Neutral Citation Number: [2020] EWHC 3929 (Fam)

IN THE LIVERPOOL FAMILY COURT

Case No. LV19C02375

Courtroom No. 25

35 Vernon Street
Liverpool
L2 2BX

Wednesday, 7th October 2020

Before:
HIS HONOUR JUDGE PARKER
Sitting as a Judge of The High Court

B E T W E E N:

THE LOCAL AUTHORITY

and

C & D

MR R HOWLING QC and MS L TARGETT-PARKER appeared on behalf of the Applicant
MS F HEATON QC and MR POVOAS appeared on behalf of the First Respondent
MR C GORTON and MR RILEY appeared on behalf of the Second Respondent
MS K BURNELL appeared on behalf of the Child through the Guardian
MR J SAMPSON QC and MR M STEWARD appeared on behalf of the Intervenor

JUDGMENT
(For Approval)

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

HHJ PARKER:

1. This is judgment in case number LV19C02375. I am concerned with a child called A. He appears through the Children's Guardian, B, and is represented by Ms Burnell.
2. The Local Authority is [redacted]. They have made an application for a care order in respect of A. They are represented by Mr Howling, Queen's Counsel, and Ms Targett-Parker.
3. The mother of A is C, who is represented by Ms Heaton Queen's Counsel, and Mr Povoas. The father of A is D, who has been represented by Mr Gorton and Mr Riley.
4. E is the intervenor, and former boyfriend of the mother. He is represented by Mr Sampson, Queen's Counsel, and Mr Steward.
5. The hearing has been a finding-of-fact hearing to determine threshold, as pleaded against the parents, although it, necessarily, incorporates allegations that the Local Authority make against the intervenor.
6. The threshold centres on A's half-sibling, F, who very sadly died on 13 July 2019, as a result of injuries sustained on 12 July 2019.

The background

7. The mother and E had been in a relationship for some five weeks. They met on a dating app called "Plenty of Fish". E would stay over, some of the nights of the week.
8. On 12 July, the mother left F in the care of E while she took A to nursery. This was for about thirty minutes. He was in nursery from 12.15pm until 3.10pm. She had started to leave the children with E, over the preceding two weeks.
9. She had made arrangements to go to the hairdresser once A had been collected from nursery later that afternoon. E offered to look after F.
10. The maternal grandmother dropped the mother off at the hairdresser's, and took A to his auntie's to see his father. Whilst at the hairdresser's the mother received a text from E saying that F had had another fall. (E had told her earlier that day that F had fallen into either the door or the wall. When she returned from dropping A off at nursery, she saw that A had dried blood around his nose.)
11. She asked if she should return home, but was reassured by E, initially. Then, subsequently, he asked for F's details, and told her that he was being taken to hospital in an ambulance. It became obvious that things were not right.
12. The mother's mobile phone battery ran out. She received a call at the hairdresser's from her sister who said that F was seriously ill, and she should go to the Hospital. The sister said that

she had put money into her account so that she could get a taxi to hospital. The mother had no bank card, so her sister said she would pay for the taxi when she got to Alder Hey.

13. Eventually, she arrived at the hospital. E was there, along with the maternal grandmother and an aunt. E left, having been asked to do so.

The issues

14. The Local Authority's primary case is that E inflicted injuries upon F on 12 July 2019, deliberately. Those injuries included the head injury which caused his death. There is no challenge to the Local Authority case that only E was present with F when he suffered the fatal injuries. The issue is whether they were deliberately inflicted injuries, or whether F fell down the stairs.

The law

15. I am grateful to all counsel for their helpful submissions with regard to the law. The following legal principles can be distilled. The burden of proof lies, at all times, with the Local Authority. The standard of proof is the balance of probabilities.
16. Findings-of-fact in these cases must be based on evidence, including inferences that can properly be drawn from the evidence, and not on suspicion or speculation.
17. When considering cases of suspected child abuse, the Court must take into account all the evidence, and furthermore, consider each piece of evidence in the context of all the other evidence.
18. The Court, invariably, surveys a wide canvas. The judge, in these difficult cases, must have regard to the relevance of each piece of evidence, in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof.
19. Amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, there is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence.
20. It is important to remember that the roles of the Court and the expert are distinct, and it is the Court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision.
21. In cases involving allegations of non-accidental injury, there is often involvement of a multidisciplinary analysis of the medical information, conducted by a group of specialists, each bringing their own expertise to bear on the problem. The Court must be careful to ensure

that each expert keeps within the bounds of their own expertise, and, defers, where appropriate, to the expertise of others.

22. The evidence of the parents, and any other carers is of the utmost importance. It is essential that the Court forms a clear assessment of their credibility and reliability.

23. It is common for witnesses, in these cases, to tell lies in the course of the investigation, and the hearing. The Court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, and distress. The fact that a witness has lied about some matter, does not mean that he or she has lied about everything.

24. The judge, in care proceedings, must never forget that today's medical certainty may be discarded by the next generation of experts, or that scientific research would throw a light into corners that are, at present, dark.

25. It is the Local Authority that seeks a finding that F's injuries are non-accidental. It is for the Local Authority to prove its case. It is not for the mother, nor the intervenor to disprove it. In particular, it is not for the mother or the intervenor to disprove it by proving how the injuries were, in fact, sustained.

26. The Court's task is to determine whether the Local Authority has proved its case, on a balance of probability.

27. With regard to any adverse inference that can be drawn from E's refusal to attend court and give evidence, in breach of the witness summons, I have had regard to the observations of Johnson J, in *Re O (Care Proceedings: Evidence)* [2003] EWHC 2011 (Fam). I deal with this in greater detail, later.

Threshold

28. The threshold document sets out a list of injuries identified. A triad of non-accidental injury; head injuries consisting of subdural haemorrhage; right-sided acute encephalopathy and bilateral retinal haemorrhages; brain swelling, with substantial mass effect, including herniation; hypoxic ischaemic brain injury; spinal cord showing very early hypoxic ischaemic injury; myelopathy, affecting both white and grey matter; limited cranial subarachnoid haemorrhage; extremely limited spinal subdural haemorrhage; bruising to the inner aspect of the left ankle region and foot, with separate apparent puncture marks, and blood staining, distally; bruising to the outer anterior aspect of the left lower leg; bruising to the front left thigh; apparent bruising, distally, of the dorsal aspect of the penis; bruising to the lower aspect of the front of the right thigh; bruising to the outer aspect of the posterior part of the mid-right thigh; bruising to the outer aspect of the upper two-thirds of the left pinna; swollen bruising

to the left forehead region above the outer part of the left eyebrow; extensive bruising to the right forehead area; essentially diffuse bruising of the nose; vertical series of bruising to the right lateral aspect of the trunk; bruising to the outer aspect of the right buttock region; bruising to the lower half of the front right arm. A suspected tear to the anus was, later, determined as no injury.

The evidence

29. There is no issue that F's death was caused by his head injury. The unchallenged evidence of Dr Du Plessis, Consultant Neuropathologist, E45 *et seq*, makes it clear that he suffered considerable brain swelling, with substantial mass effect, including herniation.
30. The most likely cause of the brain swelling was traumatic intracranial injury, combined with, and aggravated by superimposed brain swelling, due to hypoxic ischaemic brain injury, or brain injury due to insufficient blood and oxygen supplying the brain.
31. This appears to have been caused by a head impact to the left side of the head, considering the scalp-swelling evidence on this side of the CT scan, taken soon after admission, as well as clinical and post-mortem subsequent observations, confirming an impact to this side of the head.
32. Generalised brain swelling, allied with the pressurising effects of the right-sided acute space occupying subdural haematoma, causing displacement, herniation and compression of the brain. These are features which confirm life-threatening, severely raised intracranial pressure.
33. There was also evidence of tonsillar herniation, the latter reflecting a critical state of raised intracranial pressure, with potential fatal consequences, as occurred in F's case.
34. Severely raised intracranial pressure compromised blood supply to most parts of the brain due to the very high-pressure gradient against which blood needed to be delivered to brain tissue, effectively, leading to total or near total shutdown of blood supply to the brain, causing hypoxic ischaemic brain injury.
35. Magnetic resonance imaging carried out at 4.00pm on 13 July, showed the absence of blood flow within major arteries supplying the brain with blood; a feature presumed due to compression of these vessels, by severely raised intracranial pressure.
36. A similar absence of flow was demonstrated in the venous sinuses, again, reflecting extremely high pressure inside the skull cavity.
37. The neuroimaging, both, on the original CT scan, and the later MRI scans, also showed features consistent with extensive hypoxic ischaemic injury of the brain. Microscopic

examination of brain tissue confirmed global hypoxic ischaemic brain injury, which must be regarded as a secondary complication arising from a substantially space-occupying acute subdural haematoma, and attendant reactive brain swelling.

38. The spinal cord also showed evidence of very early hypoxic ischaemic injury, myelopathy, again, affecting both white and grey matter. Dr Du Plessis also found limited cranial subarachnoid haemorrhage.

39. Dr Du Plessis provided evidence that the case for a traumatic cause for the subdural bleed is based on the following:

    a. There was no evidence of any significant natural disease process affecting the brain, spinal cord or the membrane surrounding it;
    b. By far, the most common cause of an acute space-occupying subdural bleed in a child of F's age, is traumatic head injury;
    c. No condition which could, plausibly, have caused or even contributed to a so-called "spontaneous or non-traumatic subdural haemorrhage" was identified.
    d. There is evidence of a bridging brain avulsion on the same side as the subdural bleed.
    e. In the absence of any susceptibility factors for subdural bleeding, the trauma implicated in the case of a space-occupying subdural bleed in a child of F's age, would have required a so-called "high strain-rate mechanism" of a head injury, i.e., one involving very rapid and substantial acceleration-deceleration of the head. In a child of his age, the most likely would have required a substantial head impact.
    f. Unilateral space-occupying bleeds in a child of F's age are found following both non-accidental and accidental head injuries. In respect of non-accidental head injury, a mechanism involving forceful shaking alone, is unlikely to have accounted for a subdural bleed in a child of F's age.
    g. Shaking-related subdural haemorrhage also tends to bilateral rather than unilateral, and of a non-space-occupying nature.

40. Whether or not the mode of injury involved a non-accidental or accidental event, is not further reliably assisted by the neuropathology viewed in isolation. The neuropathological findings require integration with the eye pathology, the plausibility of various carer accounts, and with

multiple other external injuries in the form of bruising, including penile bruising, to establish whether or not an accident injury event is a plausible explanation for the full clinicopathological profile of this case.

41. Whilst spinal subdural haemorrhage is rare in non-accidental cases, the source of the bleed is unclear. It is either local, locally produced or, maybe, tracking from the skull cavity. It is not clear why the blood tracks or whether it is local but there is a strong association. In F's case, there is a big space-occupying bleed, so it could be as a result of tracking. It is a marker, a strong marker, for non-accidental injury.

42. The evidence of Dr Medcalf, Home Office Pathologist, at E220 is as follows:

> "Joint forensic and paediatric post-mortem examination was subsequently undertaken. On external examination in the mortuary, there was evidence of widespread trauma to the body, and this was very extensive to the face, with six separate areas of bruising identified to the forehead alone.
> Microscopic examination of two of these bruises, one from each side of the forehead, revealed histological features, consistent with impacts pre-dating the day of F's admission to hospital. This would seem to be in keeping with the mother's assertion, on interview, that on 12 July 2019, there were two bruises visible to the forehead due to known, previous incidents.
> Aging of injuries down the microscope is, certainly, not an exact science but none of the other sample bruises showed features to indicate that they were significantly older than 12 July.
> Another impact, allegedly, was sustained that morning by F running into a door. This would seem to fit with the vertical mark evident to one of the bruises to the left forehead area, although, it is rather unclear what was then responsible for impacting the nose to cause the nosebleed described by E, and also witnessed by the mother on her return home. This apparent discrepancy is particularly so, given that the bruising visible to the nose at autopsy, was to the right side, not to the left.
> Whilst the intensive medical intervention in this case, makes post-mortem injury interpretation more difficult, the bruising to the nose, for example, appeared separate from the haemorrhage around the operation site.
> Similarly, the extensive bruising to the left pinna was, clearly, unrelated to the operation, and, in my opinion, is a highly suspicious injury, even in the context of a fall down the stairs.
> The sheer number of injuries to this child is very worrying, and some injuries of themselves, i.e., individually, are deeply suspicious of abuse. The left ear bruise has already been mentioned, but other areas of injury that are concerning in isolation, include the bruising of the distal penis. The punctate nature of this bruising, it comprised multiple small separate bruises, is suspicious of pinching of the skin.

> Whilst young boys are known to, occasionally, do this to themselves, it would seem that F was not known to do this, and his mother had not seen this injury previously.
> Also, of concern in this case, is the bruising around the mandible, fingertip type. The bruising to the right side of the pubic area, the bruises to the abdomen, and also, the bruising to the feet.
> Although there was further medical bruising caused to the latter, due to needle punctures, according to the paramedics, bruising was already visible to the feet before admission to hospital.
> Whilst on the face of it, a fall down the stairs would seem to, reasonably, account for multiple bruises to the body, involving various anatomical regions, through tumbling, for example, it should be noted that it is unusual for injuries to be widespread after such falls. Fatal outcomes are also rare.
> Furthermore, it is rather odd in this case, that there was almost no skin abrasion evident. I would expect such a tumble against a carpeted floor to cause surface damage; in other words, grazing or carpet burns.
> It should also be mentioned at this point, that the repeated change in the carer's story regarding the causation of the fatal injury, is a feature that is frequently seen in child abuse, particularly, cases that are fatal after a survival period; the carer changing the story to match the outcome".

43. The retinal haemorrhages are discussed in detail in Dr McPartland's report, Consultant Paediatric Pathologist. In essence, whilst they are not diagnostic of inflicted injury, they are yet another deeply worrying feature in this case.

44. Likewise, the neuropathology is considered, in depth, by Dr Du Plessis:

> "Similarly, whilst not diagnostic of abuse, the findings are considered suspicious, and very unusual for a fall down the stairs.
> In my opinion, the overall features in this case are highly suspicious of fatal child abuse. Notably, to reiterate, the concerning findings include, but are not limited to, the carer's changing story; the distribution and number of injuries; the lack of abrasion, the ear bruising; the nose and oral bruising; the mandibular bruising; the abdominal and pubic area bruising; the penile bruising; the florid retinal haemorrhages"

45. Dr McPartland, the consultant paediatric pathologist produced a forensic ophthalmic pathology report, at E107. Her evidence was not challenged. Her findings were of:

> "Bilateral, extensive multi-layered, preretinal, intraretinal and subretinal, retinal haemorrhages, extending from the posterior pole to the peripheral retina. Bilateral severe optic nerve sheath haemorrhage, in addition to intradural haemorrhage. Mild peripapillary scleral haemorrhage in the left eye. Small areas of haemorrhage in the orbital fat around both eyes, and focally with extraocular muscle tissue on the right side. Inflammatory cell response to areas of retinal haemorrhage in both eyes. Bilateral subtle foci of hemosiderin deposition seen within the retina and optic nerve sheath haemorrhage.

> Systematic reviews of the medical literature have revealed that bilateral multi-layered retinal haemorrhages, extending to the periphery, are usually associated with non-accidental head injury, abusive head trauma.
> The mechanism of injury in head trauma that can lead to retinal haemorrhages, and optic nerve sheath haemorrhage, may be due to acceleration-deceleration forces to the head caused by shaking impact injury, or a combination of both.
> Taking into account the findings from the medical literature, in my opinion, the retinal and optic nerve sheath haemorrhages in this case are unlikely to have been caused solely, as secondary phenomena, and are typical of ocular injury seen in cases of abusive head trauma".

46. There are two reports prepared on instructions by the criminal defence team for E, disclosed into these proceedings. Dr Armour, consultant forensic pathologist, at E253, and Professor Al Sarraj, E263, consultant neuropathologist.

47. Dr Armour states, in her report:

> "It is also, my opinion that the account given by E in relation to this child's sudden collapse, is inconsistent with the severity of the injuries sustained to this child's head. A fall from a sofa onto the floor, where a child of this age strikes his head is a trivial, insignificant event.
> The post-mortem in this case, clearly, identified a very severe head injury which was unsurvivable.
> Therefore, this account of a trivial head injury is outwith the severity of the head injury F sustained. Although the skull was not fractured in this case, it is my opinion that the degree of force required to produce such a severe head injury in a child of this age, is considerable.
> In addition, I am aware of the differing accounts given by E, in that the fatal head injury could also have been sustained by dropping the boy down a flight of stairs.
> It is my opinion that the pattern and distribution of injuries to this child's head alone, are inconsistent with this account. I would also have expected some form of abrasion to some part of his body, when the child came into contact with a roughened surface.
> The presence of retinal haemorrhages which are multiple bilateral, and multi-layered, are also supportive of non-accidental injury/abusive head injury.
> The fatal head injury apart, it is my opinion that the injuries to the head and face of this child could have been caused by slapping, pinching, nipping, prodding, and, I would not exclude punching.
> There are two discrete injuries which require specific mention. The first injuries are documented in H's report as "Injury 25"; a bruise to the right side of the pubic area, measuring 1.6cm by 1.1cm, which has, clearly, been documented as being separate from the medical intervention canula mark to the right groin, and also, clearly photographed to the same effect.
> The second is the multiple small punctate bruises to the distal half of the dorsal penis. Bruising to the skin of the penis. These injuries could

have been caused around the same time, but, in any event, in my opinion, were consistent with being non-accidental in nature. They could have been caused by poking, prodding, pinching, and/or squeezing of the genital region, including the penis.

Bruising to the penis is a serious injury, which, when inflicted, would cause the child to scream out in pain, as this is incredibly painful.

I agree with the cause of death given by my colleague, H. I agree there was no natural disease to account for F's death. I agree there is no underlying natural pathology to account for his dramatic collapse and unconsciousness. F died as a result of a fatal head injury. The fatal head injury was caused by blunt force head trauma. There was no accidental cause to account for this severe life-threatening injury.

It is, therefore, my view, that, in the absence of any plausible accidental cause to account for this injury, there is no other reasonable explanation for this injury, other than non-accidental injury.

The nature of the force inflicted to this child's head, in my opinion, requires a considerable degree of force to inflict.

This injury is seen in cases of the head being impacted with a firm, hard surface. I cannot exclude a degree of shaking to explain the ophthalmic pathology.

The account or accounts given by E in relation to the fatal head injury are inconsistent with the severity of the injury this child received. The pattern and distribution of the injuries to the head are also inconsistent with his accounts.

The autopsy clearly identified bruising to many parts of this child's body with a multiplicity of bruises being, in my opinion, of different ages. Most, in my opinion, would be consistent with non-accidental injury, and some of the injuries predating the fatal assault; the bruises to the pubic region and penis being significant injuries which, when inflicted, would cause a child of this age immense pain".

48. Professor Al Sarraj, in his report stated:

> "The submitted explanation for the alleged incident by the defendant is that he was in the garden, smoking, when he heard a bang from inside, including metallic sound, believed to be the baby gate, and rushed inside to discover the child on the hallway floor, with the baby gate open.
>
> He feared the child had fallen down the stairs and was unconscious. He earlier, indicated that he heard a thud, and found the baby on the floor, possibly, having hit his head on the radiator due to falling off the back of the couch.
>
> Falling downstairs is a common accident in domestic setting, and rarely causes significant or severe head injury. However, it is still a possibility, and cannot be excluded from brain examination only.

49. The expert also referred to the case report from Lantz and Couture. Here, a fatal injury was caused by a witness stairway fall:

> "The authors suggest that, although serious head injuries are rare in stairway falls, there appears to be exceptions and supporting data that serious head

injuries, including subdural hematomas can result from short-distance falls. On the other hand, authors did not report serious fatal head injuries after reviewing a large number of cases, such as Ludwig *et al*, and Zielinski *et al*. Accordingly, and as mentioned before, the brain examination cannot differentiate between impact caused by accident or inflicted act, and both possibilities have to be excluded. I understand that the post-mortem examination had identified a number of other injuries, with extent and distribution in pattern which favours inflicted injury. However, this point is better considered by the forensic pathologist with its relationship to the described traumatic brain injury in this child".

50. The single joint expert, Dr Diana Birch, consultant paediatrician produced a report at E306, and a first addendum at E415, and a second addendum at E426. In her first report, she stated:

> "I focus here, on the bruises and marks seen by the doctors who first saw F before he died, and not the post-mortem marks which would have possibly have been complicated by marks caused by medical procedures.
> On external examination in the mortuary, there was evidence of widespread trauma to the body, and this was very extensive to the face, with six separate areas of bruising identified to the forehead alone.
> Microscopic examination of two of these bruises, one from each side of the forehead, revealed histological features, consistent with impacts predating the day of F's admission to hospital.
> With respect to F's bruises and injuries, the number of injuries is of grave concern, and the quantity, as well as the nature of the injuries, raises concern of non-accidental, inflicted injuries.
> The following marks were identified by M:
> A round bruise and swelling measuring roughly 2cm in diameter, with a vertical red mark in the middle. Mum indicated this was as a result of 'running into a door yesterday'. Presence of a linear red mark in the middle of this bruise would be consistent with this history.
> A round bruise with associated swelling on the right side of the forehead, measuring roughly 2.5cm in diameter, with petechiae to the right of this. Mum stated this occurred when he ran into her bed within the last week.
> Bruising to the right side of the bridge of the nose. No explanation given, and Mum stated she had not seen this prior to admission.
> Bruising to the inner aspect of the left ear. No explanation given, and Mum stated she had not seen this prior to admission.
> Faint bruising to the right side of the chest wall, visible on photographs only, and not visible on direct examination today. No history given.
> A faint bruise to the right hip area overlying the bony prominence. No history given but likely, accidental.
> A fading but fairly large bruise to the outer aspect of the right upper arm. No history given. Likely accidental.
> A small number of petechial bruises to the top of the shaft of the penis. No history given, and Mum was not aware of this prior to examination.

In this case, we have bruises away from bony prominences, bruising to the face, chest, ears, with some petechial eye and serious concomitant injuries, all of which, add up to a picture of suspected non-accidental injury.

F had an unexplained bruising to the left ear which is of concern, and without a plausible accidental injury, should be regarded as non-accidental.

The bruising of the ear is very concerning, in that there is purple bruising with some petechial haemorrhaging on both inner concave parts of the pinna of the ear, and also, on the raised areas of the helix and antihelix. There is also a small area of scratch and bruising behind the ear.

The petechial bruising, with bruising of the inner concave areas, is very typical of non-accidental injury, and would occur if the ear is struck directly with a slap, or boxing to the ear.

It is not a bruise which could be produced by direct impact with a hard object in an accidental fall against a corner of a piece of furniture or something similar. Neither does it have characteristics of a pinch injury.

Bruising on the pinna is commonly seen in non-accidental injury, when the injury is, generally, caused by a punch of slap which tends to impact the edge of the ear, causing bruising, or petechiae along the edge of the ear. It is often accompanied by bruising along the back of the ear, bruising or petechiae on the head behind the ear, and sometimes other injuries such as tearing or bleeding.

F also had a number of yellow bruises to the right side of the chest, which are unexplained. The chest bruising could be finger bruising caused by an adult grasping the child around the chest.

Usually, this is accompanied by a corresponding bruise from the thumb, often on the back of the chest or vice versa, and bruising from the other hand on the other side.

However, it can be that one part of the pattern is not seen or has faded.

F was found to have a small number of petechial bruises to the top of the shaft of the penis. No history was given, and Mum was not aware of this prior to the examination. However, Mother admits that she may not have seen his penis very recently, since she had allowed E to change F's nappies.

This was somewhat unusual, since Mother had not been in a relationship with E for very long; about five weeks. The petechiae are indicative of the penis foreskin being pulled or pinched.

In conclusion, there is evidence that F has suffered a severe and fatal non-accidental injury in the form of a blunt-force trauma to his head which was delivered with a great deal of force, and produced a rapid acceleration-deceleration force. The sheering acceleration-deceleration force cause tearing of the cerebral vessels, and a catastrophic cerebral bleed, which, combined with traumatic swelling of the brain tissue, raised the intracranial pressure inside his skull to a degree that the brain was herniated and the blood supply to the brain was compromised, which was incompatible with life.

F died of non-accidental, traumatic head injury".

51. At the joint meeting set out at D411, the evidence of Dr McPartland is that the haemorrhages were very extensive and numerous:

> "In accidental head injury cases, retinal haemorrhages are rare, generally small in number, not in the posterior pole, and unilateral to the impact.
> With abusive trauma, haemorrhages are numerous; too numerous to count; bilateral; located in the posterior pole to the periphery. Therefore, the fact that the retinal haemorrhages were bilateral, their positioning, the nature of them were all factors that fit in with non-accidental head injury.
> The mechanism for the causation of the injuries would be shake or impact. What is necessary is acceleration and deceleration to the head. A throw, and impact can produce the same. There are different mechanisms with a different movement trauma. The vessels are torn or with changes in intracranial pressure. It is more likely that this was a traumatic head injury.".

52. Dr Du Plessis felt the mechanism for the head injury was an impact or impacts, and there could be a shake as well.

> "This is a traumatic head injury with impact. It is non-accidental rather than accidental. Certain impacts can produce the oscillatory movement".

53. Dr Medcalf agreed that this was a fatal impact injury, that "There may be shaking as well, but there may not be".

54. Dr McPartland agreed. Dr Birch agreed, and would definitely say that:

> "These are impact injuries, and probably more than one. There was an acceleration-deceleration needed".

<u>The differing accounts of E</u>

55. (1) G1. North West Ambulance Service:

> "The crew were called to F today by his mum's boyfriend who has been looking after F. Mum was at the shops. Mum's boyfriend has heard a loud bang from the living room, and F crying. Has entered the living room to find F on the floor with substantial head injuries. Mum's boyfriend believes that the injuries are consistent with a fall from the sofa onto a hard surfaced such as a radiator or a computer tower".

(2) F142:

> "E had initially said that F had fallen from the sofa and hit his head on the radiator on the way down",

(3) F144:

> "During handover in resuscitation, E interrupted me when I explained a fall onto the radiator and state, 'Fell onto computer tower, modem thing'. Confidence to interrupt me".

(4) F135. The account to Dr Mehtar:

> "E explained that there is a sofa in the house that F often climbed on when they went out for a cigarette. He described how F would climb on the sofa, and then onto the window ledge to see them whilst they were outside. He said, behind the sofa was a small gap, and then there was a radiator. So, I tried to establish if F had fallen between the sofa and the radiator, as this would only be a small gap to fall into.
> E explained that the radiator is not the full length of the sofa, so there is a bigger gap between the sofa and the wall at one end, and this is where he had fallen into.
> E stated in this large gap there was a computer monitor, and, although he didn't specifically state F had hit his head on this, He was suggesting that that was a possibility.
> E stated he heard a noise from inside the house, and he came straight inside, which took him a couple of seconds, and found F in the gap, and that he was crying. He then picked him up, and was holding him for a bit, whilst he cried for a couple of minutes but then he went quiet, so he ran outside with him to get help, and to make a phone call.
> He told me there was a passer-by who helped him look after F until the ambulance arrived, which took approximately 20 minutes.
> Because the injuries were not what we would expect from a fall from the height of a sofa, I was questioning E to try and ascertain what, exactly, had happened. I was trying to clarify if there was anything F could have hit his head on when he fell, and he stated there was a computer tower behind the sofa, whereas, before, he had said it was a monitor.
> But, other than that, he remained consistent with his account throughout the time I was with him".

(5) When specifically asked by the maternal grandmother whether F had fallen down the stairs whilst E was not watching him, he continued to maintain his account that F had fallen from the sofa.

(6) F190. Text message from E to a neighbour at about 7.30pm on 12 July:

> "He fell off the couch like I've told about 10 doctors and nurses, plus his mum and nan, and aunties. I done everything I can for that little boy's safety, and his auntie starts fucked-up accusations. I am now stuck, walking round Liverpool, somewhere I don't know, where I am panicking that I'm getting took for something I didn't do".

(7) F1091. Text message to the police:

> "Hi, it's E here. I've been informed by my mum and sisters that you want to speak to me. I'd just like to say, I'm waiting to hear back off my solicitor, and that I didn't do nothing. The baby fell down the stairs.

I was having a fag at the bottom. Gate must have been open, and I've come running in, after hearing a bang and cry, and picked F up, and he went into the state he was in when I last saw him. I initially said he fell off the couch because I didn't want to look like a bad parent that wasn't watching him. I've got my own son to fight for, but he was looking for his mum, who had, literally, just left. I can't believe this has all been turned on me".

(8) F221. Account given to his best friend, P, during the evening of 13 July:

"E eventually said, 'The baby's in hospital', and I knew he was talking about C's child. I asked him why the baby was in hospital, and he said, 'He was jumping over the back of the sofa'. E seemed very scared, and I carried on talking to him, and, eventually, he broke down into tears, and said, 'The baby has fell down the stairs'.
He said he didn't want to tell me that the baby had fallen down the stairs, as he thought that I would judge him because I have got children myself. I then asked him how this had happened, and he said he had gone outside the house for a fag, and when he had come back in, the baby had fallen down the stairs".

(9) F93. The account given to Q a special constable, at the Police Station:

"I have been good for three years. Now, I have gone and dropped a baby down the stairs".

(10) F140. Account given to R, his niece:

"I have attended my address, and asked E what has happened. He told me that it was a complete accident, and that he was outside, having a cigarette, and he has come in, and found the young child at the bottom of the stairs".

(11) Prepared statement. F125:

"F was left in the living room with a fresh nappy and a bottle, whilst I was in the back garden smoking a cigarette, with the back door open. I think it was 3.10pm or 3.15pm, when I heard banging from inside, including a metallic sound I believed to be the baby gate. I rushed inside, and discovered F was on the hallway floor, and the baby gate was open. I feared he had fallen down the stairs.
He was unconscious, and I ran out the front door shouting, 'Help, does anyone know CPR?'. A male came into the house, and I rang 999 for an ambulance".

56. (12) Police interview. "E gave a 'No comment' interview".

(13) On the second day of the finding-of-fact hearing, E filed and served a witness statement:

"After a few minutes, I heard a bang. It was a metallic or hard bang, rather than a thud. It was followed by the sound of F crying. I ran through the kitchen, and into the hallway to find him at the bottom of the stairs. There were stair gates on the bottom and at the top of the stairs. These would not always be shut. He would often head for the

> stairs, and liked to climb the stairs with C, which she would encourage him to do. He could not open the stair gate. Although we tried to be safety conscious, we didn't always remember to close it, and I have seen it open on a number of occasions.
> When I got to the hallway, I could see F lying at the foot of the stairs. His foot, I cannot now remember which one, was still stuck over the lip at the bottom of the stair gate, and the door had swung half-shut onto him. He was lying on the floor on his back, with the loose board at the bottom, underneath him, and with his head diagonally further away from the stair gate, towards the opening of the living room door.
> He was crying. It was not a scream. He seemed dazed or out of it, and his breathing seemed different. He felt floppy and heavier than usual, and wasn't responding to me.
> I carried him into the kitchen, and put him on the rug on the kitchen floor, which you can see on the photograph at F955.
> I know that I lied about the fall from the sofa. I told her mum that story, and the paramedics, and the doctors at the hospital, and the police at first. I know I was trying to minimise it, and it became a lie that I trapped myself in.
> I knew that F had fallen off the sofa before. He used to jump onto the sofa from the arm, and had climbed onto the highchair, and it had happened with C as well.
> I was ashamed that I had left him by himself to climb the stairs unattended, and to fall down. I apologise to the Court for lying about the fall off the sofa. I know I should not have done so. I tried to minimise what had happened, and cover up for my fault for not supervising him as I should have done".

Points made on behalf of E.

57. Reference is made to his criminal record. He has convictions for battery on 15 March 2012; 21 June 2012; 4 September 2014, two offences; 25 June 2016; and one offence of assault occasioning actual bodily harm, 2 March 2016.

58. In addition, he has six offences against property; two for theft and kindred offences; three public order disorder offences; eight offences relating to police courts and prisons; one offence relating to an offensive weapon; and one miscellaneous offence.

59. I agree that there is no evidence of any of the battery offences being against a minor. I also agree that the most recent conviction for battery and assault is in 2016. I also accept that, on his release in 2017 from prison, the Local Authority undertook a risk assessment, and he was permitted to live with, and parent his son.

60. I also accept the point that the mother has given evidence that E presented as a loving, considerate, and supportive partner. E entered a relationship with her, knowing that she had two children; that he was a hands-on partner who actively sought out interaction with the

children, and, at no time, showed resentment or unhappiness about the presence of the children in the home.

61. I accept that the amount of time he spent at her home increased over time, and he appeared happy to increase his role in providing care for, and interaction with her children.

62. At no time did the mother hear E raise his voice or appear angry with her children. Discipline and boundary-setting was left to the mother, and he would support.

63. There is no evidence to suggest that he had anything other than a loving relationship with his own child, and his nephews and nieces.

64. He had some experience of dealing with children around feeding, changing and settling times. Furthermore, I accept the evidence that the children appeared fond of E, and willingly went to him.

65. I also accept that E cared for the mother's children occasionally, for limited periods of time, and appeared to actively welcome doing so.

66. I also accept that the evidence does not establish a link between "Uncle E", and E, in A's ABE interview.

67. I also accept that F had sustained injuries at a time when he was still learning to move around independently, apparently energetic and fearless. He had had two previous hospital admissions in spring 2019, associated with falls; one downstairs, and one from a highchair. He had also suffered two bumps to the head on a trampoline, and with a bedpost.

68. The mother gave evidence of A's head striking F's face on a trampoline, causing a bruise around F's eye, and also running, tripping and falling into a vertical bedpost, causing swelling and bruising to one side of the head.

69. I also accept that there is no evidence that E presented as anxious, angry or overwrought on 12 July, and that on that day, F had been left in his care for less than an hour on both occasions, and this was the second of the two.

70. There was nothing in E's presentation when the mother arrived back at home at lunchtime to indicate that he was upset or angry. E offered to look after F in the afternoon, as the maternal grandmother had not long had surgery.

71. I have also considered the submissions made in respect of the injuries and the medical evidence, and the interplay of them with the lay evidence, in pages five to eight of the written submissions of Mr Sampson, Queen's Counsel, and Mr Steward.

My findings

72. E deliberately inflicted the injuries to F's head, which resulted in his death. This was an impact injury. He also caused acceleration and deceleration to F's head, which caused the extensive and numerous bilateral retinal haemorrhages.

73. He also deliberately inflicted bruising injuries to F's forehead, ear, nose, chest, penis, pelvic area and legs.

74. I need not go any further in trying to make findings about E's conduct. That can be a matter for the Criminal Court. I make findings on those issues which are necessary and proportionate for these proceedings.

75. Two of the bruises on the forehead reported on, were caused as a result of the incidents described by the mother, relating to the clash of heads between A and F on the trampoline, and F running and tripping, and colliding with the bedpost. They both occurred before 12 July.

76. The mother has not inflicted any injuries upon F. The mother has not failed to protect F. There was nothing to put her on notice that E would act in the way that he did on 12 July.

My reasons

77. E has refused to give evidence before me. He was brought to court on two consecutive days, pursuant to a witness summons for the purpose of him giving evidence. He had attended the hearing for the first half-day only. Thereafter, he refused to come back.

78. Having provided instructions for his witness statement, he then refused to see his legal team of Mr Sampson, Queens Counsel, and Mr Steward. They went down to the cells on several occasions in an attempt to engage with him.

79. On the first day that he was due to give evidence, faced with his refusal, I sent down a written direction to him in the following terms:

> "Direction from Judge Parker to E.
> E, I have been told that you are refusing to come into court to answer questions about how F suffered the fatal injuries whilst in your care on 12 July last year, amongst other things.
> If that is untrue, then please inform the prison guards immediately, and you will be brought up to court.
> If it is true that you are refusing to give evidence, even though I have directed you to attend court by a witness summons, and have also directed that you come up to the courtroom to answer questions, then I must give you the following legal directions.
> (1) You are required to attend court to give evidence, and have been served with a witness summons to do so.
> (2) If you refuse to come up to court, you will be in contempt of court, for which you can be sent to prison or fined.

(3) It will mean that you are, as a result, refusing to answer questions which will, again, place you in contempt of court, for which you can be sent to prison or fined.

(4) The Court will usually draw an adverse inference from your refusal to come to court and answer questions that the allegations made against you, in this case, that you deliberately inflicted the fatal injuries upon F, are true.

(5) 'An adverse inference' means a negative conclusion that I may draw about your evidence, which may include a conclusion that you are lying. A statement or admission made in these proceedings are not admissible in evidence against you in the Crown Court trial that you face.

These are family proceedings and not criminal proceedings, and it is not for this Court to decide whether you should be convicted or acquitted of any criminal offences. Within these proceedings, however, the Court will have to decide whether the allegations made against you by the Local Authority are true or not.

I have to warn you, therefore, that within these proceedings, you are not permitted to refuse to give evidence on the basis that to do so, might tend to show that you have engaged in conduct of a criminal nature.

If you do give evidence that suggests you have committed criminal misconduct, that evidence would not be admissible in criminal proceedings against you, except in relation to any prosecution against you for perjury. Section 98(2) of the Children Act 1989 states that that is so.

If you were to lie, deliberately, within these proceedings, that could lead to you being prosecuted for perjury, and what you had said could be put before the Criminal Court against you.

However, it is important that you understand that if the Court gave permission, anything that you do say or file in these proceedings might be released to the police for them to use during their enquiries into any allegations that you have committed any criminal offence, and, by 'any offence', I am not referring just to perjury.

Further, if you were to be prosecuted, there could be applications in the Criminal Court for the prosecution or any co-defendant to cross-examine you about anything that you had said in these proceedings. It would be for the Criminal Court to decide on whether they should be permitted to do so.

You are now invited to discuss this direction from me with your legal team, Mr Sampson, and Mr Steward".

80. I was told that he had accepted the document, and said he would read it later. Pursuant to the invitation of leading counsel, I adjourned the matter overnight, to give him time to consider the document, and to reflect.

81. The following day, he refused to get on the bus from Her Majesty's Prison Altcourse. I then adjourned to enable counsel to prepare their respective submissions.

82. Having considered the evidence holistically, I do draw the adverse inference against E, that his refusal to come into court and answer questions, is because the allegations made against him that he deliberately inflicted injuries, including the fatal injuries upon F, are true.

83. He was left in no doubt as to the obligations on him to give evidence in the family proceedings, and the consequences if he failed to do so; potential loss of liberty and the Family Court usually drawing an adverse inference against him that the allegations against him were true.

84. He also declined to give an account to police in interview. Whilst he has a right to do so, I am able to take that into account in considering whether, in my judgment, E is giving a truthful account to the Family Court in his written statement.

85. I have also taken into account that he faces a murder trial in November. I weigh that in the balance in assessing whether I should draw an adverse inference against him.

86. I simply do not believe his explanation for changing his account. In my judgment, it is inherently implausible that he would suggest that the child had fallen from the sofa, because he was trying to minimise what had happened, and trying to cover up his fault in not supervising him as he should have done, particularly, in the face of the maternal grandmother challenging him on whether F had actually fallen down the stairs, as she did not believe his account of falling off the sofa.

87. I found the evidence of Q, the special constable at the police station, to be utterly compelling. I find, on a balance of probabilities, that E did say that he had dropped the baby down the stairs. E's accounts were not consistent. That is because he is deliberately trying to find an explanation to wriggle out of responsibility for what really happened, and none of the explanations that were given are remotely true. It is no surprise that he got himself into a mess, with the number of different accounts given.

88. In my judgment, the evidence of P, E's best friend, was unconvincing and unreliable in many respects. I find that E did say to him that the baby was in hospital because he was jumping over the back of the sofa.

89. The witness said that he knew at the time he gave the statement to the police, that the police were investigating the death of a young child, and that it was very serious.

90. Each page of the statement set out by the police has been signed by P. Further, the statement begins with a statement of truth, acknowledging that he may be liable to prosecution if he wilfully states in it anything that he knows to be false, or does not believe to be true.

91. In his oral evidence, P suggested that the conversation had taken place during a previous telephone call, and not on the occasion that they met on 13 July, when talking about E suggesting that F had fallen off the back of the sofa. He was lying.

92. The next sentence is telling:

> "E seemed very scared, and I carried on talking to him, and he eventually broke down into tears, and said, 'The baby has fell down the stairs'. He said he didn't want to tell me that the baby had fallen down the stairs, as he thought that I would judge him because I have got children myself".

93. P describes himself and E as "best friends". He was giving dishonest evidence to support his friend.

94. I do, however, accept his evidence when he said:

> "When I met him, he looked scared. I've never seen him so scared. I've never seen anyone in the state he was in. I had to push him to get detail. He was being short with me. He was saying he was in serious trouble. I was breaking him down to try and find out what actually happened. He was all stuttery and jittery".

That was evidence given by P during his oral evidence.

95. The description of E's demeanour on that occasion is entirely consistent with somebody who realised the enormity of what they had done.

96. I also attach some weight to the fact, as I find it to be, that E did not ring for an ambulance immediately, preferring to go outside and ask a neighbour if he could do CPR. This shows that E knew how serious the situation was.

97. I accept the written evidence of S, another neighbour, at F305. E's apparent reluctance to seek professional medical assistance is consistent with not wanting to alert the authorities, in the hope that it could be dealt with, with local help.

98. Whilst I accept that people behave differently in times of crisis, this action was probably because he realised that he had caused really serious harm to F. He had to be prompted to ring, even when the neighbour was present.

99. In cross-examining the medical experts, Mr Sampson, Queens Counsel, sought to bacon-slice the multiplicity of injuries suffered by F. His cross-examination sought to probe whether there were a "possible" (on just about every occasion, he was keen to stress that he was not asking the expert to say, "probable") alternate explanation for each individual injury.

100. The experts were keen to stress in response, that:

> "It is not an appropriate way to assess causation of injuries in a case like this, where those injuries are variable in nature, and have been caused

> to different planes in the body. You have to consider the constellation of injuries in the context of the explanations for them that are given for them by carers".

I agree.

101. The Court has to consider these injuries holistically, rather than individually. The Court also has to consider the nature of the individual injuries. The bruising to the ear, the penis, the mandible and the trunk are all consistent with inflicted injuries, in my judgment.

102. I accept the mother's evidence that she changed F on the morning of 12 July. I accept that bruising to the penis was not present at that time. I find that it was inflicted by E, probably, by pinching E's penis.

103. I am also satisfied that F would have been wearing a nappy which would have made this injury even more unlikely in a fall downstairs.

104. I also accept that there is no evidence to suggest that F would put toys down his nappy, or pinch his own penis.

105. I find that the bruising to the ear was not present when the mother was last home on 12 July. It was caused after she left, by E, probably, slapping F's ear. I am not satisfied that this is the type of ear injury to have been caused by a fall down the stairs, because of the position of the bruising on the inner concave of the ear.

106. Had it been an accident, I accept Dr Birch's evidence that, in an accidental knock, the damage would be more likely to affect the protruding parts of the ear.

107. I am also satisfied that the bruising to the mandible was caused by E grabbing F's face. Likewise, the bruising to F's right side of the trunk.

108. The bruising to the nose is, in my judgment, to the side of the nose, rather than to the front or bridge of the nose. That is more consistent with inflicted injury, in my judgment. Had he suffered the injury from walking into the doorframe, as suggested, the injury would be frontal.

109. That account is not helped by the linear mark to the forehead, as it is on the outside of the left eyebrow, and on a different plane. In my judgment, the injury to the side of the nose was caused by a blow.

110. It is also significant, in my judgment, that there were no significant abrasions to the body of F, consistent with a fall downstairs, which was covered in a heavy-duty carpet.

111. I also accept the evidence of Dr Medcalf, that it is unusual for injuries to be widespread after falls down the stairs. I also accept his evidence that fatal outcomes are rare.

112. I accept the one case study advanced by Lantz and Couture. However, that did not happen with F. I find that, based on a holistic evaluation of all the evidence, including the constellation of injuries, and the accounts and behaviour of E.

113. Dr Medcalf suggested that the reason that widespread injuries do not occur in falls downstairs, particularly with children, is that it is a series of small falls down a staircase. Furthermore, children have less distance to fall than adults.

114. Dr Birch suggested that children also relax more than adults, when falling. It is significant, in my judgment, that F had, actually, fallen down the stairs in April that year, when he was taken to hospital by his mother. He only sustained relatively minor injuries.

115. I accept the mother's evidence, also, that the lower stair gate was functioning correctly, and that F could not open it. Therefore, for him to have climbed the stairs, the stair gate must have been open. It also meant that, if he had fallen down the stairs, as was suggested by E, he would simply have fallen into a gate that opened.

116. I also accept the point that, on the photographs, the piece of wood that was placed at the bottom of the stairs is still in situ.

The mother

117. No party has advanced a positive case against the mother in respect of causation of any of the injuries. The Local Authority also, made it clear at the conclusion of the evidence, that they do not pursue a finding of failure to protect. The Children's Guardian agrees with the position adopted by the Local Authority.

118. There is no evidence before the Court to indicate that the mother was, or should have been aware that F was at risk in the care of E.

119. The Local Authority has invited the Court to extend the interim care order, nevertheless, on the basis that the mother is on a journey, and she recognises that she needs to be more selective about how and when her intimate relationships commence, and with whom.

120. There may need to be a debate, post judgment, as to the structure of the welfare aspects of the case going forward, in particular, because it has come to the attention of the allocated social worker that the father's new partner has two older children who were adopted after care and placement proceedings. The father's parenting assessment was due on the date submissions were given. The father's position on this issue was unknown as he had failed to engage with his legal team.

121. Based on the recent information, as a minimum, there needs to be a contact risk assessment, albeit that contact is facilitated by an aunt.

122. There is also a clear need to agree a rehabilitation plan for the return of A to the care of his mother. That would require input from the Guardian, Social Services, Mother, Father, and, possibly, members of the extended family.

123. It is suggested that the current interim care order should continue in force until A has been rehabilitated into the care of his mother, and the contact risk assessment has been undertaken.

124. The Guardian disagrees with the stance taken by the Local Authority in respect of an ongoing interim care order, as does the mother. The Guardian recommends that A returns to the care of his mother immediately. He is, currently, spending every day with his mother, and has long periods in her care. The observations are that A has a close attachment with his mother, and some confusion as to why he cannot live with her.

125. Given the length of time that these proceedings have taken, for understandable reasons, he has now lived away from his mother for over 14 months. The Guardian does not consider that A needs a phased rehabilitation, and should return as soon as practicable to the mother.

126. In respect of contact arrangements with A's father, the current arrangement, where A spends weekends with his paternal great-aunt, and has contact with his father during that time, will continue by agreement between the mother and the father.

127. In any event, even if the information around the father's partner is a cause for concern, the Local Authority could continue to work with the family under the child in need provision.

128. The mother's submissions are that, as there is no link between the mother and the findings against E, these proceedings should come to an end, with A being returned to the mother's care. That is based, in part, on a positive parenting assessment of the mother at E224, Mother's cooperation throughout the process, and the absence of any other professional intervention with her, and her wider family.

129. There is no basis for any public law order, it is contended, and reference is made to page E247 in the assessment:

> "In the event there is no further evidence presented to the Court that would question C's account, then the Local Authority would support the rehabilitation of A to C. However, a level of supervision would be required initially".

No such evidence has been provided; it is argued.

130. In light of my findings, and my exculpation of the mother, I can see no proper basis for continued interference with the mother and A's right to private and family life, under Article 8. An ongoing interim care order, would, in my judgment, be a disproportionate interference in their lives.

131. Whilst it may be the subject of debate as to whether the combined section 38 and section 31 Children Act threshold test for the making of an interim care order is met, I am not satisfied that it is necessary and proportionate to continue with any form of public law order in this case.

132. In those circumstances, I discharge the current interim care order, and bring it to an end. I do not consider that it is consistent with A's welfare for these proceedings to continue any further.

133. I do not intend to take any further action in respect of E's refusal to come into court and answer questions. He is, presently, remanded in custody, pending his criminal trial in November, on a charge of murder. In those circumstances, I do not consider that it is consistent with the public interest that committal proceedings should be pursued.

134. That concludes this judgment.

End of Judgment.

Transcript of a recording by Ubiqus
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Ubiqus hereby certify that the above is an accurate and complete record of the proceedings or part thereof