# The Little Rascals' Day Care Center Case: A Perspective on Medical Testimony in a Prominent Public Trial

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*"When you testify, Marty, tell the truth and let the lawyers go to hell."*

–Weber, New Yorker

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The authors of this commentary staff an outpatient child abuse and neglect evaluation clinic at the University of North Carolina Hospitals. This is a referral clinic for evaluations of children referred by social service agencies, law enforcement agencies, other health professionals and attorneys, both within and out of state. This clinic was one of five child abuse and neglect referral centers in the state of North Carolina during the summer of 1989. These centers back up a network of 450 physicians in all 100 counties of the state who together constitute the North Carolina Child Medical Evaluation Program (Moore, Hudson, & Loda, 1986). During the summer of 1989, we were contacted by a physician at our institution and asked to examine a child relative of one of his staff members. That child had told his family about sexual experiences at the Little Rascals Day Care Center in Edenton, North Carolina and had been seen locally by a private physician. The local examination had been inconclusive but the child had continued to make graphic reports of sexual abuse to his therapist and the parents and it was felt a second opinion was necessary. At the time we saw this first child, the day care center had already been closed for 4 months. We conducted a multi-disciplinary evaluation and shared our evaluation with his parents and therapist.

The dimensions of the problem at the day care center became clear as we began to see a steady trickle of families from this town 4 hours distant from Chapel Hill. Over the next five months we saw more than 50 children who had attended the Little Rascals Day Care Center in Edenton, NC. Our evaluations of the last few children from this day care center were completed almost one year after the closure of the center.

The first Little Rascals Day Care Center trial finally came to court during the fall of 1991 and continued for more than 10 months. This case remains the longest criminal trial in North Carolina history and resulted in 99 guilty verdicts involving 12 victims for which Robert Kelly, the husband of the owner of the day care center, was sentenced to serve 12 consecutive life sentences. A second trial against one of the women that worked at this center has also produced guilty verdicts. Five other defendants are still waiting trial. Each of the authors, and several other colleagues, examined children from the center and were subpoenaed by both the defense

and the prosecution during the first trial. That trial, associated legal maneuvering, and widespread publicity complicated our lives, tried our emotions, and tested long-standing professional relationships. In this commentary, we discuss our experiences with the case, the court, and the lessons we learned about serving as experts. We will specifically address our dealings with both the prosecutors and defense attorneys before the trial, our experiences during the trial with the attorneys from both sides, our observations about the cross-examination and defense witnesses, and subsequent dealings with the case.

## *THE MEDICAL EXAMINATIONS*

As the number of allegations in the day care center slowly became apparent to us through the summer of 1989, we attempted to apply what we perceived as a lesson from the McMartin case in California. We deliberately spread the cases among the physicians who examine abused children at our institution and attempted to have some of the children be seen at other institutions. Because of scheduling problems and patient preferences, all but one of the children who received second opinions were seen at our institution.

Our approach to the medical examination of suspected child victims is highly individualized. Children come to our clinic from varying distances and with different experiences with prior interviews. Generally, we have a one visit evaluation model with a history and associated physical examination. Older children or children who have made relatively complete prior disclosures are interviewed only by the physician. Younger children, children with confused or uncertain prior disclosures or children referred without disclosures are interviewed first by a social worker or psychologist working in the pediatric clinic setting. If more than one interview is needed, follow-up interviews are arranged with our hospital social worker or with social services or mental health professionals in the child's home community. As it was apparent early that many of the children were in therapy, we began to limit our evaluations to very focused histories dealing with specific complaints or concerns and medical examinations.

## *TRIAL PREPARATIONS*

We have an "open door" policy with defense attorneys. It has been our experience that meeting early with defense attorneys and being as fully disclosing as is legally possible minimizes the likelihood of the case coming to trial and the physicians actually having to make a court appearance. When the defense and prosecution attorneys have a chance to review the full range of evidence, they can estimate the likelihood of success at trial and find solutions that don't involve going to trial. One of us met with the defense attorneys for Mr. Kelly nearly a year before the trial actually began and reviewed the medical aspects of child sexual abuse in general.

Our first contact with the prosecutors also occurred more than a year before the trial. The parents of the children had signed releases for the medical records as we examined the children. In July 1990, a year before the trial began, the three prosecutors arranged to review the cases serially with the physician who had actually performed the exam. It was clear our written reports had been studied and questions were asked specifically to clarify the attorney's notations on their copies of our reports. Although it was helpful to review the reports orally with the prosecutors, it was likewise somewhat frustrating as it was a one-way exchange of information.

The prosecutors provided us with no information of any substance, focusing instead on the details of our reports and our interpretation of them. Thus, during the trial, peers would ask us about some particular testimony given by a parent or child that had been reported in the news. We most often had to respond with a lack of knowledge since we usually had just heard the information for the first time ourselves. Medical testimony was only a part of a much bigger picture. The testimony at this trial was like a jigsaw puzzle with hundreds of pieces and our medical testimony on each specific case was quite literally only a piece of the puzzle.

The three prosecutors divided the tasks and assigned one of the three to prepare the medical evidence and it was she who prepared us for our roles as educators of the jury. As a group we identified the relevant literature for the prosecutor and educated her about the medical aspects of child sexual abuse. Independently, the prosecu-

tor contacted other experts around the country for other views about child sexual abuse and had them review our records.

The prosecutor prepared us for our roles as teachers by dividing up the tasks of teaching. Each of us, while providing testimony under the direct questioning of prosecutors, would concentrate on an area of child sexual abuse. The first informative testimony focused on the physical examination in child sexual abuse including normal female genital anatomy, variations of normal and abnormalities, genital examination techniques, how findings relate to histories, etc. The next medical testimony concentrated on behavioral presentations of normal children and victims of sexual abuse, as well as physical findings of the anal area. The third area of medical testimony was focused on research findings and prior studies as well as reviewing many of the unknowns and current efforts to study these areas.

## *TESTIMONY AT TRIAL*

A unique feature of the trial was its extraordinary duration. The jury sat for 10 months, and until beginning verdict deliberations, jurors were not allowed to talk about the case within or outside the courtroom. For 10 months, attorneys asked witnesses questions while the jurors remained silent. We tried to keep in mind that jurors were the representatives of the community and the final arbiters of the trial process. In general, it is our policy that jurors and the greater community they represent deserve jury-friendly testimony. Our approaches included using common everyday language for body parts and descriptive terms, avoiding or clarifying specialized medical or anatomic words, and liberal use of slides and handouts.

Our goal was to help educate the jury about medical aspects of child sexual abuse. When testifying, we brought to the stand copies of the most current research studies which might bear on the medical findings. We presented information and evidence both favorable and unfavorable to both sides. Our trial experience indicates that jurors appreciate a candid and balanced approach and are generally likely to believe assertions made by physicians who use such an approach.

The cross examination process was tiresome. The mechanism of cross examination involved a restatement of our direct testimony

with a request for agreement or disagreement. Subtle variations, whether intentional or unintentional, required constant vigilance to ensure that the substance and intent were not changed. The preparation for testimony for one of us included role playing asking for question clarification, or restating the question in an answerable form. Other preparation for testimony included collecting of our credentials, including medical licensure, board certifications, and continuing medical education which had been devoted to child abuse. The physicians from our clinic had attended and even taught continuing medical education related to child sexual abuse. These experiences enhanced our qualification as experts and helped the jury weigh the value of the testimony. Expert witnesses may generally state professional opinions, whereas material witnesses may only state what they have seen or heard. It is rare that physicians are not accorded expert witness status in North Carolina, but the jury is allowed to weigh the value of their contributions.

## *DEFENSE TESTIMONY*

One of the authors (DKR) was contacted by the District Attorney prosecuting the case and asked to attend court when the Defense was presenting its medical experts. This was his first experience observing this aspect of a child sexual abuse trial or even observing peers who are testifying. Seldom do we have the time and opportunity to observe other physicians testify or even receive useful feedback on our own efforts. Observation of the defense's physicians made him acutely conscious of the large quantity of medical jargon presented to the jury without explanation. He quickly filled a notepad page with medical jargon that went undefined as he tried to recall if he too had been guilty of using jargon.

Cross examination differs from direct examination in that the witness is not allowed latitude in answering questions and thus cannot explain opinions and educate the jury about the evidence. A cross-examination of the witness may involve leading questions by the opposing attorney with requests to agree or disagree. Our observation of what transpired during the presentation of the defense was that the defense attorney himself presented much of the medical information and limited his own witness to agreeing or disagreeing. One of

the prosecutors commented to one of us that the direct testimony of the defense medical experts was a "great cross examination."

There was startlingly little disagreement between the defense medical expert and the prosecution experts over most issues related to the medical examination in child sexual abuse. The same citations were used by both experts. One of us observed during the trial that the jury members were better educated about the nuances of the medical examination for child sexual abuse than all but a small number of practicing physicians. There was strong disagreement between the defense and prosecution medical experts on only two issues: (1) whether child sexual abuse can or should be a medical diagnosis, and (2) whether prepubertal children who have been vaginally penetrated can be expected to have lasting physical signs. There was also controversy about the validity of interpretation of the medical findings solely based upon photographs without the benefit of having performed an exam.

The issue of whether child sexual abuse can be a medical diagnosis has been discussed elsewhere (Brayden, 1993; Dubowitz, Black, & Harrington, 1993). We feel strongly that a medical examination of sexually abused children can only be justified if its purpose is for detection and care of medical conditions related to the victimization. A diagnosis of child sexual abuse as an explanation of the findings of trauma is no more inappropriate than is the diagnosis of other trauma such as a gun-shot wound. We have no disagreement that courts and juries have to understand the uncertainties of medical diagnosis when the majority of children do not disclose and where the majority do not have lasting physical changes. Since 90% or more of child sexual abuse cases never come to a criminal trial, avoiding the diagnosis because of the risk that a jury might not feel entitled to draw its own conclusion could result in a much greater number of children not being helped by their families or have access to the resources of social service agencies and other providers.

We also understand the difficulty of establishing whether sexually abused young children are invariably physically damaged by penile-vaginal intercourse when disclosures are hard to accurately elicit in detail and it may be hard to determine whether complete penetration has actually occurred. We have no gold-standard as to whether penetration actually occurred in the majority of reported cases. The low prevalence of physical findings among children reported for

sexual abuse only suggests that many children are penetrated without tissue damage. Some physicians have suggested that prepubertal children's tissues are not as elastic as mature women due to the lack of estrogen and that the analogy to childbirth or other events which might stretch vaginal tissue without tears in adult women is not applicable. We have our own clinical experience as a further buttress for our opinion that penetration can occur in young children without tissue damage. Although only a single case, one of us (JCS) extracted an intact, used (and unrolled) condom from the vagina of a three year old child. Follow-up examination 2 days later revealed no signs of tears, scarring, or other trauma and the trans-hymenal diameter on labial separation was less than 6 mm. This case demonstrates with great certainty that a young child can be penetrated and, even when seen soon thereafter, have no physical damage.

## *OTHER PROFESSIONAL ROLES*

Our roles as examining physicians and expert witnesses were clearly identified for this particular trial, just as they are for physicians in other criminal child abuse proceedings. Our interactions with the families were very typical. The need of the children and their parents for thorough explanations with time to answer questions was identical to that of other families being evaluated for possible sexual abuse. The children and families shared concerns and feelings while seeking advice and counseling for ways to help their children. For example, upon completing direct testimony, one of us was contacted by the family of one of the children who had testified. During cross-examination, the child was directly accused of lying. That child, age 7 years at the time of testimony, had subsequently begun to have behavioral difficulties and the family was quite distressed about the child's behavior. The physician met with the prosecutor and suggested the child be immediately debriefed about the child's testimony and the adversarial nature of the courts. The prosecutors had planned a debriefing but were waiting for the proceedings to conclude.

## *DISCUSSION*

This trial presented numerous difficulties for us. Not the least among them was the rather new experience of finding ourselves in

adversarial proceedings with professional peers. We suspect that few physicians testifying in child abuse cases encounter conflicting medical testimony; despite numerous court experiences for each of us, this was our first encounter with a case in which the defense had medical witnesses. Hopefully, the absence of conflicting testimony in prior cases reflects the honesty and careful examination of the evidence that we undertake prior to our appearances.

Respected physicians testified for the defense in this case. We believe the combination of their and our testimony allowed the jury to make an accurate assessment of the medical components of the case. The medical evidence and our conclusions about occurrence of child sexual abuse were not the determinants of the case outcome. The children testified and their testimony was listened to by the jury.

The role of physicians as expert witnesses was again emphasized. Regardless of whether the physician was a "prosecution" or "defense" witness, providing understandable information to educate the jury in an honest and forthright fashion was all that was required. Our opinions, no matter how much knowledge we feel they are based on or how fervently we express them, were still just more information for the jury. One of the district attorneys shared with us information gathered from jurors after the trial about our testimony. The jurors noted that we appeared to be honest and forthright, even when doing so did not help the issues the prosecution was interested in advancing.

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