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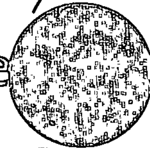
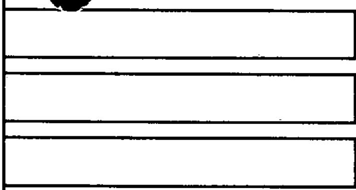
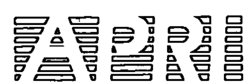


National Center for Prosecution of Child Abuse



TRAINING

Basic Training for Child Abuse Prosecutors



The American Prosecutors Research Institute

The non-profit research and technical assistance affiliate of the National District Attorneys Association

Program Information

BASIC TRAINING FOR CHILD ABUSE PROSECUTORS

May 29 - June 2, 1990

Criminal Justice Center

Sam Houston State University

Presented by

American Prosecutors Research Institute's

National Center for Prosecution of Child Abuse

in cooperation with

Texas County and District Attorneys Association

Program Goals

Few criminal cases are as troubling or challenging to prosecutors as child abuse. With the number of cases increasing, the demand for prosecuting attorneys with special skills to evaluate and try complex child abuse cases is also growing.

APRI's National Center for Prosecution of Child Abuse recognizes the needs of front line prosecutors who are required to respond with maximum effectiveness to these cases. Its unique training program brings together a wealth of practical experience and research with experts from the medical, legal, mental health and law enforcement fields to provide a comprehensive introduction to the substantive and procedural issues child abuse prosecutors face.

At the end of this seminar, participants will:

- *Understand the dynamics and indicators of child physical and sexual abuse;*
- *Be able to manage and evaluate child abuse investigations;*
- *Know how to respond to the most common problems presented by child abuse litigation;*
- *Be prepared to try felony child abuse cases; and*
- *Take advantage of a national multidisciplinary network of experts.*

This conference is supported by Cooperative Agreement Number 86-JN-CX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. The Assistant Attorney General, Office of Justice Programs, coordinates the activities of the following program offices and bureaus: the Bureau of Justice Statistics, National Institute of Justice, Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions are those of the presenters and do not necessarily represent the official position of the Department of Justice.

Training Agenda

TUESDAY, MAY 29

10:00 A.M.	**Registration**	**2nd Floor Lobby**
12:30 - 1:30 P.M.	**Welcome and Introduction to Program** Patricia A. Toth, Director National Center for Prosecution of Child Abuse	**Auditorium**
1:30 - 2:30 P.M.	**Dynamics of Victimization and Child Development** *Psychological effects of child abuse and developmental differences between adults and children.* Lucy Berliner	**Auditorium**
2:30 - 3:30 P.M.	**The Interdisciplinary Approach to Investigation and Prosecution of Child Abuse** *Coordinated responses to investigation and prosecution of child abuse are generally more successful in building strong cases and avoiding unnecessary trauma for the victim.* Seth Dawson	**Auditorium**
3:30 - 3:45 P.M.	**BREAK**	**Flag Room**
3:45 - 5:00 P.M.	**Patterns of Injury in Child Abuse and Homicide** *What prosecutors need to know about medical evidence of child physical abuse and homicide.* Dr. Ron Reeves	**Auditorium**
5:00 - 5:15 P.M.	**BREAK**	**Flag Room**
5:15 - 6:30 P.M.	**Patterns of Injury, continued**	**Auditorium**
6:30 P.M.	**Texas Bar-B-Que and Western Band** *Sponsored by Texas County and District Attorneys Association*	

WEDNESDAY, MAY 30

Time	Session	Location
7:30 - 8:30 A.M.	**Breakfast Buffet**	Flag Room
7:30 A.M.	**Registration**	Room 1205
8:00 - 9:45 A.M.	**Child Abuse Investigations** *Attendees will respond to case scenarios which exemplify common fact patterns and discuss what they should expect from the investigation.* Jill Hiatt Terrence P. Thomas	Auditorium
9:45 - 10:00 A.M.	**BREAK**	Flag Room
10:00 - 11:00 A.M.	**Child Abuse Investigation, continued**	Auditorium
11:00 - 12:00 noon	**Workshops**	
	1. Special Problems of Urban Prosecutors Wanda Robinson Mimi Rose	Courtroom
	2. Special Problems of Rural Prosecutors Seth Dawson Susan Terrell	Bates Room
12:00 - 1:15 P.M.	**LUNCH (ON YOUR OWN)**	
1:15 - 2:30 P.M.	**Support and Preparation of Child Witnesses** *Successful techniques for ensuring your key witnesses are prepared for their courtroom appearance.* Lucy Berliner	Auditorium
2:30 - 3:15 P.M.	**Interviewing Child Witnesses: An Investigative and Prosecutorial Perspective** *Techniques for interviewing child witnesses and building a reliable case.* Patricia Toth	Auditorium
3:15 - 3:30 P.M.	**BREAK**	Flag Room
3:30 - 4:00 P.M.	**Interviewing Child Witnesses, continued**	Auditorium
4:00 - 5:00 P.M.	**Anticipating and Meeting Untrue Defenses** *Identifying tactics used by accused child abusers and their counsel and how to overcome them.* Mimi Rose	Auditorium
5:00 - 5:30 P.M.	**FREE TIME**	
5:30 - 7:00 P.M.	**GROUP DINNER** **Aftermath of McMartin: Current Issues in Child Abuse Prosecution** Patricia Toth	Lowman Student Center

Wednesday, May 30 continued

7:00 - 10:00 P.M.	**Workshops (Colored dots on name badge indicate which workshop you should attend.)**	
7:00 - 8:20 P.M.	**Track A (Red dot)** **Jury Selection** *Identifying the kinds of jurors you want for child abuse cases.* Jill Hiatt	**Courtroom**
	Track B (Blue dot) **Understanding When and How to Use Expert Witnesses** *Techniques for using experts to your advantage without setting the stage for a successful appeal.* Harry Elias John Myers	**Auditorium**
8:20 - 8:30 P.M.	**BREAK**	**Flag Room**
8:30 - 10:00 P.M.	**Track A (Red dot)** **Stress Management: Avoiding Burnout** *Learn to recognize and manage effects of stress on your job performance and personal well-being.* Cabell Cropper	**Bates Room**
	Track B (Blue dot) **Expert Witness Demonstrations** *Strategies for effective presentation and cross-examination of expert witnesses.* Harry Elias Dr. Carole Jenny Patricia Toth	**Courtroom**

THURSDAY, MAY 31

7:30 - 8:30 A.M.	**Breakfast Buffet**	**Flag Room**
7:30 A.M.	**Registration**	**Room 1205**
8:00 - 9:00 A.M.	**Workshops (Choose one)**	
	1. Search Warrants in Child Abuse Cases *Guidelines for using the powerful tool of search warrants and how to avoid a host of pitfalls.* Susan Via	**Auditorium**
	2. Child Abuse Search Warrants in Texas *Unique aspects of Texas search and seizure laws.* Becky McPherson	**Courtroom**
9:00 - 9:45 A.M.	**Role of the District Attorney in Multi-Victim Cases** *The need for special handling of cases involving suspected victims of abuse or exploitation.* James Peters	**Auditorium**
9:45 - 10:00 A.M.	**BREAK**	**Flag Room**
10:00 - 12:00 noon	**Scientific Approaches to Proving Child Abuse Cases** *Uses and limitations of scientific techniques including DNA testing, serology, and hair and fiber comparison.* David Bigbee	**Auditorium**
12:00 - 1:15 P.M.	**LUNCH (ON YOUR OWN)**	
1:15 - 2:30 P.M.	**Physical Exams in Child Sex Abuse Cases** *The critical role of physical evidence and what can be expected from the medical community.* Dr. Carole Jenny	**Auditorium**
2:30 - 3:15 P.M.	**Pre-Trial Motions** *Laying the foundation for a successful trial through pre-trial motions and other preparation.* James Peters	**Auditorium**
3:15 - 3:30 P.M.	**BREAK**	**Flag Room**
3:30 - 5:00 P.M.	**State's Case-in-Chief and Demonstrative Evidence** *Techniques for ensuring that all available evidence is effectively presented.* Jill Hiatt	**Auditorium**
5:00 - 7:00 P.M.	**DINNER ON YOUR OWN**	

Thursday, May 31 continued

7:00 - 10:00 P.M.	**Workshops (Colored dot on name badge indicates which workshop you should attend.)**	
7:00 - 8:20 P.M.	**Track B (Blue dot)** **Jury Selection** *Identifying the kinds of jurors you want for child abuse cases.* Jill Hiatt	Courtroom
	Track A (Red dot) **Understanding When and How to Use Expert Witnesses** *Techniques for using experts to your advantage without setting the stage for a successful appeal.* Harry Elias John Myers	Bates
8:20 - 8:30 P.M.	**BREAK**	
8:30 - 10:00 P.M.	**Track B (Blue dot)** **Stress Management: Avoiding Burnout** *Learn to recognize and manage effects of stress on your job performance and personal well-being* Cabell Cropper	Bates
	Track A (Red dot) **Expert Witness Demonstrations** *Strategies for effective presentation and cross-examination of expert witnesses.* James Peters Wanda Robinson Steven Jensen	Courtroom

FRIDAY, JUNE 1

Time	Session	Location
7:30 - 8:30 A.M.	**Breakfast Buffet**	Flag Room
7:30	**Registration**	Room 1205
8:00 - 9:00 A.M.	**Hearsay and Other Out-of-Court Statements** *Defining what hearsay testimony is; how to use these statements and what foundation must be established.* John Myers	Auditorium
9:00 - 10:15 A.M.	**Workshops (Choose one)**	
	1. **Investigation and Prosecution of Neglect and Child Abandonment** Jill Hiatt	Bates
	2. **Prosecuting the Juvenile Sex Offender** Steve Jensen Susan Via	Auditorium
	3. **Coordinating Family Court Proceedings with Criminal Prosecution** Gail Van Winkle Reuben Young	Courtroom
10:15 - 10:30 A.M.	**BREAK**	Flag Room
10:30 - 11:00 A.M.	**Opening Statement** *How to convey a good first impression and present your facts in a tightly woven, easy to understand, believable fashion.* Wanda Robinson	Auditorium
11:00 - 12:00 noon	**Admissibility of Uncharged Misconduct** *Determining when and how the perpetrator's past conduct can be used.* John Myers	Auditorium
12:00 - 1:15 P.M.	**LUNCH (ON YOUR OWN)**	
1:15 - 2:00 P.M.	**Special Problems of Teenage Witnesses** *Techniques for dealing with witnesses whose emotions and behavior put them in conflict with authority.* Mimi Rose	Auditorium
2:00 - 3:00 P.M.	**Cross-Examination of the Defendant and Defense Witnesses** *Mastery of the opposition's witnesses is 50% preparation and 50% knowing when to stop asking questions.* Wanda Robinson	Auditorium
3:00 - 3:15 P.M.	**BREAK**	Flag Room

Friday, June 1 continued

3:15 - 4:15 P.M. **Closing Statements with Demonstration** **Auditorium**

A vital component, closing takes on added importance in light of misconceptions about child abuse, unfamiliar evidence and the secrecy with which these crimes are committed.

Harry Elias

4:15 - 5:00 P.M. **Prosecutorial Ethics in Child Abuse Cases** **Auditorium**

Ethical duties take on added importance when the victim is often legally and physically unable to help him/herself.

Tom Krampitz

5:00 P.M. **DINNER ON YOUR OWN**

SATURDAY, JUNE 2

7:30 - 8:30 A.M.	**Breakfast Buffet**	Flag Room
8:00 - 8:45 A.M.	**Plea Negotiation and Sentencing** *The DA should play an active role at sentencing to ensure that children are protected from further abuse.* Patricia Toth	Auditorium
8:45 - 9:30 A.M.	**Victim Personalization and Impact Statements at Sentencing** *Creative ideas for bringing the victim's perspective into the sentencing hearing.* Susan Via	Auditorium
9:30 - 9:45 A.M.	BREAK	
9:45 - 10:30 A.M.	**Guidelines for Assessing Sex Offenders** *Steps for gathering data so a competent sentencing decision can be made.* James Peters	Auditorium
10:30 - 12:00 noon	**Treatment of Sex Offenders** *How to critically review qualifications of a sex offender treatment professional and program and apply it to your sentencing recommendations.* Steven Jensen	Auditorium

The American Prosecutors Research Institute

and

The National Center for Prosecution of Child Abuse

applaud the support of

Continental Airlines

Empress Travel, Falls Church, Virginia

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and

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which has made this conference possible.

Basic Training for
CHILD ABUSE PROSECUTORS

May 29 - June 2, 1990
Criminal Justice Center
Sam Houston State University

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Tuesday

Resource Materials

Dynamics of Victimization and Child Development

Presented by
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THE PROCESS OF VICTIMIZATION: THE VICTIMS' PERSPECTIVE

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Abstract—Twenty-three child victims (aged 10-18 years) of childhood sexual abuse were interviewed about the victimization process, the person who abused them, and how abuse might have been prevented. Specific questions obtained information about the quality of the relationship between victim and offender, the offender's pre-abuse behavior, the explanation for the behavior given by the offender, and the child's understanding of the behavior. Results suggest that the victimization process involves three overlapping processes: sexualization of the relationship, justification of the sexual contact, and maintenance of the child's cooperation.

Key Words—Prevention, Sexual offenses, Victimization process

INTRODUCTION

PREVENTING THE SEXUAL VICTIMIZATION of children has become an important social concern. It has been established that even quite young children successfully learn prevention concepts (Conte, Rosen, Saperstein, & Chernyck, 1985; Daro, Duerr, & LeProhn, 1986; Garbarino, 1987). Some children apparently do report abuse when exposed to prevention training (Beland, 1986; Kolko & Moser, 1987). This suggests that the information about what abuse is and the encouragement to report are learned by children exposed to educational materials or presentations. It is less clear whether children are actually able to avert molestation. There is some reason to believe that in many situations children are not able to behave in the way that programs recommend, e.g., "Say no, run, and tell" (Fryer, 1987).

Prevention programs are available in many communities and in a number of formats, e.g., in person instruction, television programs, coloring books (see Conte, Rosen, & Saperstein, 1986). Much current prevention knowledge is based on anecdotal information about the victimization process. Understanding the process whereby offenders target potential victims, engage children in sexual relationships, and maintain their involvement, often over an extended period of time, will help locate areas for prevention education both for already victimized children and for children in general. This report describes one of two field studies designed to

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explore the process of victimization: one from the victim's perspective, and one from the point of view of the offender (see Conte, Wolf, & Smith, 1989).

The authors became interested in the idea of describing the process of victimization because of certain characteristics of child sexual abusers and abuse victims and commonly reported clinical phenomenon. For example, known sexual offenders do not molest every child to whom they have access. They are described as selecting victims who are vulnerable targets (Groth, 1979). The majority of victims are abused by an offender known to them prior to the first episode of abuse. Therefore, there is some point where the relationship changes, at least in terms of the overtly abusive behavior. Many clinicians working with both victims and offenders have noted that certain typical behaviors are commonly reported by clients as preceding the offenses (e.g., efforts to isolate the victim). Offender specialists have called this behavior "grooming," and one such program, Northwest Treatment Associates (Silver, nd), created a Partner Alert List containing behaviors in offenders and in children that might signal a relapse or a reoccurrence of abuse (e.g., isolating the child, child avoids offender). A comparable checklist was generated for children (Sexual Assault Center Clinical Consultation Group, 1984). The idea was that if patterns of behavior associated with abuse situations could be identified and learned, adults who care for children and children themselves could help prevent a reoccurrence. Victims would have early warning signals to alert them to potential molest situations, and partners or mothers would know what to look for as an alert to abuse. Both lists were developed out of clinical experience. We recognized the importance of more rigorous study of the victimization process. For example, we wondered if patterns or consistent elements existed in victimization situations which could be identified by child victims. Further, do children and offenders similarly describe the process? If such a process could be described, are there specific strategies or activities employed by offenders which might be successfully integrated into prevention programs?

While there have been many creative efforts to help children and the adults who care for children prevent abuse, these efforts have been based on information gained from clinical contacts with offenders and victims. The report which follows describes an effort to obtain systematic information about the victimization processes as perceived by a sample of victims.

METHOD

Children who have been victimized are key experts who can provide information about the process of victimization. A sample of victims was recruited from the Sexual Assault Center in Seattle. Children selected for this descriptive study had to have been in therapy, be willing and able to talk in detail about the context of the abuse, and give informed consent to participation. Children were chosen because we believed they had the capacity to talk about aspects of the experience and deal effectively with those aspects which might imply complicity or cooperation and evoke feelings of guilt or shame. In addition, most of the sample was drawn from older youth to maximize the amount of elaboration and detail in their responses.

The sample was by no means representative of all victimized children and their experience. For example, all children in this sample had been molested more than once, usually in an ongoing situation. About 30% of victims in nonclinical and clinical samples (Russell, 1984; Wyatt, 1985) have a single abuse experience.

The sample consisted of 23 children, aged 10 to 18 years old. Only two of the victims were boys; the offenders who abused these children were all men but one and all adults but two. The children had been victimized from a few times to a period of 12 years. The offenders included fathers, mothers' boyfriend, neighbors, and babysitters.

The children were given a semistructured interview which usually took about an hour to

complete. They were asked a series of open-ended questions about the victimization process, the person who abused them, and how abuse might be prevented. Questions included those about the quality of the relationship with the offender (e.g., Before he abused you, what kind of relationship did you have with him?); preabuse behavior (e.g., Before he did anything sexual to you, did he say anything that made you feel like he was thinking of you in a sexual way or might do something sexual?); the explanation given by the offender for his behavior (e.g., What did he tell you about what he was doing?); or their understanding of the behavior (e.g., When he first did something sexual with you, what did you think about what he was doing?). They were also asked about how the offender maintained their cooperation and silence (e.g., Did he threaten you in any way? Did he give you anything or let you do anything special because of the abuse? What did he say would happen if you told?).

The interview also included several series of statements the children were asked to endorse. One had to do with feelings about the offender (e.g., I loved him; I was afraid of him; I needed him/he took care of me). Another consisted of the 23 items from the Sexual Abuse Alert List which asked children to indicate which (if any) of the grooming behaviors the offender had exhibited. The children were also asked which of the frequently used offender justifications (e.g., I'll only do it one more time; you like it; you won't remember; you are mature for your age; I'm not really hurting you; I'm teaching about sex; I need love and affection too; you want me to do it; my wife doesn't love me) the offender had employed.

The last section of the interview addressed disclosure and where and what the child had learned about sexual abuse (e.g., Did you read or see something about sexual abuse on TV? Did you see something in school about sexual abuse?). Finally children were asked what advice they might give other children or what they might do differently now. Several examples of typical prevention messages were presented, and the children were asked if they believed their abuse might have been prevented had they employed the prevention strategy (e.g., What do you think would have happened to you if you had looked the offender in the eyes and told him, "My body is my own, and you can't touch it?").

FINDINGS

The Victims

Almost half the sample had already been victimized by more than one person (9 by 2 offenders; 1 by 3 offenders; and 1 by 5 different offenders). There was no single pattern or kind of sexual abuse victimization. Even within a group of ongoing molestation situations, there was a startling variety of types of relationships.

Alex. Alex was sexually fondled and anally assaulted between the ages of 5 and 7 by his mother's live-in boyfriend, who was a generally antisocial man who had served time in prison, was mostly unemployed, had battered Alex's mother, and was physically abusive to Alex. He dominated and intimidated the household during his three-year stay.

Barbie. Barbie was the only girl in a family of three children. She described herself as being close to and the favorite of her father since early childhood. The family was middle-class, church-going, and from the outside happy and conventional. There was no other violence in family relationships. Barbie was considered well adjusted. Her father began to sexually molest her at age 4 and by adolescence was having intercourse several times per week.

Ricki. Ricki's offender was the 14-year-old son of her mother's best friend who was the regular babysitter for two years. The babysitter was well liked and considered a nice boy. The abuse started as games and became elaborate sexual encounters. Eventually Ricki was orally and vaginally assaulted and made to perform sex acts on her friend (the offender's sister) while he watched. He would tie her up and once held a knife to her throat. The abuse occurred when she was 7 to 9 years old.

Sandy. Sandy was 12 when the offender entered the household as her mother's latest boyfriend. Sandy thought of her mother as more like a sister. Her mother, an attractive and successful business woman, agreed that she had never been very parental with Sandy although she felt she was with a younger daughter. When the boyfriend began to pay

attention and flirt with Sandy, she responded. Eventually the relationship turned into a sexual one, culminating with mother's permission in marriage at age 14. The husband quickly became physically abusive and sexually sadistic. The marriage lasted 10 months.

Tom. Tom met the woman who abused him when she moved in next door. He was 12, and she was in her early 20s. The relationship began as a friendly one but gradually at her insistence became sexual. When she began to press intercourse, Tom became suicidal. When hospitalized following a suicide attempt, he revealed the abuse.

Kathy. Because he was so friendly, Kathy was drawn to the offender's home shortly after he moved down the street. He was very interested in her and her feelings, and encouraged her to talk about her abusive home life. He became her confidant and offered the only kind of physical contact she knew. Kathy's abuse lasted from age 11 to 14 and included bizarre acts of sexual penetration, which caused severe pain and bleeding.

Attitude toward the offender. The children described ambivalent feelings for the offender. The majority ($n = 14$) described the relationship as positive; others described it as neutral ($n = 6$) or negative ($n = 3$). They reported a range of emotions: Over half said that they loved him, liked him, needed or depended on him. Almost half of the children also endorsed the statement, "I hated him." Some had known the offender their whole lives ($n = 7$). For the others, the length of time they knew the offender before the abuse ranged from 5 to 10 years ($n = 4$); 1 to 4 years ($n = 6$); to 6 months or less ($n = 6$).

The children described the quality of the relationship in a variety of terms. The positive ones included the following:

He was like my buddy instead of my stepfather.
At that time I really needed love, and he did love me and told me this. He made me feel like I was really important.
He was my mother's boss at the time. He would come over and we would have a BBQ and things like that. He was a friend of the family. I felt pretty close to him.
I got close to him because I wanted a dad.
We were very close. Everyone would say you are just like your father.
We were really good friends, best friends. After about a month I was over at her house every day from when I woke up until I went to sleep. Before she abused me, we went places, we went shopping.
I thought he was kind of funny, but he was really nice, someone I could talk to, someone who cared about me, cared enough to ask, you know, the questions nobody else did.

Other children described the relationship in more neutral terms: "He was just around." "There was nothing there." "It was basic. He was always out on the road. He wasn't around very often." "Like a normal stepfather and daughter."

Some negatively characterized it: "He was my stepfather. I was afraid of him." "He was a rough guy." "I didn't really like him. I resented him telling me what to do and wanting me to call him dad."

Pre-abuse indicators. Many of the children described the offender as doing or saying things before the molestation began which caused them to feel that the offender was thinking of them in a sexual way. (We had no way of checking the accuracy of children's reports that before sexual abuse they recognized that certain things the offender did or said were indicative of sexual abuse. It may well be that children can identify these events as "warning signs" only after the sexual abuse has taken place. Certainly, for some of the children the abuse began before they knew what was being done to them was sexual or that it was not an appropriate thing for adults to do with children. These children may have no idea what the adult's behavior was leading to. Other children may experience an uneasy feeling or discomfort, perhaps picked up from the offender's anxiety or from some sense that things were not right, which

Table 1. Sexual Abuse "Warning" Signs from the Sexual Abuse Alert List ($N = 23$)

Warning Sign	n	%
Treat you different from other kids	18	78
Tell not to tell mother about things that happen between you	17	74
Accidentally on purpose come in bedroom/bathroom when undressed	16	70
Look at you in funny or sexual way	15	65
Want to spend time alone with you, make excuses	14	61
Accidentally on purpose touch your private parts	14	61
Not respect privacy, come in room, not let close doors	14	61
Say you are special/different, only one who understands	14	61
Treat you like an adult/him act like kid	14	61
Accidentally on purpose show body naked	14	61
Do things to you that involve physical contact	13	57
Give special privileges/make you feel obligated	13	57
Ask questions/make accusations about sex and boyfriends	12	52
Come in bedroom at night	12	52
Say sexual things about your body/dress	11	48
Ask you to do things that involve physical contact	10	44
Tell you private things about your mother/his wife	9	39
Not let have friends or do things other kids do	9	39
Look at or touch your body, inspection/see how developing	7	30
Teach sex ed. by showing pornographic pictures, touching body	7	30
Treat meaner than others	7	30
Talk about sexual things he had done	6	26
Put lotion or ointment on when alone and nothing wrong	5	22

comes to be a warning sign because it is often paired with sexual abuse. The extent to which abused and nonabused children can identify certain adult behaviors as warning signs and that nonabused children can be taught that the behaviors are, in fact, danger signs deserves careful study.) The behaviors included many of the following activities:

He'd look at me funny, pat me on the rear, and wrestle.
He'd show me pornographic magazines. He would want me to come in the room and lay on the bed.
She would try to make me jealous. She'd start hanging around other people to make me jealous.
He'd give me lots of backrubs and play footsies.
He'd scare me so I'd have to hang on to him.
He would look at me from across the room in a sly look. He'd make sure to wear the shorts that he hung out in. He would look at me to see if I was looking at him.
He'd insist on drying and brushing my hair even when I didn't want him to.
When my mom bought me my first bra, he wanted to see, see it on me.
He would invite me in and let me watch while my mom and him made sex.

Verbal warnings included such statements:

He'd tell me I had beautiful legs.
He'd tell me I looked sexy in my shorts.
He'd talk about pornographic pictures and sexual things he had done.
When Burger King was big, he used to make comments about their "hot and juicy ads."
He said he liked the way I ate ice cream, which I didn't think is much different from anyone else.
He said that I had a nice body and ought to show it off.

As can be seen in Table 1, the children described a wide range of warning signs. Most of the children endorsed statements that the offender treated them differently from other children and, in an age-inappropriate way, had told them they were special or the only one who understood him, that he confided with them about matters relating to the offender's adult or

sexual relationships. Half of the children said they were not permitted to do things that other kids did or were questioned or accused about sexual activities with peers. About half described being treated more favorably or being given money or clothes. The majority agreed that the offender did not respect privacy, engaged in a lot of physical contact, and would touch them in their sexual parts or expose themselves, ostensibly accidentally.

The shift to overt sexual behavior was occasionally abrupt: "Just one day he was drunk, and it happened. I was the only one home," or "He abused me the first time I came to sleep at my friend's house." More often it was gradual, often under the guise of acceptable conduct:

He would start putting his hands down my pants. The first time I didn't think it was anything bad because he told me it wasn't. The second time I knew it was bad because I felt gross inside.

He'd keep searching his pockets, and wanted us to fish for him, my 9-year-old sister and me, and we would fish for him in his pockets. He had real long pants pockets. He used to have treats for us like that.

When you'd go swimming you put your feet in his hands and (he'd) spring you out of the water. He would be touching me under the water, sticking his fingers.

A majority of children (n = 14) said that they did not know that they were being sexually abused initially. They reported:

I didn't know there was anything wrong with it, because I didn't know it was abuse until later. I thought he was showing me affection.

She had me believing it was a boyfriend/girlfriend relationship.

I was led to believe it was a teaching process.

Neat, he's going to teach me now. Now I'm going to be an adult.

He was teaching me how to do all the stuff so when I got older and got married and stuff, I knew how to keep my body satisfied, and I was too young.

They made different attributions about the situation. Some blamed themselves (e.g., "I thought I deserved it at times because he told me I was bad and a slut because I hung around boys"). Others were not sure (e.g., "I didn't know it was wrong, but it didn't feel right." "He made it sound like it was my idea and he was willing to teach me" or "I felt guilty and good at the same time; it was really confusing").

Offender statements. The children confirmed that in most cases offenders made statements about the sexual activity to justify it (See Table 2). They would try to persuade the child that it was acceptable ("He told me he needed some love and this is the way people show their love," or "She told me we were better off now, and that we had a higher relationship") or to minimize the seriousness (e.g., "I'm not really hurting you"). More than half were told that they would like it or wanted it or that they looked older or were mature for their age. In many cases offenders talked about how they needed the contact because they were lonely or their wives didn't love them or it made them feel fetter. The children were made to feel complicit by such statements as "You didn't tell me to stop."

Coercion. Almost all of the children reported some type of coercion either to gain cooperation or to prevent reporting. A majority (n = 14) said there were threats. Some threats involved actual physical harm to the child: "He would kill me." "He used to always take out knives and threaten us; and threaten to cut off my fingers." "He once took a knife to my throat and said if you tell anyone, I will cut your throat out." "He would take a belt to my bottom."

Other threats were related to abandonment or rejection ("Your mother will leave you, and your family will be separated"; "Your mother will be mad at you").

Some involved consequences to the offender: "You don't wanta get me in trouble." "He said he would kill himself if I told." "Once he told me that he would shoot himself with his

Table 2. What Adults Might Say When They Sexually Abuse a Child

Phrase Used	Yes	%
A. I'll only do it one more time	6	26
B. I need to do this to reduce my tension	5	22
C. You like it	16	70
D. I'm teaching you about sex	7	30
E. I can't get you pregnant	6	26
F. You won't remember	4	17
G. Nobody will find out	14	61
H. I'm not really hurting you	13	57
I. I'm just going to play around	7	30
J. I won't do it anymore	10	44
K. At least I'm not screwing you	3	13
L. You are not my real daughter	5	22
M. My wife doesn't love me	9	39
N. It's O.K. since kings and cavemen did it	0	0
O. I'm just going to look, I won't touch	3	13
P. You're my daughter so its O.K.	3	13
Q. I am lonely	9	39
R. You want me to do this	10	44
S. You haven't told me to stop	7	30
T. It makes me feel better	8	35
U. I need love and affection, too	7	30
V. You look older than you really are	11	48
W. You are very mature for your age	10	44

rifle if I didn't have sex with him or I told." ". . . he would be thrown in jail, and they would murder him." Sometimes jeopardy to the family was asserted: "My family would be shamed forever." ". . . family will be broken up."

In many cases the coercion was indirect and accomplished by some form of bribery ($n = 9$) or by exploiting a child's needs or vulnerability. Children reported: "I would get special privileges. I wouldn't get in trouble for the same things my brother did." "He offered to buy me five packs of gum if I did it and if I said no, he made me do it anyway. He never did buy me anything." "Every time I asked for something after it happened, he would let me have it or do it."

More emotional coercion was employed in many cases: "He said everyone would think I was a slut," or "He would just say I would feel rotten for the rest of my life, and I would be a scum, and nobody would like me."

Most children ($n = 16$) were told to keep the abuse secret. Sometimes the child's internal fears precluded telling: "I kept the secret because I was so thrilled to have a secret" or "My mom once said that if she ever found out someone did this, she'd kill me and then she'd kill the guy."

Child Vulnerability

In many cases the sexual abuse relationship filled a significant deficit in the child's life, or disclosure posed a serious threat to the child's or parent's situation. The children were troubled and/or their parents were not resources for them.

Kathy. Kathy's father was an alcoholic and violent man prone to holding guns to family members' heads. Her mother was unable to stand up to him. Kathy does not ever remember being touched, held, or told she was loved. She was an easy mark for the neighbor man who encouraged her to confide in him about her troubled family life. He never said anything about what he was doing. Kathy's guilt over having betrayed her family, and her secret desire to have physical contact with someone was enough to ensure her silence.

Barbie. Barbie's father accomplished her cooperation for 13 years without ever saying a word to her about it. After a gradual beginning, he promoted a special relationship with her where he shared his problems at work and in the marriage. With everyone but her he was withdrawn and reclusive; only she could make him happy. Everyone said what a wonderful relationship they had, what a daddy's girl she was, and how all American the family appeared. Barbie's sense of worth was derived from meeting her father's emotional and sexual needs.

In the case cited earlier, Alex feared that if he told his mother of the abuse, she might be attacked, and he also know that she depended on the relationship financially and emotionally.

Linda. Linda's mother had manic-depressive illness. The offender was her stepfather and her mother's business partner. Linda had witnessed her mother's previous breakdowns and subsequent hospitalizations. Once the stepfather began sexually assaulting her, she feared that her mother would have a psychotic episode if she learned of the abuse or would be institutionalized without the economic support of the offender.

*Disclosure.*Obviously in all of these cases the children eventually told someone or the abuse was discovered. There was a broad range of ways in which the abuse became known. Sometimes the children decided to tell someone:

I told my mom. She just about had a heart attack. I decided to tell because my sister was starting to be abused by him too.
I told my girlfriend because he tried to do this to her.
After the third time I told my best friend at school what had happened. And her friend overheard and the lady across the street, her daughter was abused, and she called CPS to check it out.
The first time I had a relationship with a guy that wasn't sexual or anything, and he wanted to marry me. I told a girlfriend about the abuse and asked if I should tell him.

In many instances the child did not initiate the report:

Two people I lived with, they were social workers, but they were my friends. They thought my dad had done it. They kept asking.
I didn't mean to tell; we were just playing dolls. I was just acting out and she asked me why I was doing that. We were just talking, and I said, "Isn't your dad doing teaching like that?"
When my real father came to get me in Oregon, I was tired and had my head in his lap. He touched my side, and I instinctively pushed his hand away and jumped up quickly. He said, "What's wrong? Who's been playing with you?"

Sometimes someone else told: "My brother told my mom about it. He just had a feeling I was being abused." Or it was directly observed: "My mom caught us after we had just finished. He tried to make it seem like it only happened once and was a mutual thing." "A woman who was living with us walked in on us when he was fondling me. She called the police. It had happened to her and her children."

Current Beliefs

Virtually all of the children said that what they would do differently would be to have told someone earlier: "I would have told someone because it was disgusting." "Then I didn't think everyone would believe me, but now they are believing me." "I would have told a school counselor or the police.

They expressed regret at not telling because "emotionally it screwed me up. I hate men. I hate my mother. I wish I had told my first stepfather." "I would have told my mother after the first time. I would have said this guy is a real clown, he's touching me, he's talking sexual to me, I do not want this to happen, and I don't want to be hurt, and I don't want him to be taking advantage of us."

A few children described what they would say or do: "I would cut his balls off. That way he

wouldn't have anything to do with it." "I'd tell him he was a son of a bitch and a mother fucker. That way I'd be able to get my feelings out." "I would scream and push him away and yell at him." "I wouldn't just lay there now that I know what it was."

One girl did not think anything would make a difference: "I think it would have happened because I was so needy, because I didn't have anything."

IMPLICATIONS FOR TREATMENT AND PREVENTION

Although these interviews were conducted with a small sample of child victims, the statements of these children do have implications for the prevention of child sexual abuse. Sexual victimization usually occurs in the context of a relationship and is accompanied by behaviors which are designed to engage the child in the sexual activity and permit the abuse to go on over time. Despite the variety of abuse situations, common elements emerge from the descriptions of the abuse experiences provided by these children. Three different but overlapping processes can be identified: sexualization of the relationship, justification of the sexual contact, and maintenance of the child's cooperation.

Sexualization

The sexualization of the relationship most often appears to take place gradually. It may begin with normal affectional contact or in the context of ordinary physical activities. Bathing, cleaning, hugging, massaging, backrubbing, snuggling, wrestling, and tickling all become opportunities for physical contact which can progressively become sexual. Sometimes initially it seemed to the children that the genital touching was accidental. If they were very young when it happened, they may have simply not realized that it was sexual. In few of the cases did the children perceive the relationship to have abruptly changed from normal to sexual. Many of the children characterized the process as moving from nonsexual to sexual and then to increasingly intrusive forms of sexual activity although this was not always the case.

Justification

Most of the offenders were reported to have made statements to rationalize or justify the behavior. The two most common themes were to assert that it was not really sexual or to acknowledge that it was sexual but was presented as acceptable. The classic, "It isn't really sexual abuse" approach is to call the activity sex education or preparation. Other offenders may say it is a game or an inspection of the child's body. Just as frequently the offender persuades the child that he or she is old enough or unusually mature and ready to engage in this type of activity.

In a significant proportion of cases the offenders do not say anything about the sexual activity itself but concentrate on securing the child's compliance through threats or persuasion. Even in the cases where they attempt to distort the meaning of the activity, children see through phony explanations and figure out that the behavior is both sexual and wrong relatively quickly. The justifications appear to be primarily for the benefit of the offender. A noted characteristic of offenders is the variety of cognitive distortions they use to avoid confronting the reality, seriousness, and deviance of their behavior (Conte, 1985).

Cooperation

A third aspect of the victimization process is the way offenders find to engage the children in sexual relationships, keep them involved, and prevent them from telling. Sometimes it is

through threats and intimidation. Far more often they seem to have an instinct for discovering a particular child's vulnerability and exploiting it toward the end of controlling the child, thus obviating the need to use more overt forms of coercion. This approach further serves the purpose of allowing the offender to convince himself that the child is actually consenting and thereby reduces his/her responsibility.

One common method of coercion involved the exploitation of a child's normal need to feel loved, valued, and cared for by parents. Children who do not have these needs met may be susceptible to the interest shown them by sexual offenders. A variation on the theme is exploitation of a child's urge to protect parents whom they love. In this approach the offender tells the child her/his silence physically or emotionally protects the parent(s).

While the children we interviewed were able to describe the elements of victimization when we interviewed them, it is not clear that they could have done so at the time the abuse was unfolding. It is likely that only in retrospect can they identify it as a process. In some children's responses to us, the impact of counseling was apparent as they called the process leading up to abuse "grooming." Yet even when we spoke with them they were still unable to see it as deliberate or calculated. From a psychological perspective, perhaps, it is too painful and humiliating for the child to face the possibility that what was taken for a misguided or "sick" misuse of the relationship or even for real love was in fact an elaborate strategy to manipulate and use him/her without regard for his/her feelings or benefit.

Interestingly many professionals are as resistant as the victims to characterizing offender behavior as intentional sexual exploitation. This contrasts with what the offenders themselves say about their own conduct. The companion study to this one, in which offenders in treatment were interviewed, provides overwhelming evidence that they are fully aware of the process they employ (Conte et al., 1989). They report targeting children for victimization, systematically conditioning them to accept increasing sexual physical contact, and exploiting the children's needs in order to maintain them as available victims.

Prevention

Both this field study and its companion (Conte et al., 1989) point to the difficulty of the task facing prevention programs. While a process of victimization clearly exists in many cases of ongoing sexual abuse and its components can be identified, it is not clear that knowing this information will prevent the abuse from occurring. It is not currently known whether children can be taught about abuse and use this information to escape abuse prior to its occurrence or after the first attack. Knowing what abuse is and encouraging disclosure early in the abuse experience is a prevention goal well worth the effort since children are known to be more seriously affected by abuse the longer it takes place (see e.g., Conte & Schuerman, 1987).

One aspect of victimization which appears amenable to educational efforts is the justification for sexual contact given by offenders. It seems worthwhile to encourage parents and educators to insure that children have the basic information that adults are not permitted to touch genitals except under very specific conditions (e.g., for health or hygiene). The problem is that in some cases abuse may be initiated or disguised under these conditions. As one child said, "They should be told these offenders will try to trick you into thinking it's OK."

It is difficult to conceive a method to alert children to the gradual sexualization of physical contact, which appears a part of much sexual abuse, without making them afraid or suspicious about innocent touching. Offenders say that they test the children's response to contact with body parts close to the genitals or make genital contact appear accidental as they gradually approximate sexual touch. Social learning principles of desensitization and progressive approximation, support the power of this technique to condition behavior. It is inconceivable and undesirable to tell children that if a father, relative, or family friend dries them after a bath

or places a hand on their leg, they should begin to be suspicious about that adult's motives. We do not yet fully understand how children perceive the gradual conditioning process whereby nonsexual touch became sexual. For example, we wonder if the child who accepts nonsexual touch feels she/he has given consent to all touching. Children might be taught that they can say no to a behavior (e.g., sexual touch) even if they said yes or said nothing to a similar behavior (e.g., nonsexual touch).

The most insidious and powerful component of offender strategy is the least amenable to education: children's vulnerability to adult attention. In a world where large numbers of children are physically, sexually, or emotionally abused, neglected, grow up in homes with violent, alcoholic, or drug-abusing parents, or are physically or mentally handicapped or deprived, there is a huge supply of potential candidates for offenders. Even in less severely disrupted family situations, children might have a temporary period during childhood in which they feel different, isolated, uncertain, or in need. Timing might be enough to make them vulnerable.

While much is yet to be learned as we identify and educate potential victims in the general population, children who have already been abused may very well benefit by presentation of process of victimization information. The child who has already experienced the gradual progression of physical contact to sexual abuse or who has been exposed to the rationalizations employed by an offender is going to be better able to use this knowledge. For children who will be living with or in contact with a known offender, it may be essential for their protection. Presumably a major focus of treatment is reducing the vulnerabilities which made it possible for them to be victimized in the first place. Providing the children with a framework for understanding offender targeting and grooming may make assimilation of the information easier.

Victims and offenders confirm that there is a grooming process which precedes sexual abuse situations. Yet the offenders are the ones who understand and control the process while the victims are unaware targets only able to recognize the process in retrospect. Many offenders say that they would disregard a refusal by a child or that they would not pick a child who would resist (see Conte et al., 1989). Few of the children we have interviewed felt that if they had said no, the abuse would have stopped. Many expressed a belief that it would have continued or that they would have been further harmed.

Almost all of the children now believe that telling their mother or someone else right away would have stopped the abuse. Looking back on the situation at the time of the interview, they say they would have told after the first time. The advice to children offered by the majority of victims was, "Say no after the first time and go and tell someone." Offenders also report that a threat to tell someone would have the greatest impact on deterring them from abusing. This message to children may be among the most important safety education programs can deliver. As one girl said, "Tell them (offenders) there are other ways of giving love besides being sexual, there's mental. They don't need that and all it's going to do later is ruin your life."

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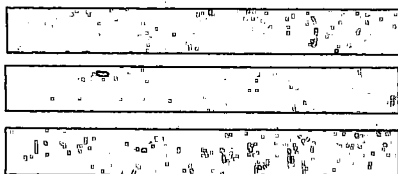
Résumé—On a interrogé 23 enfants; âges de 10 à 18 ans, ayant été victimes de sévices sexuels. Les questions ont porté sur le processus de "victimisation," la personne qui avait abusé d'eux et la manière dont le sévice sexuel aurait pu être évité. Par des questions spécifiques, on a obtenu des renseignements quant à la qualité de la relation entre la victime et l'agresseur, le comportement de l'agresseur avant le passage à l'acte, l'explication du comportement donnée par l'agresseur et le degré de compréhension de l'enfant de ce comportement. Les résultats de l'enquête suggèrent que le processus de "victimisation" implique 3 processus qui se chevauchent en partie: (1) La sexualisation de la relation; (2) La justification du contact sexuel; (3) L'obtention d'une coopération continue de la part de l'enfant.

Resumen—Veinte y tres victimas del abuso sexual de menores (de 10 a 18 años de edad) fueron entrevistadas acerca del proceso de victimización, la persona que los abuso, y como el abuso hubiera podido haber sido prevenido. Preguntas especificas obtuvieron información acerca de la cualidad de la relación entre la victima y el perpetrador, la conducta pre-abuso del perpetrador, la explicación de la conducta dada por el perpetrador y la comprensión por parte del niño/na de la conducta. Los resultados sugieren que el proceso de victimización incluye tres procesos traslapados: la sexualización de la relación, la justificación del contacto sexual, y el mantenimiento de la cooperación del menor.



Resource Materials

The Interdisciplinary Approach to Investigation and Prosecution of Child Abuse

Presented by
Seth Dawson, J.D.

TEAM BUILDING: THE MULTI-DISCIPLINARY APPROACH

I. Objectives

A. To successfully prosecute the crime of child abuse based on good investigative practices and shared information among agencies involved with parties.

B. For purposes of this training, the focus will be directed toward helping the trainees examine, and possibly develop, a multi-agency cooperative approach among CPS, law enforcement, prosecutors, health care providers, and others involved to increase the efficiency with which cases are handled.

II. Purpose of Multi-Disciplinary Teams

A. To develop a coordinated approach among important disciplines.

1. Provide a setting in which information can be shared to form a complete view of the child and family.
2. Identify the specific responses needed from all disciplines.
3. Minimize likelihood of agency conflict.
4. Minimize inconsistent statements by reducing the number of interviews and interviewers in the case.
5. Identify, confront and overcome conflicting objectives and philosophies of the different agencies.

B. Types of Teams

1. Consultation teams
2. Regulatory teams
3. Resource development teams
4. Mixed model teams

C. Goals of Team

1. To establish areas of responsibility for the various agencies involved in child abuse investigation
2. To establish procedures for each agency to follow in pursuing its part in investigations so that a common procedure will be used throughout the investigation
3. To establish areas of cooperation where the various agencies shall assist the others
4. To increase the quality and efficiency of treatment, investigations and prosecutions

D. Benefits of Multidisciplinary Teams

1. Assists role clarification
2. Expedites case decision making and action
3. Increases shared decision making
4. Enhances uniformity of case decision making
5. Increases availability of multidisciplinary expertise
6. Provides support to involved professionals
7. Increases professional expertise
8. Provides opportunity to monitor delivery of services, investigations and prosecutions
9. Assists in reducing burnout
10. Cost effective by avoiding problems due to inexperience, lack of cooperation, and case volume

III. General Principles in the Development of a Coordinated System

A. Careful Planning

B. Political Strategizing

C. Psychological Insight

D. Finesse of a Seasoned Diplomat

E. Patience and Tolerance

F. No Single Method Works In Every Community

G. Keep Objectives In Mind Throughout

IV. The Implementation Stages

A. Identify your needs

B. Develop a working group

1. Recruit participants
    a. Prosecutor
    b. Law Enforcement
    c. Child Protection
    d. Medical Providers
    e. Victim and Perpetrator Therapists
    f. Victim-Witness Advocates (CASA or guardian ad litem)

2. Identify a leader who has substantive knowledge, experience, and ability to predict, explain, and manage confrontation

3. Identify another person who will act as a facilitator whose duty is to focus on the process of sharing information during the meetings, and not one who is responsible for sharing information.

4. Agree that disharmony may exist among agencies and a premature commitment to harmony may be unrealistic. Agree to confront conflict.

5. Among recalcitrant professionals seek their advice, or ask them to train others.

C. Methods of avoiding turf battles.

1. Rotate the meeting places.

2. Select a neutral meeting place.

3. Develop "exchange days" when members of different disciplines "walk in the shoes of another."

4. Give equal attention to sharing time, task, territory and travel among agencies.

5. Share publicity and credit for the accomplishments.

D. Idea Formation Process.

1. Develop team structure and procedures for problem-solving.

2. Explore all views regarding each procedure, despite conflict.

3. Do not assume that presentation of an alternative idea or solution is the equivalent of opposition to the original solution.

4. All of this should not be done in the "public eye."

5. Public coalition formation should be reserved until problems and solutions are clearly articulated, otherwise a thorough and thoughtful solution may be thwarted under public pressure.

E. Financial Assessment and Feasibility.

1. Learn what it will cost each agency to develop the program.

   a. Do sufficient resources exist to properly accomplish the goals?

   b. If not, where are additional resources...etc.?

2. Sabotage of the entire concept can occur at this stage by one or more agencies that are resistant. Rather than alienate others by insisting on cooperation, ask: What decision would have to be made and by whom in order for you to be able to fully participate?

F. Adjustment.

1. Anticipate an adjustment period.

2. Treat modifications as normal rather than as setbacks.

V. Implementation Planning--A Must

A. Determine who will assign tasks and supervise.

B. Set an implementation schedule with agreed upon deadlines.

C. Initiate an information campaign with a "script" for every player to follow.

1. Designate a person to release information to the media.

2. Plan how and when to explain the program to employees.

D. Anticipate and manage resistance.

1. Encourage response, don't discourage objections.

2. Invite interested parties to an open forum.

E. Make clear the agencies' commitment to the program.

1. A highly visible commitment of resources can thwart pointless conflict.

2. Announcement of the program should be made by the agency head, along with mid-management and on-line supervisors.

F. Develop an evaluation process, now.

1. Two important components of an evaluation are:

a. An outcome that measures whether the goals have been met.

b. A process that documents how the program is functioning, specifically naming persons, duties and timetables.

2. Delineate what factors represent a successful program, or a failed one.

VI. Team Orientation/Training

A. Purpose and function of team must be agreed upon

B. Team composition/roles of members need to be defined

C. Team management protocols

D. Legal guidelines

1. CA/N definitions

2. Police holds

3. Reporting mechanism

4. Court process

5. Evidentiary standards

6. Testimony

E. Perspectives on child abuse

1. National scope and history
2. Community and state resources
3. Problems
4. Statistics

F. Referral/consultation process

1. Who can refer cases to the team?
2. Referral criteria
3. Forms
4. Reports

G. Format for case staffings

1. Case selection
2. Content for presentation
3. Methods for presentation

H. Group process, decision making, conflict resolution

I. Other concerns of members related to team

VII. Action

A. "Doing the work" of the program.

1. Frequent meetings should be helpful as members become better acquainted with each other.
2. Reinforce team-bonding with joint travel training, case resolution.
3. Minimize turn-over among professionals handling the cases.
   a. Discussions of team development may be needed.
   b. Attendance at training sessions for other disciplines will rapidly acquaint new personnel with another perspective.

B. Case coordination

1. Confidentiality agreements
2. Case selection criteria
3. Referral assessment criteria
   a. Acute/emergency referrals
   b. Non-acute/emergency referrals
   c. CPS/law enforcement notification

4. Case staffing guidelines
    a. Informal consultations
    b. Tele-conferencing
    c. Mini-staffings
    d. Case conferences
5. Conflict resolution
6. Case review and follow-up
7. Coordination tasks
8. Data collection

VIII. Case data base

A. Specific CA/N diagnosis
B. Child's physical/emotional/developmental status
C. Sibling's physical/emotional/developmental status
D. Mother's history and current circumstances
E. Father's history and current circumstances
F. Perpetrator's history and current circumstances (if different than above)
G. Marital history
H. Involvement of relatives/others
I. Environmental situation/current crises
J. Legal status of case (civil and criminal)

IX. Case conference questions

A. Confirmed, suspected, undetermined, accident?
B. Seriousness of injury, degree of risk for re-abuse?
C. What action has been taken by all involved agencies?
D. What are optimal treatment/investigative recommendations?
E. Which persons or agencies are responsible for carrying out treatment/investigative recommendations?
F. Have any problems been overlooked?
G. Suggested time for review?

X. Data collection

A. Number of cases referred

B. Number of cases actually staffed

C. Type of services provided

D. Numbers of cases founded vs. unfounded vs. undetermined

E. Diagnosis--type of abuse/neglect

F. Severity of abuse

G. Number of deaths

H. Number of re-abuse cases

I. Age/sex of child

J. Identification of perpetrator

K. Source of referrals

L. Geographic area of referrals

M. Number of children hospitalized

N. Number of out-of-home placements

O. Number of courts involved (civil and criminal)

P. Number of cases opened for CPS service

Q. Number of cases terminated

XI. Supporting the Program

A. Identify affected groups

1. press
2. the school system
3. parent's groups
4. corporate funders
5. the state legislature
6. community leaders

B. Present program as preliminary, thus amenable to evaluation and change.

XII. Evaluation

A. After six months, evaluation seems appropriate, using the process designed in the planning stages.

B. Be prepared for tension to arise when some goals have not been achieved. Remind all members that adjustments are part of the development process.

C. Adjustment of the number of services, or training, or public presentations may need to be made as the program becomes better known and requests increase.

D. As caseload requirements increase, thought should be given to the development of additional teams.

XIII. Institutionalization

A. Dependent upon six processes, otherwise the program may be viewed as expendable.

1. On-going supervision by agency heads ensuring that the program continues to be implemented and supported by its leadership.
2. In-service training that familiarizes all personnel with procedures.
3. Retention of trained team members.
4. Filling vacancies with members who are interested and comfortable with working in the team structure.
5. Finding solutions to professional burnout with the subject matter.
6. Rewarding good work.

XIV. Why teams fail

A. Role confusion

B. Power/control issues

C. Lack of mutual respect

D. Lack of participation

E. Lack of flexibility

F. Lack of sense of humor

G. Scheduling problems

H. Absenteeism

I. No leadership

J. Lack of coordination

K. Lack of referrals

L. No feedback on what happens to cases

XV. Why teams succeed

A. Mutual respect

B. Attend to group process

C. Shared decision making

D. Equal participation

E. Communication

F. Agency and community support

G. Commitment of members and agencies

H. Task oriented meetings

I. Logistics of meetings

J. Team training

K. Personalities involved

POINTERS FOR PROSECUTORS IN THEIR ROLE ON MULTI-DISCIPLINARY TEAMS

1. A well-coordinated system shares these four goals:

   a) educating all disciplines on the dynamics of children and the criminal justice process;

   b) establishing and maintaining consistent reporting practices;

   c) providing better quality investigations and eliminating duplication;

   d) ensuring sensitive treatment of the child victim and family.

2. The multi-disciplinary team can serve as a resource for assessing many things beyond genera background information. It may identify valuable evidence which can be used at trial. It can yield information about the impact of filing charge on the victim, the ability of the victim to testify at trial, the influence of the custodial parent upon the child, and the necessary facts that support appropriate sentencing recommendations.

3. Some states require professionals to keep information about families confidential. Effective review of cases can still be made honoring this limitation. If the meetings are observed by non-participants, clear agreement to honor this rule should be made in advance of discussion.

4. Prosecutors should encourage police and child protection workers to review cases early in the investigation. Lack of early coordination can lead to improperly managed investigations, unnecessary delay, recantation or unwillingness on the part of the victim to cooperate.

5. The multi-disciplinary group should lead to effective, efficient, coordinated investigations. Because of the ultimate decision making function held by the prosecutor, he/she should be available to offer guidance and review cases during the investigations. Prosecutors should take the lead in the development of general policies that govern the team.

6. Before establishing a new process for case review, carefully examine whether the existing policies are resulting in consistent reporting, reduction of trauma or hardship on child victims and successful prosecution. Evaluate the existing systems' responsiveness to future increases in caseload, personnel turnover.

7. If modification is appropriate, begin with YOUR OFFICE. First, gather as much information about how your office handles cases. Then determine whether other agencies cooperate, the quality of the information provided, and whether cases are referred promptly and in compliance with state reporting laws? How many are accepted or declined for prosecution? Does declination based upon "lack of evidence" represent poor investigation by either police or child protection, or overly conservative prosecution standards.

8. TAKE PROPER STEPS TO CORRECT PROBLEMS DIRECTLY ATTRIBUTABLE TO YOUR OFFICE

9. To assess the role of the other agencies, first inquire informally and gain an understanding of how each agency works. Make a list of the key personnel involved in the process. Evaluate the other agencies programs to determine the existence, quality and efficacy of

   a) training needs and opportunities;

   b) disclosure and reporting procedures;

   c) investigation and court processes; and

   d) counseling and support services.

10. Begin with Law Enforcement Agencies. Inquire:

   a) which agencies perform which investigative functions;

   b) is there overlap; and

   c) do gaps explain intra-agency problems? Ascertain whether agreement can be reached between different law enforcement jurisdictions to allow the best-equipped department investigate these complex cases.

11. Do not overlook the medical community which often includes not only direct providers such as physicians, but also crisis centers, private mental health clinicians and therapists. In the case of child fatalities coroners and medical examiners must be involved.

12. Victim/witness advocates are a natural allies. Other possible allies may be Guardian ad litem and court-appointed special advocates (CASA). Talking with them early can enlist their support. CASA and guardian ad litem participation in team-building is especially useful since they also have the approval of the court to act in the best interests of the child.

13. Dependency attorneys are also natural allies. Their experience in juvenile proceedings and family courts may be useful to help prosecutors understand the concerns of the child protection agency.

14. For more information concerning composition of multi-disciplinary teams, refer to Chapter VII "Developing a Coordinated System" and Appendix B "Select Community Efforts" of the manual Investigation and Prosecution of Child Abuse, published by the National Center for Prosecution of Child Abuse.

Outline developed by James M. Peters, Sr. Attorney, National Center for Prosecution of Child Abuse and Cabell Cropper, Director, Management and Administration, American Prosecutors Research Institute

Reference Materials

Patterns of Injury in Child Abuse and Homicide

Presented by
Dr. Ronald L. Reeves. M.D.

Ronald L. Reeves, M.D.

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By Appointment Only
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May 29, 1990

Forensic Pathology with special interest in Child Abuse and Neglect

The identification and successful prosecution of child homicides is one of the most difficult tasks we will ever face. In order to be successful in this endeavor, there must be total cooperation between all parties involved including law enforcement, the medical examiner, the prosecuting attorney, and other persons required such as medical experts. The investigation must start immediately and no steps should be overlooked. All cases must be handled as homicides until proven otherwise.

Only participants who have been specially trained in this unique and difficult type of investigation should be allowed to take a part. The requirements for collecting and documenting evidence is more exacting and necessary than in any other type of investigation. Detailed statements must be obtained immediately from all witnesses. Emotion and whim can never be allowed to influence any of the participants activities or opinions.

Delayed investigations in child homicides is even more difficult. Most cases are children who have been murdered but were originally diagnosed as having died of natural or accidental causes. If the evidence has been properly obtained and documented, successful determination of the cause of death and the prosecution of any crime can be accomplished.

The sole purpose of any investigation, whether it is the initial or subsequent investigation should be to determine the truth about what happened. Because of this, all parties involved must be totally honest and frank with one another and willing and able to ask questions that sometimes may be embarrassing or awkward.

Because of a very restricted time limit for my presentation, I have assembled various summaries, reports, letters, and court opinions to hopefully illustrate some very important points that must be considered in prosecuting these difficult cases. In order to adequately present this topic, I would need at least eight hours or more. Since that is obviously not possible, I hope that these materials will answer some of your questions that I will not have an opportunity to discuss. If there are any specific questions that you may have after reviewing this material, please do not hesitate to ask.

Ronald L. Reeves, M.D.
Forensic Pathologist
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PEARLS TO REMEMBER

I. The injuries speak for themselves.

   A. Don't try to separate them. They must be considered as a whole.

   B. Children don't injure the same as adults - therefore be sure you understand the difference.

   C. Document injuries completely as soon as possible. Then continue to collect evidence, tests, photographs and facts as long as child is alive and injuries (findings) present.

II. Get "detailed" statements by "qualified investigators from all witnesses. (In more than half of my cases involving delayed investigation, the subject confessed when he/she learned we could say in detail what really happened).

III. Any child's death must be considered a possible homicide and investigated intensely until proven otherwise.

IV. Many deaths classified as SIDS deaths are actually homicides.

   A. **ALL SUSPECTED SIDS DEATHS MUST BE COMPLETELY AUTOPSIED BY A COMPETENT PATHOLOGIST.**
   B. Children, especially infants, can be beaten to death and not have any external signs of trauma. Therefore, any evidence of trauma in infants is highly suspicious for inflicted abuse.

V. Accidental trauma is rarely fatal in infants - **but when accidental injuries do occur, they are generally predictable in appearance, location, severity, distribution, number and etc.**

VI. The absence of injury is many times more important than the injuries you see. Therefore, when documenting injuries, also photograph the entire body from multiple views with adequate close-ups of the entire body.

VII. Don't assume the medical examiner has enough or all the facts and information he needs. SEE THAT LAW ENFORCEMENT PROVIDES EVERYTHING IN A TIMELY FASHION AND PARTICIPATES IN THE AUTOPSY.

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VIII. Many medical examiners do not do complete autopsies. You must see that they do if it is to be worth anything.

A. All skin must be incised.

B. Eyes must be examined and removed if not contra-indicated.

C. Total body x-rays that are readable must be taken.

D. Must examine all cavities and orifices.

IX. Post-mortem x-rays of children are frequently misleading and don't show the injuries present.

A. Most fractures in infants are best identified by gross exam by a competent pathologist.

B. Fractured bones should be removed for histology exam and x-rays.

C. Some fractures don't show up on x-rays for 10-12 days after inflicted.

D. Interpretation of fractures in children is very much different from that of adults.

A. Rib fractures in children are very rare and are almost always related to abuse.

B. If you see even one rib fracture in a child, most exclude abuse.

C. Either multiple fractures or fractures of different ages are very serious and are from abuse until proven otherwise.

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CASE: MC, 5 Year Old WM

INVESTIGATED BY: Honolulu Police Department

MEDICAL EXAMINER'S OPINION: Child Died of Blunt Force Trauma to the Abdomen which lacerated the small bowel

DISCUSSION: Case was previously taken to the Grand Jury and the father was indicted for murder. The indictment was later dismissed because there was some question as to actually inflicted "the fatal blow". The mother and the father were chronically abusing the child.

I was asked to review this case to determine, if possible, who struck the fatal blow. My review revealed one key finding. There was no fatal injury or blow. The child had sustained non-lethal trauma three to five days prior to his death. The parents then intentionally refused to seek medical attention and at the same time continued to physically abuse him. More importantly, they had to know that he was seriously and critically ill and would probably die without proper medical attention. They sat by and watched him vomit, cry in horrible pain, become malnourished and severely dehydrated before he lapsed into a coma. It was only at this point that they sought medical attention. The lacerated bowel did not kill this child. The intentional neglect killed him. This is homicide by omission by both parents.

These new findings and this opinion was presented by the prosecuting attorney to the medical examiner who had done the autopsy as well as to a medical expert at the Kempe Foundation. Both totally agreed with my findings and conclusions. This case was recently taken back to the Grand Jury and now both mother and father have been indicted for murder by omission.

This case is presented to illustrate several important points:

1. The wording that the medical examiner uses in classifying the COD is not necessarily what you need to know from a legal standpoint. Medical examiners usually "bottom line reports" and therefore only give what they think is the proximate cause of death. The police and prosecuting attorney must understand this and be prepared to ask specific questions. This is the type of case where early contact with a medical consultant can be extremely cost effective and worthwhile.

2. You must look at the entire picture and not inappropriately focus on just one detail which is in the end not only not helpful, but may be harmful if taken out of context with all the other facts and events.

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UPDATE ON CASE: MC, 5 Year Old WM

This case went to trial in Honolulu on the week of January 22, 1990. Prior to the trial starting, the mother pleaded guilty to murder. The stepfather went to trial and the jury convicted him of both murder and manslaughter (murder for his neglect of Michael and because he knew it was practically certain that Michael would die and manslaughter for his physical beatings because he was only "reckless" when he beat the boy.)

At this time it is anticipated that the stepfather will be sentenced to life plus twenty years.

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CASE: SL 1 month WF

INVESTIGATED BY: US Air Force OSI

MEDICAL EXAMINER'S OPINION: Child Died of SIDS

PARENTS STATEMENT: Infant taken to local ER late at night, was diagnosed as having an ear infection and was given penicillin. Child was found dead in bed the next morning by parents. There was no evidence of trauma.

DISCUSSION: Case was referred by AFOSI for my review. Photographs showed what investigators and the ME called a rash. The ME was asked to explain the rash and he said it was due to an allergic reaction to the penicillin.

PROBLEMS:

1. There was no rash. The red lesions on the face were very deep abrasions caused by non-accidental trauma.

2. Re-investigation proved that although penicillin had been ordered, the child had never actually taken any.

3. This is not the way an allergic reaction to penicillin occurs.

4. There is inflicted trauma that is confined just to the face.

5. Child is too young for SIDS.

6. SIDS is a diagnosis of exclusion - which includes homicide.

7. Because of the severity of the abrasions, this should be considered overkill.

COMMENTS: Cause of Death was determined to be asphyxia due to smothering by another person. The manner of death is homicide. Because of the overkill, it was recommended that this might be the result of the killer being one of the 1-2 percent of the cases of child homicides caused by people who are certifiably psychotic. It was determined that the aunt of the child (mother's sister) killed the child by smothering her. She did this because of an extreme jealously she had of the child. That is because the aunt had pseudocyesis. This describes a female who has physical findings and signs that make her appear to be pregnant and who believes that in fact she is pregnant.

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CASE: JB, 3 month WM
DIED: 11/29/85
INVESTIGATED BY: H. C. Sheriff's Office
MEDICAL EXAMINER'S OPINION:
COD: Extensive predominantly right-sided subdural hemorrhage
GROSS DESCRIPTION OF BRAIN: "A few small patchy areas of thin subarachnoid hemorrhage are scattered over . . the brain (no mention is made of subdural)
DIAGNOSIS: "Moderate Cerebral Edema"
MICROSCOPIC EXAM OF BRAIN: No mention whatsoever is made of subdural or subarachnoid hemorrhage or of edema.
MICROSCOPIC DIAGNOSIS: Leptomeningitis, etiology undetermined.

Medical examiner was unwilling or unable to exclude accidental trauma.

Post-mortem x-rays were negative. No fracture was found.

EXPLANATION (by Father): During the 20 minutes he had left JB alone on the bed, JB rolled off the bed and was found motionless on the carpeted floor - he attempted CPR and called Emergency Medical Service.

(A SECOND EXPLANATION GIVEN BY FATHER): . . . He turned and saw JB fall from the bed onto his head causing a red spot . . . did not think injury was serious so placed JB in playpen. Twenty minutes later he found JB dead.

PROBLEMS:

1. No one willing or able to say injuries were inflicted.
2. Totally inadequate, incomplete autopsy with misleading and incorrect results.
3. Medical examiner ignored significance of past history of failure to thrive.

RESULTS:

Requested to review case by State Attorney. Although photos were of poor quality, was able to demonstrate a bruising pattern inconsistent with father's statements. Evidence was strong enough to recommend re-autopsy. Flew to Pennsylvania with State Attorney and investigators from sheriff's office and after court hearing (coordinated with prosecuting attorney in Pennsylvania) exhumed body and reautopsied it. Some of the injuries found and documented include:

1. L. 10th Rib near costovertebral junction, appears healed.

2. L. 11th Rib near costovertebral junction, appears healed.
3. L. 6th Rib, in axillary line, almost healed.
4. R. 10th Rib, ant. costochondral junction, healing separation fractures.
5. R. 9th Rib, ant. costochondral junction, healing separation fractures.
6. R. 8th Rib, ant. costochondral junction, healing separation fractures.
7. R. 9th Rib post., early healing fractures
8. R. 8th Rib post., early healing fractures
9. R. distal radius, comminuted fractures with exuberant periosteal Rx.
10. L. distal radius, single linear transverse fractures with periosteal Rx.
11. R. distal tibia, non-displaced cortical fractures with early periosteal Rx
12. Subdural, bilateral though predominately L sided, acute
13. Staining of dura, bilateral
14. Subarachnoid hemorrhage, acute and old, bilateral.
15. Interparenchchymal hemorrhage of brain stem
16. Massive intraretinal hemorrhage, right eye
17. Optic nerve sheath hemorrhage, left eye.
18. Multiple contusions of face, varying ages.
19. Multiple areas of subgaleal hemorrhage of varying ages.
20. Clinical Dx of failure to thrive, non-organic.
21. Acute fractures R. Ribs 3-7 at articulation to spine. (with hemorrhage)

<u>CONCLUSION:</u> Re-investigation and re-autopsy not only confirmed abuse but proved that JB had been abused his entire 3 months of life by being bludgeoned in the head and chest, violently shaken, jerked and twisted. With this new evidence there was no trouble getting a First Degree Murder indictment.

<u>NOTE:</u> <u>Don't automatically assume that all medical examiner reports are complete, accurate or even have the correct conclusion</u>. This case amply demonstrates that medical examiners' can not only be wrong but also miss things that a first year medical student should see. If you feel uncomfortable with the medical examiner's report ask the medical examiner questions. If he can't or won't give satisfactory answers, don't just drop it, get a second opinion from a competent pathologist.

Reautopsies are usually very beneficial <u>if</u> indicated and are not difficult to do as a general rule. So you should not hesitate to use this tool of investigation if necessary. If an exhumation is required, be sure to follow strict guidelines and procedures.

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<u>CASE:</u> K.S. 15 month WF

<u>INVESTIGATED BY:</u> The FBI

<u>MEDICAL EXAMINER OPINION:</u>

<u>COD:</u> Sudden Infant Death Syndrome

<u>MOD:</u> Natural

Autopsy was incomplete and grossly inaccurate with flagrant misrepresentation.

<u>PROBLEM:</u> Investigating agent has dead 18 month child with no evidence of trauma and a pathologist who reportedly had done a complete autopsy confirming that the child had died of natural causes. However, he felt uncomfortable with the case and contacted Dr. Reeves by phone for a consult. Based on the history provided, it was possible to say that KS was probably killed by her mother who smothered her. Also, the mother had probably tried to drown KS three days earlier. The agent was advised to re-interview the mother with this in mind and there was a possibility she would even confess.

<u>PREVIOUS EXPLANATION GIVEN BY MOTHER:</u> The night KS died, KS reportedly had walked into the living room where the mother was sitting on a couch and started to say "mama" when she just collapsed. The mother had also stated that three days earlier, that KS had collapsed and had to be taken to the hospital. This is the type of case that must be re-autopsied. Re-autopsy provided enough evidence to prove the cause of death. It also showed that the pathologist had not even opened the head, although she had described it as being normal in her report.

The mother did give numerous explanations - each different and all implausible. She finally confessed. However, as would be expected, as soon as she got a lawyer she recanted her confession and her lawyer said she had to be released since there was no evidence except the medical examiner's report which said KS had died of natural causes.

The AUSA then contacted Dr. Reeves for suggestions. Re-autopsy was recommended and then accomplished. Because of superb work of AUSA, mother was tried and convicted of Second Degree Murder.

This case illustrates so many things that can go wrong. Most are obvious. One not mentioned before - but always present is the "hired gun". Most have good credibility but just don't know what they are talking about because they don't think they need to prepare since all they want to do is just drop a little smoke screen. These can usually be handled by the prosecuting attorney using his expert witness to prepare for cross examination of the defense expert.

NOTE: Don't be misled by such things as the fact that the first autopsy was sent to the Armed Forces Institute of Pathology (AFIP) for review. Although such reviews are considered by many to be "the ultimate authoritative review" which can not be questioned. That is not so. This case serves as an excellent example.

For example, referring to the AFIP report, you will note that they only reviewed Dr. Dugan's autopsy report and her slides. Obviously if these are inaccurate, false or incomplete, then the AFIP will also reach the same wrong conclusions. Of all the high ranking doctors at the AFIP who reviewed this case, no one even mentioned the fact that there were no slides of the brain for example. They were also willing to assume there was no trauma just because Dugan said there was none. Also, No one asked to see x-rays or any police reports.

This whole case revolved around the fact that the history given by the mother was implausible and there was no acceptable medical cause of death. Using the information in context with all the facts in this case, is the only way to determine the truth about what really happened.

UPDATE

On July 31, 1989 the UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT **AFFIRMED** the guilty verdict in the case of United States of America versus Elizabeth Silvia.

ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, D.C. 20306-6000

REPLY TO: THE DIRECTOR
ATTN: AFIP-RRR

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
Tallahassee, Florida 32308

PATIENT IDENTIFICATION		PLEASE USE AFIP ACCESSION NUMBER IN ALL CORRESPONDENCE
AFIP ACCESSION NUMBER 2128474-0	CHECK DIGIT 0	SEQUENCE 2
NAME SILVIA, KIMBERLY J. A87-9	SSAN	
SURGICAL/AUTOPSY PATH ACCESSION # S		
PLEASE INFORM US OF ANY PATIENT IDENTIFICATION ERRORS		

Ellen Dugan, M.D.
Pathologist
Waynesboro Hospital
East Main Street
Waynesboro, PA. 17268

DW/jtl
DATE: 15 October 1987

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS:

1. Undetermined cause of death, undetermined manner of death; 15-month-old female dependent of US Army member, who collapsed and could not be resuscitated; date of death: 14 June 1987, Waynesboro, PA.
   a. Bilateral pulmonary edema, focal congestion and focal intra-alveolar hemorrhages.
   b. Pleural petechiae.
2. Culture, blood, lung and CSF; negative.
3. Toxicology: Not done.

We have received the autopsy protocol and slides. This case has been reviewed and coded in essential agreement with your findings.

While some bona fide SIDS cases have been reported up to 18 months of age all unexplained infant deaths in the over 12 months of age group are usually classified as undetermined until completely investigated.

FRANK B. JOHNSON, M.D.
Associate Director

Review and examination by:

Donald G. Wright, Colonel, USAF, MC
Staff Pathologist
Forensic Sciences Department

ROBERT F. KARNEI, JR., M.D.
CAPT, MC, USN
The Director

Reviewed by:

Charles J. Ruehle, M.D.
COL, USAF, MC
Chairman, Department of Forensic Sciences

AFIP F/L61 1 Jul 84

agerstown Morning Herald
3/9/88
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Fort Ritchie mother on trial

ly CLYDE FORD
Staff Writer

BALTIMORE — A Fort Ritchie woman who confessed to murder in the death of her 15-month-old daughter did so out of grief, not guilt, her defense attorney said yesterday, and Waynesboro doctors testified that they became suspicious when they could not find a natural cause for the woman's death.

In the first day of the U.S. District Court trial of Elizabeth Rose Silvia, 19, the prosecution opened its arguments saying that the woman confessed the murder to an investigating FBI agent.

Silvia is on trial in Baltimore on a charge of first-degree murder in the death of her daughter Kimberly. She is accused of suffocating the girl by putting a plastic bag over her face.

Assistant U.S. Attorney Susan M. Ringler said Silvia confessed to killing her daughter to FBI Special Agent Barry O'Neill on July 6 during questioning.

She said sudden infant death syndrome, or crib death, was listed as the cause of death after an incomplete autopsy. After Silvia's confession, a complete autopsy was done and the cause changed to suffocation.

U.S. Public Defender M. Brook Murdock, in her opening arguments, said the confession was a result of the mother's grief over her child's death, which often causes parents to blame themselves.

"The government wants you to believe this was a case of murder. It's not. It's a case of grief," Murdock said.

The girl had a history of breathing trouble, Murdock said.

Waynesboro Hospital doctors and a next door neighbor testified that Silvia told them the child had been playing when she suddenly collapsed in the living room on June 14, 1987.

Dr. Norbert P. Mathias, the emergency physician on duty, said Silvia told him the child had had a fever.

An autopsy report did not show illness, he said. He began to suspect the child may have died from abuse and wrote a letter to Washington County Social Services.

Hospital pathologist Dr. Ellen Dugan Daut said that after an autopsy, finding no other explanation for the death, she listed the cause of death as SIDS. Doctors believed the Kimberly had a history of SIDS, she said.

Daut said, however, that the same evidence that lead her to believe the cause of death was SIDS would have also pointed to suffocation.

THURSDAY, MARCH 10, 1988

Ronald L. Reeves, M.D.
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FBI agent says mother admitted killing infant

By Karen E. Warmkessel

Federal jury told of confession as murder trial gets under way.

Elizabeth R. Silvia told authorities she tried to drown her 15-month-old daughter in a bathtub and finally suffocated her with a plastic sandwich bag because she was upset about her life, an FBI agent testified yesterday in federal court in Baltimore.

Agent Barry A. O'Neill told a federal jury that the 18-year-old Washington County woman confessed to killing her daughter, Kimberly, three weeks after the child died June 14, 1987, at the Silvias' home at Fort Ritchie, an Army base near Hagerstown.

The confession was introduced as evidence at Mrs. Silvia's murder trial in U.S. District Court and read to the jury by Agent O'Neill, who also recounted an oral statement he said the defendant gave after having been advised of her rights.

The defense had tried unsuccessfully to have the statement suppressed. Yesterday, R. Anthony Gallagher, Mrs. Silvia's lawyer, sought to convince the jury that his client was a depressed and grieving young mother with a 10th-grade education who was pressured into confessing. Agent O'Neill denied any intimidation.

The FBI agent testified that, at first, Mrs. Silvia said Kimberly collapsed while playing in the living room of their home the day she died, just as the child had done three days earlier.

But later in the interview, she changed her story, saying, "Part of me says I did it, part of me says I did not," according to the FBI agent. He said Mrs. Silvia began to cry and put her hands up to her face, then admitted she had smothered Kimberly by placing a plastic sandwich bag, or baggie, over her mouth and nose.

Mrs. Silvia said she tried to revive her daughter, but Kimberly was "gone," Agent O'Neill testified. He said she told him "she hated herself and she hated everybody."

She said she killed the child because "of her life," because of a rape that she said occurred when she was 13 and because of her children screaming, the agent testified. In addition to Kimberly, Mrs. Silvia and her husband, Michael, an Army military policeman, have a son, Jamie, who was then 3 years old.

The FBI agent testified that the defendant had tried to drown Kimberly three days earlier by holding her head under the water in the bathtub. In her written statement, she said she was "under a lot of stress" and was "upset with myself, my marriage and life in general."

She said she "got a weird feeling, got lightheaded and dizzy, and felt real angry" before she pushed the child's head under the water. She said she got the same feeling right before she killed her on June 14.

Agent O'Neill testified that Mrs. Silvia told him she had been depressed since November 1986.

Yesterday, two former neighbors told the jury that the defendant became very upset the day after her daughter's death and had to be removed from her home.

Laura Adkins, who now lives in Ontario, Calif., said the defendant threw one of Kimberly's cups against the wall and screamed, "I hate you. I hate you. Why did you do this to me?"

Glenna J. Sand of Fort Ritchie said Mrs. Silvia told her, "She's dead. She's really dead. I can see her in heaven. She loves me. I can see her with Jesus." Later that day, Mrs. Silvia asked her if God forgives murderers and if they are allowed into heaven, Mrs. Sand told the jury.

Defense lawyers contend that Mrs. Silvia made "irrational" statements after her daughter's death. If she is convicted by the jury, they will try to persuade Judge Joseph C. Howard that she is not guilty by reason of insanity.

The trial is to resume Monday.

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3/10/88
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Child died of 'asphyxiation' in 'homicide,' trial told

Army wife Silvia, 19, accused of killing her daughter

By Kelly Gilbert
Evening Sun Staff

A forensic pathologist has testified at the federal murder trial of Army wife Elizabeth Silvia that her 15-month-old daughter, Kimberly, died from "asphyxiation" in a "homicide."

Dr. Ronald L. Reeves, the pathologist, testified at Silvia's trial in U.S. District Court in Baltimore that he reached his conclusion about the alleged murder after doing a re-autopsy on the child last Aug. 14, two months after Kimberly died, when the body was exhumed at the request of the FBI.

On cross-examination, however, Reeves testified yesterday that if he had made his conclusion before he had read Silvia's confession, "I don't know" whether it would have been exactly the same.

"My conclusion would probably be asphyxiation period," Reeves told defense attorney Anthony R. Gallagher. "But I had other things to go on."

Federal prosecutor Susan M. Ringler alleges that Silvia, 19, suffocated Kimberly with a plastic sandwich bag in their Fort Ritchie home in Washington County last June 14 after trying to drown the child in a bathtub three days earlier. At the time, Silvia lived with her children and her husband, Michael, an Army military policeman.

Gallagher and M. Brooke Murdock, an assistant federal public defender, claim the defendant was intimidated into confessing murder to the FBI while she was depressed and grieving about her child's death.

The trial, now 4 days old, was to move into the defense phase today.

Reeves, a former Florida medical examiner turned trial consultant, testified for the prosecution as an expert witness on forensic pathology and children's deaths.

On direct examination, Reeves said Kimberly Silvia died of "asphyxiation, suffocation, and the manner of death was homicide."

He said there was evidence the child had "aspirated" something into her lungs that could have caused pneumonia at some later date, but it did not cause her death.

Reeves said that finding, and his final conclusion about Kimberly's death, were "consistent" with the defendant's confession.

In that confession, the young mother admitted to FBI Agent Barry A. O'Neill that she smothered her daughter with a "Baggie" June 14 and that she had tried to drown her June 11.

The forensic pathologist said he performed a complete re-autopsy on Kimberly Silvia at the FBI's request, after he determined that an earlier autopsy was "inadequate."

The first autopsy was performed by a pathologist at Waynesboro (Pa.) Hospital, where the child was pronounced dead by emergency room physicians.

Reeves also said he reached his final conclusion "by exclusion" of other possible causes and circumstances surrounding the death, through medical evidence he obtained in the re-autopsy.

He said there were no bruises or other evidence on or in the child's body to suggest that Kimberly's death was accidental or that she was a victim of Sudden Infant Death Syndrome, or crib death.

"She was too old," Reeves said. "Seven or 8 months [of age] is the outer limit of SIDS."

Answering Ringler's questions, Reeves said he determined there had been a pattern of child abuse in the family that included the alleged attempted drowning of Kimberly on June 11 and an incident in November 1986 in which the defendant's son, Jamie, got pneumonia after his mother allegedly had found him face-down in their bathtub.

Reeves said his homicide conclusion was "supplemented and supported by" the mother's confession.

"You cannot ignore the environment in which something happens
. . . I investigate deaths in terms of what happened. You have to look at everything available to you," he said.

On cross-examination, however, Reeves said he did not recall saying the confession "supplemented" his findings. He said again that the confession "supported" them.

The pathologist also said the defendant's story to doctors at the hospital, that Kimberly had said, "Mommy, Mommy" and suddenly collapsed, "was not [medically] plausible."

Reeves acknowledged, under Gallagher's cross-examination, that it was "possible, yes" that Kimberly had aspirated something other than water into her lungs.

"I could not" distinguish what it was, the witness said.

At one point, Gallagher gave the witness two binders full of medical records and suggested the papers showed that Silvia's son, Jamie, now age 3, had been medically treated for a "seizure disorder" repeatedly in 1985, when he was an infant.

Reeves, who read the records for two hours during a court recess, questioned their validity.

But he acknowledged that he had not seen many of the records, and said he "assumed" that O'Neill had given him all the family medical records available before he reached his conclusion about Kimberly's death.

Finally, Gallagher pressed Reeves to admit that he decided the child's death was a homicide before he did the re-autopsy because he had read the confession and other damaging statements from Silvia's neighbors, and had discussed the case at least twice with FBI Agent O'Neill.

But Reeves insisted his decision "was based on all my research . . . it was not just taken out of the blue sky."

U.S. District Court hears murder case of mother accused of slaying toddler

By Karen E. Warmkessel

Federal prosecutors claim Elizabeth R. Silvia murdered her 15-month-old daughter, suffocating the curly-haired toddler with a plastic bag.

But defense lawyers contend the medical evidence is inconclusive and there is no proof that Mrs. Silvia, 19, killed the child, who an autopsy originally determined had died of sudden infant death syndrome, or SIDS.

"The government wants you to believe this case is about murder. It's not. It's about grief," M. Brooke Murdock, an assistant federal public defender, said. She said Mrs. Silvia confessed to the FBI several weeks later because of "overwhelming guilt" prompted by her daughter's sudden death.

Mrs. Silvia went on trial yesterday in federal court in Baltimore, charged with murdering her daughter, Kimberly, June 14, 1987, at their home at Fort Ritchie near Hagerstown.

First-degree murder cases on the federal level are rare. The case is being tried in U.S. District Court because the death occurred on the Army base where Mrs. Silvia's husband, Michael, was stationed.

Mrs. Silvia has pleaded not guilty by reason of insanity, but the jury of

First-degree murder cases on the federal level are rare.

10 men and two women will only determine her guilt or innocence on the murder charge.

If the jury finds her guilty, defense lawyers will then try to persuade Judge Joseph C. Howard to find her not guilty by reason of insanity. The judge agreed to split the trial into two phases at the request of the defense.

Yesterday, Susan M. Ringler, an assistant U.S. attorney, told the jury she would prove Kimberly's death was deliberate and premeditated.

She said that an autopsy originally listed the cause of death as SIDS but that a subsequent autopsy performed after authorities became suspicious showed that the child had suffocated.

Ms. Ringler said Mrs. Silvia first told authorities that Kimberly had collapsed while playing but later admitted to an FBI agent that she had placed a plastic bag over Kimberly's nose and smothered her. The prosecutor did not offer a motive.

Defense lawyers had tried to have the confession suppressed, but Judge Howard ruled that it could be introduced as evidence.

Ms. Murdock contended that Mrs. Silvia made "irrational" statements after Kimberly's death. She also told the jury that the second autopsy did not show anything different from the first and said, "We may never know the reason Kimberly died."

The pathologist at the hospital in Waynesboro, Pa., who performed the first autopsy testified that she would now list the cause of death as undetermined. She said the medical evidence was as consistent with suffocation as SIDS and that her opinion had been influenced by being told there was a history of SIDS in the family.

A former neighbor of the Silvias testified that the young mother came to her house twice, the day of the child's death and three days before, saying Kimberly had collapsed. The first time the neighbor was told the infant had said, "Mommy," and fallen while playing in the living room. The witness said she then discovered the child on the bathroom floor, dazed.

She said the child was taken to the hospital but did not look well after she returned.

Scientific battle ends mother's murder trial

By Kelly Gilbert
Evening Sun Staff

Testimony in the Elizabeth Silvia federal murder case has ended with a scientific, witness-stand battle between two pathologists.

The defendant, a 19-year-old Army wife who lived at Fort Ritchie with her husband Michael, daughter Kimberly and son Jamie when Kimberly died last June 14, did not testify at the trial.

Defense attorneys Anthony R. Gallagher and M. Brooke Murdock rested their case late yesterday in U.S. District Court.

Prosecutor Susan M. Ringler, who rested her case Wednesday, presented one rebuttal witness yesterday.

Judge Joseph C. Howard said he would instruct the jury today and send the 10 men and two women into deliberations after the attorneys' closing arguments.

The defense rested after Dr. Grover M. Hutchins, a Johns Hopkins anatomic pathologist, insisted again that Kimberly Silvia, the defendant's 15-month-old daughter, died of myocarditis. He said the heart disease, which he found in microscopic examination of tissue slides taken from the child's heart during an autopsy, prompted an arrythmia, or irregular heartbeat.

Hutchins, a defense witness who directs the autopsy service at Johns Hopkins Hospital, admitted on cross-examination by Ringler that he had never done an autopsy on an asphyxiation victim. Kimberly Silvia is alleged to have been smothered.

But Hutchins testified that two physicians who did autopsies on Kimberly Silvia made "totally incorrect" conclusions that she was suffocated by her mother.

"The presence of myocarditis and arrythmia is the leading probability [of the cause of the child's death], and that is what I believe occurred in this case," Hutchins said.

Dr. Donald L. Reeves, a forensic pathologist who testified Monday for the prosecution, returned to the witness stand yesterday as a rebuttal witness.

He testified that he found "necrotic myocytes," so-called round cells that were inflamed, in Kimberly Silvia's heart when he performed a re-autopsy on the child last August, two months after her death.

Hutchins said the myocytes were literally eating the child's heart tissue, which caused the "active, ongoing" myocarditis that caused the arythmia that caused her death.

But Reeves told the jury he did not consider the quantity of the myocytes to be significant enough to cause Kimberly's death, so he did not mention them in his re-autopsy report.

"In my opinion, they played no role at all in the child's death," Reeves said. "They are not adequate to account for any event or disease that would contribute to death."

At times, the witness-stand battle between the two doctors took on a my-witness-is-better-than-your-witness atmosphere as the prosecutor and defense attorneys questioned the experts' medical credentials and sought in vain to get the opposition's physician to back off from strongly-held opinions.

Reeves is a $300-an-hour Florida witness-consultant and former medical examiner who has personally performed about 2,000 autopsies, many of them in criminal cases, and supervised about 2,000 more.

Hutchins is a $150-an-hour witness who specializes in microscopic examination in pediatric and cardiopulmonary cases. He said he hasn't done an autopsy in 10 years, but regularly assists on parts of some and approves reports on 500 autopsies a year that are done under his supervision by Hopkins pathologists.

In testimony that is important to both sides in the murder case, Hutchins and Reeves both said they considered hospital records on Kimberly Silvia, investigative records and the defendant's confession to the FBI before they reached their opposing conclusions about the cause of the child's death.

FRIDAY, MARCH 18, 1988

Experts disagree on Silvia girl's death

One blames ailment, the other suffocation

By Karen E. Warmkessel

The federal court trial of Elizabeth R. Silvia, a 19-year-old Washington County woman accused of murdering her 15-month-old child, turned into the battle of the experts yesterday as two pathologists disagreed over what caused the infant girl's death.

Dr. Grover M. Hutchins, an anatomical pathologist at Johns Hopkins Hospital, stuck to his opinion that Kimberly Silvia had died of heart disease — specifically myocarditis, an inflammation of the heart muscle probably caused by a virus.

The physician, who supervises autopsies at the hospital and who testified forthe defense, said the disease resulted in heart failure.

But Dr. Ronald L. Reeves, a forensic pathologist and former medical examiner from Florida, insisted that Kimberly had died of suffocation.

Recalled as a witness by the prosecution to rebut Dr. Hutchins, he testified that he detected evidence of myocarditis but did not believe it was significant or the cause of the toddler's death last June.

The medical testimony is crucial to the outcome of the first-degree murder case, which is expected to go to the jury today.

Prosecutors contend that Mrs. Silvia suffocated her daughter with a plastic sandwich bag June 14 at the family's home at Fort Ritchie, an Army base near Hagerstown, because she was depressed.

The defense maintains that the infant died of natural causes and that the defendant was intimidated into confessing to the murder by an FBI agent. If she is convicted, defense lawyers will try to convince Judge Joseph C. Howard that she was insane.

Yesterday during cross-examination, Susan M. Ringler, an assistant U.S. attorney, got Dr. Hutchins to admit that he h[illegible]ver performed an autopsy on a c[illegible]d who had been smothered with a soft object, such as a pillow or a plastic bag.

However, Dr. Hutchins said he has had cases where children have died of asphyxiation.

The doctor also conceded that he has seen evidence of myocarditis during autopsies although the patients died of other causes.

Asked by Ms. Ringler what the cause of death would be if Mrs. Silvia had held a plastic bag over the child's nose and mouth, Dr. Hutchins stuck to his diagnosis.

"It would be my opinion that the child did not die of asphyxiation. There is no evidence that the child died of asphyxiation," he testified.

But Dr. Reeves told the jury that he did not consider the myocarditis significant. He said the heart would have been enlarged and there would have been other physical evidence if the disease were severe enough to kill the toddler.

He denied Dr. Hutchins' assertion that tiny pinpoint bruises, or petechiae, are generally present on the lungs and heart in cases of asphyxiation.

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·irl died of heart failure, witness say·

Hopkins doctor disputes suffocation theory

By Kelly Gilbert
Evening Sun Staff

·mberly Silvia, whose mother ·eth is on trial for her alleged ·r, died of heart failure, not ·ation, a Johns Hopkins physi- ·as told a U.S. District Court ju-

·. Grover M. Hutchins, director ·pkins' autopsy service, said the ·nth -old child died of myocar- ·an inflammation of the heart which probably was caused an ·thmia, or irregularity, in her ·beat.

·utchins, an anatomical patholo- ·nd specialist in pediatric and ·ovascular microscopic re- ·h, said he made that conclusion ·studying slides of the child's or- ·The slides were made last Au- by Dr. Ronald L. Reeves, a fo- ·c pathologist who did a ·topsy of the body for the FBI.

·eeves testified Monday for the ·ecution. He said Kimberly died ·phyxiation caused by suffoca- ·and said her mother, the de- ·nt, probably did it.

·lutchins testified yesterday for ·lefense. He said Kimberly defi- ·y died of myocarditis, not as- ·iation.

There was no reason for ·ves] to even consider the diagno- ·f suffocation" as the manner of ·h, Hutchins said.

·Elizabeth Silvia, 19, the wife of a ·er U.S. Army military police- · at Fort Ritchie, near Hagers- ·, is on trial for first-degree ·der.

·Federal prosecutor Susan M. ·ler alleges that the young moth- ·mothered Kimberly with a plas- ·andwich bag and later confessed murder to FBI Agent Barry A. ·eill out of guilt.

Defense attorneys M. Brooke ·dock and Anthony R. Gallagher ·tend that Silvia was intimidated · confessing and that damaging ·ements she made to neighbors ·r the child's death were products ·her grief over the loss of her ·ghter.

Hutchins, a hired consultant, tes- ·ed that Kimberly's myocarditis ·l arrhythmia were "consistent" ·h the defendant's explanation to ·bors and emergency room doc- ·that Kimberly had said, "Mom- ·, Mommy" and suddenly col- ·sed in the living room of their ·t Ritchie home.

His microscopic study, he testi- ·, showed, "There would have had have been some episode of heart

the defense that Silvia's confession and her damaging statements to neighbors were "normal" and "very common."

They may have been products of grief, not guilt, after Kimberly's sudden death, Timmel said.

Under cross-examination by Ringler, Timmel acknowledged that Elizabeth Silvia's tearful breakdown when she confessed could have b· "consistent" with either real guilt· imagined guilt.

The trial is scheduled to conti· tomorrow afternoon with Ringl· cross-examination of Hutchins. · case could go to the jury for delib· ations Friday.

THE SUN

Woman convicted in daughter's slaying

Silvia found guilty on 2nd-degree count

By Karen E. Warmkessel

A 19-year-old Washington County woman was convicted last night of second-degree murder for suffocating her 15-month-old daughter with a plastic bag last June.

The defendant, Elizabeth R. Silvia, put her hand to her face and wept as the jury foreman announced the verdict shortly after 7 p.m. in federal court in Baltimore.

Prosecutors had sought to convict her of first-degree murder but asked Judge Joseph C. Howard to allow the jury to consider the lesser charges of second-degree murder and manslaughter. Unlike first-degree murder, second-degree murder requires no premeditation.

The defense now will try to convince Judge Howard that Mrs. Silvia was insane when she killed her daughter, Kimberly, June 14 at their home at Fort Ritchie. A hearing on the insanity plea is set to begin March 28.

If the judge finds that Mrs. Silvia was sane, she faces a maximum sentence of life in prison.

The jury of 10 men and two women deliberated more than 5½ hours before reaching its verdict after a six-day trial that was marked by conflicting medical testimony about what killed the toddler.

Mrs. Silvia originally told authorities her daughter said "Mommy" and suddenly collapsed while playing at their home.

Later she admitted to the FBI that she had smothered Kimberly with a plastic sandwich bag and had tried to drown her in a bathtub three days earlier. She said she was unhappy in her marriage and depressed.

Mrs. Silvia, who was married when she was 15 and has a 10th-grade education, also made damaging statements to neighbors, asking one woman if "murderers go to heaven" and telling another she was going to have to "cover my ass" because authorities suspected she had killed the child.

But the defense argued that she had been pressured into confessing and attributed her remarks to grief.

Mrs. Silvia, who has a son, Jamie, 3, and is separated from her husband, Michael, a former military policeman, did not testify.

Dr. Ronald L. Reeves, a forensic pathologist called by the government, testified that Kimberly had died of asphyxiation caused by suffocation. However, a Johns Hopkins pathologist, Dr. Grover M. Hutchins, testified for the defense that Kimberly had died of heart failure caused by an inflammation of the heart muscle.

Yesterday, Susan M. Ringler, an assistant U.S. attorney, urged the jury not to be fooled by Dr. Hutchins' Hopkins credentials.

"He was here to sell you a bill of goods and nothing else," she said. Ms. Ringler said Dr. Hutchins did not consider all the facts of the case.

"I submit that his perspective ended at the end of his microscope."

The prosecutor said the killing was premeditated. "She did not die of a rare disease . . . that struck her down. The truth is she died at her mother's hand. Her death of suffocation was slow and violent," she said.

But Anthony R. Gallagher, Mrs. Silvia's lawyer, said the evidence was clear that Kimberly had died of natural causes. He charged that the case was "mishandled from the start" and resulted from "hysteria" over suspected child abuse.

"The case is not about murder," he told the jury. "It is about grief."

Mr. Gallagher attacked Dr. Reeves as a "man with a mission," a paid consultant who had a vested interest in the outcome of the case.

"She did not murder her daughter. Her daughter certainly died an untimely death. She is not guilty. I beseech you to find her so," Mr. Gallagher concluded.

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
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CASE: JWJ: 18 month WM

INVESTIGATED BY: The FBI
The Naval Investigative Services, Territory of Guam
The Army CID, Hawaii
Child Protection Team, TAMC

MEDICAL EXAMINER'S OPINION: None
Case was NOT reported to Medical Examiner

BABY SITTER'S STATEMENT: Her son accidentally knocked a bucket of boiling water off the stove on top of JWJ who was sitting on the floor.

PROBLEMS:

1. The FBI, NIS and CID all conducted individual investigations and determined the injuries were accidental.

2. Physicians and other health care workers treating JWJ for the two months before he died thought he was abused but never reported case after the child died.

   "Everyone thought it was someone else's job".

3. Medical Examiner was never notified and no autopsy or post mortem exam was done.

4. Investigators missed obvious findings due to lack of training and experience. More large agencies and agents were involved in the case than in most, but they failed to determine the truth.

5. Witnesses tried to tell investigators that there was something wrong - but these pleas were ignored.

6. Reportedly, no autopsy was done at request of parents. This should never be allowed to occur in a criminal case.

7. Personal friendships of certain officials with subject impeded investigation.

8. Subject was a young WF mother who was pillow of community who went to church every Sunday and even Wednesday night and had no prior history of abuse. Therefore some officials refused to consider the fact that she could have hurt this child intentionally. This

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is absurd. Negative history of prior child abuse is <u>never</u> important in excluding abuse. Positive history supports such conclusion.

9. <u>Pattern of injury speaks for itself.</u>

10. Although initial treating physician felt burns were consistent with an immersion, <u>he also stated</u> that it could have been caused the way the subject said. <u>THIS IS NOT TRUE.</u> It is very common, if not the rule, that emergency treating physicians give statements which are wrong regarding things like this when they don't have any idea what they are talking about.

11. Opinions given to investigator by physician were ignored.

<u>DECISION:</u> FBI referred case to Dr. Reeves for routine review. The photographs were all that was required to say the child was murdered. In fact this is the most classic example of inflicted immersion burn I have ever seen. From the photographs you can determine:

1. Child was placed in tub of water against his will and was held down against his will.
2. The position he was in in the tub.
3. The temperature of the water relative to the time of exposure.
4. Surface area of burn and angle child was in.
5. Injuries were intentional and nonaccidental.

<u>RESULTS:</u> Babysitter was tried and convicted in Federal Court of Second Degree Murder.

U.S. Department of Justice

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United States Attorney
District of Guam

Suite 502-A PDN Bldg
238 O'Hara Street
Agana, Guam 96910

Overseas Operator
472-7332

May 11, 1983

William Cowan, MD, USAF
Director
Armed Forces Institute of Pathology
Washington DC 20306

Re: USA v. Julia Foster
Cr. 83-0004, USDC Guam

Dear Dr. Cowan:

After a few hours deliberation, a District Court jury convicted defendant Julia Foster of second degree murder resulting from immersing a child in hot liquid from which the child sustained 3rd degree burns over 40% of its body.

This office wholeheartedly thanks your institute's cooperation by your allowing Dr. Ronald Reeves to analyze photographs submitted him by the FBI and facilitating his appearance both at the Federal Grand Jury and at the jury trial. Without your office's involvement, and specifically Dr. Reeves' professionalism and diligence, it is unlikely that the case would have been filed and successfully prosecuted -- not because of this office's intentional avoidance of child abuse cases but because of laymen's initial difficulty in recognizing these cases as child abuse.

From comments of AUSA Paul Vernier, who handled the case prosecution, and comments of people who listened to Dr. Reeves' testimony, and from my own conversations with him, the above thanks is extremely appropriate.

Thank you again for the Institute's help in this matter. We will certainly request your expert assistance in the future if such becomes necessary.

Cordially,

DAVID T. WOOD
United States Attorney
District of Guam

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
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DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
TRIPLER AMC, HAWAII 96859

REPLY TO ATTENTION OF: June 29, 1983

Department of Pediatrics

COL William Cowan, MC, USAF
Director, Armed Forces Institute of Pathology
Washington, D.C. 20306

Dear Colonel Cowan:

I am writing you to commend one of the Forensic pathologists on your staff, Major Ronald L. Reeves. I feel that he is one of the most dedicated, knowledgeable, skillful and capable experts on child abuse/neglect that I have known.

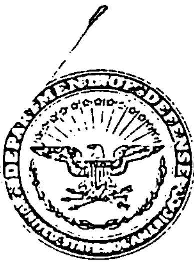
Major Reeves has been here at Tripler Army Medical Center on several occasions over the past year. He has been involved in two cases of child abuse that resulted in death. These cases were not properly referred to the county medical examiner for autopsy and prosecution of the homicide. They were reviewed by Major Reeves at the AFIP level and thanks to his expertise and diligence, they were subsequently properly reported and prosecuted.

While here in the Hawaii involved in these cases, Major Reeves addressed the Pediatric and Pathology staff of this medical facility on several occasions on child abuse/neglect from the standpoint of the Forensic pathologist. The talks have been the most informative and superbly delivered that I have ever heard. Accordingly, this command is arranging for him to address the entire staff of the hospital on the subject when he will back here in August.

It is my understanding that Dr. Reeves will be leaving the Army this fall but that there is a chance that his services may be retained by the AFIP in a civilian status. I have been an Army pediatrician for 25 years and I know of no one who has contributed more from the vantage of the Forensic pathologist in the field of child abuse/neglect than Major Reeves. I strongly indorse this very fine physician's work and I hope we will be able to retain his services at the AFIP.

Sincerely,

James W. Bass, M.D.
Colonel, Medical Corps
Chief, Department of Pediatrics



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 341ST COMBAT SUPPORT GROUP (SAC)
MALMSTROM AIR FORCE BASE, MT 59402

18 JAN 1983

REPLY TO
ATTN OF: JA

SUBJECT: Letter of Appreciation - Major Ronald L. Reeves, USA, MC

TO: AFIP/CC
Washington DC 20306

1. On 6 and 7 January 1983, a General Court-Martial was held at Malmstrom Air Force Base, Montana. This case involved a brutal assault by immersion burn on a four-year old girl. The case was hard fought and contained many legal and factual issues. I am glad to say the prosecution was successful in this case.

2. I must point out that the government would have had no case at all if it were not for the expert testimony of Dr Reeves. I found him a truly remarkable man. His testimony was complete yet easy for the ordinary layman to understand. While Dr Reeves was at Malmstrom AFB, he was kind enough to talk to medical personnel at Columbus Hospital in Great Falls, MT as well as the Malmstrom AFB Hospital, on the subject of child abuse.

3. As a base prosecutor I can tell you that in the future we will be using the services of Dr Reeves and the entire staff of the AFIP in more of our cases.

4. I am very thankful the Armed Forces of the United States have the services of such an expert as Dr Reeves.

John A. Arrigo

JOHN A. ARRIGO, Captain, USAF
Assistant Staff Judge Advocate
Chief, Military Justice

Peace . . . . is our Profession

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
Tallahassee, Florida 32308

CASE: CA, 18 month WF
DIED: 2/22/82, John Hopkins Hospital
Baltimore, Maryland

INVESTIGATED BY: FBI, Army CID

MEDICAL EXAMINER OPINION: COD: Blunt Head Trauma
MOD: Undetermined

EXPLANATION: (by Father) While playing football with CA, he tried to tackle her . . . as he lifted her off the floor he lost his balance and fell with CA under him . . . but the baby fell backwards onto the tile floor and he landed on top of her.

PROBLEMS: Won't prosecute without medical examiner's opinion.

1. Medical examiner did not do complete autopsy.
2. Medical examiner was not furnished with valuable and necessary investigation reports.
3. Medical examiner was not furnished with all hospital records and doctors' opinions.
4. CA was in hospital more than 10 days. Many bruises were fading. Those remaining were masked by very dark lividity. Medical examiner didn't incise skin looking for injuries.
5. Medical examiner didn't determine or consider child's clinical condition at time of admission.
6. Medical examiner misinterpreted autopsy findings leading to incorrect statements.
   example: "normally developed, well nourished child for age"
   Absolutely NOT true - CA was severely malnourished and dehydrated on admission to hospital. This was masked at autopsy by hospital treatment.
   CA was waterlogged causing her to be normal if you only look at the numbers.
7. Medical examiner only referred to acute injuries. There are unlimited records proving CA was also chronically abused and neglected.
8. Medical examiner unable to say injuries could not have occurred accidentally.
   a. Was only considering part of the injuries while ignoring the rest - CAN'T DO THAT!
   b. Formed opinion while working in a vacuum.
   c. Did not have police support or cooperation.
9. Many physicians in hospital thought child was abused but none transmitted their concerns to the Medical Examiner.

RESULT: Case was re-reviewed using all the information and facts available. Father was indicted by Federal Grand Jury. Pleaded Guilty.

U.S. Department of Justice

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Forensic Pathologist
4770 Lancashure Lane
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United States Attorney
District of Maryland

MHK:nbv

United States Courthouse, Eighth Floor
101 West Lombard Street
Baltimore, Maryland 21201

301/539-2940
FTS/922-4822

July 15, 1983

Dr. Ronald Reeves
Division of Forensic Pathology
Armed Forces Institute of Pathology
Washington, D.C. 20306

Re: United States of America
v. George Peter Thorne
Criminal No. HM-83-00190

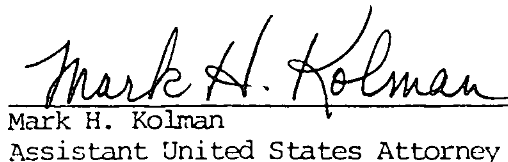
Dear Dr. Reeves:

Please be advised that on July 7, 1983, George Peter Thorne changed his plea in the above-captioned case to guilty of child abuse relating to the injuries received by Christina Thorne in February, 1982. This plea was part of negotiations with the United States Attorney's Office under which we will recommend to the Court, at the time of sentencing, that a sentence of imprisonment for fifteen (15) years be imposed on Mr. Thorne for his conduct.

I would like to take this opportunity to thank you for your participation in the successful prosecution of this matter. If you wish to contribute your thoughts to the judge for purposes of sentencing or if there are any matters which you feel we should stress at that time, please feel free to contact me. I am also available if you have any questions concerning this case.

Very truly yours,

J. Frederick Motz
United States Attorney



Mark H. Kolman
Assistant United States Attorney

TRIAL COUNSEL
FORUM

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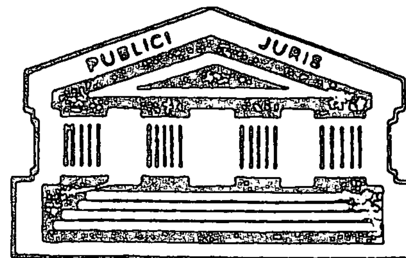

VOL II, NO. 3 DATE: MARCH 1983

This edition of the Forum contains several articles dealing with the problem of battered children. CPT Tom Benjamin of Fort Meade discusses problems of proof, provides solid advice for investigation and lists several excellent sources of expertise to assist trial counsel in the prosecution of this type of offense. A "government brief" and several "sample specs" discuss recent case law and techniques of charging in battered child cases. Also, in this month's Forum CPT Jim Underhill explores the requirements and procedures involved in obtaining an extraordinary writ on behalf of the government. And, CPT Dave Crane, Fort Bragg, provides valuable practical advice in preparing for and conducting effective voir dire.

Many trial counsel have sent us their responses to our questionnaire on TCAP services published in the December Forum. These responses will help us to better serve you. We intend to publish articles in future issues on topics suggested by you. In addition, based on your suggestions, we intend to publish an index for the Forum, in the July issue, at the end of one year of publication. We welcome your advice, your ideas and your Reader Notes!

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TRIAL COUNSEL FORUM is dedicated to fostering professionalism, excellence and pride of US Army trial counsel through the exchange of prosecutorial information and techniques. It is published monthly by the Trial Counsel Assistance Program, United States Army Legal Services Agency, Nassif Building (JALS-GA-T), Falls Church, Virginia 22041 (AV 289-1804), and it supersedes the GAD UPDATE. The views and opinions expressed in TRIAL COUNSEL FORUM are not necessarily those of The Judge Advocate General or The Department of the Army.

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Tallahassee, Florida 32308

Issues In Child Abuse/Homicide Cases

1. Child abuse is one of the most underreported and underprosecuted crimes in today's society. The factors contributing to this situation are many. Chief among these are the relative privacy of the home in which child abuse crimes occur, and the reluctance of other family members to testify against the guilty party. At Fort Meade, we have recently completed an Article 32 investigation into the beating death of a 2-month-old infant. As this was the second homicide of a child at this installation in the past year, this area has been a great concern. Therefore, it seems important to share some of the problems which have been faced in the prosecution of these cases.

2. Both cases involved a mix of family members between military and civilians. Chapter 2, AR 27-10, and the Memorandum of Understanding between the Department of Justice and the Department of Defense set forth therein, establish the procedures for determining whether the offense will be investigated by CID or the FBI. Problems arise when there is a dispute between the two investigative agencies as to who are properly the subjects of the investigation, or how the investigation should be conducted. In the most recent case at this post, the FBI was notified immediately upon the death of the infant. The FBI assumed investigation of the case because there were two civilians and one servicemember living with the child. However, the FBI agents indicated that they did not intend to interview any of the suspects until after the funeral services, approximately 2 weeks after the death had occurred. CID, with SJA approval, opposed this plan, and an agreement was reached with the FBI that allowed CID to begin the investigation on its own. However, 4 days had elapsed from the death, during which all three suspects were living together in the same apartment. This fertile opportunity for the guilty party to coerce, intimidate, or even beg the other family members not to make statements could have been avoided had all potential witnesses been interviewed shortly after the death.

3. Another reason for the immediate interviewing of all possible witnesses, to include all neighbors in the area of the suspects' house, is that very quickly witnesses will adopt the version of the facts as related to them by the suspects. Neighbors who could be valuable sources of information are going to be very reluctant to accept the allegation that their friends next door beat their baby to death. The information that they are willing to provide will be tailored to their own beliefs, and it is amazing how quickly they will adopt the explanations provided to them by the suspect family members. This resistance will be hard to overcome, regardless of how conclusive or revolting the autopsy findings may be 2 weeks later.

4. The present case presented the classic shell game to the prosecutors and the Article 32 officer. Three adults lived in the quarters in which the baby died. The autopsy revealed that the victim, a 2-month-old infant, died from massive brain hemorrhage caused by severe slapping. The time of the fatal injuries could

only be placed at approximately 2 hours to 2 days before the death. Other injuries found in this infant were six fractured ribs, approximately 3 weeks old, and severe bruising of the buttocks, approximately 10 days to 3 weeks old. All three suspects had access to the child; however, no motive for any of them to commit the assaults could be determined. Only one of the civilians was originally willing to make a statement, in which the sevicemember was alleged to have acted in a bizarre manner when around the child. At the Article 32 investigation, both civilians testified. However, the inconsistencies in their testimony as compared to their previous statements eroded the circumstantial evidence which implicated the servicemember. After seven sessions, testimony from 20 witnesses, and over 500 pages of transcript, the end result was that none of the three could be isolated as a solid suspect. The case is presently being considered by the U.S. Attorney's Office for presentation to the Federal Grand Jury.

5. The autopsy is an important part of any homicide investigation. It becomes more crucial when a diffuse pattern of injuries of differing ages may be the only way to refute the accused's explanation of accidental death. It is important to be familiar with the procedures followed by hospital personnel when a questionable death occurs, and insure that those persons who will be notified are keen to the indications of possible child abuse. If the death is wrongly attributed to natural causes prior to a complete autopsy the first trial issue has been created for the defense. An incomplete autopsy may be the prosecutor's worst enemy at trial, even if the true cause of death is properly noted and documented. Other possible causes of the injuries, regardless of their believability, need to be considered and excluded. The military is blessed with a number of forensic experts at the Armed Forces Institute of Pathology, located in Washington, D.C. The staff pathologists at AFIP have repeatedly emphasized their willingness to assist in any investigation, whether or not it involves a homicide, when medical testimony may be an important facet of the case. At a minimum, AFIP should be consulted before any autopsy is begun if there are indications that foul play might be involved in the death. AFIP pathologists will even fly to your location to complete or assist in the autopsy, if they are requested. AFIP's legal staff can also provide guidance if the question of jurisdiction or the policies of the local coroner create doubt as to who has the reponsibility to complete the autopsy. Their expertise, their willingness to assist and educate both the prosecution and the defense, and the incredible resources for the production of exhibits (photographs, charts, etc.) are virtually overwhelming.

6. Of the many resources which were utilized in the preparation of this case, of most value were the services of the Armed Forces Institute of Pathology. Specifically, Dr. Ronald L. Reeves, MAJ, MC, of the Division of Forensic Pathology, was of invaluable assistance. Dr. Reeves specializes in forensic pediatrics, and is the resident expert at AFIP on the detection and documentation of injuries occurring from child abuse. In addition to his impressive qualifications and extensive knowledge in this field, Dr. Reeves is an excellent courtroom witness and is extremely adept at reducing complex medical descriptions to understandable terms. He was guest lecturer at the TCAP Regional Seminar at Fort Belvoir in January, and has repeatedly offered his assistance to any trial counsel or other law enforcement personnel who are faced with a child abuse or homicide offense. Dr. Reeves and other members of the Forensic Pathology Division can be reached at the Armed Forces Institute of Pathology, Washington, D.C. 20306; AUTOVON 291-2361/3287. Dr. Reeves is also interested in reviewing any closed cases in which

suspected child abuse was not prosecuted for lack of physical evidence or inconclusive findings by medical personnel. Any trial counsel who has struggled and pulled teeth to get photographs, charts, drawings, or other exhibits prepared for trial will find the support provided by AFIP to be incredible. AFIP's production capabilities will likely far exceed anything available at your installation. Anyone who is preparing a case in which the medical evidence may be an issue should consult with AFIP personnel to determine what support they can provide.

7. Another resource uncovered during this investigation was the National Center on Child Abuse and Neglect, an agency of the U.S. Department of Health and Human Services. The National Center operates the Clearinghouse on Child Abuse and Neglect Information at 1700 North Moore Street, Arlington, Virginia 22209, (703) 558-8222. Lucy Younes, Legal Analyst for the National Center, is available for consultation on legal issues arising in child abuse prosecutions. The National Center maintains a vast computer storehouse of information regarding child abuse statistics and case law. Ms. Younes is interested in assisting research efforts pertaining to child abuse prosecutions, and can be especially helpful with rare or first impression issues that may arise, such as federal interpretations of state child abuse laws. Every case involving child abuse or related issues decided in Federal, state, and military courts is recorded in the computer bank, with abstracts of each case decision made available. For instance, the National Center was very helpful in providing case law regarding prosecution of parents of abused children on the theory of negligent homicide, or failure to meet a legal duty to protect the child, when it could not be proven that the parent was the one who actually inflicted the injury. The Clearinghouse also has a number of valuable publications which are available for the asking. Among these are Child Abuse and Neglect in the Military Community-Annotated Bibliography, and Child Protection in Military Communities.

8. Children are perhaps the most defenseless of all criminal victims. When the source of their fear is someone in their own home, the result is a tragedy beyond comprehension. Comparisons of the number of reported instances of child abuse to the number of prosecutions indicate that, for many reasons, this crime is too often overlooked. As prosecutors, we can only insure that every resource is utilized and every effort is expended in bringing the guilty person to justice.

CPT THOMAS J. BENJAMIN
Chief, Military Justice
Fort Meade, MD

[TCAP note: The National Clearinghouse on Child Abuse and Neglect Information, to which CPT Benjamin referred, will do the computer search of its data base and send you a complete printout. There is no charge to you or to the Army. The Clearinghouse's information specialist, Fred Parris, in conjunction with Attorney Younes, will assist you in tailoring the computer search to your particular needs. The Clearinghouse will also send you a catalogue of its available publications. For a computer search or for a catalogue, call (703) 558-8222, or write to the address in CPT Benjamin's article.]

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DEPARTMENT OF THE ARMY
HEADQUARTERS, FORT GEORGE G. MEADE
FORT GEORGE G. MEADE, MARYLAND 20755

REPLY TO
ATTENTION OF:

AFZI-JA-MJ

14 March 1983

SUBJECT: Letter of Appreciation, MAJ Ronald M. Reeves, M.D.

THRU: Commander Jerry D. Spencer, M.D., J.D.
Chief, Division of Forensic Pathology
Armed Forces Institute of Pathology
Washington, D.C. 20306

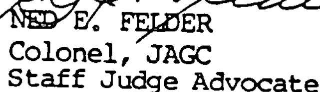
TO: Major Ronald M. Reeves, M.D.
Division of Forensic Pathology
Armed Forces Institute of Pathology
Washington, D.C. 20306

1. I wish to express the sincere appreciation of both the Post Commander, COL Giac P. Modica, and myself for the invaluable assistance you rendered to us in a recent investigation of a child homicide. You performed the autopsy in this case and made numerous trips to Fort Meade to assist the prosecutors and defense in preparation for an Article 32 investigation. Attorneys on both sides of this case have expressed to me their personal gratitude for the time and effort expended by you in explaining to them your autopsy findings, and educating them in the complexities of forensic pathology.

2. I reviewed the transcript of your extensive testimony at the Article 32 investigation, and had several opportunities to discuss the case with you directly. Your ability to translate medical evidence into tangible and understandable terms is truly remarkable. I was particularly impressed by your initiative in considering alternate explanations for the cause of death and determining their plausibility by medical analysis and consultation with other experts. You exhibited enthusiasm and dedication that are true credits to the medical profession and to the Army Officer Corps.

3. You continue to impress me and other members of the Judge Advocate General's Corps with your willingness to share your knowledge and expertise at any time, and often at personal inconvenience. An example is your recent lecture at the Regional Seminar for Army Prosecutors held at Fort Belvoir. I can assure you that your expertise and devotion to duty have already had a powerful impact, both on those law enforcement personnel who have dealt with you and those who have merely heard of your reputation. The result has been a heightened awareness of the serious problem of child abuse in the military.

4. Thank you.



NED E. FELDER
Colonel, JAGC
Staff Judge Advocate

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
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CASE: SM, 2 week WM

INVESTIGATED BY: Naval Investigative Service

MEDICAL EXAMINER'S OPINION: Case NOT referred to Medical Examiner

HISTORY: Two week old child was rushed to Tripler AMC essentially brain dead. Father, who for the first time had been left alone with the child, said child had a seizure while he was changing SM's diaper.

When he first rushed into the hospital, he was challenged by a doctor who asked "What did you do to him". The father was caught off guard and said - "I didn't do anything". After that, everyone left him alone and before long he was treated like the victim.

The pathologist who did the autopsy was not qualified to do such a case and misinterpreted the injuries and failed to identify others which were obviously important. The Medical Examiner was never notified.

I came across this case in a routine review of old cases and had the case reopened. By reviewing the medical records, autopsy report and investigation reports, it was determined that this was a Classic Shaking Whiplash Infant Death Case which could not be accidental. The case was presented at an Article 32 and subsequently at a General Court Marshal. See the attached letter.

KEY POINTS: Any death of a child deserves an autopsy by a competent forensic pathologist who understands the unique and unusual characteristics of child abuse cases. If that is not done, the case should be reviewed by such an expert. Re-autopsy may be indicated in selected cases.

Investigators assigned to such cases should be specially trained for this type of work and must be willing to question the medical examiner or anyone else to make sure no steps are left unturned.

If this child had sustained the trauma at birth, it would never have left the hospital alive. Much less gain weight and feed and develop normally.

Any death of a child should be handled as a homicide until proven otherwise. All deaths must be autopsied (completely) by Forensic Pathologists with special training and expertise in child abuse.

DEPARTMENT OF THE NAVY
NAVAL LEGAL SERVICE OFFICE
BOX 124
PEARL HARBOR, HAWAII 96860

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
Tallahassee, Florida 32308

In reply refer to

4 August 1983

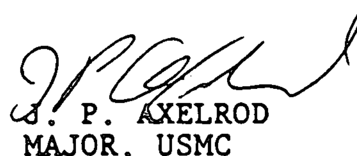
From: Senior Trial Counsel
To: Commanding Officer, Armed Forces Institute of Pathology

Subj: Letter of Appreciation for Major Ronald L. Reeves, Medical Corps, U. S. Army, in the General Court-Martial case of UNITED STATES v. Dennis W. MITCHELL, U. S. Navy

1. In the above case Dr. Reeves routinely reviewed a Naval Investigative Service report concerning the untimely death of the above accused's two week old infant son. The report concluded that birth trama could not be ruled out as the cause of the infant's death. This opinion was predicated upon an erroneous opinion of a resident pathologist who performed the autopsy and who was inexperienced in forensic pathology, particularly infant cases.

2. Dr. Reeves later review of the Naval Investigative Service Report and his subsequent investigation of the case disclosed that the child died of whiplash shaking syndrome. His identification of the mechanism of death led to further investigation by local authorities and, ultimately, to Seaman Mitchell's trial by general court-martial. Dr. Reeves' pretrial testimony was the catalyst for the accused's later decision to acknowledge his wrongdoing and to plead guilty to involuntary manslaughter. Dr. Reeves' testimony at trial was instrumental in securing the accused's sentence which included Dishonorable Discharge and confinement at hard labor for three years, the maximum punishment jurisdictionally permissible. Dr. Reeves was able to make complicated medical concepts easily understandable to all who listened.

3. Dr. Reeves' is hereby commended. Through his dedicated efforts an offender has been brought to justice whose crime would have otherwise gone undetected.



J. P. AXELROD
MAJOR, USMC

Copy to:
Dr. Reeves

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashire Lane
Tallahassee, Florida 32308

CASE: FW: 10 month old male

INVESTIGATED BY: Naval Investigative Services and the FBI (Territory of Guam)

HISTORY GIVEN BY FATHER: On September 9, 1983, at about 5:00 p.m., the father had laid FW down for a nap. About one hour later he was found dead by the father. Autopsy was done by Naval Pathologist. He could not determine cause of death although it appeared to be due to asphyxia. Findings were also consistent with a SIDS death.

The case was referred to the Regional Forensic Pathologist Consultant for the Navy at San Diego. He concluded it could be signed out as a SIDS although he could not exclude a homicide. He also could not say it was a homicide.

The case was then referred to the AFIP where the Chairman of the Department concluded that the case was suspicious, but went on to say that the manner of death was undetermined.

While the Navy was proceeding with its investigation, Dr. Reeves was contacted by the FBI to review the case. Based on the autopsy report and background investigation including FW's past medical history, Dr. Reeves advised that FW was smothered and also warned that the parents' new child's (due shortly after FW's death) life would be at great risk and it might also be killed. This was relayed directly to the U.S. Attorney in Guam by telephone. Because of opposing opinion from other Forensic Pathologists, no action was taken. This abruptly changed a couple of months later when the new child was taken to the emergency room in serious condition from asphyxia. Dr. Reeves was invited to present his case to the Federal Grand Jury in Guam which then indicted both the mother and father for murder, conspiring to commit murder and attempted murder.

DISCUSSION: The only difference between my review and that of everyone else is that I took all the facts into consideration - especially FW's past medical history. FW was seriously abused his whole life and was hospitalized five times in his short 10 months of life. No one wanted to call it child abuse until one of the last admissions when they finally took him out of the home. FW did great every time he was out of the home. He never did well at home. The day he died, he had only been returned to his mother and father from foster care for little more than one hour.

(Past Medical History is well summarized in pathology report - a copy is enclosed)

At trial, both parents pleaded guilty.

<u>PROBLEM:</u>

1. Diagnosis of child abuse was missed long before the fatal event. This death was predictable and preventable.
2. Pathologist took the time to review the extensive records of FW's past history - but then did not know how to use it.
3. The two experts simply blew it. They ignored the basic principles of forensic pathology. **You must consider all facts and evidence in context to all the surrounding events and circumstances.**
4. Background of parents strongly supports case.
5. Clear established pattern of repeated abuse - "the battered child syndrome".
6. "Failure to thrive" that is non-organic must raise the question of abuse and neglect.

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CLINICAL SUMMARY:

This infant was born in a civilian hospital in Oregon on 25 October 1982. The birth weight was 4 pounds 13 ounces. Both parents are 18 years of age and also have a 2 year old daughter. The father is an E-2 electrician. The mother is not employed outside the home. The family moved to Guam in mid-February.

Prior to this infant's death he had five hospital admissions. On 16 March 1983 he was admitted for failure to thrive at 4-1/2 months of age. He had been seen on several occasions at the Pediatric Clinic for weight loss. On 26 February he weighed 9 pounds 10-1/2 ounces. He declined in weight to 9 pounds 6 ounces on 6 March and 9 pounds 3 ounces on the day of admission. The mother reported difficulty with the baby frequently spitting up most of his formula. Physical examination revealed a cachectic appearing small 4-1/2 month old male with a marked decrease in subcutaneous tissue in all regions of the body and in the gluteal region in particular. He had a right hydrocele and perineal Candidiasis. The examination was otherwise unremarkable. During this hospital course the patient ate eagerly with minimal regurgitation. The infant initially was not socially responsive but after several days interacted more frequently with the Nursery staff with smiles and wanting to be held. He gained 1 pound 3 ounces over the 5-day hospitalization. The patient was discharged on 21 March weighing 10 pounds 6 ounces and in excellent condition. The patient was to follow-up in the Pediatric Clinic for weight check. The family was to confer with the hospital Social Worker and the Navy Relief Nurse.

Following discharge from the hospital the family failed to keep three scheduled appointments with the Pediatric Clinic. On 7 April 1983 the infant was readmitted to the hospital because of poor weight gain. In the interval between hospitalizations the child had lost 3 ounces and now weighed 10 pounds 3 ounces. The mother claimed to be feeding the infant up to 32 ounces of Isomil formula per day. She stated that she was using only one can of Isomil powder per week which would provide the baby with approximately 16-1/2 ounces of Isomil per day. The baby appeared thin and undernourished. There was moderately severe perineal Candidiasis with inguinal lymphadenopathy. Over the 20-day hospital course he demonstrated a weight gain of 36 ounces with demand feedings only. Child Protective Services was notified and was to visit the family twice a week. He was to be followed up in the Pediatric Clinic and arrangements for family visits by the Navy Relief Nurse were also made.

On 11 May 1983 the baby was seen in the Pediatric Clinic for a weight recheck. He had gained 6-1/2 ounces in the previous week. The parents, however, had noted pain on movement of the right leg for several days prior to the visit. An examination revealed a tense, tender, and swollen right thigh. There was pain on motion and manipulation of the right leg. Also noted was a moist sounding cough that occurred more frequently at night and in the early morning. This was felt to represent reactive airway disease. An x-ray revealed a spiral fracture of the left tibia and a periosteal elevation of both tibia, more pronounced on the right. There was a periosteal reaction of the right femur. The parents had no definite explanation for the injuries. A bone scan 2 days after admission at Guam Memorial Hospital showed increased uptake of the right mid-femur and mid-tibia on the left confirming the suspected fractures. A Spica cast was applied. The patient was discharged to foster care by court order on 27 May 1983.

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On 3 June 1983 Franklin was readmitted to the hospital by the foster parents because of difficulty managing the cast. The foster mother had been up for the previous 4 to 5 nights because of diarrhea and irritability. An admission physical examination revealed a right hydrocele and a questionable hernia. There was a red raw diaper dermatitis with satellite lesions extending over the entire back and groin and anterior thigh. Stool cultures were negative for enteric pathogens. A seborrheic dermatitis over his face and behind the ears was treated with 1% Hydrocortisone. The rash improved over 3 to 4 days. The Spica cast was removed on 10 June and he was discharged to his foster parents on 13 June.

On 1 September 1983 he was admitted for repair of the right inguinal hernia. He did well and was discharged to his foster parents on 2 September 1983.

On 9 September 1983 at 1300 hours he had his second DPT-OPV vaccine at the Andersen Air Force Base Clinic. His foster parents reported that he had had a slight intermittent cough for the previous few days. At 1530 on 9 September he was returned to his natural parents. They reported him intermittently crabby and attributed this to his injection earlier in the day. The father reports that he laid Franklin down for a nap on his back at approximately 1700. He checked on him 10 to 15 minutes later and he was on his stomach breathing normally. The father checked on him again around 1730. The mother went to awaken him for supper at 1800 and found him blue and unresponsive, with his face down in a pillow. The father attempted mouth-to-mouth resuscitation. He was brought to the U.S. Naval Hospital, Guam, Emergency Room by ambulance. Resuscitative efforts proceeded in the Emergency Room for about 30 minutes. He was pronounced dead at 1902 hours.

GROSS DESCRIPTION

EXTERNAL EXAMINATION:

The body is that of an unembalmed Caucasian infant that appears to be consistent with the stated age of 10-1/2 months. No contusions, abrasions, or lacerations are identified. The body weighs 18 pounds 8-1/2 ounces and measures 70 centimeters in length. The crown-rump length is 47 centimeters. Rigor mortis and moderate dorsal lividity are well developed. The scalp is covered by a small amount of fine hair. The head circumference is 45 centimeters. The irides are gray and the conjunctivae and sclerae are clear. The pupils are equal and measure 0.5 centimeters in diameter. Dentition is absent. The neck and thorax are symmetrical and free of palpable masses. The chest circumference is 45.5 centimeters. The abdomen is flat. No abnormal masses are palpable. The abdominal circumference is 42.5 centimeters. The genitalia are normally developed. The extremities are normally developed and are otherwise unremarkable. The back is unremarkable. Vertical incisions into the subcutaneous adipose tissue are made in the buttocks and down the posterior surface of both legs extending to the lower calves. No subcutaneous hemorrhage is noted. The following evidence of treatment is present: An NG tube is in place, an oral tracheal tube is in place, an arterial line is in place in the right inguinal region, EKG electrode patches are in place on the chest and abdomen, there is a partially healed right lower quadrant transverse incision measuring 4.0 centimeters in length.

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U.S. Department of Justice

United States Attorney
District of Guam

DPV(03):vsp
CR-7/WttsBrZu

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Telephone: 472-7332/7283

October 14, 1984

Ronald L. Reeves, M.D.
Associate Medical Examiner
Broward Medical Examiner's Office
Department of Pathology
Division of Forensic Pathology
5301 S.W. 31 Avenue
Fort Lauderdale, Florida 33312

Re: United States v. Watts, Criminal Case No. 84-00029,
District Court of Guam

Dear Dr. Reeves:

The defendants in the above-entitled case were sentenced on October 12, 1984. Franklin Eugene Watts, Jr. received life imprisonment and Deanna Watts received ten years imprisonment, both the maximum possible sentences to the charges under which they pled. This office is especially thankful for your genuine cooperation and admirable professionalism which made this prosecution a reality.

As you already know, this case could very well have not been prosecuted for various reasons. It was only through your sustained and vigorous support that two murderers were convicted. I personally felt very strongly about this case as I know you did. Although In the great scheme of things, it may not have the lasting notoriety of some national prosecutions, I have drawn more personal satisfaction from this prosecution than from many others.

I hope your own professional satisfaction was equal to my own.

Sincerely,

DAVID T. WOOD
United States Attorney
District of Guam

By: D. PAUL VERNIER, JR.
Assistant U. S. Attorney

Ronald L. Reeves, M.D.
Forensic Pathologist
4770 Lancashure Lane
Tallahassee, Florida 32308

<u>CASE:</u> AM 6 Year Old WF

<u>INVESTIGATED BY:</u> Ocala Police Department

<u>MEDICAL EXAMINER'S OPINION:</u> Child Died of Asphyxia due to Strangulation and Entrapment in a Refrigerator.

<u>STATEMENT BY PARENTS:</u> None. It was later determined that the father was home intoxicated and the mother was out with her boyfriend.

<u>DISCUSSION:</u> Based upon the medical examiner's opinion, the motel owner, an elderly lady who had owned and operated this small business for more than twenty years, was arrested on Christmas Eve and charged with manslaughter under an outdated and unused felony abandonment law for leaving an abandoned refrigerator on her property allowing this child to get killed.

This is an extremely interesting case since it illustrates so many things that should be done and should not be done. There was no adequate investigation done by anyone. Noone ever attempted to determine who murdered this child because everyone was so intent on prosecuting the motel owner under this outdated and vague law. The big problem is that the child did not die because she was entrapped in the refrigerator. She died because someone strangled her and then tried to dispose of the body in a hurry by stuffing it in the refrigerator. This was proven by showing that the lividity in the child was formed after death (which any competent forensic pathologist knows will happen) instead of having developed prior to death as the medical examiner had determined.

After this mistake was explained to the medical examiner and he had an opportunity to consult with other forensic pathologists, he went to the Judge on the day the trial started and told him that he would not be able to testify as to the cause of death. The case was dismissed against the hotel owner. Noone has ever been charged in this case because an investigation was never done. Local authorities have not been willing to try to determine who actually killed the child.

<u>COMMENTS:</u> This is a classical example of a case that never had a chance. There has to be a timely and complete investigation in any death of a child - especially one who should have immediately been recognized as being a homicide victim. The negligence on the part of law enforcement and the medical examiner caused extreme mental anguish and suffering for this elderly lady who had done nothing wrong. The prosecutor was so intent on trying her that he never stopped to think about the evidence or the lack of evidence. This tragic type of case should never occur and can be prevented only by corporation between all parties who are competent in their own field of expertise.

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UNUSUAL CASES AND PROBLEMS

1. A Medical Examiner in a large metropolitan office, autopsied a small child who had been brought into an emergency room DOA. The autopsy revealed that the child had died of a ruptured A-V vascular malformation. There was no significant investigation done.

Several years later I was asked to review the case because two doctors in a hospital were being sued for malpractice in not recognizing the fact that the child had a bleed of the brain. Review of the case proved that in fact the child died of blunt head trauma. We were able to prove, based on the age of the injury that there was no negligence on the part of any physician. However, because of a lack of any evidence or investigation to document who may have injured the child the case could not be prosecuted. All deaths involving children must be investigated as homicides until proven otherwise.

2. A Forensic Pathologist in Colorado testified that a child had died of severe blunt head trauma. He specifically stated that the dura was lacerated and there was a skull fracture which involved the entire skull. Interestingly, he described the brain has being perfectly normal. This contradiction should have been picked up by everyone involved including the investigators and prosecutors. The dura is extremely strong and cannot easily be torn. If there is enough force to tear the dura, the brain will be severely destroyed. Review of his autopsy photographs revealed that the severe skull fracture was only where he had cut the skin in order to reflect the scalp. The damaged dura was caused by his poor technique in removing the brain. This child was murdered but not in the way described and testified to by this pathologist. Obviously, this is a dangerous situation for a prosecutor to go into trial especially if the defense has a competent medical consultant.

3. A trial in Georgia regarding a child with immersion burns of both hands resulted in the defense bringing in five (5) forensic pathologists to dispute my contention that these were non-accidental injuries. To prove otherwise, we asked each expert to show how the hands were placed in the water. Not one of the experts could do that because none of them had stopped to actually determine what had happened and certainly never expected such a question in court. There answers varied. On rebuttal, with permission of the court, I rolled up my sleeves, used a magic marker and duplicated the burn pattern on my own hands and arms. There expert who was present at that time

agreed that it was a correct duplication of the burns. I then immersed my hands in some soapy water prepared for this demonstration and in fact showed to everyone's satisfaction that the injuries were inflicted immersion burns and that the hands were turned a 180 degrees from the way the defense experts had concluded. This illustrates several points. You don't have to accept the opinions of any expert at face value. The expert must be able to explain and support his opinion. Many experts that are for hire spend very little time trying to understand the truth since all they are interested in is testifying as to what the defense attorney wants him to say. They don't expect anyone to challenge them on specifics.

4. A small child in Georgia was rescued by his mother from his crib that had been engulfed in flames inside of their house trailer. The mother was considered a hero (by some) and there was virtually no investigation. The prosecuting attorney asked me to review the case. This is truly one of the most interesting cases I have ever seen. Review showed some horrible errors in investigation, documentation, and interpretation. Some of the errors made include:

1. There was no accidental fire. The fire was the result of arson started by the mother. When the investigators were given this opinion, the State Fire Marshal investigated and said that it was an accidental fire because there was a Bic Lighter at the foot of the bed. There was clear evidence of an accelerant. No fire studies were done.
2. The burns on the child were from hot water and not from a flame.
3. When asked, investigators said when the child was brought out of the fire that it was clothed in clean freshly pressed pants and shirt. THERE WAS NO SOOT. THERE WAS NO SINGEING OF THE HAIR. THERE WAS NO CARBON MONOXIDE INHALATION. THE CLOTHES WERE SPOTLESS AND HAD NO FIRE DAMAGE ALTHOUGH THE CLOTHING COVERED MANY AREAS THAT WERE BURNED. Anyone should realize that when a fire burns someone through their clothing bad enough to leave an injury, you would expect some damage to the clothing as well.
4. The mother stated that she had noticed the smoke while she was outside the house trailer which was closed. His room was also closed at the other end of the trailer. The child would have been dead from smoke inhalation before the mother would have even seen the smoke.

MOTHER WAS CHARGED WITH CHILD ABUSE AND ARSON. SHE CONFESSED AT HER TRIAL.

PROSECUTION OF NON-FATAL CHILD ABUSE CASES MUST BE

HANDLED JUST AS VIGOROUSLY AS DEATH CASES. Attached is a selected article from the September 1983 Trial Counsel Forum. This is a publication of the Trial Counsel Assistance Program of the United States Legal Services Agency. This is provided only to show how a prosecutor can use some of the same ideas to prosecute non-fatal cases of child abuse.

One key consideration must be given to all cases. That is the prosecutor, investigator and medical expert must consider all possible explanations for injuries and/or a death. This should be obvious but surprisingly it is commonly overlooked. This approach must start at the very beginning of any investigation and by necessity will be carried through to the end of the trial.

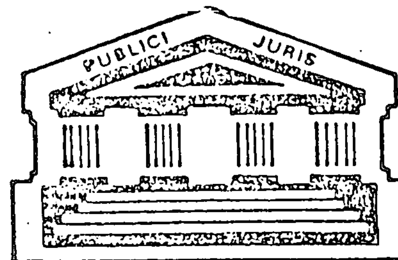
The purpose is to determine the truth and prosecute the guilty. If this is done, then the innocent will be protected. This concept is basic to any investigation that I am involved in. No expert should ever give an opinion without knowing all the facts. Once an opinion is reached, you must be able to support and prove it. This can only be done if all other possibilities have been excluded.

The trial is not the time to consider alternatives. That ideally should have been done and completed prior to even filing any charges. It must be continually reviewed and updated as the investigation proceeds. This can only be accomplished by a close working relationship between prosecutor, investigator and medical experts. I strongly recommend that other possibilities that might come up be presented up front by the prosecutor. It certainly makes you look more creditable and shows the jury you are only interested in determining the truth.

The attached Florida Supreme Court Decision addresses this issue.

TRIAL COUNSEL

FORUM



Vol. II, No. 9 September 1983

Winning the "Unfounded" Case: Use of Expert Medical Opinion

On 29 September 1982, while she was in her family's Fort Benning quarters with her stepfather, 15-month-old Tabitha Smith sustained second-degree burns over 20% of her body. The child was taken to Martin Army Community Hospital for treatment and an investigation was initiated by the CID. Tabitha was immediately photographed by the hospital photographer from six different angles.

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Private Jimmy Dean Smith, Tabitha's stepfather, gave the following account of what had happened: He had placed Tabitha in the bathtub and ran several inches of lukewarm water. He turned the water off and went to the kitchen to wash the supper dishes. Twenty minutes later, he heard Tabitha scream. He ran into the bathroom to see the child crawling away from the now-running water. After registering "deception indicated" on a polygraph examination, Private Smith changed his story slightly. He said he had left warm water running when he left Tabitha in the bathtub, and had been reluctant to admit that fact because he was afraid his wife would no longer trust him with the child. He then "passed" a second polygraph examination.

On 6 October 1982, the case agent went to the Smith quarters and placed the child in the bathtub. The faucet was at the level of the standing child's shoulder, which, in his opinion, was the most severely burned area. The child tried to turn the water on while standing in the tub. The agent measured the water temperature; it reached 140 degrees in a matter of seconds.

The local pathologist opined that the burns could have been intentionally inflicted or could have been caused accidentally. In the face of this evidence, and with the concurrence of one of the trial counsel, the agent "unfounded" the case against Private Smith.

In January 1983, Dr. Ronald Reeves of the Armed Forces Institute of Pathology (AFIP), examined the photographs. It was his opinion that the burns were intentionally inflicted, and that there was absolutely no way that they were accidentally sustained. On the strength of this opinion, Private Smith was charged with one specification of aggravated assault.

At general court-martial in August 1983, the Government presented the statement of Private Smith, the photographs of Tabitha Smith, and the testimony of Dr. Reeves. The defense, in support of its claim of accident, presented the testimony of the accused, of the CID agent, and of the soldier who later moved into the Smith quarters and had problems with the extreme heat of the water. Private Smith was convicted of assault with a means likely to produce grievous bodily harm and was sentenced to DD, CHL 1 year, and forfeiture of $275.00 per month for 12 months.

This case points up the necessity for the trial counsel to become actively involved in case investigation right from the start. Subsequent cases of suspected child abuse at Fort Benning have verified the reluctance and/or inability of local medical authorities to render strong, decisive opinions as to the cause of a child's injuries, and to stick to those opinions on close questioning. If the trial counsel discovers that weakness early, she can direct the CID to forward photographs to the AFIP for expert opinion. (The AFIP does review such cases routinely, but often this is several months after the fact.)

In the Smith case, the AFIP provided the strong, logical testimony of Dr. Reeves. Not only did he explain how the injuries were inflicted, but he explained how they could not possibly have been sustained as the accused stated. The AFIP also provided an artist's rendering of the manner of infliction of the burns which illustrated Dr. Reeves's testimony. I urge all trial counsel not to overlook this exceptional asset in the investigation and trial of child abuse cases.

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Criminal law—Circumstantial evidence—Where the only proof of guilt is circumstantial, no matter how strongly the evidence may suggest guilt, a conviction cannot be sustained unless the evidence in inconsistent with any reasonable hypothesis of innocence—Motion for judgment of acquittal should be granted in circumstantial evidence case if the state fails to present evidence from which jury can exclude every reasonable hypothesis except that of guilt—Error for appellate court to reverse conviction where state introduced evidence from which jury could have reasonably rejected defendant's hypotheses of innocence

STATE OF FLORIDA, Petitioner, vs. RONNIE S. LAW, Respondent. Supreme Court of Florida. Case No. 69,976. July 27, 1989. Application for Review of the Decision of the District Court of Appeal—Direct Conflict of Decisions. Robert A. Butterworth, Attorney General; and Maria Ines Suber, Gregory G. Costas, Bradford L. Thomas, Assistant Attorneys General, and Richard E. Doran, Assistant Attorney General, Acting Director, Criminal Division, Tallahassee, Florida, for Petitioner. Arthur A. Shimek of Shimek and Associates, P.A., Pensacola, Florida, for Respondent.

(EHRLICH, C.J.) We have for review a decision of the First District Court of Appeal, *Law v. State*, 502 So.2d 471 (Fla. 1st DCA 1987), because of apparent conflict with *Lynch v. State*, 293 So.2d 44 (Fla. 1974). We have jurisdiction. Art. V, § 3(b)(3), Fla. Const.

The question presented is whether a trial judge may send a criminal case to the jury if all of the state's evidence is circumstantial in nature and the state has failed to present competent evidence sufficient to enable the jury to exclude every reasonable hypothesis of innocence. Stated another way, does the common law circumstantial evidence rule apply when a trial judge rules on a motion for judgment of acquittal? We agree with the district court that the rule applies, but disagree that applying the rule to the facts of the instant case required the trial judge to grant Law's motion for judgment of acquittal.

The law as it has been applied by this Court in reviewing circumstantial evidence cases is clear.[1] A special standard of review of the sufficiency of the evidence applies where a conviction is wholly based on circumstantial evidence. *Jaramillo v. State*, 417 So.2d 257 (Fla. 1984). Where the only proof of guilt is circumstantial, no matter how strongly the evidence may suggest guilt, a conviction cannot be sustained unless the evidence is inconsistent with any reasonable hypothesis of innocence. *McArthur v. State*, 351 So.2d 972 (Fla. 1977); *Mayo v. State*, 71 So.2d 899 (Fla. 1954). The question of whether the evidence fails to exclude all reasonable hypotheses of innocence is for the jury to determine, and where there is substantial, competent evidence to support the jury verdict, we will not reverse. *Heiney v. State*, 447 So.2d 210 (Fla.), *cert. denied*, 469 U.S. 920 (1984); *Rose v. State*, 425 So.2d 521 (Fla. 1982), *cert. denied*, 461 U.S. 909 (1983), *disapproved on other grounds*, *Williams v. State*, 488 So.2d 521 (Fla. 1986).

The state contends that applying this rule when considering a defendant's motion for judgment of acquittal would run afoul of previous statements from this Court regarding the standard of review applicable to such motions. The state argues that the standard applied by the district court in *Fowler v. State*, 492 So.2d 1344 (Fla. 1st DCA 1986), *review denied*, 503 So.2d 328 (Fla. 1987), upon which its *Law* opinion is founded, conflicts with this Court's holding in *Lynch*.[2] The state contends that because a defendant, in moving for a judgment of acquittal, admits not only the facts as adduced at trial, but also every conclusion which is favorable to the state which may be reasonably inferred from the evidence, the trial court should not be required to grant a judgment of acquittal simply because the state has failed to present evidence which is inconsistent with the defendant's reasonable hypotheses of innocence.

Upon careful consideration, we find that the view expressed in *Lynch* and that expressed by the district court below in the instant case and in *Fowler* are harmonious. A motion for judgment of acquittal should be granted in a circumstantial evidence case if the state fails to present evidence from which the jury can exclude every reasonable hypothesis except that of guilt. *See Wilson v. State*, 493 So.2d 1019, 1022 (Fla. 1986). Consistent with the standard set forth in *Lynch*, if the state does not offer evidence which is inconsistent with the defendant's hypothesis, "the evidence [would be] such that no view which the jury may lawfully take of it favorable to the [state] can be sustained under the law." 293 So.2d at 45. The state's evidence would be as a matter of law "insufficient to warrant a conviction." Fla. R. Crim. P. 3.380.

It is the trial judge's proper task to *review* the evidence to determine the presence or absence of competent evidence from which the jury could infer guilt to the exclusion of all other inferences. That view of the evidence must be taken in the light most favorable to the state. *Spinkellink v. State*, 313 So.2d 666, 670 (Fla. 1975), *cert. denied*, 428 U.S. 911 (1976). The state is not required to "rebut conclusively every possible variation"[3] of events which could be inferred from the evidence, but only to introduce competent evidence which is inconsistent with the defendant's theory of events. *See Toole v. State*, 472 So.2d 1174, 1176 (Fla. 1985). Once that threshold burden is met, it becomes the jury's duty to determine whether the evidence is sufficient to exclude every reasonable hypothesis of innocence beyond a reasonable doubt.

If the rule were not applied in this manner, a trial judge would be required to send a case to the jury even where no evidence contradicting the defendant's theory of innocence was present, only for a verdict of guilty to be reversed on direct appeal. We agree with the *Fowler* court that

> it is for the court to determine, as a threshold matter, whether the state has been able to produce competent, substantial evidence to contradict the defendant's story. If the state fails in this initial burden, then it is the court's duty to grant a judgment of acquittal to the defendant as to the charged offense, as well as any lesser-included offenses not supported by the evidence . . . . Otherwise, there would be no function or role for the courts in reviewing circumstantial evidence, as was stated so well in *Davis v. State*, 436 So.2d [196 (Fla. 4th DCA 1983)], 200: "If we were to follow the state's logic, a trial judge could never . . . grant a motion for judgment of acquittal pursuant to Florida Rule of Criminal Procedure 3.380 when the evidence [is] circumstantial. Instead, every case would have to go to the jury."

Fowler, 492 So.2d at 1347.

We now turn to the case at bar. This is a tragic case, which deserved, and has received, many hours of careful judicial consideration. The relevant facts are that respondent Ronnie S. Law was charged by indictment with first-degree murder caused during aggravated child abuse in the death of his girlfriend's three-year-old son, Louis James Dees IV, known as "Little Jim." Little Jim was found dead in his bed on the morning of February 10, 1985. The cause of death was established to be a subdural hematoma caused by blunt trauma to the head.

At trial, Law raised several hypotheses of innocence, including that Little Jim's mother, Carol Free, may have inflicted the fatal blow; that Little Jim's, then eight-year-old, brother, Robert, may have caused the fatal injury while "roughhousing" with his brother; that the fatal injury, along with other injuries to the child's body, were caused by a series of accidental falls during the forty-eight-hour period prior to the boy's death; and that Law may have accidentally inflicted the fatal injury while playing with Little Jim. At the close of the state's case, and again at the close of all the

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evidence, the defense sought a judgment of acquittal, arguing the state had failed to contradict Law's hypotheses of innocence. Those motions were denied, and the jury returned a guilty verdict on the lesser included offense of second-degree murder. Law was sentenced within the guidelines range to seventeen years in state prison.

On appeal, the district court found the state had failed to meet its burden of contradicting each of Law's hypotheses of innocence, and held as a matter of law the trial judge erred in sending the case to the jury. The state sought review by this Court.

In reversing the conviction, the district court failed to delineate which of Law's theories of innocence remained in its view viable, stating: "Without detailing the lengthy evidence presented at trial, we find that the evidence left room for several inferences of fact, at least one of which was consistent with appellant's hypotheses of innocence." 502 So.2d at 473. In the absence of such direction from the district court, we are required to consider each of Law's hypotheses.

1. The victim's mother may have delivered the fatal blow.

This theory which rests on Law's assertion that Carol Free was the last one to check on Little Jim, who was suffering from sinus congestion, the night he died was refuted by evidence that the fatal blow likely had been delivered well before Free entered the room to check on the child's breathing. Little Jim's brother Robert testified he was in the bedroom when his mother checked on Little Jim, but did not report a spanking or beating. Law also did not report hearing Little Jim cry out. Moreover, Robert's testimony supported the inference that Law had delivered the fatal blow before the children went to bed. Robert testified that he saw Law hitting Little Jim through an open bedroom door, and that upon noticing he was being observed by Robert, Law closed the door to complete the physical reprimand without being seen. Free was asleep in another room at that time. When Robert went to bed a short time later, he testified, Little Jim was lying not on his side, as was his custom, but on his back—the position in which his body was discovered the next morning—and his lips were discolored. This evidence was sufficiently contrary to Law's theory that Free delivered the fatal blow to allow the jury to consider this contention.

2. The older brother may have caused the fatal injury while "roughhousing" with Little Jim.

Dr. Ronald L. Reeves, an eminently qualified pathologist with substantial experience recognizing child injuries and child abuse, and Dr. Everett Havard, an equally qualified forensic pathologist, gave testimony refuting Law's theory that the subdural hematoma which caused Little Jim's death could have been inflicted during rough playing between Little Jim and Robert. The defense raised the possibility that the fatal blow may have come when Robert knocked the younger boy off his feet, causing Little Jim's head to strike a barbell. Dr. Reeves testified that not only would the wound caused by such a fall be significantly different from those found on the body of Little Jim, but there would be insufficient force behind such a blow to cause the fatal injury. The doctor testified that

> [i]t's very unusual . . . and rare for a child to sustain any type of injury falling . . . we're talking about a child who is only 36 inches high . . . [s]o the maximum fall is a tumble; it's just falling, and even if it accelerated the type of impact that you get, [falling] even against an object would not give us significant injury. . . So no, I don t think that's a plausible explanation.

Both doctors testified that in their opinion the death was a homicide. Dr. Reeves testified it was his professional opinion that the death was the result of "a brutal beating." This and other testimony of the pathologists clearly contradicts the hypothesis that the fatal injury could have been caused by "roughhousing" between the children.

3. The fatal injury, along with other injuries present on Little Jim's body, could have been caused by a series of accidental falls.

On this point, also, Dr. Reeves' testimony was sufficient to raise a jury question. The defense raised the possibility that the subdural hematoma and other injuries might have been caused by Little Jim falling off a bunkbed or tumbling down dunes during an afternoon trip to the beach. Dr. Reeves reviewed in detail the pattern of marks and bruises on the body, described the type of blow which would cause the fatal injury, and concluded that

> studies have indicated and shown and personal experience has shown children falling don't sustain significant injuries . . . [If] a child running 20 miles an hour through the room trips and falls head first on a pointed edge of something, yes, he could sustain an injury that could be significant, but it would cause a laceration and possibly a skull fracture, and other things we don't see [on the body of Little Jim]. It wouldn't give this diffuse pattern of injury. So I don't think that's plausible.

This testimony was sufficiently at odds with Law's theory to send the question to the jury.

4. Law may have accidentally inflicted the fatal injury while playing with Little Jim.

Defense counsel raised the possibility that Law may have accidentally caused the boy's head injury while the two were playing on the night of Little Jim's death: that in swinging the child playfully around the bedroom, he may have inadvertently caused the boy's head to hit the floor or the bunkbed. The record reflects, however, that Law himself did not believe this to be the case. Responding to an inquiry from defense counsel, Law testified:

> I didn't swing him hard. I was doing it slowly, and I got back around here, I was going to sit him back down. I don't know if he just didn't get his footing or if I slipped, my hand slipped, and then he fell, and he hit the floor. But when he come around, he was still far enough away, he put his hands out and caught himself, and I didn't hear him hit the bed or nothing. But I thought maybe he might have or something. So I checked him, but I couldn't really see no signs or anything.

The testimony of Dr. Reeves also was sufficient on this point to raise a question for the jury. He testified that there were few parts of the bunkbed which were of the right shape to cause the head injury found on the boy's body. He further testified that

> you would also have to assume that [Little Jim's head] just happened to hit one of those few small areas that happen to be flat, which is very unlikely to have happened. Then considering and putting into connotation with the distribution on the head, the fact that you get an area on the back of the head, that means the child has gone backwards . . . you read some study on skull fractures in children, you find they don't have any . . . . [T]he only time you see skull fractures of the occipital bones in some studies is by inflicted trauma; it doesn't occur accidentally.

Other testimony by Dr. Reeves further contradicted Law's theories, leaving no doubt that the trial judge properly allowed the case to go to the jury:

> Q: You stated . . . that there is no conceivable way that these injuries could have been sustained accidentally. Is that still your opinion, sir?
>
> A : Absolutely.
>
> Q : And upon what do you base that, briefly?
>
> A : Briefly, on the fact that considering every possible explanation, every conceivable cause that I can think of, *including everything that's been proposed as an explanation as to why the injuries are here in the distribution pattern and quantity and location that we have them, there is, in my opinion, absolutely no explanation that would explain this, other than intentionally inflicted trauma on this child.*
>
> Q: [Y]ou stated that the photographs of the bruises on the deceased body are not consistent with the spanking, but with a brutal beating. Is that still your conclusion, sir?
>
> A: Yes, it is.
>
> Q: If all of these things had happened to the child that very weekend, falling off the bunkbed, falling on the barbells, hitting the coffee table, getting hit by a bike, wrestling in bed, being swung around and hitting the bed, would any of those things have caused his death, in your opinion, in this case?
>
> A: For the same reasons I've said before, unless there are extraordinary circumstances that involved each and every one of those, which would mean excessive force, which is very unlikely if not impossible to have happened without some intervening factor, no, *that would not have accounted for the injuries* because there are too many injuries too diffuse and too diverse to, in fact, be accounted for by just a few isolated injuries. And again, you are taking it out of context when you examine something like this and you see multiple injuries, diffusely, to try to explain one here and one there is sort of absurd. Kids don't sustain multiple serious injuries, especially when they are isolated in various portions of the body, accidentally all the time. *I think that would be totally incredible, and the odds against that would be significant.*

(Emphasis added.)

Because we find that it is clear from the record that the state introduced competent evidence from which the jury could have reasonably rejected each of Law's theories, the result reached by the district court cannot stand. Accordingly, the opinion of the district court is approved in part, quashed in part, and the cause is remanded for further proceedings consistent with this opinion.

It is so ordered. (OVERTON, McDONALD, SHAW, BARKETT, GRIMES and KOGAN, JJ., Concur.)

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[1]For a comprehensive review of the rule as it has been applied in Florida see Jones v. State, 466 So.2d 301 (Fla. 3d DCA 1985), *approved*, 485 So.2d 1283 (Fla. 1986).

[2]In Lynch v. State, 293 So.2d 44, 45 (Fla. 1974), we said:

> A defendant, in moving for a judgment of acquittal, admits not only the facts stated in the evidence adduced, but also admits every conclusion favorable to the adverse party that a jury might fairly and reasonably infer from the evidence. The courts should not grant a motion for judgment of acquittal unless the evidence is such that no view which the jury may lawfully take of it favorable to the opposite party can be sustained under the law. Where there is room for a difference of opinion between reasonable men as to the proof of facts from which the ultimate fact is sought to be established, or where there is room for such differences as to the inference which might be drawn from conceded facts, the Court should submit the case to the jury for their finding, as it is their conclusion, in such cases, that should prevail and not primarily the views of the judge. The credibility and probative force of conflicting testimony should not be determined on a motion for judgment of acquittal.

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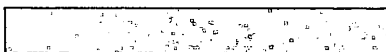
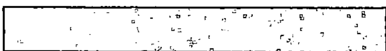
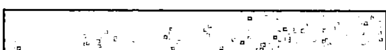
Wednesday

Case Scenarios

Child Abuse Investigations

Presented by
Jill Hiatt, J.D.
and
Terry Thomas

Investigation of Abuse

Review carefully the following scenarios. They will be used extensively in the "Investigation of Abuse" class. Please be prepared to participate in discussions of the scenarios.

Please review with prosecution in mind. Consider how the investigation should be conducted, what important points need to be covered by the investigation, anything that you believe was done wrong or could have been done better. Keep an open mind and be creative in your thinking. Consider what the probable defenses will be, the strengths and weaknesses of the case, and what information you would need to have before going to court.