Neutral Citation Number: [2021] EWFC 101

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 8 December 2021

Before:

MRS. JUSTICE KNOWLES

- -

Re T (No.2) (Care Proceedings: Fact-Finding: Genital Injuries: Supplemental judgment for publication)

- -

Nick Goodwin Q.C. and Carolyn Jones for the **Applicant**
Elizabeth Isaacs Q.C. and Kirstie Danton for the **First Respondent**
Sara Lewis Q.C. and Stuart Lewis for the **Second Respondent**
Elisabeth Richards for the **Third Respondent**
Margaret Styles for the **First Intervener**
Lorna Meyer Q.C. and Nandini Dutta for the **Second Intervener**
John Vater Q.C. and Dr. Emma Gatland for the **Third Intervener**

The names of those solicitors who instructed counsel have been omitted for anonymity.

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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

Mrs Justice Knowles:

Introduction

1. On 17 November 2021 I handed down a fact-finding judgment in care proceedings concerning a little boy called T, who was then three years old.

2. The fact-finding came about because the local authority asserted that T had sustained inflicted injuries, including (but not limited) to his genitals and anus, which were caused by someone who had been caring for him. After some 15 days of oral evidence and submissions I found that, amongst other things:

    a. All of T's injuries had been inflicted by one (or both) of two possible individuals who had care for him at the relevant time;

    b. He suffered genital injuries as a result of an inappropriate and excessive force being applied to his genital area;

    c. He suffered anal injuries as a result of a penetrative act, or attempted penetrative act;

    d. These injuries were caused on one or more occasion by an adult subjecting T to either a sexual assault or a physical assault without sexual motivation.

3. I could not reach any firmer conclusion, in the absence of a prompt forensic examination of T and against a 'wall of silence' from those who had been caring for him, about who may have subjected T to these assaults.

The evidence

4. In addition to an extensive bundle of statements, medical evidence, expert reports, and material gathered by the police investigation into T's injuries, I was also provided with copious medical records and good quality hard copy photographs of T's injuries.

5. Over the course of the hearing I heard oral evidence from a number of clinicians who saw T when he was presented to hospital by those caring for him. Those witnesses were: Dr A, a junior doctor who saw T on arrival in hospital; Dr B, a paediatric registrar to whom T was referred by Dr A; Dr F, a consultant paediatrician; Dr D, a consultant paediatrician and the safeguarding lead in the hospital to which T was admitted; Dr E who examined T at the Sexual Assault Referral Centre; and Dr L, a consultant paediatrician who examined T in August 2020 and who is the safeguarding lead for the NHS Trust responsible for T's care. I also heard expert evidence from Dr Kate Ward, a consultant paediatrician, and from Professor Amaka Offiah, a consultant paediatric radiologist.

6. Over the course of the clinical evidence I had become concerned by what appeared to be lamentable delays between T's arrival at hospital with apparent genital injuries and his examination by specialist doctors. It was sadly the case that it took eight days from the time T was first seen in the A&E department to his examination in a sexual assault referral centre despite clinicians observing injuries to his genitals and anus shortly after he first arrived at hospital.

7. Having heard submissions from the parties - and being invited by the safeguarding lead for the NHS Trust to consider whether a Working Together Rapid Review was warranted - I included a section at the end of my judgment addressing the delays in obtaining that specialist medical examination of T's anogenital injuries.

8. The purpose of this supplemental judgment is to condense my conclusions about T's medical examination (and his presentation at hospital) into a form which (a) may be useful to those making commissioning decisions in relevant areas of health services and social care; (b) may assist anyone who may enquire why it took so long for T to receive the medical examinations his case required; but which (c) will avoid any jigsaw identification of T or the public dissemination of any information which is not relevant to purposes (a) and (b).

9. What follows therefore is a heavily abridged version of my full judgment, from which all but the key discussions have been removed.

Background Summary

10. T's mother made a 111 call at 1828h on 21 July 2020. The call lasted for about 7 minutes. When asked why she had rung, the mother said the following:

> *"… erm, well he's two, I have just changed his bum and erm his balls look really swollen and like so does his penis, and his penis looks like really bruised and red and like obviously he's saying it's hurting him. He's been very grouchy all day but it's only just now that I've noticed it's all of a sudden like ballooned up…"*

When asked by the operator whether what she saw was like a rash or like a bruise, the mother said it looked more like a bruise. Having given her details to the operator, the mother answered questions to establish T's symptoms. During that process, the mother confirmed that the whole area around T's testicles seemed swollen and sore. When asked whether this had occurred in the last 24 hours, the mother said as follows:

> *"Yeah, well like I changed, when we've been to like the park, so like I changed his bum and there was a bit of a like mark I guess but do you know I didn't really think anything of it I just thought he had knocked, do you know knocked it or something or caught it. Erm but then obviously I have got back and just changed his bum and it's just swollen, yeah, really bad."*

11. The mother took T to hospital. She and T arrived in the Paediatric Accident and Emergency department at 1932h.

Hospital Admission and Thereafter

12. At triage, T was said to have swelling and redness to his penis. The base of the penis appeared bruised and there was a small bruise to the left side of his groin area above the penis. His mother was reported to say that T's penis was *"slightly red this morning, changed nappy after coming from the park. Appears bruised"*. The triage notes suggested that T had been given paracetamol for pain relief but no record exists of a hospital staff member doing so. At 2215h T was seen by Dr A to whom the mother said that she had seen a red *"rash"* on his penis that afternoon. Dr A noted that, over a few hours, this became more florid looking. The mother was said to be concerned about the

rash and possible infection but she had not noticed T tugging at his penis or complaining of pain. According to the mother, there had been no recent accident which might account for T's presentation. Though playful and smiley, T became withdrawn and quiet on examination of his external genitalia. Dr A recorded his findings as follows:

> *"… Swollen inguinal regions with mild bruising - tender to palpate, no masses, penis appears purple and purpuric, ? bruise like, cannot palpate L or R testicle. Bruising R upper ant. thigh, L hip, R buttock. Full body exam (?), small coin bruise central chest and midcentral back."*

13. In his oral evidence, Dr A confirmed that he judged T to be in pain when he examined his genitals. He took a brief social history from the mother and confirmed that he would have written down if the mother had a boyfriend but she had not mentioned this to him. He told me that the mother's response to him was cooperative and not resistant. Dr A consulted with the paediatric specialist trainee doctor, Dr B, as his examination of T had suggested to him that T's symptoms could be related to non-accidental injury.

14. Dr B examined T at 2332h. She took a history and undertook a detailed examination of T, identifying what she saw on a body map. She examined T in artificial light and did not use any specialist lighting equipment. She did not recall observing T to have difficulty walking and thought that, absent what was recorded on the body map, he looked like a well child. During her examination, Dr B attempted to establish who had cared for T and recalled asking the mother about this several times. The mother did not mention that she had a boyfriend at this stage but only did so later after Dr B had spoken to the local authority and had come back to double check who might have been caring for or had contact with T in the very recent past.

15. The injuries recorded by Dr B were as follows:

    a. a 1cm bruise under the chin;

    b. four red circular bruises measuring 0.5 cm under the chin;

    c. a 1cm that was well circumscribed on his chest;

    d. three brown bruises on the left flank measuring 1 cm in diameter;

    e. 2 cm blue haematoma (raised bruise) on the left side of the groin that was irregular in shape and tender to touch;

    f. 4 cm linear red lines which appeared like scratch marks to the skin in the suprapubic region just above the penis;

    g. a 10cm red linear bruise on the left side with skin abrasion towards the knee. The mother explained that T had grazed his leg at the park on a climbing frame;

    h. a 1 cm red-blue circular bruise on the left knee which the mother thought was due to a fall;

    i. two small brown bruises on the left leg;

    j. four small brown bruises on the front of the right leg and knee;

k. a 2 cm blue haematoma (raised bruise) with irregular edges on the right thigh next to the groin that was tender to touch;

l. a 1cm brown bruise on the right groin;

m. a 0.5 cm circular brown bruise on the right arm;

n. a 1.5 cm linear red bruise on the back of the right side;

o. a 1cm black-brown circular bruise on the right buttock;

p. a 2cm transverse brown bruise on the right calf;

q. a 0.5 cm brown circular bruise midway on the back of his left thigh;

r. a 3cm green circular bruise over the left hip;

s. a 1.5 cm circular red bruise midway on the back to the left of the spine;

t. a 1.5 cm circular brown bruise over the lower spine;

u. red-blue bruising around the whole penis including the underside and extending to the scrotum just below the penis; and

v. circumferential redness around the anus which the mother said she thought was due to loose stools though the redness did not look typical of a nappy rash.

16. Additionally T was seen to have multiple petechiae, or tiny red spots of bleeding into the skin on the back of his neck with a few on the left of his forehead. Dr B made a referral to the emergency duty social worker because of the lack of explanation for these injuries given by the mother. In her police statement, Dr B said that, in her six-year paediatric career, she had never seen this degree of bruising in a child of T's age.

17. T was admitted to hospital and, the following morning (22 July 2020), he was reviewed by Dr F, a consultant paediatrician, at about 1200h. In his oral evidence, Dr F told me that he remembered T's case well as the extensive bruising to T was the worst that he had ever seen. He took a history from the mother who told him that she had changed T's nappy before going to the park but there was nothing of concern when she did so. She had only noticed bruising in his nappy area after returning from the outing to the park. Dr F annotated the body map created by Dr B and noted the following additional marks:

a. a graze above left eyebrow;

b. a bump on his forehead (though there were no bumps on the rest of T's head);

c. Ears and frenulum were intact with no injuries in the mouth;

d. two circular bruises on right forearm anteriorly approximately 4mm in diameter;

e. a bruise on right elbow;

f. a few petechiae under the chin;

g. small bruises on the front of the chest;

h. a small bruise on the right sub-costal area;

i. significant bruising on the right groin;

j. significant bruising on the genitals;

k. right knee and lower leg, 3-4 bruises;

l. a bruise on left forearm around 4mm;

m. bruises on the left flank;

n. a bruise on left inner thigh;

o. a bruise on left knee and left lower thigh anteriorly;

p. a bruise on left upper thighs laterally around 5mm;

q. a small bruise on left lower leg around 3-4 mm;

r. several small bruises on the back;

s. a bruise on the right buttock; and

t. redness in the perianal region.

18. Dr F ordered medical photographs and told me that these did not do justice to the bruising which he saw. The bruising extended from the upper part of T's legs going into his groin, penis and scrotal area. Dr F had no doubt that T had sustained inflicted injuries. Due to the extensive bruising to T's genitals and the redness in his anal area, Dr F spoke to Dr D, one of the two child protection lead doctors for the hospital, and asked for her input. He could not be precise about when that conversation took place but felt it would have been on the day he saw T or on the next day. In addition to these matters Dr F ordered that T should have an ophthalmology review, a skeletal survey, and a CT head scan. The clinical photographs were taken on the afternoon of 22 July 2020.

19. Later that afternoon a strategy meeting took place involving the local authority and hospital staff. It concerned itself with the physical abuse of T and did not identify that he may have been sexually abused. The decision was taken to begin a child protection investigation involving the police and T was taken into police protection. Nursing staff noted that T had a red bottom which appeared sore and tender to the touch when his nappy was changed. T pointed to his genital area when asked if he had any pain.

20. On 24 July 2020 Dr D reviewed T's circumstances following her discussion with Dr F. She reviewed the medical history and examined T on the ward at about 10 am and was troubled by what she saw. The medical notes noted her initial impression as follows: *"bruising very concerning - no reasonable explanation - does not fit with accidental trauma; concentration of bruises around genitals was worrying; anal bruising with crescentic redness - sexual abuse unlikely, but in view of presentation, required*

consideration". Dr D queried whether T needed screening for sexually transmitted infection and whether he should be examined for child sexual abuse. She contacted T's social worker and discussed his case with the designated doctor for child protection in the hospital trust, Dr L.

21. At 1400h the same day Dr D returned to complete her own body map of T. Her findings were as follows:

a. a collection of deep purple bruises just below the groin on the right upper thigh. Total area of bruising 4cm by 2cm, comprised of three separate bruises with an area of central clearing. Dr D queried whether this possibly have the appearance of a pinch mark;

b. a small brown bruise on the anterior aspect of the left thigh. This was not of particular concern;

c. extensive deep purple and green bruising to the suprapubic area - an area to the left of the external genitalia measuring 5cm in diameter;

d. a 2cm diameter area of deep purple and green bruising to the suprapubic area on the right of the femur;

e. deep purple bruising to the base of the shaft of the penis;

f. a 2 cm diameter area of deep purple bruising over the upper part of the left scrotum;

g. the lower part of the left scrotum widely discoloured with a fading green colour likely to represent fading bruising;

h. a 2cm fading Brown bruise over the bony prominence of the butter on the right side;

On perianal examination –

i. AV shaped area of erythema at 12 o'clock position on the immediate anal orifice with no evidence of skin breakdown;

j. a healing laceration or fissure at 6 to 7 o'clock position at the lower aspect of the anus;

k. numerous areas of non-specific erythema (redness) over the lower half of the anal margin and, on reflection, the perianal area itself - possibly representing perianal bruising;

Elsewhere –

l. a 1cm fading bruise on the lower bony prominence of the left rib cage - not of significant concern;

m. two bruises over the bony prominence of the right knee - likely to be accidental in origin;

n. a 1cm and 2cm bruise over the right lower shin - again likely to be accidental in origin;

o. a bruise over the bony prominence of the left knee;

p. over the bony prominence of the left shin, a small bruise - likely accidental in origin;

q. a 1.5cm brown fading bruise to the left lower back;

r. a further 1.5cm brown bruise to the left lower back; and

s. a 1cm fading bruise over the iliac crest on the left side;

22. Dr D's discussion with Dr L resulted in a shared concern that T may have been the victim of sexual abuse and needed a specialist medical examination with equipment which might provide a better view of his anal area. Dr D contacted the local authority social worker to discuss her concerns about possible sexual abuse and made plain the need for a specialist examination by a Sexual Assault Referral Centre (SARC). The medical records noted that the local authority would make the referral to the SARC. In her police statement dated 3 September 2020, Dr D said this: *"…we have discussed that my recommendation would be that [T] has an urgent assessment within a sexual referral centre as a matter of urgency to avoid loss of evidence. [T] was presented to hospital on 21st July and today, 24 July, unfortunately it is unlikely that any forensic evidence would be available. However, clearly the possibility of sexual assault and any consequent sexually transmitted infection needs to be addressed…"*. In her oral evidence, Dr D told me that historically, if the clinical team was concerned about child sexual abuse, the SARC assigned doctor would come to the ward and offer an opinion. Now, the clinical team had to refer a child to the SARC for examination. In order for a child to be seen by the SARC, the clinical team had to refer the matter to the local authority as the local authority had to make the referral. Dr D also told me that it was a source of frustration to her as a paediatrician that the SARC did not see children out of hours.

23. On 29 July 2020, T was examined by Dr E, a forensic physician at the SARC. The examination was not a forensic examination as T was seen outside the window within which forensic swabs could be usefully taken. Dr E completed another body map on which the following injuries were noted:

a. 2cm by 2cm brown/green/yellow bruise over right groin back;

b. 0.6cm by 0.6cm brown bruise on the back of the right elbow;

c. 0.8 cm by 0.8 cm brown bruise on the back of the right forearm;

d. 0.5 cm by 0.5cm light green bruise over left thigh;

e. 1cm by 0.6cm red bruise on the right side of the chin;

f. 0.5cm by 0.5cm red bruise on the right side of the chin (in front of the previous injury at e) above;

g. 0.5cm by 0.5cm red bruise over the right side of the buttock;

h. redness of more than 1cm in front of the anal opening at 12 o'clock position;

i. a more than 1 cm shiny healed area at the back of the anal opening at 6 o'clock position; and

j. redness round the anal opening (perianal erythema).

24. Dr E concluded that his examination findings did not confirm or refute any disclosure of sexual assault. He noted that the timing of an examination was crucial and that a child should be seen as soon after an assault as possible as anogenital injuries were known to heal very rapidly and often completely, leaving no trace of trauma. If a sexual assault resulting in injuries had occurred, he noted that these may well have healed completely before his examination took place.

25. On 13 August 2020 Dr L conducted an initial health assessment for T as a child in care. Dr L found him to be a clean, well dressed, happy, and relaxed child who had no bruising of concern and no bruising to his genital area. Dr L examined T's anal area and described four specific findings in her report as follows:

a. the skin of the lower third of the perineum had an unusual shiny thickened appearance with blueish discolouration in a V-shaped distribution about the midline, up to the anal verge. There was no anal dilation in 30 seconds of inspection.

b. there were a few hyper-pigmented pinky-brown marks of a few millimetres across on the left and right of T's anus. AB said that these *"dots"* were left after spots of nappy rash had resolved. There were no lacerations around T's anus.

c. in the 1 o'clock position, near parallel to the median raphe, there was a relatively thick discrete white linear area of tissue radiating from the anus to just beyond the anal verge.

d. at the upper pole of finding C above, and perpendicular to it, there was the impression of a very fine hairline white line, which fell within the V-shaped area of the perineum which had skin texture and colour change (see finding a) above).

26. Dr L concluded as follows:

a. the anal laceration described by Dr D at 7 o'clock appeared to have healed without scarring *"as would be a typical clinical course*";

b. the anal scar at 1 o'clock was suggestive of sexual abuse in the absence of a history of exceptional trauma such as anal impalement;

c. the scar could predate T's hospital presentation but have been obscured by acute injuries or have been missed by non-specialist examination. Scars can be easily missed if hidden between puckered anal skin folds and visibility can be dependent upon the degree of the child's relaxation and cooperation. The scar could have arisen from an acute injury sustained after the 24 July 2020 examination, although this was the least likely explanation. The most likely explanation was that the laceration was sustained shortly before admission and *"had healed to a point of mucosal adhesion within this time but not yet undergone fibrous organisation to visible scar"*; and

d. the skin in the adjacent area was of an unusual appearance, with uncertain significance and a possible fine line scar in the horizontal plane. Magnified views using video colposcopy might assist with the clinical interpretation. No subsequent colposcopy took place.

[…]

The Medical Evidence

Haematology

27. Professor Sally Kinsey, consultant paediatric haematologist, was jointly instructed by the parties in order to establish whether T had any haematological abnormality that might have predisposed him to spontaneous bruising or bleeding or to more extensive bruising or bleeding following trauma. Her opinion was clear that T had no haematological abnormalities relevant to the physical trauma he sustained. No party pursued further testing or sought to challenge Prof. Kinsey's evidence.

Radiology

28. Professor Amaka Offiah, consultant paediatric radiologist, was jointly instructed within these proceedings. Following a careful review of the hospital imaging, she confirmed that T had sustained a fracture. In her report, Professor Offiah gave a timeline for the fracture and confirmed that T showed no signs of bone weakness or predisposition to fractures or rickets. Her evidence assisted the court with other injuries T had sustained but was not relevant to T's anal or genital injuries.

Paediatrics

29. Dr Kate Ward, consultant paediatrician, was also jointly instructed. She undertook an extensive review of the medical records and produced two reports together with written answers to questions posed by the parties. Dr Ward also gave oral evidence to assist the court.

30. Dr Ward concluded that T had an uneventful medical history and confirmed that there were no factors which predisposed him to bruising.

31. In her report, Dr Ward identified marks and bruising on T's head which were indicative of inflicted injury. The petechiae to the left forehead and the back of the neck were consistent with blunt force trauma. Petechiae often fade rapidly but were significant in the context of inflicted injury and may be associated with local compression such as gripping or grasping. Dr Ward could think of no natural cause or accidental injury which would cause petechiae in the described distribution on T. The association with fingertip bruising around T's jaw also increased the likelihood that the petechiae seen were inflicted injuries. The red circular 1cm bruise under the right side of T's chin and the four red circular bruises measuring 0.5cm under T's jaw were consistent with a grip mark or with T being grasped forcibly under his chin.

32. As for the injuries to T's limbs and torso, Dr Ward identified the following as being indicative of inflicted injury:

a. three brown bruises on the left flank measuring 1cm in diameter, caused by a possible grip or grasp mark or general blunt force trauma;

b. a 2cm raised blue haematoma on the left side of the groin which was irregular in shape and tender to touch, caused by inflicted blunt force trauma;

c. a red 4cm linear bruise to the front of the right thigh, caused by blunt force trauma such as a blow, punch or kick;

d. a red 1.5cm linear bruise on the right side of the back, caused by a slap or blunt force trauma with a linear implement;

e. a black brown circular 1cm bruise to the right buttock, caused by blunt force trauma such as a blow, punch or kick;

f. a brown 2cm transverse bruise on the right calf, caused by blunt force trauma such as a blow, punch or kick;

g. a red 1.5cm circular bruise midway on T's back to the left of his spine, caused by blunt force trauma such as a blow, punch or kick;

h. a brown 1.5cm circular bruise over T's lower spine contiguous with the left spinal bruise listed above, caused by blunt force trauma such as a blow, punch or kick; and

i. occult trauma to the abdomen, skeletal muscle or other organs evidenced by raised ALT (alanine aminotransferase). Raised ALT can be a marker for liver injury and may also be indicative of trauma to other tissues such as skeletal muscle, heart, kidney, pancreas, spleen or lung. Though an abdominal ultrasound scan was not undertaken at the time of T's admission to hospital, the raised ALT level seen in T was 159 units per litre (reference range 10-50) indicating the presence of inflammation of or damage to the liver or other organs.

33. Additionally, Dr Ward identified inflicted groin and pubic injuries, namely:

a. a blue 2cm bruise on the right thigh next to the groin which was irregular and tender, caused by blunt force trauma such as a blow, punch or kick;

b. a brown 1cm bruise on the right groin, caused by blunt force trauma such as a blow, punch or kick;

c. a blue 2cm bruise on the left side of groin, caused by blunt force trauma such as a blow, punch or kick; and

d. linear 4cm red scratches in the suprapubic region above the penis, caused by scratching or scraping;

e. The injuries to T's head, limbs, torso and groin were impossible to date from appearances alone and it was thus difficult to say when they might have been caused.

34. Finally, Dr Ward identified anogenital injuries consistent with inflicted trauma. These were as follows:

a. severe, extensive, red/blue bruising around the whole penis including the underside and over the foreskin, extending to the scrotum, caused by blunt force trauma such as a blow, punch or kick. In her oral evidence, Dr Ward considered that there was an element of grabbing, grasping, squeezing, twisting or pulling in the causation of these injuries;

b. a V-shaped redness at the 12 o'clock position in the immediate anal orifice;

c. circumferential perianal redness extending into the natal cleft;

d. wedge-shaped redness and inflammation between 11 o'clock and 1 o'clock peripherally with apparent loss of superficial tissue between 11 o'clock and 12 o'clock peripherally;

e. an area of marked excoriation between 4 and 8 o'clock on the anus;

f. a brown/blue fading bruise at 2 o'clock;

g. a healing laceration at the 6-7 o'clock position at the lower aspect of the anus;

h. a white fine scar extending from the anal verge to the perianal skin at the 1 o'clock position with an extension creating an inverted, reversed L-shape.

35. In her written and oral evidence, Dr Ward was clear that there was no plausible accidental explanation for any of these injuries. She rejected the suggestion that the anogenital injuries were accidental because there was no reported, memorable event which could account for them. These were major injuries which would have caused T extreme distress at the time they were inflicted because that area of the body has a high number of superficial nerve fibres. Likewise, the anal abnormalities were not the product of nappy rash and the superficial tissue loss was supportive of trauma. Dr Ward's oral evidence confirmed that the extent and the depth of the redness, and bruising to the anal area was much greater than would be expected from a child with mild diarrhoea. None of the anal injuries were consistent with any developmental abnormality.

36. Dr Ward's view was that the anal injury listed at h) above was consistent with a penetrating injury and was highly unlikely to have occurred without penetration because access to the anus by kicking or punching so as to cause the identified laceration was highly unlikely. I note that this view was consistent with that of Dr L. None of the anal, penile and scrotal injuries could have been caused when T was wearing his nappy and thus it was much more likely that his nappy had been removed at the time of injury. In her oral evidence, Dr Ward accepted that the anal injuries were supportive of anal sexual abuse but stated that she could not differentiate between a penetrative injury to T's anus done for some sort of adult gratification and injuries caused in the course of physical abuse by someone who lost their temper as part of a generalised assault. Dr Ward noted that a child would have to be held firmly in order to access the anal area. She was unable to exclude the possibility that anal penetration may have occurred on more than one occasion and, further, could not conclude on the medical evidence that the penile injuries had been caused on a single occasion or on multiple occasions. However, on balance, she thought that the penile and scrotal injuries would have been noticed after a single episode of assault. Finally, Dr Ward considered

that the anal injuries would have caused bleeding into T's nappy which would have been visible to a carer.

37. Dr Ward's oral evidence confirmed her view that, at the time the injuries to T were caused, he was likely to have cried and sought adult comfort. His anogenital injuries were likely to have produced a more extreme reaction with visible and audible distress for minutes thereafter, depending on how he was comforted and settled. After his anal injuries T would have been distressed for hours or possibly days and the lacerations to his anus would have been reopened every time his bottom was wiped until they had healed. Dr Ward thought it likely that T may have tried to push his carer's hand away to prevent pain when having his nappy changed. His gait may have been affected because his nappy would have rubbed against his sore areas. Dr Ward's unequivocal evidence was that T would have been in pain from the anal injuries and from those to his genitals and groin. This would have been noticeable to a carer who was wiping his bottom and changing his nappy.

38. On balance, Dr Ward considered that T's penile and scrotal injuries were likely to have been sustained within the 24 hours prior to the 111 call as the absence of subcutaneous tissue in these areas would have made bruising and injury far more visible to a carer and thus these injuries were likely to have been detected earlier.

Discussion

T's Injuries

[…]

c) Injuries to Genitals

39. In the absence of any plausible explanation, I am also satisfied that the injuries to T's genital area were also inflicted injuries. The severe and extensive bruising around T's whole penis, including the foreskin and extending into his scrotum, was caused by blunt force trauma such as a blow, a punch, or a kick or by grabbing, grasping, squeezing, pulling or twisting the affected areas. Those injuries would have caused extreme pain and distress to T when they were being inflicted and whoever inflicted them would have known that injury was likely to occur as a result of the application of inappropriate and excessive force to T's genitals. I accept Dr Ward's evidence that T would have been in pain when his nappy was changed and I note that, when he was in hospital, T indicated his genital area when asked where he was hurting on both 22 and 23 July 2021.

40. Dr Ward considered that these injuries would have been very obvious to a carer and were thus likely to have occurred within 24 hours of the 111 call being made on 21 July 2021. I accept her oral evidence that the presence of swelling tended to be an early sign of trauma and was suggestive of a recent injury. At the time of the 111 call T's scrotum and penis looked to the mother to be really swollen. Dr A, the first doctor to examine T, noted that the mother described swelling as part of the history which he took from her, and the swelling to T's genital area was visible to him.

41. Whilst the presence of swelling suggested that the genital injuries occurred within the 24-hour timeframe given by Dr Ward, the evidence indicated a degree of confusion about the observable signs of injury prior to the call to 111 and when the injuries may

have occurred. I concluded that they were likely to have happened sometime before about 1pm on 21 July 2020.

[…]

d) Anal Injuries

42. Analysing the evidence with respect to T's anal injuries has been complicated by the fact that his anus was examined by a number of doctors of varying experience at different times and using different techniques. Apparent differences in what was seen appears to be explicable on the basis that T's anal injuries were at different stages of development and resolution when seen over the course of several weeks.

43. First, no significance can be attached to the absence of a record of anal injuries to T when he was examined by Dr A. Dr A could not recall whether he had performed an anal examination but said his ordinary practice was to look at both the perianal and perineal regions albeit that he did not record this in his note. I observe that Dr A was conducting an initial examination as a relatively junior doctor. Thereafter, Dr B parted T's buttocks but did not conduct any detailed examination of his anal area save to observe that there was circumferential redness around his anus. Dr F also described redness in T's perianal region but did not document any other anal abnormalities. He had no doubt that T was the victim of inflicted injuries but had no opinion as to whether T had been sexually assaulted. None of these doctors conducted a detailed examination of T's anal area though the extensive bruising to T's genitals and the redness in his anal area prompted Dr F to seek advice from Dr D, one of the two named child protection doctors in the hospital.

44. Dr D did not conduct a forensic examination to ascertain whether or not T had been sexually assaulted because she was not qualified to do so. She too noted the extensive bruising to T's scrotum, penis and inguinal areas. Her initial examination noted the presence of anal bruising with crescentic redness and she queried whether there was a healing laceration at what seemed to be the 6 to 7 o'clock position. In the anal bodymap completed later that afternoon after a more detailed examination of T, Dr D recorded an area of redness at the 12 o'clock position on the anal orifice together with redness over the lower half of the anal margin and the perianal area, possibly representing perianal bruising. She also noted a healing laceration or fissure at the 6 to 7 o'clock position at the lower aspect of the anus.

45. Dr E's conclusions following his forensic examination on 29 July 2020 neither confirmed nor refuted child sexual abuse. He observed: (a) redness around the perianal opening; (b) redness of more than 1 cm in front of the anal opening at 12 o'clock position though he was unable to estimate when or how this was caused and noted that it could be attributable to a number of causes including rubbing, irritation or acidity from stools/urine; and (c) a shiny healed area greater than 1 cm at the 6 o'clock position on the anus.

46. Dr L, who examined T on 13 August 2020, was a very experienced specialist child sexual abuse examiner who conducted about 50 anogenital examinations a year of which about 10 were in the younger age group. She made three significant findings. First, there was a V-shaped shiny thickened area with bluish discolouration on the lower perineum. This was not a midline fusion defect as this would have been a different

shape and would have been noted at T's six week health check. This area was likely to represent healing of the same anatomical area observed by Dr D. It was an unusual injury and so Dr L was cautious about its provenance but noted that it was unclear to her what the benign explanation for such an injury would be. Second, there was white linear tissue at the 1 o'clock position radiating from the anus to just beyond the anal verge. This was an anal scar, highly suggestive of anal sexual abuse, extending deep into the anal folds. It was unlikely to be a scar from constipation as constipation fissures did not leave a scar once healed. It was more likely to be penetrative injury or a stretching of the anal circumference beyond which it was unable to maintain its integrity. Dr L noted that the anus is a sheltered part of the body and a simple blow to that area would not cause laceration. Again, it was unclear to her what the benign explanation would be. Third, there was a fine white line perpendicular to the upper pole of the scar tissue at the 1 o'clock position. This was a surprising finding which had not been seen by Dr D. There were three possible explanations, first being the scar was present but obscured when seen by Dr D; the second being that the injury was sustained after Dr D's examination; and the third being that the injury was acute and sustained before Dr D saw T but it had yet to undergo fibrous maturation into scar tissue. Dr L considered the third explanation to be the most likely and again observed that it was unclear to her what the benign explanation would be for this. Finally, Dr L noted that the lesion at 6 to 7 o'clock appeared to have healed without scarring as would be a typical clinical course.

47. Dr Ward reviewed all the anal findings and noted the following. First, the extent and depth of the redness, congestion and bruising in the anal area was much greater than one would expect from mild diarrhoea. Second, the superficial tissue loss was supportive of trauma. Third, having viewed the examination video taken by Dr E, Dr Ward was confident that there was an injury at 1 o'clock although she was unclear about the manner in which it had developed post-infliction. It was possibly a healed scar as she noted that the hospital photographs appeared to show a laceration at 1 o'clock. Such lacerations heal quickly and Dr L had seen a scar at the same site. Fourth, Dr Ward confirmed the presence of the healing laceration/fissure at the 6 o'clock position, on the lower aspect of the anus. Fifth, Dr Ward noted that some injuries healed quickly within 24-hours but some healed with a scar. This would explain the difference between the 6/7 o'clock injury and the 1 o'clock injury.

48. The above analysis allows me to be satisfied that T's anus was injured as identified by Dr Ward in her report and that these were inflicted injuries sustained through penetration or attempted penetration.

49. I accept the evidence of Dr Ward that dating the anal injuries is not possible. They were consistent with one assault or with a number of assaults. Though both Dr Ward and Dr L considered it likely that the lacerations to T's anus would have bled on infliction and would have bled every time he opened his bowels, I note that T had no observed anal bleeding in hospital. This may have been either because the lacerations were starting to heal or because he continued to suffer from diarrhoea such that anal lacerations may not have bled on opening his bowels. More importantly, after the infliction of these anal injuries, T would have been visibly and audibly extremely distressed for minutes and possibly longer (depending upon how he was comforted and settled and his temperament). He is also likely to have sought comfort when these injuries were sustained. These injuries would have caused him pain every time his bottom was wiped

until they had healed and T may have tried to push his carer's hand away when having his nappy changed.

50. As for whether it is possible to ascribe a sexual motivation to T's anogenital injuries: First, it was plainly difficult to determine a perpetrator's mindset in the absence of a confession. Second, the word "*sexual*" is imprecise. Whilst T may have been penetrated with a penis or a finger in order to arouse the perpetrator, causing incidental injuries, he might equally have been deliberately hurt to prompt the same arousal. The groin injuries might conceivably be secondary to an attempt to hold whereas the penile/scrotal injuries were more likely to be deliberate. Overall it was impossible to determine whether the perpetrator caused the injuries whilst gratifying themselves or whether the overall intention was to hurt T - albeit that the perpetrator chose sensitive sites usually associated with the commission of sexual abuse. I accept those submissions by the local authority and find that the anal injuries sustained by T were the result of sexual assault, alternatively physical assault without sexual motivation.

[…]

The Medical Investigation of T's Injuries

51. During the course of the hearing I became concerned about the delay (a) in recognising that T's genital injuries might have been indicative of a sexual assault and (b) in arranging a prompt examination of T's anus. I asked for submissions from the parties on these issues. I emphasise that what follows is not intended to be critical of the individual clinicians involved in T's care, all of whom will have been under considerable pressure, not least as a result of the continuing effects of the Covid-19 pandemic.

52. Neither Dr B who examined T late at night on 21 July 2020 nor Dr F who examined T on 22 July 2020 considered (a) that his widespread and serious genital injuries might be indicative of a sexual assault or (b) that it might be prudent to conduct an urgent forensic examination of his genitals and anus. The discussion at the strategy meeting in the early afternoon of 22 July 2020 was couched in terms of T having experienced serious physical abuse. Due to the extensive bruising to T's genitals and the redness in his anal area, Dr F spoke to Dr D, one of the two child protection lead doctors for the hospital, and asked for her input. He was not precise about when that conversation had taken place but felt it would have been on the day he saw T or on the next day. Regrettably, Dr D did not see T until 24 July 2024 for reasons which are unclear to me. Her examination of his injuries prompted her to recommend a forensic examination and she discussed a referral to the Sexual Assault Referral Centre (SARC) with the social worker assigned to T on 24 July 2020 in the afternoon.

53. Having viewed the photographs taken on the afternoon of 22 July 2020, the failure by the treating clinicians to appreciate that T's genital injuries and the extensive anal redness might be indicative of a serious sexual assault warranting an urgent forensic examination seems utterly inexplicable. The Guidance published by the Royal College of Paediatrics and Child Health in May 2015 entitled *"The Physical Signs of Child Sexual Abuse: An Evidence-Based Review and Guidance for Best Practice"* (known as the Purple Book because of the colour of its cover) contains a chapter on the genital signs of sexual abuse in boys. Its review of the literature indicated that, although not well reported, genital injuries, predominantly to the penis, occur in a small proportion

of boys who have been sexually abused. It identified a number of issues for clinical practice and I highlight the most relevant to T's case, namely that, when a boy presents with a genital injury and there is an absence of a supportive history of an accident, or if the history for the injury is inconsistent with the explanation, child sexual abuse should be considered (page 125). Anogenital injury without an acceptable explanation is an indicator for a referral for a forensic examination (paragraph 11.2.9, page 220). I note that the Purple Book is also clear that clinical signs of trauma heal rapidly and may be lost unless a child is examined within 24 hours of the alleged assault though evidence may still be present up to 72 hours and even up to one week after the alleged assault in older children (paragraph 11.3.13, page 226).

54. I have no information about the training about the sexual assault of children which is habitually given to doctors working as either a specialist paediatric trainee or a consultant paediatrician working in a hospital. I also do not know whether modern clinical practice advises such doctors to steer well clear of raising concerns about the sexual assault of a child without first consulting a child protection specialist lead doctor. However, the failure to appreciate quickly that T's genital injuries may have been indicative of sexual assault and that speed was of the essence in those circumstances resulted in delay to his examination by Dr D.

55. Following Dr D's examination, the available information suggests that the social worker ran out of time to make the referral to the sexual assault referral centre on the afternoon of 24 July 2020. I understand from Mr Goodwin QC that there are limited case recordings and the relevant team manager has left the employ of the local authority. I also understand that the social worker with whom Dr D spoke was occupied at court on this case. An entry in the medical records by one of the nurses noted that she had "*discussed with* [the social worker] *regarding CSE medical - she has been unable to organise it due to being in court all day - she has requested for the hospital to organise this but has asked if it can be done next week rather than the weekend as she would like to be present for the CSE examination alongside mum and dad as mum supervised visits should be organised by then*". The reference to the social worker being unable to organise the examination due to being in court all day was somewhat misleading, given that Dr D had not made the recommendation until the afternoon of 24 July 2020.

56. It is unclear why the social worker did not phone the SARC on the Friday afternoon to secure an appointment over the weekend or on the Monday, with the paperwork to follow. I accept Mr Goodwin QC's submission that she ran out of time and was unaware of the urgency and the scope for a SARC medical over the weekend.

57. There was therefore a second period of delay over the weekend though I note that Dr D had noted that there was no obvious clinical benefit to conducting an examination over the weekend. That entry in the medical records provides a further clue to the lack of enquiry over the weekend as the social worker would not have understood there was a clinical imperative for an out of hours appointment. However, Dr D's police statement made in response to the investigation into T's injuries described her recommendation to the social worker as being for T to have an assessment within a SARC as a *"matter of urgency to avoid loss of evidence"* though she noted that, due to the delay in her seeing him, it was unlikely that any forensic evidence would become available as part of that process.

58. On Monday 27 July 2020, the duty social worker informed the hospital that the SARC would take place on 29 July 2020 and the formal referral was made the following day. Though the social worker was on sick leave on 27 July 2020, the team manager phoned the SARC to secure the appointment time.

59. I heard evidence pointing to the need for a prompt child sexual abuse examination. Dr L told me that, in her opinion, T should have been medically stabilised and then should have had an examination within 24 hours of the concern being presented. Dr E told me that there should have been an examination within two / three days as the chances were that nothing would be detected thereafter. Finally, Dr Ward observed that different doctors had examined T on the ward each day and it was three days until Dr D saw T. Though she was sympathetic to the demands placed on the clinical team, she considered this was an issue to discuss. Her view was that the possibility of sexual assault should have been excluded a great deal earlier following T's presentation to hospital.

60. I was troubled by two aspects of Dr D's evidence: firstly that the clinical team were unable to refer directly to the SARC but had to make the referral via the local authority and, secondly, that the SARC did not see children out of hours. I invited the local authority to make further enquiries as to the basis upon which the SARC service was organised. The statement from the local authority filed in response to my request suggested that there was no formal protocol between the hospital / the police / the local authority and the SARC service. The SARC service concerned is commissioned by NHS England and states that it offers a seven-day service which for children consists of both acute and non-acute clinics. A 24-hour phone service is available seven days a week. I was told by Mr Goodwin QC that the sexual abuse and abuse strategy coordinator for the area (a post funded by the NHS, involving partnership with the local authority) had indicated that she was "*currently working on a flowchart for all the different ages in SARC and what the timescales are for forensics so every service in [area] does not make the mistakes of missing those windows*".

61. If it is correct that there is no formal protocol between the SARC and the police / the local authority / hospitals, that strikes me as a significant deficit which should be rectified swiftly in order that it is clear who has what responsibility to refer for a specialist examination, and the timescales for achieving the same, together with alternatives if the hours of operation of the SARC service mean that in any given case the examination cannot be conducted at the SARC within the most appropriate timescales. I observe that if there had been clarity about these matters the delay in examining T which occurred after 24 July 2020 may have been reduced. If Dr D is right and the SARC service did not see children out of hours, that strikes me as a service which is inevitably failing to meet the need for appropriately swift medical examinations where the sexual abuse of a child is suspected.

62. To summarise, it would appear that the delays in this case arose because there was (a) a lack of early recognition of the need by all professionals of the desirability of a specialist examination, (b) a lack of clarity over the referral process, and (c) an apparent lack of service provision at weekends with no apparent alternative provision being available. I do not know whether such delays are replicated elsewhere in England and Wales but I would be very concerned if they were. The failure to recognise what was in plain sight in this case and to act swiftly meant that an opportunity was lost to identify evidence as to the date and time of infliction of T's injuries and the identity of a perpetrator.

63. On 7 October 2021 Dr L emailed me following the completion of her oral evidence. Having listened to and reflected upon the concerns I raised about the delay in T receiving a specialist forensic examination for child sexual abuse, Dr L considered that T's case should be referred for rapid review pursuant to Working Together 2018 and for consideration of whether the threshold for a safeguarding practice review was met. Dr L commented that there may be important multiagency learning from this case.

64. Chapter 4 of Working Together, July 2018, deals with reviews of serious child safeguarding cases. The purpose of such reviews is to identify improvements which could be made to safeguard and promote the welfare of children and reviews should seek to prevent or reduce the risk of recurrence of similar incidents. Reviews operate both on a national and at a local level and locally, safeguarding partners are charged with making arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in their area. Paragraph 10 of chapter 4 defines a serious child safeguarding case as a case in which the abuse or neglect of a child is known or suspected and child has died or been seriously harmed. Serious harm in that context include serious and / or long-term impairment of mental health, intellectual, emotional, social or behavioural development and impairment of physical health. Paragraph 19 acknowledges that some cases may not meet the definition of a serious child safeguarding case but may nevertheless raise issues of importance in a local area. In these circumstances, safeguarding partners may choose to undertake a local safeguarding practice review.

65. Whether or not T's case meets the criteria for a full local child safeguarding practice review is a matter for the local professionals and safeguarding partners and is not a decision for this court. It may however be useful for this portion of my judgment - together with both the background summary which deals with T's time in hospital and the paragraphs dealing with the medical evidence - to be disclosed to the child protection leads in the relevant agencies.

66. That is my decision.