CHILDREN'S COURT OF VICTORIA

Applicant: **(Name removed) "KB"**
[Department of Human Services]

Children: **(Name removed) "CR"** [23/11/2005]
(Name removed) "KR" [23/11/2005]

MAGISTRATE:	**Jennifer Bowles**
WHERE HELD:	**Melbourne**
DATES OF HEARING:	**17, 18, 19 September 2007** **1, 2, 4, 5, 8, 9, 10, 11, 12 October 2007** **7, 22, 23, 26, 27, 28, 30 November 2007** **3, 4, 5, 17 December 2007**
DATE OF FINDINGS:	**15 February 2008**
JUDGMENT PUBLISHED:	**22 February 2008**
CASE MAY BE CITED AS:	**KB, DOHS and CR & KR**
MED. NTRL. CITATION:	**[2008] VChC 5**

REASONS FOR DECISON

Child protection – Protection application – legal representation ordered for child not mature enough to give instructions - skin lesions – failure to heal – causation – Munchausen by Proxy / Dermatologica Artifacta – earlier protection application proved by consent – expert medical evidence - whether in the best interests of the child to be placed in out of home care on a custody to Secretary order or returned to the mother's full-time care on a supervision order via a transitional period on a further interim accommodation order.

PARTY	COUNSEL
Department of Human Services [Child Protection]	**Ms S. Buchanan**
Mother	**Mr G. Holden**
CR & KR	**Mr Brown**

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D E C I S I O N

INTRODUCTION

On 23 November, 2005 (name removed) "the mother" then aged 20.5 years gave birth to (name removed) "CR" and (name removed) "KR" (hereinafter referred to as "the boys"). She was unable to identify the boys' father. The mother had previously given birth to her daughter, (name removed) "N" currently aged 4.5. N resides with her father and the mother has access with her daughter supervised by N's father.

According to the mother, she and the boys resided with a friend of the mother's, (name removed) "R", from when they arrived home from hospital until July/August, 2006. The mother gave evidence that she had been unable to contact R in order for her to give evidence in these proceedings.

When CR was 3.5 months of age the mother's evidence was that she observed a red mark or scratch under his nose which turned into a sore. Subsequently KR also developed a red mark or scratch under his nose which turned into a sore.

Further lesions developed on both of the boys. On 27 April, 2006 the boys were referred by their General Practitioner, Dr (name removed) "witness 6" to the Accident and Emergency Department (AED) at the Royal Children's Hospital (RCH).

The boys were subsequently admitted to the RCH in relation to their lesions on three separate occasions -

15 May, 2006 - 22 May, 2006

17 August, 2006 - 24 August, 2006

27 September, 2006 - 4 October, 2006

Schedule 1 is a chart which summarises the observations made by the medical professionals who saw the boys over the period 30 November, 2005 to 4 October, 2006 when they were discharged from the hospital on the final occasion. I have not included all of the details of Schedule 1 in my Decision as it would be somewhat prolix.

However, an appreciation of the matters included in Schedule 1 will assist in placing in context a number of the matters to which I have referred herein.

A Protection Application by Apprehension was issued on 29 September, 2006. The Court made an Interim Accommodation Order (IAO) to the RCH. When the boys were discharged, an IAO was made to an out of home placement.

The boys have remained in foster care since 4 October, 2006. They have had supervised access with their mother four times per week for one hour per access for the last 16 months.

BACKGROUND AND PRELIMINARY MATTERS

The grounds of the Protection Application by Apprehension dated 29 September, 2006 were ss.63(c),(e),(f) Children and Young Persons Act 1989, then in operation.

In order to appreciate the issues before the Court, it is necessary to have an understanding of the background to these proceedings which is as follows.

The doctors at the Royal Children's Hospital treating the boys had at various stages expressed concerns as to the initial cause/s of the lesions and as to their failure to heal.

On 29 September 2006 the Court made an Interim Accommodation Order to the Royal Children's Hospital. When the boys were due to be discharged on 4 October 2006 a submissions hearing was conducted in this Court.

The Department of Human Services (DHS) was seeking an IAO to a community service placement. The boys' mother sought the return of the boys on an IAO to her care. On 4 October 2006 the boys were placed by the Court on an IAO to a community service placement. They have resided together in foster care since that date, the first placement ceasing on 26 April 2007 and the boys then residing with a second foster family with whom they continue to reside.

At the conclusion of the submissions contest, the matter was booked in for a contested IAO hearing by evidence on 28 November 2006. Witnesses to be called by the DHS were not available on that date and the matter was adjourned for a three day

standby contest on
18 December 2006.

The matter did not proceed on 18 December 2006. Rather the matter resolved by consent. The protection application was found proved on grounds s.63(c),(e) and (f) and an Interim Protection Order (IPO) was made.

Both the DHS and the mother were legally represented on 18 December 2006.

At the commencement of these proceedings, a preliminary issue was raised by Mr Holden, appearing for the mother, concerning the extent, if at all, the Court was to consider the evidence which formed the basis of the protection application.

I note in this regard that although Ms Buchanan's initial position was that disposition was the sole issue before the Court and that the Court could not revisit the grounds of the protection application (PA) as the protection application had been proved, she also submitted that in order to present the DHS' case, she would seek to tender photographs of the children's wounds taken from May, 2006 onwards and to this extent the grounds of the protection application would need to be revisited.

Mr Holden stated that on legal advice the mother had accepted that there were grounds upon which the DHS could prove a protection application. However, he made a number of submissions as to why it was necessary for a determination to be made as to the reason/s for the boys' lesions and as to the role of the mother, given that the range could include deliberate infliction to a failure to protect the children in the future.

I accepted those submissions and ruled that whilst I could not revisit the finding of the grounds of the protection application being proved, nevertheless in order to determine the appropriate disposition, it would be necessary for evidence to be called which was relevant to the cause/s of the lesions and the mother's role in relation to the lesions for the following reasons:-

- It is not clear the factual basis upon which the PA was found proven. The DHS Application Report[1] dated 16 October 2006 recites s.63(c),(e)and (f) and then states:-

[1] Exhibit AB at p14

> "As described above, CR and KR have been assessed as suffering or likely to suffer significant harm. In the absence of effective intervention or change, it is believed likely that CR and KR may suffer future harm of these types and that the mother, has not and is unlikely to protect CR and KR from harm of that type."

Whilst the Application Report and other DHS Reports, for example, Disposition Report[2] and the Disposition Report[3] refer to "Dermatologica artifaecta" or "Dermatatis artifacta" (DA) and on one view of the DHS' case, the mother is responsible for the infliction of the lesions; given the aforementioned paragraph and such statements as

> "The mother's possible role in inflicting/contribution to the ulcer formation and subsequent breakdown of surrounding skin." [4]

And

> "Further concerns have been identified in relation to the mother's capacity to provide adequate care of the children, given she has denied harming the children or preventing the wounds from healing, yet there is no medical explanation for the deterioration of the wounds." [5]

it is not clear the basis upon which the PA was found proved.

This lack of clarity in relation to causation and aggravation remained during these proceedings, which I shall return to shortly.

For completeness neither the DHS' file nor the Court file shed any light in relation to the factual basis upon which the PA was proved. The magistrate who made the Order for the IPO does not have any independent recollection of the case.

Furthermore, during the proceedings there was a difference of opinion in the evidence of Dr (name removed) "witness 11" and Dr (name removed) "witness 7" from the Gatehouse Centre as to whether Dermatitis Artifacta (DA) consisted of an intentional act or whether inadvertence could suffice.

- It was not clear to me the basis upon which the DHS consented to an IPO on

[2] Exhibit AB p.3
[3] Exhibit AD p.6
[4] Addendum Report 18 December 2006 Exhibit AC p.4
[5] Disposition Report 17 October 2006 Exhibit AB p.4

18 December 2006 when the two Disposition Reports[6] signed 16 October 2006 and 13 December 2006 recommended a 12 month Custody to Secretary Order (CSO).

Whilst presumably some negotiations took place, this matter has caused me to have some concerns as to whether the mother understood she was consenting to an IPO being made and/or whether she understood she was consenting to the proving of the PA on grounds s.63(c),(e) and (f).

She has instructed Mr Holden that she understood she was agreeing to a new Order and she understood that something was being proven but she was unable to say what it was. When Mr Holden went through s.63(c),(e) and (f) with her, she denied having been taken through those provisions on 18 December 2006.

Ms Buchanan spoke to counsel who appeared for DHS on 18 December 2006 and stated the suggestion of an IPO was made on behalf of the mother. The DHS initially rejected the offer but then agreed to it. Counsel for the DHS on 18 December 2006 said she was concerned about the grounds. However, she said there was a clear understanding between counsel as to the proving of the grounds on s.63(c),(e) and (f).

Whilst it is necessary for the PA to be proved in order for an IPO to be made, it is unclear whether the mother appreciated this was the case especially in the circumstances that the DHS was agreeing to an Order which may well from the mother's perspective have been an Order which was preferable to her than a CSO. The Addendum Report prepared for the proceedings on 18 December 2006 had recommended a CSO and recommended a reduction in the mother's supervised access from four times per week to a minimum of twice per week. The IPO provided for the mother's supervised access to remain at four times per week.

As previously indicated an IPO was not an Order which the DHS had recommended in its Disposition Report[7] dated 16 October 2006 or Addendum Report[8] dated 13 December 2006. In its Disposition Report dated 16 October 2006 the following was stated in relation to an IPO:-

"This Order is considered inappropriate at this time as the Department has

[6] Exhibits AB and AC
[7] Exhibit AB
[8] Exhibit AC

assessed that protective concerns cannot be managed with CR and KR remaining in the care of the mother." [9]

Section 291 CYFA provides when a Court may make an IPO. In relation to this matter the irreconcilable difference ground is irrelevant. The Court must be satisfied that the child is in need of protection and that it is desirable, before making a Protection Order, to test the appropriateness of a particular course of action. Given the DHS' case in this matter, I could not determine as at 18 December 2006 the particular course of action it was proposed to test.

When this preliminary issue was considered before any evidence had been led, nor could Ms Buchanan identify such a course of action. It is unclear from the return of the IPO Report[10] any course of action which it had been proposed to test during the IPO.

During the course of the hearing two DHS witnesses were called, Mr (name removed) "the protective worker", and Mr (name removed) "witness 20", the Acting Unit Manager for the Children's Protection team Box Hill. The protective worker was allocated the matter on 14 December 2006. Whilst he attended Court on 18 December 2006 he was a new protective worker and did not have the conduct of the matter on that day. Witness 20 did not become involved with this matter until 21 May 2007.

No one with direct involvement as at that date was called by DHS. Witness 20 gave evidence that the DHS file did not indicate the basis upon which the IPO was agreed upon. However, he gave evidence that he could understand an IPO being agreed upon. He stated it avoided further contests, enabled a finding to be made on some grounds and enabled further assessments to be conducted.

The DHS arranged for the mother to be assessed by Dr (name removed) "witness 4", a psychiatrist. Witness 4 had recommended after seeing the mother on 15 November 2006 that she undergo further counselling.

During the IPO the mother attended three sessions of counselling with a psychiatrist, Dr (name removed) "witness 14". Witness 14 recommended further counselling being psychotherapy for the mother. The mother indicated to her that whilst she would continue counselling with her psychologist, (name removed) "witness 15", she

[9] Exhibit AB p.5
[10] Exhibit AD

did not want to attend for further treatment sessions with witness 14. Witness 14 did not consider that the mother was suffering from a psychiatric illness.

In addition, over this period of time witness 7 examined the boys and he provided reports to DHS.[11]

The Disposition Report provided to the Court on the return of the IPO recommended a two year Guardianship Order. The report referred to Dr (name removed) "witness 16", witness 7 and Dr (name removed) "witness 5" being of the opinion that the lesions were dermatological artifaecta - deliberately caused.

Despite witness 4's and witness 14's opinions being that the mother was not psychiatrically unwell and that witness 7 considered the recurrence of an ulcer on CR's thigh to be "worrying", the DHS report stated:-

> "Concerns continue to be raised about the mother's mental health as she has twice in the last three months informed DHS of 'ulcers' which she had claimed to see during access, believing these are the start of the ulcers the boys developed while in her care."[12]

- The mother has at all times denied being responsible for inflicting the wounds on the boys. The recording of her consent on 18 December 2006 as an admission of inflicting or contributing to the injuries is inconsistent with her position.
- The medical evidence relied upon to support the proving of the P.A. is exceptionally complex and technical. Prior to these proceedings the evidence had not been tested.
- In order to determine what is in the best interests of the boys, given the mother is seeking reunification and the DHS is intending to locate a permanent carer[13] it is necessary to determine the cause/s of the lesions and the mother's involvement.

Ms Buchanan submitted that whilst the Court was at large to make more specific findings in relation to the injuries, than the general findings made on 18 December, 2006 the mother's

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[11] Exhibits X and 11
[12] Exhibit AD
[13] Addendum Report 23 August 2007 Exhibit p. 5

consent to the proving of the P.A. is a factor in the scheme of this matter to be taken into account.

I would ordinarily agree with Ms Buchanan's submission. The mother was legally represented and it is important for the court record not to be revisited in subsequent proceedings.

However, in the circumstances of this case, I do not consider it would be appropriate to rely upon the mother's consent as evidence of her making an admission against interest for the purpose of these proceedings.

She has consistently denied being responsible for the wounds on the boys and as the factual basis upon which the P.A. was proved is unclear, it is difficult, if not impossible, to discern the basis of the consent being recorded.

The Court record will of course continue to indicate that on 18 December, 2006 the mother consented to the proving of the P.A on the grounds alleged.

SEPARATE REPRESENTATION FOR CR AND KR

On 17 September 2007 I found pursuant to s.524(4) CYFA there were exceptional circumstances and that it was in the best interests of CR and KR to be legally represented in these proceedings. The proceedings were adjourned to 18 September 2007 in order for legal representation to be obtained. Leave was granted for both of the boys to be represented by the same legal practitioner (s.524(5) CYFA). Mr Brown of counsel appeared for the boys.

POSITIONS OF THE PARTIES

The DHS is seeking a 12 month Custody to Secretary Order(CSO) with a reduction of supervised access to twice per week.

The mother is seeking ultimately a Supervision Order, for the boys to be returned to her care. However, given the period of time the boys have been out of her care, her position was that there would need to be a transition period via a further IAO.

On behalf of CR and KR, Mr Brown submitted that it was in their best

interests for the mother to engage in appropriate support services whilst the IAO to the current placement remained. There could then be a phased increase in the mother's access monitored by DHS including overnight stays. A Supervision Order could then be considered by the Court upon the receipt of positive feedback from psychologists and parenting skills practitioners. It was submitted that the children have been in care for 13 months and further long-term separation from their mother is not in their best interests.

WITNESSES

The following witnesses gave evidence during these proceedings.

Dr (name removed) "Witness 1"	General paediatric consultant and consultant infectious diseases**,** RCH
Dr (name removed) "Witness 2"	Head of Anatomical Pathology at RCH
(name removed) "Witness 3"	Registered nurse post graduate qualification in wound management
Dr (name removed) "Witness 4"	Psychiatrist
Dr (name removed) "Witness 5"	Consultant paediatrician, sub specialty paediatric endocrinology**,** RCH
Dr (name removed) "Witness 6"	General medical practitioner
Dr (name removed) "Witness 7"	Medical practitioner. U.K. qualification in paediatrics**,** Gatehouse Centre
(name removed) "Witness 8"	Registered Nurse

(Name removed) "Witness 9"	Registered Nurse
(Name removed) "Witness 10"	Registered Nurse
Dr (name removed) "Witness 11"	Consultant paediatrician, Gatehouse Centre
(Name removed) "Witness 12"	Registered Nurse
Dr (name removed) "Witness 13"	Dermatologist
Dr (name removed) "Witness 14"	Consultant psychiatrist, child and adult psychiatrist
(Name removed) "Witness 15"	Psychologist
Dr (name removed) "Witness 16"	Medical practitioner, currently training in paediatrics, RCH, completed 4 years training. Practising medicine 6 years.
(Name removed) "Witness 17"	Foster care worker, Anglicare
(Name removed) "the protective worker"	Child protection worker, DHS
(Name removed) Witness 18	Registered nurse
Dr (name removed) Witness 19	Paediatric clinical allergist, immunologist and immuno pathologist, RCH
(Name removed) Witness 20	A/Unit Manager Children's Protection Team, Box Hill DHS
(Name removed) Witness 21	Registered Nurse
Dr (name removed) Witness 22	General Practitioner

The central issue in this case was the role/s of the mother in causing and/or aggravating the lesions on the boys' skin. Accordingly, the evidence was largely of a

technical nature.

Save for the protective worker, witness 20, witness 17 and the boys' mother, the witnesses gave expert opinion evidence based upon their specialist medical or nursing knowledge.

I have had regard to the principles of the admissibility of expert medical evidence summarised by Heydon JA (as he was then) in Makita (Australia) Pty Ltd v Sprowles (NSWCA)(2001) 52 NSWLR 705 at [85] and applied by Coldrey J in R v Carol Mathey (2007) VSC 398 at [150]

> "In short, if evidence tendered as expert opinion evidence is to be admissible, it must be agreed or demonstrated that there is a field of 'specialised knowledge' there must be an identified aspect of that field in which the witness demonstrates that by reason of specified training, study or experience, the witness has become an expert; the opinion proffered must be 'wholly or substantially based on the witness's expert knowledge'; so far as the opinion is based on facts 'observed' by the expert, they must be identified and admissibly proved by the expert, insofar as the opinion is based on 'assumed' or 'accepted' facts, they must be identified and proved in some other way, it must be established that the facts on which the opinion is based form a proper foundation for it; and the opinion of an expert requires demonstration or examination of the scientific or other intellectual bases of the conclusions reached: that is, the expert's evidence must explain how the field of 'specialised knowledge' in which the witness is expert by reason of 'training, study or experience', and on which the opinion is 'wholly or substantially based', applies to the facts assumed or observed so as to produce the opinion propounded".

I am satisfied that all of the medical/nursing witnesses were qualified as experts to express their opinions within the realm of their expertise. In relation to the reasons relied upon by the witnesses to support their opinions, I have considered the 'observed' and 'assumed' facts in order to evaluate their opinions.

The doctors primarily responsible for caring for the boys, being witness 5, witness 1 and witness 16 demonstrated a commitment to providing optimal care for the

boys. I accept witness 13's evidence that clearly the doctors had no other agenda except to care for the boys' health.

In relation to witness 20, the protective worker and witness 17, I accept their evidence albeit that I did not consider witness 20 was fully frank in his evidence concerning his initial recommendation regarding disposition which was communicated to Anglicare.

The protective worker was of great assistance to the Court in facilitating the matter proceeding as smoothly and as expeditiously as possible. He was commended for his assistance by all counsel at the Bar table. He diligently took notes and even when unwell attended Court displaying a keen interest in the proceedings. He displayed a flexible approach to organising access when the case was proceeding. In order for there to be a productive relationship between DHS and the mother, I am confident that the protective worker's demeanour will assist in this regard.

Initially when witness 17 attended Court, she was not familiar with the details of this case prior to her involvement. However, when she was afforded the opportunity, she returned to Court having thoroughly read the Anglicare file and was of assistance to the Court; particularly in relation to the mother's access with the boys.

CHRONOLOGY

A chronology detailing the most significant events is as follows:-

February, 2006	The mother observes a red mark or scratch under CR's nose which develops into a sore. Subsequently the mother observes a similar presentation under KR's nose.
10.04.06	Witness 6 diagnoses impetigo in relation to a number of lesions on both boys' skin and prescribes EES (antibiotic).

27.04.06	Witness 6 refers the boys to AED at RCH due to the sores not responding to EES.
27.04.06	The mother attends at AED RCH with the boys and they are prescribed antibiotics and swabs are taken.
03.05.06	The mother attends at the Dermatology Department RCH and sees witness 13 and Dr (name removed) "Dr S". A further course of antibiotics is prescribed together with topical steroids.
14.05.06	The mother re-presents at AED RCH due to the presence of vesicles.
15.05.06	The boys are admitted into RCH. Intravenous antibiotics and anti viral medication is administered.
22.05.06	The boys are discharged and acyclovir and clindamycin is prescribed.
05.06.06	Review by witness 5 and (name removed) EK (Dermatology Nurse)
07.06.06	The boys did not attend a scheduled appointment
14.06.06	Review by Dermatology
03.07.06	The boys did not attend a scheduled appointment
10.07.06	The boys did not attend a scheduled appointment
17.08.06	Urgent referral by witness 6 of the boys to AED RCH
17.08.06	The boys are admitted to RCH. The boys' lesions are dressed and their hands bandaged. No medication is prescribed.
24.08.06	The boys are discharged from hospital. The Hospital in the Home (HITH) service is engaged. Visits to be twice per day.
04.09.06	Review by witness 16, wounds healing.

	The HITH visits are reduced to once per day.
18.09.06	Review by witness 16, deterioration of the lesions.
20.09.06	Review by witness 16 and witness 3, stomal therapist. Lesions dressed by witness 3.
25.09.06	Witness 16 notified by HITH that on 22.09.06 the boys did not have dressings on and that the HITH service would not continue to see the mother.
27.09.06	The boys are admitted to RCH. No medication is prescribed.
04.10.06	The boys are discharged and placed on an IAO to an out of home placement.

STANDARD OF PROOF

The standard of proof upon which I am required to be satisfied in relation to the finding of facts in this case is on the balance of probabilities.[14]

The allegations in this case are very serious, indeed it would be difficult to contemplate a more serious allegation than that of a mother harming her children in the circumstances of this case. In addition, the consequences which flow, were such a finding to be made, are also serious as is evident from the DHS' position in this case in which it is seeking to reduce the mother's access to two times one hour per week and to locate a permanent carer.[15]

The House of Lords in *Re H. and Others* [1996] AC 563 considered section 31(2)(a)of the *Children Act* 1989 (UK). It is a similar provision to s.162 CYFA.

Lord Nicholls of Birkenhead gave the majority judgment. He stated at page 586:-

> "When assessing the probabilities the Court will have in mind as a factor to whatever extent is appropriate in the particular case, that the more serious the

[14] s215(1)(c)CYFA
[15] DHS report Exhibit AF

> allegation the less likely it is that the event occurred and hence, the stronger should be the evidence before the Court concludes that the allegation is established on the balance of probability".

In *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362 Dixon J stated: -

> "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony or indirect inferences".

MUNCHAUSEN BY PROXY AND DERMATITIS ARTIFACTA

During the proceedings reference was made to the conditions Munchausen by Proxy and Dermatitis Artifacta (DA). I will first of all consider the evidence in relation to Munchausen by Proxy and then Dermatitis Artifacta.

MUNCHAUSEN BY PROXY

The condition Munchausen by Proxy was raised during evidence in these proceedings.

Witness 4 conducted a psychiatric assessment of the mother. However, he stated he was not an expert in relation to Munchausen by Proxy and it was a matter for the Court to determine the mother's involvement in relation to the ulcers on the boys' skin based upon the evidence before it.

Witness 14 in her report stated that she was not qualified to assess whether the mother had or had not perpetrated the acts alleged against her sons.

No expert witness in relation to Munchausen by Proxy was called to give evidence.

Witness 4 agreed that whilst there are multiple presentations in relation to Munchausen by Proxy, one of the usual characteristics of Munchausen by Proxy is that the parent or care giver, usually the mother, persists in presenting her child or children for medical treatment.

Witness 4 stated that the clinicians often have a sense that the person with Munchausen

by Proxy has a great deal of preoccupation or obsession with the symptoms the child is exhibiting which may or may not be severe and no degree of assurance will allay their concerns. Sometimes the person presents with a high degree of medical knowledge. He did not believe it was part of DSM-IV but stated he was not an expert and he was not familiar with the latest research. He considered that Munchausen by Proxy and Dermatitis Artifacta (DA) are, “part and parcel of the same thing”. The injuries may be caused by someone else (Munchausen by Proxy) or self inflicted (DA).

Witness 14 gave evidence that Munchausen by Proxy is a behavioural diagnosis and is categorised by DSM-IV. It is not an aetiological diagnosis. The diagnosis is made by the observation of behaviour. The behaviour is intentional and is often engaged in to seek help for unmet developmental needs. It is usually denied by the person.

Witness 1 described Munchausen by Proxy as being more of a complete psychiatric diagnosis than DA. He said that Munchausen by Proxy involves a pattern of behaviour recurrently seeking medical attention classically with your child in relation to the same medical problem or a different problem.

Munchausen's syndrome is defined in Mosby's Medical Nursing and Allied Health Dictionary (1998) -

> "An unusual condition characterised by habitual pleas for treatment and hospitalisation for a symptomatic but imaginary acute illness. The affected person may logically and convincingly present the symptoms and history of a real disease. Symptoms resolve with treatment, but the person may seek further treatment for another imaginary disease." (p.1061).

Munchausen's Syndrome by Proxy is defined as:-

> "A variation of Munchausen's Syndrome in which the parent persistently fabricates or induces illness in a child with the intent of keeping in contact with hospitals and physicians .... The mother poses as being a good parent by 'saving' the child from medical catastrophe, and the child serves as a manipulative object." (p.1061)

The behaviour of the mother as detailed in the evidence is not consistent with the definition of Munchausen by Proxy as defined in Mosby’s Dictionary.

Putting to one side the issue as to whether the mother caused or aggravated the boys' lesions and accepting her evidence that the lesions commenced under the nose of each boy, it could not be said that the mother's behaviour displayed any intention of keeping in contact with hospitals and physicians. Rather, the contrary is the case.

- She did not take the boys for medical treatment when the first sores on the boys appeared.
- She missed a number of scheduled medical appointments to review the boys at the Royal Children's Hospital (for example 7 June 2006, 3 July 2006, 10 July 2006).
- Despite the lesions in general worsening in appearance over the period 4 September 2006 to 27 September 2006 she did not attend at the hospital until 27 September 2006.
- Accepting her evidence that she could not afford the bandages to replace the ones which had "fallen off", she did not seek any medical assistance.
- She sought to discharge the boys on 21 August 2006 and 23 August 2006 from the Royal Children's Hospital.
- Whilst she was critical of the hospital staff for not "knowing what was going on" with the boys, witness 16 noted that she was mostly pleasant and co-operative but she seemed relatively unconcerned at the seriousness of the lesions.

Whilst a number of these matters raise other concerns in relation to whether the mother acted protectively towards the boys, they are not consistent with the characteristics described in relation to Munchausen by Proxy.

DERMATITIS ARTIFACTA

Witness 5 defined Dermatitis Artifacta (DA) as lesions which are not caused by any pathological organism but artificially, that is they are caused by an agent. Witness 1 stated that his understanding was that DA refers to a skin condition artificially introduced classically by trauma to yourself or to someone else.

Witness 13 stated it was a diagnosis where the skin is diseased by artificial means or trauma, usually for the result of some secondary gain, for example, an adolescent harming himself to get out of an exam.

Witness 1's evidence was that his findings in this case were consistent with DA but this did not mean he had diagnosed DA. Similarly, witness 13 stated that his diagnosis was consistent with mechanical trauma but he could not diagnose DA. He said it would require an extra step of proof or intent.

There was a conflict in the evidence of the two witnesses from the Gatehouse Centre, witness 11 and witness 7 in relation to the issue of intent.

Dr witness 7 stated that deliberateness is part of the diagnosis of DA. It must be a deliberate, conscious action, not unintentional or inadvertent. He stated that inadvertence or using a wrong cream or a wrong strength dressing would not constitute DA.

However, witness 11 whilst not directly asked about this matter stated in her reports -

> "Although I am unable to say the intent as to the further aggravation of the ulcers it is clear that these ulcers have not responded appropriately to medical treatment in the home setting and there are concerns that they are a reflection of Dermatitis Artefacta, that is injuries to the skin that have been caused by further irritation or aggravation of the wound."[16] (emphasis added)

and

> "The chronic nature of the ulcers and the lack of response to treatment leads to the consideration that there has been interference that has further aggravated the ulcers and impeded healing. Although I am unable to say whether this might have been inadvertent or intentional, it is clear that these ulcers have not responded appropriately to medical treatment in the home setting and there are concerns that they are a reflection of DA that is injuries to the skin that have been caused by further irritation or aggravation of the wound."[17] (emphasis added)

The issue of intention was raised during the proceedings. On 8 October 2007 Ms Buchanan stated "The Department does not say the harm caused was deliberate." However, in the closing submissions of the DHS the following was stated -

> ".... no specialist or expert can define exactly what was the cause of the lesions other than in general terms, such as mechanical, chemical, pressure. Despite this, regardless of the label, all are adamant there is an element of deliberation in the cause and perpetuation of the twins' widespread and

[16] Exhibit C - KR
[17] Exhibit D - CR

longstanding wounds."[18] (emphasis added)

In my view it is not necessary to reach a decided view as to whether DA requires intention to be proved. Rather, it is necessary to determine what the evidence establishes in relation to the mother's role in the cause and/or aggravation of the lesions.

It is trite to say that there is a marked distinction between a finding that the mother intentionally caused or aggravated the lesions to finding that the lesions were caused or aggravated whilst in the mother's care but that the cause could have been unintentional, for example, cross infection between the mother and the boys, environmental factors (for example rubbing on the carpet), to a finding that the mother did not intentionally or unintentionally cause or aggravate the lesions.

Given the evidence before the Court and the written submission of the DHS, the issue of the deliberate harming of the boys by the mother must be determined.

CAUSE AND/OR AGGRAVATION OF THE LESIONS

Throughout this Decision I have referred to "cause and/or aggravation" of the lesions. It has been difficult in this case isolating the witnesses' evidence in relation to "cause" and "aggravation" or "perpetuation" of the lesions.

Part of the reason for this is the manner in which medical diagnoses are made; for example, in this case, witness 13's evidence was that it was not only the physical observation of the lesions which was relied upon but also the results of the pathology tests which were conducted and the response of the lesions to particular treatments (for example bandaging the lesions without prescribing any medication during the second and third admissions). This means that initially a presumptive diagnosis may be made, for example, deep impetigo, but over time when the other matters are factored in, the diagnosis may change, for example DA. Thus, information obtained some months later is then relied upon to support the diagnosis.

This was why it was difficult to determine during the proceedings whether it was the actual cause of the lesions to which witnesses were referring or their

[18] Page 28

aggravation. In addition, at times the words were used interchangeably.

A related issue to that concerning distinguishing between the cause of the lesions and the perpetuation of the lesions is that each of the primary treating doctors first saw the boys on different dates; for example, witness 13 saw them on 3 May 2006; witness 1 saw them on 14 May 2006 and witness 5 saw them on or about 15 May 2006. None of them saw the boys when they first presented at AED on 27 April 2006.

Accordingly, there has not been one doctor who has examined the boys' lesions from 27 April 2006 until they were discharged on 4 October 2006.

It is understandable that this is the case given such matters as the lengthy period of time over which the twins attended at the RCH, the size of the hospital, the boys' initial attendance at AED and the rotation policy at the hospital. It has the benefit that a fresh analysis can take place with a possibly different doctor attending to the patient but it has the potential disadvantage that when it is sought, as in this case, to provide an opinion in relation to the initial cause or aggravation of the lesions even accepting that there are notes on the hospital file, the doctors are not necessarily comparing like with like, for example, the lesions observed by the doctor in AED on 27 April 2006 had a different appearance to those drawn and observed on 15 May 2006.

Attached to Schedule 1, I have appended the diagrams drawn by the doctors who saw the boys on 27 April 2006 and 3 May 2006 (as there were not any photographs taken of the lesions before 15 May 2006).

On 14 May 2006 the mother represented at the AED with the boys and stated that there had been no improvement in CR's lesions and little improvement in KR's lesions. Dr (name removed) "Dr P" made the following entry.

> "Last two days surrounding erythema (?) and multiple vesicles had appeared. Punched out impetiginous lesions with vesicles and ecthyma (?) lower limbs." (CR)

and

> "Last four days ↑ full ecthyma and multiple vesicles had appeared. Punched out facial impetigo and large right thigh lesion." (KR)

This presentation could be contrasted with -

- The presentation on 27 April 2006 when witness 6 did not observe any vesicles

- The presentation on 27 April 2006 before the doctor in the AED at RCH in which s/he did not make any reference to vesicles in the description of the lesions or ulcers in relation to CR and in relation to KR the doctor made a specific entry "no vesicles or (and whilst the writing is difficult to read, it appears to be) bullous".
- On 3 May 2006 Dr S described both boys' lesions and drew them. There was no reference to any vesicles being present.

Satellite vesicles consistent with HSV 1 are present in the photographs taken of both boys on 15 May 2006. There is a contrast between the number of lesions, in particular, in relation to KR, from the diagram of Dr S's on 3 May 2006 to the photographs taken on 15 May 2006.

There is a temptation in this case to consider that the appearance of the lesions commenced as is depicted in the first set of photographs which were taken on 15 May 2006. This was not the case.

witness 5 in his evidence stated that his role was to treat the boys. He was not performing a forensic function.

Whilst clinically it may be as was the evidence of witness 13 and witness 1 and witness 5, to a lesser extent, that it was not relevant for them to consider the site of the first lesion, whether it healed or the progress of individual lesions, given the large number of lesions; such matters are relevant in assessing the credibility of the mother, the actions she took and her ability to act protectively.

THE EVIDENCE OF THE MOTHER IN RELATION TO THE INITIAL LESIONS AND THE MEDICAL EVIDENCE IN RELATION TO IMPETIGO

The mother has consistently maintained that the location of the first ulcer was under CR's nose. Some weeks later she noticed an ulcer in the same location under KR's nose. Her evidence was that she first observed a red mark, then it turned into a type of a scratch and then it turned into a bigger, deeper type of sore. She did not take the boys to the doctors in relation to these sores. She gave evidence the sores under each boy's nose healed. However, further sores appeared.

On 10 April 2006 witness 6 diagnosed impetigo lesions. On 27 April 2006 he diagnosed persistent impetigo/staph infection. The Doctor in the AED RCH on the same day diagnosed ? deep impetigo albeit that in addition, a referral was made to the Dermatology Department.

Impetigo is defined in Mosby's Medical Nursing and Allied Health Dictionary (1998) as

> "a streptococcal, staphylococcal, or combined infection of the skin beginning as focal erythema and progressing to pruritic vesicles, erosions and honey-coloured crusts. Lesions usually form on the face and spread locally. The disorder is highly contagious through contact with the discharge from the lesions."[19]

Dr S on 3 May 2006 described the lesions in the following terms:

Re: CR "red lesions with yellow crusts."

Re: KR "red with yellow crust and erythema surrounding."

The RCH treating doctors were asked about the initial presentation of a sore under each boy's nose. Witness 1 stated that if CR had a sore under his nose and some weeks later his brother presented in the same way, he agreed it was consistent with impetigo. Staphylococcas Aureus (SA) can colonise in the nose. The infection may readily spread between the boys.

Witness 13's evidence was that as a site, under the nose is not an unusual site

for impetigo and witness 5 agreed. He also agreed that if the nose area is colonised with SA other areas can become infected, especially if there is a breakdown of the skin as it can be colonised quickly. He gave evidence that impetigo can spread even in the absence of a breakdown of the skin. He stated that if there is rubbing under the nose by a child's dummy, for example, infection could easily occur if the nose is colonised. Nose swabs of both boys indicated the presence of SA.[20]

A nose swab taken from the mother on 5 October 2006 also indicated the presence of SA.[21] The cultures indicated that the SA present for the mother and both boys was resistant to penicillin and sensitive to the same antibiotics. Witness 5 confirmed that infection can spread from mother to child and vice versa. Witness 13 gave evidence it is possible for the boys' mother to reinfect the wounds if she was a carrier.

ATTENDANCE ON 3 May 2006 AT RCH

The DHS has at all times maintained that the principal evidence relied upon in this case is the expert medical evidence. In the closing submissions, it was submitted on behalf of DHS that the evidence of witness 13 was

> "The most significant in the case as witness 13, alone of all the witnesses, has the greatest expertise with skin diseases and injuries to the skin of all of the witnesses."

witness 13 is a dermatologist and has practised exclusively as a dermatologist since 1998.

He gave evidence that the possible diagnoses he considered were -

- Impetigo with discoid eczema
- Immuno deficiency in the boys
- Pyoderma gangrenosum
- Dermatitis Artifacta

Witness 13 first saw the boys on 3 May 2006 with a trainee paediatrician Dr

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[19] Page 822
[20] Re CR – 5 June 2006 scanty SA – Exhibit 2C Page 7
Re KR – 5 June 2006 scanty SA – Exhibit 2B Page 14
Re KR – 14 June 2006 profuse SA – Exhibit 2B Page 10 (right nasal lesion swab)
[21] Exhibit 24 – 5 October 2006 – Light growth of SA

S. Witness 13's evidence was that as at 3 May 2006 he had concerns as to whether the lesions were caused by trauma (DA) however, as at 3 May 2006 his suspicions were small.[22]

The letters written by Dr S to witness 6, the boys' referring doctor, contained it would seem, a very definite diagnosis in relation to impetigo. The letters contained the following:

"CR certainly has impetigo ..... however, the widespread distribution makes a diagnosis of discoid eczema also likely."[23]

In relation to KR –

"KR certainly has impetigo but also discoid eczema given the widespread distribution of his lesions."[24]

Witness 13 prescribed a further course of antibiotics (Flucloxacillin and Bactroban) to treat the impetigo and topical steroids (Elocon for the body and Sigmacort for the face) to treat the discoid eczema.

The RCH file indicates that there was to be a review in four weeks and the mother was to cancel if the lesions resolved. However, the lesions did not resolve and consequently the mother re-presented the boys at AED at RCH on 14 May, 2006.

ATTENDANCE ON 14 MAY, 2006 AND FIRST ADMISSION TO RCH.

I have previously referred to the observations made by the doctor in AED on 14 May 2006.

Witness 5 was the primary physician in charge of the boys' admission on 15 May 2006. When witness 5 saw the boys in May, 2006 he described the boys presenting with

"Somewhat unusual skin lesions, obviously infected, some appearance of Staphylococci infection or impetigo."

[22] The first reference to DA on the RCH file is dated 5 June 2006 and is an entry by EK, a dermatology nurse.
[23] Exhibit O
[24] Exhibit P

Witness 5 stated that it was "quite plausible" that the lesions started out as SA and colonised HSV1. He said the initial impression was predominantly impetigo but he noted witness 1's description of the ulcers as "unusual". Witness 5 said what he found unusual was the extent of the lesions, the deep ulceration and that they had not cleared up after reasonable treatment. However, his evidence was that it was not outside the range of a Staphylococcus infection.

The boys were given intravenous antibiotics and antiviral medication to treat the impetigo/SA and HSV1.

Witness 1 gave evidence that the infectious agents which were present in the lesions in May, 2006 were SA and HSV1. He stated that each of those organisms is capable of causing skin lesions although these lesions were unusual for those organisms. He stated that the SA presentation is usually boils and rarely ulcers. In the event both SA and HSV1 are present they have the potential to aggravate the ulcer present. The natural history of both organisms is that they will cure and resolve spontaneously provided the immune system is normal.

HSV1 travels down a nerve and can cause infection. It is more likely to do so if the skin in weakened in some way. Damaged skin may encourage HSV1. If HSV1 is causing the skin problem then treating it will increase the rate of healing but again it will get better eventually whether treatment is given or not. Treatment however is required if there is a large abscess, risk of blood infection or cellulitis. Provided the organism is not resistant to treatment and the child does not have an immune deficiency, the wound will always heal and improve. As a general rule younger children have a weaker immune response than older children and adults.

Witness 1 stated that the treatment in hospital, would have cured SA in the lesions and significantly reduced SA load everywhere. However he stated it is often unsuccessful in eliminating SA from the nose. Staph can spread to areas of damaged or undamaged skin.

Witness 1 described the lesions as “unusually broad”. He agreed that HSV1[25] and SA appeared to play a role in the lesions right at the start, that is in May 2006. This would

[25] Witness 1’s evidence was that he was "not well aware" that the boys when they presented for their admission in May had widespread HSV1 on their bodies. Given that he saw the boys on 14 and 16 May, 2006 it may be that with the effluxion of time he could not recall this.

be consistent with the antiviral and antibacterial drugs which were administered. The photographs suggested to witness 1 that on 15 May, 2006 there was more than one site of primary HSV infection. It was extremely consistent with clinical satellites. Witness 1 did not believe HSV1 was responsible for all of the skin lesions; rather he believed HSV1 was most likely responsible for all of the satellite lesions. It was much harder to deduce whether there were multiple sites subsequently.

Witness 1 gave evidence that the first infection of HSV1 is generally the most virulent.

Witness 13 gave evidence that the appearance of vesicles consistent with the presence of HSV1 was a new presentation. He said that HSV1 was definitely not the cause of the lesions. HSV1 was a secondary infection which had colonised the lesions. He agreed that the presence of HSV1 would aggravate the lesions that is slow down the healing process.

On 16 May 2006 a punch biopsy was taken from CR's right thigh from a site which was typical of a chronic lesion without the complication of HSV 1. Witness 13 stated that this was because HSV 1 was a secondary event.

In the clinical notes contained in the request details -

> "? impetigo. This is a twin. Both twins have had shallow growing ulcers for ten weeks. Treated as impetigo with no response. Now also has spreading HSV infection. Nature of ulcers (one centimetre diameter) unknown. ? primary HSV ulcers. Biopsy of ulcer on right side."[26]

I will detail the results of the biopsy when I review the bases upon which witness 13 has concluded that trauma was the cause of the ulcers; suffice to say that no infective agents or viral inclusion bodies were identified. The ulcer was quite sharply defined.

Witness 11 stated in relation to the May admission –

> "Initial microbiological investigations performed at the RCH in May 2006 showed that KR's ulcers had a staphylococcal infection with a super infection of HSV."[27]

She indicated that the same findings applied to CR.[28] The word "super" she

[26] Exhibit 2A
[27] Exhibit C
[28] Exhibit D

explained meant “on top of, that is they had both".

When witness 7 was shown the photographs and was referred to witness 11's report he stated that he was not sure why witness 11 thought that HSV1 super infection came in afterwards. He said it was equally arguable and it was usually the case that the HSV1 started and the SA bacteria came in afterwards but it could happen in reverse. He said that a secondary SA infection is very common and is usually referred to as impetigo.

Prior to 3 May 2006 there had not been any clinical observations of HSV1 by any of the medical practitioners who had examined the boys. However, when they presented on 14 May 2006 the viral infection HSV1 was present. Multiple HSV1 vesicles surrounded many, if not all, of the lesions. In addition the number of lesions had increased especially on KR's right thigh.

Witness 13 stated that the underlying aetiology of HSV1 is still not ascertained. It is unusual to have HSV1 infection in areas other than the lips. It is possible if the skin is broken. It was a new development in the chronic wounds.

Witness 13 said that the prescription of steroids would not have altered the situation much and would not have made the herpes worse particularly if prescribed with appropriate antiviral treatment. However, when the steroids were prescribed the RCH file does not indicate that the boys had been prescribed antiviral medication.

Upon being shown the photographs taken on 15 May 2006 witness 1 noted the satellite lesions and said that the little spots were consistent with a herpes infection at multiple sites for both boys.

His evidence was that steroid treatment would have no effect resolving HSV1. It is possible, he said, that the use of topical steroids on ulcers infected with a viral infection may inflame them. It is certainly possible he said that the use of topical steroids made the HSV1 worse. He considered it was likely that as at 15 May 2006 that HSV1 was present in the ulcer and not just outlying from the ulcer.

Witness 13 gave evidence that there was not any clinical presentation of a viral infection as at 3 May 2006 and this is consistent with the observations of the doctors who had seen the boys prior to 3 May 2006. Witness 13 stated that the main thing in relation to HSV1 is to use antiviral medication. Quite often HSV1 spreads where there is

disturbed or broken skin where it remains localised. It is necessary to treat the HSV1 with anti viral medication and to treat the underlying skin condition.

Whilst he considered that it was an unusual presentation for eczema, he prescribed steroid medication given the discoid widespread presentation.

It would seem that the application of the steroid cream had a deleterious effect upon the boys' skin. It must be stressed that there was no clinical presentation of HSV1 being present when witness 13 and Dr S saw the boys and that the prescription of steroids was appropriate for a diagnosis of eczema.

In addition, witness 1 gave evidence that children with eczema, when they develop clinical HSV can get a severe form of HSV. Eczema can create very widespread abnormal skin and therefore viruses can manifest, for example, HSV1.

The reasons why it seems the steroids had a deleterious effect are :-

- the temporal connection with the medication being prescribed,
- the observations of the mother as to the worsening of the lesions and the appearance of the satellite lesions,
- Witness 1's evidence that the use of topical steroids on ulcers infected with a viral infection may inflame them and if HSV1 was present, make it worse,
- The RCH file entry of Dr (name removed) "Dr W" dated 16/5/06 in which he includes as a possibility primary HSV infection (chronic) with exacerbation by steroid treatment,
- Witness 6's evidence that steroids can aggravate a viral infection but a dermatological opinion would be valuable,
- Witness 5's evidence that topical steroids could spread the HSV1 but it would depend upon any prescribed medication which was being taken,
- Witness 5's evidence that steroids reduce local immunity and spread infection,
- The RCH files do not indicate that the boys were taking antiviral medication at the time.

The significance of the prescription of the steroid treatment is that a comparison with the diagram drawn on 3 May 2006 with the presentation on 15 May 2006 bears little resemblance particularly in relation to KR's lesions. From 15 May 2006, whilst there

were some new lesions, it was primarily the lesions which appeared after the infestation of HSV1 that remained throughout the period until the boys were placed in foster care.

The boys were discharged home in the care of their mother on 22 May 2006 with the prescribed medication Acyclovir and Clindamycin.

POST MAY ADMISSIONS TO RCH

Witness 13 gave evidence that the next time he saw the boys was on 14 June 2006 and he could not understand given the antibacterial treatment which had been given, why the lesions had not healed. Further pathology tests were ordered including a repeat biopsy and immune function tests.

The boys were admitted again over the period 17 August 2006 – 24 August 2006 which shall be discussed shortly.

Their final admission occurred over the period 27 September 2006 – 4 October 2006. On the second and third admissions, the boys' lesions were bandaged but there was no medication prescribed. On both occasions the lesions healed whilst the boys were in hospital.

When witness 13 saw the boys on 27 September 2006 (the day of their third admission) he compiled the following entry on the RCH file. It related to both boys -

> "It is becoming increasingly difficult to see any other cause other than traumatic injury. Both biopsies have shown no inflammatory or infective disorder. No cultures have grown any pathogens. No immunological tests or other clinical signs have shown there to be any underlying predisposition. As well significant healing occurred with dressings alone when supervised in hospital. This would not be expected to heal infections or inflammatory processes such as discoid eczema or pyoderma gangrenosum. Particularly if healing occurs again during inpatient stay the only conclusion that can be drawn is that of traumatic (non - accidental) injury."

THE MATTERS IDENTIFIED BY WITNESS 13 SUPPORTIVE OF TRAUMATIC (NON ACCIDENTAL) INJURY

The matters witness 13 identified in his file note which were supportive of trauma were -

- both biopsies have shown no inflammatory or infective disorder
- no cultures have grown any pathogens
- no immunological tests or other clinical signs have shown there to be any underlying predisposition
- significant healing having occurred with dressings alone when supervised in hospital.

There was further medical evidence given which was relied upon to support a diagnosis of trauma -

- the appearance of the lesions
- the sharply defined edges of the lesions.

I will briefly refer to this further medical evidence and then consider the evidence in relation to the matters referred to in witness 13's file note relevant to a traumatic (non-accidental) injury.

Despite the extensive experience of the numerous medical practitioners who saw the boys, none of the treating doctors had previously seen lesions which had the appearance of the lesions on the boys' skin.

The descriptions of the lesions included:-

Witness 13	"These lesions were not typical of anything ever seen before."
Witness 5	"The children presented a challenging diagnostic problem …… never seen anything like these children's lesions …… startled by the depth of the ulceration ……"
Witness 1	The lesions were not typical of anything he had seen. He observed that a majority of them had a sharply defined edge. The biopsies taken from CR's thigh confirmed a sharply defined edge and that was one reason Dr (name removed) "witness 2" suggested that a mechanical factor should be considered.
Witness 16	The lesions were "quite obviously quite shocking – the extent, size and distribution".

Witness 7	Upon viewing the photographs witness 7 stated that the lesions were so severe and so gross. He had never seen anything like them before.

I will now refer to the evidence concerning the matters relied upon in witness 13's file note relevant to a traumatic (non-accidental) injury.

1. BOTH BIOPSIES HAVE SHOWN NO INFLAMMATORY OR INFECTIVE CAUSE

Witness 2 is the head of anatomical pathology at the RCH. He confirmed that the biopsies conducted on 16 May 2006 and 14 June 2006 from CR's right thigh (the biopsy did not indicate whether it was taken from the same ulcer)[29] tested negative for infective agents such as fungus or micro bacterial agents which could cause an ulcer. Both biopsies indicated a sharply defined ulcer/s with not a lot of inflammatory infiltration at the base and no granuloma.

Witness 2 queried in relation to the biopsy requested on 14 June 2006 whether there was a mechanical factor, such as scratching, based partly upon the sharply defined margin of the ulcer and partly on the inability to find a specific cause.

Witness 2 was told that there were lesions which had the appearance of HSV 1 and other lesions which did not. Swabs which were taken from the sites suspected to contain HSV1 were confirmed to be HSV1. The lesion/s which was biopsied was not typical of an HSV1 site.

Witness 2 could not rule out but considered it was unlikely that the sharply defined edge could be explained by the removal of a dressing and a tearing at the epidermis.

Witness 2 stated that his evidence related to what he could see under the microscope in relation to the sample provided to his laboratory. He could not comment as to how representative the sample was of the other lesions on the boys' bodies.

[29] The photographs taken of CR on 15/5/06 indicate that there was only one lesion on his right thigh (Photograph Nos. 9, 10) there were not any photographs taken between 15/5/06 and 17/8/06 so it is not possible to observe whether as at 14/6/06 the additional lesions which are present in the photographs (28 and 29) taken on 17/8/06 were present as at 14/6/06.

Witness 7 gave evidence that the lesions on the boys' skin did vary in appearance, for example, some were linear, some round, they showed evidence of healing at different rates, some had defined edges and others had undermined edges. In addition, the micro biological results of skin swabs taken on 27 April 2006 indicated different results for each of the boys. A skin ulcer swab from CR was cultured and grew scanty SA[30] and there was no growth from a skin ulcer swab cultured from KR after two days.[31]

I found witness 2 to be an impressive witness. He had reviewed the test results and conducted further tests, in particular, in relation to the biopsy taken on 9 March 2007. I will refer to witness 7's evidence later in this Decision.

2. <u>NO CULTURES HAVE GROWN ANY PATHOGENS</u>

Witness 13 gave evidence that "no cultures have grown pathogens". There were microbiological examinations conducted for both boys which indicated the presence of Staphylococcus Aureus (SA) and HSV1. (Refer to the attached schedule - which details the findings).

Witness 13's evidence was that the presence of SA, for example, is not a diagnosis. Most open wounds start to colonise SA. It was his opinion that neither SA nor HSV was the primary cause of the lesions. Whilst there was a presumptive initial diagnosis of impetigo, witness 13 ruled that out as a result of the subsequent events, that is, the biopsy results, the response to treatment and that the lesions were not typical of impetigo, atypical impetigo or ecthyma.

Witness 1 agreed that even though the pathology results may confirm the presence of SA, for example, that may or may not be significant. It is for the clinician to determine whether the pathogen or organism is playing a role. In assessing the role, the behaviour of the wounds in the context of the treatment regime is taken into account.

On 17 August 2006, for example, witness 1 stated that moderate SA was cultured from swabs taken from KR's head ulcer and right foot ulcer. During the

[30] Exhibit 2C page 13
[31] Exhibit 2B Page 19

admission KR was not treated with antibiotics. The healing of the wounds in hospital confirmed according to witness 1 that there was not the need to treat with antibacterial therapy.[32] Whilst he did not consider that HSV and SA had a role in relation to the worsening of the ulcers in September, 2006 he was not as categorical in relation to the first admission in May, 2006.

His evidence was that the initial presentation in May when the boys were first admitted was consistent with infection, that is impetigo and there was active evidence of HSV1. He distinguished between the presentation of the ulcers on 14 May 2006 and 27 September 2006.

He said he had previously observed the coexistence of HSV/SA and it bore some similarities to the presentation on 14 May 2006 although the ulcers were unusually broad. The ulcers did not have this appearance on 27 September 2006.

In his statement to the police, witness 1 stated -

> "The bacteria SA can cause superficial ulcerative skin lesions but not as deep as the twins had. SA is a common skin organism and can be found even on normal skin. The virus Herpes Simplex can cause ulcerative skin lesion following initial blister formation, but not as deep or as widespread as the boys had at presentation on 27 September."[33]

The lesions were treated with the intravenous antibiotic medication Flucloxacillin and the antiviral medication Aciclovir during the May admission and the lesions responded.

Witness 5's evidence was that it was "quite plausible" that the lesions started as a SA infection and they were colonised by HSV. His initial impression was that there was a predominance of impetigo and he referred to Dr P's note on the RCH file on 14 May 2006 "chronic impetigo ? HSV component". As previously mentioned, whilst witness 5 found the extent of the lesions, their depth and that they had not cleared up with reasonable treatment to be unusual, he stated that the presentation was not outside the range of a SA infection.

During the subsequent admissions to hospital, (save for paracetamol or Intrasite gel for the facial lesions being administered) the only treatment prescribed

[32] The boys were discharged into foster care on 4 October 2006. However, on 16 October 2006 witness 16 prescribed the antibiotic Keflex for both boys for ? impetigo.
[33] Exhibit K

was dressing the lesions. The lesions either continued to heal or commenced healing whilst the boys were inpatients on their second and third admissions.

The biopsy results taken from CR's right thigh on 16 May 2006 and 14 June 2006 indicated a sharply defined ulcer. As previously indicated it was not clear whether the biopsy was taken from the same site. There were no infective organisms located which could cause an ulcer. In relation to the biopsy taken on 14 June 2006, witness 2 stated that because a specific cause was not found and the edge of the ulcer was sharply defined, it may suggest a mechanical factor.

The opinion of witness 1 ultimately after observing the effect on the lesions of the treatment in hospital, the immunology results and the biopsy results, was that there was not an infectious, immunological or dermatological diagnosis to explain the lesions. As a process of deduction something which made the lesions worse at home had not been excluded. He stated that all diagnoses are a probability diagnosis in the absence of any witnessed events. Witness 1 said it does not exclude 100 per cent the possibility that something is occurring that is not understood.

Witness 5's evidence was that the pattern of lesions at presentation and distribution and what happened subsequently and in the absence of any better alternative explanation the doctors were in agreement with the diagnosis of DA with secondary SA and HSV1. He did have concerns as to whether the boys' skin problems were in "major part if not entirely caused by trauma" as a result of the boys' presentation of 9 March 2007. However, upon receiving the biopsy results in which witness 2 considered the cause of the lesion to most likely be an insect or arthropod bite, his opinion remained that trauma was relevant to the perpetuation of the lesions.

Witness 16 did not arrive at any concluded position independent of or with the assistance of others in relation to the causation or perpetuation of the lesions. Her evidence was that it was not her role and she did not have sufficient experience for a firm conclusion to be reached.

Witness 11 was of the view that no infective or other cause had been found to explain the non healing nature of the lesions despite multiple investigations having been performed.

She stated in her report dated 22 August 2006 (just prior to the discharge from

the second admission)

> "It is clear these ulcers have not responded appropriately to medical treatment in the home setting and there are concerns that they are a reflection of DA, that is injuries to the skin that have been caused by further irritation or aggravation of the wound".[34]

Witness 3 has a post graduate qualification in wound management which includes the aetiology of wounds. Save for the lesion on KR's scalp she was of the opinion that all of the lesions were pressure sores, that is, that something has been on the surface and pushed down. She observed the lesions in September 2006. She referred to divets in the centre of the lesions. In relation to the interrelationship between pressure sores and witness 13's evidence of mechanical trauma, witness 3 stated that pressure can be deliberate and witness 13 is referring to forced pressure.

Witness 13 was the only treating doctor to ultimately exclude impetigo or SA as the possible cause of infection when the boys were admitted on 15 May 2006. It is difficult to identify what is meant by the expression "the cause of the lesions" given that the first lesions had appeared approximately three months prior to the boys' admission to hospital. However, whilst witness 13 is a dermatologist, in relation to the issue of causation, I prefer the evidence of witness 5 and witness 1 for the following reasons -

- Witness 5 has approximately 45 years experience as a paediatrician.
- Witness 5 had much more extensive involvement with the boys. He was the primary paediatrician when the boys were admitted in May and August and he has continued to review them in outpatients since October, 2006.

Likewise witness 1 who saw the boys in May, was in charge of their admission in September, recommended specific immunology tests be conducted and saw the boys both in his capacity as an infectious diseases consultant and general paediatric consultant.

Accordingly, witness 1 also had greater contact with the boys than witness 13 and was more familiar with the results of the immunology tests, for example. Whilst witness 13 shared rooms

[34] Exhibit C and Exhibit D

with witness 5 and had discussions with him in relation to the boys, witness 13's contact was comparatively limited. In his role as a consultant, his evidence was that he only had formal involvement on three occasions being 3 May 2006, 14 June 2006 and 27 September 2006.

- Whilst there are not any photographs of how the lesions presented on 3 May 2006 the diagram drawn by Dr S can be contrasted with the photographs taken on 15 May 2006. In relation to both boys, vesicles are now present and in relation to KR, there has been a dramatic increase on the number of lesions on his right thigh in particular.
- The appearance of HSV1 vesicles was as witness 13 noted a new presentation. The lesions had changed in appearance between 3 May 2006 and 14 May 2006. The coincidence of the prescription of a steroid medication, the worsening of the lesions, the appearance of HSV1 and the evidence of witness 6, witness 5, witness 1, the note of Dr W on the RCH file 16 May 2006 and witness 13 (in the event antiviral medication was not prescribed) about the impact of steroid medication on a viral infection, it seems to me there is an intervening event, namely the prescription of the steroids, which "clouds" the diagnosis of witness 13. The RCH file does not indicate that the boys were taking antiviral medication when the steroid medication was prescribed.

  There are not any photographs as I have stated of the boys' lesions on 3 May 2006 but all of the evidence indicates that there was no clinical presentation of the HSV or a viral infection at the time the steroids were prescribed. Steroids were an appropriate medication for eczema which witness 13 considered may have been present.
- The evidence of the mother as to the location of the first lesion under the nose of each of the boys and the evidence of witness 13 and witness 1 and witness 5 and that this was not an unusual site for impetigo.
- Whilst the biopsy result dated 16 May 2006 did not disclose any infective organisms, witness 13's and witness 2's evidence was that the presence of

HSV1 was confirmed by swabs which were taken and the biopsy was taken from a more typical chronic site which was not a satellite.

- The clinical notes for the biopsy 16 May 2006 queried impetigo and primary HSV ulcers.[35]
- Whilst witness 13 referred to the diagnosis on 3 May 2006 of impetigo as a presumptive diagnosis,

Dr S's letter to witness 6 stated that both of the boys "certainly" had impetigo.

- Witness 13's opinion was that HSV1 was a secondary infection and not the cause of the ulceration. He stated that whilst a culture confirmed the presence of HSV1, testing does not determine what is the primary or secondary infection. Witness 2 however gave evidence that whilst the features of a disease will change over time and histology permits an analysis of tissue at a particular point in time, sometimes they are able to determine a dominant or original cause of infection.
- The diagnosis of witness 6, the doctor in AED on 27 April 2006, witness 13 and Dr S on 3 May 2006 and Dr P on 14 May 2006 was impetigo.

3. NO IMMUNOLOGICAL TESTS OR OTHER CLINICAL SIGNS HAVE SHOWN THERE TO BE ANY UNDERLYING PREDISPOSITION

The medical witnesses involved in the treatment of the boys were experts in a number of specialties. All of them raised the issue as to the need for immunology tests to be conducted on the boys in order to exclude the boys having a defective immune system or an immuno deficiency problem which could explain the lesions and/or which would have made the lesions persist.

Immune function tests were performed on 18 May 2006, 22 August 2006 and 27 September 2006.

Witness 13 was asked about the possibility of the boys having a defective immune system or an immune deficiency problem, for example, in relation to the function of the neutrophils which are a particular type of immune cell which kill organisms.

Quite appropriately witness 13 indicated that such matters were outside his

[35] Exhibit 2A

area of expertise. His evidence was that the immunology tests conducted showed a normal immune system.

Witness 13 gave evidence that the Immunology Team was involved in the care of the boys and that, "we" referred to the Immunology Department in order to determine the tests to be performed.

However, witness 19, who runs the RCH's Department of Allergy and Immunology also gave evidence. She is dual qualified as a Clinical Allergist Immunologist and an Immuno Pathologist that is a pathology specialist for immunology. She reports on all tests which come out of the laboratory.

Contrary to witness 13's evidence she stated:-

> "We have not been consulted in relation to these children. Nobody asked us for advice on these children in terms of which tests to order."

Neither she nor anyone at her laboratory ordered any tests. They only performed the tests which were ordered.

When this evidence was put to witness 13, he explained that his Department was consulting and made recommendations, for example, that the boys' immune status be followed up. It was up to the treating clinician at the time, for example, the paediatrician to determine if and how to follow the recommendations made. He stated that if the patient had been a patient of the Dermatology Department, he would have had someone from the Immunology Department come down to see the patient.

I have reviewed the RCH files[36] in relation to both boys. Whilst there are references to the Department of Immunology there is no reference to any discussions with a particular person from the Immunology Department concerning the appropriate tests to be performed.

Witness 1 gave evidence and his file note confirmed that on 16 May 2006 he together with Dr W recommended a list of infective and immune tests to be performed. His evidence was that "We did not order the tests. We made recommendations and the Unit decides the tests to be performed."

Despite it seems the absence of the Immunology Department being involved in recommending the tests to be conducted, it is important to note that witness 19

[36] Exhibit AM and Exhibit AN

considered that the tests which were requested and performed were appropriate for children who presented with ulcers.

A test to determine whether the boys suffered from Leukocyte adhesion molecule deficiency which can cause poor wound healing and a test which looks for the presence of a marker on lymphocytes CD 11b in which a marker is used to look for a defect in the cells which prevent them from crawling properly, were requested by witness 1 and conducted on 27 September 2006 in respect to both boys and they were normal.

Witness 19 gave evidence that the boys do not have a condition known as Chronic Granulomatus Disease (CGD) in which there are two populations of neutrophils, one of which is normal and one of which the neutrophils do not produce oxygen radicals. The neutrophils normally eat bugs (oxidative bursts) and then the bug is killed. Whilst the boys do not have CGD their tests recorded the percentage (save for the test on 18 May 2006) of neutrophils which did not produce an oxidative burst.

DATE	CR	KR	CONTROL SAMPLE
18/5/06	Reported as normal oxidative burst in majority of neutrophils. It did not report two populations but according to witness 19's evidence there are.	Reported as normal oxidative burst in majority of neutrophils. It did not report two populations but according to witness 19's evidence there are.	
22/8/06	19-25 per cent	15 per cent *	5 per cent
27/9/06	15 per cent	15 per cent	11.7 per cent
* Query - there was a reference to the blood clotting			

Witness 19 considered that the most likely explanation for the test results was due to the test itself or the presence of immature neutrophils related to the young age of the boys. She was surprised at the level of consistency of KR's results but she said she could not explain that. She also stated that one can lose a lot of immune function and the other cells assist.

Witness 1 had noted that "the immune testing revealed an unusual finding of two populations of neutrophils however the overall function of these immune cells

was still within normal limits upon testing."

He requested an opinion from a haematologist, Dr (name removed) "Dr B". Dr B based his opinion upon the samples taken on 18 May 2006 and 27 September 2006. There is no reference to the test performed on 22 August 2006. Based upon the May and September tests he concluded,

> "This pattern of results may be present in patients with intercurrent illnesses or infections and in the presence of a normal previous result I believe is not consistent with a significant neutrophil function disorder."[37]

Witness 19 agreed with his opinion. Witness 1 in his statement[38] stated -

> "..... immune function testing, while showing some aberrant findings did not show abnormalities that should cause ulcers of this severity."

When witness 1 was asked whether his statement allowed for aberrant findings that may cause ulceration of this severity, witness 1 deferred to the opinion of immunology and haematology as the interpretation of the results was beyond his expertise.

Witness 19 considered that given the boys' results, there was a need to exclude that they carry XXY chromosomes, that is that genetic testing should be carried out, albeit she considered that the likelihood of both of them being XXY to be very, very, very rare especially given that they are not identical twins and she said that even if they are XXY, she would not expect them to be sick with their percentage of cells not functioning.

Whilst witness 11 in her statement[39] in relation to KR stated "Multiple investigations have been performed looking for an infective or genetic cause for these lesions - none have been found", a search of the RCH files does not indicate that such genetic testing has been performed. Witness 7 confirmed he was not aware that any genetic testing had been done and witness 16 deleted the reference to genetic testing being conducted in May and August 2006 from the DHS Application Report[40]. There are references throughout the RCH files to karyotyping to be conducted[41]. However, it does not seem that it was done. On 16 October 2006 the mother

[37] Exhibit I
[38] Exhibit K
[39] Exhibit D
[40] Exhibit AB Page 4
[41] For example, 24 August 2006, 18 September 2006

consented for HIV and chromosome testing to be conducted. Witness 5's entry for 23 October 2006 referred to chromosomes HIV pending. On 13 November 2006 further bloods immunology and chromosomes were referred to. On 12 February 2007 CR's file refers to follow-up tests of two neutrophil populations to be instituted.

There was evidence before the Court that a child's immune system improves as they get older. Witness 19 clarified this evidence. She said that the immune response of children is not necessarily different or lower than adults. Neutrophils do not change dramatically over time. Rather, the ability to make antibodies and fight viruses is poorer in babies and children than adults. She referred to this as "adaptive immunity".

I have referred to this evidence in great detail as the issue of the boys' immune system was referred to throughout the RCH files and it will be seen that the boys' healing rate has been described as "slow" even since they have been in foster care and whilst in foster care their general health has been poor. In my view it is in the boys' best interests for further testing as referred to by witness 19 to be performed.

Witness 19 was also asked about allergy testing (IGE) to asses whether there was an allergic response in the boys. Such a test has not been conducted.

As tests need to be rationalised in this case witness 19's evidence was that she would not have recommended an IGE test but she gave evidence that skin allergy tests (skin prick testing or fluid on the skin) could have been done. Witness 7's evidence was that it would have been worth conducting an IGE test. He said he would have thought the IGE levels would have been interesting.

Witness 13 did not perform allergic reaction testing as he considered there was no relevant clinical presentation. He referred to the Immunology Department as the allergy experts and noted that neither their team nor ours' thought such tests were relevant. As previously indicated, the opinion of the Immunology Department was not sought in relation to the appropriate tests to be performed.

Witness 13 considered that the lesions could not possibly be an allergic response and that there was no such allergic response that we know of which could influence healing as such.

Tests in relation to a complement deficiency/cascade for example CH50 and

CH100 could have been performed but witness 19 stated that if there was a complement deficiency, a delayed or slowness in healing would be a rare presentation. No T cell function test was performed but witness 19 said the symptoms would not be skin lesions if there was a problem with the functioning of the T cells. It would be unusual for children the age of the boys to present with a mild dysfunction of T cells because it would usually be evident when they are two or three years of age and they might present with an auto immune range of problems and infections.

When witness 19 viewed the copied colour photographs of the lesions and noting the limitations of observing photographs, she stated that she would want to rule out an auto immune blistering disorder. Witness 13 had ruled out a bullous disorder known as dominant dystrophic epidermolysis bullosa. Witness 19 also stated that acrodermatitis enteropathica should be considered, although it would not be a typical presentation for that condition.

Witness 19 was a very impressive witness.

The hospital records indicate that blood samples were taken from both boys. The full blood examination results for KR for 15 May 2006, 18 May 2006 and 4 October 2006 were tendered.[42] Any blood tests conducted in relation to CR were not tendered and were not on the RCH file.

Witness 1 gave evidence of his understanding of the test results, although he noted that he is not a haematologist and there were a number of matters outside his expertise. An opinion from Dr B, haematologist, was tendered[43] and has been referred to in relation to the neutrophil function results. A haematologist was not called to give evidence.

Witness 1 stated that the results outside the normal range meant that the result was outside what 95 per cent of the population would record. I do not propose to repeat witness 1's evidence save for noting KR's results which were outside the normal range.

- on all three occasions the results in relation to the red cell distribution width (RDW).
- on 18 May 2006 in relation to the haematocrit category (percentage of blood

[42] Exhibit 2B Page 1
[43] Exhibit I

occupied by red blood cells) and neutrophil function

- on 4 October 2006 in relation to platelets.

Witness 1's understanding was that on balance the results were within normal limits and mild changes could be seen in the context of inflammation.

In relation to 18 May 2006 the note refers to mild neutropenia with some reactive lymphocytes suggestive of infection. Witness 19 gave evidence that neutropenia commonly occurs when there is an acute infection. If so, it is transient and repeat testing should be normal, which it was in this case.

These results have been detailed for the sake of completeness. In the absence of a haematologist, I am unable to form any view about the haematology results.

4. HEALING

Witness 13 referred to the significant healing which occurred when the boys' lesions were dressed and there was no medication prescribed. This was the case for the second and third admissions.

Whilst witness 16 compared the progress of a number of CR's lesions, witness 7 was the only witness to track the healing of individual lesions from 15 May 2006 to 23 October 2006. It was most helpful. I am satisfied that the boys' lesions improved considerably (save for a lesion on KR's left thigh photographed for the first time on 23 August 2006 during the second inpatient stay) during the second and third admissions when the only treatment administered was wound dressing.

The issue of the healing of the boys' lesions is quite complex however. A statement which was frequently made during this case was that the wounds healed in hospital and deteriorated when the boys were discharged to their mother and it seemed to me that this statement was made on the basis that there was a recurring theme, that is on each of the admissions healing had occurred and then the wounds had deteriorated when the boys returned to the mother's care.

Witness 5 in his statement stated:-

"A notable feature of the twins' history was a fairly rapid recurrence of their problems when they were discharged home. After a number of readmissions the strong impression was developing that care they were receiving at home was

inadequate. On each occasion, healing was achieved well when care was given by others and not mother. Relapse or recurrence was almost exclusively whilst in mother's care".[44]

At the SCAN meeting on 2 October 2006 witness 7 stated that the story as given by the medical staff was that the lesions were clearly getting worse in the mother's care, in hospital they were getting better, markedly getting worse when they got home. Something was happening at home to make the lesions worse.

The tracking of the lesions by witness 7 was of assistance in evaluating whether this was the case.

Witness 7 produced albums he had compiled of original photographs of the boys' lesions.[45] They were in chronological order and he had provided an index to Exhibits Y and Z which assisted in being able to track or trace through individual lesions and observe their healing or aggravation.

The contrast in clarity between the original photographs and the coloured photocopies of the photographs[46] was marked.[47]

It would have been helpful had the original photographs been produced on the first day in order for them to be shown to the medical witnesses.

Witness 7 tracked the lesion under CR's right ear and a large lesion on KR's right thigh from 15 May 2006 to 23 October 2006.

In addition, witness 7 identified when new lesions had appeared and which lesions had healed.

In relation to the lesion under CR's right ear witness 7's evidence was as follows -

- Upon admission on 15 May 2006 CR had a large irregular ulcer under his right ear.
- there were not any photographs taken when CR was discharged on 22 May 2006 so it is not possible to see how the ulcer presented on this day.
- On 17 August 2006 when CR was readmitted to hospital witness 7 described the lesion as having healed a little but still quite extensive. There was a clean

[44] Exhibit 20
[45] Exhibits Y, Z and AQ
[46] Exhibits L and M
[47] For example, the lesion under CR's right ear p.33 photograph left hand column, second from the top in Exhibit M with the original Photograph 26 in Exhibit Y

dry base.[48]

- After one week in hospital there was considerable healing of the ulcer.[49]
- CR was discharged on 24 August 2006. There were not any photographs taken on that date.
- On 18 September 2006 (three and a half weeks after CR had been discharged into the mother's care) witness 7 described the lesion as still improving, smaller than on initial admission, fair amount of scabbing, dry and clean. He said that the ulcer was healing but not healing as much as one would expect when compared with the improvement after one week in hospital.[50]
- When CR was readmitted on 27 September 2006 the ulcer had recurred and was large again. It was not weeping. It had irregular edges.[51]
- On 2 October 2006 there was quite extensive healing of the ulcer whilst in hospital.[52]
- On 4 October 2006 healing had continued whilst in hospital. CR was discharged into foster care.[53]
- On 11 October 2006 witness 7 said that healing had continued. It was completely closed over but it was still quite red and reasonably inflamed but healing normally.[54]

Whilst witness 7 is not a dermatologist I accept his description of what is contained in the photographs; save for in the absence of expert evidence, it is unclear to me whether Photographs 135 and 136 represent continued healing as compared with 122.

As a result of witness 7's analysis and dealing with this lesion alone, the evidence indicates that prior to on or about 27 September 2006 there was not any deterioration or aggravation of the lesion. This represents a period of four months since CR was discharged after the first admission. The evidence confirms that the rate of healing was significantly slower when CR was in the mother's care as compared

[48] Photographs 25 and 26
[49] Photograph 40
[50] Photograph 58
[51] Photographs 75, 76
[52] Photograph 109
[53] Photograph 122
[54] Photographs 135, 136

with when CR was in hospital. Thus, in relation to CR's second admission the evidence does not establish in relation to this lesion that the lesion had deteriorated since CR was discharged into the mother's care. The rate of healing in my view is a separate issue to an aggravation of the lesion.

However, the lesion did deteriorate on or about 27 September 2006 when CR was readmitted to hospital after having been in the mother's care. I will further discuss protective concerns in relation to this matter elsewhere in my Decision.

Witness 7 identified that both the linear lesion across CR's left wrist[55] and the round lesion above it healed between 15 May 2006 and 16 August 2006.

In relation to the large lesion on KR's right thigh, witness 7's evidence was as follows -

- On 15 May 2006 two large ulcers adjacent to each other were on KR's right thigh. They were irregular in shape and the edges were undermined.[56]
- There were not any photographs taken when KR was discharged on 22 May 2006 so it is not possible to see how the ulcers presented on this day.
- On 17 August 2006 when KR was readmitted to hospital, witness 7 described the ulcers as still present but the large ulcer (which he tracked) had healed up quite well. He described it as "certainly a lot smaller, still present, quite large, healing well" although he would have expected it to heal more he said it was certainly healing.[57]
- On 23 August 2006 after six days in hospital there was considerable healing observed. The ulcer had almost completely closed over and looked dry.[58]
- On 18 September 2006 the ulcer had recurred. It was quite markedly red, inflamed and had broken down.[59]
- On 27 September 2006 KR was readmitted to hospital. The two large ulcers had coalesced into one big red confluent ulcer.[60]
- On 29 September 2006 after two days in hospital, there were signs of

[55] Photographs 5 and 6
[56] Photographs 8, 9, 10
[57] Photographs 21 and 22
[58] Photograph 34
[59] Photographs 43 and 44
[60] Photographs 56 to 58

healing.[61]

- On 2 October 2006 after six days in hospital, the ulcer was dry with a small adherent scab.[62]
- On 4 October 2006 KR was discharged into foster care. The healing in hospital had continued.[63]
- On 11 October 2006 the ulcer had continued to heal. It was dry and slightly scabby.[64]

The evidence of witness 7 indicates that the ulcer on KR's right thigh continued to heal whilst KR was in the mother's care but had deteriorated as at 18 September 2006 and there was further significant deterioration[65] when he was readmitted to hospital for the third inpatient stay on 27 September 2006.

As in the case of CR, the slow rate of healing was noted especially in comparison with three months in the mother's care and the considerable improvement after only one week in hospital.

Witness 11 was aware that there was some healing of the lesions in the home. In her reports[66] in respect of both boys she stated

> "Management at home had initially allowed some healing of the ulcers but there was evidence of worsening of the ulcers in late September."

The discharge summary for the second admission indicates that after three months the wounds remained relatively unchanged and a decision was made to readmit the boys.

In addition, it is noted that there were a number of new lesions which appeared on the boys' bodies between 15 May 2006 and 17 August 2006. For example witness 7 identified the following new lesions on CR's body which appeared between 15 May 2006 and 17 August 2006 -

- linear lesion along the back of his left heel[67]
- top of right foot[68]

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[61] Photographs 67 and 68
[62] Photograph 77
[63] Photograph 87
[64] Photograph 98
[65] Photographs 57 and 58
[66] Exhibits E and F
[67] Photograph 21

- three new lesions down the left side of his face[69]
- right forearm[70]
- top of right hand[71]
- three additional lesions on right thigh[72].

Witness 11 in her report also referred to the lesions which appeared on CR's body between 15 May 2006 and 17 August 2006. However, there were some discrepancies with the contents of her report and the photographs tendered, for example, she referred to lesion/s on CR's buttock on 15 May 2006 with a slightly linear ulceration. The photographs tendered, do not show any lesion on CR's buttocks. There are lesions with this description photographed of KR on 23 August 2006.[73] It is not clear when this lesion first appeared. Photograph 9 of CR's folder is a photograph of CR's right thigh taken on 15 May 2006 but could have been mistakenly considered to be his buttock. Witness 11 did not undress the dressings and therefore her opportunity to view the lesions was limited. Witness 7 did not physically observe the lesions. He saw the boys for the first time on 5 January 2007.

It is less clear what, if any, new lesions appeared on KR's body. Witness 7 identified an ulcer on the sole of KR's right foot[74] although he said he was relying on the fact that there was not a photograph taken on 15 May 2006. The doctor's notes on the RCH file do not refer to an ulcer on his right foot but witness 11 does in her report in respect of lesions on 15 May 2006.[75]

What is clear is that in addition to the new lesions CR presented with, which are troubling, the lesion on KR's scalp had significantly worsened when the boys were admitted on 17 August 2006.[76] Witness 11 described that lesion measuring at least three centimetres in diameter. Witness 16 described that lesion and the lesion on the sole of KR's right foot as "deep" and containing slough.

The presentation of both of these lesions, in particular, was extremely

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[68] Photograph 30
[69] Photographs 22 to 24
[70] Photograph 21
[71] Photograph 20
[72] Photographs 28 and 29
[73] Photograph 32
[74] Photographs 23 and 24
[75] Exhibit D
[76] Photographs 16 and 17

alarming.

Whilst in hospital there was significant improvement of all of the lesions on both of the boys' bodies. However, as previously mentioned witness 7 identified a new lesion on KR's left thigh which appeared whilst KR was in hospital.[77] It was photographed on 23 August 2006. Witness 7's evidence was that it remained largely unchanged[78] and when KR was readmitted on 27 September 2006 there was evidence it had started healing whilst in the mother's care[79] and it was continuing to heal in hospital.[80]

The boys were discharged on 24 August 2006 with the Hospital in the Home (HITH) providing nursing assistance to the mother. On review on 4 September 2006 witness 16 noted that all of the wounds were healing satisfactorily.

However on 18 September 2006 witness 16 noted on the RCH file in relation to CR that all of the wounds were larger in size than on the last review with "pink granulating at base". Some had adherent dressings and there was a new scratch on CR's nose and lateral to the left eye.[81]

In relation to KR she described on the RCH file all of the wounds as being significantly more ulcerated since 4 September 2006 and the wound on his head was significantly more ulcerated and deeper.

In cross examination witness 16 agreed that there were some lesions which had healed between 4 September 2006 and 18 September 2006, for example, the lesion on CR's left knee and the lesion just above CR's left knee and to the right[82] but there was a deterioration in the lesion above the knee and to the extreme right albeit that there appeared to be healing around the edge of that lesion between 18 September 2006 and the date of admission 27 September 2006.[83]

Whilst such individual lesions could be identified I accept that overwhelmingly there was significant deterioration in the majority of lesions. Given witness 16's

[77] Photographs 30 and 31
[78] Photographs 48 and 49 18 September 2006
[79] Photograph 62
[80] Photograph 89
[81] Photographs 54 and 56
[82] compare Exhibit Z photographs 51 with 67 and 68

evidence that as at 4 September 2006 the wounds of both boys were healing satisfactorily, the deterioration occurred over the period 4 September 2006 – 18 September 2006. The HITH visits were reduced from twice daily to daily from 4 September 2006.

A perusal of the HITH notes post 4 September 2006 indicate that the nurses reported that lesions were continuing to heal save for –

- 07/09/06 lesion on KR's right thigh which looked as though the healed skin had come off when the dressing was removed (witness 18).
- 08/09/06 old wounds on KR's legs have been disturbed by tapes on other areas Reg'd Nurse S).
- 10/09/06 wound on KR's scalp moist and sticky (witness 8).
- 12/09/06 wound on KR's head open and green looking (Reg'd Nurse T).

However, apart from observing KR's head wound and facial lesions, there were days on which the nurses did not observe the other lesions because the mother had bathed the boys and dressed the lesions before the nurses attended.[84]

The lesions were observed by the HITH nurses on 6, 7 and 8 September 2006.

[83] compare Exhibit Z photographs 67,68 and 86, 87
[84] For example 5 September 2006 - CR and KR; 10 September 2006 – KR

Witness 11's review of the photographs of CR taken on 18 September 2006 indicated that his ulcers had worsened with them reddening.

In relation to KR witness 11 stated that the photographs taken on 18 September 2006 of the ulcers on his legs indicated the ulcers had become worse also with them reddening. The ulcers above his upper lip showed evidence of crusting which indicated some healing and the ulcer on his head had less sloughing. Her opinion was that there had probably been "some mild healing of this ulcer".

However, the photographs indicated a significant deterioration of the head lesion between 18 September 2006[85] and the photographs taken on 27 September 2006.[86]

After two days in hospital the photographs indicate significant healing, for example, in relation to the ulcer on the sole of KR's foot, his scalp and multiple ulcers on his thighs.

Witness 11 in her statement stated

> "It is my opinion that this worsening of the ulcers while CR was in the care of the mother is consistent with Dermatitis Artefacta that is injuries to skin that have been caused by further irritation or aggravation of the wounds. The ulcers showed significant improvement when they were having appropriate treatment."[87]

[85] Exhibit Y Photographs 41 and 42
[86] Exhibit Y Photographs 53 and 54
[87] Exhibit F

Witness 11 made the same comment in respect of KR.[88]

It is of great concern that whilst the mother attended the outpatient appointments on 4 September 2006, 18 September 2006 and 20 September 2006, the lesions had been deteriorating. Apart from the mother obtaining a referral from witness 6 for a second opinion, prior to the third admission, the mother did not re-attend at the RCH or return to witness 6 save for obtaining the referral. In addition, despite the lesions deteriorating, it was reported to witness 16 that the mother had been "obstructive and abusive" towards HITH attending on 22/9/2006. The health and safety of the boys is paramount and the mother needs to demonstrate that she can respond immediately to the needs of the boys.

A further issue which arose in this case in relation to the question of healing was the rate of healing. Concerns were expressed by the treating doctors in relation to the lesions not healing and in fact being aggravated whilst the boys were in the mother's care.

Witness 13 was asked about the boys' rate of healing. His understanding was that they healed as would be expected for wounds to heal but he deferred to witness 5 who was the primary carer.

In relation to the rate of healing, witness 5 was concerned initially as to why the lesions were not healing. He stated:

> "I'd agree we were concerned by the length of time it took" and "We had concerns whether there was any immunological deficiency which would have made them persist".

The immune function tests which have previously been discussed were performed in order to address this concern.

When he was asked whether it was possible that it was something about these children which made both of them take longer to heal, he stated that he was concerned that it was something that he could not explain and that was why he called in his colleagues for their opinion. When he was asked is it possible that he has not got to the bottom of it, he answered "Never say never". He said it was possible but given the extensive process they engaged in he believed they had eliminated everything that they

[88] Exhibit E

understand.

After the boys had been in foster care for almost three weeks, witness 5 stated in relation to the boys' lesions on 23 October 2006 that there were "still fairly inflamed areas", "improving", "improvement quite slow really" and "improvement but a slow process".

Witness 13 was asked about the rate of healing of KR's right thigh as observed in the photographs taken on 9 March 2007. Witness 13 said given the nature of the wounds it was not surprising there were scars and they were consistent with scars from the ulcers save for an additional lesion which he believed was an insect bite.

A perusal of the Anglicare file[89] indicates that on 23 July 2007 some nine months since the boys had entered foster care, the carer advised Anglicare that both of the boys had had their sores flare up a bit. CR had some new sores come up on an old scar just below his right ear. The carer had said that they were "starting to go down again, as they always do".

Since being in foster care, the boys had attended the RCH for review and the carer's own doctor in relation to the boys' skin. The salient entries from the RCH files, witness 7's report, witness 22's evidence, the Anglicare file and the photographs[90] taken by the mother are as follows.

- On 16 October 2006 witness 16 prescribed the antibiotic Keflex for both boys. The diagnosis was ? impetigo. In addition, CR was prescribed an eye ointment for conjunctivitis.
- On 23 October 2006 witness 5 noted what appeared to be a new lesion on KR's right thigh. It was cultured. The result/s were not referred to in evidence and were not on the RCH file. Medication was prescribed being five times one half tablet per day according to the carer. There were no details on the RCH file.
- On 27 October 2006 the carer notified Anglicare that the sore on KR's head was infected and the carer's doctor had thought it was a Staph infection.
- On 2 November 2006 Anglicare staff noted what appeared to be a fresh wound on KR's head and a disturbed scab on his head. On 3 November 2006

[89] Exhibit 15
[90] Exhibits 16 to 19

the carer advised that KR had knocked the scab off yesterday which was why it was raw and glistening.

- On 20 December 2006 the mother first noticed a blister in the middle of one of the scars on CR's left thigh.
- On 29 December 2006 the mother said the blister had broken and left a small shallow ulcer that had formed a scab. (This story was subsequently confirmed by the foster mother when she saw witness 7 on 24 January 2007).
- On 2 January 2007 witness 22 prescribed Flucloxacillin syrup and Bactroban cream for KR. Herpes simplex 1 was detected on his face (right upper lip). CR presented with a sore on his left upper thigh and query his foot. No treatment was prescribed. The carer noted that CR's thigh "flares up" regularly.
- On 2 January 2007 the mother photographed CR's left thigh and the ulcer can be seen[91]
- On 3 January 2007 photographs of the boys were taken by the mother. The scarring on the boys' thighs is evident including the ulcer on CR's left thigh; the photographs of KR's face indicate a sore on his right nostril and disturbed skin below and to the side of his right nostril and on the right side of his forehead including what appear to be small pimple like bumps.[92]
- On 5 January 2007 witness 7 saw the boys. Contrary to KR's presentation two days earlier, witness 7 observed that KR's lips and mouth were normal. He noted that there was a very small graze beside his right nostril and "on the right side of his forehead there was a small and indistinct area of faint redness and roughening of the skin with a few, very small pinpoint areas of adherent scab".
- On 15 January 2007 an Anglicare worker observed a sore on KR's leg to be very red.
- A blistering scab behind CR's right ear was detected on 17 January 2007. On 24 January 2007 witness 7 considered it was a mosquito bite.
- Photographs of KR's right thigh on 9 March 2007 indicated the scarred tissue

[91] Exhibit 16
[92] Exhibit 17

was lumpy or raised.[93] This can be contrasted with the flat, healed condition on discharge from hospital on 4 October 2006 and subsequently on 16 October 2006.[94]

- On 15 March 2007 RCH examined the macula papules on CR and KR. Dr P noted in relation to KR that since the biopsy on 9 March 2007 the lesion on KR's back was clearing slowly and others had not developed. Witness 2 gave evidence of the biopsy taken on 9 March 2007 that in his opinion it was likely to be an insect bite.
- On 18 April 2007 an Anglicare worker noticed a cluster of what appeared to be blisters on the back of CR's left heel.
- As previously stated, on 23 July 2007 the carer stated that both boys had had their sores flare up a bit. CR had some new sores come up on an old scar just below his right ear. The foster carer noted that "they were starting to go down again (as they always do)".
- On 24 July 2007 the carer stated over the weekend a couple of small pimple looking bumps appeared on CR. They were barely visible now. None of the sores are open, weepy or blistered.
- On 27 July 2007 witness 5 prescribed Zovirax for cold sores on KR's face which developed on 26 July

[93] Photograph 8 Exhibit AJ
[94] Photographs 9, 11 and 12 Exhibit AL

2007. The photographs indicate that the ulceration was extensive.[95]

It is beyond question that since the boys have been in foster care, they have not presented with lesions which are in any way comparable to the disturbing lesions they had during May to September 2006.

A perusal of the Anglicare file[96] details the general health of the boys in addition to any skin issues they have had since being in foster care. It is apparent that the boys are frequently unwell with both of them suffering from colds and CR suffering from conjunctivitis and KR suffering from HSV1.

On 25 June 2007 the carer, who has teenage children of her own and who had only had the boys since 26 April 2007 that is, some two months stated

> "The colds are back with a vengeance. We had three clear days and we've all got head colds again. It seems we've had more colds since having the boys than we had during the entire previous year."

She also stated in an email to Anglicare on 23 July 2007 when CR had developed the flu over the preceding weekend "all this sickness is getting a little wearing". I have summarised the entries on the Anglicare file[97] which relate to the boys' health (excluding the references to lesions/sores).[98]

I am unable to assess the significance, if any, of this evidence. It may or may not bear on the issue of the immune functioning of the boys and their capacity to heal. Witness 6 gave evidence that with a lower immune system there is a susceptibility to contracting such infections as HSV1. Witness 1 gave evidence that an immune system problem or skin system abnormality is identified if a child presents with repeated episodes of HSV1. He stated that children with an abnormal immune system are more likely to have recurrent HSV1 which is more severe or more widespread or more confluent. However, witness 1's evidence was that an undiagnosed immune response or abnormal skin condition or a combination of organisms would not present how CR and KR did.

Witness 7's evidence was that if a child is regularly unhealthy then HSV1 can be virulent and very severe if there is an immunity problem. He said that whilst HSV1

[95] Photographs 3, 6 and 10 Exhibit AJ
[96] Exhibit 15
[97] Exhibit 15
[98] Schedule 2

tends to recur when a person's general health is poor, it should not affect the rate of healing of a traumatic wound.

In addition, when the boys were in the mother's care they also had episodes of illness. CR was seen by witness 6 when he was one week old with conjunctivitis. CR was also unwell prior to being discharged from hospital on the second admission.[99] He was diagnosed with gastroenteritis by witness 6 on 26 August 2006. The nurses from HITH noted that the boys were unwell on a number of occasions (for example, vomiting, diarrhoea).[100]

THE EVIDENCE OF WITNESS 7

Witness 7 has worked at the Gatehouse Centre (Victorian Forensic Paediatric Medical Service) since 1985. He is a qualified medical practitioner and has a qualification in paediatrics in the U.K. He has seen and examined several thousand children.

Witness 11 originally investigated this matter. However, witness 7 became involved when witness 11 was on leave.

According to the Disposition Report dated 16 October 2006,[101] on 29 September 2006 witness 7 allegedly said

> ""Without doubt mother is deliberately inflicting the ulcers on both the twins"; furthermore the mother was deliberately sabotaging the medical treatment of the ulcers and that there was no other medical explanation for the recurring ulcers."

Thus witness 7 appears to be stating that the mother was not only causing the ulcers but also aggravating the ulcers. However, in his evidence he stated that he could not give an opinion about the original cause of the ulcers.

On 2 October 2006 witness 7 attended a SCAN Meeting representing the Gatehouse Centre due to witness 11's absence. Prior to attending the meeting he had heard about the twins because of talk around the unit.

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[99] 23 August 2006, 24 August 2006
[100] CR – 24, 26, 27 August 2006, 16 September 2006; KR – 26, 27, 28, 29 August 2006
[101] Exhibit AB Page 2

At the time he attended the SCAN meeting, he had not seen the boys nor spoken to the mother. He had not viewed any photographs of the lesions and had not gone through the RCH file in a detailed manner. He was not familiar with the treatment regime when the boys were admitted in May 2006. He had read witness 11's reports dated 22 August 2006. It is therefore difficult to know the basis upon which witness 7 made the comment attributed to him on 29 September 2006.

He was requested by DHS to prepare a report. He would have preferred not to have prepared a report because of his exceptionally limited involvement in the case.

He prepared a report dated 20 November 2006 which included the following:-

> "After listening to the history at the SCAN meeting, it seemed to me that there were very strong grounds for suspecting that mother was deliberately perpetuating and worsening the children's ulcers whilst they were in her care."[102]

Thus, witness 7's opinion was that the mother was deliberately perpetuating and worsening the children's ulcers. However earlier in that same report dated 20 November 2006 witness 7 stated -

> "At the SCAN meeting the participants were told of the history of the chronic ulcers on both children over the last six months. There was a recurring pattern in which the ulcers would improve in hospital and then deteriorate again when the children were at home in the care of their mother. No medical cause for the ulcers had been found despite an extensive series of investigations and the opinion of the dermatologist (skin specialist), was that the ulcers were produced and perpetuated by repeated trauma."[103] (emphasis added)

This statement extends beyond perpetuation and aggravation to cause.

In witness 7's statement dated 10 January 2007[104] witness 7 had strengthened his opinion from 20 November 2006 in which he stated "there were very strong grounds for suspecting that mother was deliberately perpetuating and worsening the children's ulcers whilst they were in her care" to on 10 January 2007 stating -

> "Both of the twins have a long history at the Royal Children's Hospital. They were repeatedly admitted to hospital and treated for chronic skin ulcers until it gradually became obvious that the ulcers were being deliberately perpetuated

[102] Exhibit AA
[103] Exhibit AA
[104] Exhibit W

and worsened whilst the children were in mother's care." (emphasis added)

In addition, the protective worker completed a case note when the boys attended at the RCH on 5 January 2006 and met with witness 7. It stated –

> "Witness 7 informed the writer that he has never seen the boys before however he is aware of the case".

He was also recorded as saying

> "Yes it was the mother who inflicted the wounds and let's see the boys".[105]

Dr witness 7 expressed surprise if that was a direct quote. He said he could not imagine saying it in that form of words, that is 'inflicted'. I note it was allegedly said in response to the DHS belief that the mother had inflicted the wounds initially. Witness 7 believed he might have said "caused" or "kept going" by the mother but not "inflicted". This possible choice of words appears to blur the distinction between "cause" and "aggravation".

The protective worker's evidence was that his usual practice was to make handwritten notes and he probably did so on this occasion. He said that he would not have made anything up and that something along those lines was said but he conceded he made have misinterpreted the comment.

[105] Exhibit AP

Witness 7 gave evidence that whilst he could not definitively say how the lesions were being perpetuated or aggravated he nominated the following possibilities -

- application of heat to skin
- repeated picking or rubbing of the healing scabs
- application of some corrosive substance which could inflame or irritate the skin.

In relation to this last possibility, he considered it to be "pretty unlikely" as there were not any drip marks and it is very rare to have concentrated acid, oven cleaner, for example, in households.

Whilst he was of the opinion "I think there are very strong grounds" that the mother was aggravating the lesions, he said that he was not saying that there were no other possibilities because there may be.

When witness 7 was asked how certain he could be the mother aggravated the lesions, his evidence was that he could not tell for sure but it was suspicious because there was no other feasible explanation from the known facts and known course of the lesions. This included the lesions healing in hospital and at home many of the lesions breaking down. He said he thought one or two healed but mostly they broke down. He subsequently detailed to the Court the lesions he had tracked, to which reference has been made and which was of great assistance.

When he was referred to the copy coloured photographs[106] and observed satellite vesicles consistent with HSV1, he stated that that may cause him to soften his view a little bit, but he still had concerns. He had

[106] Exhibits L and M

never seen lesions so severe and so gross as they were in 2006.

In the absence of the mother deliberately aggravating the lesions, witness 7 considered the other possibilities to be -

- infectious diseases
- immunity problem
- skin disease

His understanding was however that all of these possibilities had been ruled out by witness 5 and witness 13.

It seemed to me witness 7 was initially reluctant to become involved in this matter because of the minimal involvement he had had and in my view that reluctance was well justified. Given that limited involvement which at the time he made his first statements did not involve any forensic investigation by himself, save for reading witness 11's statements and briefly perusing the file, I am not satisfied applying the principles previously cited in *Makita Aust Pty Ltd v Sprowles* (2001)52 NSWLR 705 that there is a basis for the opinions he has expressed at that time. In addition, when he was cross examined in relation to the contents of witness 11's statements, he did not have a good recollection of their contents. I do accept however his evidence in relation to the tracking of the lesions which he helpfully undertook, albeit it I accept he is not a dermatologist.

HOSPITAL IN THE HOME SERVICE (HITH)

When the boys were discharged after the second admission, witness 5 recommended that HITH service be provided to the mother as the task of dressing lesions on a child is difficult, and the mother had not just one but two children requiring dressings to be applied. Witness 5 was keen to minimise recurrences so that healing could be completed.

Witness 21 explained that the service required the co-operation of the parent as they needed to be at home or to contact HITH because otherwise the patients needed to be in hospital.

The DHS endeavoured to obtain as many of the nurses from HITH relevant to these proceedings to give evidence as it could. Unfortunately, a number of witnesses who would have provided relevant evidence were not available. I refer in particular to R/N B, R/N L and R/N T.

It was also unfortunate that the HITH office file could not be located. The evidence was that matters which are of a sensitive nature are reported to the liaison nurse and it seemed the reports were both oral and in writing. Written reports would be kept on the office file.

Nor was it possible to locate the relevant Plan of Care in force when the nurses who gave evidence visited the family's home. All of the nurses agreed that Exhibit 22 was not the relevant Plan of Care when they attended.

Witness 16 prepared a "Do's and Don'ts" document[107] which was provided to the mother to explain what she was required to do in order to look after the twins' lesions. The document was written in plain English. She also prepared a document for the HITH nurses[108] in relation to the tasks to be performed. It is clear from witness 16's evidence and Exhibit 21 that her intention was for the nurses to perform the following tasks:–

- to visit twice per day;

[107] Exhibit R
[108] Exhibit 21

- to repair or replace dressings on all of the boys' sores except for KR's lip;
- to assist the mother with the bathing of the boys every second day;
- to allow the sores to be air dried after a quick bath and not to wipe or clean the sores;
- to contact witness 16 if the sores deteriorated or were uncovered.

The service provided to the mother by HITH was atypical of the service generally provided by HITH. Witness 16's evidence was that the usual role for HITH was to make a few visits to parents. She said that this was an unusual situation for them as her expectation was that they would make fine assessments and have more involvement and interaction with the mother than would generally be the case. Witness 16 considered that the mother needed support and may not be able to carry out the instructions without support.

Witness 8 confirmed that the visits to the mother's home could be contrasted with the average HITH visit. She said the average stay was usually 10-20 minutes per home or if it was more complicated 1hr – 1.5 hrs. The nurses make 4-6 visits per day. She described the visit to the mother's as more complicated due to the number of dressings and because there were two children.

The service commenced on the evening of the day of discharge from hospital. The nurses were to attend morning and evening. On 4 September 2006 the frequency was reduced to daily. On 12 September 2006 R/N T sought to discharge the children from the HITH service and advised the mother to this effect. On the same day R/N T spoke to witness 16 who indicated she was not happy for the twins to be discharged. She was concerned about KR's scalp wound and the mother being left without support.

Witness 16 spoke to the HITH liaison nurse and requested that the service continue with visits once or twice per week. The liaison nurse told witness 16 that HITH required a compliant parent and partner in care. HITH considered the mother was making it difficult for the service to be provided.

When HITH sought to withdraw their service they relied upon the following factors –

- The mother was making it difficult for them to visit, for example, not being at home when the nurses visited, not answering the door;
- The mother had refused to let the nurses change the dressings and at other times would not permit them to dress a head wound on KR;
- The mother was capable of dressing the boys herself;
- The mother did not consider there was a need for the service to be involved.

It is difficult to fully evaluate a number of these propositions because as I have indicated a number of the nurses were unable to give evidence and the HITH office folder, could not be located. The nursing notes which were available had been placed on the RCH file from the red folder left at the mother's home. The nurses gave evidence that as the notes were accessible by a parent, sensitive information was not always included on the red file.

Based upon the evidence before me, I will briefly evaluate the concerns raised –

The mother was making it difficult for them to visit, for example, not being home when the nurses visited, not answering the door –

The notes made by the nurses indicate that on a number of occasions the mother stated that there were other things she was seeking to attend to and that the visits were not convenient, for example, when she said she had to pick up the twins' stepfather,[109] when she said she had been out,[110] when she said she needed to go to the Post Office.[111]

Whilst such comments are of concern because they indicate if the visits did not proceed, an inability to prioritise the health and welfare of her sons, the records indicate that on all of the three occasions, the visits took place.

I am satisfied that the practice of the nurses was to telephone the mother to advise of their anticipated arrival times. All of the nurses' evidence was consistent

[109] 26 August 2006

in relation to this matter. It would not be practical for the nurses to drive to a patient's home and for the patient not to be present. At times, the mother could not be contacted on her phone[112] which is of concern as it was important for the time of the visits to be confirmed. The boys had been discharged from hospital on the basis that the HITH service would be provided to assist the mother in the care of the boys.

These matters indicate a less than fully co-operative approach by the mother however, the chart below indicates that whilst the visits were twice daily, save for confusion over witness 9's evidence as to what occurred on 2 September 2006[113] and one visit did not occur on 3 September 2006, there were explanations as indicated for the dates of 26 August 2006 and 30 August 2006 when visits did not occur. All other appointments were kept.

I was concerned by what occurred on 26 August 2006 as described by witness 12, namely that for approximately 2 hours the boys' wounds had not been dressed and the mother was about to leave to pick up the boys' stepfather. I was also concerned by the comments of Nurse K's file note. She stated that on 2 September 2006 the mother had not been returning phone calls and was not present for the morning visit and had not wanted an evening visit to occur. It was also on 2 September 2006 according to witness 21 that the mother drove out of the property with the boys as she had arrived for the visit.

A chart of the visits from the discharge on 24 August 2006 to 4 September 2006 when the frequency of visits was reduced to daily indicates as follows:-

DATE	AM VISIT	PM VISIT
24/08/06 Discharge date		✓

[110] 15 September 2006
[111] 22 September 2006
[112] For example 31 August 2006, 2 and 10 September 2006
[113] Given R/N K's note that the mother did not want her to visit the preceding evening (02/09/06) and the mother was not present for the morning's visit (02/09/06) it may be that no visit occurred on 02/09/06

25/08/06	✓	✓
26/08/06	X mother with the boys at general practitioner	✓
27/08/06	✓	✓
28/08/06	✓	✓
29/08/06	✓	✓
30/08/06	X Confusion over outpatient appointment	✓
31/08/06	✓	✓
01/09/06	✓	✓
02/09/06	X Mother driving out with boys when RN arrived. Query witness 9 visit did occur	X Query whether any visit occurred on 02/09/06
03/09/06	One visit occurred unclear whether am or pm	
04/09/06	Outpatient appointment with witness 16. Visits reduced to once per day.	

However, once the visits became daily there were days that were missed. From 5 September 2006 to 12 September 2006 when R/N T discharged the mother from the HITH service the visits were as follows:-

05/09/06 ✓

06/09/06 ✓

07/09/06 ✓

08/09/06 ✓

09/09/06 X

10/09/06 ✓

11/09/06 X

12/09/06 ✓

It is of course unsatisfactory that visits did not occur on 9 September 2006 and 11

September 2006. There are not any notes on file to explain why the visits did not occur.

As previously indicated R/N T spoke to witness 16 on 12 September 2006 concerning discontinuing the service. Witness 16 requested that the service continue once or twice per week. She attempted to organise an appointment with the Dermatology Department otherwise she requested HITH to visit on 15 September 2006 and to continue once or twice per week.

15/09/06 – The visit did not occur. The mother thought she had been discharged from the service. She said she had been out and it was not convenient for the visit to occur. She said the wounds were healing and she had an appointment on 17 September 2006 with Dermatology and the General Medical Department. R/N S's notes indicate that The mother was not in any way aggressive and she was very reasonable throughout the conversation and she was happy for a visit to occur before 17 September 2006 when she was advised there had been a communication breakdown and the doctors were keen for a visit to occur.

16/09/06 – Visit occurred but the mother had already redressed the wounds save for KR's head wound before witness 21 arrived. Witness 21 noted that KR's head wound remained unchanged from two weeks earlier. It was difficult to assess this evidence as the visit with witness 21 did not proceed on 2 September 2006 because the mother was driving out her driveway with the boys when witness 21

arrived. Her evidence was that she observed him

in a motor vehicle.

In her police statement witness 21 described the mother as hostile and defensive towards her during the visit on 16 September 2006. She said it made her feel uncomfortable. Witness 21 was not cross examined in relation to this issue.

Witness 8 also made a statement to the police. Consistently with witness 21, she used the word "uncomfortable" as to how she felt in the mother's home as she said the mother was resistant to the visit and disinterested in what she was saying.[114] She also used the word "hostile" when she described the mother's attitude towards her during the visit on 10 September 2006.

Witness 8 was cross examined in relation to this issue. She stated that that was not probably what she meant to say. Her evidence was that the mother was hostile to the visit and she was annoyed but she was not hostile towards witness 8. She said the mother did not see the need for the visit. However, the mother's attitude towards her was 'okay'.

At the very least the evidence indicates that the mother was less than encouraging when the nurses were proposing to attend. The service was being provided to assist the mother and the boys. I will further discuss this matter in relation to the final concern raised by HITH.

In relation to the visit which occurred on 16 September 2006, contrary to witness 16's expectation, witness 21 understood her role was to ensure the dressings were intact and it was not her role to inspect the lesions. The fact the mother had dressed the lesions before witness 21 arrived

[114] Visit dated 24 August 2006

meant that witness 21 could not observe the condition of the lesions. The last time a nurse had observed the lesions was R/N S on 8 September 2006. She had observed they were healing but noted in relation to KR that some of the old wounds on his legs had been disturbed by tapes on other areas.

However, when the mother attended witness 16 on 18 September 2006 as previously indicated overwhelmingly the majority of the lesions had deteriorated. I find it concerning that the wounds were able to deteriorate without the mother being proactive on her sons' behalf and seeking assistance. In addition, in the event they had deteriorated as at 16 September 2006, by dressing the wounds herself, the mother did not give witness 21 an opportunity to view them or obtain the benefit of her expertise to help her sons.

On 20 September 2006 witness 3 applied the long term dressings consisting of Mepilex Lite and Mefix. When R/N L called the mother in relation to her visit on 22 September 2006 The mother said it was not really convenient for the visit to occur because she needed to go to the Post Office. However, the visit did occur and R/N L recorded that neither twin had any dressings on any lesion. Whilst the mother disputed this and said that not all of the dressings had fallen off, the additional concerning issue is that once again the mother was not proactive in seeking assistance for the boys.

Furthermore, the RCH file records that on 25 September 2006 witness 16 was advised that the mother did not want anyone to come and see her. It was not clear to whom the mother allegedly made this statement.

The mother had previously demonstrated an ability to act protectively in relation to the boys, for example, attending at the AED of the RCH of her own volition on 14 May 2006 when the wounds had deteriorated and taking the boys to the doctors when they were unwell. However, this ability to demonstrate initiative was not apparent during the weeks in September, 2006 post 4 September 2006 when the wounds significantly deteriorated.

The notes on the RCH files do not indicate that there were any occasions when the mother did not answer the door. However, this evidence is difficult to evaluate given that

the liaison nurse was not available to give evidence and in the event this occurred, and a visit did not take place, an entry could not be made in the red file on that day.

The mother had refused to let the nurses change the dressings and at other times would not permit them to dress a head wound on KR.

The mother was resistant towards the nurses dressing KR's head wound. Whilst it was a difficult area to dress, The mother stated to witness 8 on 10 September 2006 that the doctors had said it did not need to be dressed. Witness 16 did not give such evidence. In fact her plan of care only referred to KR's lip not being dressed.

Witness 8 described the mother refusing to allow her to dress KR's scalp wound even though it was moist and sticky and in witness 8's opinion, it should have been dressed. The evidence varied as to the role bandaging plays in assisting healing. However, it was not for the mother to be determining which lesions to dress and not dress whatever the difficulty was in keeping the dressing intact.

Apart from KR's wound on his scalp, the notes do not indicate the mother refusing to allow nurses to change dressings. They do indicate that at times the mother did not wish for the nurses to lift the dressings to inspect the lesions.

The nurses who gave evidence stated their understanding of their role in the following terms:-

- Witness 10 On bathing days (every second day) to assist with bathing and assist the mother with the dressings. On non bathing days to check the dressings were in place and to check on the general health of the boys. She did not expect to change any of the dressings; just to reinforce them if they came off.

- Witness 12 To check the dressings were intact. She understood the dressings were to be changed every second day after bathing.

- Witness 9 On the morning visit her duties were to bathe and dress one twin. The other

twin would be bathed the next morning. The evening visits were to ensure the dressings were intact.

- Witness 18 To note whether the dressings were intact when we arrived and to assist the mother by supervising change of dressings. She ran the bath and observed the mother bathing the boys and doing the dressings.

- Witness 8 To assist with bathing and the dressings on bathing day and assist with dressings on non bathing day. The aim of the visit was to monitor the progress of the wounds.

- Witness 21 Our instruction was to ensure dressings intact; not to check under dressings.

Accordingly, there was some divergence in their understanding as to their role.

In addition, there was further room for confusion as witness 16 made it clear that the boys were to have very short baths every second day and there was no reference to the boys' dressings being removed in the bath. Yet a practice grew up of the boys soaking in the bath in order to assist in the removal of the dressings.

The mother's evidence was that a few of the nurses said that there was not enough time to bathe the boys and to then dress their lesions. It would be much easier if the mother bathed them and had the boys ready for the nurses to look at the lesions and for the dressings to then be applied.

In addition, removing the dressings in the bath was said to reduce the distress to the boys when the dressings were being removed. Witness 8 agreed that it made sense for the mother to bathe the boys every second day and to use the bath as a technique being the least traumatic way to remove the dressings. However, she also gave evidence that initially the nurses were meant to be assisting with the bathing and she expected to be present when the bathing took place.

The stomal therapist, witness 3, gave evidence it was fine for the HITH nurses to soak the dressings as a method of removing them.

The mother was capable of dressing the boys' lesions herself

On numerous occasions the mother expressed that she was capable of dressing the

lesions herself.[115] A number of the nurses agreed with this assessment.[116] Witness 12 did not note any concern in relation to the mother's ability to dress the wounds.

However, R/N T on 12 September 2006 expressed concerns as to the mother not using a sterile technique when dressing KR's wound on his scalp. Ironically, despite making this observation, this was the day she 'discharged' the boys from the HITH service. Some of the nurses expressed concerns about cross infection and the mother's appreciation of the significance of adopting hygienic practices.

The mother did not consider there was a need for the service to be involved

The mother denied in her evidence that she told HITH that there was no need for them to attend; until she said she was told that she had been discharged from the service.

This evidence is contrary to a number of file notes made by the different HITH nurses and the evidence of witness 18, for example. She stated that the mother said on 7 September 2006 that she did not need the service as she was capable of doing the dressings herself. Whilst witness 18 had not referred to the discussion in her file note, her evidence was she had an independent recollection of the conversation. Witness 18 impressed as a witness whose evidence was balanced, for example, whilst she said the mother was not happy to see her, when she explained the purpose of the visit to the mother, her evidence was that the mother co-operated with the attendance and she was receptive.

This evidence is consistent with other evidence in this case, that is, as previously indicated on a number of occasions the mother intimated that it was not convenient for a visit to occur, but nevertheless the visit took place.

The mother was critical of nurses not attending at an appointed time. She gave evidence that a number of the nurses expressed a concern at the length of the visits.

[115] For example, 7 September 2006 witness 18

Given that the visits by HITH to the mother were longer than the usual service provided by HITH, it is likely that concern was raised.

Witness 12, for example, on 26 August 2006 rang the mother and when the mother said she was about to go out, witness 12 said that the visit would be quick because she was only checking the dressings were intact. The dressings were however not intact when she arrived and she dressed CR's lesions and the mother dressed KR's lesions.

As previously indicated, witness 16's file note for 25 September 2006 recorded a discussion with K from HITH in which it was reported that the mother did not want anyone to come and visit.

It was difficult for a person without experience and time consuming to dress the boys' lesions. Being at home with two active boys and waiting for nurses to attend would I imagine be frustrating. In addition, there was confusion when the mother was told the boys had been discharged from the service and then she received a phone call advising there had been a miscommunication.

In all of the circumstances, I consider it is likely that the mother expressed that she did not consider there was a need for the service to be involved.

Whilst understanding that the mother may have wanted to look after the boys herself, and it may have been frustrating waiting for the nurses, given the longstanding problems the boys had had with their skin and her acknowledgement that dressing the lesions was a difficult task, it was important for the mother to appreciate in her sons' interests, the need for the service to remain involved and all the more because of the deterioration of the lesions. It does not seem she was able to appreciate the assistance HITH was able to provide.

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[116] R/N K 03/09/06, witness 8 10/09/06 and witness 21 16/09/06

THE EVIDENCE OF WITNESS 3 REGARDING THE LONG TERM DRESSING

Witness 3 is a stomal therapist specialising in children with bowel and urine problems and children with wound and incontinence problems. In 2002 she completed a post graduate course in wound management which included determining the aetiology of wounds.

She first saw the boys on 20 September 2006. She recommended that a long term dressing be applied consisting of Mepilex Lite and covered with Mefix tape. The dressing was to remain in place for 5 – 7 days.

Mepilex Lite is a very thin silicone foam dressing which helps maintain the temperature of the wound in order to provide optimal healing conditions. She also applied a light crepe bandage to some of the lesions so that the boys could move freely.

Witness 16 initially described the dressing applied by witness 3 as consisting of Mepilex Lite, Mefix, Melolin and Hyperfix and the dressings were wrapped around each limb circumferentially. It seemed that the boys would have appeared to look like "mummies" with circumferential dressings around their wounds such that the only way the dressings could have come off would have been as a result of the mother removing the dressing, which would have been contrary to the specific instructions of witness 16.

When witness 16 resumed giving her evidence she clarified her evidence as to the precise nature of the dressings applied by witness 3. I am satisfied that the dressings applied were as described by witness 3.

The expectation was that the dressings would remain in place for 5 – 7 days but there were not the layers or the extent of circumferential dressings to which witness 16 had originally referred.

As previously discussed, when R/N L attended two days after witness 3 had

applied the dressing (or three days later according to the mother) her notes indicated that neither twin had any dressing on any lesion and that the mother told her they had fallen off. Witness 3 rejected this possibility and said "No, definitely not."

Witness 3's evidence was that the Mefix tape is very sticky and adhesive and difficult to remove. She said it was very unlikely that it would be able to be removed unless it was picked off and that at eight months of age, there was "no way these children would be able to physically remove the dressings."

She said "I know it stays on" and it was "very very unlikely that the tape would lift". She then slightly moderated her evidence when she stated that you would always have to say that it could potentially come up at the corners and that whilst it could be argued that bathing could slightly weaken the dressings, it would not cause them to come off completely. They could be reinforced.

Witness 16 also allowed for this possibility. In her "Do's and Don'ts" document she stated, "If a dressing becomes unstuck then put it back on with some more Mefix".[117]

The mother did not consider that Mefix retained its adhesive qualities particularly after bathing. In addition, her evidence was that it would lift up when it came into contact with the boys' pants and when they moved the dressings could rub off or hang by a thread. The dressings first lifted on the corners. She did not consider the dressings prepared by witness 3 lasted any longer than the other dressings.

After the boys were readmitted for their third inpatient stay, the nurses' entries record the status of the dressings. These dressings were also applied by witness 3, consisting of Mepilex Lite and Mefix and were to be in place for 5 – 7 days.

The purpose of raising this issue is not to be in any way critical of the dressings prepared by witness 3. Rather, it is in order to assess whether the mother's evidence that the Mefix lifted could be independently verified or assessed.

The nursing entries when the boys were in hospital indicate that the dressings as

early as the day after witness 3 applied them on KR required reinforcement.

The lesions were redressed on 1 October 2006 four days after they had been dressed.

Whilst there are entries indicating that the dressings were intact, the following nursing entries appear in which reference is made to the reinforcement of the dressings whilst the boys were in hospital during the third admission:-

28/9/2006	KR – dressings reinforced.
29/9/2006	CR and KR – dressing edges reinforced to be sure as some of the edges had slightly loosened from the skin.
29/9/2006	CR – dressings reinforced with Mefix.
30/9/2006	CR – "has been ~~picking~~ rubbing at one dressing on right hand."
30/9/2006	CR and KR – dressings dry and reinforced with Mefix
1/10/2006	CR –witness 1 smelly dressings remove and leave open.
1/10/2006	KR – Dressings changed as they were smelly and coming loose. Bactigras applied ½ gauze and Hyperfix over the top.
1/10/2006	CR – Dressings changed. Bactigras applied with gauze and Hyperfix.
2/10/2006	CR – Need to be taken down after mother's visit for photographs and cleaned with N/S. Suggest Mepilex Lite and Mefix dressings.
2/10/2006	KR – To be removed prior to photography and then cleaned (N/S) and redressed with Mepilex Lite and Mefix over the top.

In addition, throughout the period that HITH had been attending at the mother's home, Mefix was used.

The HITH nurses gave evidence in relation to this matter and there was some support for the mother's evidence that the Mefix would lift, for example,

[117] Exhibit R

Witness 8	She had visited on the evening of the day of discharge (24 August 2006) and dressed KR's scalp wound. Overnight the mother was required to reinforce it. (R/N B, 25 August 2006)
Witness 12	She dressed CR's lesions at 6.15pm on 26 August 2006. She attended again the next morning and even though she, a registered nurse, had dressed the lesions, the dressings on CR's leg lesions needed reinforcing as the edges of the Mefix had been coming off and his neck lesion needed redressing. She could not recall if the dressing was not effective or was not on or if it was hanging by the edge.
R/N L	She observed KR pulling at his head dressing and recommended a beanie or mittens.
Witness 8	The dressings adhere quite well but with the twins crawling, the edges may roll up.
Witness 10	She agreed with the mother that it is very hard to keep the dressings on.
Witness 12	She suggested a cotton hat to hold the dressing over KR's scalp lesion in place as KR's hair created a problem when dressing the scalp.[118]

On 4 October 2006 the boys were discharged into foster care. On 11 October 2006, one week later, they returned to RCH for review. All of the dressings had remained "well intact". Some of the dressings were not reapplied because of the healing of the lesions. The mother expressed surprise that the dressings had remained intact for that week.

[118] Compare the evidence of witness 3. Witness 3 stated that the Mefix tape was designed to go over KR's very fine hair.

However, on that evening the Anglicare file indicates that the carer advised that KR had picked off his head bandage and the carers had taken him to Healesville Hospital E.D. to have the bandage replaced.

The mother knew that it was intended when the dressings were applied on 20 September that they were to remain for 5 – 7 days. Witness 16 and witness 3 advised her that was the case. The mother considered the dressings to be similar to the previous dressings applied but they had to stay on for the longer period of time.

The mother's evidence was that she would reapply Mefix to the dressings and she did this to try and keep witness 3's dressings on.

However, she said that she applied the Mefix over and over again until the boys' pants could not fit them as their legs as their legs became to chubby. However, R/N L's file note stated that all of the bandages were off when she attended on 22 September 2006. The mother said a few were off and a few stayed on. She could recall KR's head dressing and foot dressing coming off but the dressing on his right leg stayed on. She could recall the dressing on the top of CR's foot came off but one on his ankle stayed on. She could not recall any more.

R/N L was not available to give evidence. Her diary note however is unambiguous. "On arrival neither twin had any dressings on any lesion." Consistently with additional dressings of Mepilex or Mepilex Lite not being provided to the mother, the lesions were dressed by R/N L and the mother with Mefix for the dry lesions and Bactigras / Melolin and Mefix for the moist lesions on both boys.[119] R/N L was sufficiently concerned to contact the liaison nurse, R/N B.

I find it difficult to assess R/N L's observations as she was not available to give evidence. They raise serious concerns. However, even accepting the mother's evidence, this is a further occasion on which there were lesions which were not

[119] Witness 3's expectation was that additional dressings would have been provided to the mother. She also assumed that the HITH nurses were aware of the changed dressing regime. The file notes of the HITH nurses confirm that this was not the case.

dressed and this was unacceptable and contrary to medical advice.

In addition, there are further concerns in relation to the mother's reported inability to explain or converse about when the dressings had fallen off and what the situation was in relation to them falling off. She had said that the reason for the dressings not being on was that the boys were crawling a lot and the reason for the lesions deteriorating was that they were crawling and rubbing the dressings off.

When she had attended at the RCH on 18 September 2006 many of the wounds were not dressed. She said that she did not have enough money for all of the dressings. She had dressed some of the lesions with Melolin which she had bought at the pharmacy.[120]

[120] There was some dispute as to whether dressings were left for the mother by HITH. The mother stated that on "discharge" on 12 September 2006 the red file and the bandages were removed. R/N T's note on 12 September 2006 stated that she had left a couple of days of supplies (dressings, saline etc.) and informed the mother she would have to buy more from the chemist.

Whilst I am satisfied there are protective concerns in relation to the mother not seeking assistance in order to have the lesions redressed and it is curious that the dressings remained intact during the first week in the out of home placement, I am not satisfied given the evidence of the nurses and / or their file notes that I can accept the following comment attributed to witness 7 in the DHS Application Report:

> "Witness 7 advised that the children have been admitted to the RCH on several occasion (sic) in past months and at discharge the wounds were healing and were taped. Furthermore that the mother had been instructed to not remove the bandaging, however the mother removed the bandaging and the ulcers again deteriorate."[121]

THE MOTHER

Throughout this Decision I have referred to the evidence given by the mother and the evidence of other witnesses about their observations of the mother. I do not propose to repeat that evidence.

In view of the serious allegations made against the mother an assessment of her credibility is of great significance.

When she gave her evidence the mother answered the questions put to her spontaneously. Witness 4 considered that she was "forthcoming" when he spoken to her and that she did not seem to be evasive. He also found her answers to be spontaneous. Witness 14 considered she was truthful, open and sincere.

There were a number of matters put by Mr Holden on the mother's instructions which were ultimately confirmed by other witnesses or by documentary evidence, for example:-

- The mother has consistently maintained that the first lesion on each boy commenced under their noses and then healed. The photographs and the evidence of witness 13 and witness 5 confirm that there appeared to be a healed lesion under CR's nose.
- Dr P recorded the mother's observations of vesicles appearing on the skin of

[121] Exhibit AB

both boys which was consistent with the medical evidence as to the application of steroids if there is a viral infection. It is also consistent with the mother having followed the medical advice and having applied the medication.

- It was put to witness 16 that she had had a discussion with the mother concerning the results of the boys' immunology tests and in particular about their chromosomes. Witness 16 could not recall that discussion but the RCH file confirms that on 16 October 2006 such a discussion took place.
- The mother disputed witness 16's evidence as to the number of layers of dressings and the extent of the circumferential bandaging witness 3 applied to the lesions. Witness 16 subsequently clarified her evidence which was consistent with what had been put on the mother's behalf.
- On 5 January 2007 the mother described to witness 7 her observations as to how the ulcer on CR's leg commenced. When witness 7 saw the foster carer on 24 January 2007 he stated that she "basically confirmed the story that the twins' mother had previously told me".[122]

The mother has consistently denied harming her sons and has demonstrated a commitment to them, for example, her consistent attendance at and participation during access. She has acted protectively towards the boys, for example, attending at RCH on 14 May 2006, agreeing to the voluntary admission of the boys to the RCH on 27 September 2006 and refusing to permit steroid cream to be applied to CR's chest on 23 April 2007. Elsewhere in my Decision I have referred to occasions on which I am satisfied she has not acted protectively.

I accept the mother's evidence save for I have some reservations as to how frank she has been in relation to her personal life, for example, her relationship with K. Witness 6 and witness 4 also agreed it was difficult to discern precisely what the relationship is.

[122] Exhibit X Report of witness 7 30 January 2007

In addition, on occasions I did not consider that her evidence as to the progression of the lesions, including whether they were healing,[123] to be reliable nor her ability to accurately recall the appointments the boys had with witness 6.[124]

PSYCHIATRIC EVIDENCE

I found witness 4 to be a credible witness whose evidence was balanced. The thrust of his evidence was that the mother has had an upbringing in which she has been neglected and sexually abused. She presents as a sad, vulnerable woman who is understandably angry and depressed in relation to the allegations which have been made about her and coping with not having her sons in her care.

In his report he stated -

> "Given her prior history, the requirement of caring for twins may well have been an overwhelming experience for her. I am not privy to the evidence, however it is quite possible, given the mother's developmental history and her experience of not having her inner needs met, once again she found herself in a situation whereby her experience, sense of self and her ability to relate to her children may well have resulted in the allegations of Munchausen's by Proxy and Dermatologica Artifaecta.
> ..... Psychodynamically the alleged Dermatologica Artifaecta can be understood as a cry for help from this young woman."[125]

In relation to making a determination as to whether the mother has caused the injuries and/or aggravated the ulcers, witness 4's evidence was that that was a matter to be determined on the evidence before the Court. He stated he was "less clear about" whether her presentation and the issues with which she presented amounted to Munchausen by Proxy or DA. He agreed that there are many people in the community with vulnerabilities such as the mother who do not have the condition Munchausen by Proxy.

He assessed the mother as not displaying any psychotic features and whilst he did not consider she had a depressive illness, his opinion was that she had an adjustment disorder with some depressive features. She was reacting normally under distressing circumstances.

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[123] For example, 14 May 2006, 15 September 2006
[124] Cross examination of Ms Buchanan
[125] Exhibit G

He said her presentation and account was consistent with someone who was sexually abused. She felt she was neglected and abused. This is an issue which witness 4 considered needed to be addressed in counselling as such issues present as a risk factor in relation to a person's attachments, possibly extending to their children and their emotional state.

He described the mother as being "forthcoming" about her life experiences and in his view she developed a good rapport with him. She did not seem to be evasive in answering his questions and she was cooperative and spontaneous. She was remorseful in relation to mistakes she had made with her daughter N.

She was described by witness 4 as "dumbfounded with the whole idea (that she could hurt her sons)." Witness 4 did not consider there was an inconsistency in what she said and how she said it. Her denial of harm appeared to be a genuine belief. He said there was no doubt that she loved her children.

Witness 4 recommended that the mother have long term supportive psychotherapy to work through her own issues and those related to her daughter N and her sons. He did not specify a timeframe. Presumably it would depend upon the progress made by the mother. Witness 14 stated that she understood witness 4 was of the view one and a half years of intensive treatment was required.

In addition, he stated that the mother requires considerable assistance and ongoing emotional and practical support in regard to any ongoing contact with her children. His opinion was that in the absence of such support her children "would have to be regarded as somewhat at risk in regard to her ability to manage her children".

There was a consistency in the evidence of both witness 4 and witness 14. I was also impressed by the evidence of witness 14. Witness 14's evidence was that the mother does not display any psychotic symptoms. She does not have a serious mental illness but her personality development has been adversely affected by sexual and emotional abuse she alleges occurred. Witness 14 stated that in her opinion her vulnerabilities "I think come from her upbringing". Due to the mother’s background of being inadequately parented, she is inadequately prepared for parenting herself and she requires nurturing and non judgmental support. Witness 14 critically evaluated the

mother's presentation. She described the mother as truthful, open, frank and sincere. She saw her over three sessions in February 2007. The mother expressed disbelief and distress that the boys had been removed from her care. Witness 14's report indicates that the mother denied ever harming her sons and communicated "a genuine belief in herself that she would never harm them". She is genuinely grieving that they are not in her care.

Witness 14 gave evidence that abuse always has an effect on the person abused and it presents in different ways over that person's life. If a person says they have dealt with the abuse by closing the door and moving on with their future, it does not necessarily mean that the emotional wounds have healed. A person's control over their emotions and their self esteem may be adversely affected by the abuse.

Witness 14 considered that the mother's developmental vulnerabilities could be assisted by insight oriented psychotherapy but only if the mother wanted to engage in psychotherapy. The psychotherapy requires a sophisticated degree of personal insight in which the person knows the issues or thoughts they want to change as they are not comfortable with themselves as they are. In the absence of the mother engaging in psychotherapy, witness 14 recommended that she should continue with the counselling in which she has been engaging with witness 15 as the mother considered it to be supportive and there was a trusting relationship between herself and the psychologist.

Witness 14 stated that any counselling support that the mother receives, needed to be affirming and not judgmental so that she would then be able to pass it on to her children. In addition, witness 14 stated that the mother would require agencies in the home to assist her to parent the boys and in view of the allegations which have been made, there should be medical supervision.

The mother was initially resistant to participating in psychotherapy. However, at the conclusion of the proceedings she indicated she was prepared to undertake confidential psychotherapy and indicated that her previous reluctance to engage in psychotherapy was partially premised upon a concern that it may have indicated a weakness in her character or a tacit admission that she was psychologically or psychiatrically unwell and/or that she had been involved in hurting her children.

Mr Holden explained to the mother the possibilities in relation to confidentiality and the mother's instructions were that she would be 'more than happy to attend' an appropriate psychotherapist. She stated that the person would need to be someone with whom she could relate.

THE RELATIONSHIP BETWEEN THE MOTHER AND CR AND KR

Witness 7 gave evidence that if the boys were being harmed by their mother, whether it be by poking or burning them, one could expect the boys would be in pain. He considered it would be a "fair comment" that a child would associate the pain with the person causing the pain and one might see a change in the relationship between, in this case the mother and the boys.

Witness 14 gave evidence in relation to the matters which she considered would be relevant in assessing the relationship between the mother and the boys -

- the boys' interaction with her
- the boys' spontaneity with her
- the boys' willingness to go over to her
- their attachment to her
- the mother's response to them.

The mother has consistently attended access four times per week for one hour each access for over 12 months therefore there has been an opportunity for these observations to be made.

When the mother attended at the hospital with the boys, there was no evidence of the boys being fearful or scared of her. She was observed to comfort the boys when their bandages were being removed.[126]

In addition, the case note of JC included the following observations of the boys' interaction with their mother at RCH.

"On arrival at RCH both boys smiled at mother and after greeting writer mother proceeded to collect CR from the car seat. CR cuddled mother affectionately. KR reached out towards mother

[126] Exhibit AP Casenote of KB 16 October 2006

from the stroller in which he was sitting and mother held his hand."

"CR became upset while being measured and reached out towards mother. CR also became upset when mother walked away to use the bathroom and walked quickly towards her with his arms held up on her return."[127]

There have not been any observations of the boys being fearful of the mother during access. Rather than the boys demonstrating any concerns being with their mother, the opposite has been the case. She has not been observed to "hit or hurt" the boys at any time.[128]

Witness 17 described the mother as hugging and kissing the boys and they are affectionate towards her. CR in particular is very affectionate towards her and witness 17 described him seeking her out if he falls or is upset. The Anglicare file records CR falling over and hitting his head and beginning to cry when he looked up at the mother who picked him up, rubbed his head and soothed him.[129] The mother has been described as being very gentle with the boys when she cut their hair.[130]

R/N B from the HITH team described CR as "motoring down the corridor following mum around."[131]

There has not been any anxiety observed on the part of the twins when leaving access until the week before

witness 17 gave evidence on 8 October 2007 when neither twin wanted to leave their mother's access.

The mother has demonstrated a commitment to be with the boys. She has attended all accesses and access has only been cancelled if the boys, or either of them have been unwell.

Witness 11 noted "KR appears to be developing normally and interacts appropriately with his mother."[132] and the same comment was made in relation to

[127] Exhibit AP 27 April 2007
[128] Exhibit AF DHS Report 23 August 2007
[129] 6 March 2007
[130] 28 September 2007
[131] 29 August 2006
[132] Exhibit C

CR.[133]

The mother conveyed to witness 14 that there was a strong bond between the boys and herself. She told witness 14 she could not wait to hold and touch them and see their faces. She gets upset when she has to leave.

The protective worker stated in the Addendum Report dated 10 May 2006

> "The mother has been observed to interact in an appropriate manner with CR and KR. CR and KR have been observed to show a clear attachment to their mother through their interaction with her. Support workers and the protective worker have reported that CR and KR are very comfortable with their mother, seeking her out with arms open and interacting in a positive manner."[134]

The protective worker's evidence was that whilst this is the case during the one hour access, in his view extreme supports would be required if the boys were returned to her care. She would require assistance in relation to disciplining the boys and setting boundaries. He said the access is one hour of fun time.

He also stated that a parenting service could be organised to assist the mother if the boys were to be returned to her care and if the boys were to be returned, in his view it would have to be a graduated return.

THE LAW AND FINDINGS

I have previously referred to the standard of proof which applies in these proceedings.[135]

The presentation of the lesions in May 2006

I am not satisfied that prior to the first admission to the Royal Children's Hospital, the "cause" of the lesions was trauma for the following reasons:-

- The diagnoses of the medical professionals who saw the boys' lesions between 10

[133] Exhibit D
[134] Exhibit AE Page 6
[135] Pages 17 and 18 of this Decision

April 2006 and 3 May 2006 were as follows:-

10.04.06	Witness 6	Impetigo lesions
27.04.06	Witness 6	Persistent impetigo/staph
27.04.06	RCH AED Doctor	? Deep Impetigo
27.04.06	RNN	? Ecthyma – Deep Impetigo.

- Dr S who saw the boys with witness 13 on 3 May 2006 stated in her letters to witness 6[136] in relation to both CR and KR "he certainly has impetigo". Reference was also made to a likely diagnosis of discoid eczema in relation to CR and that KR has discoid eczema. At this consultation there was no indication of the presence of HSV1.

- The lesions had a different presentation when the boys attended at the RCH on 14 May 2006. I am satisfied that the application of the steroid cream adversely impacted upon the lesions. This statement should not be seen as a criticism of witness 13 as there was no clinical presentation of a virus at the time and the prescription ordered was appropriate for eczema.

The following diagnoses were made:-

14.05.06	Dr P	Chronic impetigo ?HSV component
14.05.06	witness 1	"very unusual" lesions, deeper than expected with chronic impetigo, central ulcers c/w indolent HSV? Immuno-compromised.
16.05.06	Dr W	Possibilities include – - primary bacterial

[136] Exhibits O and P

infection (chronic) with acute HSV super-infection - primary HSV infection (chronic) with exacerbation by steroid treatment. -additional possibility- immunodeficiency

- Whilst there was no obvious infective organisms nor was viral inclusion in the bodies seen in the biopsy taken from CR's right thigh, swabs taken from the boys indicated SA, HSV1 and a few pus cells suggestive of infection were detected. Whilst it is a matter of judgement for the medical professionals to determine the role of the HSV1 and SA, the results are consistent with the diagnoses made at the time.
- The blood test results for KR (CR's were not tendered) contained a note in relation to the sample collected on 18 May 2006 "mild neutropenia with some reactive lymphocytes suggestive of infection". Witness 19's evidence was that neutropenia occurs when there is an acute infection.
- The boys' lesions responded to the intravenous anti bacterial and anti viral drugs administered to treat SA and HSV1.
- The evidence of witness 5 and witness 1 which has previously been detailed in relation to the lesions when the boys were admitted in May.

I have considered witness 13's evidence that the diagnosis on 3 May 2006 was a presumptive diagnosis and that upon observing the pattern of healing of the lesions and the treatment administered, the presentation was consistent with trauma or DA.

For the foregoing reasons, I am not persuaded that such a finding can be made.

Intentional or unintentional aggravation/perpetuation of the lesions by the mother

The DHS has submitted that:-

- the perpetuation or aggravation of the lesions is due to trauma and that
- the mother is responsible for having intentionally or unintentionally aggravated or perpetuated the lesions.

Dealing with the first issue in relation to trauma, both Doctors witness 13 and witness 1 were of the opinion that the lesions were consistent with trauma but they could not diagnose that this was the case.

Witness 5's evidence was that the most likely cause would be physical trauma as the important if not the sole cause. However, he stated there was "no conclusive evidence why the ulcer occurred" and that he "remained concerned all along" in relation to the diagnosis. He said "I did not have any better or alternative explanation". As previously indicated, witness 5 expressed concerns about the rate of healing of the twins.

I accept the evidence of witness 5.

I find that there are cogent reasons advanced by the treating doctors to support their opinion that the lesions were aggravated by trauma including:-

- The absence of any infective cause being identified
- The healing of the lesions with dressings along
- The unusual presentation of the lesions.

I also however have concerns in the absence of further tests being conducted as referred to by witness 19, as to whether there is a problem with the boys' ability to heal.

On the evidence before me, the aggravation of the wounds is consistent with trauma. However, the word "trauma" in this context encompasses a vast array of actions ranging from a deliberate act by someone to injure; to an unintentional act, for example, lesions rubbing against the carpet, the removal of a dressing which has adhered to a lesion, scratching, cross infection, environmental factors.[137]

The evidence of Doctors witness 13, witness 1, witness 7 and witness 11 was consistent. There are not any tests which can determine the agent of the trauma, for example, mechanical, burning, pressure etc.

[137] On 27 September 2006 witness 1 raised a number of questions to which he wanted answers. One question was "Are there environmental factors at home preventing healing?" It is an area of specialisation outside witness 1's expertise. The mother said that she remembered saying to witness 1 "Come to my house. Look at my surroundings." The mother had been concerned as to whether the carpet, for example, was relevant to the lesions. The RCH file

Witness 5 in his statement stated:-

> "There was no proof at any time of any trauma or other injuries being inflicted on the children".

Despite there not being any tests which can determine the agent of the trauma, there were a number of possibilities canvassed in this case including:

- application of heat to the skin (witness 7)
- repeating picking or rubbing of the healing scabs (witness 7, witness 3, nursing entry on KR's file 27 September 2006)
- application of some corrosive substance which could inflame or irritate the skin (witness 7 – albeit he considered this possibility "pretty unlikely"
- caustic burns query detergent leading to skin irritation and the mother then picked at the lesions leading to a secondary infection (Ms MC, former protective worker)[138]
- something has been on the surface and pushed down into the lesions, that is, pressure sores (witness 3)

The mother has not made any admissions in this case, rather, she has made consistent denials and there is no forensic evidence linking the mother to aggravating the lesions.

Whilst police attended the SCAN Meeting and obtained statements from witness 1 and some of the HITH nurses, there was no evidence called from the police. Thus, there was no evidence of any investigations they may have conducted (for example, the execution of a search warrant at the mother's home).

I have also had regard to the fact that the lesions which have arisen since the boys have been in foster care have been markedly different in appearance and severity to the lesions which occurred whilst the boys were in the mother's care.

In addition to considering the medical evidence, I have considered a number of risk

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does not indicate that any investigation was conducted of environmental factors at the mother's home.

factors when evaluating whether I can be satisfied that the mother intentionally aggravated the lesions including:-

- The mother is a young mother on her own bringing up twins;
- The relative lack of family support enjoyed by the mother as she only has contact with one brother.
- The mother does not have N in her care and when she was in her care she exposed N to risk and made poor lifestyle choices;
- Whilst the mother does not have a psychiatric disorder, witness 4 and witness 14 identified vulnerabilities which have been detailed and which in the absence of professional assistance place in jeopardy her ability to effectively parent.
- The mother missed a number of RCH outpatient appointments namely 7 June 2006, 3 July 2006 and 10 July 2006.
- The mother did not act protectively in relation to the boys when new lesions appeared, for example, four lesions on the face of CR on or before 17 August 2006 and when the lesions deteriorated, for example, the lesion on KR's scalp.
- It appears that the mother did not prioritise HITH visits on 9 September 2006 and 11 September 2006, such visits not occurring on those days.

I have also considered other evidence before me which would not be consistent with the mother intentionally aggravating the lesions. These matters include: -

- her relationship between the children and herself
- she loves the children and there have not been any observations of her behaving inappropriately with them or not coping with them
- there were no other injuries or bruises observed on the children. They were described as developing well.

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[138] Ms MC advised witness 14 that was how the mother caused the lesions. She did not say whether it was intentional or unintentional.

- she regularly took the boys to a maternal and child health nurse or the maternal and child health nurse came to visit her when they were in her care.[139]
- she took the boys to a mothers' group once a week when they were in her care
- The mother attended at RCH on the days when she was referred by witness 6
- she co-operated in relation to providing consent for the medical procedures, (for example, biopsies, swabs) to be conducted at RCH and for photographs to be taken.
- The mother spoke to witness 11 from the Gatehouse Centre.
- The mother gave evidence in relation to the site of the first lesion under both of the boys' noses which the medical opinion confirmed was not an unusual site for impetigo.
- The mother has been consistent in relation to her description of the location of where the lesions commenced.
- her description of the presence of vesicles on 14 May 2006 to Dr P in AED RCH and her evidence in relation to the reaction of the lesions after the steroid medication was applied, is consistent with the medical evidence and in the case of witness 13 is consistent with his evidence in the event anti viral medication was not prescribed;
- when the lesions deteriorated on 14 May 2006 she attended at the AED RCH of her own volition.
- The mother has at all times denied causing or aggravating the lesions and according to witness 4 she appeared dumbfounded at the thought she had hurt her children.
- The mother agreed to the boys' voluntary admission to RCH on 27 September 2006.

Having considered all of the evidence in this case, I am not satisfied that it has been established that the mother intentionally aggravated the boys' lesions.

I am satisfied however that there was an aggravation of the majority of the

[139] Exhibit 14

lesions whilst the boys' were in The mother's care. I am satisfied that the majority of the boys' lesions deteriorated whilst the boys were in the mother's care after the outpatient appointment on 4 September 2006 and prior to the appointment on 18 September 2006.[140]

The reason/s for the deterioration of the lesions cannot be determined on the evidence before me. Whilst DHS has submitted that the mother is responsible for the aggravation, as previously indicated there is no evidence as to the means by which it is said the mother aggravated the lesions.

[140] Witness 11 noted some healing to the ulcer on KR's scalp and under his nose but the ulcer on the scalp deteriorated again prior to the third admission on 27 September 2006.

There were a number of possibilities raised in the evidence. Witness 16 could recall that on some of the lesions dressed by the mother the gauze had become adherent. Witness 16's evidence was that gauze can adhere to a wet wound and make it deeper by lifting the granulation tissue out of the bottom of the wounds. It is possible if the gauze dries, that when it is removed it can result in the wound deteriorating as was observed. In addition, when the gauze is pulled off, it could possibly leave a clear margin.

In relation to the deterioration of the wounds prior to the third admission witness 16 in the "Do's and Don'ts" document[141] referred to the sores on the boys' legs being easily rubbed when they crawl. "If the sores are uncovered they will get rubbed and get worse".

When she saw the boys on 18 September 2006 she was concerned that the lesions had been allowed to be left uncovered and allowed to be aggravated. There is evidence prior to the wounds deteriorating that the mother had left the wounds undressed for at least 2 hours. In addition on 22 September 2006 according to R/Nurse L none of the twins had any dressing on any lesions.

I have reviewed the notes of the HITH nurses who visited the mother in an attempt to ascertain whether there is evidence of the reason/s for the deterioration.

- Witness 8 had explained to the mother the need to avoid cross infection on 24 August 2006 and spoke about separate hand towels for the nurses and soap on tap. When she returned on 10 September 2006 there were not separate hand towels for the nurses.
- Witness 18 did not believe the mother was trained in relation to the appropriate aseptic technique when applying N/Saline.
- R/N T considered the mother's technique at dressing KR's head wound not to be very sterile (12 September 2006).
- Witness 8 gave evidence that removing a dressing can aggravate a wound and she believed that on 10 September 2006 a lesion on CR's right thigh which was healed, was aggravated when the Mefix was being removed. The lesion was then dressed with Melolin.

[141] Exhibit R

- Witness 8 stated in her notes that on 7 September 2006 there was a lesion on KR's right thigh which looked as though the healed skin had come off when the dressing was removed.
- R/N S noted on 8 September 2006 that an old wound on KR's leg had been disturbed by tapes on other areas. She referred to "raw areas".

In cross examination the mother agreed that she patted the sores with a towel after a bath which was contrary to the "Do's and Don't" document. She said she did what the nurses did. Whilst the reason/s for the deterioration cannot be determined, I am satisfied that the mother did not act protectively once it became evident that the lesions were deteriorating after 4 September 2006. She did not act proactively to seek assistance for her sons. Whilst she did attend the scheduled appointments at RCH and she did obtain a referral from witness 6 for a second opinion, it was not in the boys' best interests for the time to tick by waiting for these events to occur.

The mother was provided with very specific instructions on 20 September 2006 by witness 16 in relation to the bandaging remaining in place for a week.

It seemed to me that whilst a number of the doctors in this case had minimal contact with the mother, that could not be said of witness 16. She spent the most time speaking with the mother. Importantly she impressed as a person with good communication skills and with empathy. The mother in her evidence described witness 16 as "calming". She was therefore presumably not intimidated to speak to her.

Whilst noting that the evidence in this case varied as to the significance of bandaging in the healing process and whatever may have been the difficulties with the dressings, even accepting for these purposes that they fell off, it does not absolve the mother from her then not reacting to that situation. She did not immediately ring witness 16 or HITH or attend at the RCH with the boys to explain what had occurred and to seek their advice. Her explanation for this was that she did not have a phone and as she was going out of her budget she did not have the money to purchase bandages. The mother did have support people she could have called on but she did not. She did not attend at the RCH. I do not consider she was acting in this instance

in the boys' best interests.

It is noted that when she was asked whether with hindsight there was anything she would have done differently especially after the second admission, her evidence was that she would have waited for the nurses to come; it seems in relation to them assisting her with the bathing and/or doing or supervising her dressing the lesions. She also said that she would spend more money to get the best quality bandages if the lesions reappeared and she would ensure all bandages were on the boys.

I am also satisfied that whilst there was some healing of the lesions between the first and second admissions to hospital, the rate of healing was significantly slower whilst the boys' were in the mother's care when compared with their healing in the hospital on their second admission.

Again, I am unable to determine the reason/s for the slower rate when the boys were at home.

Such factors may include that whilst in hospital on the second admission, the boys' hands were bandaged. In addition, witness 16 said to the mother on 22 August 2006 when the mother was seeking to discharge the boys "I told her that the dressings done here were different from the ones she was doing at home and the nursing staff are specialists in looking after the wounds". I also note that the evidence of the nurses detailed above may impact upon the rate of healing.

Likelihood of future harm

It was submitted on behalf of DHS that the Court should find that there is a likelihood of future harm to CR and KR were they to be returned to the mother's care.

In *Re H. and Others* at pp.590, 591

> "A decision by the Court on the likelihood of a future happening must be founded on a basis of present facts and the inferences fairly to be drawn therefrom ..... a Court's conclusion that the threshold conditions are satisfied must have a factual base and an alleged but unproven fact, serious or trivial is not a fact for this purpose. Nor is judicial suspicion, because that is no more than a judicial state of uncertainty about whether or not an event happened..... The range of facts which may properly be taken in to account is infinite. Facts include the history of members of the family, the state of

> relationships within the family, proposed changes within the membership of a family, parental attitudes and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats and abnormal behaviour by a child and unsatisfactory parental responses to complaints or allegations. And facts, which are minor or even trivial if considered in isolation, when taken together may suffice to satisfy the Court of the likelihood of future harm."

In relation to the question of likelihood that the mother would not act protectively in the future, I am not satisfied this has been established. Whilst there are risk factors including her failure to proactively act in the best interests of the boys as I have described in the fortnight leading up to the third admission, not following precisely the medical instructions she was given (for example, not dressing KR's scalp wound, leaving the boys' lesions undressed for at least 2 hours on 26 August 2006), missing outpatient appointments at the RCH and with HITH, her lack of family support and issues related to her upbringing as described by Doctors witness 4 and witness 14), nevertheless they must be balanced against the following:-

- the mother loves her sons
- there is an attachment between her sons and herself
- she has demonstrated a sustained commitment to the boys attending all accesses except if the boys were unwell, four times a week for over 12 months
- she has the support of JD and TM to whom, she gave evidence, she would turn if she required assistance
- she has not had the boys in her care for over 12 months
- despite being aware of the involvement of the Gatehouse Centre and being advised that DHS or the police would be called if she discharged the boys on the second admission, she has attended all subsequent appointments at the RCH and has co-operated with every request that has been made of her at the RCH (for example providing consent for photographs of the boys, all medical procedures)
- she has been attending a psychologist, witness 15 since November, 2006
- she is prepared to undergo psychotherapy
- she ensured that the boys were seen by a maternal and child health nurse

when they were in her care and apart from the lesions the boys were developing well

- she has not been diagnosed with a psychiatric illness
- she gave evidence that if the boys were returned to her care and there were any medical concerns with the boys, she would take them to the RCH straightaway or to her doctor's and she would ask the RCH to admit them for as long as it takes for the boys to be 100% healed. Whilst the mother's evidence was that she lost trust in the RCH, as indicated she continued to attend appointments and I am satisfied, if required, she would do so in the future
- The mother has co-operated with DHS. In the DHS Addendum Report the following is stated:-

> "The mother has continued to co-operate with the Department throughout the IAO. The mother always returns the writer's calls and complies with all Departmental requests."[142]

I have evaluated those matters and taken into account the risk factors which I have previously identified.

CHILDREN YOUTH AND FAMILIES ACT 2005

Section 10 CYFA provides that the interests of the child must always be paramount and in order to determine whether a decision or action is in the best interests of a child, the need to protect the child from harm, protect his/her rights and to promote his/her development must always be considered.[143]

Section 10(3) CYFA details the matters to be taken into account when determining what decision to make or action to take in the best interests of the child.

I have considered the matters contained in section 10 CYFA in determining the best interests of the boys. The Act is premised upon the fundamental group unit of

[142] Exhibit AF 22 August 2006
[143] Section 10(1)(2) CYFA

a parent and a child being protected, subject to the child being protected from harm.

For the reasons I have given in this Decision I am not satisfied that the mother has intentionally harmed her children. I am satisfied that there have been incidents which I have detailed and which indicate that at times the mother has not acted protectively towards her sons. In addition, I accept the evidence of witness 4 and witness 14 that the mother's ability to parent will be assisted by her engaging in psychotherapy and by support services being available to her.

Having considered section 10(3) CYFA, I am satisfied that an IAO which provides for increased access between the mother and the boys, provides for support services to be engaged in by the mother and presuming positive reports are received, a Supervision Order ultimately being made, would enable the following to occur –

- **protect the parent and child as the fundamental group unit of society and to ensure that intervention into that relationship is limited to that necessary to secure the safety and wellbeing of the children (s.10(3)(a))**

An Order providing for staged reunification between the mother and the boys would enable the parent and child relationship to be protected.

The conditions which attach to the Order and the monitoring of the mother's progress would ensure the safety and wellbeing of the children. Furthermore the protective worker gave evidence that the boys could be physically examined on a weekly basis.

The conditions attaching to the Order will include that the children are to be physically examined on a regular basis and that they are required to attend regular medical appointments. In addition, in my view it is in the boys' best interests for a condition to be included enabling additional tests to be conducted at the RCH, for example, genetic testing and any other tests recommended by witness 19.

- **Strengthen, preserve and promote positive relationships between the children and**

the children's parent (s.10(3)(b))

The submission on behalf of DHS confirmed that the CSO was sought because of the DHS' concerns that the mother had harmed her sons and had not done any work to date to address the issues surrounding her behaviour.

Given my findings in relation to the mother's role in relation to the lesions, a CSO does not strengthen, preserve or promote positive relationships between the boys and the mother. In acknowledging the seriousness of the lesions on the boys' skin, conditions will attach to the Order to ensure the safety of the boys.

- **The effects of cumulative patterns of harm on a child's safety and development (s.10(3)(e))**

Mr Brown in his submission correctly noted that there was no expert evidence called in relation to this matter.

Ms Buchanan submitted that the scarring to the boys' skin, in particular, KR "must have an impact on their sense of safety and their development". This submission was primarily it seems premised upon a finding being made that the mother has harmed her children. As previously indicated I am not satisfied that she deliberately harmed the boys. I have expressed concerns about the deterioration of the wounds, in particular over the period 4 September 2006 to 27 September 2006 whilst they were in her care but in my view these issues can be addressed with appropriate monitoring of the boys and supports being in place for the mother.

- **the desirability of continuity and stability in the child's care (s.10(3)(f))**

The boys have been out of the mother's care since they were 11 months of age. They have been in two foster care placements since 4 October 2006. The Anglicare file indicates that the current carers would review their position after approximately 12 months of the boys being placed in their care and that they would want whatever is best for the boys.

It is in the boys' best interests for the return to their mother's care to be managed to ensure that continuity and stability become a part of their lives again.

Ms Buchanan submitted that the risk of harm in returning the children without the necessary protection of harm is likely to destabilise them. I am satisfied that the conditions of an Order can provide the necessary protection.

In relation to dealing with the transition into the mother's care, it is significant that for more than half of their lives, the boys have been out of her care. When the mother was asked about any adjustment problems which may occur if they were returned to her care, she did not consider that that would be a problem.

Whilst the mother did not consider that there would be a problem and perhaps her response demonstrated some lack of awareness, in my view she demonstrated insight by not seeking the immediate return of the boys, acknowledging the period of time the boys have been out of her care. In addition, she acknowledged that there was a bond between the carers and the carers' children and she stated that she and the boys would have some contact with the carers, for example, a play day.

There was no expert evidence called in relation to the strength of the bond between the mother and the boys. The matters identified by witness 14, to which reference has previously been made, the evidence of witness 17 and the contents of the DHS Reports[144] of the observations made during access, would confirm there is an attachment between the boys and the mother.

- **the child is only to be removed from the care of his parent if there is an unacceptable risk of harm to the child (s.10(3)(g))**

In my view, a staged reunification with the appropriate supports in place does not present an unacceptable risk of harm to the boys. In respect of s.10(3)(a)CYFA I have referred to conditions which will attach to an Order to ensure the safety and wellbeing

[144] For example, Exhibits AE and AF

of the boys.

- **the desirability, when a child is removed from the care of his parent, to plan the reunification of the child with his parent (s.10(3)(i))**

An IAO with increased access and ultimately if matters proceed well, a Supervision Order will facilitate a reunification plan of the boys with their mother.

- **the capacity of the parent to provide for the child's needs and any action taken by the parent to give effect to the goals set out in the case plan relating to the child (s.10(3)(j))**

I will firstly deal with the mother giving effect to the case plan. Whilst there was evidence that witness 20 during August 2007 was recommending a 12 month CSO with a reunification plan,[145] this was prior to him meeting with the High Risk Infant Manager. The DHS case plan has been non reunification with the DHS draft suitability plan including locating a suitable permanent carer.[146] Apart from engaging in psychotherapy it seems there have not been any goals set for the mother to which the mother could give effect.

Given the nature and complexity of the concerns in this case, DHS has been guided by the expert medical opinion of the doctors at the RCH. The protective worker gave evidence that DHS has been awaiting a decision of the Court in relation to the future planning of this case.

[145] File note on Anglicare file dated 24 August 2007 although the date may be incorrect, evidence of the protective worker.
[146] Exhibit AF Addendum Report 22 August 2007 pages 4,5

Witness 20 gave evidence that there should have been a case planning meeting within 28 days of DHS involvement chaired by DHS and including the mother and any professionals involved. He could not locate any such notes of a meeting although a case note was tendered to the Court dated 5 October 2006 in which the mother initiated contact and a 40 minute discussion was held.[147] Witness 20 stated that if the Court process is quick, it may negate the purpose of having a case planning meeting.

Witness 20 described the case plan as non reunification but there had not been a case planning meeting conducted. He stated that DHS is not obliged to hold a case planning meeting within six weeks of an IPO being made, unlike the obligations when a Supervision Order or Custody to Secretary Order is made.

In relation to the mother's capacity to parent the boys, during the currency of the IPO, the mother attended at witness 14's rooms on three occasions for a psychiatric assessment to be conducted. However, she did not at that stage agree to ongoing psychotherapy. Since November, 2006 she has been seeing witness 15 who sees her role as being empathetic towards the mother and assisting her with stress management techniques.

Concerns have been raised by witness 4 and witness 14 in relation to the need for the mother to engage in psychotherapy and the support the mother will require to provide for the boys' needs. Save for one brother, the mother does not have any family support.

In general, the mother presented as someone who was prepared to accept support and who had a number of supports already in place, namely TM and JD. The mother gave evidence that if the boys were returned to her care, she would have more contact with the community supports and have more help than before. She said she would accept the help albeit that she demonstrated a reluctance to be, it would seem in her eyes, a burden to others; for example, she said she would not ask TM to be a respite carer.

[147] Exhibit AP

The mother gave evidence that she has stable accommodation and that the boys' bedroom is set up ready for them to return home.

Whilst I have expressed some concerns in relation to the mother's dealings with HITH, it seems to me that her desire to have her boys returned to her care means that she will do "whatever it takes". This was demonstrated by her preparedness to now engage in psychotherapy.

Although the mother was able to describe an appropriate daily routine in which she engaged with the boys when they were in her care and the evidence from all of the health professionals who saw the boys was that apart from the lesions, the boys were developing well, the mother may also have to acknowledge that if it is in the boys' best interests, respite may be required.

In addition, witness 5 referred to advising the mother on 11 December 2006 that there was no need to boil milk for the boys and that they did not require formula milk for any medical reason. The mother will be required to follow the medical advice she receives in relation to the boys' health.

- **Access arrangements between the child and the child's parent and siblings (s.10(3)(k))**

I have previously detailed the commitment the mother has demonstrated to attending access. In addition, witness 17 gave evidence that the mother brings appropriate provisions to access and engages in appropriate play with the boys. The protective worker also gave evidence that positive relationships have been demonstrated at access between the mother and the boys.

The access regime is extremely limited and in order to promote the attachment between the mother and the boys given their age, witness 4 gave evidence that if possible there should be a daily access but that it is the quality time rather than the absolute period of time that was important.

The evidence of witness 14 was that the children need to see their mother as much as possible to enhance their attachment and bonding with her. She did not consider daily access to be too much. Both witness 4 and witness 14 agreed it would be appropriate for the children to see their mother for a short period of time unsupervised.

The boys do not currently have access with their half sibling, N. Witness 17 had raised the topic with the mother but did not pursue it due to the mother's sensitivity in relation to the matter. The mother's evidence was that she did not know how to explain to N why the boys are not in her care. She tries to see N every weekend.

- **the possible harmful effect of delay in making the decision or taking the action (s.10(3)(p))**

Ms Buchanan submitted on behalf of the DHS that a staged reunification would create uncertainty for the boys. She submitted that given the long term counselling the mother needs to undertake, interim orders are not appropriate. She further submitted that a Custody Order would be appropriate as it would allow goals on a case plan to be developed for the mother to address.

In the Addendum Report dated 22 August 2006[148] the following is stated that

> "…… it has been assessed that it is not in CR's and KR's best interests to be reunified to their mother's care. The Department intends to locate a suitable permanent carer for the children by exploring suitable carers ……"

Consistent with this draft stability plan is the Department's recommendation that access be reduced to two days per week for a total of two hours.

I do not consider it is in the boys' best interests for access to be reduced. I accept the evidence of witness 4 and witness 14 that in order to promote the relationship between the boys and their mother greater access is required.

[148] Exhibit AF

Nor do I consider it is in their interests for reunification not to be pursued.

Any further delay in working towards reunification, given the boys have now been out of the mother's care for 15 months, would not be in their best interests provided of course that the supports are available to ensure that their wellbeing is promoted and they are protected from harm.

ORDER

The IAO to the current carers will be extended and varied. I will hear from the Parties in relation to the variation of the access condition, enquiries which have been made by DHS concerning appropriate support services, arrangements in relation to further medical tests being conducted in respect of the boys as referred to by witness 19 and whether a suitable psychotherapist has been located.

ACKNOWLEDGEMENTS

These proceedings have been protracted and complex. I would like to acknowledge the assistance of counsel during the proceedings and in particular Ms Buchanan and Mr Brown for their detailed written submissions.

Jennifer Bowles
Magistrate
22 February 2008

Diagnoses Made and Treatments Provided by Medical Professionals to
CR and KR
30/11/2005 – 04/10/2006
Schedule One

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
30.11.05	Witness 6	**CR** presented with bacterial conjunctivitis (one week of age).	Bacterial conjunctivitis	NIK
05.01.06	Witness 6	**CR** presented with a mild discharge from his right eye. He had a small amount of skin from his umbilical cord tagged		Described as 'otherwise healthy'
28.02.06	Witness 6	**CR** (3 months of age) presented with 'an infected sore near the right ear lobe'.	witness 6 did not consider CR had impetigo	Amoxil prescribed.
25.03.06	Witness 6	**CR** presented with a runny nose.		Amoxil.
10.04.06	Witness 6	**CR** presented with school sores or impetigo on his cheek and leg. witness 6's notes did not refer to the right ear lobe	Impetigo lesions.	EES (antibiotic). witness 6's evidence was that impetigo is highly sensitive to EES. The antibiotic was to be administered for approximately one week.
		KR presented with school sores or impetigo. witness 6 did not include in his notes details of the part/s of the body affected.	Impetigo lesions.	As above
27.04.06	Witness 6	witness 6 did not specify the location of the school sores on **CR**.	Persistent impetigo/staph infection. (Referral letter to RCH *EX "AM and "AN"*)	Referral to the AED of the Royal Children's Hospital.
		In relation to **KR**, witness 6's notes indicate impetigo sores "still on" KR's trunk and limbs and not responding to EES.	As above	As above. It would seem that witness 6's reference to **KR** having sores on his trunk is inaccurate given that it was not until March 2007 that there has been any evidence of sores on either boys' trunk.
27.04.06	Triage Nurse RCH	**CR** – "lesions to the left forearm, right ear and both legs"		
27.04.06	Doctor (name not	**CR** – "started on **CR's** nose but healed, now over cheeks and legs. Recent upper	?deep impetigo	Flucloxacillin and Bactroban ointment, antiseptic wash, soak lesions, swab and

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
	specified)	respiratory tract infection". Annexure 1includes a diagram and the notes prepared by the doctor. The diagram indicates one lesion under and one lesion behind **CR's** right ear and two on his face to the right of his nose. "scabbed *(indecipherable)* right cheek < 1 cm not confluent". Circular ulcers (three of varying sizes on one leg and two on the other leg) were drawn on the diagram of **CR's** two legs. The notation was "circular ulcerated areas up to 3cm diameter over thigh and shins. None on feet".		dermatology review. (The swab taken on 27/4 indicated a small amount of Staphylococcus Aureus (SA) resistant to penicillin but sensitive to Erythromycin and Flucloxacillin).
27.04.06	RNN	**CR** – Lesions legs, head.	? ecthyma – deep impetigo	
27.04.06	Triage Nurse	**KR** – "lesions to face and right thigh"		
27.04.06	Doctor (name not specified)	**KR** – Starts as scratch or small spot then becomes a scabbed crusted lesia which gets larger. Ends as ulcers. No vesicles or *bullous* No *(indecipherable)* bleeds if picks off scab. The diagram (Annexure 2) indicates two lesions on the right side of **KR's** nose being one to the side and one below his nose. There was one ulcer depicted on a diagram of **KR's** right thigh. It was described as "3cm diam. Ulcer right mid thigh, dry crust, flat edges 1-2 *erythematous* rim. No regional adenitis" .	? deep impetigo	As above. (The swab taken on 27/4/06 was described as a 'skin ulcer swab'. Unlike the swabs taken from **CR**, no organisms were cultured after 2 days).
27.04.06	RNN	**KR** - Lesions legs and head	Appearance O/W impetigo ?echthyma as lesions are deeper, well circumscribed lesions legs head.	

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
03.05.06	Dermatology Review Witness 13 Dr S	Dr S prepared the file notes. witness 13 and Dr S examined the boys. **CR** – Dr S's notes (Annexure 3) indicated "onset rash 2.5 months ago under nose spread to involve right ear, left side of face, right leg. Red lesions with yellow crusts tried before 27/4 one month Amoxil. Improving on Flucloxacillin/Bactroban". The diagram prepared by Dr S indicates 2 small dry red lesions on his face, 2 dry lesions one behind and one below his right ear, a 3 cm linear dry red lesion across his right wrist (dorsum), scab, no exudate. Lesions on his right and left legs. The right leg had a dry 2cm lesion above the knee; 1.5 cm red moist lesion on right shin, moist bleeding lesion on right shin, small scab behind right (query if should be left) ankle. In relation to his left leg 1.5 cm moist lesion on thigh. In relation to his left leg, 1.5cm moist lesion on thigh.	Impetigo and discoid eczema (given widespread distribution)	- The reference to Amoxil in Dr S's letter to witness 6 and on the RCH file is inaccurate. witness 6 had not prescribed Amoxil for the lesions. - Topical Elocan (body) and Sigmacort to lesions. - Complete 10 day Flucloxacillin. - The treatment plan on RCH file also indicates Bactroban was prescribed. - The letter dated 3/5/06 from Dr S to witness 6 (EX"O") states "**CR** certainly has impetigo….However, the widespread distribution makes a diagnosis of discoid eczema also likely". A comparison of the diagrams drawn on 27/4 and 3/5 would appear to indicate that as at 3/5 **CR** presented with a reduction in the number of lesions on his face and legs and the addition of the right dorsum wrist lesion. Review in four weeks. Mum to cancel if resolved completely.
03.05.06 03.05.06 (cont'd)	Dermatology Review Witness 13 Dr S	**KR** – Dr S's notes (Annexure 4) indicated "twin brother started with rash below nose 2.5 months ago. 3-4 weeks later **KR** also developed rash below nose, spread to involve right side of face and right leg. Lesions red with yellow crust 'and erythema surrounding.. Tried before presentation to ED Amoxil one month. Dilute dettol nocte Barrier cream. Improving since started on Flucloxacillin/Bactroban. The diagram indicated dry red circular lesions with scab on his face (two under his nose, two to the left side of his nose and two on his forehead), and two lesions on his right thigh being 2cm and 1cm	Impetigo and discoid eczema (given widespread distribution)	The reference to Amoxil is inaccurate. witness 6 had not prescribed Amoxil for the lesions. Topical Elocan (body) and Sigmacort to lesions, Flucloxacillin and Bactroban. The letter dated 3/5/06 from Dr S to witness 6 (EX "P") states "He certainly has Impetigo but also discoid eczema given the widespread distribution of his lesions". A comparison of the diagrams drawn on 27/4 and 3/5 would indicate that **KR** as at 3/5 presented with four additional red circular lesions on his face and an additional one centimetre lesion on his right thigh. The other previous right thigh lesion had been described

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
		lesions respectively dry, red scab, no yellow exudate on right thigh.		as 3cm diameter. Dr S's diagram indicated 2cm diameter. Review in four weeks. Mum to cancel appointment if lesions clear.
14.05.06	AED RCH Dr P	**CR** – two to three months of severe impetigo right face, both legs and left arm. No improvement last two weeks on Fluclox and steroid topically. Last 2 days surrounding *erythema* and multiple vesicles had appeared. "Punched out impetiginous lesions with vesicles and *erythema* lower limbs"	Chronic impetigo ?HSV component.	Swabs indecipherable and a viral culture were requested. A few pus cells and Staphylococcus Aureus was cultured and the virus HSV 1 was detected in sample taken 14/5/06. A biopsy was taken from **CR's** right thigh. Granulomas were not seen and there was no obvious infective organisms nor was viral inclusion in the bodies seen. Commence aciclovir and cease Flucloxacillin
		KR – two to three months of severe impetigo right face and right leg. Last two weeks on Flucloxacillin and full topical steroids. Little improvement last four days. ↑Full *ecthyma* and multiple vesicles had appeared. Punched out facial impetigo and large right thigh lesion.	Chronic impetigo ?HSV component	Swabs *indecipherable* and a viral culture were requested. SA was cultured and HSV 1 was detected in samples taken 14/5/06
14.05.06 14.05.06 (cont'd)	Witness 1	**CR** – "very unusual" Each of two twins has about 8 to 10 irregular somewhat circular dry ulcers approx 1-2cm diameter, sites face, wrist, legs – mainly calf/thighs. Deeper than expected with chronic impetigo. Both kids started with lesions under nose. Last 4 days surrounding redness and vesicles on several areas. Appearance – surrounds appear herpetic. Central ulcers c/w indolent HSV ? immuno-compromised. Dr Bultery ordered a number of tests to be performed. Patients back here 11.00am tomorrow emergency.		

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
		KR – As above		
15.05.06 (first admission)	Dr (name removed) (Paed. Reg)	**CR** – Skin deep crusted lesions around R ear, L heel, Knee, R ankle, thigh, L *indecipherable* surrounded by the group of vesicles of different diameter		I/V Aciclovir (antiviral) I/V Flucloxacillin (antibiotic) Panadol Dermeze – face lesions – from 18/05/06 and comfeel to the ulcerated areas.
15.05.06	Dr P	**KR** – Lesions worse HSV confirmed.		As above At some stage **CR's** (query on **KR's** file) needs punch biopsy from anterolateral edge of ulcer.
16.05.06 16.05.06 (cont'd)	Dr W	**CR** – " interesting clinical presentation"	Possibilities include :- • Primary bacterial infection (chronic) with acute HSV super-infection. • Primary HSV infection (chronic) with exacerbation by steroid treatment. Additional possibility:- • Immunodeficiency	- Continue treatment - Number of tests recommended - Punch biopsy taken from **CR's** right thigh. In the clinical notes ?Primary HSV ulcers <u>Diagnosis</u> – Inflammatory ulcer Witness 2 stated that specimens were taken from the lesions thought to be typical HSV. The tests confirmed HSV. One of the other lesions thought not to be HSV was biospied. The ulcer was quite sharply defined without a lot of inflammatory infiltration at the base. The typical features of HSV were not seen in the ulcer. Other infective agents were looked for e.g. fungus – Negative. No infectious organisms seen. No viral inclusion bodies.
16.05.06	Witness 1	**KR** – "interesting pair of infants' 'the ulcers are unusually broad'		- continue treatment - - Number of tests recommended
18.05.06		**CR and KR**		Blood sample taken from the boys. (Full blood examination across 15/5/06, 18/5/06,04/10/06). Hep C antibodies not detected. .
22.05.06 (Discharged	Witness 5	**CR and KR**		Both boys:- • Oral acyclovir and clindamycin (3 days

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
from hospital)				and 10 days respectively.) Plastics and plagioceptaly clinic review • No photographs on discharge. The nursing entry "any current lesions are healing well".
05.06.06	Witness 5	**CR** – "herpes simplex. No new lesions. Improving but not completely healed'		- Dermatology review. - Swab taken on 5/6/06 from **CR's** right foot grew profuse SA.
		KR – "Herpes simplex/Staph skin lesions. I*ndecipherable* Lesions healing but *indecipherable* still quite deep on scalp".		- Dermatology nurse to review. - Swab taken on 5/6/06 from **KR's** left leg grew profuse SA. - A nose swab from **KR** also grew SA (scanty).
05.06.06	EK Dermatology Nurse	**CR** – "deep ulcerated discoid lesions to face and legs and arms, well, thriving, feeding well, no fevers. Lesions have not cleared. HSV lesions cleared" "Current treatment - ?duorderm dressing over ulcerated lesions – changing 3-5 days….dermeze to face bd QV bath oil in bath; QV cream to body bd".	? infective cause ? artifacta	
5.06.06	EK Dermatology Nurse	**KR** – deep ulcerated discoid areas to scalp, **R** ear, **R** cheek, below nose, legs. Well thriving, feeding well, no fevers. Areas where HSV was have cleared. Lesions have not cleared since initial consult.		Spoke to witness 13. Review him Wed 7/6. Remove duoderm dressings Swabs taken Photos need to be taken. Keflex remove crusts.
07.06.06	Derm. Review	Mother did not attend		Discussed with witness 5 and witness 13. Rebook for witness 13's clinic Wed 14/6/06. Re-evaluate situation then with witness 5 and witness 13.
14.06.06	Dr (name removed) (Dermatology)	**CR** – *Granulantave* ulcers predominant extremities, also face onset 3 months of age….persisting despite RX, seen by Paed/Immunology	?Immunodeficiency disorder ?*Granulamatous* disease	Repeat biopsy of one lesion. Multiple buc and viral swabs. D/N immunology Repeat immune function tests. Review Dermatology in one week.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
		?cause		The histology of the biopsy taken on 14/6/06 was not too different from the previous biopsy. (witness 2 witness 13) There was no evidence of any infective organism or any other cause. witness 2 suggested whether there was a mechanical factor due to the sharply defined edge. The swab taken on 14/6 from **CR's R** lower leg grew a small amount of SA.
14.06.06	Dr (name removed) (Dermatology)	**KR**- "presenting with well circumscribed *granulomatous* ulcers on face and predominant extremities". A/B witness 13 and Dr (name removed). Onset 3 months of age….not resolving. Brother similar lesions	?cause ?Immunodeficiency disorder	D/W Immunology – Immune studies NAD in part. **Plan** – repeat immune function studies. Biopsy of lesion from brother **CR**. Swabs taken for micro/virology. Review in one week. - The swab taken on 14/6 from **KR's R** nasal lesion and **R** scalp lesion grew profuse SA. - No virus was detected from **KR's R** thigh ulcer.
26.06.06	Witness 5	DNA – but had attended dermatology 14.6.06		
03.07.06	Dermatology Nurse	DNA		
10.07.06	Witness 5	DNA		witness 5 contacted someone else – perhaps social worker (note on CR's file)
04.08.06	Social Worker RCH			Spoke to the mother re her failure to attend on 3/7/06. She said the boys' skin had been improving and she had been receiving regular visits from MCHN. Social worker spoke to MCHN who stated the mother had been caring for the skin wounds well and there appeared to be some improvement but she was keen to have further discussions with RCH to work out a plan to manage the wounds. She said the mother had felt she had been given conflicting

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
				information from RCH and had not been given the assistance to manage the wounds.
17.08.06	Witness 6	**CR**		**Urgent** referral to AED RCH (Referral letter for **CR** not located. On **KR's** letter there is a handwritten entry 'and CR'.
		KR – the sores on his head and face are much worse again.		**Urgent** referral to AED RCH. Referral letter states, "they will need further admission re the problem for more antibiotics".
17.08.06	Triage Nurse	**CR** – skin disorder same as twin brother. Treated here last May for chronic impetigo and HSV. Sent in by GP as other twin's condition does not seem to be improving. Lesions on face & also neck (dressed). Mother states they are all improving.		
17.08.06	Doctor – AED(not named)	**CR** – Lesions **L** face; **R** below ear; **R** arm; **L** wrist; both legs. *(indecipherable notes)*	? Dermatitis Artifacta?	- Discussed with witness 5. Agrees admission and dermatology review. - Right thigh ulcer swab taken 17/8/06 – many pus cells, few cocci, moderate SA. - Skin swab – HSV not isolated -
17.08.06	Triage Nurse	**KR** – skin disorder sent here by GP. Had been treated here at RCH for chronic impetigo and HSV infection. Discharged in May. Mother states the lesions on his legs have improved but no improvement on the ones on his face. Large lesion above right side of top lip and another on scalp (dressed)		
17.08.06	Doctor – AED (not named)	**KR**- Ongoing skin rash **R** upper lip; **R** head; legs; foot; ?getting worse, weeping. Bathing in Pinetarsol Dermesse *(indecipherable)*	? *indecipherable* ?Artifact	- Dermatology Review - Bacterial and viral swabs to ulcer taken. - **R** forehead ulcer swab- no pus cells, few epithelial cells, no bacteria seen moderate SA. - Skin swab – HSV not isolated. - **R** foot swab – HSV, isolated.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
				- **R** foot ulcer – many pus cells, nil epithelial cells, moderate SA. - Scalp swab – HSV not isolated. - Head ulcer swab – many pus cells, no epithelial cells, few gram positive cocci, moderate SA.
17.08.06 17.08.06 (cont'd)	Witness 16	**CR** – numerous non-healing chronic ulcers. - History from mother – lesions appeared when twins were about 3 ½ months old. Started as red areas that broke down to ulcers. - May admission – diagnosis chronic impetigo with HSV infection and staph. - Managed at home for about 3 months before seeking medical attention at RCH via GP. - Numerous ulcers over body in various stages of healing. Only one healed scar. - Skin away from ulcers looks normal - No shearing with rubbing - Nil bruises - Nil rashes/discolouration. - Lesions confined to face and limbs not trunk. - Right superior thigh – purulent slough. -Witness 16's diagram of the ulcers is Annexure 5.	- Dermatology review consistent with Dermatitis Artifacta i.e. mechanical injury. - Discussed with witness 5. Significant concern that these wounds are inflicted but it is not clear cut. Over last five months there has been no increase in wounds, no new wounds; ?Munchausen by proxy NAI deliberate	- Lesions swabbed for bacterial and viral m/c/s Each lesion covered with bactigra gauze melolin and mefix. - Hands bandaged. - Need Gatehouse involvement to advise. - Leave dressings intact. - Leave hands bandaged. -Careful attention not to mention NAI to the parents. - Advise the mother and K if they leave we will have to notify DHS and Police, as the twins need hospital care. - Will need Gatehouse paediatrician input tomorrow - Contact witness 5 if threatening to leave. - If twins are removed from the ward to contact Gatehouse and Police.
17.08.06	Witness 16	**KR** – numerous chronic non-healing ulcers presents for wound care. - Approx 3 ½ months old started getting 'red marks that would turn into these ulcers'. Outpatient treatment by GP for about 3 months before to E.D. - Admitted to GMB under witness 5 15/5/06 – 22/5/06. Diagnosis – impetigo with secondary HSV super-infection. - According to mother lesions appear as red mark, then turn into ulcers. - All lesions present now have been	<u>Dermatology review</u> – consistent with Dermatitis Artifacta i.e. mechanical injury. - Discussed with witness 5. Significant concern that these wounds are inflicted - ?Munchausen by proxy. - ? NAI - Not clear cut NAI over the last 5 months no increase in wounds - No new wounds	- Lesions swabbed for bacterial and viral m/c/s. - Clinical photography taken. - Each lesion covered with bactigra gauze, melolin and mefix. - Leave dressings intact tonight. - Bandage hands to prevent KR removing dressings. - Gatehouse notification tonight for advice tomorrow. - Careful attention not to mention NAI to parents as yet.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
17.08.06 (cont'd)		present since KR was abut 3 ½ months old according to mother - Will begin to heal to a stage of having thin layer of new skin then without being covered will break down again. - <u>None</u> of the lesions have healed in the entire time - Well looking except for numerous ulcers in various stages of healing. - Lesions confined to scalp, face and limbs. None over trunk. - <u>Scalp lesion</u> – deep, pink granulation tissue, yellow green slough, swabbed for bacterial and viral m/c/s, not cellulitic. - <u>R sole of foot</u> – deep slough filled, not cellulitic, swabbed for bacterial and viral m/c/s. - Witness 16's diagram of the ulcers Annexure 6. - No other bruises or lesions noted. - **R** knee – unable to passively extend knee - ? from skin lesions ? old injury		- Call witness 5 if threatening to leave. - If KR and CR are removed from the ward Gatehouse and Police are to be notified tonight. - If mother wishes to remove twins from ward overnight, contact Gatehouse intake nurse
17.08.06	Dermatology Review (*Illegible*, Moyle, Lim)	**CR** – multiple ulcers <u>unchanged</u> since *few (query four)* months ago.	Addition – appears consistent with dermatitis artifacta.	- History of HSV infection May/June '06. - Twin's (brother's) ulcers (similar lesions) biopsied – thought to be non specific. ?trauma. - Multiple previous swabs of ulcers SA – scanty to profuse. - Rx Flucolacillin - Current treatment of ulcers – Dermeze, illegible, bandage. - Clean with cotton bud/Pinetarsol. **<u>Plan</u>** :- - Stop pinetarsol - Non stick dressing. - Swab m/c/s (don't look infected at this *illegible*) of ulcers. - Photos again. **<u>Swab results</u>** (taken 17/8/06) **R** <u>thigh ulcer</u> – many pus cells, few cocci, moderate SA cultured.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
				Skin swab – No detection HSV
17.08.06 17.08.06 (cont'd)	Dermatology Review (Illegible, (names removed)	**KR** – Multiple ulcers unchanged since few *(query four)* months ago.	Addition – appears consistent with dermatitis artifacta.	- Previous biopsy x 2 – thought to be non-specific. ?trauma. - History of HSV infections May/June '06. - Multiple previous swabs of ulcers. SA scanty to profuse on multiple swabs. Rx with flucloxacillin. - Current treatment of ulcers – Dermeze, illegible, bandage. Clean with cotton bud/pinetarsol. **Plan** :- - Stop pinetarsol - Non stick dressing. - ?reaction to elastoplast. Avoid. (try *micropare instead*). - Swab m/c/s (don't look infected at this *illegible* of ulcers). - Photos again **Swab results**:- **R** forehead ulcer swab – no pus cells, few epithelial cells, moderate SA cultured. Skin Swab – no detection HSV. **R** foot swab – HSV1 isolated. **R** foot ulcer – many pus cells, nil epithelial cells, moderate SA cultured. Scalp swab – no detection HSV. Head ulcer swab – many pus cells, no epithelial cells, few positive cocci, moderate SA cultured.
24.08.06	Dr (name removed) (discharge summary)	Discharge – **CR**	- Non healing skin lesions. - Unknown cause. - Likely non-healing due to mechanical trauma.	**CR** discharged. HITH support :- - Twice daily dressing reviews and support. - For second daily dressing changes with bactigra, melolin and mefix. - Written instructions for mother on caring for wounds. **Follow up** - Review Gen. Med B in 10 days. - Review in Dermatology Clinic in one week.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
				- Repeat neutrophil function tests and karyotyping next Tuesday as per immunology. (Dr (name removed) Discharge Summary). [- Noted in discharge summary that the immunology team asked for neutrophil function testing to be performed. Unfortunately the sample clotted and will need to be repeated].
24.08.06	Dr (name removed)	Discharge – **KR**	- Non healing skin lesions. - Unknown cause. - Likely non-healing due to mechanical trauma.	KR discharged. Discharged home with HITH For twice daily reviews to replace undone bandages. For second daily changes with bathing. For bactigra, mellolin, and mefix. **Follow up** Review GMB outpatients in 10 days. Dermatology review in one week. For repeat neutrophil function tests and chromosomal karyotyping (on a Tuesday) (Dr (name removed) Discharge Summary).
04.09.06	Witness 16	**CR** - Wounds all healing satisfactory. - No new wounds. - No wound worse than discharge.		**Plan** - Blue desk now for recovering of wounds. - Bactigra on wet wounds. - Melolin. - Mefix over the top. - HACC visits to once per day. - Review next Monday (11/9/06) GMB clinic.
04.09.06	Witness 16	**KR**. Wounds healing satisfactorily		**Plan** - Blue desk for re dressing now. - HACC visits to once a day. - Review one week.
18.09.06	Witness 16	**CR** - Wounds had been progressively healing up to withdrawal of HACC last week (some wounds were static however and a few worsened) but most were slowly		- HACC withdrew visits last week. Mother doesn't want us here, Mother is often not there when we visit, mother is able to do the dressings herself. - The mother stated the boys were crawling a

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
18.09.06 (cont'd)		healing. **Today** - Wounds only partially dressed. - Most on thighs not dressed. - New scratch on nose and lateral to L eye. - All wounds larger in size than last review, pink granulating at base. -Some have adherent dressings. -Important significant worsening since HACC withdrawal last week.		lot and she did not have enough money for dressings for all the wounds. **Plan** Photographs. Admit to ward. **Addition** - No beds. - Will admit tomorrow. (Inpatient procedures to be performed [when admitted] - Wound care - Immunology review - Dermatology review) Wound swab – normal bacteria.
18.09.06	Witness 16	**KR** Wounds - All significantly more ulcerated since last seen 4/9/06. - Superficial but larger diameter wounds. - Wound on head significantly more ulcerated and deeper. - No evidence cellulitis any of ulcers, no evidence HSV super-infection. - Important – significant worsening since withdrawal of HACC visits last week.		- Hospital in the home ceased visits last Thursday. - From Thursday until now the mother states she has been dressing the wounds with Mellolin she bought from a chemist. - When asked for an explanation as to why the wounds were worse "They have been crawling, they rub the dressings off". **Plan** - Photographs - Admit to ward for review by Dermatology and burns nurses re long term dressings that could be put on and left on for one week, so wounds cannot be aggravated by any means. Additions - Photos done - No beds available. - Will try for bed tomorrow - For repeat neutrophil function tests and karyotype tomorrow as per immunology. - See **CR's** file for more history. (Inpatient procedures to be performed – [when admitted] - Wound care - Immunology review - Dermatology review) Wound swab – normal bacteria.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
20.09.06 20.09.06 (cont'd)	? *Illegible* signature	**CR and KR**		- Mother brought **CR and KR** to see witness 3 re dressings for multiple lesions. - Witness 3 applied Mepilex (lite) to all areas and then covered with Mefix. Nose and face lesion having intrasite gel x 6 times a day. - HACC will visit mother on Friday (22/9/06) - Mother to bring both children in next Wednesday (27/9/06) for further dressings. - Mother happy with this plan.
20.09.06	Witness 16	**CR and KR** Note:- Wounds on **CR's** tip of nose and beside L eye larger and deeper than when reviewed on Monday. the mother stated she thought **CR** was scratching them. No purposeful scratching by **CR** noted over more than one hour.		- Wounds dressed as above with a dressing to be left intact for one week. - Explained to the mother to leave all dressings intact for the whole week with sponge baths as needed. - the mother not to remove dressings for baths.
25.09.06	Witness 16	**CR and KR** - Contacted by HACC nurse manager Kim. - HACC nurse observed all dressings were down on Friday (22.9.06)		- (Name removed) said they will no longer go to see the (name removed) twins as the mother has been obstructive and abusive towards them on Friday 22.9.06. - (Name removed) said the mother had given conflicting stories on why the dressings were off. Witness 16 to clarify this. - HACC nurses redressed the wounds. - Twins due to see Witness 3 on Wednesday 27.9.06. - HACC did <u>not</u> contact any member of General Medical Team B on Friday as it was out of hours. **<u>Clarification</u>** – After discussion with HACC liaison Nurse (name removed), HACC Nurse (name rem'd) saw twins on Friday. Notes by (name rem'd) state that the mother had said the dressings just fell off. All dressings were off. - Dressings of Bactigra, Mellolin and Mefix

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
25.09.06 (cont'd)				re-applied and appointment made for Monday. - This morning (Monday) the mother stated, when called, that she didn't want anyone to come to see her. **Note** – Dressings were applied on Wed. 20.9.06 with hyperfix, a very durable dressing that does not come off easily even when wet in the shower. **Important** – Concern the mother deliberately did not follow medical advice re dressings despite clear verbal instruction, to the detriment of the healing of the twins' wounds. - Contacted Gatehouse – re admission advisable. - DHS notification. - Contacted witness 5 – His opinion is that the wounds have shown to heal when inpatient and worsen when the mother has sole responsibility for the boy's dressings. He feels the boy's best interest is to be admitted for medical care and DHS involvement. - Discussed with witness 1. Twins to be admitted tomorrow.
27.09.06	Witness 3 (Stomal Therapist)	**CR**		- Review wounds – they do not appear infected or improved, angry and red – some slightly deeper. **Plan** - Mepilex lite to all wounds covered with Mefix tape. - Leave intact for 5 to 7 days.
27.09.06	Witness 3 (Stomal Therapist)	**KR**		Review wounds – they do not appear to have improved. They do not look infected but are red and some are slightly deeper. **Plan** - Mepilex lite to all wounds covered with Mefix tape. - Leave intact for 5 to 7 days.
27.09.06	Meeting :-	**CR and KR** - Wounds today appeared more red and		Witness 1 said there was a need for the boys to come into hospital today as the wounds

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
27.09.06 (cont'd)	Drs (names rem'd); Care Manager (name rem'd), witness 3	aggravated tody than last Wednesday. - Lesions on **CR's** face are larger and deeper than last week. All other lesions on both **KR** and **CR** do not appear larger but will compare photography.		have shown to get worse at home after healing in hospital. Witness 1 said he wanted to find the answers to the following questions:- 1. Is there any more investigations for immune function tests required. LAD CD markers would be needed as well as repeated neutrophil function tests. 2. Are there environmental factors at home preventing healing? 3. Are the wounds being aggravated deliberately? **Plan** - **CR and KR** have had long term 5-7 day dressings applied. They will be admitted today until the above questions are answered and DHS investigation complete.
27.09.06	Dr (name rem'd)			- Summary of the history of the matter. - The appearance does not suggest vesicles (blisters). - The appearance does not suggest either herpetic or bacterial infection. - The surrounding skin is normal without evidence of exscoriation. - There were no dressings in place on review this morning. - The children have not been observed to scratch lesions/skin. **Plan** - *Illegible* - Concerns around inflicted injury. - Swabs taken. - Stomal therapy dressings - Dermatology consult. - Immunology consult..
27.09.06	Witness 13	**CR** and **KR**	Traumatic (non-accidental injury)	"It is becoming increasingly difficult to see any other cause other than traumatic injury. Both biopsies have shown no inflammatory or any infective disorder. No cultures have grown any pathogens. No immunological

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
27.09.06 (cont'd)				tests or other clinical signs have shown there to be any underlying pre-disposition. As well significant healing occurred with dressings alone when supervised in hospital. This would not be expected to heal infectious or inflammatory processes such as discoid eczema or pyoderma gangrenosum. Particularly if healing occurs again during inpatient stay, the only conclusion that can be drawn is that of traumatic (non accidental) injury."
27.09.06 27.09.06	Witness 1	**CR** and **KR**	Concerns re: possible Dermatitis Atifacta.	"As noted recurrent / relapsing ulceration that improves on impatient stay but deteriorates at home. Inflammatory / ineffective / immunological investigations largely unremarkable apart from initial swab + staph aureus and HSV on initial admission. Due to concerns re: possible Dermatitis Artefacta, poor compliance with HITH visits and unexpectedly early loss of recently applied long-term dressings, I have discussed with the mother that both **CR** and **KR** require admission for inpatient assessment and management including investigation of: - rare and unlikely immunological causes - possible traumatic causes of ulcers I have notified the mother that the boys are not allowed off the ward without direct supervision by a staff member. If she does remove the boys from the ward against advice I have informed her, I will notify protective services (DHS). I have discussed with the mother and her friend K the above again this evening. Both are upset at the thought that we could be considering recurrent trauma as a possibility,

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
(cont'd)				with K denying this as a possibility of the mother being involved in any trauma. I have discussed that we are sufficiently concerned regarding the boys' welfare without knowing why the lesions deteriorated at home that we need to investigate all possible causes.
28.09.06	Witness 1	**CR** - Normal scabs over exposed lesions….sitting unsupported/ rolling….multiple unexplained areas of ulceration. - Exposed ulcers with evidence of normal scab today (see photographs from yesterday). - Nil other evidence of trauma or underlying immune/ skin disease.		**Plan** - Full IX - social/ Gatehouse/ notify DHS/Q ref - immunological - not to leave ward without supervision until further investigations.
28.09.06 28.09.06 (cont'd)	Witness 1	**KR** - Most ulcers dressed. - exposed ulcers with fresh scab - standing holding on		- Admitted yesterday due to persistent concerns re: recurring / relapsing ulcers of skin in both KR and twin CR. - Further deterioration at home of skin ulcers without cause known. - poor compliance with HITH appointments. - improvement in ulcers during 2 previous IP stays. - BX no inflammatory skin disease. - see also notes of Dermatology. - Insufficient explanation for recurrent ulcers that improve in hospital IP stays and deteriorate at home. - Plan – complete immunol. IX - further Derm. opinion. - Gatehouse / DHS / SW - not to leave ward without supervision until investigation.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
29.09.06	Witness 16	**CR** - Dressings all intact. - lesions on face now have a formed scab with some evident decrease in size of the lesions. - well in himself. - smiling, playing.		- Immune function tests pending from 27/9/06. 15% of neutrophils showed different function to others but overall function normal - urine drug screen from 27/9/06 pending. - wound swab 18/9/06 – scanty skin flora only. - DIW witness 7 Gatehouse paediatrician. He will contact DHS to help facilitate investigation by DHS and raise the issue of need for temporary protection order of supervision of the mother while she is in hospital with the boys. **Plan** - ERC photography - leave dressings intact - document any need for repairing / reinforcing dressings over the day to see if dressings are easily rubbed off during play etc.
29.09.06 29.09.06 (cont'd)	Witness 16	**KR** Sleeping at r/v - all dressings intact - afebrile and obs. stable.		- D/W witness 7, Gatehouse Paediatrician. He will contact DHS to facilitate their investigation and raise need for supervision by DHS of the mother's visits and temporary protection order. Plan -ERC Photography today to document healing. (immune function tests pending from 27/9/06 – 15% of neutrophils showed different function to others but overall function normal).
30.09.06	Dr (name rem'd)	**CR** – remains well and happy. - indecipherable healing of facial lesions……looking scab and healing. No infection. - other dressings left in situ – has been ~~picking~~/rubbing running at one dressing on right hand. MX to partially remove ½		Results – Drug screens neg. - indecipherable - ? 2 populations - need *chromosome (query)* testing at some point. - DHS / Gatehouse involved.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
		dressing in 3/7 only. (lesion underneath healing beautifully).		
30.09.06	Dr (name rem'd)	**KR** – remaining well and happy. Eating well. - marked healing facial lesions (intrasite) rapid resolution….looking scab no evidence infection. - other dressings not taken down as per stomal RX		Results – Drug screens negative - wound swab scanty skin flora 18/9 and 27/9 -.. normal - LAD markers normal - Plan - continue - await DHS … prosecution AX as per MR53.
01.10.06	Witness 1	**CR –** - Well - some smelly dressings - exposed lesions continue to improve		- Remove smelly dressings and leave open.
01.10.06	Witness 1	**KR** - well - some dressings smelly		- Removal of smelly dressings and leave open.
02.10.06	Dr (name rem'd)	**CR** - Well - lesions healing		- ERC photos to document healing - stomal RV - scan at 1600
02.10.06	Drs (names rem'd)	**KR** - ulcers healing very well. - happy playful**.**		- For (witness 3) stomal therapy r/v - ERC photos to document healing. - Witness 3 to r/v
02.10.06 02.10.06 (cont'd)	Stomal Therapy	**CR** – RIV of dressings (some only) - Bactigras and meloin in situ on R upper foot removed. - Wound healing well dry with scab**.**		- Other dressings need to be taken down after ma's visit for photographs and cleaned with N/S. – Suggest mepilex lite and mefix dressings.
02.10.06	Stomal Therapy	**KR** – R/V of wounds. KR's R thigh. - some of the areas are drying out and improving but several are still sloughy - Not all dressings taken down as Mother here for a visit.		- Dressings to be removed prior to photography and then cleaned (N/S) and re-dressed with mepilex lite and mefix over the top. - supplies of dressing left.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
03.10.06	Witness 16	**CR** - Well, alert and interactive - skin wounds healing		**Plan** – D/C planning today for? d/c foster care tomorrow pending court case tomorrow
04.10.06	Witness 16	**CR** - Wounds continue to heal well - Dressings remain intact without active nursing intervention. - happy feeding well.		**Plan** - for re-dressing of wounds today by witness 3 (Stomal therapy) with week long dressings. - for blood test for Hep C, serum to hold,Li – *Heparun* to hold. Hep C antibodies not detected.
04.10.06	Witness 16	**KR** - Wounds healing well - dressings remain intact with minimal nursing intervention - happy and feeding well.		Plan – continue intrasite gel to lip - re-dressing application today by witness 3 (stomal therapist) with week long dressings. - blood test for Hep C, serum to hold *Li-Heparun* to hold. Hep C antibodies indeterminate.
04.10.06	Dr (name rem'd) (infant psychiatrist)	**CR –** Observed over meal time - CR a little more watchful and cautious than KR but does readily engage with strangers and no obvious anxiety distress. - Able to play a game with me, with his foot despite lesions on his leg – seems not distressed by these (but how does he manage dressings)		- Happy to assess further if requested by the Children's Court.
04.10.06	Dr (name rem'd) (infant psychiatrist)	**KR –** - KR larger of twins, settled today and enjoying his solids. - like **CR** he seems to show little anxiety when approached by strangers, nor anxiety about people touching his limbs. (how does he manage dressing changes?) - **KR** seems to be little discriminatory towards people. -Does respond to playful approaches from his brother (although food seemed more		I'd be happy to be involved in further assessment if requested by Court, or it is likely that the Court may order other mental health assessment.

Date	Doctor	Presentation	Diagnosis	Treatment/Comments
		important to him today) - settled not distressed.		
04.10.06		**CR** and **KR** discharged into foster care.		

Schedule 2

SUMMARY OF THE ENTRIES ON THE ANGLICARE FILE AND THE RCH FILE IN RELATION TO THE BOYS' HEALTH IN FOSTER CARE (EXCLUDING REFERENCES TO LESIONS/SORES)

19/10/06	CR's eyes appeared to have cleared up from conjunctivitis. KR had a snotty nose.
30/10/06	CR's conjunctivitis is not yet clear.
15/11/06	Boys "snuffly".
23/11/06	The carer gave the boys Panadol as the boys would be "snuffly a lot".
8/1/07	KR was vomiting and passing green liquid.
8/2/07	An Anglicare worker noted that CR's eyes looked red yesterday and the carer said he's also sniffly and wondering if he is teething again.
8/6/07	KR diagnosed with an upper respiratory tract infection.
12/6/07	The mother said CR seems to have conjunctivitis.
18/6/07	The mother said CR's eyes are red underneath. Anglicare worker noted CR's right eye was puffy and red.
20/6/07	The mother said CR's eye was still a bit red and can be seen when he closes his eye.
25/6/07	The colds are back with a vengeance. We had three clear days and we've all got head colds again. "It seems we've had more colds since having the boys than we had during the entire previous year." CR's eyes have become very irritated again and KR's

	cough is very chesty. KR's cheeks and forehead were very hot over the weekend.
27/6/07	The carer was worried about CR's eyes. They are watery and red under his bottom eyelids and look sore and uncomfortable.
28/6/07	Doctor confirmed CR has conjunctivitis.
2/7/07	KR's cough is still a little chesty. Both boys' eyes are clear. No signs of conjunctivitis.
24/7/07	The carer said over the weekend CR was ill with the flu. CR has a slight temperature.
25/7/07	KR has a slight fever. CR is still snotty and has a cough. The carer said the doctor said they had the flu. KR had a temperature of 40 degrees last night. He's in the first stages of what CR had.
26/7/07	KR had an uneasy night with a temperature and is unwell today. CR has the remnants of a cold.
27/7/07	KR was prescribed Zovirax for cold sores and was diagnosed with an upper respiratory tract infection.
30/7/07	CR still has a chesty cough.
14/8/07	CR has another cold. His conjunctivitis is bad again.
24/8/07	Both boys have colds again.
7/9/07	KR has herpes on his face.
20/9/07	Both boys have bad colds again.