked on the assumption that she was able to gain some pleasure from her environment. I have paraphrased her exact words but I am confident that this was the gist of them. The staff of CH care for adults. Each of them treats G as an adult and, I find, has instinctive regard for her dignity. It is, for example, now the case that she is always dressed when she meets her father, regard being taken to promote her privacy. They have taken the view that is what any young woman of G's age would prefer. I consider this to be an appropriate and sensitive approach.

69. On 8th November 2022, G returned very late from an afternoon with her parents, certainly more than an hour and a half late. Her parents had telephoned ahead to say that they were having difficulty with public transport. In my view, the carer, HLS, was sceptical about the explanation. By this time, there were already strict restrictions in place setting clear boundaries for the family's interaction with G at the home. The cut off time for return had been set at 6pm, by Court order. On this occasion, it was certainly past 7:30pm when they returned. HLS began her interactions with the parents politely and, I note, focusing on G, *"hello G, let's get you in the warm"*. Perhaps unwisely, in the circumstances, HLS intimated that the staff had no problems getting in from the same location. She then continued *"as you're not coming in, can I just have the midazolam"*. In my view, HLS had simply assumed that, given the late hour, everybody would focus on the priority of getting G comfortably to bed. Her remark, however, triggered an immediate, almost firework, reaction in both G's parents. On this occasion, GR was particularly voluble. She is a very different personality from her partner, she lacks something of his subtlety and finesse. She reacted aggressively and, in a way, calculated to intimidate the staff. Her reaction to HLS' assumption that the handover would be quick was both immediate and extreme. She did not politely enquire whether they could enter and do their checklist as usual, she went directly to the offensive, *"what do you mean we're not coming in?"* she asked. HLS responded *"because she's late. I've just got to take her from here"*.

70. GR's arguments were to hand. Though she was fully aware that the family were not allowed in the care home after 6pm, she argued *"the order doesn't say we can't take G in"*. I have not the slightest doubt that the parents were testing the boundaries and had anticipated a problem. HLS tried to diffuse the situation *"right, well right, hold on. You can come to the door of the ward"*. GR did not back down *"yeah exactly"* she said, *"you do not get G on the doorstep. I will tell you that. You do not get G on the doorstep"*. Given that HLS had already relented, that was unnecessarily combative. As if the situation were not difficult enough, LF ratcheted up the ante further, *"this is a gross insult to G's dignity, isn't it?"*, he questioned. The exchanges continued with LF and GR sparking off each other. HLS asked, *"can you just sign the midazolam in?"*. LF immediately asserted his perceived authority *"yeah, as soon as we've done the checks"*. HLS said, *"you don't need to do the checks"*. LF was having none of this, *"yeah we do."*; he responded. Another nurse arrived and the altercation continued in a similar vein. It is important to recount that, in her determination to enter the building, GR, who I find on the clear evidence of the recording, was out of control, collided the wheel of G's wheelchair with HLS' foot. At the time of preparing her statement, HLS perceived that as a deliberate act on GR's part. In cross-examination, HLS recognised that she could not be sure. In her evidence, she stated

that the foot had been sore for a few days afterwards. When challenged by Mr O'Brien KC, on behalf of GR, as to why she had not included that detail in her statement, she responded, *"her running over my foot and shouting. My foot being sore has nothing to do with G"*. Expressly, she told me and I think with an understandable degree of frustration at this process, *"we should be focusing on G"*. For the avoidance of doubt, it was being suggested to her that she had deliberately exaggerated the incident. I do not consider that she had although her written account was inaccurate.

71. In her statement, HLS had described GR as *'screaming'*. This too was said to be an exaggeration. Again, I do not consider it was. Whether it is exactly the right word or not, however, does not matter. GR's response was extreme and entirely unacceptable. After they had secured entry into CH, HLS says that they *"barged"* into the unit. That is certainly consistent with GR's obvious state of mind and indeed the earlier incident with the wheelchair. The situation was, by this time, a very long way from the swift handover that HLS had planned. Not only had the parents gone into the unit, but they had also now gone into G's room. I was also disturbed to hear that GR had taken G's trousers down to check her incontinence pad. HLS was genuinely, in my judgment, disturbed by this. In her statement, she referred to it and described GR as having *"pulled G's trousers down"*. In cross examination, she accepted that she had only pulled them *"halfway down"*. What emerges both from the statement and from her oral evidence is HLS' real concern for G's privacy and the inability of both parents to recognise it. It was perfectly clear from the framework that had been put in place that a task such as checking the incontinence pad was a nursing responsibility. GR was well aware of that. I am left with the impression that she regarded this incident as a battle that she had to win. In the end, she got all her own way and then went further. In my judgement, she deliberately crossed the boundaries. In checking the incontinence pad, GR was making a point. It simply did not occur to her that her perceived victory was at the expense of her daughter's dignity. There were a number of people present when the incontinence pad was checked and I accept HLS' evidence that the door to G's room was not closed. All this conflicted with HLS' core medical values. It plainly struck her as wrong. It is for that reason, in my judgement, that she has remembered it and put it in her statement. GR does not deny this, but she lacks any insight into how her behaviour might be perceived by others. She was fully aware that she had breached the court order, *"yeah, we broke the order so you'd better go and report us"*.

72. Before LF and GR were prepared to leave the care home, they insisted on photographing the variety of 'kit' that they needed to take out of the unit with G. These photographs were taken to signal that they were protecting themselves in some way from staff whom they perceived to be hostile to them. They were not prepared to leave until they had photographed *'absolutely everything'* (LF). Both parents addressed G, using baby talk, to impugn the professionalism of the staff, GR said to her daughter *"they're so professional"* (for the avoidance of doubt, that was delivered in ironic tone). LF responded, *"super"*. GR concluded, *"yeah, super professional, yeah my darling"*. Earlier, GR had referred to HLS as *"disgusting"*. When I asked her how she thought the staff might feel being spoken to in this way, GR said, *"I don't know how they feel"*. Nurse CB had the following exchange with both parents:

> *NURSE CB: Can I just say it's now late, [G] is in the middle of all of this. We've got other patients.*
> *LF: You really must stop creating these issues then, you know.*
> *NURSE CB: She's not had her teatime medications, there's things we need to do, and I'm asking you to leave and you're not leaving.*
> *GR: I am. As soon as we've taken a photo of them there "Nurse CB", we will.*

73. Nurse CB pressed the parents to leave. She emphasised that G herself was *"in the middle of all of this"* and that other patients required attention. Both parents were deaf to this, they simply did not engage. Though they have the most optimistic view of G's awareness, they are not prepared even to contemplate that the conflict which swirls around her might cause her stress in the way that it would to most other people. Amongst GR's parting shots that evening was the following remark:

> *"…you know when I said prison today to you, [Nurse CB], well that is an understatement. I take that back now, it's even more than a prison".*

74. Very properly, in my view, the Official Solicitor emphasises the lack of empathy shown by both parents to the potential impact on their daughter of the events of the 8th November 2022. Ms Roper makes the following submission, with which I agree:

> *"The behaviour of [G]'s parents delayed the administration of [G]'s medicine and bedtime routine and required not one, but several staff members to manage. Voices were raised such as to alert [SJ] to the fracas caused by the family. It is striking that the events deteriorated so much that [SJ], a nurse with considerable managerial experience, seriously contemplated calling the police".*

75. In respect of these incidents, the Trust seeks a finding that the parents were *'intimidating, threatening, challenging, rude and abusive'* to staff at CH. For the reasons I have analysed above, I consider that the evidence supporting such a finding is compelling. I am required to make findings on the civil standard of proof but I am bound to say that I should have had little difficulty making the finding on the criminal standard of proof. The preponderant evidence comes from LF's own recording. His insistence that I should hear it indicates to me that he has lost a sense of objectivity and capacity to reflect on his own behaviour. GR's actions that evening require to be identified for what they were i.e., grossly insensitive, and inappropriate.

76. The following day, 9th November 2022, brought further trouble. This arose whilst the staff of CH were trying to compose G in a chair, following her transfer from the bed. LF believed that the staff had failed to set up G's suction properly. Present on this occasion were EB (nurse), LF and GR. In her statement and in her oral evidence, EB told how she found G's family to be *"intimidating"*. She felt that they were *"hostile"* to the staff. She plainly found all this upsetting. She told me that she felt as if the care that they were providing was *"continuously"* being questioned. She intimated that this made her feel nervous.

77. On 9th November 2022, EB was assisting with G's transfer to her chair. This involves hoisting. Earlier in the proceedings, I had formed the clear view that it would be contrary to G's best interests for her parents to be actively involved in her hoisting [Order, 13 June 2022, §3.6]. On 8th November 2022, a 'best interests' decision had been made by CH management that the family should not be present at hoisting. This process was a focus of anxiety for staff, particularly when the family were present. Accordingly, the court orders, provided that the family were not to be present. I emphasise that the objective of these orders, which reverberates through the earlier judgments, was to try to reset the parents' relationship with their daughter. The intention was to harness their undoubted strengths and love for her but in the role of parents, not as medics or care staff. Following the advice referred to in the earlier paragraphs of this judgment, the aim was to encourage the family to enjoy G as the young woman she is and for what she has to offer, rather than to focus upon her as a raft of medical needs. The ambition was to release LF, in particular, from his preoccupation with medical lexicon and to enable him to communicate with his adult daughter, both verbally and non-verbally, in a way which maximised the opportunities for both.

78. I have never had the slightest doubt that LF has absorbed a great deal of medical knowledge and nursing skill in his journey through his daughter's life. It is impressive, but it is also obsessive. The latter has on occasions, occluded his objectivity. As I found, in my earlier judgments, the assertion of his own medical opinions, sometimes in the face of unanimous contrary views, expressed by very experienced doctors, have placed his daughter in peril. Though it is expressed in plain terms in my earlier judgment, LF cannot and I suspect never will, confront it. Neither can his family. Unfortunately, LF deploys his knowledge in a manner which is entirely counterproductive. He converts the gold that he has to offer into base metal. Were he to have chosen to share his experience, working collaboratively with the staff of CH, a great deal of painful conflict could have been averted. More than that, G's care could have been enhanced. It is not a criticism of the CH staff to say that LF could have helped them with their patient. Indeed, I strongly suspect that there is not a single member of staff who would disagree with this as a proposition.

79. LF, however, deploys his knowledge to criticise, to intimidate and I regret to say, sometimes, to humiliate those charged with his daughter's care. The Court of Protection evaluates P's best interests by looking at the broad canvas of available evidence. In that context, the case law illustrates the singular importance of parents and relatives who can act as a conduit for P's likely wishes and feelings. There is, in this investigative process, no scope for the dogmatic and inflexible. That applies with equal force to a parent as it does to an expert witness.

80. EB told me in her statement that on 9th November, she was assisting with G's transfer with her chair. G's parents were outside the room, as they were required to be during the hoisting process. EB states that the moment G had been placed into her chair, the parents came in. She describes them as effectively hovering, compliant with the letter of CH's decision nor that of the court order but not engaging with its spirit. EB said that the parents did not knock or ask if they had finished and that EB was still trying to get G comfortable. The parents were asked to take a step back but LF objected, reasoning that as the transfer had been completed, they were allowed back into the

room. I find EB's evidence here entirely convincing, it is congruent and logical. It has a banality to it which serves to reinforce its reliability. It has the hallmark of detail which points to its veracity. There is no conceivable reason why such an account should be made up. Moreover, it captures LF's attitude to the framework of the orders.

81. EB describes LF as saying *"something along the lines"* of *"why should we [step back]. You've already hoisted her so why should we move"*. The behaviour being described in relation to LF is petulant, childish and, once again, some distance from promoting G's own best interests. In fact, EB records that LF did step back, he was manifestly in the way of the carers who were trying to make his daughter comfortable. In his insistence that the embargo on his entry into the room ceased the moment G was sitting in the chair, comfortably arranged or not, LF was taking the same combative approach that I have described relating to his late return the day before. Essentially, he is taking a strict 'legalistic' approach to the interpretation of the order and CH's subsequent decision. The lay person would put it more bluntly; he is playing games with the staff, intending to make life as uncomfortable for them as possible, asserting his own dominance. This is, of course, entirely consistent with his stated avowal to do everything in his power to bring the placement at CH to an end. A little later, Senior NP's contemporaneous records note as follows:

> *"When finished EB went to fetch new suction tubing as we noticed it had been forgotten to be changed. Dad immediately asked what suction we would use in an emergency. Senior NP's explanation was that we could reach with the suction on the wall. Dad said he felt it was unacceptable for an emergency situation and asked for proof that it could reach by giving nasal suction. Senior NP have [G] nasal suction which reached from the wall, suction tubing was then put under the chair."*

82. This is a further convenient illustration of what I have just described above. I think LF's concerns were addressed adequately at the time but, in any event, the way he raised them was characteristically critical and hostile. LF disputes all this. He also disputes that he said, *"you've already hoisted her so why should we move"*. I reject his evidence on this. I find EB's account channels LF's authentic voice, thinking style and general behaviour. Indeed, I would say that the evidence of his rudeness and critical grinding, low level aggression is present in such abundance that it is almost redundant of any coherent denial.

83. It is unnecessary and disproportionate to traverse each of the many allegations set out in the schedule. My task is to resolve those disputes which, when resolved, provide sufficient material, one way or another, to ensure that future planning can be placed on a stable factual foundation. I propose to consider one further allegation under this category of alleged rude and intimidating behaviour before turning to the allegations concerning tampering with G's oxygen supply.

84. On 21st December 2022, G was returned to CH from a stay in hospital. Ms S had been told that G was ready to be discharged and so went with Nurse KP and a senior HCA, SM, to transfer G back to the care home. Usually, G would be discharged by

ambulance, but on this day there was a national ambulance strike. When Ms S arrived on the ward, the nurses asked if she would help transfer G to her wheelchair. She told me that she checked the equipment and the transfer was completed successfully. Immediately afterwards, LF and GR returned to the ward. LF pointed out that there was a very slight crack in one of the tubes for G's ventilator. The nurses were asked whether there was a spare tube but apparently there was not.

85. Nurse KP, SM and Ms S all inspected the tube. There is no doubt that it had a slight cosmetic crack but the nurses were satisfied that it was not affecting the function because the vent was secure and there was no risk of it coming loose. There appears to be agreement that G went back with the CH staff in the minibus and LF and GR travelled in their own vehicle. The minibus got back approximately 15 minutes before LF and GR. Ms S told me that they had managed to get G to her room and set up the equipment ready to hoist her back into bed. When LF and GR arrived, both were complaining that G had been exposed to risk of *"life-threatening"* proportion. By this they meant the crack in the ventilation tube. CB was trying to diffuse the situation. She repeatedly asked the couple to leave but they declined. Ms S felt they were being particularly hostile to CB and intervened, eventually ensuring that they left the room.

86. Nurse KP gives the following account in her statement:

> *"18. At this point, [LF] told me that I had put [G]'s life at risk by transferring her back with that slight crack. [LF] was saying that it had been a safeguarding concern and asking what I was going to do about it and told me that I would need to keep the circuit as evidence. I felt very intimidated by his approach and very overwhelmed that I did not know how to respond immediately. I told him that I'd speak to the managers and come back to him. This interaction really upset me and still upsets me to this day. I would never put [G]'s life at risk. I care for all of my patients, their safety is a priority to me and I would never want any of them to come to any harm. If I had had any concerns that the ventilator wasn't secure or that there was a risk to her life, I would not have transferred [G]. I had kept the piece and showed this to the managers and they also felt that as it needed as much force to disconnect as any other piece, my actions had not put [G]'s life at risk As a team, we decided it would be best if we put in safeguarding referral too, just to be sure, however it was unreportable as no harm had been caused and so we logged it as a Datix instead (this is the incident system we use for all of our incidents).*
>
> *19. This incident was alarming for me, as [LF] or [GR] had not raised any concerns prior to the transfer and I could not understand why [LF]'s concerns were raised after the transfer and not before. If they had been raised prior to transfer, we could have addressed them then whilst there were multiple other people around. I believe he wanted to wait until I was on my own to speak to me as this made me feel especially vulnerable. I felt like if they had concerns about the transfer*

> *from ITU to [CH], they never said anything to myself or my colleagues or ITU staff beforehand."*

87. In cross examination, Mr Patel put it to Nurse KP that the parents had raised this with her at the hospital and that they had offered to drive back to CH to bring a replacement port. It was further put to Nurse KP that she had told them that she would physically *"hold it together"* during the journey. My impression was that this was being suggested to emphasise the perceived precariousness of the situation. Nurse KP simply said she could not remember whether she had said that, nor could she clearly recall having heard the parents' offer to drive to CH and pick up a spare port, though she was prepared to agree that they might have. She also agreed that *"holding the port" "was not an ideal"* situation. Mr Patel pressed her as to whether this would, in fact, have been safe enough. Nurse KP conceded that it would not. The response, however, requires to be contextualised. Firstly, Nurse KP had made the assessment that notwithstanding the visible *"tiny"* crack, the port *"looked and visually appeared and felt tight and secure"*. As I understand it, LF disagrees. Nurse KP felt confident in her own assessment but thought it appropriate to check with her colleague. Her colleague also confirmed that it was tight. This tiny crack, described as being on the *"top green piece"*, was not something Nurse KP had *"ever seen before"* and she was unable to think how it *"could have happened"*. It is plain that Nurse KP carefully assessed the situation and was satisfied that G was comfortably receiving ventilation and oxygen. Moreover, and importantly in my view, Nurse KP asked the staff in ITU to examine the crack. They did so and were satisfied that it did not present a risk. Nurse KP took the decision that she would get G back to CH and change the vent there. Her answers to Mr Patel have to be considered against the full backdrop of her evidence and not in isolation.

88. It is also clear that Nurse KP was deeply shocked by LF's approach to her on his return to CH. He had travelled separately with GR and arrived 15 minutes after the ambulance. LF says, and I accept, that he went initially to G's room and *"a minute later"* he and GR went upstairs to speak with the manager (IW). I am satisfied that the parents did so to pursue a complaint. As it transpired, IW was in a meeting and so the parents returned downstairs and confronted KP. There can be no doubt, at all, that LF's manner was markedly combative from the start of this exchange. He referred to keeping the circuit *"as evidence"*, plainly insinuating a serious formal complaint or litigation of some kind. He referred to *"serious safeguarding concerns"*. This, it should be said, remains his position. What is striking from KP's evidence, written statements and the evidence of her colleagues, is that Nurse KP was deeply shocked and clearly very shaken by the force and the gravity of the allegations that were being made against her. My findings thus far, in this judgment, and in my earlier judgment to which I will turn shortly, may have inured the reader to the significance of this incident. It requires to be seen for what it is, an unbridled attack on Nurse KP's professional competence, in which it was being contended that she had risked the life of her patient. It was plainly a body blow for Nurse KP. In her statement, she said that *"it really upset me and it still does to this day"*. As I watched her, responding to Mr Patel's questions, the evidence of this was all too clear to see. In her hesitant responses, she revealed not only the strain of giving evidence, but something rather deeper and more pervasive. I had the clear impression that her professional confidence had been shaken by the events of this day. LF is a forceful, prepossessing, and articulate man. He had succeeded in causing Nurse KP to doubt whether she had

done the right thing for her patient and it is this that troubles her. Despite the strong and preponderant evidence that she has behaved with paradigm professional competence, she continues to review her actions that day with a self-critical eye. On the evidence I have heard, she need not do. Moreover, it is important to her and, for different reasons, to the family that I say this in the clearest and most unambiguous terms.

89. It is also important to note that Nurse KP considered that LF's behaviour at the hospital had seemed to her to be far more placid and much less confrontational. The force of his behaviour, on his return to CH took her entirely by surprise. The extent and spontaneity of her distress, observed by others at CH was unmistakably authentic. It reinforces the accuracy of her account to the effect that LF had made far less of the cracked tube at the hospital than he did on his return to the unit. Where and to the extent that, KP's evidence on this conflicts with that of LF, I prefer her evidence.

90. Nurse S overheard the exchanges between LF and KP. In her view, it was *"very hostile and intimidating towards [KP]"*. In the record of the incident that she prepared, she noted that Nurse KP was *"visibly upset"* by what had happened and that she had needed to take some time out to recover her composure. The situation had plainly escalated. The unit manager came down to support her staff. LF and GR were asked to leave the premises. In what is by now a pattern of behaviour, they declined to do so, preferring further to prosecute their perceived grievance. The earlier exchanges that I have set out were, unusually, not recorded. Alternatively, they were and the recording has been lost. Miss Khalique is highly sceptical about this. She submits that they have not been included because they would have been so strikingly inconsistent with LF's own case. As the recordings resume a little time later and in respect of the same incident, Miss Khalique suggests that I can infer a deliberate doctoring of the evidence, particularly having regard to the many hours of recording and voluminous transcripts. I regard this as an entirely proper submission but I reject it. I am not prepared to draw the inferences Miss Khalique suggests I should. I consider that the absence of any recording or transcript for this part of the day attracts considerable suspicion but, ultimately, this is speculative. It is not sufficiently rooted in evidence of sufficient cogency to permit me to draw inferences.

91. The audio recording is available for the meeting between the parents and the unit manager (UM). The conversation starts as follows:

> *UM: Hi. We're going to pop her back into bed now. But I''ve got to ask you to leave as well for intimidating staff. So ...*
> *LF: How is that?*
> *UM: You've really upset–- because you've pulled her out, you've upset her. [LF], I'm not getting into it with you. We're asking you–- I've spoken to [IW], and we're asking you to leave because she doesn't want to come back on the unit while you're here, and she can't nurse.*
> *GR: [UM], can I just speak to you, please.*
> *UM: No, I'm not getting into it.*
> *GR: I want to show you the broken port*
> *UM: (Overspeaking) Yeah, however, that is not [KP]'s fault. And they actually raised it in the hospital.*

> *GR: (Several inaudible words) we never said it was [KP]'s fault.*
> *...*
> **[I233-I238]**
> *UM: Right, we're not arguing–- not arguing. I'm not arguing over [G], I am not doing it.–- (Overspeaking)*
> *LF: Nobody is arguing with you, [UM]. And nobody's been intimidating or anything (Overspeaking)*
> *UM: Well, no, you have [LF]. Whether you think so or not. That's the way –*

92. LF and GR both deny that either of them had been intimidating in any way. They insisted that they had gone to the manager, IW, first:

> *"GR: But [IW], he has gone to [IW] first. He never raised it with any of the staff..."*
>
> *"LF: ... There was no – there was nothing to it. I just said I'd like to raise it and I said I came to try and see [IW]."*

93. These accounts are entirely irreconcilable with what I have set out above. They exist only, once again, in a parallel universe where there are alternate truths which do not converge. LF is constrained to contend that the nurses' accounts are made up, driven by some generalised hostile animus to him and his family. The unit manager responds to LF's suggestion that there was *"nothing to"* his exchanges with KP in these terms:

> *[UM]: Well, what I'm saying is–- unfortunately, it's hindering care now. Not just for [G] but all the other patients, because we've got a nurse who feels intimidated, whether you meant it or not, and is unwilling to come back and provide patient care.*
> *[LF]: Very convenient to keep saying that word, isn't it, [UM]?*
> *[UM]: No, it's not, [LF]. I'm trying to help a situation.*

94. Later, GR intervenes:

> *GR: We never raised anything with [KP], [UM]. And we–- I never (Overspeaking)*
> *UM: I've got a member of staff that is severely upset and doesn't want to come back on the unit.*
> *GR: Yeah. Yeah. Well, I've been crying in the car, coming, thinking how you could risk again–-*
> *UM: What I'm saying is now–-*
> *GR: Yeah.*
> *UM: What I'm saying now is that we're in a situation where all patient care is getting delayed, for [G], for the rest of the patients. So, I'm asking you, please, if you will leave–-*
> *GR: Yeah, we will leave, because now it's nearly 6 o'clock, [UM], so we will be leaving. But what I'm saying is–*

95. Even the above passages are barbed and aggressive. GR made the point that she was leaving, not because UM was asking her to but because it was nearly 6pm, the time

they were required to leave by court order. The exchange nonetheless continued with LF demanding why it was thought that he was *"intimidating" … "you keep bouncing around this word 'intimidation'"*.

96. Notwithstanding what I identify as a compelling body of evidence to the contrary, including these last passages presented on LF's behalf, both parents contend that there was, as LF put it, *"nothing about mine or GR's demeanour that was inappropriate"*.

97. In surveying the broad gamut of the evidence, it is important to consider the external professional assessment of CH. Dr S, Consultant in Neurological Rehabilitation filed a statement, dated 20th November 2022. The thrust of the document was to address G's Advance Care Plan. It had been reviewed by Dr RA, Consultant in Respiratory Medicine and Professor B, Consultant in Respiratory and Intensive Care Medicine. Dr RA overviewed the plan and commented as follows:

> *"[G] has a diagnosis of failure of nerve myelination and multi-organ sequelae of this severe neurological disorder. Her clinical course has followed that of Pelizaeus- Merzbacher-Like-Disease (PMLD), a rare autosomal recessive genetic condition, and therefore her condition is described as phenotypically PMLD. Whilst [G] was at [the children's hospital], her family were resistant to testing for the more recently sequenced human genome, which could potentially confirm the diagnosis of PMLD. I have cared for two other patients with this diagnosis so I have some personal experience of this condition.*
>
> *[CH] is a highly specialist provider of care for people with complex neurological presentations and thus there is nothing exceptional about [G]'s clinical and personal care needs there. [G] is totally dependent on others for her personal and clinical care, and she is totally technology-dependent in relation to her respiratory support. [Dr RA] and his team at [A Hospital] provide the specialist oversight of her respiratory and ventilation needs.*
>
> *I understand that the positive observations noted by [G]'s family in terms of her expressing happiness, love and motivation have not been noted by the professionals on the High Dependency Unit at [the children's hospital] or nursing staff at [the care home]. It is reported that when [G] is not being disturbed with interventions, [G] tends to fall asleep. [LF] is critical of the language used in the ACR with regard to the "burdens" of treatment. This terminology is standard in relation to ethical considerations of clinical management in relation to a patient.*
>
> *With regard to [G]'s life expectancy, none of the professionals involved in preparation of the ACP (as mentioned above) have*

> *estimated [G]'s life expectancy due to the rarity of her underlying neurological condition. As far as I am aware, only [Dr H] has suggested [G]'s life expectancy to be into the fourth decade but this needs to be balanced against the very high level of ventilatory support that [G] requires which has negative implications for prognosis. Prior to that, [Dr R], Consultant Paediatric Neurologist, who cared for [G] from infancy, predicted neurodevelopmental progress plateauing and clinical decompensation in the second decade of [G]'s life. This has been borne out by progressively increasing technology related interventions, principally total dependence on a ventilator, being introduced to support [G]'s life. For the last five years, I am informed that her support from her ventilator has been at an abnormally high level and this will almost certainly be causing barotrauma to her lungs.*
>
> *As described in the previous statements from [Dr H] and [Dr J], [G] has no lung reserve.*
>
> *Therefore, [G] has been receiving palliative care since the time she required ventilatory support to maintain her life".*

98. I have incorporated these passages, in part, because they provide a convenient reminder of G's underlying neurological condition, but also because they reflect the wider professional perception of CH as *"a highly specialist provider of care for people with complex neurological presentations"*. By way of completeness and because they may have a bearing on some of the allegations below, I would also highlight the following perceptions of LF's view of G's need for ventilatory support.

> *"[LF] considers that the ACP incorrectly dwells on [G]'s medical background. [G]'s medical background is of the utmost relevance as she has had a great deal of treatment, some of which has a direct bearing on how she is now.*
>
> *[LF] has suggested that [G] can be interpreted as being over-ventilated. My understanding of the respiratory investigations (particularly the TOSCA study) is that this view is not correct, and thus the respiratory clinicians have indicated that there is no room to wean her ventilatory support. If there are further questions on this point, they will need to be directed to her specialist respiratory consultant".*

99. By way of completeness, I should also add that there is a statement from Dr RA, dated 10th December 2022. Dr RA is a Consultant in Respiratory Medicine with over 25 years of experience of dealing with long-term ventilation in the community and 13 years' experience of dealing with tracheostomy ventilated patients transferring from child to adult medicine. Dr RA agreed with Dr S as having provided an accurate summary of G's condition in terms of her progressive respiratory failure. In particular, he was satisfied that G was not over-ventilated and it was not possible to wean her

from ventilatory support. He supported the Advance Care Plan and, as of December 2022, was *"pleased to note"* that ventilatory support provided at CH had been stable.

100. At this point, and in the context of the allegations that LF and GR have been rude, aggressive, and intimidating to staff, I turn to consider the evidential significance of my earlier findings relating to their conduct with the nursing and hospital staff. I approach this evidence with the judgment Peter Jackson LJ in ***R v P (Children: Similar Fact Evidence)*** **[2020] EWCA Civ 1088** in mind. The relevant passages are set out in paragraph 28 above.

101. In my earlier judgment, in June 2022, reported as **[2022] EWCOP 25**, I made clear findings in respect of LF's behaviour. Though I have referred to them earlier in this judgment, it is, I hope, helpful to summarise them again here:

> i. *speaking to clinical staff at the Trust in a hostile and intimidating way and questioning their competence;*
> ii. *questioning the competence of [the nursing home] staff when they visited [G] at the Hospital;*
> iii. *writing to [the nursing home] and repeatedly to the Chief Executive of the [lead group] raising numerous alleged criticisms of [the nursing home] and its staff's competence to care for [G];*
> iv. *causing journalists and a "public relations consultant" to contact the [lead group] to discuss the family's ongoing opposition to the move to [the nursing home]."*

102. I also found that GR holds a hostility to the care home, every bit as strong as LF's, *"not only is she supportive of their position but she has revealed herself to be facilitative of the disruption that he causes".* As I reread the details of those findings, I am startled at how similar they are to many of those that have fallen to be considered at this hearing. In particular, the allegations relating to Dr B where I found the following:

> *"[40] From February, Dr B considered that LF's behaviour became "challenging and verbally confrontational". On the 28th February 2022, when Dr B started to discuss with LF the anticipated discharge date on the 8th March 2022, she told me that he responded by saying, "that she should communicate with his legal team directly". As I understand LF's evidence, he does not dispute this response but contends that Dr B has put a deliberately negative gloss on it. In that same conversation, Dr B told me that LF had said that "she is a very poor doctor". Though Dr B is experienced and resilient, it struck me that as she related the conversation, in the witness box, it caused her distress. Dr B also said that LF had called her a "liar".*

103. I noted that LF had a very different version:

> *"[41] LF has a different perspective. He contends that he told Dr B that she had "behaved dishonestly" but he denied saying she is a poor doctor".*

104. Even though Dr B is a very experienced and senior consultant, I found that she had been plainly upset when LF traduced her as *"a very poor doctor"*. Though there could be no conceivable reason why she would make that criticism of herself up, LF denied that he had spoken to her in those aggressive and intimidating terms. The structure of the complaint against KP is almost identical. It is, on her account, a full throttled attack on her professional competence. It manifestly, for the reasons I have set out, caused her immediate and ongoing distress. The substance of it was denied by LF. It is almost an exact replica of the earlier incident. I found that LF had *"been creating an atmosphere of stress, general unhappiness and deep mistrust on the HDU"*. Ms Powell had submitted:

> *"It is not that he lacks insight into his behaviour and is simply unaware of what he is doing or the effect he has: he is, knowingly, frustrated and angry and taking that out on the staff, undermining them, questioning their competence, and refusing to acknowledge or respect their clinical experience and expertise".*

105. I consider that the clumsiness of LF's denial of his aggressive and intimidating behaviour towards KP conceals within it a kernel of recognition that he had, on that occasion, even by his own assessment, gone too far and caused real and lasting personal distress. Ms Powell's submission above strike me as entirely apposite here. LF does not lack insight into his behaviour, he is *"knowingly frustrated and angry"*. He does take it out on the staff *"questioning their competence and refusing to acknowledge or respect their clinical experience and expertise"*. The evidence of Nurse F is also virtually interchangeable with many of the complaints of the nursing and care staff at CH. I note that Nurse F described LF as making her *"feel very vulnerable"*, *"anxious and on edge when LF arrives on the ward"*, *"often expecting him to say something that will make her feel uncomfortable"*, *"fearful something could happen on her shift"*.

106. The same striking similarities between my earlier findings and the allegations here are seen in my analysis of the evidence of Nurse G:

> *"[35] ...Nurse G felt he is frequently rude to nursing and medical staff including herself, either by ignoring them completely or by making sarcastic comments either to G or the staff directly. She finds him to be very passive aggressive and intimidating and has found herself avoiding having any contact with him whenever possible. Nurse G stated that she and other members of staff sometimes dread coming into work knowing they have to deal with him and several members of staff have left because of his unreasonable behaviour and the effect it has had on their mental health. Nurse G feared that if there was ever any incident involving G that his behaviour would escalate, as it has done in the past, and she would have to be*

> *the person to deal with him. Nurse G reported that he has a history of not abiding to restrictions which were put in place as a result of his actions, and this makes her nervous as coordinator of a busy HDU which cares for many sick children and their families. Nurse G recalled an incident where [LF] was banned from the unit due to an incident of poor behaviour which put G at risk, and he still secretly gained entry to the unit and security and senior management needed to be called to deal with the situation. Nurse G said many of the junior staff have similar concerns and have frequently expressed these concerns to her and other senior members of staff."*

107. By way of final illustration, I note the evidence of Nurse H:

> *"[36] Nurse H stated that since the court decision in December she has felt intimidated by [LF] many times whilst caring for G and due to the way [LF] speaks to her it is becoming increasingly unmanageable. Nurse H said she has been questioned by [LF] about the current situation regarding discharge to adult service to the point where she felt like she was being bullied and made out to be a liar despite her legitimate explanation that she was unaware of the details".*

108. It is important to emphasise that LF must recognise the striking similarity of these allegations with the earlier ones from the hospital. I have already mentioned, now on several occasions in this judgment, how he rationalises this. His explanation requires to be scrutinised carefully and his *"algorithm"* theory properly put to the assay. For it to be viable, it requires me to accept that the staff of CH, at all levels, have carefully orchestrated evidence of rudeness and aggression in which they have manufactured or exaggerated an incident and colluded together, in their evidence, to construct a false case against the family, skilfully replicating the tone and tenor of the earlier complaints. Some of the incidents are, in isolation, rather banal and ambiguous. If they are contrived, I am therefore required to impart a high level of subtlety and ingenuity to this conspiracy. Further, on my calculation, it requires me to accept that something in the region of 18 employees, worked together, over many months, effectively to manufacture a labyrinth of false evidence. Such behaviour requires a motive. LF asserts that the motive is to conceal wholesale incompetence and negligence in his daughter's care. Miss Khalique, in her cross examination of LF, described this theory as 'nonsense'.

109. I have already described the impact that these proceedings have had upon the staff of CH. In attempting to encourage the witnesses to relax, I asked some general questions about their work and length of time that they had been at CH. What emerged was a clear impression of a staff who had, until the arrival of this family, been both proud of and fulfilled by their work. Many have worked at CH for a number of years. Some had been inspired and encouraged to apply for and take up more senior positions. Others had made the transition from Healthcare Assistants into Nursing. Without exception, each of those who gave evidence before me focused unswervingly on their patient. It is important to note that the many occasions in which they tried to diffuse conflict taking place in GR's presence, occurred with absolutely no knowledge that

they were being covertly recorded. Contrary to LF's intentions, the recordings in their totality, as well as in relation to specific incidents, serve actively to undermine his own case. The forbearance, patience, courtesy and professionalism of the staff is evident in abundance. The occasional expressions of frustration are more than sorely provoked. What is revealed by the evidence requires to be identified in explicit and entirely unambiguous terms. This is bullying and controlling behaviour by LF, GR and, I regret to say, albeit in a rather more subtle and nuanced way, CJ. It is calculated to corrode the confidence of the professionals involved in G's care with the deliberate intention of bringing about the stated aim of terminating the placement. Moreover, it also requires to be said that it is behaviour that is inimical to G's interest, it is actively harmful; it threatens the stability of the placement, which I consider to be important to her. It has left her permanently surrounded by conflict, which contrary to the parents' views, I consider to be entirely irreconcilable with her welfare and it affords scant respect for her autonomy as an incapacitous adult. The fundamental right to autonomy does not evaporate with the loss of capacity, it requires vigilantly to be guarded by those charged with the responsibility and privilege of caring for her.

Tampering with equipment

110. There has, on any view, been a highly unusual number of incidents relating to the equipment which sustains G's ventilation. This is not a clinical scenario which any of the nurses, HCA's or indeed management has encountered before. Miss Khalique has emphasised that there were concerns of a similar nature at the children's hosptial. Indeed, they are set out in my earlier judgment:

> *"[31]… Nurse F has noticed recently when she has been caring for G and when [LF] has left the ward that: her tracheostomy cuff has less water in than it should; her amount of oxygen has been turned up from her usual amount; the feed pump volume has changed; the monitor settings being changed from adult to child 2-7 years; the ventilator has not been properly secured onto her tracheostomy; and times where her emergency tracheostomy tray has been without duoderm as [LF] has not let her know he has used it all and it needed replenishing. Finding these things when [LF] has left and knowing this has not been done by Nurse F makes her feel as though he is trying to catch her out, she fears that these could cause harm to G and she is responsible for noticing these things quickly and amending them before anything bad happens".*

111. Miss Khalique submits that I should take this information into account as part of the wider canvas of evidence open to me in determining whether any of the family members has been tampering with G's equipment. I gave thought to this submission but, ultimately, I rejected it. These allegations, unlike the wider evidence relating to LF's behaviour, serve only to raise suspicions of covert tampering with G's equipment. They are undoubtedly similar to the allegations raised here but, in my judgement, an earlier suspicion which has never been put to proof evidentially, cannot logically provide corroborative evidential support for later allegations. In any event,

its prejudicial impact would so strongly outweigh its probative value as to make the exercise intrinsically unsafe and, to my mind, unfair. For these reasons, I do not propose to take this earlier background material into account when evaluating the allegations of tampering with the machinery at CH.

112. It is necessary to set out the parties' positions. Ms Roper makes the following submission:

> *"The family say that staff have not deliberately harmed [G]; if their case of conspiracy is accepted, however, they clearly have done; a conspiracy to keep her in what [GR] describes as a 'place of harm' would be damaging and dangerous for her. If their case is made out, that has huge implications not only for [G] but for all those members of staff".*

113. Having succinctly balanced the competing alternatives, the Official Solicitor has comprehensively rejected the family's account.

114. Miss Khalique identifies what she says are three scenarios open to the court:

> *"A. one 'rogue' member of staff at CH is deliberately tampering with [G]'s equipment;*
>
> *B. there have been a multitude of serious failings by different members of staff at CH, who have each omitted to carry out the requisite checks of [G]'s equipment and have then, en masse, provided falsified accounts to cover up their errors;*
>
> *C. [LF], [GR] and [CJ] have intentionally tampered with [G]'s equipment in the knowledge that this will quickly be identified and rectified, so as to paint CH staff as incompetent and even negligent, with the aim of undermining a placement which they never supported and to further their campaign to 'get [G] home'".*

115. Mr Patel submits that it is *"wholly and inherently implausible that G's family would put her at risk by tampering with her equipment simply to make the point that she should not be there. Whilst the strength of the family's opposition to CH is obvious (they are terrified that a serious, life-threatening incident may occur at any time), it would be a significant (and impermissible) leap to infer therefrom that they have tampered with her equipment"*. Mr Patel submits further that *"there continue to be numerous instances where G's equipment has not been set up correctly"* in circumstances where he contends that *"the family had no opportunity to tamper with her equipment"*.

116. I have already expressed my views as to the commitment, care, and professionalism of the staff at CH. I have also emphasised, repeatedly, the family's love for G and their attentive concern for her physical welfare and appearance.

117. I approach this evidence from the premise that neither the seriousness of the allegations nor their consequences, has any influence on the applicable standard of proof. The allegations are to be assessed individually and cumulatively on the civil standard of proof i.e., the balance of probabilities, nothing more, nothing less. The allegations in either direction and their suggested motives are grave and extreme. It is common sense to start with the proposition that loving parents ordinarily do not hurt their child and that conscientious professionals do not conspire against parents to keep their patient in *"a place of harm"*. That, however, is merely the starting point.

118. The most striking allegation relates to G's oxygen equipment. The professional consensus is that G should be permanently supported by 1litre of supplemental oxygen, 24 hours per day. I am satisfied that this was known to all staff and that, in light of what I have said, no member of staff would have intentionally turned the oxygen off. Historically, as noted above, LF considered that G was 'overventilated'. I am not sure whether he still considers that to be the position but I note that he has expressed the opinion that G can maintain oxygen levels *"for a few minutes, potentially longer when otherwise healthy and sedated"*. I think, LF is probably correct in his opinion. There is some evidence, derived from G's admissions to hospital that she can maintain oxygen levels for short periods on room air only. In cross examining Ms W, CJ advanced the proposition that G had been on room air at A Hospital *"for many days"*, with no oxygen. By contrast, when she was cross-examined herself by Miss Khalique, CJ said that G could not survive on room air *"for a very long period of time"*. This last remark related to G's present circumstances. I am unclear how CJ would know this. I should also say that the medical records also support the view that G could survive for some period on room oxygen alone.

119. It is plain that the staff at CH began to have concerns about the possibility of tampering with the oxygen cylinder. I have been told that they started to check the oxygen was on, with other members of staff, by opening the valve, turning on the flow meter and checking for the hiss of oxygen. As I understand it, this check had not been thought necessary in the past but had been devised to be absolutely clear what was happening in G's case.

120. The first incident occurred in the early days of G's admission to CH. The allegation brought by the ICB is that CJ *"deliberately and knowingly tampered with G's oxygen equipment by switching the valve off"*. On 27th August 2022, the nursing entry for the early morning refers to G as having acceptable oxygen levels *"on room air"*. This has been the focus of a lot of enquiry. Nurse LS wrote the entry but now says that it was a mistake. In some respects, whether or not G can manage for some time *"on room air"* is a distraction here, the fact is that the treatment plan was, as I have said, 1litre of supplemental oxygen, at all times. CJ does not accept that this was a mistake. IW (manager) told me that he discussed this with Nurse LS and also concluded that it was a mistake. Again, CJ rejects this. She told me that she thought G can survive on room air based on her experience at A Hospital and some research that she has undertaken herself.

121. The level of oxygen can be checked by either the dial on the portable cylinder or the monitor on the wall. Nurse W was clear that she had checked G's oxygen on the wall that morning. She said that she had double checked it and it read that she was on 1litre, i.e., as per her treatment plan. Nurse CB recalls that Nurse W was undertaking

the oxygen checks for all the rooms on that block with an HCA, after 8:15am. Nurse W says that only the HCA and CJ were present after she had checked the oxygen. Nurse W further told me, in the course of cross examination by CJ, that she was double checking G's oxygen precisely because there was a concern, in effect, that something untoward might be happening. She said that they could all hear that the oxygen was on.

122. In her statement, Nurse B tells me:

> *"At the commencement of the shift that day, at around 08:15, I had spoken to the staff about the organisation for that day and [Nurse W] confirmed she would do the oxygen checks in all of the rooms on [the unit]. [Nurse W] left to do the oxygen checks with [RF], HCA, who was providing enhanced care at the time.*
>
> *Once the check of [G]'s oxygen was completed, [G] was left with her grandmother, CJ, and the 1:1 nurse who sat at the door outside [G]'s room when [G]'s family were present and [G] didn't need any care.*
>
> *At around 10:50am, I was present in [G]'s room with the 1:1 nurse and CJ when CJ reported to me that [G]'s oxygen valve was off. I said I did not know how to explain that because earlier that morning [Nurse W] and the HCA had checked the oxygen valve was on and being delivered at 1 litre and no other staff had provided care to [G] since then. CJ immediately replied, "I didn't do anything". I said I was not saying that, but I just didn't know how to explain it.*
>
> *I re-checked with [Nurse W] and the HCA that [G]'s oxygen had been checked and they confirmed it had been. This concerned me because I was aware no other members of staff had interacted with [G] since then and I didn't understand how the oxygen valve was off. The oxygen valve had clearly not been off all morning because otherwise [G]'s saturations would have dropped significantly and it would have been obvious if she was struggling without oxygen for that long".*

123. In the prefacing paragraphs to the above, Nurse B stated:

> *"There have been repeated reports of staff doing oxygen checks for [G] (i.e. checking that the oxygen dial is set to the correct level and opening the valve to allow oxygen through), and a short time later being asked by members of [G]'s family to check [G]'s oxygen equipment and then finding that the oxygen valve is off. On these occasions staff have been certain that the oxygen had been turned on, sometimes verified by another member of staff, and therefore there has been no explanation for how it was subsequently found to be off. This*

> *would require a deliberate action and would not occur accidently".*

124. I accept that the above represents, in honest terms, genuine concerns identified by the staff. I do not consider that there was any rush to premature judgement. Indeed, my impression of the staff is that they were far more ready to question themselves than to condemn the family. The audio recordings and transcripts reveal that members of staff's first instincts were often to apologise to the family. The assumption was that if there was a problem with the oxygen equipment then that could only be attributable to an error on behalf of the nurses. It must be remembered that this is a family who have played an enormous part in their daughter's care for 28 years. My assessment, both of the content and tenor of the evidence from CH, is that the staff were struggling to believe that anybody, let alone members of G's family, would tamper with her oxygen supply. However, one fact which suffuses the records and statements is that it is a family member, almost invariably, who discovers that the oxygen supply is switched off. When it is a staff member, the enquiry as to whether the oxygen is on, is usually prompted by a family member. Predominately, this is LF.

125. CJ's account is that she walked into G's room and noticed that the oxygen valve was off. As I understand the evidence, Nurse B also walked in very shortly afterwards. It seems likely that CJ had seen Nurse B heading to the room. In text messages to her son much later that evening, she states *"[Nurse B] was coming"*. When she came into the room, CJ told her that the oxygen was off. Thus, CJ could only have been in G's room for a matter of minutes before the nurse arrived. When asked by Ms Roper whether G was exhibiting signs of distress, in consequence of a deprivation of oxygen, CJ said *"I cannot remember"*. I find that response both disturbing and unconvincing. If G had been showing signs of struggling to breathe, I think it inconceivable that CJ would not have noticed. Nurse B makes no reference to her patient struggling to breathe or being in any way uncomfortable. Given that the oxygen provision was the focus of such attention, I am quite sure that had G been in difficulties, both Nurse B and CJ would have noticed. Moreover, CJ's active resistance to her granddaughter's placement at CH leads me to think that she would have complained vociferously, and rightly, if G had been struggling to breathe. I think it far more likely that there were no signs of G struggling. This raises the important question of what caused CJ to check the oxygen supply so quickly after entering the room.

126. There has been a great deal of concentration on the nursing records and observation chart for the 27th August 2022. I have already commented on CJ's mastery of the documents. I should also make it clear that, in this case, the documents were all shared on the screen. Where the handwriting was obscure or the print small, junior counsel read the document out loud. CJ has been unrepresented but I have seen very few litigants in person acquit themselves so effectively in the courtroom. The nursing records show the following:

> *"[CJ] also said no O_2 was on – when looked was off – Nurse W checked the oxygen on shift commencement, which was witnessed by HCA RF".*

127. CJ attacks the integrity of this note. I understand her to be saying that because it is added in the margin, it has been *"added afterwards"* to discredit her. I wanted to clarify precisely what she was saying on this and she told me directly that she thought the oxygen had been off all night and that the record was *"suspicious"*. When I asked her what her suspicions were, she told me that she thought it was a fabricated document. I think that for CJ's account to have any coherence, she is logically driven to this as an explanation, i.e., that the oxygen had been off all night. The preponderant evidence is that G could not have sustained this oxygen deprivation and certainly not to a degree such that by 10:50am the following day, she would be displaying no signs of respiratory distress. There is no indication that G's $Sp0_2$ levels dropped at any point, which would be consistent with a momentary interruption in her oxygen supply. Moreover, for this account to hold, it would logically require a double error i.e., errors by two separate professionals, in relation to the supply of oxygen, on two different occasions. Expressly, it would require the nurse on duty the evening before, (Nurse LS), to have failed to have turned the oxygen on and for Nurse W not to have checked the oxygen, at all, the following morning. It would also require Nurse B's evidence to be either substantially embellished or entirely fabricated. I think that CJ accepts that this flows from her stated position.

128. CJ's allegation that evidence is being fabricated against her, requires confronting the fact that nobody has ever claimed that they have seen her directly switching the oxygen off. If this were a fabricated document, it is not entirely easy to see why it should have an inbuilt uncertainty to it. CJ insists that she simply did not have the opportunity to turn the oxygen valve off as she was in the constant sight of those present in the room. The HCA is stationed in the entry way to G's room, the rather confused objective of which, was to give the family privacy. CJ suggested that she was under unrelenting scrutiny, *"being stared at",* to use her phrase. It is agreed that the HCA was sitting in the entry passage and, from this position, I am satisfied that would have afforded an opportunity quickly to switch off the oxygen without her seeing it. I repeat, the HCA appeared to have the rather challenging responsibility both to observe and to permit privacy.

129. I remind myself that at the point this allegation is made, G had been resident at CH for only ten days. The corrosive atmosphere that I have described in the allegations discussed above had not yet fully settled. Certainly, there was some anxiety and suspicion but this was nothing compared to that which followed. Having set out, in some detail, the events of this day, I am required, effectively, to choose between two entirely irreconcilable alternatives. In relation to the allegations against her, there is no burden on CJ to prove her innocence. The burden remains on the ICB throughout. CJ's account requires me to accept that two professional nurses negligently or deliberately jeopardised their patient's life and subsequently fabricated adverse, but ambiguous, evidence against their patient's grandmother. The alternative is that, for what can be no more than a matter of minutes, CJ took the opportunity to switch the oxygen off and immediately drew it to the attention of the staff. I consider, having analysed the evidence in the way I have sought to above, that the latter is far more likely. It was most probably motivated to make CH staff look incompetent, driven by the desire to destabilise the placement that CJ and the family have so consistently expressed. I emphasise that CJ's account, would require G's oxygen supply to have been off all night. I consider this to be extremely unlikely.

130. I do not consider, from what I have read and heard, that switching off the oxygen for a few minutes would be likely to have jeopardised G's life. CJ told me in her evidence that she thought, based on her observations and her *"own research"* that she considered her granddaughter could survive on *"room air"*, at least for some period. I suspect that CJ may well be correct. She and her son, LF, have plainly given much thought to the question of G's ventilation over the years. Indeed, LF claimed, at The children's hospital and in the face of professional consensus, that G was *"overventilated"*. This leads me to the view that CJ would be prepared to turn off the oxygen, confident that she could discredit the unit, without actually exposing G to risk. Objectively, of course, this is extraordinarily dangerous and reckless. If it was, as I believe, motivated to secure G's release from CH, it is distorted thinking.

131. As I have said previously, GR barely uses her smartphone. She also does not email. By contrast, LF and CJ are in constant communication. Following the incident above, there were text messages between the two much later that evening. The text messages have not been interrogated but LF has filed a screenshot of some messages between him and his mother that evening (22:14 hours). They read as follows:

> *LF: When did you notice the oxygen not on? We're they in the room? X*
> *CJ: No carer by the door, almost as soon as I got there x*
> *LF: Carer was by the door ? And did you raise it with them ? X*
> *CJ: No [Nurse CB] was coming told her, checked sats and she was ok, why what's happening x*
> *LF: They said tonight "it was most peculiar" starting already , next thing will be allegations of tampering again ? Got to protect ourselves now x*
> *CJ: That [Nurse W] said after, "I definitely turned it on this morning" to which I said does that then mean she…"*

132. Whilst, for the reasons I have set out above, I have declined to accept that suspicions of tampering with G's equipment at The children's hospital can be afforded any evidential weight in this investigation, it must be noted that the fact of those earlier allegations was, of course, known to the family. That fact is part of the evidential matrix here. In the exchanges above, there is direct reference to it: *"next thing will be allegations of tampering again? Got to protect ourselves now x"*. LF has adduced this screenshot of part of a text message exchange. The extract cannot be evaluated in context, it is selective. The messaging appears to take place approximately 12 hours after the incident. Manifestly, it jars with some of the evidence that I have set out above. This is a further incident where LF's material has obvious gaps in it. Miss Khalique has, in a different context (see para. 88 above) invited me to infer that LF has deliberately doctored the material. I declined to draw that inference and whilst I am suspicious that there is some contrivance here, I do not consider that two separate suspicions are sufficient to establish a finding. I do conclude, however, that this material does not dislodge my reasoning and finding, on the balance of probabilities, that CJ switched the oxygen off.

133. As in the earlier allegations, I do not propose to determine each and every breach. As I have said, it is disproportionate and unnecessary to do so. I turn next to an incident on 29th September 2022, which has been the focus of much attention. In many ways, it

crystalises the way issues are disputed in this case. The applicants contend that this was an incident of LF deliberately tampering with G's oxygen equipment, by switching the valve off. The opposite explanation is that CH staff incompetently hoisted G, causing episodes of oxygen desaturation and distress. It is also said that CH staff failed to turn G's oxygen on, thus depriving her of oxygen. I heard from three CH witnesses: Nurse W, EB and EL. On this occasion, GR was not present and the alternative account rests on the evidence of LF alone. By this stage, CH had devised a Family Interaction Form, which was intended to monitor their concerns. On the 29th September 2022, Nurse W was responsible for writing up the record. She told me in evidence that it had been written up on the same day.

134. On this day, it is clear that G was experiencing breathing difficulties. The staff had attempted bagging and attaching an oxygen line. They also turned up the oxygen to 4 litres. None of this enabled G to maintain her $Sp0_2$. Suction had been given and there were significant secretions. By this stage, LF was not permitted in the room when treatment was given. The form records that *"dad was knocking on door continuously. Barged in and recorded the situation. Dad repositioned her and was all over G"*. The form relates that an attempt to reassure and pacify LF by telling him that G's $Sp0_2$ were still reading at 80%. The following sentence has been highlighted by the advocates:

> *"Told dad"* (i.e., about the reading) *"He was not interested – his hand went to the back of the chair. Not sure if dad switched O2 off. X2 SN checked O2 on chair. Dad said O2 was it on. I quickly turned O2 on and she maintained 88º dad still not interested at this point. [G] 97-98%"*

135. The nursing record reveals that G's $Sp0_2$ dropped to 88% as G was being hoisted. Bagging was started and LF entered the room and changed G's position. It also states that staff had tried to sort out a leak on the circuit and that LF had then *"put arm around back of chair, returned and asked if oxygen was on"*. It seems clear and it was confirmed in evidence that by this stage, staff were actively trying to assess whether LF was tampering with his daughter's treatment. As a fact, this is not disputed. Of course, it lets in the possibility that heightened anxiety might lead to the wrongful interpretation of an act which might have been entirely innocuous. Mr Patel trailed this in cross-examination, understandably, but it is not in fact LF's case. He believes this to be a deliberate conspiracy against him to conceal CH's general nursing incompetence.

136. There is a yet further document, 'The Social Leave Checklist'. This is in largely tabular format and is written up by hand. It has been scanned into the medical records. It reveals a conflict: (CH) *"valve not open on O2 cylinder on chair for vent use but checked open on the left O2 cylinder which was on and checked"*. LF recorded the following on the form: *"oxygen not on [G]'s chair for transfer – [Nurse W] put it on after 22 minutes"*. The first three staff members involved were clear that the O2 was checked prior to the hoisting and that it was full. NS, who was not in fact present for the hoisting, also states that she had checked G's oxygen was on. Nurse W said that she had not checked the O2 valve herself but had trusted her staff to have done this. She had, however, checked the flow meter. Hoisting G had always been fraught. Staff felt uneasy and found the family's criticisms undermining. On this occasion, there is

no doubt that LF had become agitated. Those present describe LF as distressed when he came into the room. Characteristically, as I have found, LF was critical of the staff:

> *LF: Can I not just put her in a good position in like two seconds?*
> *FEMALE SPEAKER: You can if it'll bring her SATS up*
> *LF: Because really it's what's best for [G], isn't it really?*
> *FEMALE SPEAKER: Okay. No, no. It's fine. It's fine.*
> *LF: I've actually heard her being audible and struggling here.*
> *FEMALE SPEAKER: I know. I know.*
> *[G] groans*
> *LF: Exactly*
> *FEMALE SPEAKER: To me it's too -- she's too far down.*
> *FEMALE SPEAKER: She should be going up a bit.*
> *LF: And this, with the greatest of respect, is the reason why we must be in here for the hoisting.*
> *FEMALE SPEAKER: Well we need to be concentrating on [G]*
> *LF: Yeah, can we then please because she's been desatting for over five minutes. I've timed it. [inaudible] Okay baby. It's okay. How much oxygen is she on?*

137. What is obvious from the transcript above is the artificiality of the exchanges (LF is recording it all on his mobile phone). This is, in my judgement, even clearer when listening to the recording. The nurse is plainly very concerned and regards this as a serious incident. LF, however, takes the opportunity to press his case to be reinstated to his direct role in the hoisting procedure. What is most striking to me and strongly inconsistent with LF's case, is the extent to which the staff are both personally respectful to LF and prepared to yield to his care experience. This exchange is illustrative:

> *FEMALE SPEAKER: We've put -- we've put her, we did have her on four but we've put her on ten just to give her a boost.*
> *LF: Okay. And the first thing which is of concern is that there's way too much dead space. W h e n s he's struggling you have to put her back on a single circuit*
> *FEMALE SPEAKER: Well we did do that.*
> *LF: Excuse me baby. Come on.*
> *FEMALE SPEAKER: There you go.*
> *LF: (Several inaudible words) top. You breathe nice. Where's your belly button.*
> *FEMALE SPEAKER: We're aware that the position is not right. We know that. That's why we've still got the hoist but we want to get her SATS up before we do that.*
> *LF: You're not going to get the SATS up in that position that's the problem with the hoisting and the sling.*
> *FEMALE SPEAKER: We're not allowed to manhandle her like that though. We have to do it properly. (Several inaudible words).*
> *LF: Yes but how long -- you know, she's been desatting for over 12 minutes.*

138. As the evidence unfolds, it becomes clear that what at first appears to be courteous, respectful diffidence to LF is in fact something rather darker. It is clear that the nurses are very intimidated by LF's controlling behaviour. The exchange ends with the nurse explaining, apologetically, *"we're doing our very best"*. At risk of overburdening this already lengthy judgment, it is important to follow this episode through:

> *FEMALE SPEAKER: (Inaudible).*
> *LF: Good girl. Can you see what [GR] was talking about with the reassurance?*
> *FEMALE SPEAKER: Yeah. I'm just watching her sats now.*
> *LF: Take your time.*
> *FEMALE SPEAKER: It's not picking up.*
> ***LF: Take your time. And the oxygen taps definitely open.*** *(my emphasis)*
> *FEMALE SPEAKER: Yeah.*
> *LF: And what's she on?*
> *FEMALE SPEAKER: She is on ten. Ten.*
> *(14.20)*
> *(clicking sound)*
> ***LF: It wasn't on, that click.*** *(my emphasis)*
> *FEMALE SPEAKER: It wasn't on.*
> *LF: That wasn't on.*
> *FEMALE SPEAKER: It wasn't on.*
> *FEMALE SPEAKER: Jesus Christ. I thought you'd switched it on.*
> *FEMALE SPEAKER: We did switch it on.*

139. At this point, LF deflects the enquiry. He says *"could you do me a favour please? Could somebody go and get [IW] for me please?"*. IW is, as stated above, the CH manager. Here, LF is signalling a complaint. It is IW to whom LF usually complained. This signal would have been clear to the staff. What is significant in my mind is that it is requested at what appeared to be a crisis point and was inevitably increasing stress and conflict where, again, calm co-operation would have been the more obvious approach. There is also, I am bound to say, despite the apparent politeness of LF's language, an imperiousness in asking the nursing staff to bring IW to the room. By this stage, the nurse (female speaker) has manifestly lost confidence in her own professional judgement and is explicitly blaming herself.

> *FEMALE SPEAKER: (Inaudible). That's too much, I'll turn her down*
> *FEMALE SPEAKER: No. You've got to open the valve. My fault. I should have double checked it.*
> *LF: (Overspeaking) so she has been desaturating for nearly 20 minutes and you didn't have the oxygen on*
> *FEMALE SPEAKER: My fault. I should have checked it.*
> *LF: And you are wishing to exclude us from [G] (Overspeaking)*
> *FEMALE SPEAKER: No.*
> *FEMALE SPEAKER: No. We're not (Overspeaking)*

140. The dynamics of these exchanges can only truly be understood by reference to the totality of the evidence. This is a pattern of behaviour which requires to be read and understood as such. As soon as the nurse declares it to be her fault, LF again presses his perceived advantage and asks whether she is wishing to *"exclude us"* from G's care. Inevitably, the answer is no. This is a complete subversion of the safeguards that have been put in place to protect G. The parent/professional dynamic here has now been overturned. The incident concludes with LF, pedagogically, summarising what he considers are the lessons to be learned:

> *LF: I'm going to suggest that we need some more checklists.*
> *FEMALE SPEAKER: Okay. Well –*
> *LF: That we need some more checklists.*
> *FEMALE SPEAKER: Like what?*
> *LF: Make sure the oxygen's on (Inaudible).*
> *FEMALE SPEAKER: Yeah. (Inaudible). Well, I've always done it.*

141. In his statement, LF summarises the key features of this incident in these terms:

> *"Under this section, [Nurse E] considers a concern I raised in respect of [G] desaturating in the morning on 29 September 2022. On this date I was waiting outside her room (as the family had been requested to do) when she was being hoisted. During this time, her alarm went off continuously. After a period of at least 5 minutes, concerned that the alarm was still going, I knocked on the door and entered the room. I asked if I could tweak her position to open her airway. When this did not have the desired effect, I asked how much oxygen she had and I was told it was 10 litres. This did not make sense to me so I asked if the oxygen was on. One of the nurses checked and the oxygen was not on, and by that time [G] had been without oxygen for approximately 22 minutes, as this was the length of time the alarm had been going off on the desaturation monitor".*

142. Three of the nurses have stated that they saw LF go around the back of the chair. LF strenuously protests that was not true. He goes further and suggests that it would not have been possible. As I understood his evidence on this point, he was saying that he was comforting G, facing the front of the chair, whilst Nurse W was standing behind it, thus making it physically impossible for him to have gone behind the chair and switch the oxygen off. There is no room for mistake or misunderstanding here. LF is accusing the three nurses of concocting a false account against him. A moment's reflection on the nurse's comments and behaviours in the above extracts signals how unlikely this is. If the nurses had got together deliberately to traduce LF, their evidence might be expected to show some level of similarity or consistency, perhaps even in the words used. It does not, indeed, quite the reverse. Nurse CM said that she *"believed"* that LF had gone round the back of the oxygen *"whilst asking what number it was"*. Nurse EB said, *"dad went round the back of the chair and said, 'have you checked the oxygen'"*. Nurse L recorded LF as having *"reached behind the*

chair and then said, "is the O2 even on"". Anybody listening to this recording can hear the stress in the nurses' voices (Nurse W described herself in evidence as *"unbelievably stressed"* on this occasion). Having listened to it, I consider her description to be entirely accurate. Her stress is almost palpable on the recording. All this stress was greatly increased by what I identify as LF's running manipulative, insidiously critical commentary. It is hardly surprising, in this heated situation, that the detail of accounts vary. However, those variations are only on the margins of the central observations. What remains consistent is the observation that LF went, in some way, behind the back of the chair. The differences in the account serve only to illustrate the fallibility of human memory for detail in stressful circumstances, conversely, I find that here, they reinforce the intrinsic honesty and accuracy of it. Where the evidence of the nurses conflicts with that of LF, I have no hesitation in preferring the former.

143. In her oral evidence, Nurse W told me that she *"just got the feeling [LF] knew what the problem was"*. Though skilfully cross-examined by Mr Patel and prepared to acknowledge both her own panic and distress, she withdrew, with the benefit of hindsight, her apology, heard on the recording. That apology was, in my judgement, the instinct of a nurse who was unable to reconcile LF's apparent concern for his daughter with a deliberate interference with her oxygen supply. Her first instinct was to assume that the professionals had made a mistake. It is an indication of her own professionalism that she not only apologised but did so immediately. This of course, is not easily irreconcilable with the conspiracy that LF advances. The withdrawal of the apology is, I find, genuine not least because the whole episode still plainly causes her sadness. She suggested that LF may have turned the valve off earlier when G's chair was in the lounge. This, in my view, is speculative. I place more weight on the evidence of the three nurses who saw LF reach behind the chair in G's room. Mr Patel pressed Nurse W by suggesting that the earlier explanation might be a mistake by staff who had failed to turn the valve on. Again, Mr Patel is required to ride two forensic horses. LF contends that the oxygen supply was switched off in consequence of professional incompetence but also asserts that the evidence of the nurses is dishonest, to conceal their negligence and to place the blame on LF. To Mr Patel's question, the nurse replied *"it sounds great, but it is not reality"*.

144. Great emphasis is placed by Mr Patel on the fact that until the point where LF asked if the oxygen was on and it was then undoubtedly turned on, the $Sp0_2$ had remained consistently low. The change when G's $Sp0_2$ level went up, it is contended, points to the oxygen having been off until that point. Nurse W was prepared to go along with this. I found her to be diffident in the witness box in much the same way that she is on the recording. However, as I have said above, I found the evidence of the three other nurses to be forensically robust and essentially consistent. Miss Khalique addresses this in her written submission:

> *"The written and oral evidence of [Nurse W], [B], [L] and [B] is consistent in that they had checked the oxygen was on, that morning. [L] states that the oxygen "was definitely turned on. I am certain that it was on as we had double checked it". It is simply unsustainable to argue that four members of trained staff, including a registered nurse, would fail to check [G]'s*

> *oxygen in circumstances where her SATs were fluctuating. Whilst it is not disputed that [G]'s SATs did increase after the oxygen was turned back on, this coincided with a change in [G]'s positioning, which staff felt was the root cause of the issue. On the recording, a member of staff can be heard stating: "[it was] definitely, definitely her position, wasn't it?"*

145. I agree with Miss Khalique that it is more likely that the resolution of G's positioning resulted in her improvement. The importance of correct positioning has been a feature of this case and indeed has been emphasised and insisted upon by LF. I consider this to be the most probable explanation for G's recovery at this incident. Moreover, it is important to emphasise that whilst I find this allegation proved on its individual facts, my finding is reinforced by the fact that, as will become clear below, LF behaved in this manner, tampering with his daughter's medical equipment on other occasions. Thus, this allegation does not exist in a vacuum of its own. In coming to an alternative evaluation of this incident, it strikes me that the Official Solicitor has failed to afford sufficient weight to this point. Moreover, with respect to Ms Roper, I am unclear how she reconciles her submission that *"the Official Solicitor does not consider that it would be safe to conclude that this allegation is made out"* with her ultimate conclusion (which I presume she does consider to be safe) that *"there was a mistake and G was left without her necessary oxygen"*. It does not follow inexorably, at least to my mind, that if the ICB's allegation is not established, LF's alternative explanation must be. This fails fully to engage with the evidential exercise or to identify and analyse the weight of the preponderant evidence. A further feature of this evidence which also requires to be emphasised is that LF was effectively raising the alarm to check whether the oxygen was on. As nursing staff have noted, this was a recurrent feature. As my analysis of the recording and transcripts reveals, LF was carefully taking every opportunity to insinuate his way back into control of G's care. The panic and stress in the nurses' voice is quite notably absent from his. This may well have been what led Nurse W to say (see para. 141) *"just got the feeling [LF] knew what the problem was"*. For the reasons I have given above, I find this allegation to be established.

146. Only a few days later, on 3rd October 2022, there was a very similar incident. Again, this arose during the hoisting. The incident involved Nurse KP. KP sets out her experience and qualifications in her statement, which I consider important to emphasise:

> *"I have been an employee of [CH] since July 2018, I started as a Healthcare Assistant, then Senior HCA (SHCA) before qualifying as a Registered General Nurse in April 2022. Whilst I have been both SHCA and nurse I have always been fully compliant with ventilator and tracheostomy training competencies. My current job role duties include assisting complex patients with holistic care within my level of knowledge/ skill which includes administering medications, tracheostomy and ventilator care, nutritional and hydration needs, and other clinical needs".*

I find it interesting and not without significance that Nurse KP started as a Healthcare Assistant and has progressed rapidly in her career, whilst working for CH. This reinforces her comment and the comments of others that prior to the arrival of G and her family, CH had been a happy and rewarding place to work. This kind of encouragement in professional progression and retention of staff all supports the general consensus that the corrosion of morale is, as asserted, attributable to the behaviour of this family.

147. Nurse KP sets out the general procedure that is deployed with G prior to family visits:

> *"On the unit, we will always undertake [G]'s checks prior to her family coming into the unit. First we will check her chair, check over the vent on the chair and then check that all of her equipment is replenished. Before we hoist [G] from her bed to her chair, we are required to transfer the oxygen too and so we will always undertake checks on the oxygen prior to transferring [G]. There is always at least 2 staff members and usually this would be 3 staff members. At least two of us will visually check the valve on the cylinder and turn it on. We will then make sure everyone else in the room can hear it is on by listening to the hissing sound. We will then transfer [G] over to the chair vent and we will monitor her SATS during the whole process so that we know her oxygen is stable and remains stable. We would then use the hoist to move [G] into her chair".*

148. When evaluating the behaviour alleged against KP on 3rd October, it is obviously important to place it in the context of what I find had occurred on 29th September 2022. The events of that day inevitably made the staff particularly cautious and wary. In her oral evidence, Nurse KP confirmed that on 3rd October, Nurse S had undertaken the initial checks on the oxygen cylinder and that they had both heard the hissing sound, indicating that the oxygen was on. It has been part of LF's and CJ's case that it was possible for there to be a hissing sound even if the valve was off. Nurse KP had not encountered that. In both her oral and written evidence, she was clear that she had seen LF, at the back of G's chair, which is where the oxygen cylinders are located. She was also very clear that as she was coming around the chair to do the final checks and before she had a chance to look at the cylinder, LF told her it was switched off. In her evidence, she said that LF's hand was on the valve but she had not seen him actually turn it off. Again, when it was put to her that LF was being intensely scrutinised and could not have done this unnoticed, Nurse KP said *"that everyone was doing their own job focusing on G"*. She explained that it would only be possible to see LF move the valve if they had been at the back of the chair. Mr Patel diligently pursued LF's belief that the oxygen cylinder only *"clunks"* when the valve is opened for the first time. Nurse KP disagreed. With fidelity to his instructions, Mr Patel suggested to Nurse KP that the family had told them that they needed to be careful to ensure that the valve was opened as well as the flow meter. Nurse KP agreed that the family had indeed told her that but politely reminded Mr Patel *"we knew that anyway"*. It is instructive to step back from this exchange to note the implication in Mr Patel's question i.e., that "the family" consider that they were in charge,

instructing the professionals as to how they should operate. Even Mr Patel's question illustrates the distortion of the dynamics in this case, the underlying assumption of it, would be regarded as quite ridiculous in any other case.

149. Mr Patel also put to Nurse KP that G can breathe on room air if attached to a ventilator. Certainly, this is what LF believes. But Nurse KP's response was, effectively, that she did not know the answer to that. She emphasised that the care plan for G mandated oxygen on a permanent basis, *"24/7"*. For this reason, Nurse KP said that she had never attempted to support G without oxygen. She plainly considered that such an experiment would be unethical.

150. Ms NS describes her experience:

> *"I have worked at [CH] for seven years, in this time I have developed my knowledge in a variety of different skills including; Tracheostomy care, ventilators training, first aid and emergency first aid, PEG and JEJ training and much more. As a senior Healthcare assistant I assist the nurse with the running of the shift, delegating staff members, deliver Tracheostomy care, assist with personal care and assist patients with their nutrition and fluid intake".*

151. NS was also clear that LF said that the oxygen was not on and that he corrected it and said that it had made a *"clunking noise"*. She was asked about the significance of that noise and told me that the clunking sound is sometimes heard and sometimes not. She put it in this way in her second statement:

> *"I refer to my previous statement which sets out that this noise does not happen every time the oxygen is turned on and does not only happen when the valve is first opened. The clunking sound can be heard intermittently and only on some occasions".*

152. On this occasion, it is common ground that G's O_2 remained stable. The reasonable inference from this is that she had been receiving a stable O_2 supply. Mr Patel again put his client's view that G could maintain acceptable SpO_2 levels on room air. Like her colleague, NS was quite shocked by the question. She responded that *"we wouldn't try that"* and added, *"at least not intentionally"*.

153. It is illuminating to look at LF's written statement relating to this incident:

> *"The next alleged incident was on 3 October 2022, when it was reported that [G] was transferred and stable in her chair and that I then said that the oxygen valve was off and I turned it on. I was completing my daily checks at the time, and there have been numerous occasions when I have found her oxygen valve was turned off when I checked the chair. On this occasion the valve was turned off. I cannot account for why this was the case as I was not present earlier.*

> *However, the oxygen made a clunking noise when it was opened for the first time. When I asked [Nurse KP], she accepted that she had heard it and admitted this to [Nurse CS] in my presence. [Nurse CS] rudely and abruptly told [Nurse KP] to stop talking and to be quiet. The fact that there was a clunk would contradict the evidence that the oxygen was on as this sound only happens when turning the oxygen cylinder on for the first time. I note the evidence in [NS]'s statement that the "clunck" sound is made each time the cylinder is turned on. This is not correct. It is contradicted by the evidence from [Nurse CS] at paragraph 10 of her witness statement who says that the "clunk sound can sometimes be heard when the valve on the oxygen opens first". I have an audio recording which confirms the account set out above".*

154. It is a sad feature of this case that LF remains so preoccupied with tasks like *"completing his daily checks"*, as he puts it. Once again, LF had been busy covertly recording G and the nursing staff. Yet again, though he appears unable to comprehend it, the recording undermines his own case. Immediately after LF stated that the oxygen was not on, several members of staff spontaneously express their clear astonishment, *"we tested it"* one voice said, *"the oxygen was on"*. Another voice said, *"I heard it hiss"*. Yet another voice said, *"they were on"*. There is none of the self-recrimination and professional doubt exhibited by Nurse W at the similar incident, four days earlier but a clear team confidence that the oxygen had been on. Along with the factual evidence, that I have analysed above, these recorded responses, revealing the nurses' reactions are important. I emphasise I am hearing responses in real time and not solely evaluating a witness's recollection in the witness box. Miss Khalique and Ms Roper refer to the evidence in respect of this allegation as compelling. I agree. I find that LF deliberately tampered with G's oxygen equipment by switching the valve off. As is plain from Mr Patel's questions, LF plainly considers that G can breathe independently, at least for short periods. I am confident that in his own mind he would not wish to hurt his daughter but the danger generated by his actions is obvious. It also is important to say that it is a terrible violation of his daughter's autonomy. It risks physically jeopardising her wellbeing, triggering, at very least, real discomfort. It also compromises her dignity. LF has real capacity to sooth, pacify and reassure his daughter. I believe that the professionals consider that G receives pleasure and reassurance from her father's touch. It is profoundly sad that the man to whom she looks for protection has become a danger to her.

155. It is important that I deal with an allegation that CJ deliberately and knowingly tampered with G's oxygen equipment by switching the valve off on 11th October 2022. The key witnesses to this alleged incident are SJ and SS. I found SJ to be a very impressive witness. I also found SS to be calm and measured. The following paragraphs set out SJ's experience and her role at CH:

> *"I worked as a Community Health Care Assistant (HCA) for 3 years, and the hospital as an Auxiliary Nurse before commencing my nurse training which I completed in 2005. I have experience of working in hospitals in high dependency and intensive care, acute cardiac medicine, urology and*

> *general surgery. I was appointed as a Sister on the surgical unit in 2014. In late 2018, following a work injury I left clinical practice to work as a nurse analyst in a solicitors' firm. However, I missed the clinical side and this led to me joining [CH] as a Nurse in September 2020.*
>
> *It is my responsibility as Unit Manager to manage the ward effectively and efficiently and support the nursing staff with patient care provision. This includes assisting with hands on care as and when required, communicating with the family of patients and the Multidisciplinary Team, keeping up to date with care plans, arranging 1:1 support, supervising a team of staff, ensuring standards of excellence are aimed for, completing benchmarking and audits, arranging transfers to hospital, and assisting during patient admissions and settling-in periods".*

156. Nurse SJ has a body of experience both in management and nursing care, including high dependency and intensive care, which undoubtedly makes her a very considerable asset to CH. She presented to me as professional, clear thinking and strikingly fastidious in her attention to detail. She described herself as *"paranoid"* about checking and getting things right. Before she said that, I had already formed that impression of her. I also sensed that her role, because it is essentially supervisory, had enabled her greater protection from the forceful behaviour of this family which has so demoralised the CH staff. She had retained a professional distance. I emphasise that in saying this, I imply no criticism of those who struggled to do the same. This professionalism is also evident in her dealings with CJ on this occasion. I found Nurse SJ to be firm but polite and ready to recognise that CJ herself is always at pains to be courteous even when she is being critical of staff. I also formed the strong impression that Nurse SJ was disinclined to be distracted by the family's own agenda and to concentrate unswervingly on G. I have seen Nurse SJ's contemporaneous note relating to this incident. Nurse SJ's conversation with CJ, reflected in the note, reinforces my view of her. I strongly suspect that Nurse SJ rarely makes mistakes but she volunteered to CJ that she had made a mistake the previous evening concerning G's humidifier. She told CJ that it was not a mistake she would normally have made but she rationalised it as having become *"flustered"* by G's parents. It is, to my mind, an indication of Nurse SJ's experience and integrity that she declared her mistake, when she had no need to do so, to a family who were vigilant in finding fault. She used it as an opportunity to try to communicate to CJ that the family's constant questioning of the staff's professionalism was counterproductive and that the impact on them risked having an impact on G.

157. It is important that I emphasise the significance of this exchange. I agree with the thrust of Ms Roper's submissions in relation to it. CJ's reaction was entirely without grace, kindness or any generosity of spirit. She told Nurse SJ that she already knew about her mistake because LF had told her. Her response was to say, *"you wouldn't leave a poor driver to drive on their own"*. There are a number of features about this remark which capture the character of the relationship between the family and the staff. First, the family regard the staff, virtually without exception as far as I can see, as *"poor drivers"* i.e., incompetent professionals. Implicit within the remark and

which also reflects the family's belief, is that without any professional training or qualifications, it is they who are there to supervise and direct the *"poor drivers"*. I do not wish to detract from the quality of care that the family is able to give but their sense of superiority towards such manifestly experienced and obviously committed professionals is very striking.

158. Ms Roper insightfully regards this episode as having presented a real opportunity for CJ to engage and better to understand how the family could help staff provide G with a really high quality of care. CJ's failure to grasp the hand being offered to her signals, I regret to say, that there is very little hope of a constructive collaborative working relationship between this family and any care or medical professionals. Any family has a right to challenge a doctor or nurse. Sometimes families do know better. They know their relative in a way that strangers do not. But all this is a far cry from the behaviour of this family. What they do not accept is the professional's right to challenge them in the best interests of their patient.

159. Nurse SJ told me that on the evening of 10th October 2022, LF reported that the O_2 cylinder was nearly empty and accordingly, she replaced it. LF agrees that this conversation took place. She recounts having turned the valve on and turned the O_2 level up to ten litres *"so that she could hear the hiss"*. She does this to ensure any residual O_2 runs out quickly. The following morning, Nurse SJ and HCA SS were involved in transferring G from bed to chair. On this occasion, the parents were not present but CJ was. SS and another HCA had checked the O_2 that morning and later, SS recounts checking it again before starting the hoisting. She recalled turning the dial to ten litres to confirm the hissing sound to check O_2 was coming through. Nurse SJ clarified in oral evidence that she had personally checked the equipment again the following morning. She told me, and I accept, that this is something she does 'automatically' so that *"I can go away and know it has been done- it gives me reassurance"*. There was some incident of a minor nature regarding a collapsing shelf which caused some distraction. SS was required to attend to it and, she relates, that as she was doing so, she saw CJ go round the back of G's chair to the cylinder, from which position she announced that the oxygen was off. SS said that they had all just checked this and were clear that the oxygen was on. CJ responded by asking if SS was calling her a liar. Nurse SJ also had a conversation with CJ almost immediately after the oxygen was discovered to have been switched off. She told me that she addressed CJ in these terms:

> *"You said you were calling me a liar and I said I couldn't call you a liar and I can't attempt to explain how this occurred when it was checked several times by different people"*.

160. The above is the core evidence i.e., the account of the witnesses. Behind this is a raft of documentary evidence including care records and a written up joint account prepared by Mr L, who was not in fact present at all during the incident. IW also prepares an account, although he too, was not present and his summary overview can only be hearsay. There are undoubtedly discrepancies in the documentation. However, I agree with Miss Khalique and Ms Roper that there are key and consistent features in the evidence. First, two HCAs and an extremely experienced nurse (who all agree has a fastidious personality) all insist that they checked G's oxygen that morning and were clear that it was on at the valve. Second, the collapse of the shelf created a

disturbance and CJ was seen to go around the back of G's wheelchair. Third, at that point, despite the checks, CJ announced the oxygen to be off.

161. I note that Nurse SJ's contemporaneous account is less detailed than her subsequent written and oral evidence. But it does record that she had opened the valve the previous evening and that it had been checked by the HCAs before transfer. It is, I think, typical of her that the detail of the note focuses more on G, who is recorded as having come to no harm, and with her concern for the family's impact on the morale of the staff.

162. Ms Roper addresses the contemporaneous record in her closing submissions thus:

> *"[SS] 's contemporaneous account was prepared jointly with another HCA, coordinated by [Mr L], which creates some scope for confusion. She was asked questions about this statement and said it incorporated her recollections with others. This records that [CJ] declined to leave the room when requested for hoisting, but stood by the door. It also records that the O2 had been checked prior to transfer and set to 2L and that there had been "auditory confirmation [a hiss] that valves were open". The record states that [Nurse SJ] only arrived after the O2 had been checked, that the transfer was smooth and that [G] 's SpO2 did not drop at all. It says the shelf "fell forward slightly" and that [CJ] moved the cylinders to support the vent tray, after which [Nurse SJ] came in. Neither [SS] nor [Nurse SJ] say in their written evidence that [CJ] had done this, and [Nurse SJ]' recollection is that she was there at an earlier stage. What is notable is that because [Ms C] was new to supporting [G], they report that "they verbalised each step in order for Grandma [CJ] to hear and so that it is reinforced in own minds".*

163. Like the Official Solicitor and Miss Khalique, I find the evidence of Nurse SJ to be of pellucid clarity. She engaged confidently and openly with Mr Patel's questions, had a demonstrably clear recollection of events, openly recognised the discrepancies in some of the documentation but was clear that she had followed her usual meticulous regime and checked the cylinders. G's SpO_2 might reasonably have been expected to drop in hoisting had the oxygen been disconnected, the contemporaneous records all state that it did not. I found SS to be a similarly impressive witness. Her evidence had the hallmark of detail, her responses to Mr Patel were kind and measured, particularly in response to CJ's deft and clinical testing out of the inconsistencies in the evidence regarding when she was said to have gone to the back of G's chair. Those discrepancies I have found, ultimately, to be eclipsed by the wider preponderant evidence. I also reject CJ's assertion that the notes had been falsified. As Ms Roper says, these were prepared long before any fact-finding hearing was in contemplation. Ms Roper submits that CJ momentarily switched off the oxygen valve on G's portable oxygen cylinder and contends that this accords with *"a pattern of behaviour"*. She suggests CJ was seeking to illustrate the incompetence of CH and *"in a way that she thought was designed not to expose G to any risk"*. I agree with this submission but would emphasise that whilst CJ may well have thought this action would not expose

G to risk, it is self-evident that tampering with the oxygen supply of a vulnerable young woman must carry inherent risk. Accordingly, I find that CJ did switch off the oxygen valve on this occasion. Having made a similar finding in relation to events on the 27th August 2022, I consider that both findings, separately arrived at, serve to reinforce each other.

164. It is contended that only 4 days earlier i.e., 7th October 2022, LF and GR deliberately tampered with the extension tube for G's ventilator. On this occasion, it was the ventilator attached to her wheelchair. LF's contention is that the staff had failed to set up the vent circuit correctly. The tubing for G's ventilator has an extension tube, the purpose of which is to provide additional length when transferring G either from her bed to her chair or vice versa. The account of the nurses, particularly that of Nurse SJ, in her statement, is that when transferring G, the regular ventilator tube is unclipped for what I understand to be a matter of seconds and the extension tube is then attached, thus the ventilator continues to work throughout. I do not think the family disagree with this as a mechanism. Self-evidently, speed is the essence of the process. It is for this reason that Nurse SJ emphasises that the extension tube is always set up carefully and checked prior to the transfer, to avoid delay, which might result in an interruption of the O_2 supply.

165. On the morning of 7th October, it is common ground that Nurse SJ was involved with G's transfer. Also present was SS and TC both HCAs. Nurse SJ had been on duty the night before and had assisted with G's transfer from bed to chair. She recalled this day with some clarity. In particular, she was very clear that the night before she had set up the extension tube for the ventilator on G's chair, ready to be used the following morning. Moreover, the next day, she checked the extension tube, in accordance with her usual practice. Whilst G was being dressed, the chair was placed in the lounge. LF and GR deny that they were anywhere near the chair. When G was ready, the chair was brought from the lounge to G's room. In the context of my analysis of the other allegations below, I note that on this occasion, it was Nurse SJ who noticed that the extension lead was set up incorrectly. One of the ends of the tube extension had been put in the wrong way round. There was no incident because it had been spotted before G's ventilator had been removed and, accordingly, she had not been exposed to risk of harm. However, Nurse SJ was quite certain that she set it up properly the night before and rechecked it that morning. As I have already mentioned, Nurse SJ is very experienced, including in ICU. She described herself as *"intense"* when it came to checking.

166. It is a feature of the rules that have been put in place, that the parents are not permitted to be in G's room whilst she is being dressed. On a practical level, that overcrowds the room, given what is involved. It also avoids compromising her dignity and privacy as a young woman. The fragility of her bones makes her constantly vulnerable and she requires sensitive handling at all times. On this day, Nurse SJ recalls that the parents attempted to sit in the 'patients lounge' and had to be redirected to the quiet lounge. This struck her as odd, she told me, as they usually wait in the 'quiet lounge'. Mr Patel points to a discrepancy in the records. The records state that the parents were *"attempting to sit in the patient's lounge"*, whereas the oral evidence was that they were already *"sitting in the patient's lounge"* and needed to be redirected. I find this discrepancy, if it can truly be interpreted as such, to carry little, if any, evidential significance. In a short time, Nurse SJ recalls that the parents were

knocking on the door of G's room, asking to come in, before G had been fully dressed. Nurse SJ asked them to wait. She recalls that they did wait but they continued to knock. Again, the parents dispute this.

167. Eventually, they entered the room unbidden. When it was then necessary to hoist G into the wheelchair, the parents agree that they opened the patio door windows and stepped back. Nurse SJ recalls that they were reminded that they should not be in the room at all at this point and asked them to leave. LF knew very well that he should not be there but he told me that as he had opened the patio doors and was standing, on what he referred to as the *"curtilage"*, he was, in his view, effectively within the rules. I asked him directly if he was just making a nuisance of himself. He denied this and said that he was afraid for G. As I have stated before, this is a phrase LF uses a great deal. When I pressed him, he said he was afraid of G *"suffocating"* or *"desaturating"* or some other unspecified type of harm. Having listened to LF give evidence at length and on a number of occasions, I by no means discount the possibility that his fear is genuine even though it may be entirely unfounded. As I understand her evidence, Nurse SJ compromised and asked the parents to step by the door. This, they agreed to do.

168. It was at this point the extension was seen to be incorrectly positioned. Both parents emphasise that nobody had actually seen them tamper with the vent. T, the HCA, addresses this point in her statement:

> *"…[O]n 7 October 2022 I was doing checks in [G]'s room with [Nurse SJ], unit manager. During the morning check I saw [G]'s wheelchair and it was set up correctly with the tubing for her ventilator. The wheelchair was placed in the lounge outside of [G]'s room whilst we were getting her ready to go out with her parents who were waiting in the lounge. However, when the wheelchair was brought back into [G]'s room, we immediately noticed that the ventilator tubing was not set up correctly because the green filter that is supposed to go into the green end of the dry circuit had been attached to the clear end, and the clear end was attached to the green circuit.*
>
> *I cannot explain how this happened when I had seen it set up correctly before the wheelchair was placed in the lounge with [G]'s parents."*

169. I note and regard it as significant that both the parents agreed that the wheelchair was always kept in the patient lounge, i.e., not in the quiet lounge. I am satisfied that the parents were both sitting in the patient lounge this day, before they were moved, and that this was unusual. I am also entirely satisfied that the extension tube had been set up correctly by Nurse SJ and checked. Thus, I find that the tube was tampered with and that the parents had the opportunity to do so. One further characteristic of Nurse SJ's evidence which requires to be identified and which I consider reinforces her reliability as a witness is her candour and willingness to accept mistakes. On an earlier day, she had forgotten to put G's coat on before hoisting. She was going out with her parents that afternoon. Mr Patel put this error to her as part of his case that

the staff were generally incompetent. She immediately accepted her mistake, I sense that she was frustrated by her error mostly for the inconvenience it would cause to G. Given Nurse SJ's general approach to her responsibilities, I consider this error was very much out of character. It is also important that I say that the distractions repeatedly created by the parents generate an environment in which mistakes are likely to be made. Nurse SJ did not proffer this as an explanation. Moreover, I was left with a clear impression that despite this high-octane corrosive conflict, Nurse SJ recognised the importance of LF's relationship with G and, on some level, respected the degree of knowledge that he has acquired over the years. Indeed, I agree with Ms Roper that she demonstrated empathy with rather than hostility towards G's family. I recall that she spontaneously volunteered praise to LF regarding the professionalism with which he managed the straps for G's chair.

170. Mr Patel has had to navigate the evidence very carefully. Though Mr Patel has cross-examined thoroughly on the alleged errors of the staff, LF goes, at least on occasions, a good deal further. In response to Counsel he confirmed, without any hint of ambiguity, that it was his case that the staff had raised this false allegation against LF and GR deliberately to *"cover up"* their own error. The more he was pressed on this, the greater his invective became. His assertion that the care home had conspired to create a raft of false allegations to cover up their own incompetence is one of the highest gravity. Neither is it possible easily to reconcile with the alternative view he sometimes expressed that the staff at the care home were *"well-meaning but overwhelmed"*. Eventually, LF said that the staff had engaged in this conspiracy because *"things have gone so spectacularly wrong"*. It was, he said, *"easier to blame the family rather than give notice"*. I do not recognise the logic of that last remark, particularly given the hesitancy of the care home initially to accept G's care in the face of LF's proactive opposition. By way of completeness, it is important that I record that LF's theory of conspiracy extends beyond the care home. He described it as *"shocking"* that both the ICB and the lead group operating CH *"supported by others"* (unnamed) *"fight tooth and nail to keep her in a place of harm where she is neglected"*.

171. It is interesting to compare GR's evidence with that of her husband. I regret to say that I found her to be a very unimpressive witness. She was, at times, both petulant and rude. When she was asked, for example, whether she accepted Nurse SJ's evidence to the effect that she had checked the circuit twice that day, she replied, *"if she says she did"*. Her tone of voice was hostile and the words were intended to be ironic. When Miss Khalique put her case to GR that she and her husband, either separately or together, had deliberately tampered with the tubing to cast further aspersions against the staff of the care home, she replied as follows:

> "*No, absolutely not. They do these things and try and blame the family. I will never forgive [the care home]. I am in shock at what they are trying to do*".

172. I am satisfied that the tubing was deliberately tampered with. Though the index of suspicion is greater against LF, given that I have made similar findings on other occasions against him, the nature and extent of what I find to be GR's lies and the enmeshment in what I regard as LF's distorted and irrational theory of conspiracy leads me to the conclusion that she cannot be discounted as a perpetrator. I agree with both the ICB and the Official Solicitor that the appropriate finding here is that either

or both parents tampered with the tubing in the patient lounge. For the avoidance of doubt, I dismiss the family's counter allegation that the tubing was set up negligently.

173. On 8th November 2022, it is contended that LF and GR deliberately damaged the dial on G's oxygen valve. It is further alleged that they failed to inform staff of the damage which resulted in malfunction in the oxygen equipment. This allegation is of a different complexion from the other behaviours I have been considering. In some ways, it is potentially even more serious. On 30th March 2023, I granted permission to the ICB to obtain a report from Dr Marc Beale, BSc. D.Phil., an expert in assistive technology, to comment on the cause of damage to G's oxygen valve, which occurred on 8th November 2022. Dr Beale's report was received on 19th May 2023. The conclusions have not been challenged:

> *"My conclusions on the damage to the oxygen flow meter are set out below - on the balance of probabilities.*
>
> *I understand that the oxygen flow meter was attached to the wall in [CH]. There would be no need to remove it to apply excessive force to the adjustment knob, nor to try to remove it axially by hand or using a lever. Indeed, both types of damage would require firmly mounting the device to enable sufficient force to be applied to have caused the damage. The damage was most probably inflicted by applying excessive twisting force to the adjustment knob. Measurements suggest this was in excess of 8 times the force required for normal operation of the flow meter. It is possible, but much less likely, that axial force was applied to the adjustment knob. If this was the case, the damage to the flow meter was also clearly deliberate".*

174. In a passage headed 'Executive Summary', Dr Beale states:

> *"In my opinion, on the balance of probabilities, the oxygen flow meter was damaged by the application of excessive force to the adjustment knob. It is most likely that excessive turning force was applied once the knob had reached its end-stop. My tests indicate the force applied was probably at least a factor of 8 greater than the force required to adjust the knob in normal operation. The only reasonable conclusion is that this excessive force was applied with the intention of damaging the flow meter. I note that any reasonable and well-intentioned person could be expected to have known they had damaged this item, that it was safety-critical and that it should have been reported to staff. I also note that secondary damage to the adjustment knob is consistent with it being forced back into place after the primary damage had occurred. This suggests that the damage to the flow meter was apparent to the perpetrator, and that it should have been reported to staff".*

175. In her oral evidence, Nurse SJ describes checking G's oxygen and suction equipment, following comments made by LF earlier that morning to the effect of

"*how staff would know the oxygen valve and the suction are both working?"*. That struck her, at the time, as a very odd question. She later discovered that she could not turn the dial. Nurse SJ recalls asking Nurse LS to assist her, but it quickly transpired that the valve was broken. It is described as having the *"inside ... squashed / pushed backwards"*. Dr Beale, in more precise and technical language, confirms this. Miss Khalique submits that there are three possible explanations for the damage to the valve on 8th November:

> *A) a member of staff at CH accidentally applied excessive force and broke the valve and failed to report this, so as not to implicate themselves;*
> *B) a member of staff at CH deliberately broke the valve, either as a purely malicious act or else to frame G's parents; or*
> *C) [LF] or [GR] intentionally broke the valve following the dispute with [Mr W] and [Nurse CB] at a challenging and intense meeting, earlier that day.*

176. I am not sure that Miss Khalique's first option is, strictly speaking, compatible with the unchallenged evidence of Dr Beale and, in particular with his view that:

> *"The only reasonable conclusion is that this excessive force was applied with the intention of damaging the flow meter"*.

However, I would be prepared to accept it as a potential explanation if it could be rooted in the broader canvas of the evidence. Miss Khalique submits:

> *"On the balance of probabilities scenario 'C' is the most likely option. In respect of 'A', there would be no reason for a member of staff to try and cover up 'accidental' damage to the valve. All those who have given evidence have been clear that they wish the best for [G], that they value caring for her, and there is no evidence that any one of those individuals would intentionally have exposed [G] to risk due to faulty/damaged equipment. Indeed, this case was not advanced on behalf of any family member to any of CH's witnesses in cross examination. Similarly, as to 'B', no evidence has been advanced to support a case that an individual staff member, or a collective of staff, would maliciously cause damage to [G]'s equipment and such a scenario is nothing more than fantastical"*.

177. I am bound to say that the proposition that any member of the care and nursing staff at CH might break this dial and not draw it to their colleague's attention is one that I regard as unfeasible. I cannot root it in any of the evidence that I have heard and it is inconsistent with the overwhelming evidence of the commitment of CH to G's welfare. Even had I come to the conclusion that the staff were, in some way, negligent or incompetent in the way that the family suggest, it would be a very great leap to find that they would conceal an accidental breakage which exposed their patient to risk. I have no difficulty, at all, in discounting this possibility.

178. In their oral evidence, GR and LF were taken to the notes of the meeting, which had taken place on the morning of 8th November. This had been scheduled to discuss the issue of the family being present during hoisting and the impact this was having on staff. It will be obvious from this judgment that this was an extremely sensitive issue. It is plain that both LF and GR were upset and agitated that day. They were both hostile and verbally aggressive as the following extracts from the meeting reveal:

> *"Nurse B – No one wants to have a hostile atmosphere everyone wants to work together for [G] best interests. The staff just feel under pressure and distracted/intimidated by your presence.*
> *GR – Do you think your staff who have known [G] for 5 minutes care as much as we do as her parents. The anxiety we have when we leave her due to the safety is terrible.*
> *Nurse B – That is not what I am saying we are all in the care profession and care for all our patients and want what is best for them. If staff are working in environment where they feel under pressure then*
> *this could lead to an unsafe environment for [G]*
> *GR – You have always wanted to exclude us but we will not leave her due to the incidents. IW showed your true colours on day one when you wouldn't allow us back in to set the TV up you are just power hungry. IW what can you do to stop the incidents happening".*

179. The deeply hostile feelings that GR and LF have to CH rise very clearly to the surface in what is obviously an acrimonious meeting:

> *"GR – Maybe you [Nurse B] I like you but it has been clear from the start that he (IW) doesn't want us involved. We know all about your relationships with external agencies and your secret emails with [the children's hospital] and the NHS to get [G] here.*
>
> *LF - The atmosphere is not conducive to a good working relationship due to pre-conceived ideas you have given staff before we arrived.*
>
> ..
>
> *"GR – We never had any problems at [A Hospital] as it was more relaxed and we worked together [G] was happy and laughing and she is depressed again since she has come back to this prison. I said to the newspaper in 2021 this was a prison.*
> *IW – You mention environment that is not conducive to a good working relationship due to preconceived ideas but that is exactly what you have just described – describing us as a prison and [LF] you mentioned on the first day that any relationship is forced and under false pretences, you have*

> *never wanted this to work. You have given staff what you perceive as advice such as filter placement and then safeguarded that exact thing.*
> *Nurse B – In relation to hoisting the staff will not hoist while you are present in the room.*
> *LF – You can't deprive her liberty and family time.*
> *Nurse B – We are not doing that we are just asking for 10 minutes while we hoist her out so you can then spend quality family time".*

180. The rancorous exchanges continue:

> *"GR – IW your staff are not trained to [look] after her I am not speaking to you anymore and will only speak in writing* ***(left the meeting)***
> *LF – We was told this was a specialist ventilation centre but we never wanted her to come here anywhere but here we would have went to Exeter. We know all about you and just want [G] here as she is a cash cow for the [the lead group]. We know about directors who are paid by [the lead group] and the [the Trust] tentacles spread far and wide. We know about your self cert inspections and CQC didn't even speak to us following raising concerns*
> *IW – What do you mean? Back handers or something?*
> *LF - I didn't; mention that why are you saying that I didn't mention that*
> *Nurse B – I would see why IW would come to that conclusion form what you have said?*
> *LF – You would wouldn't you.*
> *IW – What do you mean by self-cert?*
> *LF – Sorry, self-certification inspections*
> *IW – That is a measure put in place to ensure good practice for CQC inspections etc.*
> *LF - I have got everything recorded I know what goes on.*
> *IW – you do know it is illegal to record/film anyone with their consent.*
> *LF– What my daughter?*
> *CB – What about the staff you can't do that.*
> *IW – If you want to go down that route, we can get an independent company to install CCTV in [G] rooms this would be done under BI decision and they would monitor*
> *DJ – I am sure they would be independent.*
> *Meeting ended".*

181. There can be no doubt that LF and GR were extremely angry at this meeting. The applicants argue that it was in this state of anger that LF or GR deliberately and with force damaged the oxygen valve in G's room. As will be noted from the above minutes, GR had left the meeting early and in high dudgeon. The applicants submit as follows:

> *"[We] invite the court to find that following this plainly tense meeting, either [GR] or [LF] deliberately and with force damaged the oxygen valve in [G]'s room. If an individual perpetrator cannot be identified, they should both be considered to form part of the pool of perpetrators. Both had the opportunity and the motivation to damage the valve whilst in [G]'s room that day, following the heated meeting with [Nurse B] and [IW].*
>
> *There is thus a real possibility that either [LF] or [GR] was the perpetrator of the damage to the valve and the court is invited to find either [GR], who left the meeting early and returned to [G]'s bedroom in her angry state, or [LF] upon his return from the meeting, intentionally caused the damage. It is significant that [GR] will have been alone in the room (or with a 1:1 at the door who is likely to have given her some privacy with [G]). During that time alone in the room, which is accepted to be at least 10 minutes, [GR] had access to the valve in question and had the opportunity to break it. [LF] also had an opportunity, when he arrived later in [G]'s room".*

182. I approach the evidence on this allegation in this way. I accept the unchallenged evidence of Dr Beale that the only reasonable conclusion is that excessive force was applied **with the intention of damaging the flow meter** (my emphasis). I do not consider, for the reasons I have analysed above, that this was *"an accident",* unacknowledged by a member of staff, nor do I consider it even remotely likely that it was caused deliberately and maliciously by a member of staff, to traduce the parents in some way. It is damage caused by excessive force, most likely in frustration and anger. It occurred on a day when both parents were manifestly frustrated and angry. It may not be entirely without significance that the damage was caused to the oxygen flow meter, given my earlier findings. So much of the evidence in this case has centred upon the provision of oxygen to G. As is clear from this judgment, I have already found that LF had tampered with his daughter's oxygen supply on other occasions. I also accept the evidence of Nurse B and SJ that LF had asked questions concerning the equipment on the wall earlier that day and that those questions struck the nurses as odd, given that nobody had suggested that it was not working. LF denies that he had any conversation with the nurses about the flow meter earlier that day. I am, either directly or inferentially, invited to conclude that the nurses have lied or in some way *"made up"* this earlier conversation. I entirely reject this alternative account, not least, because Nurse SJ's evidence on the point was both clear and measured and also rather tangential to the substantive allegation. The proposition requires a highly cynical, subtle dishonesty. There was no attempt to overstate the significance of the conversation by Nurse SJ, which she seemed ready to accept did not necessarily carry any evidential significance. I am entirely satisfied, on the balance of probabilities, that it was the parents who deliberately damaged the flow meter, acting in anger and frustration. It also strikes me that given the intensive regime of care provided to G, the damage was likely to have been observed reasonably quickly. I do not consider that the evidence points strongly to one or other of the parents, either could have caused this damage.

183. I turn now to the events of the 9th December 2022. G had plainly been having a difficult day. She was experiencing abdominal spasms. It was certainly the nurses' view that she was in pain. CJ had come to visit her and she too considered that G was distressed and in pain. The nurses gave PRN (pro re nata) medications to try to provide immediate pain relief. This continued throughout the day. When G was having the spasms, her oxygen levels were dropping quite low. The pain relief did not appear to have sufficient effect. CJ was noted to be anxious and was asking that G be given more midazolam. Nurse M considered CJ's anxiety to be entirely natural, however, CJ repeatedly asked for G to be provided with a suction procedure which is undertaken in Intensive Care Units where additional saline is poured. The staff at CH do not follow such a procedure and declined to do so. The nursing staff were in regular communication with the General Practitioner who eventually advised that G should go to hospital. CJ is described as *"pushing for more midazolam"*. This was notwithstanding that Nurse M had decided that this was not appropriate. Midazolam is, she told me, a strong medication which requires to be administered cautiously and as had become clear, it was not being effective in relieving pain. Benzodiazepine is a medication used for anaesthesia and procedural sedation. Eventually, the ambulance was called.

184. There is much dispute as to what happened when the paramedics arrived. It is common ground that CJ did not agree that G should be taken to the A Hospital. I accept the predominant evidence that CJ was frustrated and angry when it was decided by the paramedics that G should go to S Hospital. She contacted her son, who spoke to one of the paramedics on the telephone. LF pressed the case for A Hospital. The paramedics could find nothing in the paperwork to suggest that G needed to go to there. In any event, S Hospital was the closer hospital. It has been suggested that this dispute caused a delay in the transfer. In the event, I do not consider the evidence supports that suggestion. Nurse B made the following note in the Family Interaction Records:

> *"Two members of staff were in the ambulance with [G] Nurse and senior health care assistant. [CJ] travelled behind and followed us to [S Hospital]. When we arrived at A & E [CJ] told the consultant she was trained and happy to do suction which they agreed. [CJ] asked for a bag and saline, saline and 2 x bottles were poured down the tracheostomy by [CJ] and five minutes later [CJ] gave [G] suction".*

185. I note that when LF and GR arrived, they took over the care:

> *"[LF] had said that [G] was dehydrated as we won't give her enough fluids however that was proven otherwise when the consultant had done her blood gases. [G]'s sats were still dipping [LF] had moved [G]'s oxygen from 4-6 litres with no direction from any medical staff 5 minutes he went to the oxygen bottle where he asked me to check whether it was on the proceeded to tell me it was off and to put it on. I explained to [LF] that the oxygen was on 4 litres by our staff and hadn't been touched by anyone. I felt very uncomfortable and intimidated when he singled me out by saying it's always you*

> *with the oxygen. My colleague was still in the room at this point so I had to take a minute and remove myself away from the situation as was feeling very upset and undermined and felt dad's tone of voice was getting very aggressive. Before [LF] had arrived at A & E [CJ] had commented to hospital staff how well looked after [G] is at [the care home] and how we've done everything we could possibly could. Once Dad arrived [CJ]'s demeanour changed and could feel a tense atmosphere within the family dynamics."*

186. A good deal of what is set out above is not contentious. What is agreed is the extent of CJ and LF's active involvement in G's care. It is also common ground that LF thought that G was dehydrated; that G's $Sp0_2$ were still dipping and that LF took charge of moving G's oxygen gauge. All this was taking place in the Accident & Emergency Department of S Hospital. This is an unrecognisable clinical scenario i.e., that it was family members and not nursing staff providing clinical care. Nurse B did not involve herself with G's medical care. Responsibility had now been transferred to the hospital and she was not permitted to do so. She had effectively handed over to the hospital staff. Nurse B then states:

> *"About 5 minutes after that, he asked me to check that [G]'s oxygen was on and then he proceeded to tell me it was off and turn it back on. I said to [LF] that he knows it has been on at 4 litres this whole time and that no one had touched the oxygen valve except him since [G] had arrived at hospital. Also, if [G]'s oxygen had been off all the way from [the care home] up to now, she would not have survived. [LF] then said to me, quite aggressively 'It's always you with the oxygen'."*

187. It is important to emphasise that LF was criticising Nurse B for having negligently failed to turn on G's oxygen. There is no doubt at all that Nurse B was profoundly upset. She simply confirmed that G would be admitted and left the hospital. I note that she said goodbye to G before she left. Insofar as that last point is disputed, I unhesitatingly prefer Nurse B's evidence. It resonates with everything that I have heard and read about the approach of Nurse B and her colleagues to G. It is an instinctive concern for a woman who is respected by those caring for her.

188. The pertinent issue is whether having been transferred to the ambulance, G would have been using the paramedic's oxygen cylinders or those from the care home. LF remains adamant that the cylinders were those used at the care home. The paramedic, SL, has prepared the following statement:

> 1. *I make this statement from my own personal recollection of events, and also with access to Patient Report Form (PRF).*
>
> 2. *On 9 December 2022 I was on shift with my colleague [KH], Emergency Medical Technician, and [ET], supernumerary Paramedic. A 999 call was made at 14:57, describing [G]'s worsening oxygen saturations and query severe abdominal*

pain. We dispatched at 16:57 and arrived on the scene at [the care home] at 17:19.

3. *On arrival at the scene, I recall speaking to nursing staff and discussing [G] with family members who were at the scene. I also liaised with [G]'s father by telephone. The PRF confirms that there was an Advanced Care Plan in place at the time, stating that CPR would not have been in [G]'s best interests, but that she was to be transferred to [S Hospital] A&E in the event of an emergency. I recall that [G]'s father did not wish for [G] to be transferred to [S Hospital], he expressed that he wanted her to be transferred to [A Hospital].*

4. *I made attempts to escalate to an Advanced Paramedic, however unfortunately these attempts were unsuccessful. At this stage, [G]'s condition began to worsen, query due to increasing abdominal pain. A decision was made to transport her to [S Hospital] A&E, with a view that she could be transferred from there in the event this became necessary at a later stage. We left the scene at 18:08 and reached [S Hospital] at 18:21.*

5. *To the best of my knowledge, normal ambulance policy regarding oxygen therapy was followed. I believe [G] was on oxygen supplied by [the care home] on our arrival. This would then have been switched to the ambulance portable oxygen cylinder prior to transferring [G] onto the ambulance stretcher.*

6. *Once on board the ambulance the oxygen supply was then switched to the larger oxygen cylinder fixed in the vehicle. On arrival at hospital the oxygen would have been again switched back to the ambulance portable cylinder. Once [G] had been transferred to the hospital bed, she was switched to the hospitals fixed oxygen supply with hospital staff informed.*

7. *As far as I recall, the reference within the PRF to 89% oxygen levels on room air was information supplied by [the care home] prior to our arrival. [G]'s oxygen saturation levels remained from 96% - 98% while she was conveyed to [S Hospital] for further treatment. To the best of my knowledge, [G] remained on oxygen therapy from our arrival at the scene until handover at hospital with the usual short delays involving removing the oxygen tube from one cylinder to another.*

189. The paramedic was asked to recall this incident many months later. As is clear, he can only speak of what is usual practice. However, what is striking is the detail involved in the usual arrangements. Firstly, the patient is transferred to the ambulance portable oxygen cylinder prior to transfer to the ambulance on the ambulance stretcher. In the ambulance, the oxygen is switched, again, to the larger oxygen

cylinder fixed in the vehicle. The process is replicated on arrival i.e., G would have been switched back to the ambulance portable cylinder for transfer to the hospital. Whilst the paramedic cannot confirm for certain that there was no departure from the usual arrangements that day, there is nothing at all to suggest that there was. I note that paragraph 3 of the statement contains a level of detail that reflects a significant degree of recall of the particular features of this callout. A second paramedic, ET, expresses her recollection in a separate statement, in these terms:

> 1. *I do not recall whether [G] received oxygen from [the care home] or ourselves while in the ambulance. However, it is highly unlikely as part of our normal practice that we would use a patient's own oxygen supply while in the ambulance as we have larger oxygen cylinders in the vehicle to use. I do not recall ever having administered the patient's own oxygen which makes this highly unlikely to have ever occurred.*
>
> 2. *I do not recall when [G] was switched from the [the care home] oxygen supply to our oxygen supply, however as part of our normal practice, we would switch a patient to our own oxygen supply as soon as possible in order to control the level of oxygen delivered.*
>
> 3. *I do not recall whether [G] relied solely on air during the transfer by ourselves. However, the PRF does state in the 'observations' section that [G] was administered oxygen during the incident and whilst observations were taken.*

190. I emphasise that ET highlights that she does not recall *"ever"* having administered the patient's own oxygen. She infers from this that this *"makes this highly unlikely to have ever occurred"*. I consider that to be a fair and balanced observation. On its own, I find it persuasive but it is reinforced by the broader evidential canvas.

191. Mr Patel places much weight on the fact that Nurse M's record states that G was *"on our portable O_2 cylinder"*. However, both she and Nurse B were insistent, in oral evidence, that G was transferred to hospital on the paramedics' own oxygen equipment. Nurse B was taken to her written note which records that G was *"put on our own oxygen cylinders which were still on 4 litres. The transfer from [the care home] was delayed"*. Nurse B said that in her view, this was *"clearly"* an error. She pointed out that she had been on a 13-hour shift. Mr Patel pressed on this but, on this point, Nurse B was implacable. She was *"100% sure"* that G was on the paramedic's oxygen from the moment she left the care home. In some circumstances, that degree of confidence might be suspect, but it is to be remembered that concern about the oxygen being switched off was ever present at this stage in the care home. It had, I find, become the focus of the nurses' anxiety. In this context, I find Nurse B's very clear recollection of transfer to the paramedic's oxygen to be reliable. Furthermore, her evidence and that of ET is essentially corroborative. It is also notable that despite his strong opposition to this account, LF was not present at the care home, nor was he in the ambulance and he did not arrive at the hospital until G had already been transferred to A & E from the ambulance. Of course, it requires to be identified that if

the ambulance staff had failed to switch the oxygen on then LF would have had to address an apparent contagion of poor practice or negligence spreading from the care home nursing staff to the paramedics. This would not fit with his critical narrative against the staff of the care home. Whilst this is theoretically possible, it is unlikely to the point that it stretches credulity. I also note that the nursing records state *"Dad shouted to carer that O_2 was not switched on whilst transferred. Dad switched on and sat ↑99%"*. There is an undoubted evidential pattern of LF 'discovering' that the O_2 has been switched off.

192. Miss Khalique and Miss Kirkbride make the following written submission:

> *"It is highly unlikely if not fantastical to suggest that this happened and that the paramedics would not have observed this omission. It begs the question as to how [G]'s SATS remained between 96% - 98% whilst she was conveyed to hospital, as confirmed in the witness statement of [SL] (paramedic) (§8), if she had no oxygen supply during transfer. It is submitted that the evidence of the four professionals is to be preferred and no convincing justification has been advanced as to why all of these witnesses would be mistaken and/or deliberately falsifying accounts. For the avoidance of doubt, the counter allegation that CH staff failed to turn the oxygen on is denied (1(a)(iii))"*.

193. They further submit:

> *"The contemporaneous note of [Nurse M] sets out that shortly before pointing out that the oxygen was not on, [LF] had turned up the O2 cylinder of his own accord [R1/A427], without the agreement or permission of the medical staff present. [Nurse M] maintained in oral evidence that she heard [LF] state: "I'm turning this up a little bit". In that moment, whilst touching the cylinder, [LF] had an opportunity to switch the machine off"*.

194. I agree with this submission. I have very little difficulty in coming to the conclusion that LF switched the machine off. I also note that LF took the opportunity, on this admission, to broadcast his litany of complaints against the care home. It is to be remembered that on any view, G was unwell and in a great deal of pain on 9th December. As I have previously mentioned, this was distressing to staff and to CJ. The pain was such that midazolam had not helped. LF's focus, at this point, ought to have been on G's wellbeing and not upon his criticisms of the care home staff. Manifestly, it was neither the time nor the place. It was also a distraction to the staff. As recorded above, he told the hospital staff that *"60 plus safeguarding complaints"* had been raised and that they were all in the process of being *"dealt with"*. He complained that G was dehydrated, because of neglect by the staff at the care home. This was comprehensively disproved by the blood gas tests. It must also be noted that LF volubly criticised Nurse M for having failed to turn the O_2 on. On my findings, he would have known this to be untrue. It was a shameful incident calculated to intimidate the nurse. I regret to say that this was bullying and highly manipulative behaviour. Miss Khalique speculates that LF was taking the opportunity, G having

been transferred from the care home to the hospital, to ensure that she was not returned. Though I find that to be entirely plausible, I am not prepared to speculate on LF's motivations. That said, the vituperative hostility to this placement is abundant. They do not dispute it of course, contending that it is justified.

195. As I have stated in the earlier passages of this judgment, I do not consider it necessary or proportionate for me to address each and every alleged "breach" in the way that the Scott Schedule is pleaded. That would serve merely to expand this already extensive judgment and further to feed into the high-octane 'lawfare' that this case has become and which I am resolved to stop. To describe the closing written submissions I have received as voluble, is an understatement. Ms Roper and Mr Harrison's submissions alone are 182 pages. I do not say that as a criticism but as an illustration of the body of material that has been presented. In my judgement, I have identified what I consider to be the key incidents. These enable me properly to evaluate the nature and extent of any future risk and provide a foundation for a forensically objective evaluation of G's *"best interests"*, predicated on a substratum of determined facts as opposed to allegations. To each alleged breach, is a countervailing allegation of negligence or malpractice. My findings make it clear that the countervailing allegations made by LF, on the issues I have addressed, are entirely without substance. It is unnecessary for me to traverse each of the family's allegations of negligence against the care home, just as it is unnecessary to resolve every alleged breach. These proceedings are structured to resolve facts for the purposes that I have set out i.e., where G's best interests lie. They are not apt to facilitate a trial on essentially tortious allegations, especially where the investigation of those allegations casts no light or further light on the issues in focus. This keeps G at the centre of the process. The Court of Protection must be vigilant to guard against its process being hijacked in such a way.

196. Inevitably, incidents have crystallised during the course of the evidence that were not pleaded in the Scott Schedules. Frequently, they are linked to an alleged breach of court order and arise from the background material, usually, leading up to or surrounding the central allegation. Thus, it is material that was available to and considered by the parties prior to the hearing itself. It is trite law that neither the court nor the parties are rigidly restricted to material in the Scott Schedule. That would be absurd and, in a case such as this, entirely inimical to the investigative nature of the proceedings.

197. I propose to deal only with one further allegation relating to an incident put to CJ regarding events on the 24th September 2022. Once again, this revolved around the tension generated by the hoisting process. CJ was at the care home on her own on this occasion. She was asked to go to the quiet lounge to enable there to be some hoist training given to a relatively inexperienced member of staff. On any view, that is a perfectly reasonable request. In light of the background to this case, it was also a sensible request. CJ had a characteristically detailed recollection of the incident and engaged with the questions surrounding it. I repeat, CJ is an eloquent woman, presenting her case impressively and, it seemed to me, with a striking level of confidence. The notes taken by Nurse B record the following:

> *"11am…. Prior to hoisting I requested if [CJ] could remain in the quiet lounge during hoisting so staff could concentrate and*

> *explain things to someone who had not hoisted [G] regularly. [CJ] politely said that [LF] had asked her to be in the room so it put her in a difficult decision [sic]. I said I understood but it would be our preference today to give the staff some space. [CJ] said she would like to remain in the room but wouldn't speak so she didn't distract anyone and would stand in the door way".*

198. Miss Khalique suggested to CJ that her *"polite refusal"* stemmed from her son having told her that she must stay in the room. CJ substantially agreed with this. She said that she had a discussion with LF and that he had indeed wanted her to stay. CJ told me that she fully agreed with this plan because she had previously seen G becoming distressed when hoisted. CJ asserted that she did not consider that she was in the way. She negotiated her terms to *"stand in the doorway"* and *"not to speak"*. She told me that she remained there *"just in case"*. She added that it was a reasonable request for *"safety reasons",* given that a new member of staff might not have been able to position G properly. In some ways, this incident is far less significant, in isolation, than many of the others that I have been addressing but, in the context of the wider evidence, it is illustrative of CJ's mindset and how overbearing she has become. I asked her whether her presence in the room might cause a young trainee to be nervous and whether they might be more confident and able to learn better if left to train with colleagues alone. CJ reluctantly conceded that this 'might' be the case but, she told me, she was not there doing *"a job"*, she was there as G's grandmother. This, I am afraid to say, is entirely disingenuous. It is spinning language and playing word games. It mirrors many of LF's own responses. CJ is well aware that one of the central objectives of the move to CH was to "reset" the roles, to enable the family to let go of their burning need to control G's medical care and to enable them to regain something of the enjoyment of an ordinary family life. In other words, to be a grandmother and parents and not doctors and nurses. CJ did not remain in the room to provide grandmotherly support for G, she was there, under her son's instruction, specifically to monitor the staff's professional competence. She was there as a self-appointed supervisor *"for safety reasons*", to use her own words. She was not there as a grandmother. A grandmother would have left the room at the request of the professionals. Moreover, CJ was looking to find fault rather than to help. All this generated a febrile atmosphere which enhanced the prospect of human error by staff who were uncomfortable and intimidated. Time and again, when she conducted her own cross examination, I was struck by CJ's condescending attitude to the CH staff, wreathed though it was, in a veneer of courtesy. The staff/family dynamic in CH had become dangerously distorted and dysfunctional.

199. I asked CJ whether she had ever suggested to LF that he might be frightening staff by his own highly intimidating behaviour. She was simply not prepared to engage with this, *"I am raising issues too"* she told me. This is not merely a lack of insight into LF's behaviour, but it is active endorsement. Indeed, much of her own behaviour is very similar.

200. Finally, it is important to record that since my orders in March 2023, further restricting LF's and GR's involvement in their daughter's care at CH, there has been no repetition of any *"unexplained"* switching off of the ventilation supply. CJ contests this, claiming that there has been one further incident in which she

discovered the oxygen supply was switched off. In view of my findings, I am not prepared to rely on CJ's observation. She is an unreliable chronicler of these events. The incident has not been pleaded nor investigated. Having evaluated the allegations in a particularised way, I also consider that the cessation of incidents surrounding G's ventilation following the restrictive regime, serves to corroborate my earlier findings.

201. Three of the counter allegations made by LF against the staff at CH have been established. First, there were two separate occasions where G's medication was missed. There was a further incident in March 2023 when saline was used instead of water in G's tracheostomy. I do not wish to diminish the importance of this. The staff have acknowledged their failing and admissions were made in response to the Scott Schedule. However, I consider it to be fortunate that given the confusion and hostility generated by the family's approach, there were no further or graver incidents.

202. It will be important for those managing this family in the future to be able to make themselves aware of this court's findings in a convenient and accessible way. For this reason, I set out, below, the nature of the findings I have made in narrative form. I also consider that this may be of wider benefit to the parties.

The findings in narrative

203. At the outset of these protracted proceedings, I considered that a plan which liberated G from the children's hospital environment, where she had been for over a decade and for the whole of her adult life, was essential and very long overdue. The objectives were to restore something of her own personal dignity, to afford respect to her as an adult and to promote her autonomy within the limited spheres of her circumstances. Having accepted the evidence which concluded that she was now in the final stages of her life, I was attracted to the family's plan that she moved to a home environment with the support of a bespoke and necessarily extensive care package. I was also persuaded that before this could realistically be contemplated, it was necessary for G to live, for a period, outside the hospital environment in order that the full range of her needs could realistically be assessed. I had in mind a period of decompression that would afford a home placement a real prospect of success. I also expressly stated that even if that plan would risk shortening G's life, its potential to improve the quality of it, for the remaining time she had left, would likely be worthwhile.

204. The conflictual relationship between the family and the clinical team at the children's hospital had generated a hostile environment, which threatened to compromise G's wellbeing. The extent to which LF dominated the medical regime and for such an extensive period, is profoundly troubling. Though I was sympathetic to the hospital staff, I considered that they had not been sufficiently proactive in calling a halt to what had been happening. The move to the identified care home was intended, in the words of the lead consultant, to enable LF to *"unlock"* his role as a father and, in particular, to release him from his highly medicalised approach to his daughter.

205. At the children's hospital, LF had been *"intimidating, hostile and highly critical"* of the nursing staff. He had made them feel *"unsure"* of their own professional competence and *"fearful for their jobs"*. They felt that they were *"constantly being*

assessed" with their *"judgement tested"*. I emphasise that these phrases are taken from their own statements.

206. When I concluded that G's best interests lay in a move to CH, LF and his family were vigorously opposed to the decision. They had opposed it at the hearing and they did not accept the judgment. Given the way I had framed it i.e., as a conduit to a move home, it is difficult to understand what ignited the fire of such hostility. Objectively, it was without any foundation but LF could not have been more determined to sabotage the placement, even before the move. This, he has admitted. Having watched him in court, now over many hours, I consider LF's reaction was driven by fear. I have already commented that he uses that word a great deal. He expresses it as being afraid for his daughter but as I have listened to him, I have become increasingly convinced that his fear stems from his sense of being marginalised and losing control over his daughter's day-to-day medical care. The two have undoubtedly become conflated in his own mind, he believes that only he can deliver the care his daughter needs and that only he can keep her safe. I do not doubt that this fear is genuine. It causes him visible distress. During this hearing, I have seen that distress, which is painful to watch, not least because of his determined but ultimately futile efforts to control and conceal it. The more distressed he becomes, the more extreme his allegations. None of this is tempered or assuaged by his mother or partner. On the contrary, they feed it and exacerbate it. The adjectives used by each of the family in their criticisms of CH have ratcheted upwards, they now include: *"abusive", "dangerous", "frightening", "disgusting"*. They characterise the home as a *"prison"* and the regime as *"torture"*. Most distorted of their perceptions is their belief that G enjoys the conflict that rages over her bed because she perceives it as her family fighting her corner. The tremors that she displays, on the family's account, on these occasions are interpreted as exhibiting pleasure.

207. The instinct of every doctor, nurse, carer and, if I may say so, Judge, is one of sympathy to the family of a young woman whose body and brain has been ravaged by this profound degenerative neurological condition. LF's entire life and that of his partner GR, has been focused on his daughter, especially since the diagnosis. For 10 years, the couple lived in the hospital grounds. This was unprecedented in the hospital's experience. Their own personal life has been almost entirely sacrificed. They would not see it as a sacrifice. I think that they would regard it as a privilege. However, it has, in my judgement, been unhealthy for them. Their parental energies have become distorted and misdirected. They are angry, hostile and combative. Their behaviour to the nursing staff in the children's hospital has been not merely replicated at CH, it has been intensified. It is necessary for me to identify it for what it is, a pattern of sustained, controlling and bullying behaviour. Nobody listening to the evidence of the staff of CH, at this hearing, could doubt the wounding psychological impact it has had on so many of them. Their experience has been traumatising, the process of giving evidence was retraumatising. Some of them, I have no doubt, will struggle for a long time in consequence of their encounter with this family.

208. I have found that each of these family members was involved in tampering with G's ventilatory support. I have made direct findings against LF and CJ and have been constrained to find that GR was, with her partner, in a pool of two potential perpetrators on two occasions. GR rarely uses her smartphone or email. I have commented in my earlier judgments on how isolated her life appears to have become.

LF and CJ are in constant communication. Their perspectives and mindsets are entirely enmeshed. This said, GR provides total support for them both. The gravity of these findings is self-evident. Part of the family's wide-ranging explanations for what has occurred has extended to asserting that CH staff have deliberately fabricated allegations of tampering with machinery, to provide a cloak for their own incompetence. The allegations of intimidation, it is suggested, have been falsely and dishonestly lifted from the statements of the children's hospital nurses, again, as a foil for their own negligence. These feverish allegations, I consider, are not only contrary to the preponderant weight of the evidence, they are a reflection of the family's own desperation and distorted thinking. In this context, the inherently improbable proposition that an otherwise loving parent would compromise their daughter's ventilatory support becomes conceivable. Not only does the evidence I have analysed establish the findings but what I find to be the irrationality of the family's damaged belief structure supports the view that they would do anything to cause the breakdown of this placement. The interference with the ventilatory support was, in my view, calculated to provide evidence of negligence at CH. As some of the recordings demonstrate, staff were at least initially, prepared to contemplate their own negligence before suspecting the family. That is the intuitive instinct of committed professionals, it is the antithesis of the extreme and calculatedly dishonest activity that the family accuse them of.

209. The nursing staff at CH have, they told me in evidence, been unable to detect anything like the level of awareness in G that her family believe she retains. What is clear to me though is that they continue to look for it, remain open to the possibility of it and, even more, genuinely hope to discover it. What they are clear about, however, is that the parents, both in equal measure, have the capacity to soothe and comfort their daughter in the way that only a parent can. It is in this role that they make their greatest contribution and it is precisely this that the care plan was designed to 'unlock' and enhance.

210. It is an extraordinary feature of the history of this case that for much of her time at the children's hospital, G went out in her wheelchair for long afternoons, seemingly every day. That was also unprecedented. This is a hospital for very sick children. At CH, this regime has continued, albeit now less frequently. Whilst out in the community, there has never been a single incident of concern regarding G's general welfare or more particularly, any real difficulty relating to her ventilatory support. The quality of practical care afforded by her parents and grandmother is unimpeachable. They are meticulous about G's appearance and attentive to it. The difficulties with G's care are all confined to CH. There has been no significant problem with G's mobile ventilatory support. This long-established pattern reinforces my view that interference with the oxygen and other equipment, in the way that I have found, is intended to discredit the care home staff. It does not seem to be directly intended to harm G, though the risk of harm must surely arise.

211. Whilst the evidence, in my judgement, strongly supports this rationalisation of the family's behaviour, it can only be speculative and it is, accordingly, necessary to confront the fact that any parent or adult who compromises their child's ventilatory support i.e., interferes with breathing, must be regarded as posing a serious risk from which that person must be protected.

212. It is not difficult to see how trying to obtain appropriate services, good quality care and treatment for a sick child with such a profoundly degenerative condition could so easily become a battle against 'the authorities', by which I mean the ICB, the doctors, the nurses and all of those employed by the State, charged with responsibility for G's care. To an anxious parent, the system will, perhaps inevitably, be perceived as lethargic, bureaucratic, inconsistent and even heartless. As the family themselves accumulated a body of knowledge about their daughter's condition, they would, over the years, have encountered newly qualified, eager, young professionals with limited experience, in whom they may have struggled to reposit their trust and confidence. There are inevitable tensions in these relationships. What has happened in this case however is far beyond this. This was a family utterly determined to engineer the breakdown of their daughter's placement at CH. The lengths that they were prepared to go to are not only alarming, they are quite chilling. Objectively, interference with the ventilatory support must be regarded as creating a risk to life.

213. The ICB and the Official Solicitor will now have to give careful thought to the future arrangements for G's care. Thought will also have to be given to the scope and ambit of any further proceedings in the Court of Protection. The court itself has become a theatre of conflict. The family's enthusiasm for litigation, as I find it to be, is a different facet of their behaviour within the care home and earlier in the hospital. It is disruptive, calculated to cause distress. It has, at times, degenerated into 'lawfare' and rather than promoting G's welfare, the court process risks becoming inimical to it.