**Neutral Citation Number [2004] EWCA Crim 50**

Case No: 2001/4928/C4

**IN THE SUPREME COURT OF JUDICATURE**
**COURT OF APPEAL (CRIMINAL DIVISION)**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22nd January 2004

**Before :**

**LORD JUSTICE KENNEDY**
**MR JUSTICE CURTIS**
and
**MR JUSTICE FORBES**

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**Between :**

**R**
**- and -**
**Kevin John Brown**

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**Mr Ferm** (instructed by **V. Waugh, Easington Colliery, Co Durham**) for the appellant
**Mr Duffield** (instructed by **Treasury Solicitors**) for the Crown

Hearing dates: 15th & 16th December 2003

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# JUDGMENT

**Lord Justice Kennedy:**

1. On 19th July 1996 in the Crown Court at Newcastle upon Tyne this appellant was convicted of rape and was sentenced to 7 years imprisonment. On 26th March 1997 his appeal against conviction was dismissed by a different constitution of this court.

2. On 18th July 1997 his application was received by the Criminal Cases Review Commission which then carried out its own inquiries, including in particular obtaining three medical reports, and in a Statement of Reasons with a confidential annex dated 29th August 2001 the CCRC sets out why it has decided to refer the case back to this court. Pursuant to an order of this court the confidential annex has been disclosed to the appellant's legal advisers, and its contents are central to one of the grounds of appeal which are now relied upon, but before we get to those grounds of appeal we must first set out the background to this case.

**Background.**

3. The appellant was born on 8th March 1965, so he is now 38 years of age. In early February 1995 his girl friend was DS who lived with her son M at an address in Durham. M was born on 13th October 1989, so he was then 5¼ years of age. The house was a two bedroom semi-detached council house, and the other house to which it was attached had been occupied since November 1994 by Deborah McKechnie, a 27 year old woman who lived alone. The wall between the two houses was thin, so it was all too easy to hear what was going on next door.

4. The appellant did not live at the home of DS, but he was a regular visitor, and on Monday 6th February 1995 he was child-minding for the evening whilst DS was out. Next door Deborah McKechnie watched television and then went to bed. In a statement she made next day she said that she was in bed by 11.55 pm. Her small bedroom was, it seems, separated from M's bedroom by the thin dividing wall. When she was in bed she heard a lot of movement in the house next door - doors shutting, footsteps downstairs and upstairs and eventually the front door being opened and slammed shut, but at this stage she heard no voices. Then the radio was switched off. Miss McKechnie said that it could have been after midnight when that happened. Someone walked very heavy footed up the stairs and then a male voice which sounded local sang really loudly "Remember you're a womble". Then Miss McKechnie heard the child's bedroom door open, and she could hear footsteps going into that room. At that stage she switched off her bedroom television which had been operating with the sound turned off, and switched on her bedroom light. She was wide awake and listening hard to what was happening next door. Her statement to the police continues –

> "I heard someone climb onto the bed in the room next door and then the little boy started to shout straight away 'leave us alone'. It was as if he knew what was going to happen. I felt sick. I froze. I just knew what was going to happen. Then a man said 'I won't hurt you' or 'it doesn't hurt you'. His voice sounded very hard at this time, quite gruff. I could hear

> movement on the bed, sounds of sheets and people moving around. The child was screaming by this time saying 'leave us alone get off us'. I was sat up on my pillows listening against the wall. Then the child let out one very loud scream, and I could hear the bed knocking, a slow regular beat. The boy was constantly screaming, then coughing as if he was choking with crying. I could hear him sobbing and really yelping and screaming. Then sobbing as if to get his breath - then screaming again. The knocking on the bed continued throughout this. I was stood up by this time, crying. I just didn't know what to do, or how to help the boy. There was a pause in the knocking and I heard the boy say 'me bum hurts'. He was still crying, but the screaming had stopped. Then the knocking started again. I had to run to my toilet where I was physically sick."

Miss McKechnie said that before she went into the bathroom she went downstairs and telephoned her sister, and told her what she could hear. She even put the cordless telephone to the wall in the bedroom in the hope that her sister could also hear but she could not hear anything, and told Miss McKechnie to ring the police. It is common ground that the telephone call to her sister was at about 12.50 am on Tuesday 7th February 1995. After the telephone call the child was still crying but the knocking had stopped. After ten minutes or so Miss McKechnie's sister rang back and offered to ring the police for her, but Miss McKechnie declined that offer and then rang the police who came round.

5. Miss McKechnie had previously been troubled by the noise next door, to the extent of contacting the police, but thereafter there were no problems. She had also it seems had some concerns about the little boy, especially when the noise was loud. Once before Christmas she had heard "the same scream I heard last night" but although she felt uneasy she heard nothing else. On the night of 6th/7th February 1995 she was, she said, very distressed by what she heard and could not forget the little boy's scream "leave us alone" and "I just wanna go to bed".

**Subsequent events and trial.**

6. We have dealt in some detail with the contents of the statement made by Miss McKechnie because her evidence was one of the main pillars of the prosecution case, and there is no transcript of her evidence at the trial. She seems to have given evidence broadly in accordance with her statement, and what she said is summarised at page 6G to 10 of the judge's summing-up. She did say that the start of the incident which caused her alarm was "five or ten minutes after I went to bed, after midnight", which is difficult to reconcile with the unchallenged evidence of her sister, Angela Donnelly, who says that she was telephoned by Deborah at about 12.50 am and was able to be satisfied as to the time because she looked at the clock.

7. M's mother, DS, said that she had gone out at about 6.45 pm on the evening of 6th February and was back by 12.03 am. The appellant was in the living room fully dressed watching television, and reported no trouble with the little boy. She found M lying on her bed, and he wanted to stay there, but she refused and carried him into his own room, which made him upset. The appellant's recollection was that it was he and not Miss S who carried the boy to his own bed, but Miss S said that when she went upstairs it was not quite 12.10 am. M cried for about ten minutes, and the only time she was not with him was when she was in the bathroom. She then went to bed with the appellant and it seems that they had intercourse before the police arrived in response to the telephone call made by Miss McKechnie. The appellant denied any impropriety towards M, and has maintained that denial to this day. Furthermore the version of events given by DS in evidence, was, it seems, the account that she gave from the outset.

8. The boy's clothing was examined and no seminal staining was found on the underpants which he was wearing at the material time. Some seminal staining was found at the bottom of the sheet which had been on his bed, but it could not be linked to the appellant, and may have got onto the sheet any time after the sheet was last washed.

9. At about 5.30 am on 7th February 1995 M was jointly examined in the presence of a police woman by Dr George and Dr Smith. His mother brought him for examination. Dr George was the principal police surgeon for the Durham Constabulary, who had been working as a police surgeon for 18 years, and who also worked as a general practitioner. Dr Smith was a consultant paediatrician working at Dryburn Hospital, Durham, who had considerable experience in examining children alleged to have been subjected to physical or sexual abuse. Dr George recorded M as being a "nice, pleasant, co-operative patient, not withdrawn in any sense at all who was very trusting and bold". Although questioned he made no complaint of having been subjected to sexual abuse. As to what the doctors found there is really not much dispute. Dr Smith described the main injury as "a large fresh tear or anal fissure present at 12 o'clock which is anteriorly". There were also two small marks on the right hip, and a burn on the thumb. No one regarded the thumb injury as of any relevance, and Mr Duffield for the Crown now accepts that for present purposes the mark on the hip had no significance but that concession was not made at the trial. Unfortunately the two examiners did not agree as to the significance of the anal tear. Dr Smith considered that in the absence of constipation, and there was no evidence of that, the tear must have been caused by external trauma, by stretching the anus until it burst, and that would have been very painful. There would have also been bleeding, but no blood was found. The injury could have been caused by a finger used roughly, or a penis, or some other object, and its appearance, with no sign of healing, was in his judgment consistent with the damage having been done six hours or so previously when Miss McKechnie was disturbed. Dr George disagreed. He noted, as did Dr Smith, the demeanour of the boy, and in his opinion the appearance of the injury to the anus taken together with the other surrounding circumstances was such that the damage could not have been caused within the last twelve hours. In the area of that injury there was no sign of any lubricant having been used, there was no bruising, and there were no stretch marks. He separated the anus to have a look, and the child was not uncomfortable and did not react. There was no bleeding until he stretched the scar,

which did cause a little bleeding, but so little that it was not noticed by Dr Smith. It was not, in his opinion, a chronic anal fissure.

10. The third medical witness called at the trial was Dr Camille San Lazaro, who examined M on 14th February 1995, one week after the alleged incident. She was a consultant paediatrician and lecturer in forensic medicine at the University of Newcastle upon Tyne who had particular expertise in examining children suspected of child abuse, and in dealing with constipation. In this court Mr Ferm submitted that she may well have been regarded by the jury as a tie-breaker. The judge referred to her as "very experienced" and her evidence was clearly favourable to the prosecution. She said that the anus was normal, apart from a very thin papery friable scar at the anterior end of the anus. As to when the injury was sustained she said -

> "It was utterly compatible with an injury taking place around the time that it was suggested it had taken place but it could also have been an injury which had taken place a little before or a little after that."

As to what caused the injury she said that it was –

> "Something blunt because it isn't a sharp tear that has stretched and over stretched usually abruptly the anus and as the anus has not been able to accommodate whatever it was and split."

She did not regard constipation as being at all a likely cause of the injury. The injury could have been caused by a finger roughly applied, but a penis was in her opinion more likely. Dr San Lazaro recorded that M was a quiet little boy who gradually warmed up and participated in the examination process in an animated excited fashion, showing no terror of anal examination. Towards the end of her cross-examination Dr San Lazaro said that she had taken the history from the boy's mother and from the boy meticulously as to constipation and such matters and -

> "There is a history of diarrhoea for a long time which had only settled two or three weeks previously and his stools had been absolutely normal since that time."

That took Mr Cosgrove QC for the defence by surprise. There had been no previous reference to diarrhoea.

11. When the judge began to sum up he told the jury that they had "heard some very unpleasant evidence about a squalid and horrifying incident which took place at No 23 Durham Gardens in Witton Gilbert on the night of 6th February of last year." That was a curious observation with which to begin a summing-up, because of course the case for the defence was that there had been no such incident at all; but the judge did go on to deal with the burden of proof and to review the evidence in the normal way. Having referred to the joint examination by Dr Smith and Dr George the judge said –

> "Members of the jury, you may wonder whether that tear, or fissure, was just what you would expect if Deborah McKechnie is right in what she says. How did that tear get there, if not by reason of buggery?"

As the evidence then stood that rhetorical question was, as it seems to us, entirely reasonable. Neither constipation nor the use of a finger seemed on the medical evidence to be at all likely. At the close of the prosecution case there had been a submission that there was no case to answer on the charge of rape, but that had been rejected by the trial judge.

**The 1997 Appeal.**

12. On appeal to this court in 1997 there were six grounds of appeal. In ground 2 it was submitted that only indecent assault and not rape should have been left for the consideration by the jury. That was rejected. At 8F-G of the transcript Henry LJ said -

> "The jury were entitled to take the view that both movement of the bed and the extent of the pain (as reflected in the screams) pointed clearly to penile penetration."

In grounds 1 and 3 attention was drawn to the conflict between two witnesses for the prosecution, namely Deborah McKechnie and the child's mother. If the mother was right as to the time of her return then Miss McKechnie must have misinterpreted what she heard because there was never any suggestion that the mother connived at the serious offence, or that it could have taken place in the house after her return without her being aware of it. As this court said "everyone knew what the Crown's case was", and in the end the jury was entitled to conclude that the mother must have returned much later than she said she did.

13. The remaining three grounds of appeal related to criticisms of the summing-up, which was said to be so unbalanced as to make the conviction unsafe, the most significant criticism being of the judge's opening remarks, to which we have already referred. When those remarks were considered in context this court found that there was no reversal of the burden of proof.

**CCRC enquiries and fresh grounds of appeal.**

14. Recognising that there were two main pillars supporting the prosecution case, namely the evidence of Deborah McKechnie and the findings at the time of the joint medical examination, the CCRC sought and obtained fresh expert assistance in relation to each of those areas. It was clear from Deborah McKechnie's own evidence that between 11.55 pm and 12.50 am she was in bed, and for at least part of that time she must have been either asleep or attempting to sleep, and Dr Peter Fenwick, a consultant

neuropsychiatrist, was asked to report as to the reliability of a witness who had been in that condition.

15. In relation to the findings of Dr George and Dr Smith further assistance was sought from Dr Clarke, a consultant forensic physician with a particular interest in all forms of physical and sexual abuse, and from Professor Keighley, a gastrointestinal surgeon who is head of the Department of Surgery at the Queen Elizabeth Hospital, Birmingham. In the light of the three fresh medical reports the matter was referred to this court, and Mr Ferm, who had not previously represented the appellant, was instructed to draft further grounds of appeal which can be summarised thus-

> (1) In the light of the evidence of Dr Fenwick, if that evidence be admitted, there must be doubt not as to the integrity but as to the reliability of the evidence of Deborah McKechnie.
>
> (2) In the light of the evidence of Professor Keighley and Dr Clarke, if that evidence be admitted, there must be doubt as to the cause of the damage to the boy's anus observed by Dr Smith and Dr George.
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> (3) The judgement of Eady J in Lillie and Reed v Newcastle City Council [2002] EWHC 1600 QB, which was delivered on 30th July 2002, discredited Dr San Lazaro in a way which impacts upon her evidence in this case.
>
> (4) Although the point was not taken at trial, it was wrong to permit Deborah McKechnie to say that what she heard made her physically sick, and if that evidence was to be admitted the judge should have given the jury careful directions in relation to it.
>
> (5) In any event there was no sufficient evidence of rape as opposed to indecent assault.

In response to the fresh evidence the Crown obtained a further report from Dr Smith, and a report from Dr McLain, a consultant paediatric gastroenterologist. Dr San Lazaro was also asked to respond, but the Crown then decided not to place any further reliance upon her.

16. At the start of the hearing in this court it was agreed that we should hear all five medical witnesses *de bene* esse, and reserve the question of admissibility to be dealt with in this judgment.

**The fresh evidence.**

17. Dr Fenwick has studied sleep, and he was able to assist us as to the mental states resulting from an arousal from sleep onset or stage one sleep, particularly where the person aroused has themselves had a traumatic emotional experience in the past. At

some stage after the hearing in the Crown Court it emerged from a social services file, and from general practitioner records, that Deborah McKechnie had herself complained in 1994 of being raped in June 1992, so the incident with which we are concerned occurred just over a year after she made her complaint.

18. As Dr Fenwick explained, when a person settles down to sleep the body relaxes, and the sleeping process is initiated. The brain rhythms change and a new mental state supervenes known as the hypnagogic state, between sleeping and waking. When a person is in that state the thinking process becomes distorted, and dream like images may arise. There can be an enhancement of emotional thinking (such as increased anxiety) and there is nearly always a distortion of sensory perception. Sounds can become very loud and laden with meaning, and there may be active hallucinations which give a spurious meaning to the perceived world. Then the individual passes into stage one sleep, which is accompanied by further bodily relaxation and marked slowing of brain waves. Thinking does not stop, but continues with illogical thought processes. If the subject is woken from either sleep onset or stage one, and if the imagery has been either emotional or distorted, those feelings and thoughts are carried over into the waking state. The individual may not even realise that they have been asleep, so they can wake up with problems enlarged.

19. Looking at the witness statement of Deborah McKechnie and at the summary of her evidence given by the judge when he summed up Dr Fenwick noted that she never said that she had gone to sleep, but the lapse of time between 11.55 pm when she went to bed and 12.50 am when she made the first telephone call was not otherwise adequately explained, and it was noteworthy that in her witness statement she said that she knew what was going to happen. Mr Duffield told us, and we accept, that she did not say that in the witness box. But in the opinion of Dr Fenwick the probability overall was that Miss McKechnie was aroused from the early stages of sleep and, living alone, she was emotional because of her own past experience and her concern for the child. If she had known - if it be the case - that the child's mother was next door her perceptions of what she heard might have been totally different.

20. Dr Clarke was Divisional Police Surgeon with Merseyside Police for 35 years to 1993, and examined the children on behalf of parents during the Cleveland Child Sex Abuse Inquiry in 1987. He was clearly impressed by the lack of any sign of abnormality upon examination by Dr Smith and Dr George other than the damage to the anus. There was also no pain and no complaint. By reference to well known texts Dr Clarke pointed out that -

> "Anal fissures are caused most commonly by constipation or diarrhoea, with idiopathic (unknown) causes second, and buggery the least common. There is no difference in the shape of the fissure scar caused by any of these mechanisms."

That, he said, applies to children as well to adults. If only five or six hours prior to examination an erect adult penis had been applied to the bottom of this five year old boy with such vigour as to cause him to cry out in pain and cause damage to his anus Dr Clarke would expect him on examination to display evidence of bleeding and

bruising, to be suffering discomfort and pain, and to be anxious about what the doctors wanted to do to him. There was no sign of that. He drew our attention to paragraph 6.16 of the 1997 Second Edition of the Report of the working party of the Royal College of Physicians entitled "Physical Signs of Sexual Abuse in Children". That paragraph reads -

> "In our opinion, based on the clinical experience of members of the Working Party, **acute anal fissures are not unusual in young children who have not been abused**. They may be associated with constipation, threadworms, napkin rash, diarrhoea, eczema and lichen sclerosis, they are usually midline in either the anterior or posterior position."

The emphasis is not ours. It appears in the Report. When cross-examined Dr Clarke accepted that the absence of any sign of lubricants, semen, blood or bruising is not decisive, and that an abused child may be passive on examination, but he said that is more likely in the case of a child who has been repeatedly abused and in the present case there is no evidence of that. He was asked about the possibility of the anal damage having been caused by diarrhoea, and said that because of the lack of supporting symptoms and behaviour he thought it more likely that the cause was idiopathic, something which was causing no problem and would never have been noticed if the child had not been medically examined. He thought the absence of previous problems militated against the diagnosis of a chronic fissure.

21. Professor Keighley noted that when Dr San Lazaro examined the anus seven days after Dr Smith and Dr George she found a thin papery scar which was white and friable, so the lesion was still present and healing but not completely healed. In his judgment that was a very important observation, because he would have expected a tearing injury caused by a thrusting penis to have been completely healed 8 days later. Professor Keighley distinguished between a tear and a fissure, which he described as an ulcer affecting the anal margin with an unhealed base and often slightly swollen edges, usually occupying just one small segment of the clock face. A fissure, he said, can be acute, in which case it could not possibly be examined digitally, or it can be chronic. Chronic fissures come and go, and in 30 to 40% of cases there are observable anal skin tags. No such tag is recorded in this case, but Professor Keighley believes that it was probably a chronic fissure that was being examined. They often do bleed a little on parting of the buttocks, as Dr George noted in this case, and they are slow to heal. Furthermore the damage was at one of the two common sites for a fissure. The most common cause of chronic fissures is idiopathic. They may be caused by constipation, or by diarrhoea followed by a reluctance to go to the toilet, so the late-emerging history of diarrhoea two or three weeks prior to Dr San Lazaro's examination could be relevant. Professor Keighley accepted that a chronic fissure will have begun at some stage as an acute fissure, and if after healing it breaks down again there will probably have been a precipitating factor. At page 17 of his report Professor Keighley listed those features which, in his opinion suggested that the damage to the anus in the present case was not caused by buggery, namely -

> "1 There was no bruising.

> 2 There was no scratching on the perineum.
>
> 3 The alleged victim was not frightened.
>
> 4. There was no evidence of a star-shaped laceration round the anus.
>
> 5. There was no semen on the perineum or in the anal canal.
>
> 6. There was no evidence of lubricant.
>
> 7. The lesion described in the anus is much more in keeping with anal fissure than a tear because it was still present 7 days later.
>
> 8. It is likely that the fissure was chronic because it was painless and didn't bleed when the buttocks were parted.
>
> 9. There was a possible history of diarrhoea which might have precipitated an earlier acute fissure that had not healed and was chronic at the time of examination on 7th February 1995."

At page 18 he concluded -

> "The evidence that the anal lesion was caused by sexual abuse is uncertain in this case. There are too many features here to suggest that this was a chronic anal fissure, and was probably idiopathic and might originally have been caused by a previous history of diarrhoea."

22. Dr Smith was not surprised that the boy was not distressed and did not experience pain because he took care to explain to him what was going to happen, and handled him with care. The doctor said he had as good an opportunity as Dr George to examine him, and did not himself distinguish between a tear and a fissure. He saw no sign of bleeding, and on examination found no hard stool in the colon. He did not consider diarrhoea as a possible cause of what he observed, but, despite what is said in the RCP report he has never, even when working in the Middle East, seen a child with an anal tear or a fissure caused by diarrhoea. If that is the cause of irregularity there will be other signs, such as a rash, which were not present here. In his judgment what was seen by Dr San Lazaro was the continuation of the healing process, and unlike Professor Keighley he was not surprised that the injury had not healed completely in seven days, although he did accept in cross-examination that healing in two to five days would be normal. He accepted that the bruising around the anus would be significant if it were present, but neither its absence nor the presence of only one tear pointed, in his judgment, away from the conclusion that the damage was caused by external trauma. Chronic constipation can cause fissures but that is unusual in child hood, and a chronic anal fissure is very very rare, except in conjunction with a bowel disease. Dr Smith was questioned about the history he obtained from the boy's mother. It seemed clear to us that his recollection of that history-taking is now far from clear, but he said that the mother was co-operative and did not tell him of any

other problems. Although he believed what he saw was caused by external blunt trauma he could not exclude other causes, but other possible non-abusive causes were not investigated.

23. Dr McLain also said that he had never seen damage to the anus caused by diarrhoea without excoriation, and that could easily be distinguished from a tear. Bruising would be additional evidence of abuse, but its absence does not mean that penetration by a blunt object has not taken place. He agreed with Professor Keighley that the majority of tears do heal within two to five days but the leading text book indicates that the period can be longer. In the circumstances of this case he considered it to be realistic to ignore constipation as a possible cause of injury, and he said that sometimes children seem indifferent to being examined and indifferent to pain. Like Dr Smith he pointed out that examining doctors do try not to cause pain. Unlike Professor Keighley he did not analyse the case against buggery, and in the light of what is now known, for example in relation to diarrhoea, he accepts that there were deficiencies in the history-taking and in the elimination of non-abusive causes which render proof by elimination unsatisfactory, but he believes that that the most likely cause of injury was penetrative force. The approach of Professor Keighley he regarded as just about possible, but highly unlikely.

**Admissibility and Grounds of Appeal**

24. We revert to Mr Ferm's first ground of appeal. The evidence given by Dr Fenwick could have been called at the trial, and that is a matter to which we must have regard when deciding whether or not to receive that evidence (see section 23(2)(d) of the Criminal Appeal Act 1968). In order to overcome that difficulty Mr Ferm invited our attention to Deborah McKechnie's own sexual history which was not known to the defence at the date of the trial, but which Dr Fenwick considered to be significant. Mr Duffield submits that the interests of justice do not require that the evidence of Dr Fenwick being received because at the trial there was no reason to think that Deborah McKechnie was unreliable simply because she might have been aroused from sleep.

25. In our judgment the arguments for and against the reception of the evidence of Dr Fenwick are finely balanced because the sexual history of Miss McKechnie only served to enhance evidence which the doctor could have given in any event, and in Steven Jones [1997] 1 Cr App R 86 Lord Bingham CJ said at 93D that -

> "It would really subvert the trial process if a defendant, convicted at trial, were to be generally free to mount on appeal an expert case which, if sound, could and should have been advanced before the jury."

Clearly Dr Fenwick's evidence is capable of belief and would have been admissible in the Crown Court, but we doubt if standing alone it could afford a ground for allowing the appeal, and so in the end we conclude that it is not necessary or expedient in the interests of justice for that evidence to be received at this stage.

26. We turn to the evidence of Professor Keighley and Dr Clarke. Here Mr Ferm points to the boy's history of diarrhoea as something that was understandably unknown to the defence until such a late stage in the trial that it was impossible properly to assess its relevance. That is true, but, as Mr Duffield acknowledges, the really compelling reason for receiving the evidence of Professor Keighley and Dr Clarke, and also the evidence of Dr McLain and the further evidence of Dr Smith, is that together with the existing evidence given at the trial they enable this court to re-assess the medical evidence as to the irregularity that was observed. So the interests of justice do require that this additional medical evidence be received and we receive it. Mr Duffield submitted that having received it we should nevertheless reject Professor Keighley's preferred option of a pre-existing chronic fissure as unrealistic. The condition, he submits, is shown to be rare in children and the paediatricians had no experience of it being caused by diarrhoea. Mr Duffield accepted that a simple tear would normally have healed within seven to eight days, but he submitted that the findings of Dr San Lazaro should not be made to carry too much weight, and that not too much should be made of the absence of pain or of the other indications of trauma which are sometimes seen such as semen, lubricants, bruising and resistance to examination.

27. In our judgment when the fresh evidence given by Dr Clarke, Professor Keighley, Dr Smith and Dr McLain is read together with the evidence given at the trial it becomes immediately apparent that at the trial the medical issues were over simplified, to the detriment of the defence, hence the judge's rhetorical question "how did that tear get there, if not by reason of buggery?" First of all a respected specialist does not accept that there was a tear. He believes that what was observed was a chronic fissure. He is fortified in that belief by what Dr San Lazaro observed a week later. Then, both he and Dr Clarke emphasise that the ultimate cause of such abnormalities is often unknown, and they believe that if this abnormality was caused by the sort of vigorous buggery the sounds of which Deborah McKechnie believed that she overheard it is surprising that a few hours later there was no bruising, no bleeding, no soreness and a happy relaxed child. Dr Smith and Dr McLain do not find that so surprising, but if the jury had the advantage of hearing the additional medical evidence that we have heard it seems to us that they would have been bound to have had serious doubts about the extent to which they could rely upon the medical evidence to assist them to a conclusion. It is no longer simply a question of whether to prefer the evidence of Dr Smith and Dr San Lazaro to that of Dr George, and thus conclude that what the doctors found was wholly consistent with what the prosecution alleged. It now has to be recognised that what was found is capable of a number of explanations. The medical evidence raises questions which may be difficult to answer, but that very fact undermines one of the main pillars of the prosecution case.

28. The difficulties now faced by the prosecution in relation to the medical evidence are aggravated by their reliance at trial on the evidence of Dr San Lazaro who, in the subsequent case of Lillie, was completely discredited in relation to her handling of a number of allegations of sexual abuse prior to February 1995. Mr Duffield therefore conceded that if we were to take the view that at the trial the evidence of Dr San Lazaro formed a significant part of the prosecution case then the Crown would be in difficulty in resisting this appeal. He submitted that in reality her evidence was not of great importance, but we disagree. She was called because she had examined the boy at the behest of social services, but she was presented as immensely experienced, and

may well have persuaded the jury to prefer the evidence of the Dr Smith to that of Dr George.

29. Mr Duffield made the powerful point that leaving aside the differences of medical opinion and the difficulty of reconciling the time of the alleged assault with what both the appellant and the boy's mother say about her return home the fact remains that at 12.50 am Deborah McKechnie began to make telephone calls because of what she said she heard. No one has questioned her integrity, and when the boy for whose safety she was concerned was examined there was an abnormality of the anus. That, Mr Duffield submits, cannot simply be attributed to coincidence.

30. We do see the force of that argument, but, for the reasons we have given, we regard the conviction as unsafe. As we indicated during the course of the hearing we were not impressed by Mr Ferm's submission that the jury should not have heard from Deborah McKechnie that she was physically sick. It was relevant evidence as to the impact on her of what she heard, and required no special direction from the trial judge. In the light of her evidence the judge was in our view right to leave the count of rape for consideration by the jury. But if, as we understand from the CCRC Statement of Reasons, there was no reason to fear collusion between the appellant and the mother of the boy because she gave up her association with the appellant as soon as the allegation of abuse was made, we are surprised that nothing seems to have been made of that point at the trial. Similarly the possible innocent explanation mentioned by the CCRC for the seminal staining found upon the sheet on the boy's bed – namely vaginal leaking if the mother sat on the child's bed after intercourse elsewhere - does not seem to have been explored, and the bruising found on the boy's hip was given a significance which in this court was accepted to be inappropriate. But in the absence of a full transcript we say no more about those peripheral points.

**Conclusion.**

31. Were it not for the fact that the trial took place 7½ years ago and the appellant has served his sentence we would have ordered a re-trial, because the prosecution can still present a strong prima facie case, but because that sentence has been served we simply order that the appeal be allowed and the conviction quashed.