Available online at www.sciencedirect.com
ScienceDirect
Journal of Forensic and Legal Medicine 14 (2007) 503–514
JOURNAL OF FORENSIC AND LEGAL MEDICINE
www.elsevier.com/jflm

Original Communication

An evaluation of 'confirmatory' medical opinion given to English courts in 14 cases of alleged child sexual abuse

Mary Pillai *

Cheltenham General Hospital, Department of Obstetrics and Gynaecology, Sandford Road, Cheltenham GL53 7AN, United Kingdom

Received 9 July 2006; received in revised form 29 November 2006; accepted 30 November 2006
Available online 28 March 2007

Abstract

Fourteen cases of alleged child sexual abuse, where the medical opinion rated a high degree of concordance with the history or suspicion of abuse given to the doctor, were reviewed to evaluate the objectivity and reliability of the medical evidence. It was common practice for physicians conducting the medical examination to form conclusions that the child had been sexually abused on the basis of the examiner's willingness to accept statements by the child, the adolescent, the caregiver or the investigator without determining if this information was accurate and obtained through the use of appropriate interviewing techniques. In the prepubertal children, evaluation of the examination findings revealed anatomical descriptions that were normal or non-specific, rather than supportive of abuse. In the teenagers, inadequate consideration was made of the behavioural and physical differences that occur with adolescence.

The physical findings were not interpreted using research derived knowledge concerning the variations of "normal" and the particular conditions that may be mistaken as abuse. The medical reports of these examinations suggest to this author a possibility of the significance and relevance of physical findings being unduly and unwittingly over-emphasised, despite the cases all having occurred post the Cleveland Inquiry [Butler Sloss E. Report into the Child Abuse Enquiry in Cleveland, 1987. London, HMSO] and some as recently as 2005. This may reflect emotional involvement in the case and the doctor taking on a role of advocacy for the child. It is sometimes difficult for physicians to step out of the medical role where they do have the responsibility to diagnose and into a role where their information is only a piece of the puzzle and it is the work of the court to determine if sexual abuse has occurred. The role confusion between medicine and forensics must be sorted out in order for physicians to provide an objective assessment. The main conclusion of this paper is that it identifies significant training needs among doctors undertaking child examinations for suspected sexual abuse.

Keywords: Expert opinion; Child sexual abuse; Evaluation of ano-genital findings; Hymen evaluation; Anal findings

1. Background

This paper examines the validity of opinions given by doctors to the court in 14 cases of alleged child or adolescent sexual abuse, where the medical opinion was strongly supportive or diagnostic of such abuse. The issue being examined here is the validity of the evidence *not* a determination of whether or not child abuse had occurred.

The past 20 years has seen a considerable increase in our understanding of child sexual abuse (CSA). While controversies and disagreements certainly still exist, a body of knowledge has been developed on the epidemiology, manifestations, and sequelae of the sexual misuse of children. Although the total evidence base is still relatively small, variations of normal in anal and genital anatomy have been better clarified.[1–8] Twenty years ago, the assumption appears to have been that CSA in prepubertal girls mirrored adult sexual activity. Given the very different dimensions of prepubertal genital anatomy it was expected that there should be signs in most cases. This appears wrong. We have learned that the physical examination is most often normal, even in the face of a history that would suggest genital injuries should be present.[9–11] Similarly great weight has been accorded to what the child says.[12] While the child's information is important, we have also learned

* Tel.: +44 8454 222337; fax: +44 8454 222403.
E-mail address: mary.pillai@glos.nhs.uk

1752-928X/$ - see front matter © 2007 Elsevier Ltd and FFLM. All rights reserved.
doi:10.1016/j.jflm.2006.11.006

there is considerable importance to establishing the manner in which the child's information was elicited.[13]

2. Methods

The cases included came to the author's knowledge between 2000 and 2006, through being approached to provide an independent expert report. The author is a practising obstetrician gynaecologist within the NHS, with a special interest in paediatric and adolescent gynaecology. For a number of years the author has also provided a service to Gloucestershire Constabulary for forensic sexual assault examination of children and adults.

From 2000 to 2006 the author was instructed as an independent expert in 24 cases involving children under 16 from outside the county. Cases of suspected abuse where the author was involved in the primary examination of the child were not included. The criteria for inclusion was that the case involved a child under 16 years, and a high degree of certainty had been expressed by one or more doctors conducting the primary forensic medical examination that the anatomical findings were indicative of sexual abuse. In 14 of the 24 cases a high degree of certainty of sexual abuse had been opined. The remaining ten cases were excluded because there was no relevant medical examination of the child owing to the allegation being too historical (three cases), because the level of certainty that the finding was caused by abuse was only intermediate (one case), because the case information available to the author was incomplete (three cases), or because the findings were opined to be normal or non-specific (three cases). In total the 14 cases included opinions from 27 different doctors, and are typical of those encountered by the author.

Instructions were received from the prosecution in two cases, the defence in three cases, the family court in seven cases, and in connection with a case appeal or review in two cases. In one case the court instructed the author to re-examine the child, owing to disputed findings. In several cases the author attended a meeting of experts which sometimes included review of photographic records. The timescale of legal proceedings in these cases had ranged from 1990 to 2005.

Details of cases have been carefully anonymysed to ensure confidentiality and compliance with the Data Protection Act and the common law duty of confidence, as set out in *The Protection and Use of Patient Information* issued under cover of HSG(96)18. Discussion of the appropriateness of reporting anonymysed cases was held with several of the legal professionals involved, with two independent experts in Medical Ethics and Law (Centre for Ethics in Medicine, University of Bristol), and with the Criminal Cases Review Commission, who instructed the author in Case 8. Those cases where a conviction was obtained are already in the public domain.

At the present time the RCP(UK) report on interpretation of genital findings in children is withdrawn and is in the process of revision.[14] A North American collaborative statement consisting of a comprehensive listing of findings in non-abused children and medical and laboratory findings associated with suspected CSA was first published in 1992.[15] This has sometimes been known as the ''Adams Classification System'' and has been revised regularly in response to newly published research findings, to arrive at the current (2005) revision.[16] New data has largely confirmed the original classification and only minor changes exist between the original and the current revision. It is not intended as a diagnostic tool, but rather was developed to assist in the interpretation of physical examination findings and laboratory results. Despite collaborative consensus, it is not universally accepted in the US and it should be regarded as a work still in progress. It should also be acknowledged, that although there is now a much larger literature on CSA than a decade ago, there is still comparatively little primary data detailing the anatomical and microbiological data in normal non-abused children and cases of sexual abuse. The revised Approach to Interpretation is derived from the available peer reviewed primary data.[16] The findings in the 14 cases have been evaluated against this (Table 2), but account has also been taken of the original 1992 classification since some of the cases date back to that time.

3. Results

The medical examinations involved between one and three doctors in each case. In total 27 different doctors examined the 14 children. They included 18 paediatricians, seven forensic physicians and two gynaecologists.

Some cases involved only civil or family court proceedings, some involved only criminal proceedings and a few cases involved both family and criminal court proceedings. Criminal proceedings arose in cases 4, 5, 6, 7, 8, 9, and 13. Convictions were obtained in cases 6, 7, 8 and 13 which are therefore in the public domain.

Table 1 details why each child came to be forensically examined and the reported ano-genital findings with the interpretation detailed in reports by the examining doctor/s.

3.1. View of the mother/carer

In four of the prepubertal cases (1, 2, 4 and 5) the child's mother thought her genital region looked abnormal and open. The position of the hymen, just inside the tissues that form the entrance of the vagina, mean it is covered by the labia and may not be visible simply by the child lying with her legs apart. There is a range of different findings among 'normal' children. In some cases the hymen orifice can be visualised with the child lying in a frog-leg position, however in many children visualisation of the hymen requires retraction of the labia, and sometimes it is necessary to place the child in the knee–chest position to see the posterior 180° completely. For this reason, even if the hymen were abnormal, a parent would not be expected to notice