

B.T. V. DR. C. JEKYLL

Sexual Abuse Investigation in a
Western Canadian Province

Part 1

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(Pseudonymed version - actual complaint to the
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The assessment of a prepubertal child for sexual abuse is an onerous responsibility for any medical practitioner, and one not to be taken lightly. Though medical findings are not always found when an allegation has been made, the role of the physician is pivotal as part of the process of validating or invalidating such a claim. As Robert Reece MD has noted in his definitive work on the subject¹,

Without responsible validation, the first critical step to effective therapeutic intervention, the needs of the child are not met...comprehensive and objective analysis of the historical, behavioral and medical findings results in an appropriate therapeutic, protective, and legal response. Implications of an allegation are serious for the child victim, the family, and the alleged perpetrator. True advocacy for children is of value only when it is based on objectivity and understanding of the limitations of our diagnostic and investigative skills. Unbridled advocacy does not serve the best interest of children.

It will be suggested here that the examination and validation of a sexual abuse allegation made by the mother of Jennifer T, age 4 at the time, and conducted by Dr. C. Jekyll of the Child Safety Centre, was grossly inadequate and resulted in catastrophic effects on both the child, and the father who was the accused. The forthcoming analysis will show that Dr. Jekyll failed to follow standard diagnostic procedures, and as a result, his confirmation of the abuse gave Manitoba CFS all the confirmation it needed to deprive father and child of access to each other. In addition, this confirmation also legitimized the continued psychological abuse of the child by the mother, CT, who we will allege is using the tactic of a sexual abuse allegation to deprive the father of continued access to the child.

¹Reece, Robert M MD (1994) Child Abuse: Medical Diagnosis and Management. Lea & Febiger: Baltimore. pp 195.

This report will show that the phenomenon of Sexual Allegations In Divorce^{2 3 4} is at work in this case, and yet Dr. Jekyll did not take the time to learn that the child came from a family that was in the midst of a divorce, where custody and access were the most contentious issues. That is not to say that all cases of abuse arising under those situations are necessarily false, but it does mean that any doctor who does not know the rudimentary facts of the child's history, and the context in which an allegation is made, is doing the child, his patient, a grave disservice, not to mention the effect on the adults affected by the allegation. Mr. T. and his parents have not seen the child for two years as a result of Dr. Jekyll's confirmation of abuse.

We believe that in a significant way, Dr. Jekyll harmed the child with his unquestioning trust of a social worker's motivations, and in this particular case, has made the child vulnerable to the manipulations of her mother. We will show that the child may be the victim of the Munchausen Syndrome By Proxy^{5 6 7} as perpetrated by her mother, C.T.. This syndrome can be a deadly experience for the child victim, and is far more significant than the SAID Syndrome due to its permanence. Unlike SAID, MSBP is not over when the divorce is won by the accusing parent; the syndrome will continue until it is detected by a caring physician, or until the child is seriously harmed.

²Faller, Kathleen Coulbourn (1991) Possible explanations for child sexual abuse allegations in divorce. *American Journal of Orthopsychiatry*. 1:1. pp 86-91.

³Jones D & Seig A (1988) Child sexual abuse allegations in custody or visitation cases: a report of 20 cases. In E.B. Nicholson & J. Bulkley (eds) Sexual Abuse Allegations in Custody and Visitation Cases. Washington, D.C.: American Bar Association.

⁴Green A (1986) True and false allegations of sexual abuse in child custody disputes. *Journal of the American Academy of Child Psychiatry*. 25. pp 449-456.

⁵Meadow, Roy (1992) False allegations of abuse and Munchausen syndrome by proxy. *Archives of Disease in Childhood*. 68. pp 444-447.

⁶Rosenberg, Donna Andrea (1994) Munchausen Syndrome by Proxy. In Reece. pp 178-266.

⁷Libow, Judith A and Herbert A. Schreier MD (1986) Munchausen Syndrome by Proxy: the perversion of mothering. *American Journal of Orthopsychiatry*. 56:4. pp 602-611.

MSBP is characterized by adult caretakers who find a curious sense of purpose and recognition in the midst of the medical disasters that they themselves create for their children. They pose as perfect mothers, while all along submitting their children to endless rounds of unnecessary tests, doctors, lies, medications, treatments and examinations. This is not benign child abuse; the child's sense of reality is completely distorted, and there are those parents who have literally harmed their children in order to present them to the medical community for treatment. Some children have died when the inducement of illness went too far, or when the parent sensed a danger to having this syndrome exposed. We believe that the intense violence and escalation of allegations in the T. case shows the 6 year old Jennifer is in grave danger. Had Dr. Jekyll taken the time to take a history on this child, she might have been spared the trauma of living violent memories of sexual abuse which she has not experienced. Recovery of Jennifer T is not certain, and will take a great deal of commitment from the people who care for her.

This paper will show that Dr. Jekyll failed to adequately safeguard the child by his slipshod methods of assessing the allegation of sexual abuse made against BT.

Standard diagnostic procedures for determining the validity of a sexual abuse allegation are not mysterious, and there is considerable consensus in the professional literature that they include the following:

- (1) historical details and behavioral indicators reflective of the alleged contact;
- (2) symptoms that result from the contact;
- (3) acute genital/anal injuries and/or chronic residual;
- (4) forensic evidence, and
- (5) sexually transmitted diseases⁸.

It may seem self evident to suggest that objectivity and an appreciation of the limitations of clinical observations must always be taken into the account, but in the T case, Dr. Jekyll made a definitive finding when he states the following: "I felt this as a damaged

⁸Reece (1994) pp 223 and Cole, Wendy MD (1990) False allegations of sexual abuse in custody and access cases in Child Sexual Abuse Allegations: Custody and Access Litigation. published by the Continuing Legal Education Society of British Columbia, pp 7.1.04.

prepubescent vaginal passage, totally compatible with digital penetration - multiple - chronic⁹. This finding of vaginal penetration is inconsistent with the disclosure history of this case, and points to the first serious indictment of Dr. Jekyll's examination. It should be pointed out that such definitive conclusions are discouraged in the medical literature. The author of a recent medico-legal article states that sexual abuse is an "event rather than a diagnosis...; conclusive findings of sexual abuse should be left to the court room and is not the prerogative of physicians."¹⁰

A review of the medical literature suggests that any physician who fails to take an adequate medical history before a sexual abuse examination is being careless. Ferry Grunseit MD says, "The medical history is an integral part of the assessment or examination of any patient. Indeed, a doctor would be considered most careless and unprofessional if he or she proceeded to just examine the patient without taking any kind of history."¹¹ The cornerstone of evaluating a medical problem is the medical history, even more so in an examination for sexual abuse, for the history of the alleged incident gives a physician clues as to what to look for in the way of forensic evidence. Yet, Dr. Jekyll admits that he did not have or take a history of the allegation before his examination of the child in this case. He writes, following questions arising once the conflicting report became known:

"I think you are aware that no significant analyses of the caretakers of Jennifer were known to me prior to my examination,

⁹Jekyll C MD. Letter to social worker Jan Fenwick dated November 20, 1992.

¹⁰Coleman, L (1989) Medical examination for sexual abuse: have we been misled? *The Champion*. **XIII**. pp 5-16.

¹¹Grunseit, Ferry MD (1989) Child sexual abuse: the medical examination and the Doctor's report. In Winfield, R (ed) The Expert Medical Witness. Federation Press: New South Wales. pp 125.

and quite likely (I don't know) the same for my colleagues.
(emphasis his)

The suggestion that Drs. Prayer and Answered did not have the allegation history is probably inaccurate, as their examination occurred after the Parent Child Assessment conducted March 11, 1994 by CSC social workers S. Dogood and M. Trusted.

This remark makes Dr. Jekyll appear as though he, too, is also cognizant of the implications of failing to take a history of the allegation before examining the child.

The following is suggested as a definitive list of the information a doctor should obtain before beginning a sexual abuse examination:

- (1) How access by the alleged perpetrator was achieved;
- (2) How the child was engaged in the inappropriate activity and how the activity was represented to the child;
- (3) progression of the activities over time;
- (4) what rewards, threats, bribery, coercion, and/or intimidation was used to maintain the child in the activities over time;
- (5) where the contact occurred;
- (6) the frequency of contact
- (7) the child's description of how he or she felt when engaged in the contact;
- (8) specific details of what the child experienced and any discomfort associated with the events, including observations by the child in regards to bleeding, bruises, or ejaculate;
- (9) circumstances surrounding either accidental or purposeful disclosure;
- (10) to whom the disclosure was made and the response of that individual;
- (11) what the child would like to happen now that disclosure has occurred.¹²

The lack of knowledge of the history in this case is especially damaging, given the violent nature of the disclosed events in this matter, events which allegedly occurred in the presence of professional supervisors provided by Olsten's Health Care, as well as the child's paternal grandparents. The father had agreed to obtain supervisors at

¹²Reece, pp 200.

his own expense as a result of a previous allegation made by his ex-wife that he had threatened to take the child out of the country.

Dr. Jekyll should have specifically determined "how access by the alleged perpetrator was achieved" under these conditions. In addition, though the violent scenes of terror and threat are most graphic, they specifically exclude penetration of the vaginal area, but do allege penetration of the anus with a "knife-like" tool. Nevertheless, Dr. Jekyll did not seek any evidence of anal penetration, and instead found evidence of trauma to the hymen. Indeed, he reported seeing only hymenal remnants in the child, however, this area of his examination will be dealt with later in this report. A physician should focus on what the child has allegedly experienced in order to "identify residual damage to the alleged contact, presence of forensic evidence, and risk of contracting a sexually transmitted disease"¹³.

Finally, and we would argue critically, Dr. Jekyll did not take extra precautions in examining the child, given the acrimonious and long standing divorce procedure existing between the father and mother, which had been ongoing since 1988, fully four years prior to the abuse allegation. Estimates of the frequency of fictitious sexual abuse claims in custody or visitation disputes range from 8 to 30%, with claims as high as 55% reported by one author^{14 15 16}. In June of 1996, the Chief Executive Officer of Winnipeg Child and Family Services admitted that only 15% of allegation in divorce cases were substantiated¹⁷. Jan Paradise MD et al found that cases where a custody/access dispute existed were more likely to occur when the child in question was less than 4 years of age. They suggest that a child's young age may reflect the "greater likelihood that a child will become

¹³Reece, pp 200.

¹⁴Benedek, E.P and D.H. Schetky (1985) Allegations of sexual abuse in child custody cases and visitation disputes. In Emerging Issues in Child Psychiatry and the Law, edited by the authors. Brunner/Mazel: New York. pp 145-156.

¹⁵Wallerstein, J.S. (1985) Children of divorce: emerging trends. *Psychiatric Clinicians of North America*. 8. pp 75-85.

¹⁶Paradise, Jan MD, Anthony L Rostain MD and Madelaine Nathanson, PhD (1988) Substantiation of sexual abuse charges when parents dispute custody or visitation. *Pediatrics*. 81:6. pp 837.

¹⁷Johnson, Glen (June 23, 1996) Hundreds Tagged as Kid Molesters: 560 men falsely accused of child abuse. *Winnipeg Sun*. pp 1-3.

a focus of contention if he or she is younger, and therefore perhaps more easily influenced or less able to provide a detailed and consistent history¹⁸.

The history of the T. family's divorce has been one of an increasing escalation of allegations made only by the mother, which had as its goal the elimination of visitation access by the father and his family.

In addition to the allegation above noted, which prompted the father to suggest supervisors in order to re-initiate visits, the history is rife with other allegations that point to the mother's vindictive and unremitting effort to deprive BT of access to his child, Jennifer. Other charges made by the mother include:

- 1) That the father had no parenting skills;
- 2) That the father's smoking irritated heretofore unknown allergies of the child, although the father did smoke during the marriage;
- 3) That the child was also allergic to the cat, although the family did have a cat during marriage;
- 4) That the father was manipulative and violent; though she later admitted in a later report that the marriage was violence free;
- 5) That the father was cruel to animals, claiming that the father poisoned a neighbor's dog, and also that he tortured the family cat;
- 6) That the father forged a cheque on her bank account and called police, who dismissed the charge;
- 7) The mother claimed in affidavit that the father cheated on his business taxes;
- 8) The mother sent a letter to Unemployment Insurance claiming father was committing fraud; UIC cleared father of any wrongdoing;
- 9) After father hired an agency to provide supervision, mother phoned them and told them father was dangerous and was going to abduct the child, which necessitated the hiring of alternative supervisors;
- 10) In an effort to preclude visitation with the paternal grandparents, the mother alleged that the grandfather also had no parenting skills;

¹⁸IBID, pp 839.

- 11) Mother alleged that the paternal grandmother was incapable of caring for the child due to physical incapacities (letter of refutation provided by family doctor);
- 12) It was alleged that the paternal grandmother was incapable of caring for the child as mother claimed she received information from a psychiatrist that the grandmother was "mentally incapable of looking after a child" (letter of refutation provided).

Subsequent to the sexual allegations made,

- 13) That the paternal grandfather "had hurt her in her bum when her clothes were off"; she indicated he "poked her bum and hurt it with his fingers";
- 14) Mother claimed the child had disclosed during a routine changing of clothes (as told to CFS social worker) then later claimed that disclosure occurred in the context of personal safety teaching provided to her by the mother (as found in Winnipeg Police Report). Mother later denied making this claim to the police;
- 15) Disclosure surrounding the father's actions include:
 - the father hurt her with a strawberry pin
 - the father put something sharp, like a knife, in her bum;
 - she had blood flicked on her face;
 - the paternal grandmother wiped blood from her privates and gave her a bath to stop her private parts from hurting;
 - the father hurt her with his pliers;
 - the father pointed a gun to her head;
 - the father kept long knives and assorted guns under his bed;
- 16) These "abuse incidents allegedly took place in the home of the paternal grandparents and with professional supervisors present. It also allegedly happened behind a locked bedroom door, though no bedroom doors are equipped with locks as witnessed by police investigation of the home.

More detailed assessment of this disclosure material can be found in the Dogood/Trusted report, in addition to affidavits made by the mother (supplied upon request). Perhaps the most significant and incriminating aspect of the disclosure is the fact that the mother, upon allegedly hearing this story of violent sexual interference on October 20, 1992, did not have the child examined by a physician until November 5, 1992, 16 days later.

It is obvious that Dr. Jekyll did not have even a rudimentary knowledge of the disclosure made in this matter and instead took the social

worker Jan Fenwick's referral material that the child had been "abused" as established fact, and this was all that was known to Dr. Jekyll at the time of his examination. As such, he failed to give careful scrutiny to the anal area of the child which would probably show residual damage had the "knife-like" object in fact been shoved into the child. A finding of sexual abuse is suspect if "the history does not match the physical findings"¹⁹.

Given the history of allegations in the T. case, this was tantamount to giving the mother permission to psychologically pressure the child into these terrifying disclosures, and certainly had implications for the manner in which CFS dealt with the matter. CFS procedure included submitting the child to a play therapist (S. Heartless) who was also told in referral that the child had been sexually abused, and therefore this, too, must be added to the process of legitimation set in motion by Dr. Jekyll's haphazard examination. Dr. Jekyll failed to make note of the "history of escalating allegations by the custodial parent against the non-custodial parent, such as the chronic visitation restrictions, a late arising sexual abuse complaint, and the evidence of brainwashing; these factors are consistent with either a conscious or unconscious endorsement of a false allegation"²⁰.

In addition, he failed to consider the secondary gains that the accusing parent would achieve from the allegation such as financial incentives, retaliation, resolving past marital discord, revenge, punishment, reliving a previous post traumatic stress, vindication, compliance, and a host of other factors. It is just as important to

¹⁹Cole, Wendy MD (1990) False allegations of sexual abuse in custody and access cases. In Child Abuse Allegations: Custody and Access Litigation. Published by the Continuing Legal Education Society of British Columbia. pp 7.1.05.

²⁰Robin, Michael, ed (1991) Assessing Child Maltreatment Reports: the Problem of False Allegations. Haworth Press: New York. pp 122.

examine these factors as it is to carefully study how the allegations of child sexual abuse evolved²¹. The above description of the consistently negative allegations made by the mother, and in the absence of retaliatory allegations made by the father, suggests that this situation is one where the custodial parent, "in an intentional and vindictive manner, set out to terminate visitation/ensure custody, by alleging sexual abuse", and further suggests that the mother may have repeatedly questioned the child, "and actively coached the child to lie²²".

²¹IBID, pp 149.

²²Cole, pp 7.1.03.

The impact on the best interest of this child, now 6 years old, can not be underestimated. Quoted in the Alberta Report this year, Dr. Ralph Underwager has said that the damage to children from a false abuse claim is traumatic to a child and adds: "It is extremely violent to treat children who haven't been abused as if they have been. The consequence is an unresolved conflict between the child's own perception of reality with the distorted perception of revered authority figures, like parents [and social workers]"²³.

This story also quotes a study conducted at Oxford University's Westminster College, which compares the effect on children to that "of being raised in a war zone." Children become excessively anxious, depressed and fearful, says the study, and Underwager concurs, remarking that [the children] do not know where the next attack is going to come from."²⁴ Underwager says that it is also very difficult to distinguish between the symptoms of a genuinely abused child and a child who has been traumatized by therapy. The child in this case has expressed stark terror of her father, and it is suggested that this is a result of the significant legitimation that has been given to the mother's cruel and terrifying actions, initiated by way of Dr. Jekyll's diagnosis.

The impact that Dr. Jekyll's findings have had upon the life of BT cannot be calculated. This father has not seen his child since October of 1992. He endured interrogation by police and the possibility of criminal prosecution for several months following the allegations. Ultimately, the Crown declined to prosecute after a complete investigation. BT was advised that in spite of the physical evidence, due to the presence of family and professional supervision during visitation, the father had no opportunity to commit the crime. Nevertheless, the CFS continued with its demands for a "full confession" from BT and used access to his child as leverage in its efforts to obtain false confession. In addition, the father was asked to write a letter and make a videotape for his child of this confession, and as well, he was to apologize to the mother for the "harm" he had caused to them both. BT has declined to settle the matter in this fashion.

²³McGovern, Celeste (1994) *Alberta Report*. October 3 issue. pp 44.

²⁴IBID. pp 45.

As well, it must be kept in mind that even the father initially gave credence to Dr. Jekyll's report, and had to live with the knowledge and the daily fear that the child continued to be in danger from the unknown perpetrator who might still have access to her. Though this concern was somewhat alleviated by the subsequent examination of Drs. Prayer and Answered, the oppressive fear for his daughter's safety during this time cannot be underestimated. Now the fear remains for him that his only child continues to be psychologically manipulated into recounting the brutal memories implanted by her mother, and his concern revolves around the issue that the child is not safe in the care of a woman who would impose such graphic thoughts and intrusive process on a helpless four year mind.

His successful life, personal well being and confidence have all reversed dramatically since the allegations of sexual abuse arose, and this shows no sign of abating, since Manitoba CFS refuses to reconsider their stance about the allegations made against him, in spite of the second physical report and positive assessment conducted by the Child Safety Centre. The cost to BT's parents, BT Sr. and MT, is also tragically high.

The paternal grandparents of Jennifer T still dwell on the visits they had with their grand daughter two years ago as though they were yesterday, poignantly showing visitors to their home the many albums of photographs filled almost exclusively with pictures of this child enjoying the company of the T family. As they, too, have been implicated in the violent acts which are alleged to have occurred in their home with their co-operation, Dr. Jekyll's substantiation of abuse has affected them almost as significantly as it has BT. Where once these two people were active, successful and respected members of Winnipeg's vibrant Portuguese community, they have subsequently withdrawn from active social life since the allegations surfaced and were corroborated by Dr. Jekyll's report. Though vestiges of their old world, generous charm remain, the senior T's have been traumatized by their experience. Nevertheless, they remain committed to supporting their only son through this shattering experience, and still hold on to the hope that they will one day see their only grand daughter once again.

Dr. Jekyll's failure to consider any of these factors as part of the history of the child suggests a cavalier attitude to the seriousness of such an allegation, but it is perhaps indicative of his unquestioning acceptance of referral materials provided by CFS social workers. Schuman has written, "in some quarters there is such a degree of

sensitivity or outrage about possible child abuse that a presumption exists that such abuse has occurred whenever it is alleged.²⁵" The assumption that all sexual allegations must be the result of actual abuse would certainly seem to be the case for Manitoba's Child and Family Service. Recent data obtained in the province in march of 1994 make the claim that fully 51% of the children in foster care have been sexually abused²⁶. Compare this figure to the national U.S. rate which as of 1990 constituted 14% of all reported cases, and keep in mind that up to 60% of those are determined to be "unfounded"²⁷. This suggests that Manitoba CFS has produced the largest sexual abuse rate in the western hemisphere, and it should be noted that all sexual abuse cases do not necessarily require physical evidence to be substantiated.

²⁵Schuman, D.C. (1984) False allegations of physical and sexual abuse. Paper presented at the Annual Conference of the American Academy of Psychiatry and the Law. Nassau, Bahamas.

²⁶Parker, Roy (1994) Unpublished data. Visiting professor at the University of Manitoba.

²⁷Besharov, D. (1990) Gaining control over child abuse reports. *Public Welfare*. 48:2. pp 34-80.

This report suggests that Dr. jekyll is a physician favoured by the Manitoba Child and Family Service because of his blind acceptance of referral information provided by social workers. Accurate diagnosis of sexual abuse is based on many factors, including the integrity and the prejudicial biases of the doctor. We believe that Dr. Jekyll is selected by the CFS as a "known advocate", and one more likely to "find" sexual abuse²⁸. The phenomenon of social agencies gradually developing "favourites" are what Benedek and Schetky call a "new cottage industry":

Many of these "experts" seem to be self-proclaimed and biased, always finding sexual abuse where alleged, and some seem to be unaware of [or choose to ignore] the long-term effects the false allegation might have on a child, parent, or a child/parent relationship. Many of these professionals have great difficulty accepting the possibility that some alleged offenders are innocent.²⁹

In their study of child protective services, Jones and McGraw observed that many practitioners appeared to have had their minds made up well before sufficient information had been obtained³⁰, and Dr. Jekyll's examination appears to confirm that this phenomenon is here in Winnipeg. Gardner suggests that the substantiation of a sexual abuse examination must take into account any "known biases of the assessor", particularly in custody/access disputes, as well as the assessor's

²⁸Gardner, R. (1991) Sex Abuse Hysteria: Salem Witch Trials Revisited. New Jersey: Creative Therapeutics. pp 119.

²⁹Benedek and Schetky. In Robin, Michael (ed) (1991) Assessing Child Maltreatment Reports: The Problem of False Allegations. Haworth Press: New York. pp 95.

³⁰Jones, G & J. McGraw (1987) Reliable and fictitious accounts of sexual abuse to children. *Journal of Interpersonal Violence*. 2. pp 27-45.

experience in court testimony and previous similar cases³¹. Certainly, we do not dispute that Dr. Jekyll has a great deal of experience, however, the foregoing has shown that this very experience may have served to compromise his integrity more than it has made him an impartial assessor of sexual abuse. This report demands that his status as "favourite physician" of the Child and Family Service be taken into consideration in this investigation. Even Dr. E. Mengele, a Winnipeg Psychologist who also does a great deal of work for CFS and has "known advocate" problems of his own, has stated in his report dated April 26, 1994:

This will not be the first time that I have had to consult in a case confused by contrasting opinions by two recognized experts in the field employed by the same agency. Indeed, the previous occasions have involved the same two personalities in the same order. In the previous cases as in this, the two experts and the Child Safety experts never to my knowledge consulted to help us understand how two so seemingly opposite findings could occur, and therefore, left those more directly involved in the investigation and assessment of the allegations confused.

In addition to these problems with Dr. Jekyll's findings, the case for the false accusation of BT does not stop there. The forthcoming section deals with the conflicting physical reports in this matter and an attempt will be made to analyze Doctor Jekyll's report to determine whether it is consistent with the finding of sexual abuse. As well, this analysis will determine whether it is possible that those findings could have been present during his examination of November 5, 1992, and still leave no evidence of the trauma, to be found by the subsequent examination of Drs. Prayer and D. Answered, undertaken December 8, 1993 at the desperate and persistent request of the father of Jennifer, BT.

MEDICAL ANALYSIS

To initiate the medical analysis, the substantive text of Dr. Jekyll's diagnostic letter provided to CFS social worker Jan Fenwick November 20, 1992, is reproduced in its entirety. The text of the diagnostic

³¹Cole, pp 7.1.04.

letter of Drs. prayer and Answered (dated January 12, 1994) and also provided to Jan Fenwick, will arise as the discussion warrants.

Here, then, is Dr. Jekyll's diagnosis of Jennifer T as seen 16 days after disclosure:

I examined this girl on November 5, 1992 in the Sexual Assault Clinic at Children's Hospital.

There was a widely patent vaginal opening measuring .8 cm x .8 cm in the vertical and horizontal dimensions.

The hymenal rim was virtually flat (absent) from one to five o'clock, on the left. On the right, between six and eleven o'clock, the rim was thickened and retracted (draw) towards the wall of the vagina.

At the lower quadrant, the hymenal edge was "double" with a tissue concavity or "cup" in the center.

I felt this as a damaged prepubescent vaginal passage, totally compatible with digital penetration - multiple - chronic.

First Paragraph

Again, let it be stressed that November 5, 1992 was sixteen days after disclosure, a fact that should have been pointed out here. As well, the exam took place 23 days after the child's last visitation with the alleged perpetrator, under supervised conditions in the home of her grandparents.

Second Paragraph

The terms used to describe the .8 cm x .8 cm measurement of the vaginal opening are unusual given that the medical literature uniformly expresses this measurement in millimetres, rather than the percentage of a centimetre. To the medically untrained, it would be easy to

mistake this expresses as a full 8 centimetres, that is 3 1/8 inches. This is a dramatic visualization of a child's vaginal opening. The lengths are here expressed as line drawings (approximate):

8 mm _____*
8 cm _____

*figure depicted is 10 mm due to computer limitations

Drs. Prayer and Answered also express this measurement as a percentage of a centimetre, and so it is difficult to determine whether Dr. Jekyll used this type of measurement expression to inflame the visualization of the orifice to the layman, or whether Drs. Prayer and Answered followed the expression style of their predecessor so as not to discomfort him. It may be the general practice of physicians at the Child Safety Centre to use the more misleading expression of this measurement, and yet, this would contradict the standard practice as illustrated in the medical literature^{32 33 34 35 36 37}.

³²White, S MD, & Ingram D MD (1989) Vaginal introital diameter in the evaluation of sexual abuse. *Child Abuse and Neglect*. 13. pp 217-224.

³³Horowitz, D MD (1987) Physical examination of sexually abused children and adolescents. *Pediatric Review*. 9. pp 25-29.

³⁴Bamford, F MD & R. Roberts MD (1989) Child Sexual Abuse, II. *British Medical Journal*. 299. pp 377-382.

³⁵Cantwell, HB MD (1981) Vaginal inspection as related to child sexual abuse in

The use of the term "widely patent" to describe the vaginal opening is misleading and inflammatory. The medical community has reached a consensus on this issue. A recent international conference with representatives from Europe, North America and the Middle East was held, which had the mandate of evaluating existing knowledge regarding the ways in which child sexual abuse allegations could be investigated most productively. The conference produced a document of consensus signed by 20 attendees, and it had this to say about the significance of the size of the vaginal opening:

girls under thirteen. *Child Abuse and Neglect*. 7. pp 171-176.

³⁶Heger, A MD & Emans SJ MD (1990) Introital diameter as criterion for sexual abuse: a commentary. *Pediatrics*. 85. pp 222-223.

³⁷Paul, DM MD (1986) What really did happen to Baby Jane?: the medical aspects of the investigation of alleged sexual abuse of children. *Med Sci Law*. 26. pp 85-102.

The size of the hymenal orifice is no longer viewed as a reliable indicator of abuse; even children who have received significant hymenal injuries as the result of sexual abuse may have relatively small openings. In fact, the size of the hymenal orifice varies so widely from child to child in both abused and non-abused children that the width of the hymenal rim has replaced the size of the vaginal opening as a marker of sexual molestation.³⁸

³⁸Lamb, Michael MD (1994) The investigation of child sexual abuse: an interdisciplinary consensus statement. *Child Abuse and Neglect*. **18:12**. pp 1021-1028.

Since the mid-80's, considerable research has been conducted to distinguish between normal versus damaged hymenal appearances^{39 40 41 42}.

It was once thought that an opening of more than 4 mm was evidence of abuse, however, this consensus was reached only because only abused girls were ever measured. Now that studies have been conducted on non-abused population groups, the general consensus is that the maximum non-abused transverse diameter in prepubertal girls is less than or equal to 10 mm^{43 44 45 46}. Reece says definitively that "measurements of the hymenal orifice obtained during an examination have low predictive value and may not be helpful in determining whether penetration has occurred⁴⁷." For this reason, the 1 mm deviation between the Jekyll measurements and those of Drs. Prayer and Answered (.7 x .7 cm) are not diagnostically significant.

IN CONCLUSION, IT IS STATED THAT DR. JEKYLL'S DESCRIPTION OF THE CHILD'S VAGINAL OPENING AS "WIDELY PATENT" IS INFLAMMATORY AND INACCURATE, AND THE CHILD'S OPENING FALLS WELL WITHIN THE ACCEPTABLE BOUNDARIES OF NORMALCY.

Paragraph 3

³⁹Jenny, C MD, Kuhus, ML MD & Arakawa F MD (1987) Hymens in newborn female infants. *Pediatrics*. 80. pp 399-400.

⁴⁰Mor, N MD & Merlob P MD (1988) Congenital absence of the hymen only a rumor? *Pediatrics*. 82. pp 679.

⁴¹Rock JA MD & Azzizz R MD (1987) Genital anomalies in childhood. *Clinical Obstetrics and Gynecology*. 30. pp 682-696.

⁴²Berenson A MD, Heger A MD & Andrews S MD (1991) Appearance of the hymen in newborns. *Pediatrics*. 87. pp 458.

⁴³Bay, J MD et al, pp 42.

⁴⁴Goff CW MD et al (1989) Vaginal opening measurement in prepubertal girls. *American Journal of Diseases in Childhood*. 143. pp 1366.

⁴⁵Emans SJ MD et al (1987) Genital findings in sexually abused, symptomatic and asymptomatic girls. *Pediatrics*. 79. pp 778.

⁴⁶Heger A MD and Emans SJ MD, pp 222.

⁴⁷Reece, pp 214.

In this paragraph, there is a confusion of terms that mystifies this description unnecessarily. For example, Dr. Jekyll describes the lateral sides of the orifice with both clock positions, and also their opposite left and right positions at the same time. This review of the literature has not found one instance of this misleading description.

What we have found is that descriptions used the clock positions as seen from the physician's perspective, with the anterior (upper) midline point being 12 o'clock and the posterior midline point being 6 o'clock. It is not understood why Dr. Jekyll would use this nonconformist method of describing a typical element of a diagnostic description.

This report finds that Dr. Jekyll's description of the hymenal rim as being "virtually flat (absent)" is again inflammatory and misleading.

This descriptive bias refers to the wall from the anterior one o'clock position and down towards the five o'clock position, while thickened and retracted (drawn) towards the wall of the vagina between 6 o'clock and 11 o'clock. Leaving aside for a moment the fact that Dr. Jekyll has failed to describe the 12 o'clock position as though it did not exist, his dramatic description of trauma here has serious problems.

Midline posterior damage towards the 6 o'clock position is consistent with trauma, however, such trauma would be evident until the child reached puberty, and would therefore have had residual markers to be found by Drs. Prayer and Answered eleven months later. Dr. Lamb makes this definitive statement about residual evidence found after trauma in the prepubertal girl:

Deformations of the hymen remain visible from the time of penetration until the onset of puberty and may provide the clearest indication that penetration occurred. Such deformations of the posterior hymenal rim do not occur naturally and are unlikely to be caused by any other known trauma, including straddle injuries.⁴⁸

⁴⁸Lamb, pp 1026.

The medical literature since 1990 is stable on this point. McCann et al followed three girls, ages 4 months, 4 years and 9 years, who were selected for recent trauma. The girls were followed for periods ranging from 14 months to three years (within the time span between the current exams here under discussion) and found that changes observed as a result of trauma did remain stable while the children were in Tanner Stage I (as is the subject child herein). Irregular edges of the damaged tissues showed a "smoothing off" of these edges over time. One finding that did persist in all three girls was the narrow hymenal rim at the point of injury. As well, transections (lateral cuts) and clefts were visible as indentations in the hymenal rim as long as the girl did not reach puberty^{49 50 51}.

Another residual finding of the McCann et al study was the discovery that vaginal ridges associated with mounds or projections on the edge of the hymen appeared to be the result of the disruption of the hymenal membrane⁵². No such ridges on the vaginal wall were described by Jekyll in spite of the significant trauma he alleges to have seen at the time of his examination. These ridges were not the result of trauma, but were exposed as a result of the trauma; it was their exposure rather than their existence that were significant. Such ridges would have been noted by Drs. Prayer and Answered had the ridges been present, as they were persistent in the McCann study until the final examination.

The original injuries of all the girls in the McCann study occurred along the posterior or lateral hymenal rim, between 5 and 9 o'clock. As well, Reece notes that "an interruption of the edge of the hymenal membrane extending to the floor (posterior 6 o'clock) of the vagina is specific to traumatic penetration⁵³". Dr. Jekyll's findings note damage to the hymenal rim extending from the posterior 6 o'clock position to the anterior 11 o'clock position, but the second medical exam found no evidence of residual.

⁴⁹McCann, JOHN MD, Joan Voris MD and Mary Simon MD (1992) Genital injuries resulting from sexual abuse: a longitudinal study. *Pediatrics*. **89:2**. pp 307-317.

⁵⁰Emans SJ MD et al, pp 778.

⁵¹Paul et al, pp 94-95.

⁵²McCann et al, pp 309.

⁵³Reece, pp 215.

THE ANALYSIS OF THIS PARAGRAPH CONCLUDES THAT HAD DR. JEKYLL'S FINDINGS BEEN PRESENT AT THE TIME OF HIS EXAMINATION, RESIDUAL FINDINGS TO THE TRAUMA DESCRIBED WOULD HAVE BEEN DISCERNIBLE DURING THE SECOND EXAM CONDUCTED 11 MONTHS LATER BY DRS. PRAYER AND ANSWERED.

Paragraph 4

Dr. Jekyll said, "At the lower quadrant [midline posterior between 5 and 7 o'clock positions is standard terminology] the hymenal edge was "double" with a tissue concavity or "cup" in the center." There are several problems with this statement.

Most significant is the tissue concavity or "cup" in the centre as described by Dr. Jekyll. No such description of hymenal disruption is present in the literature. To go by the appearance of the cup, we can only determine that Jekyll may be referring to a transection (healed lateral tear) or cleft (notch in hymenal tissue), and these are significant findings of damage which would have shown healing residual in the Prayer-Answered exam report. Such tears or clefts may be rounded and healed over 16 days after trauma, however, "they leave angular notches⁵⁴" which do not disappear until puberty.

THEREFORE, THIS PARAGRAPH SUMMARY CONCLUDES THAT THE "CUP" IS EITHER A NATURALLY OCCURRING INDENTATION CONSISTENT WITH THE SHAPE OF A CRESCENTIC HYMENAL MEMBRANE, OR IT IS A CLEFT OR TRANSECTION WHICH WOULD HAVE BEEN VISIBLE AS RESIDUAL IN THE PRAYER-ANSWERED EXAM.

Paragraphs 4 and 5 taken together

Given the finding of Prayer-Answered, that the child has a crescentic hymen with "no evidence of old or recent traumatic change", we suggest the following possible, if strange, explanation for difference in these findings. It is suggested that, with the exception of the "thick and retracted" hymenal rim between 6 and 11 o'clock, Dr. Jekyll has come close to describing a normal appearing crescentic hymen! The following description of a normal crescentic hymen shows some amazing similarities, albeit, without the flamboyant language used by Dr. Jekyll:

⁵⁴McCann, pp 309.

When the orifice appears crescentic, no hymenal membrane tissue is evident between approximately the 11 and 1 o'clock positions; the superior edge of the hymenal membrane interdigitates with the vaginal walls laterally, leaving a posterior rim of tissue that is variable in its width⁵⁵.

In short, the top (anterior) of the hymenal ring appears absent, with a variable thickening at the posterior edge between anywhere from 3 to 9 o'clock positions, going downwards to 5 and 7 o'clock. As well, photographs of a crescentic hymen appear to have a natural concavity at 6 o'clock, though it could not be interpreted as traumatic. Indeed, most prepubertal girls (80%) have crescentic hymens^{56 57}.

THE PARAGRAPH ANALYSIS OF 4 AND 5 THEREFORE CONCLUDES THAT DR. JEKYLL MAY HAVE MISTAKEN A NATURAL APPEARING CRESCENTIC HYMEN AS "ABSENT", AND OVERDRAMATIZED AND EXAGGERATED HIS FINDINGS WITH INFLAMMATORY LANGUAGE. THIS GAVE THE APPEARANCE OF A FINDING OF ABUSE IN LAYMAN'S TERMS, BUT WHEN ANALYZED ACCORDING TO FINDINGS IN THE MEDICAL LITERATURE, DR. JEKYLL CAME "CLOSE" TO DESCRIBING A CRESCENTIC HYMEN.

General Comments as it Regards Dr. Jekyll's Procedures and Failure to Obtain Lasting Forensic Evidence of His Abnormal Findings

The finding of sexual abuse has far reaching significance to the child and the accused, so it is a grave concern that Dr. jekyll failed to

⁵⁵Reece, pp 215.

⁵⁶Mor et al, pp 681.

⁵⁷Cantwell, pp 172.

take colposcopic photographs of his alleged findings, as is recommended by all of the medical literature. The Child Safety Centre is equipped with this expensive technology, so a lasting question remains as to why Dr. Jekyll failed to perform this task. Not only would this have ensured that there would be "evidence to corroborate his dramatic findings, cut they could also have been used to obtain a second opinion about his diagnosis.

Failure to take pictures resulted in the necessity of having the child re-examined in order to clear up the incongruencies of the investigation. It caused serious problems for all parties concerned, and there is no professional excuse for being so haphazard in this examination, which could have sent a man to jail. That it did not do so is a result of the monumental effort of the father to obtain a second opinion. Dr. Jekyll has ignored the father, and indeed, did not bother to advise him of his findings, nor did he attempt to clarify the confusion in this case as it began to arise.

Dr. Jekyll's neat, quick and deadly surmise that the child's hymen in this case was "virtually flat (absent)" gave the exact impression he wished it to: indisputable findings of sexual abuse. Yet, his examination did not even make any attempt to describe the hymen in terms recognizable and used by responsible medical clinicians.

Reece cautions physicians with the admonition to be accurate, particularly if findings of abuse or residual are found. He defines methods of description which are considered standard in the medical literature, as he writes, "[the physician] must describe the wound characteristics and their location using two points of reference from the midline. Both major and minor characteristics of the injury should be described⁵⁸.

Dr. Jekyll's report to social worker Jan Fenwick bears no resemblance to the common language used in modern medical literature. It would appear that Dr. Jekyll does not bother himself with speaking as other

⁵⁸Reece, pp 223.

physicians do, and this is to the detriment of his patients who must bear the consequences.

Reece cautions every clinician that, when describing the orifice of a potentially abused child's "hymen or hymenal tissues...it is important to be as specific as possible concerning the character of the hymen, and avoid inaccurate and non-descriptive terms." Dr. Jekyll's report uses non-descriptive terms and adjectives, such as "virtually", "absent", "double", "thickened", "multiple", "chronic", and "totally compatible with digital penetration". These leave no doubt as to the impression he wishes to leave the layperson who must try to understand the report - GUILTY.

Emans points out that the magnifying lens of the colposcope is extremely effective at detecting microtrauma, and as well, it effectively collects medical and legal evidence⁵⁹. When visualizing all of the nuances of genital and anal anatomy, the physician's equivalent to the astronomer's telescope is the colposcope, says Reece. "In the last 6 years, the colposcope has achieved widespread acceptance as the instrument of choice to assist and improve visualization of anatomy and its documentation. Scar tissue may also be more important with a colposcope as its avascular appearance contrasts with surrounding vascularized tissues⁶⁰. Reece states without equivocation:

Photodocumentation of all abnormal findings should accompany every examination. The photograph memorializes evidence of residual damage from the alleged contact and can be used for a second opinion.⁶¹

The question must be asked: Was Dr. Jekyll too busy to use this equipment which was available to him? once problems arose with Dr. Jekyll's original diagnosis of 1992, he wrote another letter to Jan Fenwick dated January 20, 1994. This letter explained that the differing postures of examination used to view the child's hymen "could account for the 1 mm difference in channel diameters, not a crucial variant in any event." Dr. Jekyll is quick to minimize findings that bring his judgement into question, but is far less inclined to take

⁵⁹Emans et al, pp 778.

⁶⁰Reece, pp 208.

⁶¹Reece, pp 209.

similar considerations for his patients and their parents, when he maximizes what may be normal findings to satisfy the legitimation needs of the CFS social worker.

It is significant that Dr. Jekyll goes on in the same letter to say that the passage of time between the two examinations provided "considerable time for a retractile (elastic) organ to undergo change, albeit not to reconstitute a hymen which I had felt (and still feel) was absent." What concern he shows even now, for his patient and her hapless, tormented father. This statement, perhaps more than any other, more even than all of the inadequacies of his investigation and evidence gathering, show the haded, callous and self interested nature of the man, Dr. C. Jekyll.

Professionals in many medical centers throughout the world employ a multi-method anogenital examination procedure, in which magnifying devices are used to visualize the tissues and cameras are used to record the findings. In some centers, both the interview with the child and the anogenital examination are videotaped for subsequent review. Even when such records are available, however, medical examiners need to prepare detailed reports of their findings, written in a form that is comprehensive to non-medical personnel in the legal and social welfare communities, yet sufficiently detailed to permit independent evaluation by other medical experts⁶². Where are Dr. Jekyll's reports? Why were none of these methods used in his examination of the child? Why did he fail to take even cursory history in this matter? He certainly shows an understanding of its importance in his second letter to Jan Fenwick when he writes,

The medical examination can only be considered in context with the myriad of other historical and behavioral components existing in the girl and her caretakers. In a prepubertal child, it is virtually never a major determinant and, even more dismally, can only very rarely help as to the IDENTITY of an alleged offender.

(His emphasis)

The foregoing analysis shows that Dr. Jekyll is far more sure of his diagnoses when it can do the most harm, that is, at the beginning of this investigation, and he leaves no room for any alternate interpretation of his findings outside of sexual abuse. His terminology is vague and grandiosely certain at the same time, and his

⁶²Lamb, pp 1026.

full co-operation with the CFS prosecutorial needs in this matter cannot be denied by any reasonable person. Dr. Jekyll gave social worker Jan Fenwick what she wanted, a definitive diagnosis of sexual abuse. We have already established the traumatic impact of Dr. Jekyll's unprofessionalism. The only question that remains is, how many others has he done this to?

We will end this report of this tragic episode of medical incompetence with the following advice provided by a physician who surely understands the sensitivity of sexual abuse investigation far better than does our Dr. Jekyll:

Above all, the examining physicians should realize the responsibility to accept these individuals as patients and to exert all available skills in the physical examination, the proper collection and processing of laboratory specimens, and the provision of court testimony if the need arises. Anything less constitutes gross neglect of the patient and potential participation in the miscarriage of justice.⁶³

For the sake of BT, his parents and his daughter Jennifer, we ask that the colposcopic photographs taken by Drs. Prayer and Answered be examined by a competent and unbiased clinician, so that this terrible story can be laid to rest once and for all.

ADDENDUM: In September of 1995, The College of Physicians and Surgeons of Manitoba issued a stern reprimand to Dr. Jekyll for "failing to follow acceptable standards of procedure for a consultant in a child abuse case." Dr. Jekyll continues to hold his position as Director of the Child Safety Centre.

Following the College's findings, the Chief Executive Officer of Winnipeg CFS indicated that the case of BT would be "reviewed" in light of the new findings. The CEO took no such action. He did, however, resign his office in June of 1997.

⁶³Reece, pp 227.

Today, Jennifer T, is now ten years old, and has not seen her father and grandparents since she was four. The mother continues to take the child to a psychologist where new and elaborate scenes of violence and degradation continue to emanate from the child. The psychologist she sees is with the same office she has been going to since she was four years old, when the allegation was substantiated.

In November of 1996, Mr. T launched a civil law suit against Dr. Jekyll and the CEO of Winnipeg Child and Family Services. The matter is currently before the court.

Since 1996, Manitoba's Child Welfare system has observed the resignation of the Deputy Minister, the Assistant Deputy Minister, the Director of Child Welfare, and the CEO of Winnipeg CFS. In June of 1997, a highly placed child welfare official approached Mr. T to advise that the "opportunity for new dialogue" on the case was at hand.

The father and his parents have still not lost hope that they will one day see Jennifer again, and end the nightmarish abuse memories which have consumed her entire childhood years.

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