1999 Crimes Against Children Conference

The 11th Annual Conference presented by
the Dallas Police Department
and the Dallas Children's Advocacy Center

August 2-5, 1999 ♡ Hyatt Regency Hotel ♡ Dallas, Texas

Your Name:_____

The Dallas Children's Advocacy Center and the Dallas Police Department dedicate this 1999 Crimes Against Children Conference Book to:

Hyatt Regency Hotel - Dallas

In appreciation of all they have done and continue to do for the benefit of children. Since the inception of the Center in 1991, they have spent over one thousand hours annually working with our children, helping with mailings and data entry and providing necessary repairs and cleaning in addition to donating beautiful receptions.

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The 1999 Crimes Against Children Conference is co-sponsored by:

Children's Advocacy Centers™ of Texas, Inc.

Federal Bureau of Investigation

Office of Juvenile Justice and Delinquency Prevention

and

Assistance League of Dallas

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Children's Trust Fund of Texas

Dallas Police Association

Dallas Office of the FBI

Fox Valley Technical College

Greater Dallas Crime Commission

Junior League of Dallas

Office of the Attorney General of Texas

Office for Victims of Crime

RGK Foundation

Texas Bar Foundation

Texas Child Fatality Review Team Project

We wish to thank the following agencies and individuals for their continued work for the protection of children and their support in making this conference possible:

Assistance League of Dallas

Dallas Children's Advocacy Center League

Dallas Police Association

Dallas Junior Forum

Harold's Stores, Inc.

Hyatt Regency Hotel - Dallas

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MobileComm

and

Many Dedicated Community Volunteers

We wish to thank the following agencies for their support in making this conference possible:

Alliance for Children

Catholic Counseling Services

Child Protective Services

Children's Assessment Center

Children's Medical Center at Dallas

Collin County Children's Advocacy Center

Collin County Sheriff's Office

Dallas County District Attorney's Office

Dallas Sheriff's Office

Federal Bureau of Investigation

Las Vegas Metropolitan Police Department

National Center for Missing and Exploited Children

Naval Criminal Investigative Service

Office of the Texas Attorney General - Crime Victims Compensation

Plano Police Department

Tarrant County District Attorney's Office

Travis County Children's Advocacy Center

United States Department of Justice

University of Texas Southwestern Medical Center Dallas

CITY OF DALLAS

THE DALLAS POLICE DEPARTMENT

The Dallas Police Department is known nationally as a leader in the investigation of crimes against children. This reputation is based not only on an efficient organizational structure, but also through a very strong commitment to the multi-disciplinary approach to these investigations through its partnership with the Dallas Children's Advocacy Center. Additionally, the Dallas Police Department has made a substantial commitment of both personnel and financial resources that enable it to have committed, pro-active, professional and highly trained detectives assigned to the investigation of child abuse.

The organizational structure of the Dallas Police Department provides for four specialized squads to respond to crimes against children. They are the **Child Abuse Squad, the Child Exploitation Squad , the Internet Crimes Against Children Squad and the Sex Offender Apprehension Program (SOAP)**. This structure ensures not only an efficient law enforcement response, but one in which the coordination of the other involved agencies is made possible. This is made possible because all investigations involving the abuse of children conducted through the Dallas Police Department are coordinated through the Dallas Children's Advocacy Center. Following is a description of the operation of each of these squads:

The **Child Abuse Squad** is responsible for the investigation of all cases of child abuse (both sexual and physical, including fatal cases) where the offender is either a family member or someone living in the child's home. This investigative responsibility matches the guidelines of Child Protective Services so as to provide a true team approach to child abuse investigations. In each case that is investigated by a Child Abuse detective, there is a Child Protective Services caseworker also assigned to the case. This approach allows for a coordinated response by both law enforcement and Child Protective Services, from the initial interview, through the many phases of the investigation, to the final disposition of the case. At every major step of the investigation, the detective and the Child Protective Services caseworker and/or their respective supervisors, are coordinating their response.

Questions like the following are routinely answered in this fashion or in the formal weekly case staffings:

- Who is the most appropriate person to conduct the initial interview of the child, the offender or the witnesses, police or CPS?
- Can the arrest of the offender be timed so as to prevent the emergency removal of the child from the home?
- Is it in the best interest of the child to testify against the offender or should the prosecutor attempt to plea bargain the case to prevent further trauma to the victim?

The **Child Abuse Squad** is comprised of eight detectives, one sergeant and one clerk. These personnel are physically located at the Dallas Children's Advocacy Center along with a unit of Dallas County Child Protective Services caseworkers.

S/N 753-027-318
POL-00152

The **Child Exploitation Squad** consists of three different sections under the supervision of one sergeant:

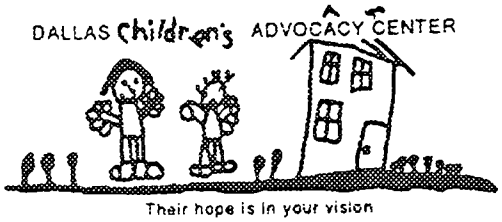
The **Child Exploitation Squad** is responsible for investigating sexual abuse and sexual exploitation of children committed by non-family members. Among the crimes investigated by this unit are stranger-stranger sexual assaults, child sexual abuse involving multiple offenders and/or victims, child pornography and juvenile prostitution. This squad conducts pro-active investigations and works on many incidents that are not reported to law enforcement. Both conventional methods and undercover investigations are utilized to accomplish this. While the personnel assigned to this squad are not physically located at the Dallas Children's Advocacy Center, and the majority of the cases investigated by this squad do not involve Child Protective Services, the same level of services to the child is afforded as this squad also coordinates all their investigations through the Dallas Children's Advocacy Center. This squad consists of six detectives and one research intelligence specialist.

The **Child Exploitation Squad** and the Dallas Office of the Federal Bureau of Investigation are currently operating a joint federal task force to combat crimes against children. This task force joins the local law enforcement jurisdiction with that of federal law enforcement to ensure these crimes are being addressed at every level of law enforcement.

The **Internet Crimes Against Children Squad** is responsible for investigating the sexual exploitation of children via the Internet. Among the crimes investigated by this squad are computer related child pornography and cases where the perpetrator uses the computer to meet and/or solicit children for sexual purposes or any other case of child exploitation involving computers. Both conventional methods and undercover investigations are utilized to accomplish this. This squad consists of one detective, one sheriff investigator and one assistant district attorney.

The **Sex Offender Apprehension Program (SOAP)** Squad is responsible for tracking registered sex offenders to ensure they are complying with the requirements of the registration law. This squad conducts hundreds of compliance checks every month to locate those registered sex offenders who are not obeying the restrictions and requirements placed on them by law. This squad is comprised of four detectives from the Dallas Police Department and three investigators from the Dallas County Sheriff's Department. This squad conducts weekly meetings to discuss investigative strategies. These meetings consist of personnel from the Dallas Police Department, Dallas County Sheriff's Department, Dallas County Community Supervision and Corrections Department (Probation), Dallas County District Attorney's Office, Texas Department of Criminal Justice (Parole Division), Texas Department of Public Safety (Texas Rangers), and the Federal Bureau of Investigation. Since this squad began operation in October 1997, approximately 700 arrests have been made of sex offenders.

The **Child Abuse Squad,** the **Child Exploitation Squad, Internet Crimes Against Children Squad** and the **Sex Offender Apprehension Program (SOAP)** are under the command of one lieutenant.



The Dallas Children's Advocacy Center: Teamwork to Help Abused Children

The tragedy of brutally abused children is one of the most devastating, yet largely hidden, crises confronting our city today.

More than 12,000 cases of child sexual and physical abuse were confirmed in Dallas County over the past three years. These horrifying acts often leave young children scarred for life, physically and emotionally. To see the effects of this abuse is shattering.

Until 1991, young victims in Dallas suffered through another nightmare — the tangled, painful and usually ineffective efforts of various disjointed agencies to investigate the abuse and punish the abusers.

The Dallas Children's Advocacy Center (DCAC), a not-for-profit organization, was formed by leading Dallas civic leaders to create a unique public/private partnership to confront this problem. It combines the public resources of the Dallas Police Department, Child Protective Services and the Dallas County District Attorney's Office with the private resources of Children's Medical Center, the Department of Pediatrics at the University of Texas Southwestern Medical Center and its own staff to create a fast and effective means to

- Investigate child abuse, and
- Help restore the child to physical and mental health.

This team approach has revolutionized the handling of child abuse cases in Dallas and has set a national standard for dealing effectively with society's youngest victims.

An agency staff dedicated to the issue is housed in a restored Victorian home on Swiss Avenue, where eight police detectives, seven Child Protective Services specialists and seven professional DCAC staff provide therapeutic counseling and conduct investigative work. Assistant district attorneys and medical personnel bring additional expertise to the team.

Together, they help children 14 years and younger and their non-offending family members through the investigation and treatment of the most severe and complex cases of sexual and physical abuse in Dallas County. The result has been an increased number of convictions of serious child abusers and more effective help for abused children.

Since the inception of the Advocacy Center in 1991, 2100 children have received treatment through the therapy program. In 1998, Dallas Children's Advocacy Center cases prosecuted through the Child Abuse Unit of the District Attorney's office recorded a conviction rate of 93%.

While government agencies pay the salaries of the personnel who serve at the Dallas Children's Advocacy Center, all other operating funds are generated by gifts from individuals, corporations and charitable foundations. This is truly a case that serves and depends on — all the people of the community.

6/10/99

Additional copies of the 1999 Crimes Against Children Conference notebook are available.

Please complete the attached form and mail with your payment to:

Dallas Children's Advocacy Center
P.O. Box 720338
Dallas, Texas 75372-0338
ATTENTION: Jessie Shelburne

Name _____

Agency _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

e-mail _____

$35.00 each for Single Copies

$25.00 each for Two or More Copies

$10.00 for Shipping & Handling

Texas residents please include 8.25% sales tax.

TOURS OF THE DALLAS CHILDREN'S ADVOCACY CENTER

The Dallas Children's Advocacy Center is located in a 3-story, turn-of-the-century house in historic east Dallas. The Dallas Police Department Child Abuse Unit and a team of Child Protective Service specialists are housed at the Center where they conduct investigations into physical and sexual child abuse. The Center also has a volunteer staff and a therapy center. The volunteers assist with the day to day operation of the Center along with greeting and attending child victims and their non-offending parents. The therapy center provides counseling to children whose cases are handled through the Center.

TOURS WILL BE CONDUCTED:

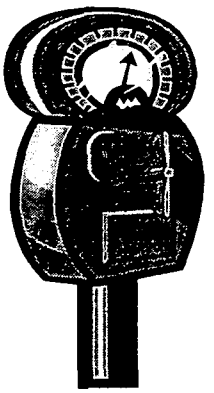
Monday, August 2, 1999
1:00 p.m.
2:45 p.m.

Tuesday, August 3, 1999
9:45 a.m.

Wednesday, August 4, 1999
9:45 a.m.
1:00 p.m.
2:45 p.m.

Thursday, August 5, 1999
9:45 a.m.

Please meet at the front entrance of the Hyatt Hotel 15 minutes prior to departure. A volunteer will greet you and you will be transported to the Dallas Children's Advocacy Center for a tour of the facility. Tours will be based on availability. See personnel at the information booth for more information about DCAC tours.



PARKING

There are several options for parking at the Hyatt Hotel:

1. Valet at front door $12.00/day

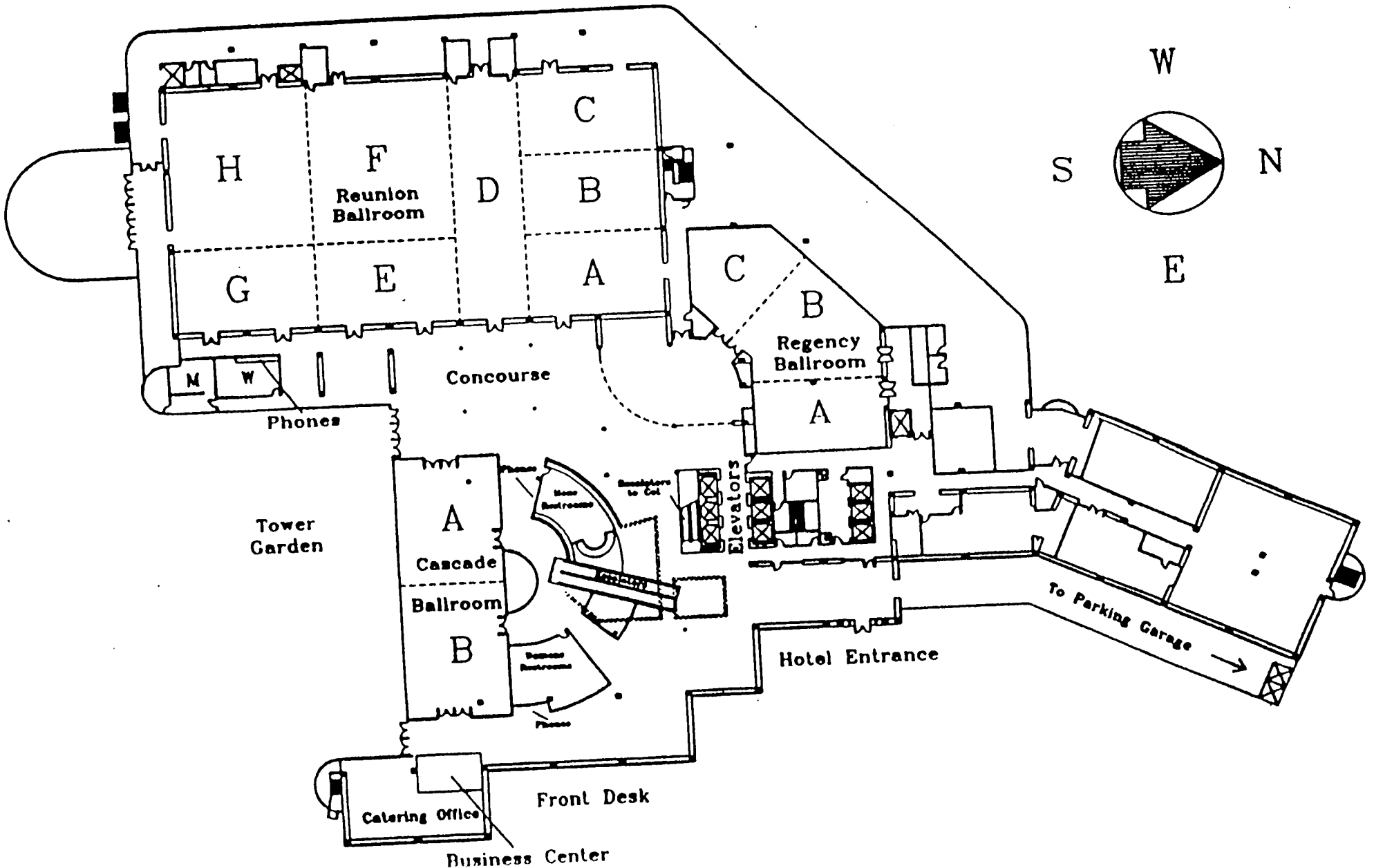
2. Self Park $7.00/day

   This lot is located on the north side of the hotel at the bottom of the hill.

3. Reunion Arena $2.00/non-event day
   $7.00/event day

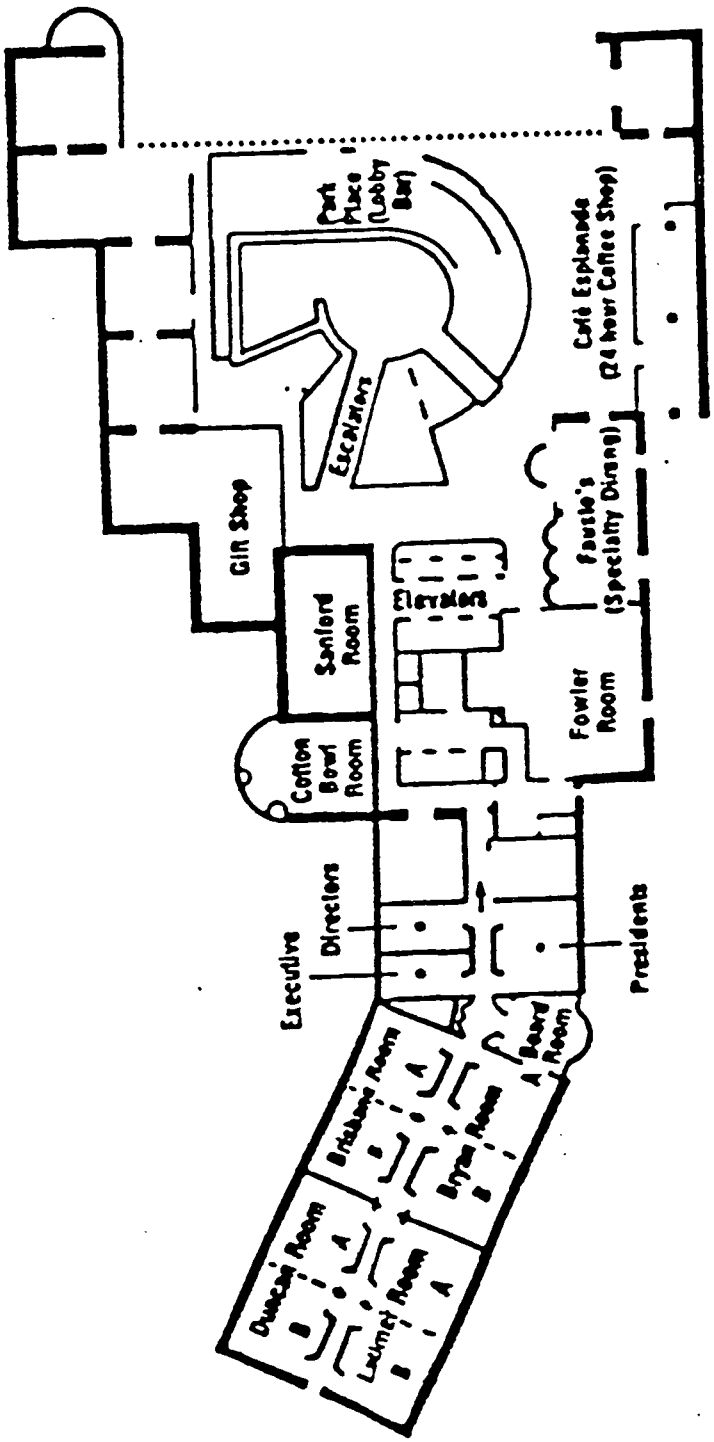
   This lot is located on the south side of the hotel. It is a little bit of a walk, but less expensive. We are not aware of any event occurring there during the week of the conference so the cost should be $2.00/day.

HYATT REGENCY DALLAS AT REUNION



Atrium Level

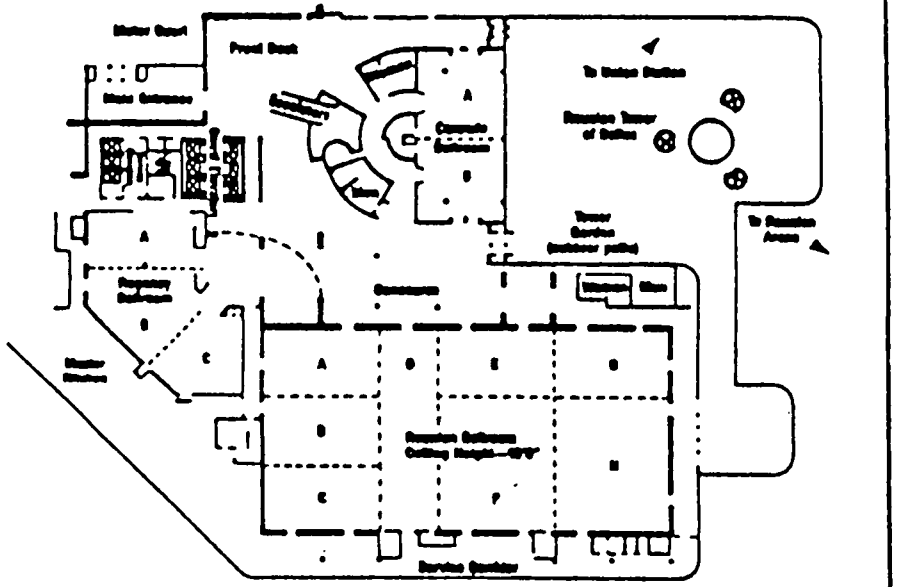
Restaurants/Cocktails/Meeting Rooms



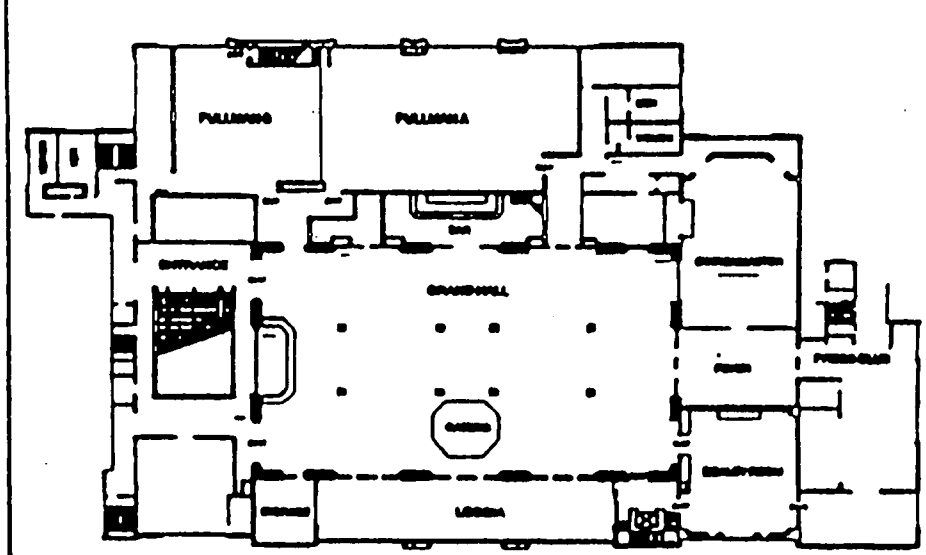
HYATT REGENCY DALLAS AT REUNION

HYATT REGENCY/UNION STATION FLOOR PLANS

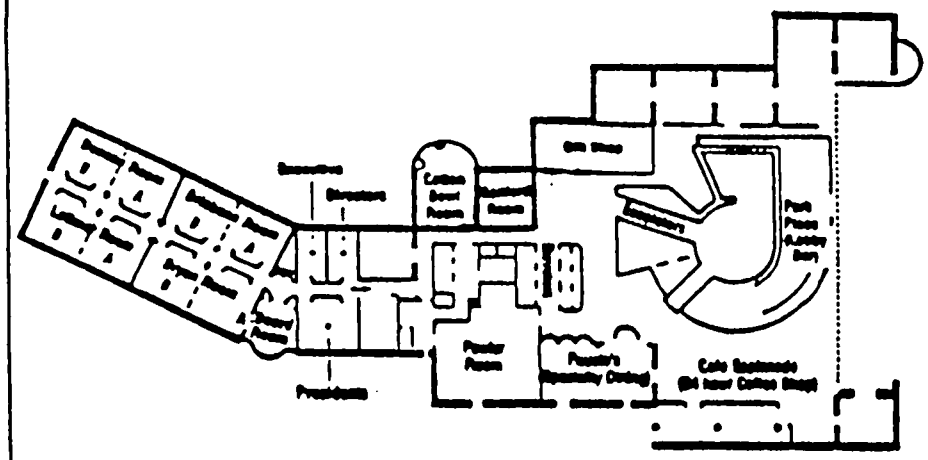
LOBBY LEVEL—Registration/Ballrooms/Union Station/Reunion Tower



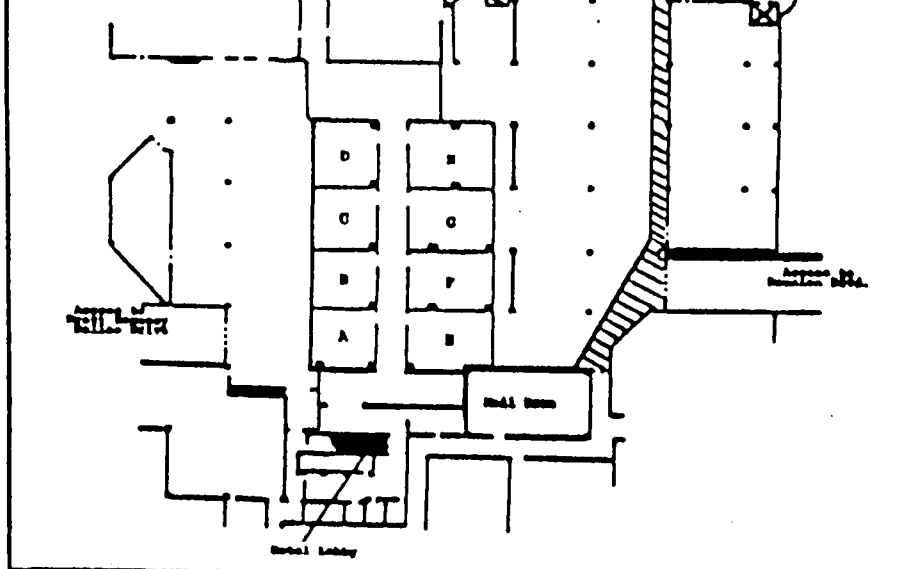
UNION STATION—Banquet and Meeting Facilities



ATRIUM LEVEL—Restaurants/Cocktails/Meeting Rooms



GROUND LEVEL-The Colonnade Exhibit Hall/Meeting Rooms



1999 Crimes Against Children Conference
Speaker Roster

Randell Alexander
Morehouse School of Medicine
Department of Pediatrics
720 Westview Dr., SW
Atlanta, GA 30310-1495
404/756-1330 (Phone)
404/756-1357 (Fax)

Daniel Armagh
National Center for Prosecution
of Child Abuse
99 Canal Center Plaza
Suite 510
Alexandria, Virginia 22314
703/519-1681 (Phone)
703/549-6259 (Fax)

Christopher Avery
Federal Bureau of Investigation
11700 Beltsville Drive #200
Calverton, Maryland 20705
301/586-4519 (Phone)
301/586-4499 (Fax)

Peter Banks
National Center for Missing & Exploited
Children
2101 Wilson Blvd.
Arlington, VA 22201-3077
703/235-3900 (Phone)
703/235-4067 (Fax)

Diane Birdwell
Office of the Attorney General
Crime Victims' Compsensation Division
512/936-1241 (Phone)

Dr. Mary E. Case
6039 Helen Avenue
St. Louis, MO 63134
314/522-6410 x 6500 (Phone)

Donald Cavender
Supervisory Special Agent
Federal Bureau of Investigation
FBI Headquarters
935 Pennsylvania Avenue, NW
Washington, DC 20535
540/720-4732 (Phone)
540/720-4792 (Fax)

James T. Clemente
Supervisory Special Agent
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia 22135
540/720-4732 (Phone)
540/720-4792 (Fax)

Martha Coakley
Middlesex District Attorney
40 Thorndike Street
Cambridge, MA 02141
617/494-4050 (Phone)
617/225-0871 (Fax)

Kellie Cole
Clinical Director
Collin County Children's Advocacy Center
1555 Ave K
Plano, Texas 75074
972/576-0814 (Phone)
972/578-1720 (Fax)

Andy Contreras
Contreras & Associates
1721 Brazos Trail
Plano, Texas 75075
972/881-0360 (Phone)
972/423-6861 (Fax)

Cathy Crabtree
Program Coordinator
Children's Advocacy Centers of Texas, Inc.
PO Box 4860
Austin, TX 78765-4860
512/441-4115 (Phone)
800/255-2574 (Phone)
512/441-4331 (Fax)

Robert Cummings
Dallas Police Department
106 S. Harwood Street #225
Dallas, Texas 75201
214/670-4683 (Phone)
214/670-3957 (Fax)

Colleen Doolin
Dallas County District Attorney's Office
Juvenile Division
2600 Lone Star LB 22
Dallas, Texas 75212-6307
214/698-2285 (Phone)
214/698-5551 (Fax)

James Doyle
Computer Investigations & Technology Unit
One Police Plaza, Room 1110D
New York, New York 10038
212/374-4247 (Phone)
212/374-4249 (Fax)
jrdoyle@ix.netcom.com

Cindy Dyer
Family Violence Unit
Dallas County District Attorney's Office
133 S. Industrial
Dallas, Texas 75207
214/653-3721 (Phone)

Jennifer Eakin
Supervisory Special Agent
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia 22135
540/720-4732 (Phone)
540/720-4792 (Fax)

Robert Hugh Farley
Federal Child Exploitation Strike Force
Cook County Sheriff's Police Department
1401 S. Maybrook Drive
Maywood, Illinois 60153
708/865-4875 (Phone)
708/865-6576 (Fax)

Lamoyne Farr
Federal Bureau of Investigation
11700 Beltsville Drive #200
Calverton, Maryland 20705
301/586-4519 (Phone)
301/586-4499 (Fax)

Byron Fassett
Dallas Police Department
Child Exploitation Unit
106 S. Harwood St., #225
Dallas, Texas 75201-5294
214/670-4982 (Phone)
214/670-3957 (Fax)

Tim Gallagher
Dallas County District Attorney's Office
Organized Crime Division
133 N. Industrial
Dallas, Texas 75207
214/653-3666 (Phone)

Nancy Hagan
Executive Director
Alliance for Children
908 Southland Avenue
Fort Worth, TX 76104
817/335-7172 (Phone)
817/335-8482 (Fax)

Nancy Hammer
National Center for Missing & Exploited
Children - International Division
2101 Wilson Blvd.
Arlington, VA 22201-3077
703/235-3900 (Phone)
703/235-4067 (Fax)

Marilyn Herrick
Manager-Child Advocate Program
Dallas Children's Advocacy Center
PO Box 720338
Dallas, Texas 75372-0338
214/818-2600 (Phone)
214/823-4819 (Fax)

Mark A. Hilts
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia 22135
540/720-4712 (Phone)
540/720-4790 (Fax)

Brian Holmgren
National Center for Prosecution
of Child Abuse
99 Canal Center Plaza
Suite 510
Alexandria, Virginia 22314
703/739-0321 (Phone)
703/549-6259 (Fax)

Michael V. Johnson
Plano Police Department
909 E. 14th Street
Plano, Texas 75074
972/516-2130 (Phone)
972/516-2037 (Fax)

1999 Crimes Against Children Conference
Speaker Roster

Brian J. Killacky
Chicago Police Department
Bureau of Investigative Services
Area Three Violent Crimes Unit
2452 West Belmont Avenue, 2nd Floor
Chicago, Illinois 60618
312/744-8261 (Phone)
312/744-5130 (Fax)

Gerry Klahr
Collin County Sheriff's Office
4300 Community Avenue
McKinney, Texas 75070
972/547-5100 (Phone)
972/547-5304 (Fax)

Ronald C. Laney
Missing and Exploited Children's Program
Office of Juvenile Justice
and Delinquency Prevention
US Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
202/616-7323 (Phone)

Kenneth V. Lanning
Supervisory Special Agent
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia 22135
540/720-4732 (Phone)
540/720-4792 (Fax)

Dan Lesher
Dallas Police Department
106 S. Harwood Street #225
Dallas, Texas 75201
214/670-5178 (Phone)
214/828-2611 (Fax)

Livia Liu
Dallas County District Attorney's Office
Organized Crime Division
133 N. Industrial
Dallas, Texas 75207
214/653-3821 (Phone)

Sandra Martin
Travis County Children's Advocacy Center
1110 E. 32nd Street
Austin, TX 78722
512/472-1164 (Phone)

Charles S. Masino
Phoenix Police Department
4232 W. Cielo Grande
Glendale, Arizona 85310
602/780-2187 (Phone)
602/780-2187 (Fax)

A. Todd McCall
Federal Bureau of Investigation
703/632-4507 (Phone)

David Montague
Tarrant County District Attorney's Office
401 W. Belknap
Fort Worth, Texas 76196
817/884-1622 (Phone)
817/884-1667 (Fax)

J. Tom Morgan
DeKalb County District Attorney's Office
DeKalb County Courthouse
Decatur, GA 30030
404/371-2561 (Phone)

Maureen O'Connell
Clinical Services Coordinator
The Children's Assessment Center
2500 Bolsover
Houston, Texas 77005
713/986-3492 (Phone)
713/986-3553 (Fax)

Gary O'Connor
Lower Gwyneed Township Police
1130 N. Bethlehem Pike
Spring House, Pennsylvania 19477
215/646-5300 (Phone)
215/646-8096 (Fax)

Bruce Duncan Perry
Baylor College of Medicine
713/770-3750 (Phone)

Donna I. Persaud, MD
Children's Medical Center
1935 Motor Street
Dallas, Texas 75235
214/456-2870 (Phone)
214/456-6390 (Fax)

Kate Porter
Dallas County District Attorney's Office
Child Abuse Division
133 N. Industrial
Dallas, Texas 75207
214/653-3706
214/653-3845

Kimberly Poyer
United States Attorney's Office
Special Proceedings Section
Washington, DC
202/305-4882 (Phone)
202/514-8784 (Fax)

Gary Purdue
University of Texas Southwestern
Medical Center at Dallas
5323 Harry Hines Blvd.
Dallas, Texas 75235-9158
214/648-2041 (Phone)
214/648-8464 (Fax)

Ryan Rainey
United States Attorney's Office
Washington, DC
202/305-4882 (Phone)
202/514-8784 (Fax)

Robert M. Reece
Massachusetts Society for the
Prevention of Cruelty to Children
399 Boylston Street
Boston, Massachusetts 02116
617/587-1512 (Phone)
617/587-1582 (Fax)

Fred Rich
Dallas Police Department
106 S. Harwood #225
Dallas, Texas 75201
214/670-1348 (Phone)
214/818-2611 (Fax)

Ruben Rodriguez
National Center for Missing
and Exploited Children
2101 Wilson Blvd. #550
Arlington, Virginia 22201
703/516-7161 (Phone)
703/235-3846 (Fax)

Terri E. Royster
Supervisory Special Agent
Federal Bureau of Investigation
Behavioral Science Unit
FBI Academy
Quantico, Virginia 22135
540/720-4732 (Phone)
540/720-4792 (Fax)

Chuck Ruckel
Collin County Sheriff's Office
4300 Community Avenue
McKinney, Texas 75070
972/547-5100 (Phone)
972/547-5304 (Fax)

Bradley J. Russ
Portsmouth New Hampshire
Police Department
Bureau of Investigative Services
3 Junkins Avenue
Portsmouth, New Hampshire 03801
603/436-2511 (Phone)
603/427-1574 (Fax)

David Sapadin
Center for Fundraising Management
131 W. Mulberry
San Antonio, Texas 78212
210/737-6445 (Phone)
210/737-2739 (Fax)

Patricia A. Simon, DDS
University of Texas
Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, Texas 75235-9109
214/648-3034 (Phone)
214/648-2918 (Fax)

Janet E. Squires, MD
Children's Medical Center
1935 Motor Street
Dallas, Texas 75244
214/456-2329 (Phone)
214/456-6390 (Fax)

E. Christian Smith
Child Abuse Liaison
Dallas County District Attorney's Office
133 N. Industrial
Dallas, Texas 75207
214/653-3832 (Phone)
214/653-3845 (Fax)

1999 Crimes Against Children Conference
Speaker Roster

Steve Storie
Family Violence Unit
Dallas County District Attorney's Office
133 S. Industrial
Dallas, Texas 75207
214/653-3721 (Phone)

Dawn Teague
Naval Criminal Investigative Service
202/544-8866 (Phone)

Patricia Toth
437 Lopez Avenue
Port Angeles, WA 98362-6506
360/417-5404 (Phone/Fax)
PATOTH@worldnet.att.net

Victor E. Vigna
Las Vegas Metropolitan Police Department
Vice/Narcotics Bureau
400 E. Stewart Avenue
Las Vegas, NV 89101
702/795-3111 (Phone)

Theresa Kern Vo
Private Practice
214/676-2546 (Pager)

Bill Walsh
Dallas Police Department
106 S. Harwood St., #225
Dallas, Texas 75201-5294
214/670-5936 (Phone)
214/670-5759 (Fax)

Sarah Winkler
Children's Trust Fund of Texas
1884 State Highway 71 West
Cedar Creek, Texas 78612
512/303-5067 (Phone)
512/303-4655 (Fax)
swinkler@ctf.state.tx.us

Rita Yeakley
Dallas County District Attorney's Office
Juvenile Division
2600 Lone Star LB 22
Dallas, Texas 75212-6307
214/698-2285 (Phone)
214/698-5551 (Fax)

Roger Young
Special Agent
FBI-Las Vegas, Nevada
702/385-1281 (Phone)

RANDELL ALEXANDER

Randell Alexander MD, PhD, is an academic pediatrician who serves on the Executive Board of the American Professional Society on the Abuse of Children and co-chairs its task forces on Munchausen Syndrome by Proxy and Child Fatalities. He has been vice-chair of the US Advisory Board on Child Abuse and Neglect, has been on the Board of Governors for the National Committee to Prevent Child Abuse and is a member of the Committee on Child Abuse and Neglect of the American Academy of Pediatrics. Randy served as chair of Iowa's state child death review team and is now a member of Georgia's. He has published and lectured extensively on Shaken Baby Syndrome, Munchausen Syndrome by Proxy and other forms of child abuse. He is frequently called upon to testify around the country on serious and fatal child abuse cases. Currently, he serves as Director of the Center on Child Abuse at Morehouse School of Medicine.

DANIEL ARMAGH

Daniel Armagh received his bachelor's degree from the University of Oklahoma with honors where he received the American Jurisprudence Award for Achievement in the study of Legal Process in Contract Law. Mr. Armagh also studied at Queen's College, Oxford University, United Kingdom. He joined the staff at American Prosecutors Research Institute in 1995 and became Director of APRI's National Center for Prosecution of Child Abuse in 1996. Under Mr. Armagh's direction, the Center's expert staff provides training and technical assistance to prosecutors and other professionals nationwide concerning the investigation and prosecution of sexual, physical and fatal child abuse. Before joining APRI, Mr. Armagh was an assistant district attorney for Lawrence County, Pennsylvania and as such, he was the director of the Sensitive Crimes Unit with emphasis on the prosecution of crimes against children. Mr. Armagh has litigated cases involving child abuse for ten years and has tried over 150 jury trials. He has argued before the highest courts on appellate issues in Oklahoma and Pennsylvania and has authored various articles in the area of child abuse. His most recent article, entitled, *A Safety Net for the Internet: Protecting Our Children*, was published in the Juvenile Justice, (Vol. V, No. 1), US Department of Justice (1998).

CHRISTOPHER R. AVERY

Christopher R. Avery is a Special Agent with the FBI. He is a native of Denver, Colorado and a graduate of the University of Tennessee at Knoxville. He served as a production manager for a manufacturing company prior to joining the FBI and has extensive background in computers. SA Avery has been assigned to the Innocent Images national initiative in the Baltimore Division for three years.

PETER BANKS

Peter Banks is the Director of Training and Outreach at the National Center for Missing and Exploited Children. He has extensive experience training law enforcement, medical, social service and legal professionals in the field of child abuse and neglect both nationally and internationally. Mr. Banks has 23 years of law enforcement experience with the Metropolitan Police Department in Washington, DC. To include 13 years as an investigator and 4 years as a Supervisor in the Child Abuse Unit where he investigated both civil and criminal allegations of abuse. Mr. Banks has been involved with child safety on the Information Highway since 1993 and is responsible for implementing programs designed to assist law enforcement in the investigations of the victimization of children online.

DIANE C. BIRDWELL

Diane is on staff as a Public Information Officer with the Crime Victims' Compensation Division, Office of the Attorney General in Austin, Texas. She is a 17-year veteran of the media serving in various capacities over the years as editor, columnist and staff writer. She possesses first hand experience in the area of victim services and victimization. Most recently Diane has been part of a team writing for the first time, an advanced track training curriculum for Crime Victims' Compensation to aid seasoned professionals in the victim services field.

MARY E. CASE

Dr. Mary Case is a graduate of the University of Missouri, Columbia, Missouri and St. Louis University School of Medicine. She did her residency training in pathology at St. Louis University Health Sciences Center and is board certified in anatomical pathology, neuropathology and forensic pathology. Dr. Case is an Associate Professor of Pathology at St. Louis University. She serves as Chief Medical Examiner for St. Louis, St. Charles, Jefferson and Franklin Counties. Dr. Cases primary practice of medicine is forensic pathology. She has special interests in the areas of children's injuries and head trauma. Dr. Case is a native Missourian. She enjoys traveling, shopping, gardening, reading, aerobics and dogs. She is particularly interested in encouraging young women in medical fields and generally in women's issues in the home, family and work place.

DONALD L. CAVENDER

Donald L. Cavender is a Supervisory Special Agent with the FBI. He has been with the Bureau for nine years. Prior to his assignment to the Computer Analysis and Response Team (CART) Unit at FBIHQ in August 1998, he was assigned to the Houston Field Office where he was the CART Coordinator and worked narcotics and public corruption cases. Prior to joining the FBI, SSA Cavender worked in industrial and computer aided design.

JAMES T. CLEMENTE

James T. Clemente is a Supervisory Special Agent with the FBI assigned to the National Center for the Analysis of Violent Crime (NCAVC), where his duties include profiling and behavioral support for the Innocent Images national initiative and other crimes against children (CAC) cases. SSA Clemente has been with the FBI since 1987 and has worked a variety of violent crimes and major offender cases. He earned his Juris Doctor from Fordham University and spent three years as a prosecutor for the New York City Law Department.

MARTHA COAKLEY

Martha Coakley, an attorney since 1979, is the Middlesex District Attorney. An Assistant District Attorney from 1986-1987 in the Lowell District Court, Public Protection Bureau and Superior Court and from 1989-1997 in the DA's central office. Coakley also served as a Special Attorney for the Justice Department's Boston Organized Crime Strike Force from 1987-1989. Coakley resigned her position in December 1997 to campaign in the 54 cities and towns of Middlesex. From 1991-1996 Martha Coakley distinguished herself as Chief of the Child Abuse Prosecution Unit, which has been recognized as a national model. The Unit screens in approximately 800 reported cases of child abuse per year. Many of the thousands of criminal cases Coakley has investigated and prosecuted have been widely noted including Commonwealth v. Louise Woodward (child killing) 1997; Commonwealth v. Corby Adkinson and Nancy Adkinson (sexual/physical abuse of their children) 1997; and Commonwealth v. Dennis E. King (murder) 1990. Martha Coakley has been on the forefront of statewide public policy discussions and initiatives to improve the criminal justice system. She created and chaired a county-wide multidisciplinary Physical Child Abuse Task Force. She has served on the Children's Justice Act Task Force and has spearheaded legislative efforts with the Department of Social Services, the Department of Public Health, and concerned pediatricians to create a Child Fatality Review Board in the Commonwealth. Coakley has testified before the legislature on behalf of an anti-stalking bill and has consulted with the Department of Public Health and the Governor's Office on the Sexual Abuse Nurse Examiner's (SANE) program, and on alternatives to the current statutory rape laws. She has earned the respect of the law enforcement and legal communities. She has been honored by the Massachusetts State Police for her "time and energy extended on behalf of the Department of State Police." She was commended by her former colleagues at the District Attorney's Office for her "years of dedication, commitment, and outstanding service." The Coalition for Victims of Violent Crime has recognized Martha Coakley for her "doggedness, patience and willingness to work a case for years if necessary to get a conviction." Martha Coakley has served as Board Member and President of the Women's Bar Association of Massachusetts. She has participated in the Massachusetts Bar Association Law-Related Education Lawyer-Teacher Partnership. In addition, Coakley served as visiting faculty for the MCLE-NELI Trial Advocacy Program and as a Chair of Program on the Trial of a Child Abuse Case. Martha Coakley earned a BA degree cum laude from Williams College in 1975 and a JD degree in 1979 from Boston University School of Law where she served as an instructor to first year law students. Coakley practiced at Parker, Coulter, Daley & White and Goodwin, Proctor & Hoar, both in Boston from 1979-1986 before joining the Middlesex District Attorney's Office. Ms. Coakley resides in Arlington. She frequently

addresses national and local community and professional groups about child abuse, domestic violence, and criminal justice issues. Coakley serves as an active volunteer in "Neighbors in Deed," a parish based program that reaches out to elderly and infirm neighbors.

KELLIE COLE

Kellie Cole is a Licensed Professional Counselor-Supervisor and a Registered Play Therapy Supervisor. She has over 8 years experience working with traumatized children and their families. She co-authored the curriculum, "Building Blocks" for child witnesses of domestic violence and wrote a program to build sexual abuse prevention skills for K-12. She has served on the Board of Directors for the Texas Association Against Sexual Assault for 4 years where she chaired the Child Advocacy Task Force. In addition, she served on the Planning Board to charter the 1999 APSAC State Chapter and was on the Task Force that opened the Denton County Children's Advocacy Center. Recently, she was on the 1999 Conference Planning Committee for the Texas Association for Play Therapy. She has presented at numerous local, state and national conferences. Currently, she is the Clinical Director at the Collin County Children's Advocacy Center in Plano, Texas.

ANDY CONTRERAS

Andy Contreras, independent consultant for nonprofit organizations and businesses has worked for youth serving organizations such as Boys & Girls Clubs of America, YMCA and Woods Psychiatric Institute for the past 25 years. He has a B.Ed. Degree in Counseling and Music from Hardin-Simmons University in Abilene, Texas. A few of the awards Andy has been recognized for are sharing lead trumpet in International jazz tour in England, France, Germany, Austria and Switzerland, being named Outstanding Young Man in America, Young Kansan Award and the Friend to Youth Award.

CATHY CRABTREE

Cathy Crabtree joined the staff of Children's Advocacy Centers of Texas, Inc. In January 1999 after serving for six years as Executive Director of the Young County Family Resource and Child Advocacy Center in Graham, Texas. A graduate of West Virginia University, Cathy was the founding director of the Children's Advocacy Center in Graham and a founding member of the board of directors of Children's Advocacy Centers of Texas, Inc.

COLLEEN J. DOOLIN

Colleen J. Doolin started work as an assistant district attorney for the Dallas County District Attorney's Office in 1986 and has tried hundreds of cases. She began working in the Child Welfare Division in 1994 and has tried about 20 termination of parental rights cases to juries and judges. Ms. Doolin graduated from the University of Texas at Austin, where she received her Bachelor of Journalism in 1975 and from the University of North Texas where she received her Master of Journalism in 1980. She received her Juris Doctor in 1985 from the Cornell Law School where she was an Article Editor for the Cornell Law Review, was on the Law Review Board of Editors and played polo with the Cornell Polo Club. She was the 1997 recipient of the SPCA Distinguished Community Service Award and has won back-to-back blue ribbons for her knitting at the State Fair of Texas in 1997 and 1998.

JAMES DOYLE

James Doyle is a 17-year law enforcement veteran. He has served as a detective, commanded a joint federal narcotics and firearms task force in Harlem, commanded a detective squad, commanded the Housing Police Department's Intelligence Unit, served as the Detective Bureau training coordinator and is currently assigned as a detective supervisor of the Computer Investigation and Technology Unit. Sergeant Doyle has been assigned to the Computer Crimes Unit since its inception and has been responsible for the formation of guidelines, investigative procedures and policies in the area of high tech crime. He is responsible for the operations and investigations conducted by the CITU. He has been called upon to provide training lectures for law enforcement agencies around the country. Sergeant Doyle received his BA from Fordham University. He has received training from FLETC, Department of Justice, FBI, NWCCC and HIDTA in computer crime investigation, forensic analysis, fraud and white collar crime investigations. He is a member of the DOJ National Cybercrime Training Partnership. He is the current President of the Northeast Chapter of the High Technology Crime Investigations Association.

CINDY DYER

Cindy Dyer is considered one of the most accomplished individuals at the Dallas County District Attorney's Office in Family Violence matters. After graduating with a Juris Doctor from Baylor School of Law in 1993, she was hired by the Dallas County District Attorney's Office where she is now supervisor of the Family Violence Division. Cindy has been a highly solicited instructor since she began lecturing on Family Violence issues statewide in 1994. She was one of the featured speakers for the Texas District and County Attorney's Association's Domestic Violence Seminar in 1996 and the Key Personnel Seminars in 1996 and 1997. Ms. Dyer was awarded the John McPhaul Local Achievement Award in 1997 by the Texas Council on Family Violence, where she also served as a presenter at the annual statewide conference. As a prosecutor, Cindy has the expertise to address, among other things, the legal aspects of Family Violence, Protective Orders, trial strategies and legislative law updates. Cindy Dyer's continuing commitment to educate individuals about Family Violence is just one of the many qualities that makes her an invaluable asset not only to the Dallas District Attorney's Office's campaign against Family Violence, but to the communities of the state of Texas.

JENNIFER EAKIN

Jennifer Eakin is a Supervisory Special Agent with the FBI, assigned to the National Center for the Analysis of Violent Crime (NCAVC) where her duties include profiling and behavioral support for the Innocent Images national initiative and other crimes against children (CAC) cases. SSA Eakin joined the FBI in 1984 and has worked a variety of violent crimes and major offender cases. She served on the United States Attorney General's Violent Crimes Task Force, specializing in crimes against children. She has a Masters Degree in Clinical Counseling from Webster University.

ROBERT HUGH FARLEY

Robert Hugh Farley is a 25-year veteran of the Cook County Sheriff's Police Department in Chicago, Illinois. As a Detective, he has 23 years experience investigating crimes against children. At present he is the Commanding Officer of the Cook County Sheriff's Police, Child Exploitation Unit. From 1988 to 1997, he was detailed from the Cook County Sheriff's Police Department, Special Operations Unit, to the Federal Child Exploitation Strike Force where, as a Deputy United States Marshal, he investigated child pornography and child exploitation in an undercover capacity. Detective Farley holds a Bachelor of Science degree in Education and a Master of Science Degree in Criminal Justice and Corrections, both from Chicago State University. Detective Farley has provided technical support, consultant services and has been a senior instructor for the US Department of Justice, Child Abuse programs since 1986. His published works include several books, articles, technical papers and agency protocols on the subject of child abuse investigative techniques. He is also the author of child abuse related legislation. As a nationally recognized expert and instructor on child abuse investigative techniques, Detective Farley has trained thousands of police officers and professionals throughout the United States, Canada and Russia. As the result of his training curriculum, the child abuse investigative techniques he developed have been implemented by hundreds of police departments, child protection agencies, child advocacy centers and prosecutors throughout North America. For his work in child abuse, he has received numerous awards, some of which include the 1985 Law Enforcement Award from the University of Southern California, DCI, the 1986 Superior Public Service Award from the City of Chicago, the 1987 Appreciation Award from the US Customs Service and the 1988 Recognition Award from the Cook County States Attorney. From 1988 to 1996 he was named to Who's Who in the Midwest. In 1991, he was recognized both by the United States Attorney's Office with their Award for Public Service and the International Juvenile Officer's Association with their Police Officer of the Year Award. In 1992, he was honored by the Chicago Police Department with their Award of Appreciation and in 1993 the US Postal Inspection Service presented him with an Award of Commendation. In 1995 the Illinois Professional Society on the Abuse of Children presented him with their annual Law Enforcement Commendation. In 1996, the Cook County Sheriff presented him with the Certificate of Excellence as the Police Detective of the Year. In 1997 he was honored by the Chicago Bar Association with a Certificate of Appreciation and the United States Attorney's Office with a Letter of Recognition. Detective Farley is a member of the Illinois Department of Children and Family Services Statewide Advisory Committee on Child Abuse, the Illinois Attorney General's Violence to Children Task Force, the Cook County States Attorney's Mass Molestation Task Force, the Cook County Child Fatality Review Committee, the Illinois Art Therapy Association, and is a past chairman of the Illinois Police Association.

LAMOYNE J. FARR

Lamoyne J. Farr joined the FBI in 1988 and was assigned to the Birmingham Division until his transfer to the Baltimore Division in 1992. SA Farr has worked cases involving numerous federal criminal violations, including child pornography and child sexual exploitation facilitated by users of the Internet. SA Farr has a Bachelor of Science degree in Professional Aeronautics from Embry-Riddle Aeronautical University and is a former air traffic controller and teacher. He is a self-taught computer programmer and an avid computer hobbyist. SA Farr has been assigned to the Innocent Images national initiative since January 1997.

BYRON FASSETT

Sergeant Byron Fassett has been with the Dallas Police Department for 20 years. He served as sergeant over the Family Violence Unit for 3 years before moving to the Child Exploitation Unit in 1990. Sergeant Fassett is responsible for supervising the Child Exploitation Squad which consists of 15 detectives and is divided into 3 teams, the Investigations Team, the SOAP (Sex Offender Apprehension Program) Team and the Internet Crimes Against Children Team. This squad investigates child pornography, juvenile prostitution, harmful employment, sexual assaults of children by non-family members/strangers, violations of the sexual offender registration law, computer crimes against children and any other case involving the sexual exploitation of children. This unit also conducts pro-active and undercover investigations related to the sexual exploitation of children. Sergeant Fassett has instructed at the Dallas Police Department Academy, the North Central Texas Regional Police Academy, the Annual Governor's Training Conference on Child Abuse, Southern Regional Children's Advocacy Center and for various other agencies and conferences throughout the country. He is the past president of the Crimes Against Children Investigators Association. This association is comprised of law enforcement and child protective services investigators in the North Texas region.

TIM GALLAGHER

Tim Gallagher has been with the Dallas County District Attorney's Office since 1990. Since 1992 he has worked in the Organized Crime Division where he prosecutes vice-related offenses including Possession and Distribution of Child Pornography, as well as Solicitation of Children over the Internet. Prior to working in the District Attorney's Office, Mr. Gallagher was a polygraph examiner for several years. He has extensive experience and training regarding the interview and interrogation of sex offenders.

NANCY HAGAN

Nancy Hagan is the founding Executive Director of Alliance for Children, the Tarrant County Child Advocacy Center program. She is immediate past president of Children's Advocacy Centers of Texas and is currently on the Board of Directors. She is past president of Texas CASA.

NANCY B. HAMMER

Nancy B. Hammer is the Director of the International Division, started at the National Center for Missing and Exploited Children (NCMEC) in June 1996. As Director of the International Division, Ms. Hammer is responsible for maintaining NCMEC's agreement with the State Department to handle cases coming into the United States under the Hague Convention on the Civil Aspects of International Child Abduction. The International Division's primary role is to provide advice to law enforcement, attorneys and parents regarding international abduction and to coordinate the return of US children who have been abducted overseas.

MARILYN HERRICK

Marilyn Herrick has been the Manager of the Child Advocate Program at the Dallas Children's Advocacy Center since December 1993. Marilyn is the facilitator of the weekly team review case staffings, the Dallas County Child Death and Infant Mortality Review Team, provides training to grand juries in Dallas on a quarterly basis and developed the training to the 3rd year medical students at UTSWMC in their pediatric rotation. She was instrumental in the development and implementation of the criminal case tracking system for DCAC.

MARK A. HILTS

Mark Hilts, a Supervisory Special Agent, has been with the FBI over 11 years and is assigned to the National Center for the Analysis of Violent Crime (NCAVC) of the FBI's Critical Incident Response Group. As a member of the NCAVC, SSA Hilts provides operational assistance, including crime analysis, offender profiles and investigative strategies to law enforcement agencies involved in child abduction and other violent crime investigations. Prior to his assignment to the NCAVC, SSA Hilts served for 7 years in the Miami Division where he was primarily responsible for investigations involving violent crime. Prior to joining the FBI, he served for 6 years as a police officer with Plano Texas Police department.

BRIAN HOLMGREN

Brian Holmgren joined the staff of the American Prosecutors Research Institute National Center for Prosecution of Child Abuse as a Senior Attorney in November 1995. Prior to that he was an assistant district attorney in Kenosha County, Wisconsin for ten years where he directed their sensitive crimes unit. As an assistant district attorney, Mr. Holmgren tried more than 160 jury trials, including 125 felonies and handled hundreds of child abuse cases. He was a Board Member of the Wisconsin chapter of the American Professional Society on the Abuse of Children and a frequent lecturer on child abuse topics at statewide and national conferences. Mr. Holmgren received his undergraduate degree from the University of Chicago in 1981 and his law degree from Vanderbilt University in 1985. Mr. Holmgren's duties at the Center include providing training and assistance to prosecutors and other professionals across the country concerning the investigation and prosecution of child maltreatment cases. He is also actively involved in research and writing on various topics involving child abuse prosecutions. The Center also provides technical assistance and research on the current issues facing professionals in responding to child maltreatment.

JOANNE M. JENSEN

Joanne Jensen is a Special Agent with the Naval Criminal Investigative Service, Dahlgren, VA. Joanne Jensen graduated from the University of Massachusetts, Amherst, MA and received her Bachelor's degree in 1977. Joanne was a US Postal Inspector domiciled in the New York City area from January 1978 until her transfer to the US Department of Labor, Washington, DC in February 1984. In September 1985, Joanne transferred to the Naval Criminal Investigative Service (then known as the Naval Investigative Service). Joanne has been assigned to Camp Lejeune, NC, Quantico, VA, Washington, DC and presently Dahlgren, VA. She has worked numerous joint investigations with the Federal Bureau of Investigation as well as other Federal and State Law Enforcement agencies.

MICHAEL V. JOHNSON

Detective Mike Johnson is a native of San Antonio, Texas. He earned a Bachelor degree in Criminal Justice at Southwest Texas State University. Detective Johnson joined the Plano Police Department in September 1982. Upon graduation from the police academy, he spent four months as an undercover narcotics officer. After being assigned to the Patrol Division for four years, Johnson transferred to the Criminal Investigations Division as a juvenile detective in 1986. Since then, he has become recognized as an expert in child abuse cases. Detective Johnson is a founding member of the Collin County Children's Advocacy Center, where he serves as a child abuse investigator. In 1996, he was named the Center's "Child Advocate of the Year." In 1998, he was appointed to the National Board of Directors for the American Professional Society on the Abuse of Children (APSAC), and in 1999, he was elected president of the APSAC Texas state chapter. He has served on the Board of Directors for the National Network of Children's Advocacy Centers and on the advisory boards for the Junior League of Plano, the Education and Training Division of Child Protection for Children's National Medical Center in Washington, DC and the Law Enforcement Subcommittee for APSAC's Sixth National Colloquium. Detective Johnson also served on Senator Florence Shapiro's Blue Ribbon Committee where he was instrumental in formulating the now instated, "Ashley's Laws." Detective Johnson is considered an ambassador for child advocacy. He frequently lectures at federal, state and local programs focusing on child maltreatment, and speaks to citizens' groups and other police organizations on child abuse issues.

BRIAN J. KILLACKY

Since 1990, Brian has been a detective with the Area Three Violent Crimes Unit of the Chicago Police Department. This unit handles all homicide, sex, robbery and related violent crimes for five police districts along the north side of Chicago. This area is considered one of the most culturally diverse in North America. During his assignment, Brian has investigated serial murder, mass murder, baby murders and serial rapists. From 1980 to 1990, Brian was assigned to the Special Investigation Unit which was formed after mass murderer John Gacy tortured and murdered thirty three young boys in Chicago. During that time, Brian investigated hundreds of cases involving child pornography, child molestation and juvenile prostitution related violent offenses. Brian has lectured for Ron Laney and the Office of Juvenile Justice and Delinquency Prevention since 1987.

GERRY KLAHR

Lt. Gerry Klahr has been with the Collin County Sheriff's Office for over 20 years. During that time he has served as a reserve deputy, patrol deputy, criminal investigator and support services supervisor. His current assignments include Coordinator of the Collin County Law Enforcement Child Abuse Task Force and Team Leader of the Sheriff's Office Tactical Operations Team. Lt. Klahr has a bachelors degree in marketing and has worked in the Consumer Products Industry in various sales and marketing positions. He also holds the rank of Captain in the Communications/Electronics Branch of the US Army Reserve.

RONALD C. LANEY

Ronald C. Laney was appointed Director, Missing and Exploited Children's Program, in May 1994. He acted in the position from January 1993 through April 1994. From 1981 through April 1994, he had been the Law Enforcement Program Manager at the Office of Juvenile Justice Delinquency Prevention (OJJDP). He has developed a series of National Law Enforcement Training programs that are offered throughout the country today. Over 15,000 law enforcement personnel have participated in these training programs since 1982. Prior to coming to OJJDP, Mr. Laney served as program manager in the Law Enforcement Assistance Administration for five years. Ron Laney has a bachelor's degree in criminology from the University of Tampa and a master's degree in criminal justice from the University of South Florida. Ron served in the US Marine Corps from 1964 to 1970 before being wounded during his second tour in Vietnam and medically retired. He also served as a probation officer in St. Petersburg, Florida, during 1974 and has received numerous awards from local and state law enforcement organizations for his work in juvenile law enforcement.

KENNETH V. LANNING

Kenneth V. Lanning is a Supervisory Special Agent with the FBI assigned to the National Center for the Analysis of Violent Crime (NCAVC) of the FBI's Critical Response Group. SSA Lanning has consulted on hundreds of missing and exploited children cases during his career with the FBI. He has taught law enforcement officers across the nation and abroad on the topics of sex offenders, sexual exploitation of children and child abduction. He is the 1996 recipient of the 1996 recipient of the Outstanding Professional Award from APSAC for outstanding contributions in the field of child maltreatment and the 1997 recipient of the FBI Director's Annual Award for Special Achievement for his career accomplishments in connection with missing and exploited children investigations.

LIVIA LIU

Livia Liu is an assistant district attorney with the Dallas County District Attorney's Office. She has been with the District Attorney's Office for four years. The last two years she was assigned to the child abuse unit. She is currently working on cases involving crimes against children on the Internet.

SANDRA MARTIN

Sandra A. Martin has been a part of the Travis County Children's Advocacy Center project since its beginning in 1989. She has been Executive Director since 1991. Prior to this, she was the Executive Director of CASA of Travis County. She has a graduate degree in child development and is a LMSW, licensed social worker. Sandra has 30 years experience in work with abused children, juvenile delinquency, emergency shelter, parenting education, early childhood development, volunteer services, non-profit administration and crime victim services.

CHARLES S. MASINO

Charles Masino retired from the Phoenix Police Department on February 10, 1995, after 20 years of service. Mr. Masino spent the last 14 years of service as a detective in the assault detail and specialized cases of domestic violence and missing persons. Mr. Masino established the first domestic violence squad of detectives in 1981 and was responsible for the investigation of all missing children, non-family abductions, that occurred between 1981 and 1995 as the lead investigator or part of an investigative team. In 1983 he was appointed by the police chief to represent the department as their expert in domestic violence and served on various committees as the department representative. He is nationally recognized and published in both areas. Mr. Masino is currently the chairperson of the Arizona Governor's Commission on Violence Against Women.

A. TODD McCALL

Anthony Todd McCall entered duty as a Special Agent with the Federal Bureau of Investigation in November 1990. McCall was assigned to the Dallas Division of the FBI in March 1991. McCall was initially assigned to the Dallas Office. In August 1991, McCall was appointed to the Dallas Evidence Response Team. In July 1992, McCall was transferred to the Fort Worth Resident Agency in the Dallas Division. In September 1992, McCall was promoted to Team Leader for the Evidence Response Team. McCall then began teaching crime scene schools focusing on trace and DNA evidence collection, preservation and packaging. McCall has made presentations to groups as varied as a group of deputy sheriffs to a large group of crime lab scientists at an international symposium. McCall is currently serving as Dallas Evidence Response Team Coordinator/Senior Team Leader. In this position McCall is responsible for managing the day to day operations of the team as well as managing large scale crime scenes. McCall has participated in or managed nearly 100 crime scene investigations since becoming an ERT member in 1991. McCall has been involved in a number of high profile cases such as the fire at the Branch Davidian Compound near Waco, Texas, the bombing of the Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma and the bombing of the United States Embassy in Dar es Salaam, Tanzania, Africa. McCall testified in the trials of Timothy McVeigh and Terry Nichols, both convicted in the Murrah Building bombing. McCall has also participated in several local cases involving the abduction and murder of young females. These include: the Fall 1994 abduction, rape and murder of Lisa Rene, Arlington, Texas and Pine Bluff, Arkansas; the Winter 1996 abduction and murder of Amber Hagerman, Arlington, Texas and the Spring 1997 abduction and murder of Sarah Patterson, Granbury, Texas.

DAVID MONTAGUE

David Montague is a career prosecutor with 15 years of experience in the District Attorney's Office of Tarrant County, Texas. He received his Bachelor's Degree in History from the University of New Mexico and attended law school at the University of Texas, graduating in May of 1982. Between 1990 and 1995, he designed and built a vertical prosecution unit dedicated to handling all cases of child sexual abuse and child homicide in his community. He has lectured throughout the state of Texas on numerous child abuse topics including legal issues, investigative issues and his research into jury decision-making in child sexual abuse cases. In his current administrative role in the District Attorney's Office, he participates in numerous boards, committees and planning groups. His service on the local advocacy center board, Alliance for Children, began at the time the board was initiated. He also serves on the local Child Fatality Review Team and is currently on both the Children's Advocacy Centers of Texas Board and the Board of the National Network of Children's Advocacy Centers.

J. TOM MORGAN

J. Tom Morgan was elected District Attorney of the Stone Mountain Judicial Circuit (DeKalb County), the second most populous judicial circuit in Georgia, in November 1992. The DeKalb District Attorney's Office has 100 employees, including 32 lawyers, 18 investigators and 7 paralegals. Mr. Morgan is responsible for the prosecution of more than 7,000 felony cases each year. Mr. Morgan joined the DeKalb County District Attorney's staff in January 1983 as an assistant district attorney. The following year, he was appointed to serve as a special prosecutor of child sexual assault and physical abuse cases by then District Attorney Bob Wilson. Mr. Morgan was the first prosecutor in Georgia to be appointed to specialize in this area. Since 1984, he has prosecuted more than 500 cases of child abuse. A nationally known expert on the prosecution of crimes against children, Mr. Morgan has written and lectured extensively in this area. He has taught law enforcement officials in more than 30 states, in Puerto Rico and in Europe. He has been featured in *People* and *Parenting* Magazines, on CBS television's "48 Hours", the Cable News Network (CNN), and the "Oprah

Winfrey Show." In 1988, Governor Joe Frank Harris appointed Mr. Morgan to serve on the Georgia Children's Trust Fund Commission. In the fall of 1989, Mr. Morgan was appointed by the Governor to serve on the state task force which investigated the unexplained deaths of children in Georgia. This task force's final report resulted in remedial legislation which was enacted by the General Assembly in 1992. Mr. Morgan was a founding board member of the Georgia Center for Children, Inc. Where he presently serves as Chair of the Advisory Committee. The Center is a private non-profit organization which provides free psychological counseling for abused children in DeKalb and Fulton Counties. He was an original board member of the National Organization of Child Advocacy Centers and served on the board of the Georgia Council on Child Abuse from 1986 to 1994. He is also a faculty member of the National College of District Attorneys in Houston, Texas. In 1990, he was awarded the Distinguished Faculty Award by the National College of District Attorneys, the first prosecutor in the state of Georgia to receive this award. In 1993, Governor Zell Miller appointed Mr. Morgan to serve as the Chairperson of the Child Abuse Prevention Panel, a group created by the Georgia General Assembly to monitor the implementation of the state child abuse prevention plan and report to the governor, recommending measures to reduce child abuse and child fatalities occurring by other than natural causes. Mr. Morgan has drafted several pieces of legislation which were enacted by the Georgia General assembly. Among theses are a bill establishing a special exception to the "hearsay rule" for children, a bill abolishing the competency requirement for child witnesses and a bill mandating child abuse protocols in Georgia counties. In January 1994, Mr. Morgan was appointed by Donna Shalala, Secretary of Health and Human Services, to serve on the United States Advisory Board on Child Abuse and Neglect. This 15-member board made recommendations to the President and Congress on issues related to child abuse and neglect. He was the first prosecutor to be appointed to this board. Mr. Morgan also serves on the boards of the DeKalb Rape Crisis Center, Mission New Hope, a substance abuse prevention, education and treatment coalition for metropolitan Atlanta, Decatur-DeKalb YMCA, Decatur Rotary Club and HIDTA, a high intensity drug trafficking area task force under the US Department of Justice. In December 1996, he was elected by the district attorneys of Georgia to serve as Georgia's representative on the Board of the National District Attorney's Association. In 1997, he was selected to serve on the Telemarketing Fraud Enforcement Task Force Curriculum Development Committee coordinated by the American Prosecutors Research Institute to train prosecutors and investigators in the prosecution of criminal telemarketing fraud cases. Also in 1997, he was appointed by Lt. Governor Pierre Howard to serve on the State of Georgia Senate Structured Sentencing Commission, which was formed to study and make recommendations to the State Senate during the 1998 legislative session on 'abolishing paroles in the state of Georgia.'

MAUREEN O'CONNELL

Maureen O'Connell LMSW-ACP, is the Clinical Services Coordinator of the Children's Assessment Center in Houston, Texas. The Children's Assessment Center, a multi-disciplinary, multi-agency child sexual abuse program, serves the nation's largest volume of children at a single site. Ms. O'Connell, who chairs the multi-disciplinary team process, provides consultation, evaluation, individual, family and group therapy for cases of child sexual abuse. A licensed social worker and marriage and family therapist in the State of Texas, Ms. O'Connell is frequently called upon to provide expert testimony in both the civil and criminal courts. She has extensive training experience and has presented locally, regionally and nationally on a variety of topics regarding the treatment of poly-abusive families. Ms. O'Connell holds a Bachelor of Arts from DePaul University, Chicago, Illinois and a Masters of Social Work from the University of Houston, Houston, Texas.

GARY O'CONNOR

Gary O'Connor is a Sergeant with the Lower Gwynedd Township Police Department. He is a Senior Consultant and Trainer with the Office of Juvenile Justice and Delinquency Prevention, Washington, DC. He has conducted training in 49 states for various criminal justice agencies, including the Federal Law Enforcement Training Center, Fox Valley Technical College, National School Safety Center, National Center for Missing and Exploited Children, National District Attorneys Association, National Council of Juvenile and Family Court Judges and many others.

BRUCE DUNCAN PERRY

Bruce Perry is the Senior Fellow of the CIVITAS Initiative, a national children's advocacy organization based in Chicago. He serves as the Thomas S. Trammell Research Professor of Child Psychiatry and the Vice-Chairman for Research in the Department of Psychiatry and Behavioral Sciences at the Baylor College of Medicine in Houston, Texas. Within the Baylor College of Medicine clinical system, he serves as Chief of Psychiatry at Texas Children's

Hospital. Dr. Perry has secondary appointments in Pediatrics, Pharmacology and Neuroscience. Dr. Perry was an undergraduate at Stanford University and Amherst College. He attended medical and graduate school at Northwestern University, receiving both MD and Ph.D. degrees.

DONNA I. PERSAUD, MD

Donna I. Persaud, MD is an assistant professor, Department of Pediatrics, University of Texas Southwestern Medical Center, pediatric attending at Children's Medical Center. She is a member of the REACH Team (Referral and Evaluation of Abused Children) which performs approximately one thousand medical evaluations of suspected abuse cases per year. She regularly provides medical expert guidance and court testimony on child abuse cases in Dallas County.

KATE PORTER

Kate Porter has been the Supervisor of the Child Abuse and Family Violence Divisions of the Dallas County District Attorney's Office since 1995. She was the lead prosecutor in approximately 140 jury trials in addition to working with the prosecution of capital murder child death cases and prosecuted cases in misdemeanor and felony courts. She supervises fourteen attorneys, seven investigators and support staff. Ms. Porter received her J.D. from Oklahoma City University School of Law and her B.A. in journalism from the University of Oklahoma. She received the American Jurisprudence Award, Constitutional Law I and was listed on the Law Faculty Honor Roll. She is licensed to practice law in Texas. Ms. Porter currently serves on the Dallas County Child Death Review Task Force and chairs the Program Committee of the Dallas Children's Advocacy Center.

KIMBERLY L. POYER

Kimberly Poyer is a Licensed Clinical Social Worker. Ms. Poyer received her Bachelors of Social Work at the University of Illinois. She received her Masters of Social Work at Washington University. Ms. Poyer is employed at the United States Attorney's Office in the District if Columbia. She is the first Child Interview Specialist hired by the Department of Justice to work in the US Attorney's Office. Her duties include interviewing, assessing and evaluating child victims and witnesses of numerous types of crimes. Ms. Poyer works with the children to determine their competency for criminal court and assists the attorneys and children with court preparation. Prior to working with the US Attorney, Ms. Poyer was employed at The Children's Hospital in Denver, Colorado. She was the Co-Director of the Child Advocacy and Protection Team. This was a multi-disciplinary team that evaluated 1200 cases a year of fatal child abuse, physical and sexual abuse, as well as neglect. Ms. Poyer has instructed graduate students in social work and provides training to professionals on various topics in the topics in the field of child abuse and neglect.

GARY PURDUE, MD

Dr. Gary Purdue is a Professor of Surgery at the University of Texas Southwestern Medical Center, Dallas. He is co-director of the Burn Center at Parkland Memorial Hospital.

RYAN H. RAINEY

Ryan Rainey is an Assistant United States Attorney in Washington, DC, working in the Child Abuse Section. After receiving his JD from Loyola Marymount University Law School in 1985, Mr. Rainey joined the Los Angeles District Attorney's Office. As a Deputy Prosecuting Attorney, Mr. Rainey worked in the Sexual Crimes and Child Abuse Unit handling physical and sexual abuse cases and specializing in child homicide cases while also taking an active role in the Child Death Review teams in the state of California. From June 1993 until August 1995, Mr. Rainey served as a Senior Attorney with the National Center for Prosecution of Child Abuse located in Alexandria, Virginia. In this position, Mr. Rainey provided training to attorneys, law enforcement, social workers and other professionals involved in all stages of the investigation and prosecution of child neglect, physical and sexual abuse and fatalities. Mr. Rainey continues to lecture nationally on such subjects as interviewing children, use of experts and investigating child homicides.

ROBERT M. REECE

Robert M. Reece, MD is Clinical Professor of Pediatrics at Tufts University School of Medicine and Director of the Institute for Professional Education at the Massachusetts Society for the Prevention of Cruelty to Children, Boston, Massachusetts. The Institute provides current medical information about all forms of child abuse to professionals working with child abuse. Individuals using this training have included health care providers, social workers in public and private agencies, law enforcement personnel, attorneys, judges and treating clinicians. Dr. Reece has worked as clinician, teacher and researcher in child maltreatment since the early 1970's. He is the editor of the book *Child Abuse: Medical Diagnosis and Management* (1994, Lea and Febiger, Malvern, Pa.) And of *The Quarterly Child Abuse Medical Update*, a publication seeking to keep clinicians informed of recent medical developments in child abuse. He was honored as the American Professional Society on the Abuse of Children's "Outstanding Professional in the Field of Child Abuse" in 1997 and was named in the peer-reviewed books Best Doctors in America for two consecutive years.

FRED RICH

Sergeant Fred Rich has been a Dallas Police Officer for 30 years and a supervisor for 24 years. He has been assigned to the Child Abuse Unit for the past 10 years. He is a member of the Dallas County Child Death Review Team.

RUBEN RODRIGUEZ

Ruben Rodriguez is the Director of the Exploited Child Unit at the National Center for Missing and Exploited Children (NCMEC). Prior to coming to NCMEC, Mr. Rodriguez was a detective with the Metropolitan Police Department in Washington, DC, where he was assigned to the Intelligence Division. Mr. Rodriguez has been a guest lecturer at the University of Maryland, the FBI Academy in Quantico, VA, The British Senior Police College in Bramshill, England, and several law enforcement conferences speaking on the issues of missing and abducted children and the sexual victimization of children.

TERRI E. ROYSTER

Terri E. Royster is a Supervisory Special Agent with the FBI. She has a Bachelor of Science degree in Psychology and a Masters of Arts degree in Forensic Psychology. Prior to entering duty with the FBI in June 1989, she had been employed with a halfway house, a court service unit as a Psychologist with the Virginia Department of Corrections. SSA Royster was certified as a Police Instructor in 1993 while assigned to the Washington Field Office. She was assigned to the Behavioral Science Unit at the FBI Academy in Quantico, VA in May 1996. She spent one year developing a course on juvenile crime and behavior that was implemented in the 191st session of the FBI National Academy in September 1997. SSA Royster is a member of the Virginia Homicide Association and the Homicide Research Working Group. She is considered adjunct faculty of the University of Virginia.

CHUCK RUCKEL

Chuck Ruckel holds a masters of science degree in management and has worked for the Collin County Sheriff's Office for the past eleven years. Chuck came to law enforcement late in life, having spent the previous twenty plus years in private industry. For the past three years, Chuck has been a criminal investigator with the Sheriff's Office. In September 1997, he was chosen as the first (and only) investigator for the newly formed Collin County Child Abuse Task Force. He is responsible for the investigation of all rural child abuse cases (physical and sexual) within Collin County. This area represents a population base of approximately 75,000 people.

BRADLEY J. RUSS

Bradley J. Russ was appointed as the Chief of Police for the Portsmouth, New Hampshire Police Department on January 1, 1999. He is a twenty year veteran of that agency and rose through the ranks having worked in the Patrol, Detective and Administrative Divisions. He has been a senior instructor for the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP) since 1986. During that time he has provided training to thousands of child protection professionals including: law enforcement officials, child protective services workers, prosecutors, judges, school administrators, mental health providers, victim advocates and individuals from a wide range of human service agencies. Topics presented include child abuse investigation, management of juvenile operations,

child protection team strategies, community based responses to child protection issues, early intervention/primary prevention/education solutions, case management, unit commander responsibilities, public policy and a wide range of community and law enforcement strategies. Prior to his appointment as Chief, Brad was in charge of the Bureau of Investigative Services where his responsibilities included management and supervision of the criminal investigative, youth services, narcotics and crime prevention programs. Brad has also held a number of supervisory positions within the Division and served as a detective assigned to conduct major investigations. Commander Russ was one of the original-founding members of his state's first full child protection multi-disciplinary team in 1983 and was instrumental in the creation of New Hampshire's first Child Advocacy Center. The Child Protection Team has expanded its role to include an interdisciplinary response to a wide array of child protection issues. Brad was also instrumental in the creation of the Seacoast Assessment Team which currently serves as a community based system designed to provide early intervention and prevention services to assist children and their families. The Attorney General appointed Brad as the co-chair of a task force, which led to the implementation of statewide child abuse investigative protocols. He has served as the Legislative chair for the NH Task Force on Child Abuse and is currently the first vice-president of the New Hampshire Police Association. In addition to providing training and technical assistance on a national level, Commander Russ continues to teach at the University of New Hampshire as well as his state's police academy on a regular basis. He is the author of several articles and has helped develop a number of national training programs. He has served as a technical advisor on a number of projects and hosted a nationally distributed video training program on the subject of child abuse and exploitation funded through the Office of Juvenile Justice and Delinquency Prevention. Commander Russ received his B.A. from the University of New Hampshire and graduated from the 163rd session of the Federal Bureau of Investigation's National Academy.

DAVID SAPADIN

David Sapadin, Executive Director of The Center for Fundraising Management, has taught thousands of your colleagues these subjects. He is an attorney with more than 20 years of fund raising and public policy experience. He is accomplished in every facet of fund raising including major gifts, campaign direction, joint promotions with corporations, grants and annual appeals. He can analyze your problems and help you arrive at the right strategy. He earned his BA from Brooklyn College, his JD from The George Washington School of Law and a MPH from The John Hopkins School of Public Health and Hygiene.

PATRICIA A. SIMON, DDS

Patricia A. Simon, DDS, is Director of Orthodontics at the University of Texas Southwestern Medical Center. She is a dental consultant for the child abuse team at Children's Medical Center in Dallas and is actively involved in educating dental professionals in the recognition and reporting of child abuse.

JANET E. SQUIRES, MD

Dr. Squires is Director of General Academic Pediatrics Division, Department of Pediatrics, University of Texas Southwestern Medical Center and Director of General Pediatrics, Children's Medical Center. She is board certified in Pediatrics with specialty boards in Pediatric Infectious Diseases.

E. CHRISTIAN SMITH

E. Christian Smith, MA is the Child Abuse Liaison with the Dallas County District Attorney's Office. She has been with the District Attorney's Office since 1996. She previously advocated for child sexual abuse victims in Nueces County through the Children's Advocacy Center in Corpus Christi, Texas.

STEVE STORIE

Steve Storie began his career as a police officer for the Plano Police Department in 1977, until he was elected as a Constable for Collin County in 1986. In 1990, Steve joined forces with the Dallas County District Attorney's Office, where he is an Investigator for the Family Violence Division. Steve is one of the most experienced instructors for the Family Violence Unit and has been recognized statewide for his efforts. He has been awarded with both the Instructor and Master TCLEOSE certificates, with the Denton District Attorney Award for Community Service (1995) and with the Texas Department of Protective and Regulatory Services Volunteer Award (1997). Steve's topics of expertise range

from an Investigator's perspective on Family Violence to the collection of evidence. Having instructor experience with over 100 agencies statewide, Steve is among the most requested instructors and his experience, training and practical solutions make him one of the most effective District Attorney's weapons in the fight against Family Violence.

PATRICIA TOTH

Patricia Toth is a lawyer, trainer and expert consultant on issues related to the investigation and prosecution of child abuse cases. Her previous experience includes working as a federal child exploitation prosecutor, directing the National Center for Prosecution of Child Abuse and trying cases as a Washington state prosecutor. She has presented training throughout the US and internationally, written extensively on child abuse issues and was 1994 President of APSAC.

VICTOR E. VIGNA

Detective Vigna is a 10-year veteran of the Las Vegas Metropolitan Police Department (LVMPD). He has been involved in over 300 child prostitution investigations since 1994. Detective Vigna was a principal in the implementation of a program named OPERATION S.T.O.P. (Stop Turning Out Child Prostitutes) which helps with the rehabilitation of exploited child prostitutes. As a result of his efforts with S.T.O.P., Detective Vigna was awarded the LVMPD's Exemplary Service Award and Victim's Service Award. Detective Vigna is involved in police and security personnel training and has instructed at the FBI Academy at Quantico, VA.

THERESA KERN VO

Theresa Kern Vo, Ph.D., is a psychologist with 9 years experience working with abused children. She has worked in an Advocacy Center setting and is a trainer with the Southeast Region Children's Advocacy Center. She is a frequent speaker at local and national conferences on issues related to the psychological aspect of abuse of children. She is the Clinical Director of the Dallas Crisis Team and provides Critical Incident Debriefing to law enforcement and other emergency services personnel. She is the Administrator for Catholic Counseling Services, an agency of Catholic Charities and has a private practice. She is President of the Dallas Psychological Association.

BILL WALSH

Lieutenant Walsh is a 19 year veteran of the Dallas Police Department and commander of the Investigations Unit of the Youth and Family Crimes Division, which includes the Child Abuse, Child Exploitation and Family Violence Squads. He currently serves on the boards of both the American Professional Society on the Abuse of Children (APSAC) and the National Network of Children's Advocacy Centers. Lt. Walsh has received many awards for his professional achievement, including being selected as the 1990 Dallas Police Officer of the Year and receiving the State of Texas Special Achievement Award for Public Service.

RITA YEAKLEY

Rita Yeakley has been an assistant district attorney for Dallas County for the past eleven years. She has been the chief prosecutor of the 305th District Court in the Juvenile Division since 1991. Prior to 1991, she prosecuted adults in the misdemeanor, felony trial and Child Abuse Division. She has the unique background of having prosecuted both adult and juvenile sex offenders.

ROGER YOUNG

Special Agent Young has been with the FBI for 24 years. In the past 22 years, he has been directly involved or consulted in over 1000 cases involving the sexual exploitation of children, child prostitution and obscenity. He has testified as an expert witness on many occasions in state and federal court and before the Nevada legislature. As a police instructor, SA Young has provided training for more than 10,000 local, state and federal law enforcement officers. In October 1992, SA Young was presented with the Career Achievement Award by the Career Achievement Award by the California Lutheran University Alumni Association for his achievements in the fight against the sexual exploitation of children and obscenity.

Volunteer Manual Outline

I. **Introduction**
- A. Welcome Letter
- B. Fact Sheet
- C. Our Children
- D. CAC Staff
- E. Board of Directors
- F. Child Protection Team
- G. CAC Board of Directors, Guild, and ??????
- H. The Report Card
- I. Definition of Children's Advocacy Centers of TX, Inc.
- J. Children's Advocacy Centers of Texas
- K. Better Business Bureau Guide to Charities in Austin
- L. TCCAC Tax Exempt Permit Information

II. **TCCAC Operational Policies and Procedures**
- A. General Policies
- B. Daily Operations
- C. Solicitation Guidelines

III. **Child Abuse**
- A. Recognizing Child Abuse
- B. Responding to Disclosure
- C. Glossary of Children's and Adolescents' Mental Health Terms
- D. Child Abuse: Reducing the Risk For Your Child
- E. ABCs for Teachers who Suspect Child Abuse

IV. **The Criminal Justice System**
- A. The Constitution Proclaims...
- B. Family Code: Defining Abuse
- C. How to Report Child Abuse
- D. The Child Protective Services Investigative Process
- E. *"Childproofing the System"*
- F. The Child Protection Team Investigative Process
- G. *"Interviewing the Child Victim"*
- H. Child Fatality Review Team

V. **CAC Volunteer Program**
- A. Training Requirements
- B. Position Descriptions
- C. Guidelines
- D. Student Intern Guidelines
- E. Pledge of Confidentiality

F. Media Release Consent
G. Volunteer Job Request Form
H. Monthy Hours Log
I. Family Greeter Guidelines
J. Child Assessment Program Guidelines
K. SibCare Guidelines

VI. We Pray for Children

VOLUNTEER ROLES

Family Greeter Program:
Volunteers provide a support system for the child and family during the child abuse investigation process. Responsibilities include greeting the child and family, assisting in distribution of information packets, interacting with the child throughout the interview process, and helping facilitate the interview process in the best interest of the child, family and team members.

In addition to the CAC Volunteer Orientation training, Family Greeters are required to attend a specialized training designed to educate volunteers about the interview process, family greeter guidelines, and interacting with children; and conduct three observations of the Family Greeter process.

Family Greeters are scheduled on a four hour/once a week basis.

Court School:
Volunteers work with CAC staff and representatives from the Travis County D.A.'s office to help educate children and their families about the court process. Children and their parents are taught about the criminal justice system and participate in a mock trial. Court School occurs in two 6 pm-8 pm evening components taking place at the Center the first night and an actual courtroom the second night. Volunteers participate directly with children and their families.

In addition to the CAC Volunteer Orientation training, Court School volunteers are required to atte[illegible] a Court School orientation session.

Court School occurs on Tuesday evenings bi-monthly from 6 pm-9 pm. To participate, volunteers must be available for both evenings of a session.

Group Therapy
Co-facilitators assist, plan and participate with a licensed therapist for the Sexual Abuse Group Therapy program. Co-facilitators participate in post-group staffings and provide administrative support for group activities. Qualified volunteers can participate as co-facilitators working alongside licensed therapists during group sessions

SibCare volunteers provide childcare for siblings of the children participating in group therapy session. Volunteers plan activities, set up snack, and interact with the siblings while the rest of the family is in group.

Project Monitor volunteers help maintain order and safety before, during and immediately following the Group Therapy program.

In addition to the CAC Volunteer Training, volunteers are required to attend a specialized training designed to educate volunteers about the interview process, family greeter guidelines, and interacting with children, as well as a brief orientation to the program prior to beginning the volunteer role.

Qualifications to Co-facilitate: coursework and/or practical experience providing clinical services (may substitute 6 months of reliable, responsible family greeter experience); and a recommendation from a faculty member/CAC staff member.

Group is conducted 4 times a year in ten week sessions. Volunteers participating in any role are asked to commit to all 10 weeks of a session.
Co-facilitators must commit to participate from 6 pm-9 pm all ten weeks of at least two sessions of group throughout the 1st year of volunteer service.
SibCare and Project Monitor volunteers must be available from 6 pm-8 pm each Wednesday evening.

Children's Assessment Program
Volunteers provided assistance to a pediatrician who conducts medical exams for evidence gathering purposes on children who have reported abuse. Responsibilities include setting up medical exam room, restocking supplies, assisting during exam process and clean up of medical room at the end of the day, and family followup.

In addition to the CAC Volunteer Training, volunteers are required to attend a specialized training designed to educate volunteers about the interview process, family greeter guidelines, and interacting with children, as well as an individual orientation to the program with the medical assistant.

Volunteers must commit to Wednesdays between the hours of 10 am-4:30 pm for approximately 4 hours.

Community Partners
The **Rainbow Room** is an emergency supply room available to Child Protective Service caseworker so they are able to easily access supplies that a family in crisis may need. Volunteers provide support to Chilld Protective Services caseworkers by helping in the Rainbow Room. Volunteers help sort through donated items, restock shelves, cnduct weekly inventory, provide administrative assistance and work on special projects designed to ease the workload of CPS caseworkers.

The **Adopt-a-Caseworker program** matches businesses, organizations and individual with a CPS caseworker to provide an additional resource for caseworkers to rely on in times of crisis. Volunteers help recruit organizations and businesses by doing presentations in the community, working with the Community Partners Coordinator to follow up and monitor adoptions, and helping develop an effective administrative system.

Volunteers must attend an orientation session for whichever program is of interest.

Rainbow Room volunteers are scheduled weekly between 8 am-5 pm for a minimum of three hours.
Adopt-a-Caseworker volunteers schedule volunteer activities with the Community Partners Coordinator.

Multidisciplinary Casetracking
Volunteers provide data-entry support to help maintain critical statistical information regarding the children who receive services at the Center.

In addition to the CAC Volunteer Training, volunteers are trained on the software program on individual basis.

Casetracking volunteers are scheduled on a weekly or as-needed basis. The scheduling of this role is flexible.

Special Events
The Center conducts our Annual National Association of Professional Athletes Celebrity Golf Tournament to help raise funds vital to our survival. Volunteers are encouraged to help with any and all of the activities associated with this event: Pre-tournament committees, preparations, the pre-party, tournament or awards dinner.

Each year, the Center volunteers sell raffle tickets from July to October for a BMW Z3 convertible. Tickets are sold at various locations and events around Austin by volunteers willing to support our organization. At the end of October, we celebrate the end of selling raffle tickets with a Gala where the car and other prizes are given away. Volunteers are encouraged to participate on committees, with selling tickets, decorating for the Gala, etc.

Special event volunteers are required to attend a short orientation at least one week prior to participating in an event.

Interns
Graduate and/or undergraduate students may participate in a variety of program tasks and responsibilities from clinical direct service to administrative support.

Training Support
The Center develops, coordinates and implements a variety of trainings focusing in on the Child Protection Team members and investigating and prosecuting child abuse. Volunteers may participate in the development of training materials, coordination efforts and on-site training registration.

Child Fatality Review Team
The Center coordinates and hosts the bi-monthly team of community agencies that meet to review the facts of deaths of children in the Travis County area. Volunteers participate in development, compilation and follow-through of death records and collateral materials and in the coordination of an annual report of the findings.

CHILDREN'S ADVOCACY CENTER

VOLUNTEER REQUEST

Date Requested: _____ Needs to be completed by: _____

Requested by: _____ ☐ Please see _____ for questions

****

Job Description:

_____

_____

_____

_____

_____

☐ _____ **Job Completed** _____ **& returned to** _____

check & initial **Date/Time** **Staff Member**

If this job wasn't completed:

Please indicate what was done & who was notified:

_____

_____

_____

_____

CIVIL (SECTION 261- TEXAS FAMILY CODE)

Emotional Abuse: mental or emotional injury that **results in an observable or material impairment in growth, development, or psychological functioning; also, causing or permitting the child to be in a situation** in which the child sustains a mental or emotional injury that results in an observable or material impairment in growth, development, or psychological functioning.

Sexual Abuse: sexual conduct harmful to a child's mental, emotional, or physical welfare; compelling engagement in sexual conduct as defined by Section 43.01 of the Texas Penal Code; causing, permitting, encouraging, engaging in or allowing the photographing, filming, or depicting of a child if the person knew or should have known that the resulting photograph, film, or depiction is defined as obscene by Section 43.21 of the Texas Penal Code.

Abandonment: leaving a child in a situation that exposes the child to a substantial risk of mental or physical harm, without arranging for necessary care, **and a demonstration of an intent not to return.**

Medical Neglect: failing to seek, obtain, or follow through with medical care for a child, resulting in or presenting a substantial risk of death, disfigurement or bodily injury or an observable and material impairment to the growth, development, or functioning.

Section 22.041: Abandoning or Endangering a Child: having care, custody, or control of a child younger than 15 years, intentionally leaves the child in any place without providing reasonable and necessary care, **under circumstances which no reasonable, similarly situated adult would leave a child of that age and ability, exposing the child to risk of harm or imminent danger of death, bodily injury or physical or mental impairment.**

Physical Abuse: physical injury that results in substantial harm or **genuine threat of substantial harm; including an injury that is at variance with the history or explanation given; also failure to make a reasonable effort to prevent an action by another person that** results in physical injury that results in substantial harm.

Neglectful Supervision: placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond their level of maturity, physical condition, or mental abilities and results in harm or substantial risk of harm; also, placing a child in or failing to remove a child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child.

Physical Neglect: failure to provide food, clothing, or shelter necessary to sustain life or health, excluding **failure caused primarily by financial inability** unless relief services have been offered and

CHILD ABUSE

Refusal to Accept Parental Responsibility: failure by **the person responsible for a child's care to permit the child to return home without making arrangements for the child after the child has been absent from the home for any reason , including residential placement or having run away.**

CRIMINAL (TEXAS PENAL CODE)

Section 261.101: Requirement to Report (Texas Family Code): A person having **cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect by any person shall immediately make a report. The requirement to report applies without exception to an individual whose personal communications may otherwise be privileged**, including an attorney, a member of clergy, a medical practitioner, a social worker, and a mental health professional.
A professional, including teachers, nurses, doctors, and day care employees shall make a **report not later than the 48th hour** after the hour the professional first suspects that the **child has been or may be abused or neglected. A professional may not delegate to or rely on another person to make the report.**

Section 21.11: Indecency with a Child: engaging in sexual contact with a child; exposure of anus, or any genital part, knowing the child is present with intent to arouse or gratify the sexual desire of any person.

Section 22.04: Injury to a Child: intentionally, **knowingly, recklessly, or with criminal negligence, by act or omission causes a child: serious bodily injury; serious mental deficiency, impairment, or injury. An omission in this section is an offense if: the actor has a legal duty to act, or, has assumed** care, custody, or control of the child.

Section 22.01: Sexual Assault/ Aggravated Assault: intentionally or knowingly causes the penetration of the anus or female sexual organ of a child by any means; causes the penetration of the mouth of a child by the sexual organ of the actor; causes the sexual organ of a child to contact or penetrate the mouth, anus or sexual organ of another person, including the actor, or causes the anus of a child to contact the mouth, anus, or sexual organ of another person, including the actor.
The offense is aggravated if the victim is younger than 14 years of age.

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TRAVIS COUNTY CHILDREN'S ADVOCACY CENTER
Volunteer Training Agenda

Monday, February 8, 1999

[redacted]pm-6:35 pm	Welcome/ Staff Introductions/ History of the Center	Sandra A. Martin, Executive Director Travis County Children's Advocacy Center
6:35 pm-6:50 pm	Volunteer Introductions/Icebreaker	Sandra A. Martin, Executive Director Travis County Children's Advocacy Center
6:50 pm-7:00 pm	Confidentiality	Sandra A. Martin, Executive Director Travis County Children's Advocacy Center
7:00 pm-8:30 pm	The Child Protection Team Panel: CAC-Amanda Van Hoozer, Victim Services-Kim Bird, Law Enforcement-Nancy Zimmerman, CPS-Randy Shell, District Attorney-Dayna Blazey	Amanda Van Hoozer, Program Services Director Travis County Children's Advocacy Center
8:30 pm-9:00 pm	Our Children	Kim Bird, Supervisor Family Violence Unit/Victim Services

Tuesday, February 9, 1999

6:00 pm-6:45 pm	Welcome/ The Cost of Abuse for a Child	Rick Hatfield, M.Ed LPC Private Therapist *(specializing in child therapy)*
[redacted]pm-7:45 pm	Signs & Symptoms of Physical Abuse & Neglect: Slide Presentation	Sharen Soliz, Detective Child Abuse Unit/Austin Police Department
7:45 pm-9:00 pm	Signs & Symptoms of Sexual Abuse: Video Presentation	Amanda Van Hoozer, Program Services Director Travis County Children's Advocacy Center

Thursday, February 11, 1999

6:00 pm-6:20 pm	Welcome/ Our Community and Child Abuse	LaRu Woody, Director Family Justice Division Travis County District Attorney's Office
6:20 pm-7:00 pm	The Civil versus Criminal Court Systems	LaRu Woody, Director Family Justice Division Travis County District Attorney's Office
7:00 pm-8:00 pm	Children's Rights/CASA	Cathy Cockerham, Program Director CASA *(Court Appointed Special Advocates)*
8:00 pm-8:30 pm	Volunteer Opportunities:	Michael Torres, Associate Director Travis County Children's Advocacy Center
[redacted] pm-9:00 pm	CAC Volunteer Commitment: Be Part of the Solution	Michael Torres, Associate Director Travis County Children's Advocacy Center

Revised: 8/17/98 2:43 PM

Specialized Training Agendas

Family Greeter
Tuesday, February 16, 1999

6:00 pm-6:10 pm	Welcome	Marcia Wilson, Clinical Director Travis County Children's Advocacy Center
6:10 pm-6:30 pm	The Interview Process	Cyndi Cantu & Carly Moore, Forensic Interviewers Travis County Children's Advocacy Center
6:30 pm-6:45 pm	A Family Greeter Volunteer	Marcia Wilson, Clinical Director Travis County Children's Advocacy Center
7:00 pm-8:00 pm	Guidelines for Volunteers Interacting w/Clients & Families	CAC Program Staff Travis County Children's Advocacy Center
8:00 pm-8:45 pm	Questions & Answers	
8:45 pm-8:55 pm	The Next Step: Observations	Amanda Van Hoozer, Director of Program Services Travis County Children's Advocacy Center
8:55 pm-9:00 pm	Adjourn	Amanda Van Hoozer, Director of Program Services Travis County Children's Advocacy Center

DEBRIEFING SESSIONS QUESTIONAIRE

DATE: **APPOINTMENT DATE/TIME:**

VOLUNTEER'S NAME:

PROGRAM:

What is going well for you?

What difficulties you are experiencing?

Is this schedule working well for you?

What suggestions or requests do you have?

Volunteer Signature

Designated Staff Signature

01/12/98 11:04 AM
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Volunteer Opportunities

at the
Travis County
Children's Advocacy Center

Volunteers provide the critical support needed for the Children's Advocacy Center to successful ly meet the needs of child abuse victims and their families. As a Volunteer, you will have the chance to learn, meet others, and make a difference in a young child's life.

Family Greeters provide a support system for the child and family during the child abuse investigation process.
(M-F, 8:30 am-12:30 pm, 10 am-2 pm, or 12:30 pm-4:30 pm)

*

Graduate and/or Undergraduate **Interns** participate in a variety of program tasks and responsibilities from clinical direct service to administrative support.

*

Volunteers help educate children about the judicial process with the **Court School** program.
(Bi-monthly, 2 nights, 6:00 pm-8:00 pm)

*

Medical Exam volunteers help ease the child's and parent's fears and provide assistance to the pediatrician during forensic medical exams.
(Wednesdays, 11:00 am-4:30 pm)

*

Child/Parent Support Group volunteers assist by co-facilitating groups or provide child care for the siblings in the family.
(Wednesdays, 6:00 pm-8:00 pm)

*

Volunteers support Child Protective Services caseworkers and help families by volunteering in the **Rainbow Room** and **Adopt-A-Caseworker** program. (flexible)

*

Volunteers Also:

Participate in our **Celebrity Golf Tournament** (July 9th) and our **Raffle/Gala**. (July-October)

Help with **Yard/household maintenance**

Offer **Administrative assistance** with special projects

Training is mandatory for all volunteers.
All volunteers are required to complete an application, records check and an interview prior to attending training.

FOR INFORMATION ON VOLUNTEERING, PLEASE CALL
MELISSA FAZ @ 472-1164

HOW DO I HELP THIS KID?

DIRECT INTERVENTIONS FOR TRAUMATIZED CHILDREN

CRIMES AGAINST CHILDREN CONFERENCE, 1999

Presented by: **Kellie Cole, M.Ed., LPC-S, RPT-S**
Collin County Children's Advocacy Center
2205 Los Rios Blvd. Plano, TX. 75074
972-663-6600

"All In A Little Time"

It all began when I was born
Like a rosebush without a thorn.
A period of time with no one there,
I had hopes and dreams and Grandparents who care.
I didn't have a single doubt in my mind
Then she returned, sweet and kind.
I trusted her and she abused that,
Now I feel like punching her with a bat.
Now that my life has changed, I have problems;
I must cope with it and solve them.
Today is totally different; I live with a stranger.
Could this be good or could this be danger?
What ever this is you know who to blame.
Her excuse was "I love you", how lame!
It's not my fault, I learned that now.
But I had to put up with it somehow.
This isn't the beginning or the end.
I didn't lose, nor did I win.

Written by a 13-year-old female survivor of physical and sexual abuse.

In exploring the various approaches in helping children heal from the trauma of child abuse it is critical to consider what comes most naturally.

The most natural form of communication and expression for children is play and activity. Play has intrinsic value and allows for the expression of individuality. When non-directive, children are granted the freedom to organize their experiences, thus bringing a feeling of empowerment and completeness.

Using symbolic representation, a child or teen can take an unmanageable situation, traumatic event, or feeling and change it into a manageable experience, leading to the development of healthy coping skills.

The therapist's responsibility is to meet the child or teen at his/her developmental level and communicate through the medium with which the child is most comfortable. The therapist facilitates freedom, decision making, self-responsibility, consistency, spontaneity, empowerment, validation, and affirmation.

In determining which symbolic and play techniques to utilize in working with an abused child or teen several areas must be explored.

MEDIATING FACTORS

These factors mediate the impact of abuse on children. (Eliana Gil, 1991)

- Age of the child at the time of abuse. There are indications that the younger child is more vulnerable to damage. The latest research on brain development, by authors like Bruce Perry, supports that the first three years of life are the most critical in laying the foundation for healthy cognition's, emotions, and relationship skills.
- Chronicity. Helplessness and vulnerability increase as the length of time the abuse continues increases, leading to refined defense mechanisms.
- Severity. Physical abuse and neglect in severe forms can lead to developmental delays, failure to thrive, lack of attachment, brain damage, and other problems. Sexual abuse involving sadistic acts and/or penetration has been associated with a greater negative impact.
- Relationship to offender. Being abused by a loved one can lead to a generalized view of the world including "all people are bad", "people who love you hurt you", and "no one will protect me".
- Level of threats. Threats can produce generalized anxiety and fear in the child, interfering with daily routines and school performance. Children may perceive covert threats as serious and realistic.
- Emotional climate of the child's family. Factors associated with families that perpetuate child abuse include high levels of stress, mental health problems, spouse abuse, poor communication and coping skills, divorce, and isolation.
- The child's mental and emotional health. Good psychological health prior to abuse may lead to resisting damaging effects of abuse. Problems prior to abuse may compound the ability to heal and experience safety.
- Guilt felt by the child. Guilt has been associated with children exhibiting longer recovery periods and a greater impact from the abuse.

- The sex of the victim. (Briere, 1989) Indicated that males show long-range serious problems and greater psychopathology.
- Parental responses to the child's victimization. Numerous researchers have emphasized the pivotal role the non-offending parent plays in enhancing a child's recovery. A non-supportive parental response may lead to greater trauma for the child.

OTHER FACTORS

Anna Salter has researched the impact of sadistic versus non-sadistic sexual abuse on children. She places the trauma and response to sexual abuse on a continuum. This indicates that reactions and level of trauma may be associated with: perception of abuse, relationship to offender, threats and amount of force used, and whether sadism was the approach of the offender.

Additionally, Anthony and Cohler (1987) studied the variable of resiliency in children. They looked at recoil and regression along with biological factors to indicate whether a child bounces back from a traumatic experience, or becomes embedded in the event itself.

Eliana Gil (1991) looked at internalization and externalization of children's traumatic experiences as tools in determining interventions in the child's therapy.

THE USE OF PLAY THERAPY WITH TRAUMATIZED CHILDREN

Play therapy is a magical healing process that generally evolves through the following stages:

Stage I:	Building trust and consistency in the therapeutic relationship. Involves an exploration of the relationship and testing for protection.
Stage II:	The expression of needs, feelings, testing limits, re-enactment of trauma.
Stage III:	Resolving issues, experiencing relief, feeling empowered, integration of self.
Stage IV:	Preparing for graduation and achieving separation.

In stages two and three the emergence of themes in the child's play will become evident. Themes may represent the following:

1. Internal struggles
2. What the child has experienced
3. What the child has been deprived of, is needing, wishing for, fantasizing about

Common themes for abused children include:

* Power/Control
* Anger/Blame
* Trust/Relationships/Abandonment
* Nurturing/Rescuing/Security
* Boundaries/Intrusion
* Violation/Protection
* Self-Esteem/Identity/Image
* Fears/Anxiety
* Confusion/Disintegration
* Loyalty/Betrayal
* Loss/Death/Grief
* Loneliness/Isolation
* Adjustment/Change

THE USE OF TECHNIQUES

During the second stage of the healing process the use of techniques can be integral in helping a child move into and through stage three.

In considering the use of techniques, it is crucial to note that every child integrates their abuse differently and brings their own unique experiences into the play therapy relationship. The issues that abused children must deal with are complex and varied, requiring the therapist to develop a consistent approach to each case while allowing for variation in the application and selection of techniques. The following are critical points to keep in mind when introducing techniques into the therapeutic relationship with children.

- I can learn the most about children from children
- Every child is a unique individual and must be given the freedom to be themselves
- Children must be treated with respect
- Children must be allowed to work at their own pace
- Children are resilient and can overcome
- The child will take the therapist where they need to go in recovery
- Children have a right to remain silent
- Children learn and grow best with consistency and security
- Children need to be heard, admired, and valued
- Children's value comes from being, not doing
- I have no expectations of the child
- Every child integrates their abuse in their own way
- The child is the leader
- Children need choices; they need to feel powerful
- Children have a right to all of their feelings
- Children have a right to privacy and confidentiality
- Children have a right to say "No" and have that word respected

THE USE OF TECHNIQUES SHOULD MOST OFTEN COME OUT OF SPONTANEOUS, UNSTRUCTURED FREE PLAY.

In using a technique with a child there is a three-step process to follow:

Step 1: Introduction: This should come in the form of a suggestion, i.e. "I wonder if you could draw that for me? Always give the child a choice of medium or approach, i.e. "You can choose paints or chalk." *EXPECT AND RESPECT RESISTANCE.* Give children the choice of taking a break from or stopping the activity. If the child is not ready for something, DON'T push it. Interjecting your own ideas and beliefs is only necessary when addressing safety and/or helping a child who has been stuck in replaying the trauma attempt resolution.

Step 2: Activity: Be very present with the child and follow their lead. Use your own internal barometer to determine whether you need to track their activity, be silent, or dialogue.

If the child stops the activity prematurely, respect that and offer a reflection that indicates your respect, i.e. "You decided that was too hard for you to think about today. You took care of yourself by knowing when to stop." If the child is involved in the activity, remind them of the time remaining in the session so there is ample time to complete the activity or find a stopping point. Once the activity has stopped, it is important to ask the child open ended questions to assist them in integrating new ideas, i.e. "Can you tell me about this part?" "How did it feel to make this piece?" Asking the child to enter into the metaphor or symbol can further integration and awareness. "If you were this part and could speak, what would you say?" Finally, offering a connection to their own internal world can facilitate true insight and change, "I wonder if this is true in your life?"

Step 3: Closure: For activities that evoke intense reactions or emotions, offering unstructured free play for the last 10 minutes can be helpful. Give the child a choice about how they want their project stored. Acknowledge the work they have done (encouragement, not praise). Offer the opportunity to share information learned about themselves with someone else or to keep that private. Keep in mind it is never a good idea to end a session before the child has had the opportunity to process the activity and their feelings.

The following pages include materials and techniques that I most often utilize in my work with abused children.

The following is a list of supplies or concepts that I find to be the most useful when working with children. Many of them tend to be "creative materials" that build on the creative energy inherent in children. Following this list, I have included various activities for using them with children.

CLAY This is an excellent medium that can provide many different experiences for the child. It allows for tactile stimulation and can be manipulated, molded, shaped, torn-up, reshaped, pounded, thrown, poked, mashed or squeezed. It can also be used with water, which can bring about regression or body memories. Using clay, abused children can work on anger, grief and loss, change, self-esteem, shame, body image, identity and stress.

SAND Sand is another medium that can be molded and shaped. It is also tactile and can be used with water. I recommend the fine sand that dries quickly and does not produce much dust. Sand allows for free association and for some children represents distinctive phases of healing. Some themes represented in sandplay are chaos, power struggles, resolution, boundaries, and vegetation. Using the sand, children can bury/unbury, create, hide, protect, destroy, be messy, cleanse or clear away (externalizes what is inside), progress, regress and create or remove obstacles. Through sand play, the child becomes more present and connected with the environment.

WATER Water is extremely important in working with sexually abused children. For some children, their abuse may have taken place or been centered around the use of water. Therefore, water may be used to re-enact the trauma or repair damage. For many children, it is the vehicle through which they cleanse themselves of the shame and "dirty" feelings they hold inside. In therapy, children should always have access to water. When a child begins to perform "cleansing rituals" in the playroom, send restorative messages, i.e. "You are a clean boy", "It feels good or new to be clean."

ART THERAPY This involves a rather broad group of materials. In focusing on activities and techniques with abused children, I tend to use finger paints, tempera paints, drawing and collages. Each item listed employs various properties and allows for tactile stimulation, as in the use of fingerpaints. Through art, children can represent parts of themselves, their environments, their fantasies, struggles and needs. They can symbolically cover up or destroy parts of themselves, the world or others they do not like. Some techniques, such as House Tree Person and Kinetic Family, are helpful assessment techniques.

RELAXATION Many abused children come into therapy exhibiting symptoms of Post Traumatic Stress Disorder. Common symptoms among children I have worked with include nightmares, enuresis and anxiety. It is helpful to teach children how to get in touch with their bodies and help themselves relax. A well-rested or relaxed child is more capable of developing insight. Relaxation techniques empower children and help them feel in control of their bodies, a treasure many lose when sexually or physically abused. A tape recorder, relaxation tapes and scripts are good tools to have.

GUIDED IMAGERY Abused children commonly use coping skills or "survival" skills that allow them to disconnect from the intensity of their feelings or repress memories of their abuse. Guided imagery, when a child is ready, can provide them with a safe avenue in which to explore some of their feelings and symptoms of their abuse. It allows the child to break their trauma into manageable pieces and reconnect with themselves and their environment. It can also be a valuable tool with which to explore aspects of the self, create safety in times of stress and facilitate some art activities. The use of metaphors and paradox fall into this category, creating insight and awareness.

PUPPETRY Puppets can provide safe characters for children to talk to or through. They can be used to work through relationships, demonstrate perpetration or victimization, produce constructive endings, display fantasies and provide avenues for aggression and the need to feel powerful. A child who is not ready to disclose aspects of his/her abuse or feelings of betrayal is often able to act out the abuse through puppets. Children will often tell a puppet more information than they would tell to the therapist. It is important to have both people and animal puppets demonstrating a variety of characteristics.

MEDICAL KIT A medical kit can be critical to a traumatized child's recovery. These days, most children will have a sexual assault exam to gather forensic evidence regarding their abuse. The medical kit can be used prior to the exam to facilitate "structure-release" play or may become important in the child's play therapy as they emulate the exam experience through the use of the medical kit. In addition, children can play out themes of power and victimization as they take turns being the patient and the healer. They may also create restorative or healing themes as well as demonstrate ambivalent feelings towards themselves, the perpetrator, family members or you. Specifically, the syringe may be used to work through issues surrounding penetration and pain and the *real* stethoscope becomes an important tool to realize that they are resilient and whole.

BOUNDARIES For children who have been violated, boundary work becomes an important recovery area so that they defer shame to the perpetrator, work through the initial shock of being violated, accomplish developmental social tasks, learn assertiveness and practice anti-victimization concepts. Important tools for boundary work include ropes, yarn, string, toy fences and barricades and blocks or cardboard boxes and bricks. In addition to these ideas, it is important to always have a place in the play therapy room that can create a natural boundary between you and the child. For many play therapy rooms, the two-sided easel lends itself to allowing the child to set a space and distance boundary.

MUSIC Music creates a sensory experience and an expressive medium that can be controlled by the child. For children who are apprehensive, withdrawn, non-communicative, selectively mute or have difficulty with emotional expression, music may create the perfect outlet for mastering their environment and internal conflicts and emotions.

ANGER BOX An anger box includes items that can be torn, ripped, crushed, crumpled, thrown and stomped. These items may include egg cartons, old phone books, paper scraps, cardboard, packing peanuts and small boxes. The anger box provides an outlet for children who express destructive or constructive negative emotions as they relate to their abuse.

PENETRATION While not all sexually abused children have suffered penetration, it is still important to include materials that could facilitate healing for the child who was sexually penetrated. Some of these items include: a toy syringe, a cobbler's bench, a pounding block with a real hammer and nails, swords, knives and animals or puppets with open mouths.

DOLL HOUSE Many abused children have issues surrounding home life. Some were molested by a relative, live-in foster care or with other relatives, have suffered through a divorce, have a parent in jail and/or may struggle with boundaries at home. All children need at least one doll house, with a wide array of furniture and dolls, to help them deal with these issues.

NURTURING Toys that facilitate nurturing play allow the child to repair damage that was done to their sense of safety, security, ability to trust, love, be loved, ability to ask for help and to their sense of self. It also allows the child to play out fantasies, wishes, need for power or to emulate their home environment. These toys can provide for regression and allow children who were abused pre-verbally to regress to prior or missed stages of development. Finally, nurturing toys provide relief when the child experiences an anxiety disruption in their play. This occurs when the play is too intense for the child to handle and they abruptly stop or disrupt their play to switch to play that is structured and/or nurturing. Nurturing toys include kitchen supplies, water, sand, music, baby dolls, the doll house, a diaper bag with diapers and baby bottles and art materials.

DRAMATIC PLAY This allows the child to take on particular attributes, either strong or weak, and act them out. It can also be used to reverse roles and work with polarities. The child may assign the therapist a role (the child always decides who/what the therapist will be and do or say). It is important to include lots of variety for dramatic play. Include dress-up clothes and props that allow children to explore or try out gender roles, super heroes, fantasy figures, community helpers, evil creatures or monsters, powerful beings, villains, rescuers and law enforcement (always include a black robe, like a judge wears - graduation gowns work great!).

Next is a list and brief description of the techniques and activities I use most often. Some had been collected from books, articles and other publications, some have been borrowed and modified from other therapists, some are my own and some have been created by children. I hope that you will find them helpful.

"Trash Bag Exercise": Using a plain grocery sack, the child and I sit facing each other with the bag inbetween. We talk about icky, yucky things we normally put in the garbage. This is fun and the therapist should ham it up. We then talk about what it would be like to have to carry the bag with you everywhere. This is sort of what it's like to carry around bad or yucky feelings inside. The child is then asked to think about things that have happened to them or icky feelings they have inside. As they talk, the therapist writes each down on a small piece of paper. The child gets to put them in the garbage bag. The child can stop when they are ready. Following the exercise, the child can write on the bag if they like. In following sessions, the child can pull something from their bag to work on. We try to replace the icky stuff in the bag with good stuff.

"Pain Getting Better": In this exercise, I ask the child to use something to draw or paint with. I then ask the child to separate a large piece of paper into three sections. In the first one I ask them to draw a picture of their "pain". In the second, I ask them to draw a picture of what their pain would look like if it were "all better". In the third, they draw what happened to change the pain. This externalizes the pain, instills hope and establishes direction.

"Recovery Road Map": On a large piece of paper, I ask the child to draw or write, in the bottom left hand corner, their abuse or biggest problem. In the upper right hand corner, I ask them to draw a picture of recovery. On the rest of the paper, they are instructed to draw a "map" of their recovery, including how much time they think it might take, obstacles in the way, people they will have to deal with and resources they can use to get better. This works particularly well with teenagers.

"Restoration of Power": Using something that the child can attribute magical powers to (some kids have chosen marbles, shells, puppets or created their own character) you and the child conduct a ceremony, which might take several sessions, to restore power to the child and remove power from the perpetrator. You can incorporate drawings, sand tray, clay or other materials in order to squash the perpetrator's powers. Guided imagery, metaphors or art can also be used to restore power to the child. Children are definitely the directors in this exercise.

"Nightmares": There are many different ways to give children more control over their dreams. Some things I have done include: Having the child draw or act-out their nightmare and then change the ending. Create a magic wand and give it magic words to make the bad dream go away. Use guided imagery and relaxation techniques to create pleasant scenes in the child's mind. It is extremely important to involve parents or caregivers in these activities so that they can also help the child. Dream catchers are popular and can be made during a therapy session.

"The Rosebush": This is a technique developed by Violet Oaklander and can be found in her book "Windows to Our Children". It is a wonderful exercise that can be modified and used with children of all ages.

"Worry Wall": The worry wall can be done on any wall or door of the room. It is a place where children can identify the things that they worry about, write or draw them on a piece of paper and tape them on the wall. (The bigger the worry, the higher up on the wall it goes). Abused kids often worry about many things. You might want to create worry roads on the wall to address the different types of worries, i.e. "worries about my body", "worries about court", "worries about my family", etc. The child removes the worry when they no longer worry about that issue, thus tracking their own recovery. To protect confidentiality, worries are taken down after the child leaves each session. The title "Worry Wall" stays on the wall to help children realize other kids worry, too! Thanks to Stacie Gensler for this one!

"Feelings Wall": The feelings wall is basically the same concept as the worry wall. You can create this

type of activity to help children identify, understand, integrate and master a variety of issues and/or feelings relating to abuse. Remember that abused children may need help identifying their feelings before they know how to share them.

"Memory Books": Some children have sustained numerous traumas related to the abuse. For those who seem to have been through many changes, have faced multiple losses or taught themselves to "disconnect" from their abuse, a memory book may be helpful. To keep this idea child-directed, introduce the idea with a short explanation and listen for how the child might want to create a memory book.

"Life Line": A life line is a similiar concept as the memory book and I use it to help children who have a tough time remembering their past. Most children choose to do this on a long piece of newspaper print and draw in the numbers from "0" to how old they are today. The child then decides how they want to fill in the life line. Family members or foster parents can be excellent resources for this activity as they can provide the dialogue and perhaps pictures and memorabilia to help the child get started. I have seen children develop a sense of self, a history that they could own and a sense of completeness with this activity.

"A Page In My Book": Abuse can cause children to feel different from their peers and they may also feel like the abuse consumes their life. A Page In My Book helps children break the abuse down so that it does not seem so big. It also helps them focus on all parts of who they are instead of just one. It attempts to integrate their abuse experience into their life and to see themselves as a survivor. I typically ask kids, "If your life story were a book, how many pages would be about the sexual abuse?"....."what would the rest of the book be about?"...."who would get to read it?"....etc., etc.

"Cleansing": Sexually abused children sometimes hold misconceptions about things that have happened to their body. If their perpetrator penetrated them or ejaculated on them, in them or around them or was the same gender, they may think that they have something "stuck on them", in them, are pregnanat, are gay or are damaged. There are a variety of ways you could help the child change their distorted thinking and associated feelings. Providing the child and family members with age-appropriate information about sexual abuse and the body is very important. In addition, you may need to initiate a "ritual" or "set of rituals" that the child can perform to help them believe that they are OK. Eliana Gil has a great idea in Play in Family Therapy.

"Journaling": Children as young as three or four like to journal about their feelings. Journaling helps children cope with life outside of play therapy, learn how to take care of themselves, brings on self-awareness and self-validation, keeps them in touch with feelings, provides a constructive outlet, helps strong emotions become more manageable and helps them understand all feelings are OK. I typically give kids spiral notebooks with age-appropriate feeling charts glued to the inside cover.

"Family of Clay": Adapted from Violet Oaklander. Make each member of your family with clay, in the shape or form of an animal. Pretend that each one is talking about being in the family, but is saying things like the animal might say. Make connections between the animal and the family members attributes. Very often, I use spontaneous techniques when children are using clay, based on whatever has come forth in their mind. I often ask them to become the clay or object they have made.

"Self Image": It is always important to have a mirror in the play room. Whether a child freely looks at themselves can indicate their level of shame and image of self. Sometimes I ask the child to look in the mirror and describe what they see. Many children cannot do this at all and others can only describe themselves negatively. To work on self-image, I have used body outline drawings, positive affirmations, the hokey-pokey and sensory experience exercises.

"Feelings": It is crucial to have a poster in the playroom depicting various emotions. The poster itself leads to many exercises in labeling and owning feelings. I often use cardboard boxes, masks or balloons to talk about feelings. With a cardboard box, we are able to talk about "My inside self and my outside self". Using masks,

we can identify the ways we hide behind feelings and balloons are helpful to demonstrate what happens when you stuff your feelings.

"Sensory Exercises": Some children have such a damaged sense of self or are so disconnected from themselves I sometimes start with some basic sensory exercises. This helps to get them in touch with their environment, themselves and what they like and don't like. It also allows them to have their own opinions. I may bring in different things for them to touch, smell, hear, see, taste and feel. We make lists of the things they like and the things they don't.

"Regression": I typically do not do much more than provide access to and permission for the child to use various things that may facilitate regression and self-nurturance. Real baby bottles, pacifiers, blankets, diapers, wet wipes and baby powder are appropriate supplies to provide. Minimal encouragement can sometimes begin remarkable repair work. This is particularly helpful for children who experienced pre-verbal trauma. Statements from the therapist idicating babies are good and deserve to be held, cuddled, fed, can be helpful.

"Court Room Drama": For children who need to prepare for court, have already been or just need to experience some justice, I use dramatic play. This allows them to try out different roles, decide the perpetrators fate, build strength to face the court room or play judge and jury. A black robe, handcuffs, rope and a gavel can be helpful in setting the scene.

Board Games: I utilize board games and card games that focus on specific issues. Some board games help children to feel more powerful simply by providing them with correct information, such as "Sexual abuse is never a child's fault." Two of my favorite games are card games called "Let's talk about touching in the family" and the other is called "Let's talk about touching".

Books: There are so many wonderful, therapeutic books for children of all ages that the list is too exhaustive to supply. Some tell stories and others are workbooks. If you don't find one that addresses a particular issue, write your own, it's easy!

"My World": This activity uses a circle drawn on paper and asks the child to put things inside that they like about their world and don't like about their world. It is also an excellent way to help suicidal children talk about the part that wants to live and the part that wants to die. Thanks to Elaine Johnson for this one.

"Parts of My Heart": This exercise helps the child explore positive and negative feelings and memories about significant people in their life. At the top of a piece of paper, I write "Parts of My Heart About _____". I draw four hearts and either list + and - feelings below each heart or allow the child to come up with the feelings. In each heart, they write or draw a memory about that feeling.

"Whole Person": This exercise helps children accept all of their developmental aspects as well as acknowledge and support the importance of self-care. On a large piece of paper or dry erase board, the idea is introduced that many parts make up a person. I write intellectual, emotional, social, phsycial, spiritual and sexual. We discuss what each means and the child shares their ideas. The most difficult is sexual and most often the most important one to talk about.

"Regret vs. Responsibility": Children who have been abused often believe it is their fault. Helping children distinguish between "Regretting" that they didn't tell sooner and being "Responsible" for it happening is a crucial step in helping place responsibility in the right place. Thanks to Karen Nash for this concept!

I order most of my supplies through therapeutic supply companies, like Kids Rights; Child's Work, Child's Play; Constructive Playthings; Red Flag Green Flag Resources; and Anna's Toy Depot. Give me a call if you would like to get a copy of these publications for yourself.

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Why play therapy helps abused children

p. 1 Play Therapy Interventions

> add techniques from here

Mediators in effects of child abuse

p. 3 Healing Power of Play

add: Anna Salter Sadistic vs. nonsadistic ...

Differential effects of abuse (Finkelhor) need to be considered as impacting tx. i.e - culture, age, justice system, effects of abuse.

Chicken or egg?

Impact of abuse is on a continuum - p 7

Stress resistance & resiliency p 11

Internalized vs externalized

Victim ≠ trauma p. 10

MISSING CHILDREN

Sgt. Gary R. O'Connor
Lower Gwynedd Police
Spring House, PA 19477

A TEST OF KNOWLEDGE

1. T F Law Enforcement agencies with written policies and procedures concerning missing children respond more effectively than those who do not.

2. T F Most children who are reported missing are runaways and are not a law enforcement concern.

3. T F Approximately 850,000 children a year are entered into NCIC as missing children.

4. T F Missing Children are unlikely victims of sexual exploitation.

5. T F A reasonable waiting period (24 hrs) is appropriate before entering adolescent runaways into NCIC.

6. T F A deputy or officer should be dispatched on all missing children cases.

7. T F The primary motivation for non-family abductions is ransom.

8. T F 75% of the victims of child abduction homicides are killed within the first three hours.

9. T F Child abductors tend to be socially competent.

10. T F All 50 states have Missing Children Clearinghouses.

11. T F The best tactics against child predators are prevention and preplanning by law enforcement.

12. T F Most non-family child abductions occur more than 5 miles from the child's home.

13. T F The NCMEC and FBI can be of great assistance in child abduction cases.

14. T F Frequently the most serious problem with family abduction cases is not in locating the child but in recovering him or her.

15. T F FPLS can assist in locating an abducting parent.

THE FIRST 48 HOURS

- Victim Concerns
- Initial response by Law Enforcement
- NCMEC Assistance
- FBI Assistance

CHILD ABDUCTION HOMICIDE STUDY

- 521 victims
- 419 killers
- 44 states

VICTIM CHARACTERISTICS

- W/F
- 11.4 yrs. of age
- Considered a normal kid

KILLER CHARACTERISTICS

- W/M
- 28 yrs. old
- Criminal history

HOW SOON WAS THE CHILD MURDERED?

- 44% in the first hour
- 74% in the first three hours
- 40% were dead before they were reported missing

IMPLICATIONS FOR LAW ENFORCEMENT

- Need for a pre-planned response
- To include clearinghouse and NPO involvement

INITIAL RESPONSE

- Preserve initial report
- Dispatch officer/deputy
- Preserve any potential scenes
- Enter child into NCIC
- Broadcast known details
- Assume worst until proven otherwise

INITIAL RESPONSE (con't)

- Initiate pre-plan
- Notify and request FBI Assistance
- Mutual aid
- NCMEC
- State Clearinghouse / NPO

INITIAL RESPONSE (con't)

- Search of premises
- Interview complainant
- Obtain detailed description
- Assess risk

DETERMINE VALIDITY

- Location
- Time of Day
- Potential Witnesses
- Area Search
- Child's and Family's History

FOCUS ON CHILD

- Description
- Photos/video
- Friends/siblings
- Interests
- Problems

FOCUS ON CHILD (con't)

- ID possible abduction site
- Check parental attitudes
- Family finances
- Child's room

NEIGHBORHOOD CANVASS

- Conduct as soon as possible
- Use prepared canvass questionnaire
- Preferable to use skilled investigators
- Free officers from CFS

NEIGHBORHOOD INVESTIGATION

- Appoint neighborhood investigative coordinator
- Photograph and video neighborhood
- Determine dynamics of neighborhood
- ID areas where victim may have been taken
- ID areas where suspect may have been
- Check for prior attempts
- Check known sex offenders

ESTABLISH COMMAND POST

- Utilize interagency resources as needed
- Set up away from victim's home
- Ability to accommodate large numbers of personnel
- Establish security
- Set up information management system
- Tip lines
- Trap and trace

LIAISON OFFICER TO VICTIM FAMILY

- May be a role for Clearinghouse
- Brief family
- Trap and trace, log and record
- Contact with Command Center
- Tags and visitors

LIAISON OFFICER (pt. 2)

- Secure residence
- Search thoroughly
- Additional photographs, video
- Enhance victim info
- Interview friends
- Check diaries, letters, computers
- Obtain fingerprints, hair samples, dental chart

LIAISON OFFICER (pt. 3)

- Counsel family
- Explain procedures
- Link family with support / NPO's
- Help family meet basic needs
- Sense of security and professionalism

CASE ORGANIZATION & MANAGEMENT

- Administrative Head
- Lead Investigator and Agency
- Media Coordinator
- Support Coordinator
- Special Operations Coordinator
- Pre-planned mutual aid

MEDIA COORDINATOR

- Single spokesperson
- Prepared statement
- Anticipate questions
- No deadlines for results
- Give law enforcement / NCMEC number only
- Reward information

SEARCH COORDINATOR

- Organize both ground and air searches ASAP
- Utilize trained bloodhounds
- LE with all search elements
- Whatever it takes
- Positive ID on all searchers

FIRST 48 HOUR ACTION NON FAMILY CHILD ABDUCTION

- Hotline receives call from law enforcement / parent
- Hotline attempts to obtain photo of missing child
- Hotline faxes waivers, bio and required other forms to parent/law enforcement
- When photos/forms are received; on-call Imaging Specialist process is initiated
- Hotline verifies and flags entry of missing child in NCIC

HOTLINE NOTIFIES

NCAVC (FBI)
On Call Case Manager
Selected media outlets

CASE IS ASSIGNED TO CASE MANAGER

- Contacts parent/family; explains local resources
- Contacts law enforcement agency; explains NCMEC resources and services
- Facilitates poster preparation and dissemination
- Initiates information search Case Analysis Support Division
- Offers project ALERT assistance to law enforcement agency

PHOTO IMAGING / PHOTO DISTRIBUTION

- Missing child poster created and placed on the NCMEC web site
- Placed on Web site ALERT page
- Broadcast faxed to law enforcement agencies designated by investigator
- Distributed through national poster program
- Targeted to appropriate locations
- Exposed to national television and print media markets

NCMEC BRANCHES

- Provides on site assistance to parents and family members
- Provides local assistance to law enforcement
- Assists in the dissemination of posters and information locally

Colleen J. Doolin
Assistant District Attorney
Dallas District Attorney's Office
2600 Lone Star Drive, 2nd Floor
Dallas, Texas 75212

Tim M. Wheat
Fulbright & Jaworski L.L.P.
2200 Ross Avenue
Ste. 2800
Dallas, Texas 75201

TERMINATION OF PARENTAL RIGHTS

The 1999 Texas Legislature brought several changes to the section of the Texas Family Code dealing with the termination of parental rights. House Bill 1622, which detailed those changes, will become law, effective Sept. 1, 1999. Although the changes may not be numerous, they will benefit the judicial system and help with termination proceedings.

The legal termination process has long been referred to as the "death penalty of civil cases" because it refers to the "death" of the parent-child relationship. The relationship between a parent and his or her child is of Constitutional importance because of the belief that it is a parent's absolute right to reproduce and raise children as that parent sees fit. However, in some instances, our society has intervened and told a parent that the way that parent "sees fit" is not acceptable and that it is necessary to remove that child from the parent and transfer the child to more appropriate caretakers.

The Legislature has outlined the factors for involuntary termination of parental rights in the Texas Family Code, Sec. 161.001. The 1999 amendments and changes that were deleted are in brackets, and the amendments and sections that were added are underlined.

Sec. 161.001. Involuntary Termination of Parent-Child Relationship

The court may order termination of the parent-child relationship if the court finds by clear and convincing evidence:

(1) that the parent has:

(A) voluntarily left the child alone or in the possession of another not the parent and expressed an intent not to return;

(B) voluntarily left the child alone or in the possession of another not the parent without expressing an intent to return, without providing for the adequate support of the child, and remained away for a period of at least three months;

(C) voluntarily left the child alone or in the possession of another without providing adequate support of the child and remained away for a period of at least six months;

(D) knowingly placed or knowingly allowed the child to remain in conditions or surroundings which endanger the physical or emotional well-being of the child;

(E) engaged in conduct or knowingly placed the child with persons who engaged in conduct which endangers the physical or emotional well-being of the child;

(F) failed to support the child in accordance with his ability during a period of one year ending within six months of the date of the filing of the petition;

(G) abandoned the child without identifying the child or furnishing means of identification, and the child's identity cannot be ascertained by the exercise of reasonable diligence;

(H) voluntarily, and with knowledge of the pregnancy, abandoned the mother of the child beginning at a time during her pregnancy with the child and continuing through the birth, failed to provide adequate support or medical care for the mother during the period of abandonment before the birth of the child, and remained apart from the child or failed to support the child since the birth;

(I) contumaciously refused to submit to a reasonable and lawful order of a court under Subchapter D, Chapter 261 [264] (which deals with Child Welfare Services);

(J) been the major cause of:

(i) the failure of the child to be enrolled in school as required by the Education Code; or

(ii) the child's absence for the child's home without the consent of the parents or guardian for a substantial length of time or without the intent to return;

(K) executed before or after the suit is filed an unrevoked or irrevocable affidavit of relinquishment of parental rights as provided by this chapter;

(L) been convicted or has been placed on community supervision, including deferred adjudication community supervision, for being criminally responsible for the death or serious injury of a child under the following section of the Penal Code or adjudicated under Title 3 for conduct that caused the death or serious injury of a child and that would constitute a violation of one of the following Penal Code sections:

(i) Section 19.02 (murder);

(ii) Section 19.03 (capital murder);

(iii) Section 19.04 (manslaughter)

(iv) Section 21.11 (indecency with a child);

(v) [(iv)] Section 22.01 (assault);

(vi) [(v)] Section 22.011 (sexual assault);

(vii) [(vi)] Section 22.02 (aggravated assault);

(viii) [(vii)] Section 22.021 (aggravated sexual assault);

(ix) [(viii)] Section 22.04 (injury to a child, elderly individual or disabled individual);

(x) [(ix)] Section 22.041 (abandoning or endangering child);

(xi) [(x)] Section 25.02 (prohibited sexual conduct);

(xii) [(xi)] Section 43.25 (sexual performance by a child; and

(xiii) [(xii)] Section 43.26 (possession or promotion of child pornography;

(M) had his or her parent-child relationship terminated with respect to another child based on a finding that the parent's conduct was in violation of Paragraph (D) or (E) or substantially equivalent provisions of the law of another state;

(N) constructively abandoned the child who has been in the permanent or temporary managing conservatorship of the Department of Protective and Regulatory Services or an authorized agency for not less than six months, and:

(i) the department or authorized agency has made reasonable efforts to return the child to the parent;

(ii) the parent has not regularly visited or maintained significant contact with the child; and

(iii) the parent has demonstrated an inability to provide the child with a safe environment;

(O) failed to comply with the provisions of a court order that specifically established the actions necessary for the parent to obtain the return of the child who has been in the permanent or temporary managing conservatorship of the Department of Protective and Regulatory Services for not less than nine months as a result of the child's removal from the parent under Chapter 262 for the abuse or neglect of the child;

(P) used a controlled substance, as defined by Chapter 481, Health and Safety Code, [:(i)] in a manner that endangered the health or safety of the child, and:

(i) failed to complete a court-ordered substance abuse treatment program; or

(ii) [repeatedly,] after completion of a court-ordered substance abuse treatment program, continued to abuse a controlled substance [in a manner that endangered the health or safety of the child];

(Q) knowingly engaged in criminal conduct that has resulted [results] in the parent's:

(i) conviction of an offense; and

(ii) confinement or imprisonment and inability to care for the child for not less than two years from the date of filing the petition; or

(R) been the cause of the child being born addicted to alcohol or a controlled substance, other than a controlled substance legally obtained by prescription, as defined by Section 261.001(7); and

(2) that termination is in the best interest of the child.

Ground I corrected what appeared to be a typographical error, deleting "Chapter 264," which involves a discussion of Child Welfare Services and seems irrelevant to parents and court orders, and substituting "Subchapter D, Chapter 261," which involves investigations of reports of child abuse or neglect. The sections which are the most applicable to this ground are Sections 261.303, 261.305, 261.306:

Sec. 261.303. Interference With Investigation; Court Order

(a) A person may not interfere with an investigation of a report of child abuse or neglect conducted by the department or designated agency.

(b) If admission to the home, school, or any place where the child may be cannot be obtained, then for good cause shown the court having family law jurisdiction shall order the parent, the person responsible for the care of the children, or the person in charge of any place where the child may be to allow entrance for the interview, examination, and investigation.

(c) If a parent or person responsible for the child's care does not consent to a medical, psychological, or psychiatric examination of the child that is requested by the department or designated agency, the court having family law jurisdiction shall, for good cause shown, order the examination to be made at the times and places designated by the court.

Sec. 261.305. Access to Mental Health Records.

....

(b) If a parent or person responsible for the care of the child does not allow the department or designated agency to have access to medical or mental health records requested by the department or agency, the court having

family law jurisdiction, for good cause shown, shall order that the department or agency be permitted to have access to the records under terms and conditions prescribed by the court.

....

Sec. 261.306. Removal of Child From State.

....

(b) The court may render a temporary restraining order prohibiting the person from removing the child from the state pending completion of the investigation ...

....

Each of these sections addresses serious attempts of the Department to investigate child abuse or neglect. The Legislature has rightly recognized the gravity of a parent or caretaker attempting to block the Department's investigation -- presumably to hide his or her own culpability or shield someone else's culpability -- by preventing the examination of the child, concealing mental health or medical records, or worse yet, going so far as to flee the state with the child in violation of a temporary restraining order. The parent or caretaker's actions in violating any of these Court orders were recognized by the Legislature as being reason enough to be a ground for termination.

Ground L added the crime of manslaughter, Penal Code Sec. 19.04, to the laundry list of crimes for which a person may be convicted, placed on community supervision, including deferred adjudication community supervision, bringing the total number of such crimes to 13. This was a necessary amendment, because it makes sense to have a ground of termination be based on a person's recklessness in causing the death of an individual. A person who was reckless enough to cause someone's death deserves to have that action be a ground for terminating their parental rights; the argument being that anyone who was that reckless can hardly be trusted to have custody of and care for a helpless child.

Ground P concerns repeated and chronic drug use by a parent in a manner that endangers the health or safety of a child. The Legislature slightly reworded this ground, making it two-pronged. The first prong is that the use of the controlled substance was used in such a manner as to be harmful to the child, It seems obvious that any use of such a substance would impair the decision-making faculties of the parent and thus be harmful to the child. It will be hard for a parent to maintain that yes, they use drugs, smoke crack, shoot up, snort, or whatever ... but their use of these drugs is not harmful to their child. You may have to become a little bit creative and argue that the use of drugs impaired the mental faculties of the parent, causing them to have less earning capability, thus preventing them from providing for their child, or that the use of drugs impaired their physical faculties, keeping them from cleaning the house and providing a safe environment for their child. If they drive with the child in the car during their drug use, they are bought and paid for. The second prong can be either that the parent failed to complete a court-ordered drug program OR that after the parent completed the program, they continued to abuse the controlled substance.

(Q) knowingly engaged in criminal conduct that <u>has resulted</u> [results] in the parent's:

(i) conviction of an offense; and
(ii) confinement or imprisonment and inability to care for the child for not less than two years from the date of filing the petition; or

Ground Q was greatly expanded. The Legislature added the stipulation that the person must first be convicted, which does not include being placed on community supervision or deferred adjudication probation. It is arguable whether the Legislature contemplated a conviction with a built-in shock probation as falling under the requirement of a conviction.

The second stipulation added the word "confinement." A confinement may be in county jail for a misdemeanor offense, which added a whole range of crimes to this ground, which formerly had only included felonies. Thus, someone who had been confined in the county jail for a two-year sentence on a Driving While Intoxicated conviction three years ago would qualify under this ground. Deliberate criminal acts show a disregard for the welfare of the child, since the parent cannot care for the child while confined or incarcerated. The argument gets weaker as the crimes get more minor and the sentences get smaller. For example, would a jury buy the argument that they should find a ground of termination for a mother who wrote a bad check two plus years ago from the date of filing the petition and spent a couple of days in jail? Yes, she was unable to care for the children for those few days, but maybe her aunt cared for them. A stronger argument is for a 45-day sentence for criminal mischief.

Defense attorneys might try to argue against this ground for a person who was placed on probation or deferred adjudication then was later revoked or adjudicated. They might try to say that the parent must first be convicted. Your argument is that this is the very type of behavior that the Legislature contemplated because the parent had a chance to be with his or her child and then CONTINUED to violate the rules, resulting in the parent's confinement.

The test for terminating the parent-child relationship, as you can see from the text, is two-pronged. The first prong involves malfeasance or nonfeasance by the parent, and the Family Code gives eighteen ways that a parent can do this, in grounds (A) through (R). The second prong involves the concern for the welfare of the child, or what is in the child's best interest.

Additional grounds and circumstances justifying an enabling a termination are found within the Texas Family Code Sec. 161.003, entitled "Involuntary Termination: Inability to Care for Child" and in Texas Family Code Sec. 161.004, entitled "Termination of Parental Rights after Denial of Prior Petition to Terminate." However, we will be concerned for the purposes of this talk, with Sec. 161.001.

The District Attorney's Office represents the Department of Protective and Regulatory Services as its legal counsel in suits affecting the Parent-Child relationship (not for all purposes). As such, the DA's Office files lawsuits on behalf of the Department. Most child welfare cases come to the attention of the Department when there is a report of abuse or neglect, and thus, the highlighted grounds (D) and (E) are in most if not all of the Department's pleadings when a termination case is filed. Of course, the

Department will file pleadings which include as many grounds of termination as can be ascertained when the decision is made to proceed with this lawsuit against the Respondent parents. This is a VERY, VERY important point, and one which the lawyer must not take for granted. If you do nothing else, scour your case file for ALL the grounds of termination you can gather to put in your Petition for Termination. When you are voir diring your jury, this gives you more ammunition for your strikes. Get the jurors to agree that EACH ground of termination, standing alone, is enough to prove the first prong. Remember, all jurors may not find all your grounds. If you have 12 grounds alleged, each juror may privately find for a different ground, but you still have your first prong.

Once it is shown that a parent committed one of the grounds for involuntary termination and also that it is in the child's best interest, society has decided that the remedy is to terminate that parent-child relationship. These cases are emotionally complex and can be very draining. Also, there are stacks of documents and materials, multiple witnesses, numerous exhibits, and sometimes mass confusion. So, in looking at how to put together a termination trial in a tidy package, we will discuss six major areas:

A. Pretrial Preparation
B. Discovery
C. Voir Dire
D. Witnesses
E. Exhibits
F. Argument and Summation

These will certainly get you started, and hopefully will provide you with some insights and new ideas as you start preparing for your own termination trials.

A. Pretrial Preparation

Here is where you may well win or lose the case. There is no question that every case rises or falls on the facts, but in most of the cases, the information is so voluminous that you need to carefully review and assess it so you will know what the facts are and know how to present them. Here is a pretrial preparation checklist, which is by no means exhaustive:

1. <u>Check your Court file.</u>

You must carefully review the Court's file to make sure you have all your ducks in a row as to the legal requirements of the case. Specifically, has everyone been served, has the proper amount of time passed for the service to be ripe, is the return in the file, were they served with the latest pleadings or merely an earlier version of the pleadings, are any relinquishments file-stamped and in the court jacket, was there an affidavit of status or affidavit from the caseworker about any biological father, and ad infinitum. It may be useful to you to sit down with the Court's file and mark each important paper with a sticky note or paper clips to facilitate the judge's finding it easily during the proceedings. Check with your judge to find out what he or she prefers. If the judge objects to having any object

placed in the file, make yourself a list of the papers and dates and give a copy to your judge.

2. Review your discovery.

Remember, the Texas Supreme Court has brought forth the final draft of the 1999 revisions to the Texas Rules of Civil Procedure. This paper does not profess to be a treatise on the new Rules. You should take an in-depth seminar on the new Rules to become familiar with them.

Become familiar with the following Rules, which will govern most of your discovery:

Rule 194. Request for Disclosure (new)
Rule 196. Requests for Production and Inspection to Parties; Requests and Motions for Entry onto Property
Rule 197. Interrogatories to Parties
Rule 198. Requests for Admissions
Rule 199. Depositions upon Oral Examination

That said, review your discovery, whether it is under the old or the new Rules. Few things are more annoying than finding out at the last minute that some discovery requirement has not been complied with and you have to scramble during the trial to fill in some missing piece. Make sure you supplement your discovery promptly and cheerfully. Good will can take you a long way in getting the proceedings going smoothly. Remember, if you always hold people's feet to the fire on small things, they will do the same thing to you.

3. Read your case and all materials connected with it.

The Child Protective Service case files are usually quite voluminous, and need to be cataloged for your trial. You will need to label the various parts of the file that you will need for trial, tooled to the type of case you have. The dictation needs to be carefully read and you need to think about how to fit it into your trial plan. Read and study the medical reports, looking for any statements the Respondent parents make to medical personnel. Note all the child's injuries and treatment by the doctors. This is something you will want to expand on, because many times, the injuries are the key to the case. Juries do not like abusive bullies, and the better you can have the doctors explain the child's injuries, the more sympathetic the jury will be to your plea for permanent relief.

Read and study the reports on the Respondent parents drug treatment or parenting classes or counseling. Learn how they acted in these classes, and look for witnesses to testify about the parents' behavior and progress or lack of it. As you read through your materials, it is helpful to use sticky notes to "flag" things that you will need to remember in piecing the case together. You want your case to form a global "whole" with each witness and piece of evidence providing an important part of that "whole."

4. Select your witnesses and designate the order of their testimony.

Selection of witnesses is a time-consuming and very rewarding exercise. This forces you to review each person's testimony and what they can contribute to the totality of the case. Always, in trial preparation, be looking to develop the big picture. What will each person who testifies add to the big picture? If a witness is redundant of another witness or only has a bit piece to add, strike that person from your witness list. Remember, the more witnesses you put on, the more people the defense attorney has to throw rocks at. The O.J. Simpson case is an example of that type of overzealous prosecution, which bored the whey out of everybody and provided the defense with a lot of contradictions in testimony. The more witnesses you have, the more likely that someone is going to say something different from the others.

Order of witnesses is a very important strategy. Sometimes it is an obvious choice to lead off with your main caseworker, and other times it is equally obvious to end with the caseworker. You might want to start with your physician, if there are shocking medical facts. A civilian fact witness to neglect or abuse might be another choice. In whatever order you decide, it is vital to have the order of witnesses make sense to the jury. Think hard about your transition from one witness to the next and how you are going to accomplish this. Your case will be like a well-conducted symphony if you can make the transition from one witness to the next look easy and natural. I was preparing for a Termination jury trial recently, and decided to group my CPS caseworkers and then group my Assessment Center experts, even though this order was not chronological. It depends entirely on what type of case you have.

Once you have selected your witnesses, deciding what each person will contribute, and designated the order in which they will testify, you are holding your case in the palm of your hand. From that completed but rough sculpture, you can start to refine and polish your case and add the finishing touches.

5. Package your facts.

The trial lawyer has to decide how to present the case to the jury, and there is no one way to do it. Case presentation strategy depends entirely on the facts and circumstances of each individual case. Some cases are very, very long and summaries are the most effective way to present the evidence. Some cases are short, and may be presented factually and chronologically. Some cases lend themselves to putting on a number of caseworkers, and some cases need only one caseworker. Some cases call for a number of experts. In this sense, cases are like quilts. The materials are all in front of you, but it is up to you, the trial lawyer, to decide how to piece them together to form the pattern you want to hold up to the jury.

6. Put on your case.

It is my personal opinion that a case should be put on with an absolute minimum of repetition and that it is most effective to try the case as swiftly as possible without leaving out any important details. Juries are intelligent and do not need to be repeatedly hit over the head to get your point. The more work you put into a case, the better you can consolidate

your evidence and witnesses, and the more the jury will appreciate it. However, do not be afraid to repeat key points. During one of my last jury trials, the Respondent Father was a drug dealer who habitually carried a very dangerous rifle known as a "Manstopper" by the police. I had every policeman who testified refer to the "Manstopper." According to the Respondent Father, who testified, "It won't just take his leg off, it'll cut a man in half." The case was later affirmed by the Fifth District Court of Appeals in Dallas, and I was amused to note that the justices also referred several times to the "Manstopper" in their written opinion.

7. Specialized statutes.

Verify that specialized statutes, such as the Indian Child Welfare Act, do not apply to alter your burden of proof or affect the trial issues. If this type of statute does apply, make sure you familiarize yourself with it and comply with all the notification rules, etc.

B. Discovery

Child Welfare cases are Discovery Level 2 under the new Rules. The discovery period begins when suit is filed and continues until 30 days before the trial date in cases under the Family Code, which these are.

The Rules now permit Requests for Disclosure, which may be a one-page request for information under new Rule 194, which allows parties to get names and addresses of parties and witnesses, experts, witness statements, and medical records, among other things. A sample Request for Disclosure will follow. The Request for Disclosure will cut down on the items asked for in your request for Production, Rule 196, which you can tool to the documents needed in your specific case. The Request for Production must be served on the party no later than 30 days before the end of the discovery period. With regard to depositions for a Level 2 case, Rule 199, each side may have no more than 50 hours of oral depositions, with some exceptions. Each side is limited to 25 Interrogatories, Rule 197, which may be sent all at once, one at a time, or in any combination the attorney deems most advantageous to his or her case. If your questions have subparts, each discrete subpart is deemed to be one Interrogatory.

However, the Rules did not substantially change with respect to Requests for Admission, Rule 198, which are limitless, but must be served 30 days before the end of the discovery period. If the other party fails to respond within 30 days of service, it is deemed an admission.

Always keep in mind that you **MUST** continue to supplement your Discovery, as much trouble as it is. In a recent case, an attorney failed to supplement the Discovery with regard to the main Child Protective Service caseworker, who had left the Department between the time the case was going on and the time of trial. She was still living locally, was available and willing to testify, but the Respondent parent objected that the current address, which had become available to the State, had not been supplied in the Discovery. The Judge ordered that the State could not call the caseworker. What is the remedy for this? Don't forget -- if the Guardian Ad Litem is not under that Discovery restriction, simply ask the Guardian to call that witness. That is

what happened in this example, and the State prevailed with a unanimous verdict for Termination.

The following provide a number of examples of a Request for Disclosure, three sample Interrogatories for a total of 75 questions (I tried not to be repetitive), and a sample Request for Production. Please feel free to copy, adapt, or add to them in whatever way fits your fact pattern.

The first example, the Request for Disclosure, has a full heading with the style of the case, Court, Case Number, County, and State, and complete information after the signature, such as the full name, title, address, telephone number, FAX number, and Bar Card Number; then a Certificate of Service and signature. In the interest of space, these items have been omitted from the rest of the examples; however, they need to be included in the Discovery you send to the Respondents.

No. 0000000

IN THE INTEREST OF
JOHN DOE, ET AL
CHILDREN

IN THE 1ST DISTRICT
COURT OF
ATLANTIS COUNTY, TEXAS

REQUEST FOR DISCLOSURE

TO: Respondent Mother Jane Doe, by and through her attorney of Record, Joe Snow, 1111 Capitol Drive, Atlantis, Texas 70000.

The following is a Request for Disclosure in the above-styled case, in accordance with Rule 194, Tex. R. Civ. P. Pursuant to Rule 194, you are requested to disclose, within 30 days of service of this request, the information or material described in Rule 194.2.

Specifically, the information requested consists of:

(a) the correct names of the parties to the lawsuit;
(b) the name, address, and telephone number of any potential parties;

(c) the legal theories and, in general, the factual bases of your claims or defenses;
(d) the amount and any method of calculating economic damages;
(e) the name, address, and telephone number of persons having knowledge of relevant facts, and a brief statement of each identified person's connection with the case;
(f) for any testifying expert:
(1) the expert's name, address, and telephone number;
(2) the subject matter on which the expert will testify;
(3) the general substance of the expert's mental impressions and opinions and a brief summary of the basis for them, or if the expert is not retained by, employed by, or otherwise subject to the control of the responding party, documents reflecting such information;
(4) if the expert is retained by, employed by, or otherwise subject to your control;
(A) all documents, tangible things, reports, models, or data compilations that have been provided to, reviewed by, or prepared by or for the expert in anticipation of the expert's testimony; and
(B) the experts's current resume and bibliography;
(g) any and all discoverable indemnity and insuring agreements;
(h) any and all discoverable settlement agreements;
(i) any and all discoverable witness statements;
(j) if this suit alleges physical or mental injury and damages from the occurrence that is the subject of the case, all medical records and bills that are reasonably related to the injuries or damages asserted or, in lieu thereof, an authorization permitting the disclosure of such medical records and bills;
(k) if this suit alleges physical or mental injury and damages from the occurrence that is the subject of the case, all medical records and bills obtained by you by virtue of an authorization furnished by the requesting party.

Pursuant to Rule 194.4, copies of documents and other tangible items ordinarily must be served with the response. If the responsive documents are voluminous, your response must state a reasonable time and place for the production of documents, and you must produce the documents at the time and place stated, unless otherwise agreed by the parties or ordered by the court, and must provide the requesting party a reasonable opportunity to inspect them.

Your attention is directed to Rule 194 for additional information concerning this Request. Specifically, no objection or assertion of work product is permitted to a request under this Rule.

Respectfully submitted,

(name)
Assistant District Attorney
2600 Lone Star Dr., LB 22
Atlantis County, Texas 75212
(214) 698-2285
Fax #: (214) 698-5551
Texas Bar Card: 00000000

CERTIFICATE OF SERVICE

On this the ____ day of _____ 19___, the undersigned attorney hereby certifies that a true and correct copy of the foregoing has been forwarded to the Attorneys of Record in the above entitled and numbered cause.

(name)
Assistant District Attorney
Plaintiff's Attorney
(Address)

No. 1 Set of Sample INTERROGATORIES TO RESPONDENT

TO: Respondent Mother, Jane Doe, by and through her attorney of record, Joe Snow, 1111 Capitol Drive, Atlantis, Texas 70000.

The following Interrogatories are submitted to the above named Respondent under the terms and provisions of Rule 197 Texas Rules of Civil Procedure, and under the terms and provisions of said Rule, respondent is required to answer these interrogatories separately and fully in writing and under oath as provided by said Rule within thirty (30) days after service thereof.

INTERROGATORY NO. 1:
State the name, address, telephone number and date of birth of each person to whom you have been married.
ANSWER:

INTERROGATORY NO. 2:
State each address at which you have resided since (date).
ANSWER:

INTERROGATORY NO. 3:
State the name, address and telephone number of each person with whom you have resided since (date).
ANSWER:

INTERROGATORY NO. 4:
State the name, address and date of birth of each child for whom you are the biological (father / mother) other than the children the subject of this suit.
ANSWER:

INTERROGATORY NO. 5:
State the nature and date of occurrence of each criminal offense of which you have been convicted or have received a deferred adjudication.
ANSWER:

INTERROGATORY NO. 6:
State the name, address and telephone number of each probation officer to which you have been assigned as a result of any criminal offense and state for which criminal offense each such probation officer was assigned.
ANSWER:

INTERROGATORY NO. 7:
State the name, address and telephone number of each parole officer to which you have been assigned as a result of any criminal offense and state for which criminal offense each such parole officer was assigned.
ANSWER:

INTERROGATORY NO. 8:
State the punishment which you received for each criminal offense listed in response to Interrogatory No. 5, including any conditions of probation or parole which you received for each criminal offense.
ANSWER:

INTERROGATORY NO. 9:

State the name, address and telephone number of each Alcoholics or Narcotics Anonymous group which you have ever attended.

ANSWER:

INTERROGATORY NO. 10:

State the name, address and telephone number of each person who has acted as your group leader or sponsor in any Alcoholics or Narcotics Anonymous group.

ANSWER:

INTERROGATORY NO. 11:

State the date of your attendance at any Alcoholics or Narcotics Anonymous meetings and specify with respect to each date the group listed in response to Interrogatory No. 9 which you attended.

ANSWER:

INTERROGATORY NO. 12:

State the name, address and telephone number of each substance abuse rehabilitation program in which you have been enrolled other than Alcoholics or Narcotics Anonymous.

ANSWER:

INTERROGATORY NO. 13:

State the dates of your enrollment in each program listed in response to Interrogatory No. 12.

ANSWER:

INTERROGATORY NO. 14:

State the name(s) of your primary counselor(s) or therapist(s) at each program listed in response to Interrogatory No. 12 and specify which program each listed person worked for.

ANSWER:

INTERROGATORY NO. 15:

State the name, address and telephone number of each counselor therapist, psychologist, physician, psychiatrist or other mental health or health care professional which you have seen for any substance abuse or mental health problem other than those listed in response to Interrogatory No. 12.

ANSWER:

INTERROGATORY NO. 16:

State the reason for your attendance, admission or sessions at or with any group, program or person listed in response to Interrogatory Nos. 9, 10, 12, 14 and 15.

ANSWER:

INTERROGATORY NO. 17:

State your current employment, since when you have been so employed and the days and hours which you work.

ANSWER:

INTERROGATORY NO. 18:
Please identify each of your children by name and date of birth and for each, please state each and every school each child attended including name, location, phone number, date enrolled, date discharged, and the reason for each and every discharge from each and every school for each child.
ANSWER:

INTERROGATORY NO. 19:
How many times have you (impregnated a woman/been pregnant) excluding the times that resulted in the births of the children the subject of this suit?
ANSWER:

INTERROGATORY NO. 20:
For each such pregnancy listed above, state (the woman's name and address / the approximate date of conception) the length of such pregnancy and the outcome, i.e. miscarriage, abortion, birth.
ANSWER:

INTERROGATORY NO. 21:
If any of the pregnancies listed above resulted in the birth of a child not included in this lawsuit, please state what happened to each such child and each child's whereabouts.
ANSWER:

INTERROGATORY NO. 22:
Identify (name and date of birth) the each child you have had or adopted to date and for each child identify (name, address and phone number and date of birth) the biological father or the mother and state whether or not you were legally married to each biological father or mother.
ANSWER:

INTERROGATORY NO. 23:
State the name and location (name, address and phone number) of each caretaker, babysitter and day care facility or other facility or agency that each of your children have been left with or in the care of <u>by you</u> since their birth and the approximate dates the children were left with each person or facility and the length of time each child was left on each occasion.
ANSWER:

INTERROGATORY NO. 24:
State the date, the reasons and the circumstances on each occasion, under which each of your children were left with each caretaker, babysitter, or day care facility you listed in the preceding question by date, in date order.
ANSWER:

INTERROGATORY NO. 25:
Identify (name, address and phone number and date of birth) any persons of the opposite sex, not spouses, that you have lived with or resided with for three or more days as a household or family unit since your 17th birthday.
ANSWER:

Respectfully submitted,

_____

No. 2 Sample Set of INTERROGATORIES TO RESPONDENT

1. Please state your full name, including any aliases you may have previously used if any, and your date of birth and the dates of birth you used with any alias names if any, and the city and state in which you used said alias names and dates of birth if any;

	Name	Dob	City/State (alias)
Name:			
Alias 1:			
Alias 2:			

2. Please state each residence address and telephone number where you lived within the last five years (in order, oldest first) and the name of the person you lived with at each location;

	Address	Telephone Number	Person Lived With
1.			
2.			
3.			

3. Please state your correct full name, correct Date of Birth, driver's license number and State of issuance, and correct social security number.

4. Identify (name, date of birth) any aliases or alias names you have used previously, if any, and state when and in what context you used each alias name for each occasion that you used an alias name and state the reason you used each alias name.

5. Have you used any social security numbers or drivers license numbers, and if you have used any other such numbers at any time, please include all such numbers also along with the name and date of birth you used with them.

6. State the name of each of your parents and their current address and location.

7. If you do not live with your parents, state the name of your caretaker or guardian and their address and location and the length of time you have lived with said caretaker or guardian.

8. If you currently work, please identify the name and location (name, address and phone number) of your employer.

9. Are you or have you ever been a member of a Church, if so, state the name or names of the church(s) and the locations.

10. Please state the grade level of your education, any degrees you hold, and give the date and type of any disciplinary actions instituted against you by any school or facility you have attended within the last four years; and names of all schools attended, and dates of attendance.

11. With respect to each employment, job, or income producing activity you have had in the last four years, please state the type of work or activity, the name and address of the employer, if any, the dates of employment for

each job, from beginning to end, and the salary or pay received for each employment and the reason for the termination of each employment.

12. Please state the offense dates, offense types, and city and state (location) of all juvenile offenses, if any, that have been alleged against you by any person or institution or organization, or that you have been taken into custody for, since your 7th birthday, and the cause number, court number and court location, if any, that arose therefrom.

13. Further, please include any offenses you committed, but were not arrested for or that did not result in any charges being brought against you, if any, including all felony and misdemeanor offenses you committed and the date and location of commission of each offense and the type of offense.

14. With reference to all juvenile adjudications that have been found against you by any court, please state the Name of the offense, the date of the offense, the date of the adjudication and Court and Cause number of each adjudication.

15. Have you attended or been hospitalized or committed to any facility, hospital, or institution since your 7th birthday? If so, state the dates, from beginning to end, you were hospitalized or committed or attended, the name and location of the facility and the length of time you stayed in each facility or hospital. Facility, as defined above includes any penal institution or jail, any juvenile facility or placement or detention center or other criminal justice facility including half-way houses, hospitals, mental hospitals or mental institutions and drug treatment or alcohol abuse treatment facilities or programs either inpatient or outpatient or the Texas Youth Commission.

16. Have you ever received counseling or treatment for any emotional or mental disorder from any public or private facility or program? If so, please state the name of such program or facility, the name of the person or persons doing the counseling or treatment, the nature of the counseling or treatment and the dates each facility was attended and the locations of each facility or program attended.

17. State whether or not you have ever used or taken any illegal drugs or intoxicants including but not limited to marijuana, cocaine, heroin, LSD, and/or amphetamine(s) and/or any inhalants such as paint, thinner etc. or any liquor, wine or other intoxicant, and if so state the drug or inhalant or intoxicant and the beginning and ending dates that you used the drug or inhalant or intoxicant.

18. State whether or not you have ever delivered, carried or transferred any illegal drug or controlled substance to any other person or persons and the dates and location and type of drug for each delivery or transfer transaction.

19. Have you ever used, taken, sniffed, or ingested any illegal drug, controlled substance, or narcotic drug or chemical.

20. Identify by the Type of suit, Name, Cause Number, date filed, State and District Court Name and Number and County, all lawsuits and/or legal proceedings to which you have ever been a party or a witness.

21. State the amount of your total average monthly income from whatever source, list your gross income from each source and the name of the source of income, any deductions made in your income, the type and amount of each deduction, and the resulting net take-home amount from each source each month.

22. What is the total amount of your income for the last year.

23. Please identify and state your correct full maiden name, and if you are married, your full married name, your date of marriage, if any, your correct Date of Birth and correct Social Security number.

24. Have you ever used, taken, sniffed, or ingested any illegal drug, controlled substance, or narcotic drug or chemical when you had any of your children in your possession or constructive possession or when you, were pregnant with any of your children.

25. If you have ever tried to receive help, or did receive help to enable you to provide for you and/or your children, please identify the name, location (name, address, phone number), and date of each and every facility, both private and public, that you approaches for help along with the name of the person, if known that you spoke with, including what help, if any, the facility provided. "Help" includes but is not limited to food, clothing, money, lodging, gas, counseling and/or treatment.

_____
(name)
Assistant District Attorney

No. 3 Sample Set of INTERROGATORIES TO RESPONDENT

1. Concerning each incident of any abuse, neglect or physical or emotional endangerment to any of your children, which you have any knowledge of, whether or not said abuse, neglect or endangerment resulted in a referral to a child welfare, child protective services, or police agency in Texas or any other state, please state the date(s) of occurrence of each incident or event, and the nature of the abuse, neglect, or physical or emotional endangerment occurring on or about that date, including the name of the child or children affected by that abuse, neglect or endangerment;

2. Concerning each incident of any abuse, neglect or physical or emotional endangerment to any of your children, which you have any knowledge of, whether or not said abuse, neglect or endangerment resulted in a referral to a child welfare, child protective services, or police agency in Texas or any other state, please state the identity and location (name, address, and phone number) of each person who committed or caused or is responsible for the abuse, neglect, or physical or emotional endangerment, and the name and location of the child welfare agency and/or police agency that investigated each incident, if any.

3. Concerning each incident of any abuse, neglect or physical or emotional endangerment to any of your children, which you have any knowledge of, whether or not said abuse, neglect or endangerment resulted in a referral to a child welfare, child protective services, or police agency in Texas or any other state, please describe in detail the conduct, including acts and omissions, engaged in by each person who committed or caused or is responsible for each incident or event of abuse, neglect, or physical or emotional endangerment listed in Interrogatories 1 and 2.

4. If any of your children have been treated or examined on any occasion in any hospital, any outpatient setting, residence, school, physicians office or clinic for any endangering physical injury or medical condition or abuse, including but not limited to, any bruising, slap marks, whip marks, failure to thrive, any broken bone of any type, any head or facial injury, any burn, or any sexual abuse, please identify each and every date of treatment or examination and the nature of the injury and/or abuse and/or endangering physical injury or medical condition involved on that date.

5. If any of your children have been treated or examined on any occasion in any hospital, any outpatient setting, residence, school, physicians office or clinic for any endangering physical injury or medical condition or abuse, including but not limited to, any bruising, slap marks, whip marks, failure to thrive, any broken bone of any type, any head or facial injury, any burn, or any sexual abuse, please identify the identity and location (name, address and phone number) of each attending physician or each person treating or doing the examination, if any, on each occasion.

6. If any of your children have been treated or examined on any occasion in any hospital, any outpatient setting, residence, school, physicians office or clinic for any endangering physical injury or medical condition or abuse, including but not limited to, any bruising, slap marks, whip marks, failure to thrive, any broken bone of any type, any head or facial injury, any burn, or any sexual abuse, please identify the name and location of the hospital,

office, residence, school, outpatient setting or clinic where any treatment or examination was performed for each occasion.

7. If any of your children have been treated or examined on any occasion in any hospital, any outpatient setting, residence, school, physicians office or clinic for any endangering physical injury or medical condition or abuse, including but not limited to, any bruising, slap marks, whip marks, failure to thrive, any broken bone of any type, any head or facial injury, any burn, or any sexual abuse, please identify the identity and location (name, address and phone number) of each person responsible for the child receiving each injury or abuse and/or who caused or contributed to each injury or abuse or any endangering physical injury or medical condition.

8. If any of your children have been treated or examined on any occasion in any hospital, any outpatient setting, residence, school, physicians office or clinic for any endangering physical injury or medical condition or abuse, including but not limited to, any bruising, slap marks, whip marks, failure to thrive, any broken bone of any type, any head or facial injury, any burn, or any sexual abuse, please identify the conduct and date of occurrence of the conduct, that each person identified in Question 7 engaged in, either by act or omission, which caused or resulted or contributed to each injury or abuse or any endangering physical injury or medical condition.

9. "Facility" as defined in this question and in Question 10 includes any penal institution or jail or other criminal justice facility including half-way houses, hospitals, mental hospitals or mental institutions and drug treatment or alcohol abuse treatment facilities or programs either inpatient or outpatient. If you have attended or been hospitalized or committed to or lived in any facility, hospital or institution, medical, penal, treatment or otherwise, since your 14th birthday, please state the dates (beginning and ending) you were hospitalized, committed or attended, and the identity and location of the facility, hospital or institution (name, address and phone number);

10. Please state the reason (factual basis and conduct you engaged in) that caused you to be in or attend each facility, as defined in Question 9.

11. "Identify" in this question and in Question 12 means the Court name and location (City/County/State), Cause Number, offense name and type, date of commission, and whether or not you were convicted. Please identify each Criminal Charge that has been brought or alleged against you since your 17th birthday, including all Convictions and Arrests, whether or not said arrest resulted in a conviction.

12. Please identify, as it is defined in Question 11, by offense name (type and date of commission) and location (City, County, and State of commission) all offenses you have committed, but were not arrested for or that did not result in any charges being brought against you, if any, including all felony and misdemeanor offenses you committed.

13. If you have received counseling or treatment for any emotional or mental disorder from any public or private facility, program, or counselor, please identify the name and location (name, address and phone number) of each facility, program and counselor; the dates you attended; and describe the

conduct you engaged in that caused you to receive the counseling or treatment.

14. State whether or not you have ever used or taken any illegal drugs or intoxicants, including but not limited to marijuana, cocaine, crack, heroin, LSD, and/or amphetamine(s) and/or any inhalants such as paint, thinner etc. or any liquor, wine or other intoxicant, and if so, identify the drug or inhalant or intoxicant and the dates that you used the drug or inhalant or intoxicant.

15. State whether or not you have ever delivered, carried or transferred any illegal drug or controlled substance to any other person or persons and the date of occurrence, location and type of drug for each delivery or transfer transaction.

16. Have you ever used, taken, sniffed, or ingested any illegal drug, controlled substance, or narcotic drug or chemical when you had any of your children in your possession or constructive possession or if you are a female, were pregnant with any of your children.

17. Have your parental rights to any child or children been terminated by any Court on any prior occasion. If your answer is Yes, identify the Case (Case Name, Cause Number), and Location of the Court (name, address and phone number) where the order of termination was entered.

18. Identify each Court Lawsuit or Court Case (Type of suit, Style and Cause Number, date filed) and location of the Court (name, address and phone number), for all lawsuits, civil and/or criminal and/or any legal proceedings to which you have ever been a party or a witness.

19. State the amount of your total monthly income from whatever source, list your gross income from each source and the name of the source of income, any deductions made in your income, the type and amount of each deduction, and the resulting net take home amount from each source each month.

20. Identify (name, address and phone number) the Schools each of your children now attend and those they have attended in the past, including the dates each child attended each school from beginning date to discharge date.

21. Identify each residence address location (address and telephone number) where you lived since the birth of your first child or within the last five years whichever is greater (in order, oldest first);

	Address	Telephone Number
1.		
2.		
3.		

22. Have you ever used any false social security numbers or false drivers license numbers, and if so, please identify each such false drivers license number and false social security number and the date of birth and name you used with each number and state the reason you used each false number.

23. Identify each job and/or income producing activity of any type have you had in the last ten years. "Identify" in this question means, with respect to each employment, job or income producing activity you have had in the last ten years, please state the identity and location (name, address and phone number) of each employer, if any, the dates of each employment beginning to end, and the type of employment or job activity you performed, and the salary or pay received for each employment or activity and the reason for the termination, if any, of each employment or business activity. Please state the above in date order, oldest first.

24. State the kind, type and amount of each of your current monthly expenses by category including the following specific categories and any others you may have: housing, utilities, transportation fees (including gas, and insurance), car payments, loan payments, insurance of any kind, tax expenses, food, work expenses, medical expenses not covered by insurance, clothing, laundry, grooming, entertainment, alcoholic beverages, cigarettes, drugs of any type, currently owed child support (including the amount paid per month and the total amount owed), current outstanding debts including credit card debts (total amount owed and amount you are paying per month), child care expenses for any of your children, legal fees, church contributions, and union or professional dues.

25. State whether or not you have any bank accounts of any type, including checking, savings, credit union, certificates of deposit or any other negotiable instrument account including stocks and bonds. If so, state the name and address and phone number of each financial institution or brokerage house and credit union, account number, and amount currently in the account. Also state whether or not you have any sums of money kept in any locations other than those listed above, and if so, the amount and location of such.

Respectfully submitted;

_____
Assistant District Attorney
Texas Bar Card:

REQUEST FOR PRODUCTION

NOW COMES, (name), Assistant District Attorney for Dallas County Child Protective Services Unit of the Texas Department of Protective and Regulatory Services and files this Request for Production pursuant to Rule 196 in the above entitled and numbered cause, and would show the Court as follows:

I.

Petitioner requests that Respondent, (name), produce for inspection and/or copying the following designated items which are documents or tangible things which constitute or contain matters within the scope of Rule 196 which are in the possession, custody, or control of the Respondent and further to permit entry on any property designated below which is in the possession or control of the Respondent for the purpose of inspection, photographing, testing, measuring or sampling the property or any designated object or operation thereon within the scope of Rule 196.

Petitioner requests the listed items be produced at the office of Petitioner, located on the 2nd floor of the Henry Wade Juvenile Justice Center, 2600 Lone Star Dr. which are offices of the District Attorney of Dallas County, Texas or mailed or delivered to said office within 30 days after the date of service of this request. The requested items are as follows:

1. Any and all, psychological evaluations of Respondent, reports from any mental health worker concerning Respondent, and psychiatric evaluations of Respondent.

2. Any and all drug treatment records of Respondent from any facility inpatient or outpatient.

3. Any and all photographs, videotapes, or audiotapes whether of Respondent or the subject children or both which are relevant to the issues of best interest or any ground of termination of parental rights.

4. All income tax records and supporting records and income tax returns of Respondent for the tax years 1998, 1997, 1996, 1995, and 1994.

5. Any and all A.F.D.C. records or identification cards or applications of the Respondent.

6. Any and all Food Stamp records or identification cards or applications of the Respondent.

7. Any and all medical records of the children the subject of this suit, including but not limited to records of immunizations of the children.

8. Any and all medical records of Respondent, including but not limited to records of all hospital visits, and records of all doctor visits for the years 1998, 1997 1992, 1991, 1990, and 1989.

_____
Assistant District Attorney

C. Voir Dire

Included in this section are two sample Voir Dires for a child welfare case, developed by members of the Dallas County District Attorney's Office. Michael Munden and Lisa Moye are to be credited with the first example, which is highly comprehensive and will cover most contingencies. The second example is a shortened version. It is hoped that the ideas put forth in these examples will help you or one of your colleagues to select the twelve people who will hear your case.

This is intended to be a laundry list of things you can go over with your jury panel, and if your judge does a very comprehensive voir dire, you may wish to cut out some of these items in order to avoid repetition. Carefully select only the questions that fit the particular facts of your case, and do not waste the jury's time with irrelevant questions.

Also, please remember that Voir Dire is a two-way street. You do not want to simply lecture your jury panel. You want to get a dialogue going with the panel members so you will know where their true hearts lie. It is difficult to justify a strike if the person on the panel has not said one word to either you or the other attorneys. So, get them talking. Cut to the chase, and develop a question that you believe will be central to your case. Get an answer from each person on the panel. You will be surprised how quickly you can do that.

When you get to the questions, just ask the ones that are pertinent to your lawsuit and your facts. Don't just ask the question then go on to the next person, ask follow-up questions if the panelist's answer needs a follow-up. If you have, for example a person who has been raised by a foster parent, ask if it was a positive experience. Ask how they felt about their natural parent not raising them (angry, grateful, indifferent, etc.)

VOIR DIRE ON SUIT TO TERMINATE PARENTAL RIGHTS

INTRODUCTION:

MAY IT PLEASE THE COURT:

My Name is _____. I am an Assistant District Attorney for _____ County, Texas, and I work for your duly elected District Attorney in this county, _____.

Judge _____ _____ has previously introduced the other attorneys and parties in this case.

*** Do any of you know any of these attorneys sitting before you?**
*** Any one who has ever been a client of either Mr/Ms. _____ or his/her partner, _____?**
*** Any of you know any of the parties here today? Mr./Ms. _____ or Mr./Ms. _____ ?**
*** Any of know any of the following persons who are known to one or more of the parties in this action:** [LIST ALL PERSONS NAMED BY OPPOSING PARTY IN DISCOVERY DOCUMENTS.]

The District Attorney's office represents the Texas Department of Child Protective Services in cases affecting the welfare of children, such cases are commonly referred to as Child Welfare cases. Some of you may know that the duties and responsibilities of the DCCPSU of the TDHS is a legal mandate to protect children in this county, even if that means protection from their parents?

These are cases in which the State of Texas asks Courts and Juries to make decisions affecting the legal relationship between Parents and Children in situations in which children are endangered.

Serving as a juror in a case like this is a grave responsibility; however, sometimes a situation arises in which the State has no choice but to ask a jury to terminate a Parent-Child Relationship. We believe this case is one of those situations.

This particular case concerns the welfare of (number of child(ren):
Name:
Age:
Sex:

In this case the State of Texas will be asking you to terminate-- that means to END FOREVER-- the parent-child relationship between each of these children and _____, their biological mother.

The State of Texas will also be asking you to terminate the parent - child relationship of _____ from a man who is her possible biological father _____.

The State of Texas will also be asking you to terminate the parent - child relationship of _____ from a man who is her possible biological father _____. However, this termination involving _____ will be by default because he has failed to file an answer or appear although duly served with citation in this case.

GROUNDS FOR TERMINATION:

In order for the State to terminate parental rights, the standard of proof must meet a **two prong test**. The State must Prove **a sufficient ground**

for termination AND must then prove that **termination is in the best interest of the child.**

1. There are different **categories of grounds** for termination. I should point out that each of these grounds for termination is a very serious violation of a parental relationship. The different categories of grounds for termination are:
   a. Abandonment of a child
   b. Non-support of a child
   c. Endangerment of a child
   d. Acts or omissions of a parent that constitute endangerment of a child.

2. In this case the State of Texas has alleged two <u>primary</u> grounds:.
   a. You will be asked to determine if each of these two Parents placed his/her child or knowingly allowed the child to remain in conditions or surroundings which endangered the physical or emotional well-being of the child OR
   b. You will be asked to determine if each of these two parents engaged in conduct or placed the child with someone whose conduct endangered the child's physical or emotional well-being.

3. These two grounds involve ENDANGERMENT? Endangerment means to "expose to loss or injury" or "to jeopardize."

   a. <u>Physical Endangerment</u>: A parent can endanger a child by exposing the child to domestic violence, or by not protecting a child from physical violence or sexual abuse. Likewise, if a parent leaves his or her child with caretakers or even a spouse, who is unsafe, that is also endangerment.

   b. <u>Neglect</u>: But, endangerment is more than direct physical violence toward a child, such as beating a child or burning a child. A parent can endanger a child by neglect, such as not feeding him properly, not providing necessities or medical care.

   c. <u>Emotional Endangerment</u>: There is also PHYSICAL ENDANGERMENT and EMOTIONAL ENDANGERMENT and the law does not draw a distinction between emotional and physical endangerment. Parental conduct which results in a dysfunctional emotional or psychological state in a child is just as much a ground for termination as parental conduct which results in a broken arm or skull fracture.

   d. <u>Indirect Endangerment</u>: Also the conduct creating the endangerment need not be directed at the child, ie. drug usage, domestic violence, and the conduct creating the endangerment does not necessarily have to occur in the presence of the child in order to endanger the child.

*** Does anyone have any questions regarding the definition of endangerment of a child?**
*** Does anyone disagree with the definition that a parent who knowingly places a child with another who exposes that child to harm or injury is endangerment?**
*** Does anyone believe that neglect could never warrant termination of parental rights?**

*** Does everyone understand the definition of neglect?**
*** Not providing a child with a clean place to live?**
*** Not providing adequate supervision for the child?**
*** Not providing for the necessities of life, such as food, clothing, etc.**
*** Does anyone believe that neglect could never warrant termination of parental rights?**
*** Does anyone believe that neglect could not be endangerment?**
*** Does anyone feel that the endangerment standard is to low, ie. does anyone feel that the standard should involve actual physical injury to a child in order to terminate parental rights?**
*** Any of you require proof that is greater than the law's definition of ENDANGERMENT?**

The **second test** that the State must prove in order to terminate parental rights is the issue of **the Best Interest of the Child.** If there is a sufficient ground for termination, is such termination in the Best Interest of the Child?

The Texas Supreme Court, in the case Holly v. Adams, (__ SW2d __) has established criteria that Courts and Juries can use in determining what is in the BEST INTEREST of the Child. The criteria include: Needs of the Child -where will those needs be best met?

1. Danger to the Child-where is it more likely to occur?
2. Parental abilities or lack thereof-Do the parents have or lack the ability to provide care and protection for the child?
3. Plans for the child by those seeking custody--Does that person have plans that are in the best interest of the child?
4. Stability of the home--Is the home of the person seeking the child one that will provide the stability a child deserves and requires?
5. Acts or omissions of Parents which indicate that the parent-child Relationship is not a proper one .--Has a parent by his actions or omissions shown that he or she is not a proper parent?

You should be advised that WITHOUT TERMINATION ADOPTION IS NOT POSSIBLE.

CLEAR AND CONVINCING EVIDENCE:

Parental rights must be terminated if the States proves AT LEAST ONE GROUND for termination and that termination is in the BEST INTEREST OF THE CHILD---Not the Parent.

The burden of proof in this case is on the State of Texas. The Standard of Proof for termination is Clear and Convincing Evidence.

CLEAR AND CONVINCING EVIDENCE is that measure or degree of proof that will produce a firm belief or conviction as to the truth of the allegations sought to be established.

Does everyone understand the burden of proof? That it is by Clear and Convincing Evidence?

YOUR DUTY AS JURORS:

The reason that we are all interested in any personal opinions or beliefs that you may have, is because it will be your duty as jurors to judge the credibility of the witnesses and evaluate the evidence from the witness stand.

Do each of you understand that in examining the credibility of the witnesses, each of you as fact finders, may consider the demeanor of the witness, and may consider the weight to be given the testimony, using your common experience as an adult member of our society? You may not speculate to create evidence not introduced, but you do not have to throw out your best judgment or your common sense.

Do each of you understand that in considering the credibility of the witnesses, you will find it your task to believe all the witnesses, some of them or none of them? You may believe parts of each witnesses testimony, but not all? That will be your task as fact finders in this case. **Again, is there anyone who feels that he or she cannot undertake that responsibility?**

ISSUES:

The issue that you will have to determine involves the issue of which parent should be named primary possessor of the child:

CUSTODY QUESTIONS:

1. Can you give custody to a father?
2. Is there anyone on the jury panel who was reared primarily by their father?
3. Is there anyone on the jury panel who was reared primarily by their mother or some other member of their family?
4. Do you have an opinion right now that either a father or a mother ought to have custody of small children?
5. The judge will instruct you that your primary concern shall be "the best interest of the child." Can each of you promise that this child will truly be your primary consideration?
6. If there is going to be a winner or loser in this case, can each of you be sure that the winner is the <u>child</u>?

QUESTIONS FOR PANEL:

The judge has explained the purpose of voir dire--to select a jury who can decide this case based upon the evidence. It is in the Best Interest of the Children who are subjects of this suit that the jury that hears this case be fair and impartial.

We need a jury that can follow the Judge's instructions and decide the case based upon the evidence introduced in Court--from the witness stand and through exhibits--and make a final decision based only upon that evidence. The case should not be decided on BIAS, PREJUDICE or SYMPATHY.

We are not here to determine what may be in the best interest of any parties (or parents) to this lawsuit--except the children.. It is your responsibility to determine what is in the BEST INTEREST OF THE CHILD.

So in order to select a jury from this panel, the attorneys in this case are given the opportunity to ask some of you some questions. This is not meant to pry into your personal affairs or to embarrass you. It is important to know if you have had experiences in your life that would create a good reason that you could not be fair and impartial to serve on this jury for this type of case. For instance, some of you will be perfectly fine in a criminal case, an automobile case, a case involving contracts, etc. but for

some reason may not be appropriate for this case. There may be some of you who will decide that you could not sit on this type of case for one reason or another. We need for you to be forthcoming with your thoughts and feelings about serving on a case involving the termination of parental rights.

Because we are dealing here with sensitive and painful issues, these questions may be difficult for you to answer. If you prefer not to answer a question before the whole panel, let us know. You can speak later to the judge and attorneys privately. Please don't's let any discomfort you may feel prevent you from responding to a question. It is in the best interest of the children who are the subjects of this suit that the jury consist of those best suited to serve.

I'll ask questions to you as a group and you can respond now by row by raising your hand if you need to respond to the question.

OR

As Judge _____ has explained to you, none of the attorneys intends to make you uncomfortable with our questions, but we feel that we need to get to know you as well as possible in order to determine those persons who could be the fairest, based upon their life experiences and opinions, to sit on this jury. Each of you, we feel, is qualified to sit on some jury, but you may have had some experiences that makes is inappropriate to one side or the other to sit on <u>this</u> case. That's our purpose so please bear with us and please answer the questions candidly

Has anyone had any contact with a situation involving child abuse or neglect, whether by witnessing, reporting it, or yourself or a close friend of family member involved in such a situation?

A. Has anyone had any contact with DCCSPSU of the TCPRS or any other child welfare agency?
B. Are there any current or prior foster parents among you?
C. Are there any of you who know any foster parents?
D. Has anyone here every been involved in a dispute involving child custody?
E. Is there anyone here who did not raise their own child(ren)? Who had a relative or friend to rear them?
F. Has anyone ever adopted a child?
G. Anyone among you who is adopted?
   If so, at what age?
   1. By whom, relative? friend? adoption agency? Anyone here who was raised by anyone other than his natural parent?
H. Anyone here who works with children, such as Teachers, Pediatricians, daycare worker, etc.?
I. Anyone here with any type of medical training?
J. Anyone here with any type of legal training?
K. Anyone here with any type of social work experience including persons who may do volunteer work?
L. Anyone here with any type of psychological training?
M. We anticipate that the evidence in this case will involve testimony of psychiatrists, psychologists, therapists. Are there any among you, who for one reason or another, feel that you cannot accept the testimony of a psychiatrist or psychologist?
N. Does everyone understand that the duties and responsibilities of the DCCPSU of the TDHS is a legal mandate to protect children in this county, even if that means protection from their parents?
O. Does anyone believe that neglect could never warrant termination of parental rights?

P. Does everyone recall the definition of neglect?
Q. Not providing a child with a clean place to live?
R. Not providing adequate supervision for the child?
S. Not providing a child with the necessities of life, such as food, clothing, etc.
T. Does anyone believe that neglect could never warrant termination of parental rights?
U. Does anyone believe that neglect could not be endangerment?
V. The law applies the same standard to all parents, whether poor, educated or uneducated? Does everyone believe that is fair?
W. Does anyone believe that the law should apply different standards of protection of children based upon the circumstances of the parents? Ie. different standards for different parents?
X. Anyone had personal contact with CPS--make referral, been investigated?
Y. Any of you who have been adopted a child through an agency?
Z. Any of you who are adoptive parents?
AA. Any of you who are foster parents?
AB. Any of you who have reared children who are not your biological children?
AC. Any of you who have had someone else, for whatever circumstances, to rear you own children?
AD. Any of you who have been reared by someone other than your natural parents?
AE. Any of you who have been involved in a dispute involving child custody? Allegations of A/N?
AF. Any of you who have been involved in a paternity suit?
AG. Any of you who are single parents? Any problems regarding visitation or support that could affect your being a juror on this case?
AH. Any of you suffered from substantial abuse problem ?
AI. Any of you receive treatment for drug/alcohol treatment?
AJ. Any of you who have close friends or family members who suffered from substance abuse problem or received treatment for such problems.?
AK. Any of you require proof that is greater than the law's definition of ENDANGERMENT?
AL. Have any of you left a child for any substantial period of time, for such reasons as military service, incarceration, missionary work, job transfers?
AM. Any of you who feels that the tie or bond between a parent and child should never be severed regardless of the circumstances.
AN. Anyone here require that the state bring you the testimony of the child in order to terminate their parent's rights?
AO. IF STATE OF TEXAS proves this case by Clear and Convincing Evidence, could you participate in a decision which would terminate parental rights?
AP. Are there any of you who believe that the Parent-Child Relationship is such a sacred thing and that no matter what the circumstances, you could not sit on a jury charged with making that determination?
AQ. Are there any of you who could not find termination of a parent's rights no matter what the circumstances? You just couldn't do it? Does anyone have any questions of any matters discussed during this voir dire?

Because we are dealing here with sensitive and painful issues, these questions may be difficult for you to answer. If you prefer not to answer a question before the whole panel, let us know. You can speak later to the judge and attorneys privately. Please don't's let any discomfort you may feel prevent you from responding to a question. It is in the best interest of the children who are the subjects of this suit that the jury consist of those best suited to serve.

AR. Anyone on this panel who has ever been arrested for any reason other than a traffic violation?
AS. Anyone here the parent of a child that has been the victim of sexual abuse?
AT. Anyone here been accused of sexual abuse?
AU. Anyone here been the victim of sexual abuse?
AV. Does anyone want to approach the Bench to discuss any private matter regarding any question previously asked or for any other reason that you feel that you could not be fair and impartial in this case?

Thank you very much for your time and attention. We know you are all busy persons and we very much appreciate your service, particularly in a case as difficult as this one.

VOIR DIRE EXAMINATION--TERMINATION

1. CIVIL SUIT under Texas Family Code -- not criminal
   a. Object -- to terminate parental rights of parents so child may be ADOPTED
2. PURPOSE -- to pick a fair and impartial jury; follow the law
   a. Court is a CIVIL court -- civil proceedings; State is the Petitioner for TDPRS, represented by DA
3. NAMES of Respondent, Parties, Attorneys
   a. Does anyone know the parties?
4. LEGISLATURE -- sets standards
   a. Grounds for Termination in Family Code
   b. Best Interest of Child, not best interest of parents
5. PETITION -- alleges GROUNDS for termination + BEST INTEREST
   a. Requests Terminate and Appoint TDPRS as PMC
   b. So Child may be Adopted
6. BURDEN OF PROOF
   a. CLEAR AND CONVINCING EVIDENCE -- that measure or degree of proof that will produce a firm belief or conviction as to the truth of the allegations sought to be established
   b. SHOW -- at least ONE GROUND of termination + BEST INTEREST to terminate
7. GROUNDS FOR TERMINATION
   a. Petition alleges ... (read grounds aloud to jury and discuss)
   b. ENDANGERMENT
      1. ENDANGER means to place in Harm, Jeopardy, or Danger
      2. Endanger is the KEY -- did parents' conduct endanger child either physically or emotionally, either one sufficient
         a. Physical Endangerment
         b. Emotional endangerment
         c. NOT abused/neglected; don't have to prove abuse, neglect
   c. BEST INTEREST -- Tex. Supreme Ct. (Holly v. Adams, SW2d) has given us criteria for best interest
      1. desires of child
      2. emotional and physical NEEDS of child now and in future
      3. emotional and physical DANGER to child now and in future
      4. parental abilities or LACK thereof of persons seeking custody
      5. programs available to assist those seeking custody
      6. PLANS for child by individuals seeking custody
      7. STABILITY of Home or proposed placement
      8. ACTS or OMISSIONS of the PARENT which indicate the existing parent-child relationship is not proper
      9. any excuses by parent for these acts
8. JURY TRIAL
   a. JURY'S DUTY
      1. Jury is judge of facts, credibility of witnesses
      2. not bound by opinions of witnesses
      3. determine weight to give testimony
      4. determine what is reasonable and believable
      5. RESOLVE CONFLICTS in evidence
   b. JUDGE'S DUTY
      1. Judge of Law
      2. Gives law in charge -- must follow the law
   c. EVIDENCE

1. what attorneys say is NOT EVIDENCE
2. NOT bound by opinions of witnesses
3. may consider and weigh all evidence and give it weight it deserves
4. may disbelieve a witness
5. evidence comes from the witness stand and physical items introduced
6. there will be conflicts in evidence, resolve conflicts

9. QUESTIONS:
   a. anyone know RESPONDENT or his attorney?
   b. anyone who would not want to sit on a jury on a TERMINATION case?
   c. anyone who would require a stricter BURDEN of State than clear and convincing evidence?
   d. anyone who has had any contact with TDPRS or any child welfare agency in reference to a situation of ABUSE or NEGLECT?
   e. anyone who has any contact with a situation of CHILD ABUSE?
   f. anyone involved in a dispute over CUSTODY OF A CHILD/divorce, etc., with TDPRS or anyone else?
   g. any FOSTER parents, any ADOPTIVE parents?
   h. any GRANDPARENTS?
   i. any TEACHERS?
   j. any CHILD CARE WORKERS?
   k. anyone who has allowed another person to CARE FOR or RAISE their child or children?
   l. anyone who has had a child under age five with a broken leg/arm/head injury?
   m. anyone who was raised by a relative, friend or adoptive parent?
   n. anyone feel so strongly about the TIE between parent and child that they could NOT INTERFERE?
   o. anyone with any PHYSICAL PROBLEMS preventing them from sitting on jury -- hard of hearing, etc.?
   p. anyone with any medical, psychological, legal TRAINING?
   q. any problems with long trial?

D. Witnesses

In many of these types of cases, the witness list may be 40 or 50 people long, because the Discovery motions will demand that you list everybody who has any connection to the case, because if you do not list that person, you may be prohibited from calling them. However, in reality, you may need only a fraction of that number. It is a wise practice to sit down with your caseworker and cull your list very hard. Then, cull it again. The fewer witnesses you call, the less likely the jury is to become confused. Note what each witness can testify to out to the side, then consolidate your list by selecting the fewest witnesses who can testify to the most factors. Remember, you do not need to put each little factor in. Often, a judicious selection of the facts you want to present can provide a more persuasive case that parading one witness after the other, each of whom can contribute one or two facts that are different.

The next thing is to get with each witness you intend to call, either in person or by phone. The most effective method of witness preparation is in person, face to face. This is extremely time-consuming, but it is worth the effort when you are able to distill the finely tuned facts with regard to the case. Schedule the time to visit your most important witnesses, and hit the road. Some witnesses are obvious telephone interviews, as you will learn through your case preparation. Never leave your main caseworker to a telephone interview. Go to the Department for your interview. Many times, you will discover important information from your caseworker that can only be supplied through additional Department records or through sources at the Department (possibly additional witnesses you could not anticipate or prior referrals that did not show up initially).

E. Exhibits

Deciding which exhibits to use is where the fun comes in. This is the area where you are thinking globally about your case in trying to decide how to viscerally impact your jury. Some examples of exhibits useful in this type of case include:

1. <u>Charts</u>

You can have extremely good facts, and if you don't package them right, they will bore your jury. Think about how to visually present your great facts to get the most impact out of them.

* For example, if you have 11 prior referrals, you will get a lot of mileage out of presenting a large chart listing them for your jury to see. Furthermore, the chart remains up after the witness has stepped down, and the jury keeps being reminded of how remiss the Respondents were and how they acted in bad faith, because they continued to fail to keep their family safe.

* Another chart idea is the number of medical referrals and the reasons for them. This was used in a case where the child had been hospitalized on numerous occasions because the mother did not believe in doctors or medicine and the child's disease became so life-threatening that the case finally ended in a successful termination trial.

* In another case a lawyer used a chart to show the number of times the Respondents moved to avoid being detected by Child Protective Services and how they were chronic job-hoppers. The chart, which was filled in by the numerous witnesses in front of the jury, went on for six or seven pages. Needless to say, this took a lot of advance preparation, but it was extremely effective, and was favorably commented on by members of the jury, who voted unanimously to terminate.

2. Maps and diagrams

Maps are very useful to show a crime scene or where abuse or neglect occurred. The witnesses can fill in information about the neighboring areas, to show that the Respondents surrounded themselves and their children with dope dealers, gang members, juvenile delinquents, and other unsavory people. Diagrams can be used to show rooms in houses where various events occurred or where items were found, such as garbage, rotten food, animal feces, or filthy clothing. In one recent case, the Respondent parents presented themselves as "recyclers" -- but in reality, their house was filled with 12 TONS of garbage! The Respondent Mother had to be restrained from taking items she claimed to be recycling out of one of the numerous garbage trucks the city sent to clean up the mess.

3. Skeletal drawings and models of body parts

These drawings are so important in showing injuries. Your Forensic Science lab personnel can probably supply you with drawings of the body and various body parts, such as the skull, trunk, arms, and legs. Blown up, these can be highly effective when your physician uses a large, red marker to illustrate how the injury looked internally. This is particularly effective when there is a skull injury and the red marker is used to show the internal bleeding under the skin or the dura. A model such as a styrofoam wig stand can be used to demonstrate trauma to the skull and injuries to the head. A physician can talk all day and dryly discuss stacks of medical records, but the injury really comes alive for a jury when they can see it for themselves in scarlet letters.

4. Dolls

An obvious use for dolls comes to mind in sex abuse cases when a witness uses an anatomically correct doll to demonstrate something about the crime. These dolls sometimes are used by child witnesses to show a jury what happened, since the child's language might not be very sophisticated.

Dolls can be used for other demonstrations, also. In one case a Respondent mother was sitting in a hospital room with a nurse and several aides, and suddenly the mother jumped up, ran to a crib, flung her infant at the crib, then fled from the room, sobbing. It is a tribute to the resilience of human infants that this one was not severely injured or killed by her mother's action. The lawyer had the nurse re-enact the scene using a baby doll, with a box lid for the crib. This demonstration, which was carefully planned, only took a few seconds to complete, but the jury was electrified. Again, a unanimous verdict of termination.

5. Weapons

Any time you can produce a weapon that a Respondent parent has used against a child, you will have the jury's undivided attention. One Respondent mother hit her infant daughter with a wooden block the child was playing with on the floor. The infant looked surprised, then hurt, then started to cry. The caseworker took the block away from the mother, preserved it, and gave it to the district attorney, who introduced it into evidence then used it very effectively during final argument. Once again, a unanimous verdict of termination.

6. Business Records

There are many types of business records you can use in your trial, such as medical records, school records, counseling records, drug treatment records, psychological records. As soon as you know that you are going to have a jury trial, talk with your caseworker and go over the file to make sure you order any records you will need well in advance. When the records come in, be sure to check them, because sometimes with very voluminous records, sections are left out and may need to be reordered. Also, check to make sure you have all the pages, and that they are in the right order. A constant problem is not being able to read the reproduced pages very well. Do your best, and keep your highlighter and sticky notes handy. It is helpful to read any medical-type records with an expert to help you translate the abbreviations and jargon. Once you learn what all that means, you will be ahead of the game.

It is purely a strategy decision whether to file any business records fourteen days in advance of trial with the court using a business records affidavit or whether to call the custodian and introduce them at trial. If you file the records in advance of trial, the Respondent's attorney will have a chance to read them and know what to expect (assuming no discovery has been filed on you). If you call the custodian, you will have the advantage of surprise, but that's another witness you have to deal with in terms of scheduling.

7. Photographs

Effectively used, photographs can be extremely helpful in demonstrating home or living conditions, injuries, a scene, evidence such as drugs or weapons. Photographs can be used to show a sequence of events or show changes in people or living conditions. For example, you might use a photograph of an infant who was undernourished and underweight and then use a later photograph to show how the infant had improved with good nutrition and care. Be thinking whether you need your caseworker or investigator to take current photographs of anything you want to illustrate. Also be thinking whether you want to have any old photographs enlarged or mounted for a jury trial.

F. Argument and Summation

Final argument provides the best adrenalin rush in trial work, in my opinion. This is your chance to sum up your case and draw conclusions from the evidence. The jury now can have the benefit of the way you see the

evidence shaping the case. You should preface your statements with the words, "It is a reasonable conclusion from the evidence that ... " and you can then present your observations and valuable opinions for the jury.

Some lawyers are naturally dramatic and appeal to a jury's emotion. Others are factual and appeal to a jury's intellect. Some are a mix of both styles. Whichever style or mix of styles you have, shooting from the lip is not a wise practice in preparing a closing argument, because valuable points can be overlooked. No matter how tired you are or how well you know your case, it is smart to write down the points you want to make and the conclusions you want to draw, then glance at your notes during the closing to make sure you have not forgotten anything. These cases tend to be lengthy and you want to be sure to tie the whole thing together.

Finally, don't worry about looking at your notes. Juries do not mind if lawyers consult their important papers because, after all, lawyers are supposed to have important papers to consult. But, I can tell you from personal experience that you will have far more impact by appearing to speak extemporaneously. You can give this appearance by reading over your notes several times while the other lawyers are speaking, then putting your notes where you can look at them if you need to, getting up, and letting your argument flow.

I hope these notes and suggestions have helped; good luck!

THE EVALUATION OF BURN INJURIES

Gary F. Purdue, M.D.

Burns in children create many diagnostic and therapeutic problems not seen in adults. Approximately one-third of burn unit admissions are children under the age of 15 years and 1/3 of all burn deaths involve children. Burns are second only to motor vehicle accidents as the leading causes of death in children older than one year. Most pediatric burns occur in the home and are very often the result of adult inattention or carelessness. However, about ten percent are the result of deliberate abuse by adults.

The skin is the largest organ of the body with third and deep second degree burns causing permanent scarring. In addition, grafted burns have permanent loss of organ function being unable to appropriately sweat, lubricate and protect from normal wear and tear. The large burn affects other body organs and creates increased risk for infection and even death.

Scald burns are the most common type of accidental injury in children (50-60%), followed by flame burns (30%) and burns caused by contact with hot solids (10%). Chemical and electrical burns are rare in children. Males predominate (about two-thirds), but this gender difference is not as large as in adults (75% male). Flame burns are frequently very severe, often involving burning clothing, prolonged exposure and panic resulting in either flight or complete immobilization.

It is very difficult to make definitive statements based only upon patient age, as any groupings are also influenced by patient size and the other factors influencing burn severity. For this discussion, an infant is less than one year old, while a toddler is 1-3 years old. Because these children can't talk or understand, history is dependent on their families.

Extent of Injury

Estimation of the amount of body surface area (BSA or TBSA) permits planning of immediate medical management and fluid therapy and dictates the needs for definitive care. Estimation of burn size is most simply made using the "Rule of Nine's" which divides the body surface into areas which are multiples of 9% of the total. The anterior and posterior trunks and each leg account for 18% each, each arm and the head for 9%, and the perineum 1%. This method is not applicable to children as the head accounts for relatively more and the legs for relatively less. Only second and third degree burns are tabulated when calculating burn size. Lund-Browder or Berkow charts provide correction for age, and permit more accurate assessment of burn size.

Depth of Burn

While depth of injury is important in determining the choice of care and the ultimate outcome, initial evaluation is often very difficult as the wound changes appearance on a daily basis. Characteristics of first, second and third degree burns will be discussed. Burn depth is usually very difficult to estimate, especially in the early post-burn period. This is in large part due to the thinness of a child's skin. The depth of scald burns, especially in dark skinned infants, is notoriously difficult to estimate, and is frequently a degree deeper than originally appreciated. Underestimation of burn depth often occurs, even with experienced observers. Burn depth must be reevaluated several times weekly to determine both prognosis and the need for surgical intervention.

Location of the Burn

Burns of the face, hands, feet and perineum/genitalia each present special

problems in their management and greatly increase the morbidity of a given burn.

Age

Burns in persons younger than 2 or older than 60 years of age have a much higher mortality and morbidity than burns of similar severity in persons between these ages.

Pre-Existing Disease

Pre-existing disease may directly cause the injury (congenital disorders or seizures), while medical problems such as diabetes mellitus and retardation present family stressors and problems which may profoundly affect the course and outcome of their burn.

Circumstances of Injury

Multiple trauma may be present in the burn patient just as in the victim of any violent accident. The patient may have fallen from a significant height, have been trapped in a motor vehicle accident, or have had a significant inhalation injury. Patients involved in a fatal fire and those removed by firemen are at special risk.

IMMEDIATE WOUND CARE

Immediate (0-30 seconds) cooling of the burn by the application of cool tap water usually provides immediate pain relief. The use of cool water rather than ice is emphasized.

Fluid Resuscitation

The most important aspect of the initial care of a patient with a major burn is fluid resuscitation. All patients with burns of more than 20% body surface area as well as children or elderly patients with smaller burn require intravenous fluids for optimal management. Modifications often have to be made for resuscitating children.

Abuse by burning

Child abuse must always be considered when evaluating a burned child. The pattern of burn injury is carefully evaluated with special attention paid to the presence of multiple burns (of the same or different ages), the presence or absence of splash marks, spared areas, bilateral symmetry ("stocking and glove" distribution), and well demarcated waterlines. The soles of the feet should always be inspected for the presence of any burn (even first degree). Non-burn trauma such as bruises, whip marks, fractures and head trauma are noted, and old medical records reviewed for prior injuries. If abuse is suspected, skull, chest and long bone x-ray series are obtained. The examiner must ask himself/herself the following questions: Is the appearance, pattern and depth of burn consistent with the given history? Does the given history remain constant with repeated telling?

Recently, increased attention has been given to all aspects of child abuse. One common, but often unappreciated, method of deliberate injury is by burning, which accounts for about 10 percent of all child abuse. 10-25% of pediatric burns are deliberately inflicted by adults, with mortality approaching 30%, significantly higher than for accidental burns and having a 30-70% potential for further injury.

Our own study of age distributions of both abused and nonabused subgroups differ only in patients under one year old, a time when mobility and climbing skills are limited, and in patients age five or older, where abuse by burning is relatively rare. Hospital stay is significantly longer for abused children with small burns, <10% TBSA. Most burns are caused by tap water, in sharp contrast to the general pediatric population where only 9% of injuries are caused by tap

water. Patterns of scald injury are: random splash, including injuries caused by running water and immersion. No abused children exhibited the classic accidental spill injury, a pattern that seldom occurs in child abuse. Rather, injury is caused by deliberately placing the child under flowing liquid or by immersion in liquid. Although a random spill injury might be deliberate, other historical or physical factors should be present to show deliberate injury. Immersion burns occur when the patient falls into or is placed into a container of hot liquid. Accidental injuries are characterized by splash marks, varying depths of burn, indistinct borders and multiple areas of burn as the patient struggles get out of the hot liquid. By contrast, in deliberate injuries, burn depth is uniform, almost monotonous in appearance, burn wound borders are distinct, and present as sharply defined waterlines, which are nearly straight lines delineating the areas of unburned skin from burned areas. Three-quarters of scald burns in our series were of the immersion type. Nearly all occurred in tap water, with the remainder being caused by immersion in "boiling water". The classic forced immersion type with central spared areas on the buttocks caused by contact with the cool bottom of the container is rare. While the time-temperature relationships required to cause a burn injury have been well evaluated, it is extremely improbable that the unrestrained child will sustain isolated deep partial or full thickness extremity burns by accidental immersion in hot tap water.

Flame burns were the second most common cause of burn injury, characterized by extreme depth and relatively circumscribed area when compared to accidental burns. In all cases, the given history was not consistent with the injury. Accidental injuries caused by hot solids have lack of apparent pattern caused by patient movement, while deliberately inflicted burns faithfully depict the outline of the hot object although brief contact with a very hot object will produce a shallow sharp edged burn.

Inflicted burns are frequently manifested by characteristic patterns of injury which are, fortunately, rarely concealed. Burn distribution in the abused group concentrated on the buttocks and distal limbs. Two thirds of our children with tap water scald injuries sustained burns of the buttocks and/or perineum, a finding consistent with the observation that these injuries often involve toilet training and soiling of clothing. Simultaneous deep scald burns of the buttocks, perineum and both feet was pathognomonic of deliberate injury. Other immersion injuries involved circumferential burns of the extremities in the distribution of stockings or gloves. The history of injury should be carefully correlated with the observed pattern of injury, burn depth and appearance. Photographs should include all body parts. Physical examination of all burned children includes evaluation of the entire skin surface for both the burn injuries and evidence of other trauma such as healed burns, bruising, slap or whipping marks or evidence of sexual abuse. Evaluation and documentation of the burn pattern must be precise and include notation of the presence or absence of splash marks, uniformity of burn depth, bilateral symmetry, presence of spared areas and sharpness of demarkation between burned and unburned areas. The soles of the feet and palms of the hands should be evaluated for the presence of more superficial burns. Unusual circumstances surrounding the injury are often present. Healed or multiple burns were present in 8% of our series. Non-burn trauma must be carefully evaluated in the context of the child's motor skills. Young children frequently sustain soft tissue injuries in the course of normal maturation. However, their magnitude and number is limited. Multiple rib fractures in a 6 week old and bilateral subdural hematomas, multiple rib fractures and bilateral lower extremity fractures in a 4 month old are not normal wear and tear injuries. Any bruises in a child younger than 6 months demand investigation.

Because the incidence of death and further injury are so high, it is important that all persons caring for children to be aware of the manifestations of deliberate burn injury and maintain an appropriate index of suspicion.

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3. Deitch, E.A., Staats, M.: Child abuse through burning. J. Burn Care Rehab., **3**:89-94, 1982.
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EVIDENCE RESPONSE TEAM

Federal Bureau of Investigation
by Supervisory Special Agent A. Todd McCall
FBI Academy-Evidence Response Team Unit
Quantico, Virginia

-HISTORY OF THE EVIDENCE RESPONSE TEAM (ERT) CONCEPT
- -Created for 1984 Summer Olympics in Los Angeles, CA
- -Recommended Bureau-wide in Summer 1991
- -Mandated by Director Louis Freeh in October, 1994

-MAJOR CASE IMPACT OF ERT
- -World Trade Center bombing, 1993
- -Oklahoma City Federal Building Bombing, 1995
- -Centennial Park Bombing, 1996 Summer Olympics, Atlanta
- -TWA Flight 800 disaster, New york, 1996
- -Middle East Bombings, African Bombings
- -Littleton, Colorado, School Shootings, 1999

-FOCUS OF THE ERT IS **NOT** THE SO-CALLED "MAJOR CASE"
- -Bank Robberies
- -Child Abductions
- -Body Recoveries

-WHAT MAKES THE ERT DIFFERENT?
- -All Volunteer Team Make-Up
  - -eight members per team
- -Training
  - -80-hour basic
  - -specialized schools
- -Equipment
- -Twelve Step Search Process
- -Documentation
  - -standardized bureau-wide
- -Turn Key Operation

-OTHER BENEFITS OF THE ERT
- -Direct contact/connection with the National Center for the Analysis of Violent Crime

-CONCLUSION

ESTABLISHING A CHILDREN'S ADVOCACY CENTER: BUILDING A STRONG FOUNDATION

OVERVIEW

I. History of Movement – Current Status of CAC Development

II. Program Components

III. Community Needs Assessment

IV. Identifying Leaders in Your Community

V. Selecting a Model

VI. Identifying and Generating Start-up and Continuation Funding

VII. Development of Interagency Agreement and Working Protocols

ESTABLISHING A CHILDREN'S ADVOCACY CENTER: BUILDING A STRONG FOUNDATION

DEFINING A CHILDREN'S ADVOCACY CENTER

A Children's Advocacy Center (CAC) is a child-focused, facility-based program where representatives from many disciplines meet to discuss and make decisions about the investigation and prosecution of child abuse cases, the assessment and treatment of child victims, and the prevention of further child victimization.

This multidisciplinary team approach brings together the many professionals needed to offer comprehensive services: law enforcement, child protective services, prosecution, medical, mental health and others. CACs are locally-based programs designed by professionals and volunteers to meet the special and varied needs of this unique and vulnerable population of crime victims within a community.

Communities that have developed a CAC, experience a myriad of benefits that include immediate follow-up to child abuse reports; more efficient and effective medical and mental health services; reduction in the number of forensic or investigative interviews child victim interviews must endure; increased successful prosecutions; enhance public awareness regarding child abuse; better informed potential jurors; and consistent support for child victims and their non-offending family members

THE MULTIDISCIPLINARY TEAM

This comprehensive approach, with follow-up services provided by the CAC, ensures that children receive child-focused services in a child-friendly environment – one in which the child's needs remain the primary focus from the first report through case disposition and beyond.

Establishment of a Children's Advocacy Center is a laudable goal for any community. It is also a huge challenge. Bringing together the various professional disciplines involved with child abuse cases and child abuse victims is a complex and often delicate task. While they may have a shared end goal -- to prosecute and punish those who people who hurt our children and to provide those children who have been hurt with the necessary tools to survive and heal -- each has a very specific role and responsibility in that process. Often times, those roles are in conflict or are duplicative and it is sometimes this reality that leads to the re-victimization of the child victims and their non-offending family members. The multidisciplinary approach to this problem is intended to assist these professionals in finding a common ground, in developing strategies for compromise and collaboration. These strategies must allow each of them to meet their specific obligations without further harming the very children they have dedicated themselves to protecting and providing for.

THE COMMUNITY

Communities must also have a place at the table if efforts to establish a Children's Advocacy Center are to succeed. These children belong to the community and, long after the professionals have done their jobs, these children will still belong to that community. They are the future of that community.

Therefore, it is the community that must rise to meet the continued needs, heal the remaining wounds and acknowledge and understand the enduring scars. It is the community that must pick up where the professionals leave off and ensure that these children are provided with the tools they will need to become healthy, happy, law-abiding and productive citizens capable of making a positive contribution to their community – wherever it might be. Fortunately, communities are recognizing their obligations and responsibilities to their children and – through the establishment of Children's Advocacy Centers – are responding to the call for help.

Communities can provide vital encouragement and support to the professionals charged with investigating and prosecuting child abuse cases as well as those charged with assessing and treating the physical and emotional needs of child victims. Communities can provide financial support of these individuals and agencies to ensure they maintain the necessary level of expertise so vital to doing this work well. Communities can provide a professionally appropriate yet child-friendly facility where the needs of these professionals and these children can both be met. Communities can provide all these things through the establishment of Children's Advocacy Centers.

Working together and building a strong foundation is key to the successful development of both a Children's Advocacy Center and the multidisciplinary team it represents. This is not an easy task.

Few things this important and this worthwhile are.

CHILDREN'S ADVOCACY CENTER
ORGANIZATIONAL DEVELOPMENT CHECK LIST

This checklist summarizes the developmental tasks which need to be completed in establishing a Children's Advocacy Center. Key organizational issues are included, followed by questions which will need to be addressed at that particular step of the process. Activities are listed in approximately the order in which they will need to occur, recognizing that some will need to take place concurrently, and that there will be variations in process and sequence within each community.

_____ **Convene a working committee or task force of key individuals**
Who needs to be involved?

_____ **Select leadership**
Who will convene the group and guide the process?

_____ **Conduct a needs assessment of the extent of the problem in the community**
What is the extent of the problem and how can a CAC help improve community response to child abuse?

_____ **Develop statements of vision and mission**
What is our vision of the future?
What is our mission in working to actualize this vision?
Does our mission statement address:
Who we are? What we do? For whom? To what end or purpose?

_____ **Determine CAC service population**
What geographical area will be covered?
Will only sexual abuse victims be served? Physical abuse? Severe neglect?
Other forms of child victimization?

_____ **Gather information on various CAC models**
What are the possible options?

_____ **Select the CAC approach that best fits the community**
What approach will best fit our community?

_____ **Develop interagency agreement and obtain agency commitment**

What approach do participating agencies agree on?

_____ **Determine organizational structure**

How will your CAC be structured?

Will it be an independent nonprofit? If so, who will seek 501(c)3 tax exempt status and file for incorporation?

Or will it be affiliated or sponsored by a participating agency (prosecution, child protection, law enforcement, hospital-based, etc.)?

_____ **Determine which services will be offered on-site or through referrals**

What program services will be offered at the CAC?

Will medical exams and mental health therapy be offered on-site or through referrals?

_____ **Select site and design or acquire space for child-appropriate facility**

Where can agency be located for maximum accessibility?

What space (size and design) needs to be available for program?

Will facility be purchased or leased, new or renovated?

_____ **Staffing and agency roles**

What staff roles and qualifications are needed?

Which staff will be hired by the CAC?

What others be assigned to the program by participating agencies?

Will assigned staff be located at the CAC facility?

Will a "master interviewer" be hired by the CAC or will agency investigators conduct all interviews?

_____ **Multi-disciplinary team protocol development**

How will the participating agencies, MDT and CAC all work together?

Who will comprise the MDT? Same team for all cases or possibly different team for each case?

How will joint investigative interviews occur?

Will interviews be audio or videotaped?

How will cases be tracked and reviewed by the team?

_____ **Research potential sources of support**

Who can/will help and in which ways?

_____ **Plan and carry out resource development**
What resources will be needed, how will they be obtained, by whom?

_____ **Plan and implement community outreach and awareness campaign**
How will the community be informed about the new program?

_____ **Development of governance board or advisory structure**
Who will make policy decisions or provide guidance to CAC?
How will the board of directors or advisory board be structured?
How will members be recruited, oriented and retained?

_____ **Develop policies and procedures for security and safe-guards (internal financial controls, liability insurance, conflict of interest policies, etc.**
How will children, program, board and staff will be safeguarded?
Do written policies and procedures include: staffing screening, confidentiality, safety, client records, intake, investigation, therapy and child abuse reporting, no perpetrators on-site?

_____ **Volunteer recruitment, screening and training program development**
How will volunteers be recruited, screened, trained and supervised?

_____ **Provide training for program staff and the community**
How will training be provided, by whom and for which groups?

_____ **Consider providing child abuse prevention programming**
What role will the CAC take regarding prevention? Primary? Secondary?

_____ **Develop program evaluation and accountability plan**
How will program be evaluated and demonstrate accountability?

_____ **Cultivate leadership on ongoing basis**
How will leadership be developed to ensure the long-term viability of the organization?

INTERROGATION of SUSPECTS in CHILD ABUSE CASES

Presented by

Lt. Bill Walsh

Youth and Family Crimes Division

Dallas Police Department

at the

1999 Crimes against Children Conference

Dallas, Texas

August 2, 1999

Child Abuse Cases

- Little or no medical evidence
- Usually never any witnesses
- Interviews of children are difficult and often challenged
- Abuse is usually not an isolated occurrence
- Children are often not viewed as credible witnesses

INTERVIEWING

vs.

INTERROGATION

Interviewing

- Exchange of information through two way conversation
- Non-accusatory by design and nature
- Acceptable to take notes throughout
- Lasts between 30-60 minutes
- Usually not a custodial situation

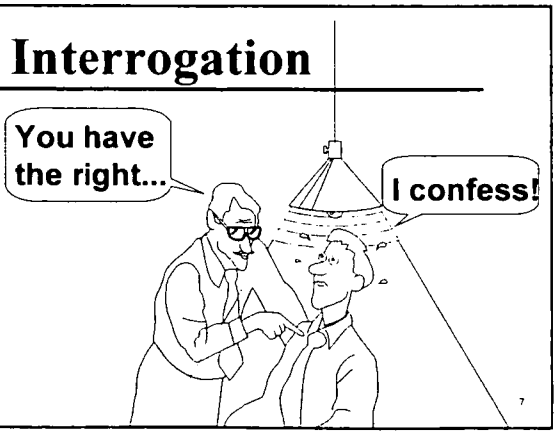
Interviewing

- Miranda warnings not required
- Subject may or may not be the suspect
- Subject should be "locked" into their side of the story
- Subject may give preview of their alibi or information for themes

Interviewing

- Statements should be documented
- Subject's opinions can be solicited
- Subject given an opportunity to tell their side
- Interviews are done before interrogations

Interrogation



Child Abuse Cases

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- Usually never any witnesses
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2

Evidence

- Child's testimony
- Interviewer's testimony
- Medical evidence
- Physical evidence
- Eyewitness testimony
- Accomplice testimony
- Suspect's confession

3

Evidence

Child's testimony
Interviewer's testimony
Medical evidence
Physical Evidence
Eyewitness testimony
Accomplice testimony

"I did it."

4


Dallas Times Herald

Man admits molesting 40 kids

Ex-YMCA worker sentenced in 3 cases

5

Interrogation

"The defendant's own confession is probably the most probative and damaging evidence that can be admitted against him."

Justice Byron White
Bruton vs. U.S.

6

Overview

- Interview vs. Interrogation
- Interrogation Issues
- Conducting the Interrogation

7

INTERVIEWING

VS.

INTERROGATION

8

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10

Interviewing

- Statements should be documented
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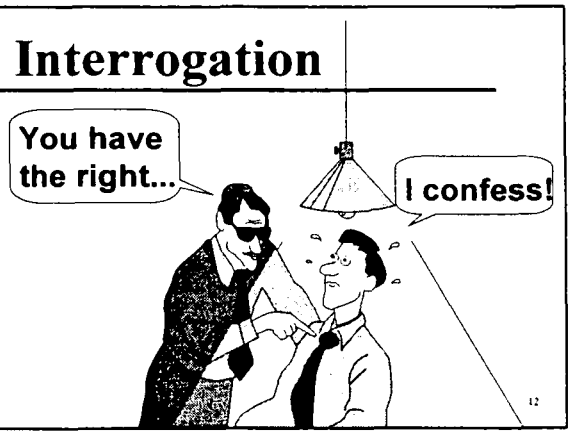
11

Interrogation



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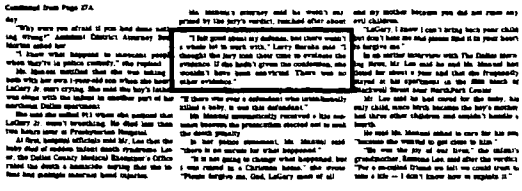
Interrogation

- Systematic method of obtaining information through questioning, confrontation and persuasion
- Accusatory by design and nature
- Subject is believed to be guilty
- Subject may or may not be under arrest or the focus of the investigation

13

FW woman convicted in beating death of Dallas infant



"I felt good about my defense, but there wasn't a whole lot to work with," Larry Baraka said. "I thought the jury took their time to evaluate the evidence. If she hadn't given the confession, she wouldn't have been convicted. There was no other evidence."

Interrogation Issues

Legal Issues

- Voluntariness of the confession is the fundamental issue in determining admissibility
- "Totality of the circumstances" is the test for voluntariness

17

Legal Issues

- Using trickery or deceit does not necessarily invalidate a confession
- Involuntary confessions can lead to :
  - exclusion of evidence at trial (fruit of the poisonous tree)
  - allegations of civil rights violations

18

Legal Issues

- Interrogation practice is ruled by:
  - U.S. Constitution (Bill of Rights)
  - State law
  - Departmental policy
- State law and local policies may be more restrictive

19

Constitutional Amendments

- Fourth Amendment
  - Exclusionary Rule, search and seizure
- Fifth Amendment
  - right to remain silent
- Sixth Amendment
  - right to counsel
- Fourteenth Amendment
  - due process clause

20

Suspect's Waiver

- Once suspect invokes right to remain silent or demands an attorney, questioning must cease immediately

21

Murder case dropped as judge throws out evidence

22

By Steve Scott
Staff Writer of The Dallas Morning News

A Richardson truck driver who once faced a possible death sentence in the slaying of his mother saw the charge against him dropped Thursday after a judge threw out crucial evidence that defense lawyers said police had obtained illegally.

Dallas County prosecutors dismissed a murder charge against Terry Lynn Brown after a hearing Thursday morning. Mr. Brown's lawyers argued that Richardson police had ignored their client's repeated requests for a lawyer and had used his relatives to pressure him into discussing the crime.

Police Chief Kenneth Yarbrough was out of town and unavailable for comment.

"We're surprised and concerned about the dismissal of the case," said Sgt. Ray Pennington, the department's spokesman. "But since we haven't had time to review the ruling or discuss it with the district attorney, we have no other comment."

During Thursday's hearing, defense at-

23

Suspect's Waiver

- Once suspect invokes right to remain silent or demands an attorney, questioning must cease immediately
- Interrogator can not urge suspect to change their mind
- Suspect can re-initiate conversation

24

Interrogation

- Miranda warnings required if it is a custodial situation
- Not advisable to take notes early on
- Ideally a one-on-one situation
- Advisable to have interrogation observed by another investigator

25

Observation

- Visual, audio, or video
- Protects interrogator from:
  - physical assaults
  - false allegations of misconduct
    - » verbal abuse
    - » physical abuse
    - » racial slurs
    - » sexual harassment

26

Observation

- Provides opportunity for coaching
- Provides second chance for obtaining a confession if the first fails

27

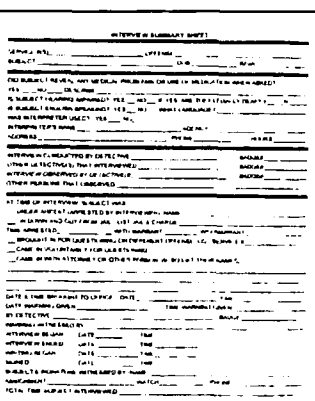
Officer fired, arrested in sex assault of boy, 15

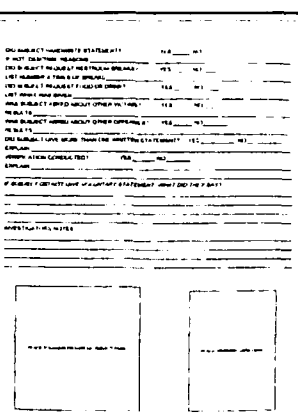
28

Observation

- Provides a witness to interrogation
- Provides opportunity for note taking
  - Completing the interview summary form

29





Interrogation

- Usually open-ended as to time limit
- Must be conducted in a private place
- Must be conducted without interruptions and distractions
- Interrogation is not a substitute for a thorough investigation

32

Investigative Process *

- Interview the victim or witnesses
- Investigate the allegations
- Collect evidence
- Identify the suspect
- Interview the suspect
- Interrogate the suspect
- Continue the investigation
  - * The order may vary

33

Interrogation

- Interrogation is like selling a product
- Interrogator must overcome the suspect's objections (denials)
- Success comes from:
  - personality
  - perception
  - perseverance
  - practice

34

Appearance

35

Appearance

- Non-uniform appearance
- Casual or business clothes
  - Loosened tie, sleeves rolled up
- No badge
- No gun, handcuffs
- No pager

36

Posture

- Sitting upright, frontally aligned
- Eventually sitting on edge of seat
- Open appearance
- No barriers in front of subject
- Avoid standing

37

Characteristics

- Confident
- Interested
- Enthusiastic
- Knowledgeable
- Experienced
- Thorough
- Self-controlled

38

Characteristics

- Confident
- Interested
- Enthusiastic
- **Knowledgeable**
- Experienced
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- Self-controlled

39

Characteristics

- Patient
- Good bluffer
- Seeking the truth
- Non-judgmental
- Sympathetic
- Understanding
- Professional

40

Characteristics

- Patient
- **Good bluffer**
- Seeking the truth
- Non-judgmental
- Sympathetic
- Understanding
- Professional

41

Speech & Voice

- Confident
- Controlled
- Conversational
- Appropriate vocabulary for suspect

42

Speech & Voice

- Avoid harsh, legal words
  - use *"touch"*, *"sex"*, *"inappropriate behavior"*
  - instead of *"molest"*, *"rape"*, *"sexual assault"*
- Be very careful about using profanity
  "You no good %^$#&*^% !"
  - allegations of coercion in court
  - violation of departmental policies

43

Facial Expressions

- Can be used to demonstrate:
  - interest and attention
  - agreement
  - sympathy and understanding
  - disgust and disbelief
  - anger
- Nodding, shaking of the head

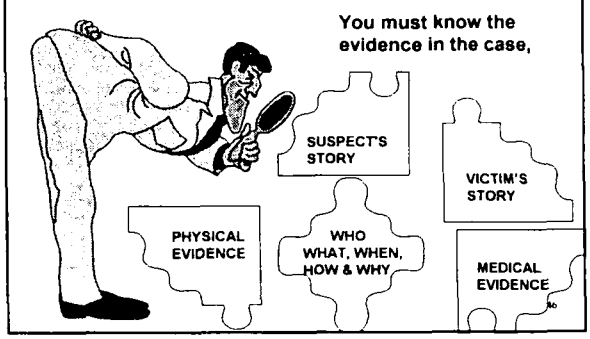
44

Flexibility

- Ability to alter the following as needed:
  - Strategies and themes
  - Body language
  - Speech
- Person with the most options will usually prevail in an interrogation room

45

Preparation



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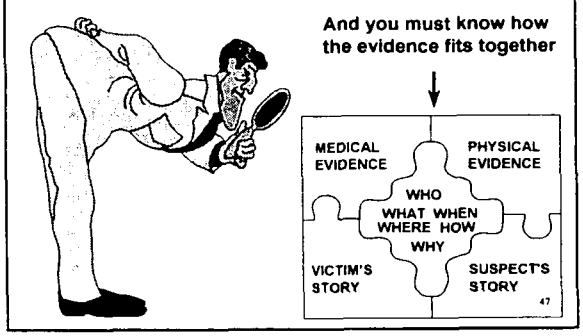
Preparation



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Know the Case

- Know the answers to:
  - who, what, where, when, how, why
- What is the extent of the abuse?
  - fondling vs. penetration
  - one victim vs. many victims
  - one injury vs. multiple injuries
  - permanent vs. temporary injuries

48

Know the Case

- How long has the abuse been going on?
  - first time, last time, how often, special occasions?
- What was said or done to insure secrecy?
  - threats, promises, privileges, gifts, blackmail?

49

Evidence

- What evidence do you have?
  - physical, medical, forensic, testimonial
- Can and should additional evidence be obtained before the interrogation?
  - search warrants
  - witness interviews
  - one-party consent telephone call

50

Know the Suspect

51

Know the Suspect

- Criminal history
- Outstanding warrants
- Prior law enforcement contacts
- CPS history
- Alcohol or drug problem
- Fears, motivations, weaknesses

52

Know the Suspect

- What is their community reputation?
- Are they currently on any medication?
- Employment, financial, marital status
- Past behavior may provide insight into current behavior
- Medical condition? Any disabilities?

53

Ex-church worker convicted of molesting boy

A Dallas man who had worked as a youth director at a Seagoville church was convicted Thursday of two counts of molesting a 13-year-old boy he met there.

Robert Joseph Cagle, 36, faces up to life in prison and a $10,000 fine when the jury meets to consider punishment Friday in state District Judge Jay Hemphill's court.

He was convicted of two counts of aggravated sexual assault involving the 13-year-old. He faces four other charges in Dallas and three in Rockwall for similar incidents involving the same boy and two other youths.

Police said Mr Cagle met the boy at Robinwood Baptist Church in Seagoville in fall 1989. The boy said that from August to October 1990, Mr. Cagle took him to movies, to play miniature golf and on other outings, and molested him after ward.

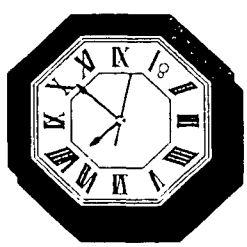
Police reports said Mr. Cagle took the boys to his grandmother's house near White Rock Lake, where he fondled and sodomized them.

It was not clear from testimony and police reports whether Mr. Cagle met the other boys at the church too.

The defense argued that the 13-year-old was fabricating the story but prosecutors presented evidence that when confronted with the accusations, Mr. Cagle admitted the molestations to the boys' parents, to his employers at the church and to a friend.

54

Timing



55

Timing

- Maximize your advantage
- Coordination with CPS is critical if they are involved
- Minimize suspect's moral support
- Minimize embarrassing or angering suspect if possible

56

Timing

- Reduce opportunity for defense attorney involvement
- Maintain element of surprise
- Not uncommon for victim to warn suspect
- Ideally, law enforcement should make initial contact with suspect

57

Timing

- Balance good preparation, with the element of surprise
- Poor preparation may result in unsuccessful interrogation
  - Suspect now alerted to investigation

58

Timing

- Delayed interrogations may result in:
  - removal or destruction of evidence
  - construction of alibis, defenses
  - defense attorney involvement
  - suspect's flight from jurisdiction
  - pressure on victim
  - unanticipated suspect actions

59

Timing

- Decision when to interrogate is decided in a case by case manner
- Interrogator must decide
  now vs. later?
- Weigh the benefits of each

60

Suspect's Status

- Voluntarily came in for interview
- Custodial situation?
  - under arrest
  - picked up for questioning
- If suspect confesses, will they be able to leave?
- Custody is a subjective determination

61

Setting the Stage

- Control the location
  - Conduct interrogations at your office
- Limit unplanned interruptions
- Take care of personal business
  - phone calls
  - restroom breaks
  - personal commitments

62

Setting the Stage

- Ideally, interrogations are conducted in a one-on-one situation
  - you can not control a third person's verbal and non-verbal language
  - suspect has to focus solely on the interrogator
  - Psychologically, it is easier to admit a mistake to one person

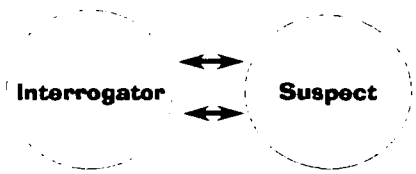
63

Suspect's Guilt

- Suspect's guilt is like their own little secret
- What is the definition of a secret?
- A secret is something that we tell to one person at a time.

64

One on One



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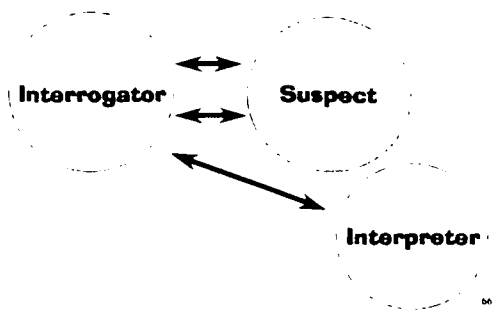
Using an Interpreter



66

How Much Time?

- Open-ended situation
- Not limited within reasonable time
- Suspect primarily determines when they will confess and not before
- Interrogator's impatience tells suspect to hold out

67

Interrogation Process

- Interview the suspect
- Confront the suspect with his guilt
- Overcome objections & denials
- Use themes and strategies
- Obtain the first admission of guilt

68

Interrogation Process

- Obtain a complete narrative account of the abuse
- Clear up any misunderstandings
- Obtain a formal statement
- Post-interrogation interview
- Verification
- Follow-up if indicated

69

The Interrogator

- May or may not be the case investigator
- Considerations
  - gender
  - race
  - language
  - case dynamics
  - experience

70

Conducting the Interrogation

In the Beginning

- Introduction
- Establish control
- Explain the purpose of talking to them
  - "I have only heard one side of this."
  - "This is your opportunity to tell me your side of this."
  - "I am very thorough and want all the facts before I decide what to do."

72

Miranda Warnings

- Convey this as a routine procedure
  - "You have probably seen this on TV"
- Read from a printed card
- Suspect and interrogator should initial, time and date the card (evidence)
- Suspect must understand their rights
- Suspect must waive their rights
  - "Do you want to tell me your side?"

73

Pre-Confrontation

- Evaluate verbal & non-verbal language
- Identify possible themes
  - "What do you think should happen to someone who has done...."?
- Identify weakness motivations, fears,
- Note any defenses offered
- Note any possible alibis

74

Pre-Confrontation

- "Do you know why you are here to talk to me today?"
  - Confrontational
  - Avoidant
- Evaluate any impairments
- Evaluate competency

75

Use of Props

- Bring in the "case file"
- Case evidence
  - witness affidavits
  - medical reports, lab tests
  - video tapes, audio tapes
  - victim's photograph
  - crime scene photographs

76

Confrontation

- "Our investigation proves you are the person responsible for ...."
- Evaluate the suspect's response
- "The reason I am taking the time to talk to you today is...."

77

Confrontation

- Convince the suspect his guilt is known and it can and will be proven
- Denying their guilt at this time is useless

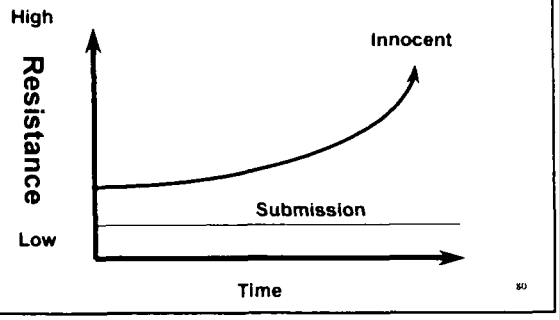
78

During the Interrogation

- Limit the suspect's denials
- Observe the suspect's body language
  - look for defensive posture
  - look for theme acceptance
  - look for submission
- Do not take notes until suspect confesses

79

During the Interrogation



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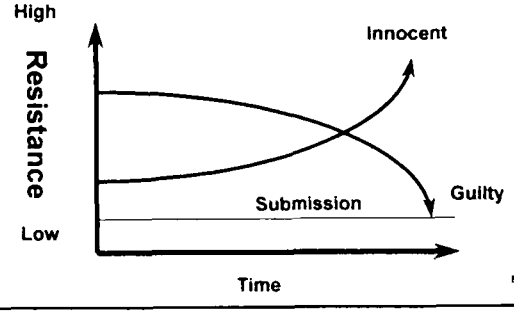
During the Interrogation



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Suspect's Verbal Language

- Look for changes in suspect's :
  - tone of voice
  - loudness and clarity
  - speed of delivery, pauses
  - body language
- Truthful person tends to talk bluntly, uses realistic terms when discussing the incident

82

Suspect's Verbal Language

- Suspect focuses on irrelevant issues
  - "I live two doors down, not next door"
- Excessive politeness or respect
  - when it is out of place
- Delays before answering questions
  - may cough, take deep breath , change position
- Repeats the question asked
  - "Did I go into her bedroom?"

83

Suspect's Verbal Language

- Suspect responds with his own question
  - "Why do you think I would do that?"
- Suspect answers with incomplete sentences
  - "Well, it could be...."
- Suspect answers with qualified or political answers (used to evade, avoid lying)
  - "To the best of my knowledge...."
  - "Not really...."
  - "If I recall correctly...."

84

Suspect's Verbal Language

- Suspect claims he can't remember
  - "I don't remember touching her"
- Suspect tells story with significant changes over time
  - "A liar needs a good memory"
- Suspect makes a verbal slip of the tongue
  - "Yes..., I mean no I didn't do it?

85

Suspect's Verbal Language

- Suspect swears on their innocence
  - "Honest to God..."
  - "I swear on a stack of bibles..."
- Suspect uses inappropriate laughter
  - Interrogator: "Did you touch the little girl?"
  - Suspect: (Phony laughter) Touch the little girl, I made love to her all night long"

Themes

Different strokes,

Themes

Different strokes,

for different folks

Alternatives

- "I know that you did _____ there is no reason to deny it. I just need to know, is this the first time you have done it or have you done it before?
- "It is the first time isn't it? Isn't it?"

Alternatives

- "There is no doubt that you did _____ I just need to know, did you plan this thing out in advance or did it just happen?"
- "It just kind of happened didn't it? Didn't it?"

Deception

- Legal and ethical for law enforcement
- It is not ethical for CPS to use
- Can not be used to get a waiver of suspect's rights
- Proper use of deception by law enforcement does not make a statement inadmissible

Deception

- Use with caution, you lose if the suspect feels they can not trust you
- Courts look for outrageous conduct and that could possibly make an innocent person confess
  - fabricated evidence
  - coercive tactics

92

Deception

- "What would you say if I told you..?"
  - "I spoke with your wife and she said..."
  - "Your semen was found..."
  - "Your DNA was found..."
  - "Your fingerprints were found ..."
  - "The lab tests indicate that..."
  - "The doctor said that..."

93

SLIDING SCALE OF CRIMINAL CULPABILITY

Sliding Scale

- Suspect is given an opportunity to confess in a manner that:
  - is psychologically acceptable to him
  - makes behavior appear less reprehensible
  - minimizes the gravity of the crime
  - transfers some or all of the blame to others
  - allows them to be seen as the "victim"

95

Sliding Scale

The abuse

Less Severe	More Severe
One time	Many times
One victim	Many victims
Spontaneous	Planned
Will never do it again	Will do it again

96

Sliding Scale

Sexual Abuse

Less Severe	More Severe
Fondling	Penetration
One victim	Many victims
Spontaneous	Planned
Isolated incident	Multiple incidents
"Consensual"	Force involved
No weapon	Weapon used

97

Sliding Scale

Physical Abuse

Less Severe	More Severe
Bruises, fractures	Death
Isolated incident	Chronic abuse
Impulsive	Intentional
Temporary	Permanent

Sliding Scale

Fatal Abuse

Less Severe	More Severe
Accidental	Intentional
Isolated incident	Chronic abuse
Impulsive	Intentional
"Shaken Baby"	"Battered Child"
Neglect	Intentional

FW woman convicted in beating death of Dallas infant

FEELING MODE
VS.
CRITICAL THINKING

You want them thinking emotionally,

You want them thinking emotionally, not logically.

Blame the Victim

- They initiated the act, seduced the suspect
- They exaggerated the extent of the abuse
- They are promiscuous, sexually active
- They provoked the act
- They misinterpreted the suspect's actions
- They did not say "No"

104

Blame the Parents

- They should have not allowed the child to....
- They ignored the child's need for love & attention
- They should have known something was wrong and stopped it
- They neglected the child

105

Blame the Spouse

- They were unwilling or unable to satisfy the suspect's emotional and sexual needs
- They have failed as a parent
- They should have known something was wrong and stopped it
- They neglected the child

106

Blame Alcohol & Drugs

- They depress inhibitions
- They stimulate sexual interest
- They make people aggressive
- They impair judgment
- "You wouldn't have done that if you were sober, would you?'

107

Blame Outside Factors

- Suspect was under unusual stress
- Combination of factors caused suspect to make a mistake
  - "the stars were just aligned right"
- Society has failed the suspect
- The media is to blame for its portrayal of children

108

Suspect Themes

- Suspect is not a bad person, what they did was bad
- Suspect was showing affection
- Suspect wanted to get caught so they could stop their behavior
- Suspect was educating the child
- What happened was not intended

109

Suspect Themes

- Criminal record
  - No record - this is first mistake
  - Record - "Society" failed to help them
- CPS history
  - CPS failed to help them
- Suspect was abused as a child
- Suspect's actions were not that bad compared to other cases

110

Physical Abuse

- Minimize the injury
- Highlight a good prognosis
- There is a thin line between discipline and abuse
- Children are easily hurt
- Children are very stressful

111

Physical Abuse

- Abuse was not isolated, not chronic
- "If you lie about how it happened, I have to assume you are lying about why it happened"
  - "Did you intend to do that?"
- Suspect should not have been put in that situation
- Suspect is a victim of circumstances

112

Sexual Abuse

- Incest is less traumatic than non-familial abuse
- Non-familial abuse is less traumatic than non-familial abuse
- Suspect did not make the child pregnant, or give them a STD
- No force/weapon was used

113

Sexual Abuse

- Child was not injured
- Child was not seriously injured
- Child was not fatally injured
- Suspect acted alone

114

Other Themes

- "Is this all you did or are you responsible for....?
- Alternative questions
- "You can't change what you did before you entered this room"
- Use stories to make the point
- Who deserves special consideration?

115

Stepping Over the Line

Appropriate Conduct

Inappropriate Conduct

X

116

Stepping Over the Line

Appropriate Conduct

Inappropriate Conduct

X

117

Stepping Over the Line

Appropriate Conduct

Inappropriate Conduct

X

118

Stepping Over the Line

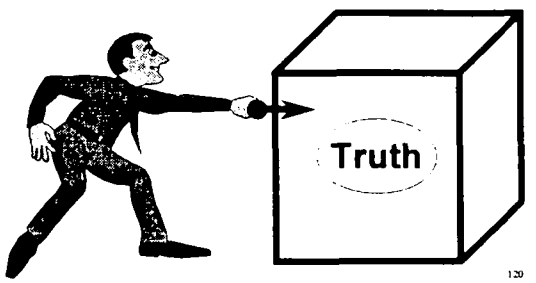
Appropriate Conduct

Inappropriate Conduct

X X

119

Cracking the Ice



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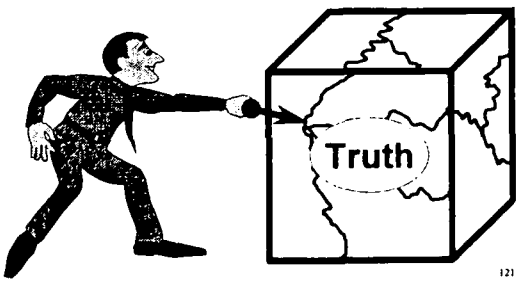
Cracking the Ice



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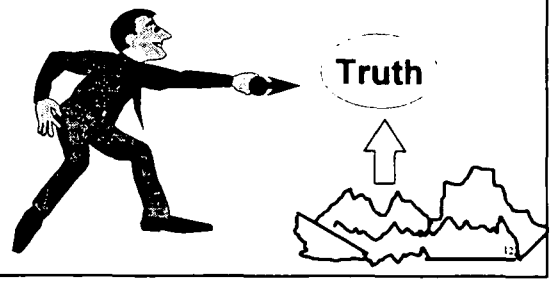
Cracking the Ice



Afterwards

- Verify the suspect's credibility by offering them a chance to confess to a crime they did not commit
- A great defense to charges of coercion
- Carefully document or have this witnessed

123

Afterwards

- Safeguard the statement and warning card
- Take the suspect's picture
- Ask about other victims, crimes, offenders, evidence
- Ask them to sign a consent to search

124

Afterwards

- Encourage the suspect, treat them with respect
- You may have to talk to them again on this case
- Ask them why they talked to you
- Advise the prosecutor and others that need to know

125

Afterwards

- Don't stop working
- Confessions can be suppressed for numerous reasons
- Corroborate the details of the confession

126

If No Confession

- Suspect's verbal statements may:
  - be useful for impeachment
  - put them at the scene
  - identify alibi witnesses
  - lead to the recovery of evidence or other corroboration
  - "lock them" into a story or an alibi
  - give a preview of their defense

127

Finally

- Continue working
- Continue looking for other evidence
- Continue looking for other witnesses
- Continue looking for other victims
- Continue to stay in contact with the victim and their family

128

LT. BILL WALSH
Youth & Family Crimes Division
Dallas Police Department
106 S. Harwood St. Rm. 225
Dallas, Texas 75201
214-670-5936
214-670-3957 Fax
800-381-4779 Pager
bwalsh4122@hotmail.com

INTERVIEW SUMMARY SHEET

SERVICE #(S)_____OFFENSE_____

SUBJECT_____ DOB_____ R/S/A_____

DID SUBJECT REVEAL ANY MEDICAL PROBLEMS OR USE OF MEDICATION WHEN ASKED?

YES_____NO_____DESCRIBE_____

IS SUBJECT HEARING IMPAIRED? YES___ NO___ IF YES, ARE THEY LEGALLY DEAF? Y_____N_____

IS SUBJECT ENGLISH SPEAKING? YES___ NO___ WHAT LANGUAGE?_____

WAS INTERPRETER USED? YES____ NO____

INTERPRETER'S NAME_____AGENCY_____

ADDRESS_____PHONE_____HOURS_____

INTERVIEW CONDUCTED BY DETECTIVE_____ BADGE#_____

OTHER DETECTIVE(S) THAT INTERVIEWED_____ BADGE#_____

INTERVIEW OBSERVED BY DETECTIVE(S)_____ BADGE#_____

OTHER PERSONS THAT OBSERVED_____

AT TIME OF INTERVIEW, SUBJECT WAS:

___UNDER ARREST (ARRESTED BY INTERVIEWER) NAME_____

___ON DOWN AND OUT FROM JAIL LIST JAIL & CHARGE_____

TIME ARRESTED_____ WITH WARRANT _____ W/O WARRANT_____

___BROUGHT IN FOR QUESTIONING ON DIFFERENT OFFENSE LIST SERVICE #_____

___CAME IN VOLUNTARILY FOR QUESTIONING

___CAME IN WITH ATTORNEY OR OTHER PERSON (IF SO LIST THEIR NAMES)

_____

_____

_____

DATE & TIME BROUGHT TO OFFICE DATE_____ TIME_____

DATE WARNING GIVEN_____ TIME WARNING GIVEN_____

BY DETECTIVE _____ BADGE_____

WARNING WITNESSED BY _____

INTERVIEW BEGAN: DATE_____TIME_____

INTERVIEW ENDED: DATE_____TIME_____

WRITING BEGAN: DATE_____TIME_____

SIGNED: DATE_____TIME_____

SUBJECT'S SIGNATURE WITNESSED BY (NAME)_____

ASSIGNMENT_____WATCH_____PHONE_____

TOTAL TIME SUBJECT INTERVIEWED _____

DID SUBJECT HANDWRITE STATEMENT? YES_____ NO_____

IF NOT, DESCRIBE REASONS_____

DID SUBJECT REQUEST RESTROOM BREAKS? YES_____ NO_____

LIST NUMBER & TIMES OF BREAKS_____

DID SUBJECT REQUEST FOOD OR DRINK? YES_____ NO_____

LIST WHAT WAS GIVEN_____

WAS SUBJECT ASKED ABOUT OTHER VICTIMS? YES_____ NO_____

RESULTS_____

WAS SUBJECT ASKED ABOUT OTHER OFFENSES? YES_____ NO_____

RESULTS_____

DID SUBJECT GIVE MORE THAN ONE WRITTEN STATEMENT? YES_____ NO_____

EXPLAIN_____

VERIFICATION CONDUCTED? YES_____ NO_____

EXPLAIN_____

_____

IF SUBJECT DID NOT GIVE VOLUNTARY STATEMENT, WHAT DID THEY SAY?

_____

_____

_____

_____

INVESTIGATORS NOTES

_____

_____

_____

_____

PLACE POLAROID PICTURE OF SUBJECT HERE

PLACE WARNING CARD HERE

CHILDREN WHO WITNESS HOMICIDE

Kimberly Poyer MSW LCSW
Ryan Rainey JD

Crimes Against Children Conference
Monday August 2, 1999

1. Scope of the problem
    1. District of Columbia
    2. National Statistics
2. Working with children on crime scenes
3. Assessing child witnesses
4. Interviewing child witnesses
    1. Interviewing protocol
5. Trial practice
    1. Why do children need to testify??
    2. Trial preparation
    3. Alternatives to live testimony
    4. Recantion
    5. Sentencing
6. Ethical issues

THE SCOPE OF THE PROBLEM

HOMICIDE

Children witness many types of homicides

Sibling, parent, loved ones, friends, acquaintances, and strangers

The US has the highest homicide rate of any industrialized nation

Child Fatalities

110/100,00

77% of victims are under the age of 3

80% of children are killed by their parents

10% of kids by another relative

**When a child witnesses a child fatality there is an *extremely high* probability that they will know the perpetrator intimately

Homicide/Suicide

'98 largest study to date

88-92 North Carolina female victims of homicide where perp committed suicide

Children of victim (+/- perp)

Witnessed the H/S, were in the immediate vicinity, found parents bodies, or were killed in 43% of the cases

Victim separated from the perp (41%)

Past domestic violence (29%)

DOMESTIC VIOLENCE

Between 3 and 10 million children witness domestic violence every year

Children are present in an overwhelming majority of domestic violence 911 calls

Between a 1/3 and ½ of all families where women are being beaten, their children are being physically abused by the abuser and/or sometimes the battered woman

Children are at an increased risk for being murdered or physically injured in the crossfire by the abuser

Many parents minimize or deny the presence of children while the mothers are being assaulted

PHYSICAL ASSAULTS

49% of assaults are committed by individuals known to the victim

SEXUAL ASSAULTS

Approximately 34% of rapes occur in the victims home

67% of rapes were committed by individuals known to the victim

SCOPE OF THE PROBLEM IN THE DISTRICT OF COLUMBIA

	BEST	WORST
LBW Babies <2500G	Alaska 4.9% of births	DC 14.6% of births
Infant Mortality	New Hampshire 5.6/1000 live births	DC 17.4/1000 live births
Child Death Rate ages 1-4	New Hampshire 13/100,000	DC 57/100,000
Teen Violent Death Rate ages 15-19	Hawaii 34/100,000	DC 393/100,000
Teen Birth Rate ages 15-17	New Hampshire 15/1,000 females	DC 102/1,000 females
Juvenile Violent Crime Arrest Rate Ages 10-17	Vermont 41/100,000	DC 1,548/100,000
Percent of teens who are HS Dropouts Ages 16-19	Connecticut 4%	Louisiana, WV 13%
Percent of teens out of school and out of work, ages 16-19	CN, IO, KS 5%	WV 18%
Percent of children who live in poverty	NH, DE 11%	DC 37%
Percent of single family homes	Utah 16%	DC 58%

Annie Casey Foundation 1996

In this country children witness violent crime on a daily basis: homicide, rape, assault, and domestic violence. Although child witnesses may not be physically injured during the assault the long-term psychological affects of witnessing such events can be devastating. Adults may minimize or deny the presence of children while these crimes are occurring. However, when children are questioned about events they have witnessed, either visually or auditorially, depending on their stage of development, they can provide detailed description of these events. Children who are victims or witnesses to violent crime are at an increased risk for delinquency, violent criminal behavior, and adult criminality.

Child Witnesses to Domestic Violence

It is estimated that between 3 and 10 million children each year witness domestic violence and are present in the majority of domestic violence police emergencies. Between a third and half of all families where women are being beaten, their children are also being physically abused by the abuser and/ or the battered woman. Children who are present during domestic violence are at an increased risk for being murdered or physically injured during the physical altercation. Children who are exposed to domestic violence experience feelings of terror, isolation, guilt, helplessness, and grief. Many children exhibit psychosomatic complaints such as headaches, stomachaches and multiple medical problems. Children can experience problems with depression, anxiety, embarrassment, and if exposed to violence for an extended period of time, ambivalence. Children act out what they see and violent behavior can be a manifestation of exposure to domestic violence.

Child Witnesses to Sexual Assaults

Approximately 34% of rapes occur in the victim's home where the probability of a child being present to witness the sexual assault of their mothers or caretakers. Depending on the age of the child and their knowledge of sexual activity, their perceptions of the assaults and reactions to it may be significantly different. Younger children may have difficulty understanding the event due to cognitive confusions and need assistance in clarifying the reality of the event from their own age appropriate cognitive distortions. Children who are present during a sexual assault are at significant risk for developing a Post Traumatic Stress Disorder. Children may have recurrent and intrusive thoughts about the sexual assault. Repetitive play or reenacting the event allows the child master and understand what happened. During these events loss of control and the inability to protect their mothers may leave children feeling anxious, depressed, vulnerable, and angry. After witnessing a sexual assault children may become more concerned with their own safety and may exhibit more anger and irritability than prior to the assault.

Child Witnesses to Homicide

Unfortunately children witness many different types of homicide. They may witness the death of a sibling, parent, loved one, or a stranger. Child fatalities occur at a rate of 110 per 100,000 and 77% of the victims are under the age of three. 80% of these children are killed by their parents, while another 10% are killed by another relative. When a child witnesses a child fatality it is highly probable that they may know the perpetrator intimately. Many times the perpetrator may be their own parent. Psychic trauma occurs when a person is exposed to an extreme traumatic stressor and their response to the event involves intense fear, helplessness, or horror. A child who witnesses a homicide will likely be traumatized and experience a wide range

of grief responses. Many times children will have recurrent and intrusive thoughts about the homicide, traumatic anxiety provoking dreams, and a diminished interest in activities. When preschoolers witness homicides they may present as withdrawn, subdued, and muted. Preschoolers may develop anxious attachments to survivors and tend to have a short period of sadness after the event. School-aged children can exhibit a greater variety of behaviors and can become more irritable, rude, and argumentative. School-aged children also have more medical complaints after witnessing a homicide. Adolescents tend to react to homicides in a manner that resembles adults with Post Traumatic Stress Disorders. Adolescents can experience feelings of rage, shame, betrayal, rebellion, and develop antisocial behaviors. Just as adults experience a wide range of emotions after a death and grieve in uniquely different ways, Children should be afforded the same opportunities to express their grief.

Working with child witnesses starts at the crime scene. A child's developmental level will affect how they react. Infants and Toddlers (0-2) are unable to verbally recall an event but can maintain affective memories and may present as fearful, anxious, numb, or muted. Pre-school children (2-6) are unable to sequence events and tend to give information in pieces. Children at this age can be frightened, anxious, mute, calm after witnessing an event. School-age children (6-10) can tell you about an event and may experience anger, depression, fear, anxiety, or be calm while discussing what they witnessed. Early Adolescents (11-14) can talk about an event and understand the implications. They can be angry, withdrawn, excitable, teary, or monosyllabic while discussing the event. They can also complain of nausea, headaches, sleep problems, and crying spells. Adolescents (15-18) have behaviors that can be very inconsistent. They may talk like adults but still not understand. Adolescents can have problems anger, violence, withdrawal, and substance abuse after witnessing violent events.

The statements you get from children are ***extremely*** important. Document all statements and the demeanor of the child (crying, shaking, angry). Document the context of the scene (where was the child, what was going on at the scene during this statement). Remember that direct quotes from the child are important. Try to talk to the child in a quiet place that is away from the confusion of the scene and away from other people. Check with your jurisdiction because several types of statements may be admissible in court that can corroborate the child's testimony

Cases involving child victims can be stress provoking and complicated. Many people and systems become involved in these cases including: family members, police, clergy, hospital staff, prosecutors, Guardian Et Litems, civil attorneys, criminal defense attorneys, child protection agencies, family courts, and therapeutic clinicians. Several factors can assist with the management of the case and facilitate the child's well being.

* Create as much as possible "child friendly" practices when working with children.
* ***Trained personnel*** should interview children as soon as possible after the event.
* Involve trained clinicians ***immediately*** when managing these cases.
* Have standard interviewing protocols for child victims/witnesses.
* Have a clinician assess if the child is psychologically capable to testify in court.
* Prepare children for court in a manner that is ***developmentally*** appropriate.
* Create a team approach when handling cases that involve child witnesses.

RELIABLE CHILD-FOCUSED INTERVIEWING

The most important element to consider when interviewing child witnesses is their developmental status and how trauma can impact the interviewing process. Children are not a homogeneous group and within similar developmental parameters they can vary in their language, cognitive, social and memory abilities, affective state, resiliency, as well as emotional maturity. For many child witnesses, what they have experienced or witnessed in the past can have a direct impact on their perception of the witnessed event and how they process the overwhelming amount of stimuli that occurs throughout the duration of the event. Therefore, the interviewer must assess the child and mold the interview to the child's stage of development. The use of developmentally and therapeutically sensitive techniques is essential when you want to obtain reliable information from children. The forensic interviewing protocol should incorporate a state-of-the-art research based methodology. This forensic interview allows a person to gather factual information from a child, as well as assess the child's presenting affective state. The interview is divided into several distinct phases through which an interviewer is expected to move in a sequential and organized manner.

RAPPORT BUILDING

*Rapport building is a crucial phase of the interview because it lays the foundation for what is to follow
*Rapport building facilitates an emotional connection between the child and the interviewer
*Developmentally appropriate introductions should be made as well as discussing taping or viewing considerations
*Discuss neutral nonthreatening topics such as school, social contacts, and recreational interests
*Use open-ended questions to elicit information
*Assess child's level of cooperation, body language, and affect
*Introduce art materials and allow the child the option to draw or color throughout the interview

DEVELOPMENTAL ASSESSMENT

*Evaluate child's language and speech
*Adapt your language and vocabulary to fit the child's
*Determine if the child understands prepositions , time, and has the ability to sequence events

ASSESSMENT OF COMPETENCY

*This assessment should be conducted for children 8 years old or younger, developmentally disabled victims, or in specific cases where a child's credibility has been questioned

COMPETENCY

Does the child understand the difference between truth and fantasy and appreciate the obligation to tell the truth

Does the child have sufficient "mental capacity" at the time of the incident to observe and record accurate impressions

Does the child have sufficient memory to retain an independent recollection of the observations

Can the child communicate this memory and understand simple questions about the incident

BOLSTERING TO REDUCE SUGGESTIBILITY

*This should be done with all children
*Present guidelines to help the child understand that they are not allowed to guess or approximate their answers
*Explain that some questions may be asked twice but that the interviewer is not looking for a different answer
*All people can be suggestible if questioned inappropriately, coercively, or in a suggestive manner

ELICITING INFORMATION

*Information should be gathered by questioning with the most open-ended techniques that are developmentally possible for the child
*A questioning continuum should be followed when eliciting information
*The types of questions used and information needed are tailored to each individual interview.

TRAUMA ASSESSMENT

*Develop evaluation criteria for all children
*Assess for Post Traumatic Stress Disorders
*Assess for reactive depression symptom clusters
*Inform child of symptoms they might experience

CLOSURE

*Allow the child to ask you questions
*If a child has become upset during the interview, this is the time to help them regain their composure
*Give the child an opportunity to express questions, worries, or concerns about the interview
*Thank the child for participating in the interview process rather than for providing a disclosure of abuse
*Dispel any misperceptions that may have arisen during the interview
*Give the child permission to return at a later date if they remember more information

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MEDICAL EVALUATION of CHILDREN for SEXUAL ABUSE

Janet Squires M.D.
University of Texas Southwestern
Medical Center at Dallas

Medical SA Evaluation

- The basics / normal anatomy
- Signs of trauma
- Sexually-transmitted diseases
- The acute assault victim

- What medical providers can determine
- What non-medical professionals should know

Child Sexual Abuse: Definition

Engaging a child in a sexual activities that

- the child cannot comprehend
- for which the child is not developmentally prepared and for which the child cannot give informed consent
- that violate taboos of society

Reasons for Genital Examinations in Children

- Routine examination
- Physical complaint or behavioral complaint, concerning for abuse
- Suspicion of abuse by parent or other adult caring for child
- Referral from CPS or legal system

Medical Complaints Suspicious for Sexual Abuse

- Genital bleeding
- Vaginal discharge
- Bruises, scratches, etc.
- Genital skin lesions
- Genital warts
- Irritation,discomfort
- Genital trauma not consistent with history
- Urinary discomfort, frequency
- Enuresis
- Encopresis
- Pregnancy
- Miscellaneous: pain, fatigue, sleep problems, anorexia

Behavioral Complaints Concerning for Sexual Abuse

- Behavior changes (e.g hostility, aggression)
- Regression
- Sexualized play, masturbation
- Sleep disorders
- Eating disorders
- School problems
- Self abuse
- Promiscuity

Goals: Genital Exam for Sexual Abuse

- Seek medical conditions needing treatment
- Evaluate for "evidence" - includes biologic residual after assaults, signs of trauma, and infection
- Support healing process, including body image and feelings of self-worth

Requirements

- Child-friendly environment
- Choices for the child
- Calm demeanor and honest explanations
- Nurse experienced in positioning child (e.g. labial traction in girls)
- Health care provider who knows anatomy and knows normal / abnormal

Genital Findings: Non-Abused Girls

McCann, 1990, n=93
- erythema vestibule 56%
- periurethral bands 51%
- labial adhesions 39%
- mounds 34%

Berenson, 1992, n=211
- mounds 7%
- labial agglutination 17%
- vaginal ridges 25%

Gardner, 1992, n 79
- redness/vascularity 44%
- avascular areas 27%
- hymen bumps 11%

Focus on the Hymen: "A big issue about a little tissue"

- No congenitally absent hymen
- Significant injury does not occur from
  - masturbation
  - physical activities like dance, gymnastics, horse or bike riding
  - tampon usage
- Straddle injuries rarely hurt hymen, except in dramatic cases of impalement

Anal Sexual Abuse

- Acute findings may include bruising, redness, swelling, lacerations
- Chronic findings may include laxity, dilatation, funneling
- SA infections include genital warts, GC
- EXAM IS RARELY HELPFUL IN ASSESSMENT OF ABUSE

Sexually-Transmitted Diseases in Children

- Specific for Abuse
  - Gonorrhea
  - Syphilis
  - HIV (unless congenital or transfusion)
- Highly Suspicious
  - Chlamydia
  - Trichomonas
  - Herpes simplex II
  - Hepatitis B (unless congenital or transfusion)
  - Genital warts after age 2

Other Causes of Irritation or Vaginal Discharge

- Infections
  - nonspecific vaginitis (gardnerella), yeast, skin warts, molluscum, shigella, group A strep, worms, pinworms
- Local irritants
  - poor hygiene, diaper rashes, stool/urine incontinence
- Foreign bodies
- Bugbites, mites
- Skin/mucosa "sensitive states"
  - low estrogen states, bubble bath vulvovaginitis, eczema
- Trauma

Evaluation: Acute Sexual Assault

- Examination can be normal
- Forensic specimens sought if < 72 hours - usually are negative in children
- Tests for STD indicated
- Treatment considerations:
  - STD prevention (Ab injection + oral dose(s))
  - pregnancy prevention
  - HIV prophylaxis (?)

Medical Finding of Sexual Abuse

- Normal examination
- Nonspecific findings
- Concerning / Suspicious findings
- Specific / Definitive findings

Nonspecific Findings: Examples

- Vulvar (skin) irritation
- Vestibule mucosa redness and friability
- Large hymenal opening
- Non-specific vaginitis
- Labial adhesions
- Urethral dilatation
- Anal skin tags

Concerning Findings: Examples

- Bruising, lacerations, bites on skin
- Hymen narrowings (partial transections)
- Hymenal scars
- Anal scars outline midline
- Chlamydia, trichomonas infections
- Genital warts after age 2

Specific Findings: Examples

- Sperm, seminal fluid
- Pregnancy
- Gonorrhea, syphilis, HIV
- Acute trauma without compatible cause

- Hymen abnormalities: transection, absence, posterior rim < 1 mm.

Conditions Mistaken for Sexual Abuse: Examples

- Normal variants
- Anatomical problems:
  - lichen sclerosis, prolapsed urethra, labial adhesions
- Nonspecific vulvovaginitis and proctitis
- Accidental injuries, straddle or impaling
- Infections:
  - Group A strep vaginitis
- Foreign bodies
- Intestinal disorders:
  - Anal fissures, encopresis, Crohn's disease

What Non-Medical Professionals Should Know

1. Most children who have been sexually abused have normal examinations.
2. Most findings of trauma disappear quickly.
3. Most exams are not emergencies.
   - *If medical complaint ... need to be seen.*
   - *If "outcry" ... interview, social data most important.*

Should Know (continued)

4. Colposcopes help, but not that much.
5. Exams are rarely diagnostic.
6. A doctor can never rule out child sexual abuse.

Should Know (continued)

7. Not all doctors are equal.
8. Custody battles are the pits for everyone.
9. The medical examination is not primarily forensic.

The Bottom Line

Janet Squires M.D.
University of Texas Southwestern Medical Center at Dallas

CASE ANALYSIS: JEREMY STROHMEYER INVESTIGATION

The murder and sexual assault of seven-year-old Sherrice Iverson by Jeremy Strohmeyer, a high school senior, occurred Memorial Day weekend in May 1997.

This crime took place at Primm, Nevada, formerly known as Stateline. Primm is a small township located approximately forty-five (45) miles south of Las Vegas, Nevada, on Interstate Highway 15 at the state line between Southern California and Nevada.

The nationally televised trial of Strohmeyer in Las Vegas, Nevada, was to begin on September 8, 1998; however, on the morning of this same date, Strohmeyer entered a guilty plea, pleading to all of the counts charged in the state indictment by the Clark County District Attorney's Office, Las Vegas, Nevada.

Many law enforcement agencies at all levels in California and Nevada worked together during this investigation, but it was through the concentrated efforts and case coordination of Las Vegas Metropolitan Police Department (LVMPD) Homicide Detectives Phil Ramos and Jimmy Vaccaro that facilitated the conviction of Strohmeyer.

The following pages contain the Indictment of Strohmeyer by the State of Nevada, the Guilty Plea Agreement, and a report of the contents of the AVI (Audio Visual Image) entitled, "SLAMMING A 6 YEAR OLD," that Strohmeyer received on his computer via the Internet the day before he traveled from California to Primm and committed the crime.

IND
STEWART L. BELL
DISTRICT ATTORNEY
Nevada Bar #000477
200 S. Third Street
Las Vegas, Nevada 89155
(702) 455-4711
Attorney for Plaintiff

ORIGINAL

FILED

AUG 1 12 28 PM '97

CLERK

DISTRICT COURT
CLARK COUNTY, NEVADA

THE STATE OF NEVADA,

Plaintiff,

-vs-

JEREMY STROHMEYER,
#1507326

Defendant(s).

Case No. C144577
Dept. No. XIII
Docket G

INDICTMENT

STATE OF NEVADA }
COUNTY OF CLARK } ss.

The Defendant(s) above named, JEREMY STROHMEYER, accused by the Clark County Grand Jury of the crimes of **MURDER (OPEN MURDER) (Felony - NRS 200.010, 200.030); FIRST DEGREE KIDNAPING (Felony - NRS 200.310, 200.320); and SEXUAL ASSAULT WITH A MINOR UNDER SIXTEEN YEARS OF AGE WITH SUBSTANTIAL BODILY HARM (Felony - NRS 200.364, 200.366, 0.060)**, committed at and within the County of Clark, State of Nevada, on or about the 25th day of May, 1997, as follows:

COUNT I- MURDER (OPEN MURDER)

did then and there wilfully, feloniously, without authority of law, and with premeditation and deliberation, and with malice aforethought, kill SHERRICE IVERSON, a human being, by manual strangulation or suffocation; said killing being deliberate and premeditated and/or perpetrated by means of child abuse and/or being committed during the perpetration or attempted perpetration of kidnaping, sexual assault and/or sexual abuse of a child.

COUNT II - FIRST DEGREE KIDNAPING

did wilfully, unlawfully, feloniously, and without authority of law, lead, take, entice, carry away or kidnap SHERRICE IVERSON, a minor, with the intent to keep, imprison, or confine said SHERRICE IVERSON from her parents, guardians, or other person or persons having lawful custody of said minor, or with the intent to hold said minor to unlawful service, or perpetrate upon the person of said minor, any unlawful act, to-wit: murder and/or sexual assault and/or inflicting substantial bodily harm.

COUNT III - SEXUAL ASSAULT WITH A MINOR UNDER SIXTEEN YEARS OF AGE WITH SUBSTANTIAL BODILY HARM

did then and there wilfully, unlawfully, and feloniously sexually assault and subject SHERRICE IVERSON, a female child under sixteen years of age, to sexual penetration, to-wit: digital penetration, by inserting his finger into the vagina of the said SHERRICE IVERSON, against her will, or under conditions in which Defendant knew, or should have known, that the said SHERRICE IVERSON was mentally or physically incapable of resisting or understanding the nature of Defendant's conduct; the defendant's conduct resulting in extreme trauma and substantial bodily injury, to-wit: bruising and tearing to the vaginal area.

COUNT IV - SEXUAL ASSAULT WITH A MINOR UNDER SIXTEEN YEARS OF AGE ~~WITH SUBSTANTIAL BODILY HARM~~ .

did then and there wilfully, unlawfully, and feloniously sexually assault and subject SHERRICE IVERSON, a female child under sixteen years of age, to sexual penetration, to-wit: penile penetration, by inserting his penis into the vagina of the said SHERRICE IVERSON, against her will, or under conditions in which Defendant knew, or should have known, that the

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said SHERRICE IVERSON was mentally or physically incapable of resisting or understanding the nature of Defendant's conduct.

DATED this 31st day of July, 1997.

STEWART L. BELL
DISTRICT ATTORNEY
Nevada Bar #000477

ENDORSEMENT: A True Bill

Foreperson, Clark County Grand Jury

Names of witnesses testifying before the Grand Jury:

Daniel Eitnier, Primm Valley Resorts, Director of Corporate Security

David Thomas Cash, Jr.

Giles Sheldon Green, M.D.

Leroy Iverson

Agnes Lee

Aleana Garcia

Terisa Cotrell

Phillip Ramos, LVMPD

97AGJ041X/97FG0219X/ts
LVMPD 970525-0452
MURD.; 1° KIDNAP.;
SA V/16 - F

GMEM
STEWART L. BELL
DISTRICT ATTORNEY
Nevada Bar #000477
200 S. Third Street
Las Vegas, Nevada 89155
(702) 455-4711
Attorney for Plaintiff

ORIGINAL

FILED IN OPEN COURT
SEP 8 1998 19
LORETTA BOWMAN, CLERK
BY SUE DEATON
Deputy

DISTRICT COURT
CLARK COUNTY, NEVADA

THE STATE OF NEVADA,

Plaintiff,

-vs-

JEREMY STROHMEYER,
#1507326

Defendant.

Case No. C144577X
Dept. No. XII
Docket R

GUILTY PLEA AGREEMENT

I hereby agree to plead guilty to: FIRST DEGREE MURDER, FIRST DEGREE KIDNAPING, SEXUAL ASSAULT WITH A MINOR UNDER SIXTEEN YEARS OF AGE WITH SUBSTANTIAL BODILY HARM and SEXUAL ASSAULT WITH A MINOR UNDER SIXTEEN YEARS OF AGE, COUNTS I, II, III and IV, as more fully alleged in the charging document attached hereto as Exhibit "1".

Other than the potential death penalty as to Count I, the Defendant agrees to stipulate to the maximum sentences otherwise provided by law and that all four (4) sentences shall run consecutive to each other.

In that regard, the sentence for Count I, First Degree Murder, pursuant to NRS 200.030 4(g)(1), shall be Life Without the Possibility of Parole.

The sentence for Count II, First Degree Kidnaping, pursuant to NRS 200.320(1)(a), shall be Life Without the Possibility of Parole, to run consecutive to the sentence imposed for Count I.

The sentence for Count III, Sexual Assault With a Minor Under Sixteen Years of Age With Substantial Bodily Harm, pursuant to NRS 200.366(2)(a)(1), shall be Life Without the Possibility of Parole, to run consecutive to the sentences imposed for Counts I and II.

The sentence for Count IV, Sexual Assault With a Minor Under Sixteen Years of Age, pursuant to NRS 200.366(3)(g)(1), shall be Life With the Possibility of Parole after a minimum of Twenty (20) years served, to run consecutive to the sentences imposed for Counts I, II and III.

Notwithstanding the theoretical parole eligibility as to Count IV, I understand that due to the sentences to be imposed for Counts I, II and III, I shall never be eligible for parole.

The State agrees to withdraw the Notice of Intent to Seek Death.

The Defendant understands and agrees that by his plea of guilty, he now and forever waives any and all opportunity in the future to litigate or relitigate, any and all legal and factual issues raised prior to his plea of guilty.

CONSEQUENCES OF THE PLEA

I understand that by pleading guilty the State can prove beyond a reasonable doubt the facts which support all the elements of the offense(s) to which I now plead as set forth in Exhibit "1".

I understand that as a consequence of my pleas of guilty the Court shall sentence me to imprisonment in the Nevada State Prison for Life Without the Possibility of Parole as to Count I, First Degree Murder; imprisonment in the Nevada State Prison for Life Without the Possibility of Parole as to Count II, First Degree Kidnaping; imprisonment in the Nevada State Prison for Life Without the Possibility of Parole as to Count III, Sexual Assault With a Minor Under Sixteen Years of Age with Substantial Bodily Harm, and imprisonment in the Nevada State Prison for Life With the Possibility of Parole with parole eligibility beginning at TWENTY (20) years as to Count IV, Sexual Assault With a Minor Under Sixteen Years of Age, all counts to run consecutively. I understand that the law requires me to pay an Administrative Assessment Fee.

I understand that, if appropriate, I will be ordered to make restitution to the victim(s)

offense(s) to which I am pleading guilty.

I understand that I am not eligible for probation for the offenses to which I am pleading guilty.

I understand that the sentencing judge will order the sentences imposed as to each of the four (4) counts in the Indictment to be served consecutively.

I understand that the Court has agreed to impose the sentences set forth in this agreement.

I also understand if, at any time, this plea agreement is set aside or its resultant convictions are set aside, for any reason, the State reserves the right to reinstate the notice to seek the death penalty in any subsequent proceedings.

I understand that the Division of Parole and Probation will prepare a report for the sentencing judge prior to sentencing. This report will include matters relevant to the issue of sentencing, including my criminal history. This report may contain hearsay information regarding my background and criminal history. My attorney and I will each have the opportunity to comment on the information contained in the report at the time of sentencing. The District Attorney may also comment on this report.

WAIVER OF RIGHTS

By entering my plea of guilty, I understand that I am waiving and forever giving up the following rights and privileges:

1. The constitutional privilege against self-incrimination, including the right to refuse to testify at trial, in which event the prosecution would not be allowed to comment to the jury about my refusal to testify.

2. The constitutional right to a speedy and public trial by an impartial jury, free of excessive pretrial publicity prejudicial to the defense, at which trial I would be entitled to the assistance of an attorney, either appointed or retained. At trial the State would bear the burden of proving beyond a reasonable doubt each element of the offense charged.

3. The constitutional right to confront and cross-examine any witnesses who would testify against me.

4. The constitutional right to subpoena witnesses to testify on my behalf.

5. The constitutional right to testify in my own defense.

6. The right to appeal the conviction, with the assistance of an attorney, either appointed or retained, unless the appeal is based upon reasonable constitutional jurisdictional or other grounds that challenge the legality of the proceedings.

VOLUNTARINESS OF PLEA

I have discussed the elements of all of the original charge(s) against me with my attorneys and I understand the nature of the charge(s) against me.

I understand that the State would have to prove each element of the charge(s) against me at trial.

I have discussed with my attorneys any possible defenses, defense strategies and circumstances which might be in my favor.

All of the foregoing elements, consequences, rights, and waiver of rights have been thoroughly explained to me by my attorneys.

I believe that pleading guilty pursuant hereto is in my best interest, and that a trial would be contrary to my best interest.

I am signing this agreement voluntarily, after consultation with my attorneys, and I am not acting under duress or coercion or by virtue of any promises of leniency, except for those set forth in this agreement.

I am not now under the influence of any intoxicating liquor, a controlled substance or other drug which would in any manner impair my ability to comprehend or understand this agreement or the proceedings surrounding my entry of this plea.

My attorneys have answered all my questions regarding this guilty plea agreement and its consequences to my satisfaction and I am satisfied with the services provided by my attorneys.

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I hereby acknowledge that the transcript of the confession attached hereto is a true and accurate transcription of my confession to Detective Phil Ramos given May 29, 1997, beginning at approximately 2:20 a.m. in the offices of the Long Beach Police Department.

DATED this 8th day of September, 1998.

Jeremy Strohmeyer

JEREMY STROHMEYER
Defendant

AGREED TO BY:

District Attorney
STEWART L. BELL

CERTIFICATE OF COUNSEL:

I, the undersigned, as the attorney for the Defendant named herein and as an officer of the court hereby certify that:

1. I have fully explained to the Defendant the allegations contained in the charge(s) to which guilty pleas are being entered.

2. I have advised the Defendant of the penalties for each charge and the restitution that the Defendant may be ordered to pay.

3. All pleas of guilty offered by the Defendant pursuant to this agreement are consistent with the facts known to me and are made with my advice to the Defendant.

4. To the best of my knowledge and belief, the Defendant:

a. Is competent and understands the charges and the consequences of pleading guilty as provided in this agreement.

b. Executed this agreement and will enter all guilty pleas pursuant hereto voluntarily.

c. Was not under the influence of intoxicating liquor, a controlled substance or other drug at the time I consulted with the defendant as certified in paragraphs 1 and 2 above.

Dated: This 8th day of September, 1998.

ATTORNEY FOR DEFENDANT

ATTORNEY FOR DEFENDANT

i:\mvu\strohmey\gpa\rmf

FEDERAL BUREAU OF INVESTIGATION

Date of transcription 03/03/98

On March 2, 1998, a file labeled KID004.AVI, which was copied onto a 3 1/2 inch disk, was reviewed by a Special Agent of the Federal Bureau of Investigation (FBI). The following observations were made:

At the beginning of this file are the words printed all in capitals, "SLAMMING A 6 YEAR OLD."

This file shows movement and the first view seen when looking at the file after the title is the view from behind of what appears to be a nude adult white male and a nude juvenile white female. The white juvenile female is lying on her stomach face down on what appears to be a bed or sofa covered with light-colored blankets or sheets. Also light-colored blankets or sheets are on the floor in front of the bed or sofa. The adult white male is on top of the juvenile white female and appears to be engaging in sexual intercourse with the juvenile female from behind.

The second view that is seen of the same adult white male and juvenile white female is a side view, and shows movement as the adult male withdraws his penis from the vaginal area of the female, is on his knees on the floor at the edge of the bed or sofa, is between the juvenile female's legs, and lifts the legs of the juvenile with each of his hands and moves into the vaginal area of the female with his penis.

After the two above views are shown on this file, there is nothing more observed.

Investigation on 03/02/98 at Las Vegas, Nevada

File # 62D-LV-28873 Date dictated 03/3/98

by SA ROGER T. YOUNG:hc

Cyber "Pedophiles": A Behavioral Perspective

By

SSA Kenneth V. Lanning
FBI Academy
Quantico, VA

REPRINT

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INTRODUCTION

Throughout history, individuals who sexually victimize children have frequented the places where children gather. School yards, parks, and malls have been prime contact places. Offenders have also used technological advancements (e.g., cameras, telephones, automobiles, etc.) to facilitate their sexual interests and behavior. In the 1990's, home computers, online services, and the Internet have become new points of contact and new technological tools. We have historically warned our children about the dangers associated with strangers, but often neglected to help them understand that sex offenders are often people they have come to know either in person or now online.

Like many molesters, individuals attempting to sexually exploit children through the use of computer online services or the Internet tend to gradually seduce their targets through the use of attention, affection, kindness, and gifts. They are often willing to devote considerable amounts of time, money, and energy to this process. They will listen to and empathize with the problems of children. They will be aware of the music, hobbies, and interests of children. Unless the victims are already engaged in sexually explicit computer conversation, offenders will usually lower any inhibitions by gradually introducing the sexual context and content. Some offenders use the computer primarily to collect and trade child pornography, while others also seek online contact with other offenders and children.

Children, especially adolescents, are often interested in and curious about sexuality and sexually explicit material. They will sometimes use their online access to actively seek out such material. They are moving away from the total control of parents and trying to establish new relationships outside the family. Sex offenders targeting children will use and exploit these characteristics and needs. Adolescent children may also be attracted to and lured by online offenders closer to their age who, although not technically "pedophiles," may be dangerous.

Illegal Sexual Activity

Computer-related sexual exploitation of children usually comes to the attention of law enforcement as a result of citizen/victim complaints, referrals from commercial service providers, and inadvertent discovery during other investigations. Cases are also proactively identified as a result of undercover investigations that target high risk computer sites or utilize other specialized techniques.

Sexual activity involving the use of computers that is usually illegal and therefore the focus of law enforcement investigations includes:

1. Producing or possessing child pornography
2. Uploading and downloading child pornography
3. Soliciting sex with "children"

Using the computer to solicit sex with "children" could include communicating with actual children as well as with law enforcement officers taking a proactive investigative approach and pretending to be children or pretending to be adults with access to children. After using the computer to make contact with the "child," other illegal activity could involve traveling to meet the child or having the child travel to engage in sexual activity.

One problem area for the criminal justice system are cases involving adolescents using the computer to solicit sex with other adolescents and to traffic in child pornography that portrays pubescent "children." For purposes of child pornography and illegal sexual activity, the Federal statutes and many local statutes define children or minors as individuals who have not yet reached their eighteenth birthday. Therefore, such behavior may be technically illegal, but may not be sexually deviant.

Legal Sexual Activity

Sexual activity involving the use of computers that is usually legal includes:

1. Validating sexually deviant behavior and interests
2. Reinforcing deviant arousal patterns
3. Storing and sharing sexual fantasies
4. Lying about your age and identity
5. Collecting adult pornography that is not obscene
6. Disseminating "indecent" material, talking dirty, "cyber-sex," providing sex instructions, etc.
7. Injecting yourself into the "problem" of computer exploitation of children to rationalize your interests

Although many might find much of this activity offensive and repulsive and special circumstances and specific laws might even criminalize some of it, it is for the most part legal activity.

UNDERSTANDING BEHAVIOR

The investigation of child sexual exploitation cases involving computers requires knowledge of the technical, legal, and behavioral aspects of computer use. However, because each of these areas is so complex, investigators must also identify experts and resources available to assist in these cases. Exploitation cases involving computers present many investigative challenges, but they also present the opportunity to obtain a great deal of corroborative evidence and investigative intelligence. This discussion will focus primarily on the

dynamics of offender and victim behavior in the computer exploitation of children.

Offenders

The general public, the media, and many child abuse professionals sometimes simplistically refer to all those who sexually victimize children as pedophiles. There is no single or uniform definition for the word "pedophile." For mental health professionals and as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV, Washington, DC: American Psychiatric Association, 1994), it is a diagnostic term referring to those with recurrent, intense sexually arousing fantasies, urges, and behaviors involving prepubescent children. For most, however, it is just a fancy word for a child molester. Are all child molesters pedophiles? Are child molesters with adolescent victims pedophiles? Are individuals who collect and use the Internet to obtain both child and adult pornography pedophiles?

As I use the term, pedophiles are individuals whose erotic imagery and sexual fantasies focus on children. They do not settle for child victims, but, in fact, prefer to have sex with children.

Not everyone using a computer to facilitate having sex with children or trafficking in child pornography is a pedophile. In addition, there is no legal requirement to determine that a subject or suspect in a case is a pedophile and often it is irrelevant to the investigation or prosecution. As will be discussed such a determination may sometimes be useful in developing a variety of investigative approaches. To avoid confusion with a mental health diagnosis and possible challenges in court, however, use of the term "pedophile" by law enforcement should be kept to a minimum. In my work and case analysis, a pedophile is just one example or sub-category of what I refer to as a "preferential sex offender." The term preferential sex offender is merely a descriptive label used only to identify, for investigative purposes, a certain type of offender.

The advantages of law enforcement use of the term preferential sex offender include: (1) it is descriptive, not diagnostic; (2) it is probative, not prejudicial; (3) it can include both offenders who sexually molest children and those who "just" collect child pornography; (4) it can include offenders whose child pornography is only a small portion of their large pornography collections; and (5) it can include those with preferences for adolescent victims and for adolescent pornography (e.g., hebephiles, ephebophiles). How to recognize and identify such offenders will be discussed shortly.

Computer Offenders

Offenders using computers to sexually exploit children tend to be white males and usually fall into two broad categories:

1. **Situational Offender (Dabbler)** - Usually either a typical adolescent searching online for pornography and sex or an impulsive/curious adult with a newly found access to a wide range of pornography and sexual opportunities. When they break the law, such dabblers can obviously be investigated and prosecuted, but their behavior is not as long-term, persistent, and predictable as that of preferential offenders.

2. **Preferential Offender** - Usually either a sexually indiscriminate with a wide variety of deviant sexual interests or a "pedophile" with a definite preference for children. The main difference between them is that the pornography/erotica collection of the sexually indiscriminate preferential offender will be more varied, usually with a focus on their particular sexual preferences or paraphilias, whereas a pedophile's collection will focus predominately on children. Also, the sexually indiscriminate offender is less likely to directly molest children, especially prepubescent children.

Other miscellaneous "offenders" include: media reporters who erroneously believe they can go online and traffic in child pornography as part of a news expose; pranksters who disseminate false or incriminating information to embarrass the targets of their "dirty tricks"; older "boyfriends" attempting to sexually interact with adolescent girls or boys; and concerned citizens who go overboard doing their own private investigations into this problem. As will be discussed, investigators must be cautious of all overzealous citizens offering their services in these cases. Only law enforcement officers as part of official, authorized investigations should be conducting proactive investigation or downloading in child pornography on a computer.

Although a variety of individuals sexually victimize children, preferential sex offenders are the primary sexual exploiters of children. They tend to be serial offenders who prey on children through the operation of child sex rings and/or the collection, creation, or distribution of child pornography. Using a computer to fuel and validate interests and behavior; to facilitate interacting with child victims, or to possess and traffic in child pornography usually requires the above average intelligence and economic means more typical of preferential sex offenders. The computer sex offenders discussed here tend to be white males from a middle class or higher socioeconomic background.

Recognizing Preferential Sex Offenders

An important step in investigating sexual exploitation of children is to recognize and utilize, if present, the highly predictable sexual behavior patterns of these preferential sex offenders. If the investigation identifies enough of these patterns, many of the remaining ones can be assumed. However, no particular number constitutes "enough" - just a few may be enough if they are especially significant Most of these indicators mean little by themselves, but as they are identified and accumulated through investigation, however, they can constitute reason to believe a suspect is a preferential sex offender.

You cannot hope to determine the type of offender with whom you are dealing unless you have the most complete, detailed, and accurate information possible. The investigator must understand that doing a background investigation on a suspect means more than obtaining the date and place of birth and credit and criminal checks. School, juvenile, military, medical, driving, employment, bank, and sex offender and child abuse registry records can also be valuable sources of information about an offender.

A preferential sex offender can usually be identified by the following behaviors:

1. Long-Term and Persistent Pattern of Behavior

    A) Begins pattern in early adolescence
    B) Is willing to commit time, money, & energy
    C) Commits multiple offenses
    D) Makes ritual or need-driven mistakes

2. Specific Sexual Interests

    A) Manifests paraphiliac preferences (may be multiple)
    B) Focuses on defined sexual interests and victim characteristics
    C) Centers life around preferences
    D) Rationalizes sexual interests

3. Well-Developed Techniques

    A) Evaluates experiences
    B) Lies and manipulates, often skillfully
    C) Has method of access to victims
    D) Is quick to use modern technology (e.g. computer, video) for sexual needs & purposes

4. Fantasy-Driven Behavior

A) Collects pornography
B) Collects paraphernalia, souvenirs, videotapes
C) Records fantasies
D) Acts to turn fantasy into reality

On an investigative level, the presence of paraphilias often means highly repetitive and predictable behavior focused on specific sexual interests that goes well beyond a "method of operation" (MO). The concept of MO-something done by an offender because it works and will help him get away with the crime-is well-known to most investigators. An MO is fueled by thought and deliberation. Most offenders change and improve their MO over time and with experience.

The repetitive patterns of behavior of preferential sex offenders involve some MO, but are more likely to also involve the less-known concept of sexual ritual. Sexual ritual is the repeated engaging in an act or series of acts in a certain manner because of a sexual need; that is, in order to become aroused and/or gratified, a person must engage in the act in a certain way. Other types of ritual behavior can be motivated by psychological, cultural, or spiritual needs. Unlike MO, ritual is necessary to the offender but not to the successful commission of the crime. In fact, instead of facilitating the crime, it often increases the odds of identification, apprehension, and conviction because it causes the offender to make need-driven mistakes.

Ritual and its resultant behavior is fueled by erotic imagery and fantasy and can be bizarre in nature. Most important to investigators, offenders find it difficult to change and modify ritual, even when their experience tells them they should or they suspect law enforcement scrutiny. Understanding sexual ritual (i.e., need-driven behavior) is the key to investigating preferential sex offenders.

Investigators must not over- or under-react to reported allegations. They must understand that not all computer offenders are stereotypical "pedophiles" who fit some common profile. Keeping an open mind and objectively attempting to determine the type of offender involved can be useful in minimizing embarrassing errors in judgment and developing appropriate interview, investigative, and prosecutive strategy. For example, the fact that preferential offenders as part of sexual ritual are more likely to commit similar, multiple offenses, make need-driven mistakes, and compulsively collect pornography and other offense related paraphernalia can be used to build a stronger case.

In computer cases, especially those involving proactive investigative techniques, it is often easier to determine the

type of offender than in other kinds of child sexual exploitation cases. When attempting to make this determination, it is important to evaluate all available background information. The following information from the online computer activity can be valuable in this assessment. This information can often be ascertained from the online service provider and through undercover communication, pretext contacts, informants, record checks, and other investigative techniques (i.e., mail cover, pen register, trash run, surveillance, etc.).

* Screen Name
* Screen Profile
* Accuracy of Profile
* Length of Time Active
* Amount of Time Spent Online
* Number of Transmissions
* Number of Files
* Number of Files Originated
* Number of Files Forwarded
* Number of Files Received
* Number of Recipients
* Site of Communication
* Theme of Messages & Chat
* Theme of Pornography

A common problem in these cases is that it is often easier to determine a computer is being used than to determine who is using the computer. It is obviously harder to do a background investigation when multiple people have access to the computer. Pretext phone calls can be very useful in such situations.

Exaggerated Example: An investigation determines that a suspect is a 50-year-old single male who: does volunteer work with troubled boys; has two prior convictions for sexually molesting young boys in 1974 and 1986; has an expensive state-of-the-art home computer; has a main screen name of "Boylover" and one screen profile that describes him as a 14-year-old; has for the last five years daily spent many hours online in chat rooms and the "alt.sex.preteen" newsgroup justifying and graphically describing his sexual preference for and involvement with young boys; and brags about his extensive pornography collection while uploading hundreds of child pornography files all focusing on preteen boys in bondage to dozens of individuals all over the world. If such a determination were relevant to the case, these facts would constitute more than enough probable cause to believe this suspect is a preferential sex offender.

Knowing the kind of offender with whom you are dealing can go a long way in determining investigative strategy. For example, it might be useful in developing offender interview strategy, evaluating the consistency of victim statements, proving intent, assessing the admissibility of prior acts, learning where and what kind of corroborative evidence might be found (i.e., the existence and location of other victims and child pornography or erotica), etc. It might even be included in a search warrant affidavit to add to the probable cause, to expand the nature and scope of the search, or to address legal staleness problems. With either of the preferential types (i.e., sexually indiscriminate or "pedophile") of computer offenders, the

characteristics, dynamics, and techniques (i.e. expert search warrant) previously discussed concerning preferential sex offenders should be considered.

"Concerned Citizens"

Many individuals who report information to the authorities about deviant sexual activity they have discovered on the Internet must invent clever excuses for how and why they came upon such material. They often start out pursuing their own sexual/deviant interests, but then decide to report to the police either because it went too far, because they are afraid they might have been monitored by authorities, or because they need to rationalize their perversions as having some higher purpose or value. Rather than honestly admitting their own deviant interests, they make-up elaborate explanations to justify finding the material. Some claim to be journalists, researchers or outraged, concerned citizens trying to protect a child or help the police. In any case, what they find may still have to be investigated.

Investigators must consider that these "concerned citizens" reporting such activity may:

1. Motivated by a need to rationalize or deny their deviant sexual interests, have embellished and falsified an elaborate tale of perversion and criminal activity on the Internet.

2. Whatever their true motivations might be, have uncovered individuals using the Internet to validate and reinforce their bizarre, perverted sexual fantasies and interests (a common occurrence), but who are not engaged in criminal activity.

3. Whatever their true motivations might be, have uncovered individuals involved in criminal activity.

One especially sensitive area for investigators is the preferential sex offender who presents himself as a concerned citizen reporting what he inadvertently "discovered" in cyberspace or requesting to work with law enforcement to search for child pornography and to protect children. Other than the obvious benefit of legal justification for their past or future activity, most do this as part of their need to rationalize their behavior as worthwhile and to gain access to children. When these offenders are caught, instead of recognizing this activity as part of their preferential pattern of behavior, the courts sometimes give them leniency because of their "good deeds." Preferential sex offenders who are also law enforcement officers sometimes claim their activity was part of some well-intentioned, but unauthorized investigation.

USE OF COMPUTERS

The great appeal of a computer becomes obvious when you understand sex offenders, especially the preferential sex offender. The computer could be a stand alone system or one utilizing online service capability. The computer---whether a system at work or, more likely, a personal computer at home---provides preferential sex offenders with an ideal means of filling their needs to: (1) organize their collections, correspondence, and fantasy material; (2) communicate with victims and other offenders; (3) store, transfer, manipulate, and create child pornography; and (4) maintain financial records. The sex offender using a computer is not a new type of criminal. It is simply a matter of modern technology catching up with long-known, well-documented behavioral needs. In the past they were probably among the first to obtain and use, for their sexual needs, new inventions such as the camera, the telephone, the automobile, the Polaroid camera, and the video camera and recorder. Because of their traits and needs, they are willing to spend whatever time, money, and energy it takes to obtain, learn about, and use this technology.

Organization

Offenders use computers to organize their collections, correspondence, and fantasy material. Many preferential sex offenders in particular seem to be compulsive record keepers. A computer makes it much easier to store and retrieve names and addresses of victims and individuals with similar interests. Innumerable characteristics of victims and sexual acts can be easily recorded and analyzed. An extensive pornography collection can be cataloged by subject matter. Even fantasy writings and other narrative descriptions can be stored and retrieved for future use.

One problem the computer creates for law enforcement is determining whether computer texts describing sexual assaults are fictional stories, sexual fantasies, diaries of past activity, plans for future activity, or current threats. This problem can be compounded by the fact that there are individuals who believe that cyberspace is a new frontier where the old rules of society do not apply. They do not want this "freedom" scrutinized and investigated. There is no easy solution to this problem. Meticulous analysis and investigation are the only answers.

Communicate to Fuel and Validate

Many offenders are drawn to computers utilizing online service capability to communicate and validate their interests and behavior. This is actually the most important and compelling reason that preferential sex offenders are drawn to the on-line computer. Now, in addition to physical contact and putting a

stamp on a letter or package, they can use their computer to exchange information and validation. Through the Internet, national and regional online services, or specialized electronic bulletin boards, offenders can use their computers to locate individuals with similar interests.

The computer may enable them to obtain active validation (i.e., from living humans) with less risk of identification or discovery. The great appeal of this type of communication is perceived anonymity and immediate feedback. They feel protected as when using the mail, but get immediate response as when meeting face to face.

Like advertisements in "swinger magazines," computer online services are used to identify individuals of mutual interests concerning age, gender, and sexual preference. The offender may use an electronic bulletin board to which he has authorized access, or he may illegally enter a system. The offender can also set up his own or participate in other surreptitious or underground online bulletin boards.

In addition to adults with similar interests, offenders can sometimes get validation from the children they communicate with online. When it is provided to them, children needing attention and affection may respond to an offender in positive ways. They may tell the offender he is a "great guy" and that they are grateful for his interest in them. In communicating with children, and in a few cases with adults, offenders frequently assume the identities of children

Validation is also obtained from the fact that they are utilizing the same cutting edge technology used by the most intelligent and creative people in society. In their minds, the time, technology, and talent it takes to engage in this activity is proof of its value and legitimacy.

Sadly, I have come to suspect that some individuals with potentially illegal, but previously latent sexual preferences have begun to criminally act out when their inhibitions are weakened after their arousal patterns are fueled and validated through online computer communication.

Offenders' need for validation is the foundation on which proactive investigative techniques (e.g. stings, undercover operations, etc.) are built and the primary reason they work so often. Although their brain may tell them not to send child pornography or not to reveal details of past or planned criminal acts to a stranger they met online, their need for validation often compels them to do so.

Child Pornography

Because of computers utilizing online services, child pornography is now more readily available in the United States than it has been since the late 1970's. An offender can now use a computer to transfer, manipulate, and even create child pornography. With the typical home computer and modem, still images can easily be digitally stored, transferred from print or videotape, and transmitted, with each copy being as good as the original. Visual images can be stored on hard drives, floppy disks, CD-ROM's, or DVD's. With newer technology, faster modems, digital cameras, and better computers, similar things can now be done with some moving images. For now, however, it is still difficult to transmit the most preferred child pornography format--high quality, lengthy moving images (e.g. videotape, films).

The other invaluable modern inventions for pornographers, the video camera and recorder, are now being integrated into and through the computer. Multimedia images with some motion and sound and virtual reality programs can provide an added dimension to the pornography. The information and images stored and transmitted can be encrypted to deter detection.

Some of these uses are now small problems that can eventually become big problems. Computer software and hardware is being developed so rapidly that the potential of these problems is almost unlimited. In the future, most communication systems in a home (e.g., telephone, television, fax, videotape, music, newspapers, financial records, etc.) may be funneled through a computer.

The ability to manipulate digital visual images may make it difficult to believe your own eyes. Television commercials now make it appear that Paula Abdul is dancing with Gene Kelly and John Wayne is talking to a drill sergeant. Half-way through the movie "Forrest Gump," Lt. Dan's legs are no longer visible. With computer graphics programs, images can be easily changed or "morphed." This is similar to the technology that is used to "age" the photographs of long-missing children.

Computer-manipulated and, soon, computer-generated visual images of "children" engaging in sexually explicit conduct may call into question the basis for highly restrictive (i.e., possession, advertising, etc.) child pornography laws. Under the Child Pornography Prevention Act of 1996, the Federal definition of "child pornography" has been expanded to include not only a sexually explicit visual depiction using a minor, but also any visual depiction that "has been created, adapted, or modified to **appear** (emphasis added) that an identifiable minor is engaging in sexually explicit conduct." Although this new law makes prosecution of cases involving manipulated computer images easier, it also means that it is no longer possible in every case

to argue that child pornography is the permanent record of the abuse or exploitation of an actual child. This law is currently being challenged in a variety of cases and jurisdictions, which will ultimately establish its constitutionality. If this law is found unconstitutional, only existing obscenity laws may apply to such manipulated/simulated child pornography.

Investigators must also recognize and understand that not all collectors of child pornography physically molest children, and not all molesters of children collect chid pornography. Not all children depicted in child pornography have been sexually abused. For example, some have been photographed without their knowledge while undressing, others manipulated into posing nude. Depending on the use of the material, however, all can be considered exploited. For this reason, even those who "just" download or collect child pornography produced by others play a role in the sexual exploitation of children, even if they have not physically molested a child.

Computer offenders who "just" traffic in child pornography are committing serious violations of the law that do not necessarily require proving that they are also child molesters. If it is relevant and the facts support it, such individuals can be considered preferential sex offenders because such behavior is an offense. Some computer offenders who traffic in child pornography, especially the sexually indiscriminate preferential sex offender, may have significant collections of adult pornography as well. In some cases, they may even have far more adult than child pornography. Such offenders may not be "pedophiles," but can still be preferential sex offenders.

Maintenance of Financial Records

Offenders who have turned their child pornography into a profit making business use computers the same way any business uses them. Lists of customers, dollar amounts of transactions, descriptions of inventory, and so on, can all be recorded on the computer. Because trafficking in child pornography by computer lowers the risks, there may be an increase in profit-motivated distribution.

VICTIMS

Offenders can use the computer to troll for and communicate with potential victims with minimal risk of being identified. The use of a vast, loose knit network like the Internet can sometimes make identifying the actual perpetrator difficult. On the computer, the offender can assume any identity or characteristics he wants or needs. Children from dysfunctional families and families with poor communication are at significant risk for seduction. Older children are obviously at greater risk than younger children. Adolescent boys confused over their sexual

orientation are at particularly high risk of such contacts. By no reasonable definition can an individual with whom a child has regularly communicated online for months be called a "stranger."

The child can be indirectly "victimized" through conversation ("chat") and the transfer of sexually explicit information and material or can be evaluated for future face-to-face contact and direct victimization. The latest technology even allows for real-time group participation in child molestation by digital teleconferencing by computer.

Investigators must recognize that many of the children lured from their homes after online computer conversations are not innocents who were duped while doing their homework. Most are curious, rebellious, or troubled adolescents seeking sexual information or contact. Investigation will sometimes discover significant amounts of adult and child pornography and other sexually explicit material on the computer of the child victim. Nevertheless, they have been seduced and manipulated by a clever offender and do not fully understand or recognize what they were getting into.

Investigators and prosecutors must understand and learn to deal with the incomplete and contradictory statements of many seduced victims. The dynamics of their victimization must be considered. They are embarrassed and ashamed of their behavior and rightfully believe that society will not understand their victimization. Many adolescent victims are most concerned about the response of their peers. Investigators who have a stereotyped concept of child sexual abuse victims or who are accustomed to interviewing younger children molested within their family will have a difficult time interviewing adolescents molested after online seduction. Many of these victims will be troubled, even delinquent children from broken homes.

Although applicable statutes and investigative or prosecutive priorities may vary, officers investigating computer exploitation cases must generally start from the premise that the sexual activity is not the fault of the victim even if the child:

* Did not say no
* Did not fight
* Actively cooperated
* Initiated the contact
* Did not tell
* Enjoyed the sexual activity
* Accepted gifts or money

Investigators must also remember that many children, especially those victimized through the seduction process, often:

* Trade sex for attention, affection, or gifts
* Are confused over their sexuality and feelings
* Are embarrassed and guilt-ridden over their activity
* Describe victimization in socially acceptable ways
* Minimize their responsibility & maximize offender's
* Deny or exaggerate their victimization

All these things do not mean the child is not a victim. What they do mean is that children are human beings with human needs and not necessarily "innocent angels God sent us from heaven." Sympathy for victims is inversely proportional to their age.

When law enforcement officers are pretending to be children as part of authorized and approved proactive investigations, they must remember that the number of potential offenders is proportional and the appeal of the case is inversely proportional to the "age" of the "victim." Because there are far more potential offenders interested in older children, pretending to be a 15- or 16-year-old will result in a larger online response. The resulting case, however, will have far less jury appeal.

After developing a relationship online, offenders who are arrested attempting to meet with children (or individuals they believe to be children) to engage in illegal sexual activity, often claim that they were not really going to have "sex." They claim the discussed sex was just a fantasy, was part of an undercover "investigation," or was a means of communicating with a troubled child. In addressing this issue of intent or motivation, investigators must objectively weigh all the offender's behavior (i.e., past history, honesty about identity, nature of communications, who was notified about activity, overt actions taken, etc.). Ultimately, a judge or jury will decide this question of fact.

SUMMARY

Investigators must be alert to the fact that any offender with the intelligence, economic means, or employment access might be using a computer in any or all of the above ways, but preferential sex offenders are highly likely to do so. As computers become less expensive, more sophisticated, and easier to operate the potential for abuse will grow rapidly.

OROFACIAL TRAUMA IN CHILD ABUSE/BITE-MARK ANALYSIS

Patricia A. Simon, D.D.S.
Assistant Professor Division of Oral and Maxillofacial Surgery
Director Section of Orthodontics
University of Texas Southwestern Medical Center
Dallas, Texas

Objectives:

- To be able to recognize the signs and symptoms of child abuse which manifest as orofacial trauma.
- To understand implications and seriousness of dental neglect.
- To be able to identify a human bite-mark.
- To understand the criteria and limitations of bite-mark analysis and identification.
- To understand the potential aid dental professionals can provide in identifying and reporting child abuse.

OROFACIAL TRAUMA IN CHILD ABUSE/ NEGLECT

I. Dentistry's Role in Recognizing Orofacial Trauma in Child Abuse:

A. Orofacial region is dentistry's area of expertise

B. Patients/parents typically return to the same dentist, but avoid the same physician and ER. Public perception of dentistry's role.

C. Estimated 1-10% of children visiting the dental office will show signs and symptoms of abuse (ADA News, May 1995)

D. Orthodontists, Pediatric Dentists, and Oral and Maxillofacial Surgeons very likely to see orofacial signs and symptoms

E. Dentists are mandated reporters, yet less than 1% of all cases reported are reported by dentists.

F. 85% of the dentists surveyed by the ADA in 1994 believed that they had never seen signs of child abuse and neglect among their patients.

II. Categorization of Head and Facial Trauma

A. Landmark study by Becker, Needleman and Kotelchuck--JADA 1978. Retrospective study found that 65% of child abuse involved trauma to head and facial structures.

B. Of the head and facial injuries, three categories defined:

1. Head trauma 33%
2. Facial injuries 61%
3. Intraoral trauma 6%

III. Extraoral Trauma

A. General Information

1. The face is the focus of human interaction and is an area which is fully exposed. As a result, it is often targeted in abuse.
2. Patients presenting to the emergency room with head or facial trauma are 12% more likely to be victims of domestic violence than those who present with other injuries. For patients who present with facial injuries, in the absence of a history of motor vehicle collision, the possibility of domestic violence must be explored. (Ochs, 1996)
3. Bruises/Burns
   a. look for patterns of bruises/burns
   b. examine for origin and evaluate stage(s) of healing
   c. Ages of Bruising
      i.

Age	Color
0-2 days	swollen, tender, red
0-5 days	red, blue, purple
5-7 days	green
7-10 days	yellow
10-14+ days	brown
2-4 weeks	cleared

4. Burns
   a. 60% of burns can be viewed while child is clothed
      i. immersion burns
      ii. cigarette burns (end 500 degrees F)
      iii. patterns
5. Bite-Marks
   a. 65% can be seen without disrobing
   b. can be inflicted by adult, self, or other child

B. Specific Injuries

1. Ears
   a. This is part of a dentist's extra-oral exam
      i. Bruises, cut, "cauliflower ear" indicates slapping, pinching, pulling or twisting
      ii. A perforated tympanic membrane (ear drum) should also be considered suspicious
2. Neck
   a. Also part of the dentist's purview, and may show rope burns, scratches, bruises
3. Nose
   a. Broken, bruised, deviated septum
4 Lips
   a. Scars on the lips are very rare, and repeated trauma should be

suspected if scars are present.

i. Burns - burning implements, force feeding hot foods
ii. Rope burns - at corners of mouth would suggest gagging
iii. Tears at corners of mouth - forced opening

5. Fractures-A blow to the face can cause fractures of the facial bones. The type of fracture and the bones involved will depend on the force, direction and point of impact.
   a. Black eyes-look for possible orbital, zygomatic, or nasal fractures
      i. screening film: Water's view
   b. Limited movement of lower jaw (mandible) may indicate a fracture of the jaw joint (condyle) or cheek bone (zygoma)
      i. mandibular fractures often occur at two sites, usually opposite sides
      ii. look for malocclusion
      iii. screening film: panograph or PA Cephalograph

IV. INTRAORAL TRAUMA

A. SOFT-TISSUE: The oral cavity is lined with soft tissue. These tissues include:
   a. gingiva/tongue
   b. buccal mucosa
   c. hard/soft palate
   d. frenum attachments
   e. lips

1. Examination of the gingiva, frenum, tongue, and palatal tissues can show signs of both physical and sexual abuse. Injuries may include:
   a. Torn maxillary frenum - may indicate forced feeding
   b. Torn lingual frenum - forced feeding/forced oral intercourse
   c. Bruises/ecchymosis - tongue or hard/soft palate - forced feeding/forced oral intercourse.
2. STD's - intraoral infections may be of sexual origin including gonorrhea, condyloma acumination (venereal warts), syphilis, herpes, moniliasis, trichomonas, erythema/petechial palate.

B. HARD TISSUE: The hard tissues of the oral cavity include the facial bones (maxilla), the lower jaw (mandible), and the teeth.

1. Bony injuries include:
   a. Alveolar fracture - bone holding tooth in the socket
   b. Maxillary fracture- upper jaw becomes detached from skull; look for open bite or lacerations to palatal areas
   c. Mandibular fracture - look for step in occlusion.
2. Dental injuries include:
   a. Chipped/fractured teeth
   b. Missing teeth - inappropriate exfoliation pattern
   c. Fractured roots - evidence of root tips
   d. Discolored teeth - evidence of trauma

3. Evaluation of dental injuries with radiographs -- can also aid to determine normal eruption patterns.

C. DENTAL NEGLECT: "The willful failure of a parent to seek and to obtain treatment for orofacial problems that make routine eating difficult or impossible; cause chronic pain; delay or retard a child's growth or development; or make it difficult or impossible for a child to perform daily activities such as playing, working or going to school".
   1. Defined b American Academy of Pediatric Dentistry
   2. May be the first sign of overall neglect
   3. Low income families show > 75% of dental neglect
   4. Includes:
      a. Untreated decay
      b. Periodontal disease
         i. abscess
         ii. fistula
         iii. gum disease

BITE-MARK ANALYSIS

The recognition of a mark as a human bite is important, because of the implications imparted as to the incident which caused the bite to occur. Equally important is identifying the person who made the bite. The identification of bite-marks is still a controversial aspect of forensic science for reasons that will be described in detail.

I. Human Bite-Marks

A. Bites
   1. common in childhood play
   2. a primitive form of assault
   3. seen in forcible rape and hand-to-hand mortal combat
   4. seen in some folk remedies
   5. seasonal incidence
   6. may be self-inflicted

B. Incidence
   1. Location by increasing order:
      a. Lower extremities
      b. Trunk
      c. Face/neck
      d. Upper extremities
   2. Age by increasing incidence:
      a. Preteen
      b. Preschool
      c. Infant
      d. Toddler
   3. Location by age:

a. Infants: genitalia and buttocks as a form of punishment
b. Others: random location, random bites, well-marked—assault or sexual abuse

4. Males > Females
5. Greatest complication is infection due to the large number of bacteria in the oral cavity

II. History

A. William the Conqueror - "indentured-servants"
B. Bite-Marks in Court:
C. 1870 - Ohio vs. Robinson - earliest recorded bite mark case
D. 1954 - 1954 - Doyle vs. State (Texas) - first case involving admissibility
E. 1972 - Illinois vs. Johnson - first case leading to conviction
F. 1976 - People vs. Milone (Illinois) - disagreement between experts -- wrong man convicted
G. 1979 - Bundy vs. Florida - bite-marks high profile in media

III. Bite-Mark Analysis Challenged

A. Perceived lack of scientific merit and potentially prejudicial aspects.
   1. Admissibility?
      a. Fundamental validity and scientific basis
      c. Previous lack of standards for collections and use of evidence.
   2. Impartiality?
      a. Forensic odontologist employed by law enforcement
      b. Police provide suspects for evaluation
      c. Rarely offered models of non-suspects
B. 1978 - A California law journal recommended suspension of bite mark evidence until standards were set.
C. 1981 - American Board of Forensic Odontology -- committee formed:
   1. to develop guidelines on the collection of evidence from the victim and suspect.
   2. to attempt to quantify and measure value of bite mark evidence through universal scoring system.
   3. to improve communication and give meaning to "matching point" (No attempt to indicate levels of confidence).
D. 1999- Rescinded score sheet. Point values no longer utilized.
E. 1995- ABFO bite mark. Guidelines and Standards.

IV. Classification of Bite-Marks

A. Identification of a bite-mark
   1. Periphery marked by lines or points representative of teeth
   2. U-shaped, broad

3. Often has a central "thrust mark"

B. ABFO Classification
   1. Class I – Erythema
      a. An increased redness of the skin that is caused by capillary enlargement.
   2. Class II – Contusion
      a. An injury in which the skin is not broken, but the underlying blood vessels are disrupted. A bruise.
   3. Class III – Abrasion
      a. A minor wound resulting from scraping or rubbing away of skin.
   4. Class IV – Laceration
      a. A jagged tear. The result of being forced apart.
   5. Class V – Avulsion
      a. A pulling off or tearing away.

V. COLLECTION of EVIDENCE

A. From Victim
   1. Recognition as human bite
   2. Appropriate authorization form victim to obtain evidence
   3. Description of bite mark
      a. color
      b. location
      c. shape
      d. size
      e. type of injury
   4. Photographs
      a. Adherence to stringent requirements for accuracy of reproduction
         (1) orientation
         (2) resolution
         (3) with and without scales
      b. Preservation of information over time
   5. Salivary Swabbing
   6. Special Techniques
      a. Impressions of surface (indentations) of bite
      b. Preservation of tissue samples (post-mortem)

B. From Suspect
   1. Ascertain that necessary search warrants, court orders, or legal consent was obtained.
   2. History of dental treatment performed after or around date of bite- mark.
   3. Photographs
      a. Extra-oral
      b. Intraoral
      c. Photos of inanimate materials
   4. Examination

a. Extra-oral
b. Intraoral

5. Dental Impressions
6. Sample bites in appropriate materials
7. Special situations
   a. microbiologic cultures
   b. salivary samples

VI. ANALYSIS of EVIDENCE and COMPARISON

A. Compare 1:1 representation of bite to suspect's dentition
   1. Score guide (recall that ABFO has rescinded score guide)
      a. Gross evaluation
      b. Tooth position
      c. Intra-dental features

B. SUMMARY OF RESCINDED ABFO SCORE SHEET

FEATURES	POINTS
Gross	
All teeth present	One/arch
Consistency in arch size	One/arch
Consistency in arch shape	One/arch
Tooth Position	
Same labiolingual position	One/arch
Same rotational position	One/arch
Vertical position	One/arch
Spacing	One/arch
Intradental Features	
Mesiodistal width	One/tooth
Labiolingual width	Three/toot
Incisal edge curvature	Three/tooth
Other distinctive features	Three/tooth
Miscellaneous	
One edentulous arch	Three

VII. PROBLEMS

A. Accuracy of imprint
   1. pre- and post-mortem changes
   2. variability of precision of mark-distortion
   3. inanimate objects - good imprint initially; distortion with change in

temperature or humidity

C. Permanence
   1. Change in dentition over time

D. Uniqueness
   1. Science has not definitely established any individual identity to dentition or distinct nature of bite patterns.
   2. Only a few teeth in bite-mark
      a. Cannot impart uniqueness to bite
      d. Need at least 4-5 teeth marks present

The Children's Assessment Center

THE CHILDREN'S ASSESSMENT CENTER
CLINICAL SERVICES PROGRAM

The Clinical Services Staff of the Children's Assessment Center adheres to the following philosophy of treatment of incest and sexual abuse:

1. Child sexual abuse is harmful to children.
2. Victims are not responsible for child sexual abuse under any circumstances.
3. We are committed to preventing future trauma, violence or re-victimization.
4. Child molestation is either the result of a deviant arousal pattern and/or the inappropriate conversion of non-sexual problems into sexual behavior.
5. Clients are respected and their self-determination is paramount in the helping process.
6. We recognize that our clients come from a variety of cultures and experiences and strive to make our services culturally appropriate.
7. Treatment will be provided by a team of therapists or a therapist in consultation with the team.
8. Confidentiality is limited. Reports will be made to Children's Protective Services and Law Enforcement as required by law. In open CPS cases, information disclosed in therapy may be shared with Children's Protective Services to assist in case management and case planning.
9. There are times when a sex offender (either adult or juvenile) can be reunified with his or her family. Generally this process would occur in cases when the offender is admitting guilt, the entire family engages in an appropriate treatment program and required treatment goals have been met.

SERVICES

The Clinical Services Program of The Children's Assessment Center offers services to clients who are referred by CPS, Law Enforcement and other community resources: victims of child sexual abuse, their non-offending parents and other relatives or caregivers (including foster parents and alleged perpetrators). Self-referred clients from the community may be seen on a limited basis.

I. Assessment-coordinated with specialized interviewers and medical assessments:
   a. formal psychological evaluations of individuals
   b. crisis assessment of individuals
   c. assessment of family functioning/interactions
   d. referral for psychiatric, speech and hearing, or other specialized assessments

II. Treatment:
   a. individual
   b. group
   c. victims
   d. caregivers
   e. siblings
   f. others
   g. family
   h. family therapy
   i. FTP

III. Consultation & Education:
   a. to staff/volunteers/partners agencies
   b. to community

FAMILY TREATMENT PROGRAM

The Family Treatment Program of The Children's Assessment Center exists to assist families who wish to be reunited after being separated because of the occurrence of child sexual abuse within the family system. This program is currently designed to treat adult offenders only. In order for families to be treated in this program, they must meet certain requirements. These are:

1. The alleged offender must be willing to attend this treatment program which is specifically focused on sexual offending. If in denial of the offending behavior, they will be permitted to attend therapy for a period of 60 days to see if they make progress toward moving out of denial. If at that time, they are continuing to deny any offending behavior, the family will be referred back to CPS for alternative treatment.

2. The non-offending partner must express a desire to consider reuniting with the alleged offender.

3. The victim child must not be opposed to the possibility of reunification with the offender.

The treatment program is structured as follows:

1. In these cases, the treatment will be provided by a team of therapists and reunification will be monitored by a team of professionals. This team will include the therapists, the CPS worker and supervisor, and the probation or parole officer if applicable.

2. The following family members will be involved in treatment: the offender, the non- offending spouse/partner, the victim(s), and the siblings of the victim(s). The offender, the non-offending partner and the victim must participate in-group therapy, individual therapy if needed, and family therapy as appropriate. The offender will not be included in family therapy until he/she is taking full responsibility for the abuse and an apology session has been held. Extended family members will be offered treatment if it is deemed necessary for the successful outcome of the reunification.

3. While the family is in treatment and until unification occurs, the offender must be the one who leaves the home, not the child.

Overall, any dysfunctional family patterns resulting in or providing the opportunity for sexual abuse will be addressed and changed. These may include but are not limited to: isolation, problems in communication, lack of boundaries and power imbalances.

The Clinical Services team of The Children's Assessment Center believes that intrafamilial child sexual abuse can be a treatable problem. Treatable is defined as helping the offender learn ways of minimizing the risk of re-offense. It does not imply a cure. It must be accepted by the family that the risk must continue to be monitored after reunification occurs and that certain restrictions may be placed on the offender after returning home.

Referrals for this program will be received from Children's Protective Services. After an initial intake appointment is completed with all family members, the family will be assessed for appropriateness for this program. If accepted into the treatment program, the CPS worker will be notified and the family will begin treatment. It is anticipated that reunification will take no less than 12 to 18 months.

FEES

Services are paid for through several sources as follows:

Contract with Children's Protective Services on open CPS cases
Medicaid
Private Insurance
Crime Victim's Assistance
Self-Pay - a sliding scale fee is available based on family income

It is the policy of The Children's Assessment Center that no sexually abused child will be refused services because of lack of financial resources.

Transportation will be provided if necessary.

1999 Crimes Against Children Conference

Workshop: Beyond the Basics: Program Components
Grand Jury Training

Presented by : Marilyn Herrick

The Dallas Children's Advocacy Center has been providing training on child abuse issues to the members of the Dallas County Grand Juries for more than 6 years. The training consists of a child advocate from the Dallas Children's Advocacy Center presenting material to the members of the Grand Jury. A short thirteen minute videotape on child sexual abuse is shown after which there is time for questions. Grand Jury members also receive a specially developed handbook on both child physical and sexual abuse to keep as a reference. The handbook is divided into two sections; child sexual abuse and child physical abuse and child fatalities.

Under the heading of Child Sexual Abuse the table of contents lists the following topics:

Statistics on Child Sexual Abuse
Children as Witnesses: Memory, Honesty and Suggestibility
Behavioral Indicators of Child Sexual Abuse
Family Dynamics of Child Sexual Abuse
Offenders
Progression of Child Sexual Abuse
Child Sexual Abuse Allegations in Custody and Visitation Disputes
Medical Findings in Child Sexual Abuse
Natural Sexual Exploration During Childhood

Under the heading of Child Physical Abuse and Child Fatalities the following topics are listed:

Child Physical Abuse and Child Homicide Statistics
Common Intentional (Non-Accidental) Injuries
Situations Which are Possibly Child Abuse and Dictate a Report to the Authorities
Situations Which are Child Abuse and Dictate a Report to the Authorities
Interpreting Common (Non-Accidental) Injuries

The videotape is invaluable and poses the following questions: Did it really happen? Who's telling the truth? Who's not? Why did the child wait so long to tell? And do I have enough information to make a determination of what really happened? On the videotape the director of the REACH Clinic of Children's Medical Center of Dallas (responsible for many of the sexual abuse exams of children) explains why physical findings are uncommon in child sexual abuse exams.

Sex Offender Apprehension Program *(SOAP)*

Presented by

Lt. Bill Walsh

Youth and Family Crimes Division

Dallas Police Department

At the

1999 Crimes against Children Conference

Dallas, Texas

August 3, 1999

SEX OFFENDER

S.O.A.P.

APPREHENSION PROGRAM

What is *SOAP*?

- Innovative law enforcement response to managing sex offenders that reside in the community
- Based on:
  - A pro-active response
  - A multi-agency team approach
  - A zero tolerance philosophy

3

SOAP Team

Core Team Members

- Dallas Police Department (5)
- Dallas County Sheriff's Department (3)
- Dallas FBI
- Dallas County Department of Community Supervision (Probation)
- Texas Department of Pardons and Paroles (Parole)

4

Sex Offenders

- Majority have victimized children
- Numerous victims in their lifetime
- Highly motivated to commit sex crimes

5

Sex Offenders

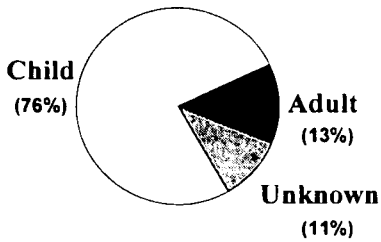
- High rate of recidivism
- Rehabilitation is questionable
- Potential for ever escalating offensive behavior and violence

6

Child Sexual Abuse

- 61% of all rape victims are under 18 yrs. old
- Girls 12-15 are victims of violent crime at a rate 84 % higher than the general public
- While victimization can occur at any age, the ages between 7 and 13 years represent the peak period of vulnerability
- 40% of imprisoned sex offenders reported that their victims were less than 12 yrs. old.

Victims of Registered Sex Offenders



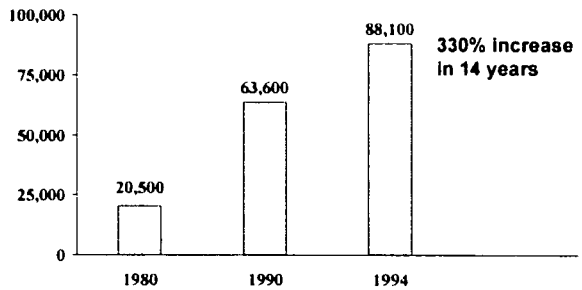
8

Sex Offenders

- Sex offenders typically do not go to prison for life
- Majority are going to return to the community they left
- Number of convicted sex offenders is on the increase
  - more in prison
  - more on community supervision and parole

9

Sex Offenders in State Prison



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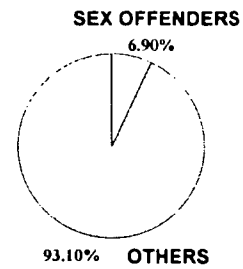
Sex Offenders in State Prison



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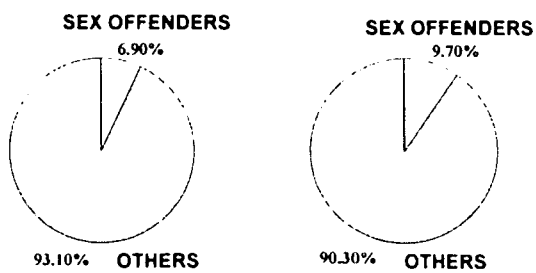
Sex Offenders in State Prison



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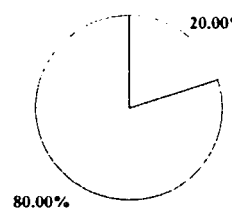
Sex Offenders in State Prison

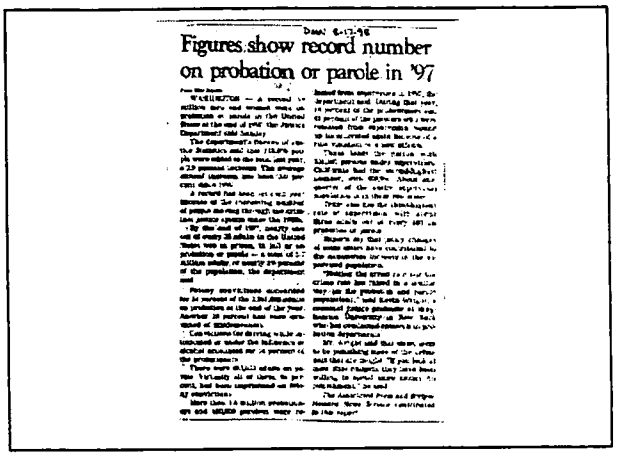


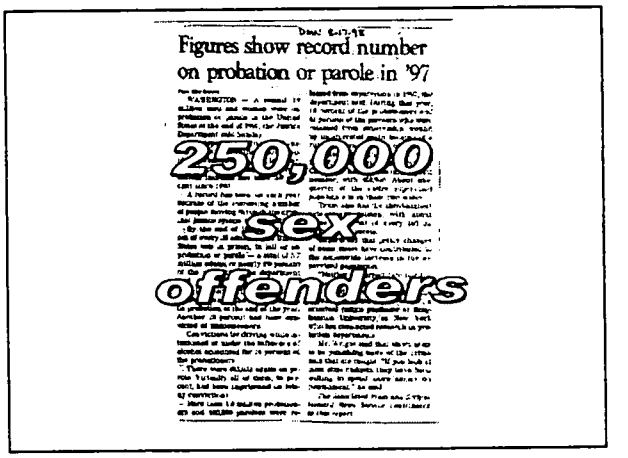
SEX OFFENDERS

In 10 states, sex offenders comprise 20% of the entire prison population.

1994

13


Figures show record number on probation or parole in '97



SOAP Program Goals

- Respond to concerns about the activities of known or suspected sex offenders from:
  - other law enforcement agencies
  - the courts
  - the public
- Insure timely arrest of sex offenders for:
  - registration law violations
  - probation & parole warrants
  - new or old arrest warrants

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SOAP Program Goals

- Reduce the number of sex crimes
- Insure sex offenders comply with every provision of the Texas Sex Offender Registration Law
- Assist probation and parole officers in insuring sex offenders comply with the terms of their release
- Assist courts in insuring sex offenders comply with terms of bonds

17

SOAP Program Goals

- Improve coordination and cooperation among law enforcement agencies in sex crimes investigations through:
  - information sharing
  - surveillance
- Educate the public about sex offenders
- Educate the legislators about the need for new legislation

18

Program lets authorities keep steady watch on sex offenders

By Pete Slover
Staff Writer of The Dallas Morning News

The acronym suggests something needs to be scrubbed: SOAP.

The cops in the Sexual Offender Apprehension Program endorse that image.

"If sex offenders can't play by the rules, they're going back to the penitentiary," said Dallas police Lt. Bill Walsh, who hatched the program to monitor registered child molesters and other sex offenders.

Since November, the SOAP squad has played part sentinel, part snoop and part welcome wagon, letting the city's 2,000 registered sex offenders know they're being watched. They've arrested more than 100 alleged violators in the process.

No other Texas agency has ever focused primarily on enforcing registration laws, which require fresh-from-prison sex offenders to tell police where they live.

SOAP is modeled after a similar operation in San Jose, Calif., the only other such program in the country. The Dallas version is financed through a $292,000 grant from the criminal justice division of the governor's office, with money and office space kicked in by the city of Dallas

Please see PROGRAM on Page 8A.

and sheriff's office investigators — part of the Sexual Offenders Apprehension Program — arrest a convicted sex offender earlier this month on charges he violated his probation.

2-17-98

The Dallas Morning News: David Leeson

Program lets authorities keep steady watch on sex offenders

Continued from Page 1A.

and Dallas County Sheriff Jim Bowles.

Opponents argue that sexual registration laws invade the privacy of convicts who have paid their debt and deserve to live in peace.

The prospect of SOAP officers hanging out and making inquiries around the neighborhood could make it harder yet for law-abiding sex offenders to live undisturbed, said Dallas lawyer Elliot Shavin, who teaches a legal clinic at Southern Methodist University.

"When the police themselves are involved in causing the neighbors to protest or march around with signs, then it raises real concerns," he said.

"My gut reaction is that police can decide to crack down on a certain type of crime. That's a decision they're entitled to make as long as they abide by constitutional concerns."

Lt. Walsh said police have not just a right but a duty to keep an eye on sex offenders.

"If they can abide by the laws and conditions of probation or parole, they have every right to be here," he said. "If they can't, we don't have to wait for them to re-offend."

Most days, the squad's five Dallas detectives and three sheriff's investigators fan out across the county from the Dallas Police Department's downtown headquarters.

Two-investigator SOAP teams knock on doors and trail parolees and probationers in the name of zero-tolerance: If a convict is supposed to travel only to and from work, live at a certain address, avoid children or abstain from alcohol or pornography, the SOAP team knows.

"Good morning!"

The upbeat greeting from sheriff's investigator Sid Wheat appeared to puzzle the convicted rapist, peering out the sliding glass door of the Red Bird-area home listed on his sex-offender registration.

After serving 17 years of a 50-year sentence for raping a 16-year-old girl, the man is free on parole. He was less than pleased with the terms of his release, including the surprise visit, or "compliance check," by the SOAP team.

"It's not fair," the 36-year-old convict protested over the noise from *Judge Judy*, a courtroom TV program playing on a nearby set. "They never told me about any of this."

His chief complaint was the electronic monitor strapped to his ankle, a device that detects and notifies authorities if he wanders out of range of a transmitter attached to his home phone line.

The gizmo makes the compliance check redundant: If the parolee had skipped out, the alarms would have already gone off.

But since the SOAP team's computers aren't linked to parole systems, its files didn't show the parolee was wearing a monitor. In this case, the communication gap spelled harmless overkill — the cops checked on a guy who really didn't need checking.

Still, the confusion illustrates a problem SOAP aims to address.

The complete picture on any offender can be scattered through the records of numerous police departments, prosecutors, probation officials, prison authorities and parole officers.

SOAP hopes to streamline the flow of information. Weekly staff meetings bring the team together with probation, parole and FBI representatives so the groups can cut across usual bureaucratic channels to share information about sex offenders and tips from the public.

Gathered in a board room recently, the squad heard a grim caseload of suspected violators brought to them by parole and probation officials: a child molester living within 100 feet of a school, a couple of bogus registration addresses, a convicted pedophile attempting to lure a child to his car, fresh molestations that could serve as grounds for new cases.

Mostly old hands at this kind of work, the detectives recognized some of their clientele from earlier arrests.

After divvying up the work, the group members discussed how they could extend their zero-tolerance approach through the legal system. They agreed that Dallas County prosecutors and grand juries, confronted with their first wave of sex-offender registration cases, could use a little training.

"The grand jury seems to want to know the offender's registration history," said Dallas police Sgt. Byron Fassett, the squad's supervisor, lamenting the tendency to go soft on first-time violators.

"If I said, 'I paid my taxes in 1993, 1994 and 1995, I just missed 1996,' nobody's going to let me skate on that."

Later, to explain how they maintain sanity and sensitivity against a day-in, day-out tide of the creepy and perverse, the detectives pointed to the humor on the station house walls.

"You're not paranoid. We are watching you," says one hand-lettered sign, part of a collage of insider jokes and photos that lend a gritty cop-clutter to the place.

But the whimsy doesn't displace the seriousness of purpose. And while suspects and cops are fair game, victims are regarded with a somber respect.

"I got two kids. That's why I do it," said Dallas police Detective Bob Cummings. "Some people don't like this kind of work, but somebody's got to do it."

Detective Cummings and his partner, sheriff's investigator Chrissy Guerra, recently raced to meet a pair of parole officers who had called SOAP after a rapist under their supervision tested positive for drugs. In a pre-arrest meeting at a McDonald's, the parole crew expressed clear pleasure at the speedy SOAP response.

Moments later, Ronnie Mathis, who was paroled just before Christmas after nearly nine years in state prison, was on his way back to the penitentiary, arrested while working at an Oak Cliff tire shop.

On the way to book-in, the officers smiled at what they classified as a success. From the back seat, Mr. Mathis complained about the hassles of parole supervision, then went silent with a few words of half-hearted swagger.

"That's fine. I'll go back for two years, and then I'll get out free and clear," he said, nodding at his electronic monitoring anklet. "No more of this."

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PROJECT NARRATIVE

THE FOCUS AND ACTIVITIES OF THE PROPOSED PROJECT.

The focus of the Sex Offender Apprehension Project (SOAP) is twofold. One focus is to insure that sex offenders that are mandated under the Sex Offender Registration Program (Article 6252-13c.1 Government Code), comply with the conditions of the statute. The second focus is to provide intense supervision, surveillance and investigation of these offenders by specially trained police detectives during the time the offenders reside in the community. The activities of this project will include visits by the detectives to the residence and/or place of business of every registered sex offender that resides in the City of Dallas. During these visits, the detectives will conduct in-depth interviews of the registered offenders to insure that they are in compliance with both the requirements of the registration law and the specific terms of their probation or parole. An additional activity of this project will be the intense active investigation of serious habitual sex offenders that are paroled into the community to insure that they do not commit additional crimes. Undercover investigative techniques, including covert surveillance, will be used to monitor those offenders that fit the profile of a Serious Habitual Sex Offender (SHSO). This profile will be developed as an additional activity of this project. The purpose of this surveillance activity will be to apprehend these violent predatory sex offenders in the act of violating any state or municipal law, or the conditions of their probation or parole, so that they can be returned to prison before they have the opportunity to commit another violent sex crime.

Bill Walsh
Lieutenant

CITY OF DALLAS
Police Department
Youth and Family Crimes Division
Investigations Section
106 S Harwood Room 225
Dallas, Texas 75201

Telephone 214/670-5936

1. What is the specific problem to be addressed by this application?

The specific problem that will be addressed by this application is the substantial risk that convicted sex offenders pose to the community. There are currently over 1000 registered sex offenders residing in the City of Dallas. Research and experience has shown that sex offenders have a very high rate of recidivism, which means that they pose a very high risk of committing additional violent sex crimes after being released from custody. While all these sex offenders are under the supervision of either the Probation or Parole Departments, it is a fact that the caseloads of these probation and parole officers are much too high to allow for the intense supervision that convicted sex offenders warrant. It is not unusual for a probation officer in Dallas County to have over 45 convicted sex offenders on their caseload.

While it is commonly accepted by everyone that convicted sex offenders pose a very real threat to the community, the reality of the situation is that they are not subjected to the intense supervision and surveillance that would help insure that they do not commit additional sex crimes. Too often, we wait for the convicted sex offender to strike again before we do anything. How often have you heard about a convicted sex offender, either on probation or parole, sexually assaulting and/or killing yet another victim? I already know the answer, far too many times.

The Texas legislature has responded appropriately to citizen's concerns about the threat posed by sex offenders by passing the original registration law in 1991 and amending it in both 1993 and 1995. But, even though there is a sex offender registration law in Texas, there are no local programs or organized activities to insure that sex offenders are complying with the law. The goal of this project is to change that situation. This project will insure sex offenders comply with the registration law and continue to stay in compliance during the period of time in which they are subjected to the registration law. Currently, no public official in Texas knows the true compliance rate for the Sex Offender Registration Program. This project will not only determine that compliance rate, it will take a pro-active approach to insuring sex offenders fully comply with not only the terms of the registration law but that conditions of their probation and parole as well.

2. Explain the nature and extent of the problem using verifiable statistics.

In 1993, a convicted sex offender abducted, sexually assaulted and murdered a six year old girl named Ashley Estelle in Plano, Texas. The offender in that savage attack was eventually arrested and prosecuted for the crime of Capital Murder and he is currently awaiting execution. That offender was later identified to be Michael Blair, a convicted sex offender who was on parole status when he committed the murder. Several years prior to the murder, Blair had been convicted of breaking into a Dallas residence at nighttime and molesting another little girl in her bedroom. For that crime, Blair spent several years in prison and was eventually released on parole to Dallas. At the time of his release, Texas did have a sex offender registration law, but Blair was not required to register because his conviction occurred before the law went into effect in September 1991. In a response to the public outrage surrounding this brutal murder and in an attempt to prevent a reoccurrence of this horrific event, Texas State Senator Florence Shapiro drafted several pieces of legislation that were collectively known as "Ashley's Laws", in memory of the little Plano girl. Among the laws enacted by the Texas State Legislature was amendments to the Sex Offender Registration Program. This much improved law became effective on September 1, 1995. The provisions of this law permitted public notification of sex offenders that committed crimes against children. The law also required that sex offenders, convicted of certain sex crimes, were required to register with the local law enforcement agency within 10 days of moving into the community. This law required such registration either after the offender was released from prison on parole, or after being placed on probation. The theory was that law enforcement could do a better job of protecting children from sex offenders in the community if they knew who these convicted sex offenders were and where they lived. The problem is that while Texans have the sense that they are being protected against sex offenders because of the registration law, the reality of the situation is that we do not know for a fact if sex offenders are in fact complying with the requirements of the law. Additionally, and more importantly, we have no idea if the registration law is deterring sex offenders from committing new crimes.

Many studies have found that sex offenders, especially those that victimize children, have higher rates of recidivism than other types of violent offenders. This means that they usually are not rehabilitated and that they will most likely re-offend, even after being prosecuted and incarcerated for earlier crimes. Additionally, studies have found that preferential child molesters may have many victims in their lifetime. Research studies and this author's experience have also shown that child molesters often increase the severity of the crimes they commit as time goes on. The offender that exposes himself, may then progress to more serious crimes like

molestation, rape, kidnaping and maybe even murder. The progressive nature of their criminal behavior demands that sex offenders be subjected to close monitoring.

Currently there are over 1000 registered sex offenders residing in the City of Dallas. More alarming t[redacted] that number is the fact that over 900, or 90% of them, have committed sex crimes against children! In a study conducted by Dr. Gene Abel of the New York State Psychiatric Institute, it was found that "child molestation is a more serious and frequent crime than rape", Dr. Abel found that child molesters were found to be "responsible for molesting an average of 68.3 victims, more than three times the number of adult women assaulted by each rapist". These statistics are low compared to a study released in early 1996 by the U.S. Justice Department's Bureau of Justice Statistics. This study which was based on interviews of 14,000 inmates at 277 prisons in 45 states in 1991, found that "pedophiles (preferential child molesters) often are repeat offenders, sometimes with up to 100 offenses". The study also found that 66% of the sex offenders in prison targeted children as victims and more than half the child victims of sexual assault were younger than 12 years of age. Thus the situation in the City of Dallas is that we have over 900 sex offenders that pose a very real danger to young children.

The author of this grant project has had two recent experiences that highlight the need for this project. The first involved the investigation of the abduction and sexual assault of a 15 year old girl on her way to school. The suspect was quickly apprehended and found to have been paroled to Dallas just 3 months prior. He had served nearly 15 years in prison for several sexual assaults. This dangerous offender was released into the community without the level of supervision and surveillance deserving of his past criminal record. As this offender was convicted of his crimes before 1991, he did not have to register as a sex offender. Under the proposed Sex Offender Apprehension Program, this offender would have been interviewed by detectives when he arrived back in the community, putting him on notice that law enforcement was aware of him and what he had done. Additionally, he would have been put under covert surveillance from time to time to see if he was engaging in any criminal conduct. It is quite possible that this offender would have been observed violating some law or condition of his parole and had his parole violated prior to the rape of the girl. Another possibility is that this offender might have been caught in the act of trying to abduct the girl.

The other author's other experience also illustrates the need for the SOAP project. After the abduction [redacted] a little girl named Amber Hagerman in Arlington, Texas, Dallas police detectives were asked to follow up on a lea[redacted] That lead was that the offender that was observed by a witness abducting the girl was observed driving a black pick-up truck. Dallas detectives were asked to check all the registered sex offenders that lived in Dallas that were known to drive similar trucks. Six registered sex offenders were found to drive black trucks. When the detectives went to the residences of these individuals, they found that 3 of the 6 no longer lived at the location that they listed when they registered. Additionally, some no longer owned the black truck and they had not updated the registration file with their new vehicle information. These two incidents illustrate the need for a program where convicted sex offenders are monitored for compliance with the registration law and those that are serious habitual sex offenders are subjected to intensive surveillance to insure that they are not committing new crimes and are abiding by the terms of their probation and parole.

When researching this project, the author contacted the Dallas County Sheriff's Office (DSO) to discuss their experience with convicted sex offenders residing in Dallas County. During this discussion, the author learned that there are currently over 280 outstanding arrest warrants for sex offenders in Dallas County that need to be served. Currently, the DSO does not have adequate resources to serve these warrants. This project would make it a priority activity to assist the DSO in serving these outstanding arrest warrants.

3. What resources are currently being used in the applicant's geographic area to address this problem and how do those resources work together?

Currently in the City of Dallas, there are three resources working to address the problem of sex offenders. They are the Dallas Police Department, Dallas County Probation and the Parole Department. The Dallas Police Department is responsible for registering sex offenders and probation and parole are responsible for supervising those offenders on their respective caseloads. Each agency shares information with the others but they are best described as three parallel approaches dealing with sex offenders rather than one comprehensive approach. T[redacted] police department registers sex offenders and investigates sex crimes committed in the community. Probati[redacted] and parole supervise the sex offenders on their caseload to insure that they are in compliance with the terms of their release. Probation, parole and police rarely work together to supervise, monitor or to investigate the activities of sex offenders. This project will insure that these agencies coordinate their response to sex offenders.

4. Identify the gap in available resources or services that makes this application necessary.

This project is necessary for the following reasons. First, there are no resources currently available to provide for a dedicated law enforcement unit to insure that sex offenders are complying with the Sex Offender Registration Program upon their parole or upon being placed on probation. Additionally, there is no follow-up to insure that theses same offenders continue to comply with the registration law for the period of time they are subjected to the law. Offenders convicted after September 1, 1995, for the crimes of Aggravated Sexual Assault, Indecency With a Child and Sexual Performance by a Child are required to register for a lifetime. This clearly illustrates lawmaker's concern about the ongoing risk these offenders pose to the community.

Secondly, there are inadequate resources for either probation or parole to carefully supervise the sex offenders on their caseload. In Dallas County, it is not unusual for a probation officer to have 45 sex offenders on their caseload. It is almost impossible for the probation officer to have contact with the probationer more than once or twice a month. This project will assist both probation and parole in their efforts.

The third gap is that many sex offenders that are currently being released on parole into the community are not required to register because they were convicted before the registration law went into effect. Therefore, the police department does not know who they are, where they live or what vehicles they drive. Our first contact with them currently is too often when they commit another sex crime. This project will identify and interview those offenders when they arrive in the community.

5. If funded, how would the proposed project work with the community and with other agencies toward impacting the problem stated above?

If funded, this project would join with probation and parole as well as other law enforcement agencies in the area to establish a comprehensive, coordinated and pro-active approach to supervising, monitoring and investigating sex offenders. Members of the specialized unit that would be formed under the Sex Offender Apprehension Program project would work to insure that sex offenders comply both initially and long-term with the registration law. Members would identify, contact and interview sex offenders that were released into the community that did not have to register under the registration program. All sex offenders, whether they were registered or not, would be evaluated to see if they met the profile of a Serious Habitual Sex Offender. This profile will be designed as an activity of this program. If they fit this profile, they would be subjected to random covert surveillance and any violations of the conditions of their probation or parole would be reported to their parole or probation officer for appropriate action, including but not limited to revocation of their status.

This project would enhance the efforts of the sex offender registration units of local law enforcement by providing them with current updated information about registered offenders. The value of the registration program is greatly diminished if the information on where sex offenders live or which vehicles they drive is not current.

This project would work closely with state legislators by giving them feedback as to what actually works and what does not work with the registration law. Suggestions on needed reforms to the law would be proposed to insure that the Texas registration law is the best in the country. Information on compliance rates will also be made available to lawmakers so that they can amend the law as necessary to improve compliance.

This project will also work with members of the community as it will serve as the clearinghouse for all tips and complaints about activities involving sex offenders. The public will be made aware of this project and encouraged to report any suspicious activity of known or suspected sex offenders. The specialized unit will in turn investigate those activities. Finally, this project will serve as a model for the State of Texas on how sex offenders should be monitored.

6. What are the specific activities proposed for this project? Please include information on target area, population, and number of people served.

The activities of this project include the formation of a unit of detectives that will be specially trained on issues related to sex offenders and how they commit sex crimes. These detectives will perform several activities simultaneously. The primary activity will be to insure that every registered sex offender that resides in the City of Dallas is in compliance with the terms of the registration law and that the information listed on their registration record is current. The detectives will accomplish this by actually visiting the residence of the sex offender and conducting in-depth interviews to insure that the offenders still reside at that location and that the information on file for them is current. If the offender cannot be located at his residence, the detectives will visit their place of employment to do the same. If it is discovered that an offender is in violation of any requirements of the registration law, they will be criminally charged for t

on and arrested. Then, depending on whether they

are on probation or parole, the appropriate authorities will be notified so that proper action can be taken. This action could include having their probation or parole being revoked and the offender being sent to prison.

Prior to making these visits to the offenders' residences or places of business, detectives will research the offender so that they know the crimes he has committed and what the terms of his probation or parole are. If the detectives observe any violation, such as an offender having unsupervised contact with children, they will notify the appropriate probation or parole officer so that proper action can be taken. In those cases in which an offender is released into the community but for whatever reason does not have to comply with the registration law, they will also be visited by the detectives and subjected to the same in-depth interview. The detectives will seek the assistance of the parole or probation officer with any offender that refuses to cooperate in the interview. Files will be created on these offenders and photographs will be taken.

The detectives assigned to this unit will also design a profile of a Serious Habitual Sex Offender. This profile will be constructed after reviewing both the research literature, a review of other offender profiles that are being utilized throughout the country and a review of the criminal records of the most dangerous registered offenders. Once this profile is developed, offenders that fit this profile will be placed under increased scrutiny, including but not limited to covert surveillance. It is hoped that by placing these habitual offenders under surveillance, they will be observed committing some violation of either state or municipal law or the terms of their probation or parole so that they van be returned to prison before they have the opportunity to commit additional sex crimes.

This special unit of detectives will also investigate any leads or tips from the public regarding known or suspected sex offenders. This will serve to let both the public and the offenders know that sex offenders are being monitored.

Initially, this project will concentrate on the 1000 sex offenders that reside in the City of Dallas. The number of sex offenders that will be released into Dallas that do not have to register is estimated at 200 during the first year. In subsequent years, the plan is to expand this project to the Dallas-Fort Worth Metoplex area by having other law enforcement agencies, as well as propbation and parole, assign personnel to this unit.

7. Explain how the proposed project activities will address the stated problem.

The proposed activities of this project will reduce the threat that sex offenders pose to the community. This will be accomplished by insuring that sex offenders comply with the registration law for the entire period of time they are subject to its requirements. This project will assist the probation and parole officers in insuring that sex offenders abide by the conditions of their release. Offenders that do not will have their probation or parole revoked and they will be sent to prison. Through the various activities described in this program narrative, the detectives assigned to the Sex Offender Apprehension Project will "put some teeth" in Texas' Sex Offender Registration Program. As a result, some sex offenders will be deterred from committing other sex crimes, others will be arrested for other criminal violations and returned to prison and for those that will continue to commit new sex crimes, law enforcement will have current information on them which will aid in their apprehension.

8. List the measures that the project will use to determine the effectiveness of the project and its impact on the stated problem.

The measures for this project are as follows:

a. Registered sex offenders checked for compliance.
b. Registered sex offenders prosecuted for violating registration law.
c. Registered sex offenders prosecuted for violation of their probation or parole conditions.
d. Registered sex offenders prosecuted for new sex crimes.
e. Non-registered offenders interviewed.
f. Non-registered offenders prosecuted for violation of their probation or parole conditions.
g. Non-registered offenders arrested for new sex crimes.
h. Investigations conducted on possible or known sex offenders.
i. Number of surveillances conducted.

9. Provide all available current information for each of the effectiveness measures listed above.

There is no current information on the effectiveness of the measures listed above as this is a new project. The first year of the project will establish a baseline for future effectiveness measures

10. What are the project's goals for each effectiveness measure by the end of the grant year?

The goals for this project are as follows:

a.	Registered sex offenders checked for compliance.	1000
b.	Registered sex offenders prosecuted for violating registration law.	200
c.	Registered sex offenders prosecuted for violation of their probation or parole conditions.	100
d.	Registered sex offenders prosecuted for new sex crimes.	50
e.	Non-registered offenders interviewed.	200
f.	Non-registered offenders prosecuted for violation of their probation or parole conditions.	50
g.	Non-registered offenders arrested for new sex crimes.	25
h.	Investigations conducted on possible or known sex offenders.	250
i.	Number of surveillances conducted.	100

Criteria for Law Enforcement and Child Protective Services Investigative Response

	CRISIS CASE - ACUTE	CRISIS CASE - CHRONIC	DELAYED CASE
VICTIM	Emotions are high. Cooperation is high, depending on if the outcry was purposeful or accidental. Safety issues are prevalent and are more likely an issue.	Emotions are high. Cooperation is high. Safety issues may still be prevalent.	May have talked to multiple people, such as family, therapist, and the perpetrator. May be in various stages of recantation. May have experienced the non-offending parent's response and may be dealing with those dynamics.
SUSPECT	Not aware of allegation. Least likely to polarize, create an alibi, ask for an attorney, hide or destroy evidence. Highest probability for confession. Most able to be manipulated.	Not aware of allegation. Still least likely to polarize, create an alibi, ask for an attorney, hide or destroy evidence. High probability for a confession.	Aware of allegation. Has had time to polarize, create an alibi, ask for an attorney, hide or destroy evidence, pressure the victim to recant, manipulate the non-offending parent. Lower probability for confession.
NON-OFFENDING PARENT	Emotions are high. Cooperation is high to bring victim in for interview, statement, consent to search, and release information. Support for victim is optimal.	Emotions are high. Cooperation is high. Support for victim is optimal.	Has worked through numerous phases (i.e., anger at victim and suspect, rationalizing the suspect's behavior). May have misconceptions of the criminal justice system that have to be dealt with to gain cooperation.
WITNESS	Cooperation is high.	Cooperative.	May cooperate, but statements will not be as detailed.
VICTIM INTERVIEW	Highest probability for details to be given that can be corroborated. Iceberg Effect may be higher. Safety issues need to be considered by the interviewer. Essential to determine who was the initial outcry witness.	High probability for details to be given that can be corroborated. Iceberg Effect may be high. Safety issues need to be considered by the interviewer.	Defense mechanisms are in progress. Details may not be as clear. Safety issues need to be taken into consideration by the interviewer.
MEDICAL EVIDENCE	Highest probability for direct medical evidence (i.e., sperm, hair).	High probability for non-direct but supportive evidence (i.e., vaginal tear).	No direct evidence, but may have supporting evidence.
CRIME SCENE EVIDENCE	Highest probability that there is a crime scene and that evidence can be collected, such as panties, sheets, porn, etc. Highest probability to corroborate the victim's statement (i.e., the Vaseline is kept under the bed).	There may still be a crime scene, but it is more likely that it has been altered. May still be able to collect evidence, such as panties or sheets. More difficult to corroborate victim's statement as to location of items (i.e., the Vaseline is kept under the bed).	High probability that crime scene has been altered or no longer exists (clothing washed, furniture moved).

Detective Mike Johnson
Plano Police Department

Corroborative Points Investigative Technique

The **Corroborative Points Investigative Technique** is not a departure from, but an addition to, the traditional *Who, What, When, Where*, and *Why* of an investigation. It seeks to place the investigator inside the mind set of prosecutors who are required to bolster (corroborate) every statement, element, and point made in the case.

Corroborative Points have different "values." Some, such as a detailed confession, can stand alone. While others, such as theme pornography, may not prove an offense, they are still supportive of the allegation. Better yet, *Constellations of Corroborative Points*, though individually circumstantial, can – and have – the ability to prove cases.

An investigator's effectiveness is rooted in his ability to know and utilize the advantages and disadvantages of these techniques and, with consideration of certain *Windows of Opportunity*, administer them in a **timely** investigative manner. Multidisciplinary skills-based training in our communities should focus instruction in these individual areas.

Corroborative Points should be viewed the same way one views a carpenter and his tools: the more tools a carpenter has mastered, the more ornate the project.

Below is a list of the more common areas of corroboration.

Corroborative Points

- Confession
- Crime scene
- Medical evidence
- Independent other victims
- Dependent other victims
- Criminal history
- Pre-text phone calls
- Search warrants
- Sex offender typology
- Private databases
- Canvassing
- Trash runs/abandoned property
- Social history
- Pornography
- Background check
- Other sexual partners
- Photo documentation
- Collateral witnesses
- Polygraph

Detective Mike Johnson
Plano Police Department

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The investigative windows of opportunity

by Detective Mike Johnson
Plano Police Department/Collin County CAC
Plano, Texas

The single most important advantage a Multidisciplinary Team or lone investigator has in any type of child abuse investigation is the investigative "window of opportunity."

Simply defined, these are the precious minutes which occur either during or immediately after the initial outcry. This is the optimum time to conduct investigative functions and to glean the most detailed information. For every hour that goes by after the initial outcry without investigative intervention, information critical to case evaluation is lost. As days pass, critical information may be lost forever.

Each child abuse case presents six "windows of opportunity:"

Forensic interview of child abuse victims

Children typically outcry for a multitude of reasons, which can be characterized in two areas: the purposeful outcry and the accidental outcry. The purposeful outcry usually occurs when the child, for the protection of herself or a sibling, tells someone that the abuse is occurring. This outcry is frequently accompanied by a heightened emotional state in the child, who may state that she is "tired" of the abuse. Conversely, the accidental outcry occurs when the child makes offhand statements or the abuse is observed by a parent, sibling, or another person. Although the child isn't prepared to make the outcry, the resulting crisis has the same accompanying heightened emotional state, which allows investigators to obtain more detailed information.

The window of opportunity for conducting this interview is immediately after the child makes the outcry. In other words, if the outcry is made in the school setting at 10 a.m., the window of opportunity begins at 10:01 a.m. With each minute that goes by without intervention, several factors begin to occur, none of which are helpful to the investigation:

1. *The process of multiple interviews.* The child may be consoled by counselors, nurses, or school personnel who may not be trained in the importance of this information or in the area of forensic interviewing. All of these "unofficial" interviews can cloud the pure information that should be obtained from the child during the forensic interview.
2. *The family's access to the child.* School personnel may notify the child's parents—the non-offending one and the potential perpetrator—who will then have access to the child. Additionally, siblings in the household have been known to be unsupportive of child abuse victims due to the emotional upheaval that the child's outcry causes in the home.
3. *An "alienation of affection" may set in.* The child comes to understand very quickly that her outcry has caused a considerable amount of emotional reaction from those around her.

Interview of the Non-Offending Parent

Interviews with the non-offending parent can yield incredible amounts of detailed information that can be corroborated by investigators. The investigative window for this interview begins with the first person who speaks with the non-offending parent about the abuse allegations. The professionals who do this, typically from law enforcement and child protective services, are in a position to observe the non-offending parent's first reaction (including surprise or non-surprise) and make a critical assessment decisions. Every day that goes by after the outcry increases the chance that the non-offending parent will be made aware of the allegations by the child or school officials, thus depriving the investigator of the opportunity to be present during the parent's initial reaction.

The emotions of the non-offending parent during these early stages can be used to accomplish numerous investigative functions. It is during this time that the non-offending parent is often most cooperative, providing detailed information about the incident and surrounding circumstances or cooperating

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search warrant. Investigators who miss this window of opportunity risk having the non-offending parent contacted by the perpetrator or defense counsel, both of whom will always suggest non-cooperation with investigators.

Investigators often fail to realize that the strength of the victim is tied directly to the strength of the mother, who is frequently the non-offending parent. To demonstrate this, I often ask this question: "If you had to choose one type of person on whom to spend all of your clinical treatment budget, would you choose the victim, the non-offending parent (mother) or the sibling, especially if your goal is finding resolution in the criminal justice process?" The answer I usually get is the "victim," but that's not accurate. If you don't support the non-offending parent's issues, she won't bring the victim in for treatment or encourage the victim's progress.

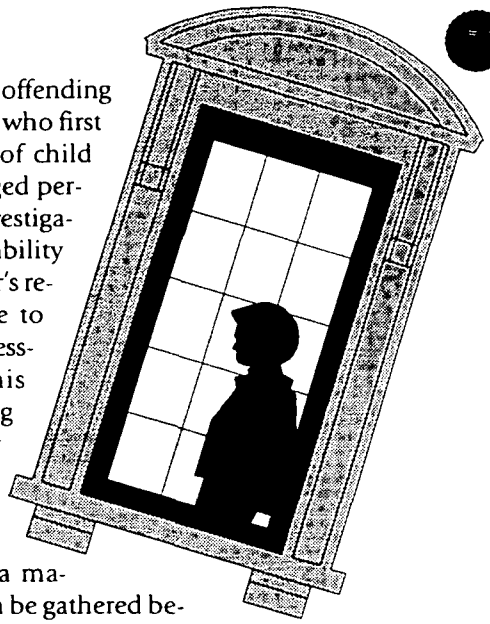
The non-offending parent is often dealing with issues such as humiliation, anger, abandonment, mistrust, loss of affection, jealousy, and questions about her parenting skills. She may be in need of job training, welfare, emotional support, etc. Despite these factors, we typically direct all of our resources toward the victim and leave the mother with no one to turn to except the perpetrator, who may be actively trying to win her back. If she reunites with the perpetrator, then you have lost your victim because the perpetrator will work to persuade the mother to be uncooperative and pressure the victim to recant. If we strengthen the non-offending mother, she will make sure the child's needs are met. Therefore, the best answer to the above question is that treatment should be provided to all three: the victim, the non-offending mother, and the siblings.

Interview of Collateral witnesses

As with the non-offending parent and the perpetrator, the investigators who ask the first questions have the window of opportunity with collateral witnesses. This is especially critical because the information provided by many of these witnesses can be tainted by the perpetrator, defense counsel, non-offending parent, or others. The witnesses may align themselves with the non-offending parent, the perpetrator or the child, thereby making their information less objective and more subjective.

Investigators are continually challenged to identify and interview collateral witnesses. This is one of the weakest areas in all child abuse investigations. Defense attorneys know this and frequently try to use it to their client's advantage by charging that the investigators were not acting as objective fact-finders but as subjective believers who spoke only with witnesses they believed would complement the state's case.

Character witnesses suggested to investigators by defense attorneys should be interviewed or at least a statement attempted. If investigators refuse to interview a character witness, defense counsel is in an excellent position to portray the investigative process as biased against his client. This area is referred to as "fertile ground" for impeaching the credibility of the investigator and the investigation.



Perpetrator

As with the non-offending parent, investigators who first broach the subject of child abuse with the alleged perpetrator have the investigative advantage. The ability to see the perpetrator's reaction is invaluable to the investigator's assessment. However, this raises an interesting dilemma for many investigators regarding when the interview should take place. Should a majority of information be gathered before approaching the perpetrator, or should the investigator interview him in the earliest stages? In my experience, after the forensic interview of the child is completed and the non-offending parent and witnesses have been interviewed, the next most critical function is the interview with the perpetrator. Ideally, especially with cases involving in-home abuse, this should be accomplished within 1-3 hours after the forensic interview of the child and the interview of the non-offending parent.

Most perpetrators could be described as manipulative, controlling, and narcissistic. A long delay in interviewing the perpetrator gives him time to work on an alibi or an excuse as to why he could not have committed the offense. It also allows him a chance to access those involved in the outcry (including the victim, non-offending parent, or school officials) to determine how much of the allegation was revealed. It has been my experience that perpetrators will only confess to what they think the investigators already know. In a related issue, child protective service workers and law enforcement need to have a mutual agreement about what details of the allegation should and should not be discussed during interviews conducted with the perpetrator by CPS workers.

Finally, a delayed interview gives the perpetrator time to contact a defense counsel. Nancy Lamb, an attorney in Elizabeth City, North Carolina, and I present training sessions on "Combating Defense Strategies in Child Sexual Abuse Cases." Ms. Lamb's research found that on numerous occasions, defense counsel stated that an accused perpetrator should never speak to investigators. According to Ms. Lamb, they specifically recognize that any statement made by the perpetrator, including a confession, is always detrimental to the defense of their client.

Medical evaluation

The investigative window of opportunity for performing the forensic medical examination of a sexual assault victim is immediately after the perpetrator disengages from the assault

the child. There is a recognized 72-hour window for conducting this medical evaluation. However, the initial hours after the assault provide the medical forensic evaluator the best opportunity for identifying marks, bruises, or tears, which immediately begin to heal, as well as for collecting other biological evidence such as semen, saliva and lubricants, which immediately begin to be absorbed, wiped or transferred away.

Crime scene evaluation

The window of opportunity for conducting the investigative function of evaluating a crime scene is immediately after the assault, before the perpetrator or others have the opportunity to disturb it. For every minute that goes by, the crime scene is altered. Whether investigators are involved in the case immediately after the incident or several months later, every attempt should be made to use as many crime scene identification techniques as possible, especially photodocumentation.

A few years ago, we had a case in which a 13-year-old boy made an accidental outcry at school that his father was sexually abusing him. When we began interviewing him, we discovered that the last incident had occurred that morning before the father left for work. However, the father had left in a hurry and forgotten his underwear beneath the boy's bed and a jar of petroleum jelly on the nightstand. Realizing that the crime scene was still intact, we rushed over to the house and received permission to search from the mother, who was extremely cooperative. As we had hoped, the items were exactly where the boy said they would be. Without these pieces of evidence, our entire case would have been different.

Recognizing the windows of opportunity is a critical step, but it is useless if procedural issues prevent investigators from accessing them.

Gaining better access to the windows

Recognizing the windows of opportunity is a critical step, but it is useless if procedural issues prevent investigators from accessing them.

Some of the most common errors that violate the investigative window of opportunity occur at the earliest stages of outcry, typically at a school by officials who delay in recognizing the abuse and reporting it to appropriate authorities. Instead, they elect to notify the non-offending parent and/or the perpetrator. Therefore, it is crucial to establish appropriate procedures and protocols and ensure that all school officials understand them. In addition, law enforcement needs to ensure that a detective is promptly notified about each call and that the detective responds immediately, instead of waiting until the next work day. Other early violations include the lack of knowledge of child abuse phenomena and hesitation to get involved with a case because one member of the team is not available to respond immediately.

Everyone involved in a case (including the multidisciplinary team, child advocacy center, and individual investigators) needs to review cases for procedural problems that may be causing coordination delays in the ability of investigators to respond immediately. The suggested evaluation technique for the quality of a case is to review:

1. *The exact time the child made the outcry;*
2. *Who spoke with the child before CPS or law enforcement became involved;*
3. *When the perpetrator was first notified;*
4. *When the non-offending parent was notified;*
5. *Identification of collateral witnesses and how long it took before they were contacted;*
6. *The last occurrence of the offense; and*
7. *How long it took before the crime scene was evaluated.*

Reviewing these situations will better illuminate the violations of the investigative window of opportunity. It also begins the discussion for finding the procedures to place investigators in the best possible position to access the detailed facts and information needed to protect the children in the community.

We also need to have a cooperative response system for child protective services and law enforcement. Law enforcement operates on a **call for service** system, which means if you call 911, a police officer will respond day or night. However, child protective services operates on a **priority system** in which a caller contacts a hotline and the call-taker evaluates the problem. If it meets certain criteria, a priority is placed on the call and the information is subsequently sent to the local CPS jurisdiction for evaluation by a supervisor, who will assign a caseworker to investigate. These two systems are inherently incompatible. Both address their agencies' policies and procedures, but neither gives paramount attention to the needs of the child. Specific issues, such as risk assessment by child protective services, medical evaluation, crime scene evaluation, and interviews of important parties should take precedence. No system should violate the investigative windows of opportunity by forcing the investigators to delay their response, thus losing access to detailed information. The cases in which we have been most successful were identified and investigated within 6-8 hours, from the initial outcry to the major parts of the investigative conclusion.

Simply stated, the protection of a child hinges on the intervenor's ability to acknowledge that children disclose for a multitude of reasons, and the child protection team must be ready to mobilize on behalf of the child when the outcry is first made. Windows of opportunity are not contingent upon caseloads, schedules, or notification procedures. When the child is ready to be protected, the child protection team must be ready to respond.

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FORENSIC INTERVIEWING OF CHILD VICTIMS

August 3, 1999
Kimberly L. Poyer MSW, LCSW
Child Interview Specialist
United States Attorney's Office
Washington, DC
202-353-8070

I. **Creating a child focused practice**

II. **Forensic interviewing of children**
- Rapport building
- Developmental assessment
- Bolstering to reduce suggestibility
- Assessment of competency
- Eliciting information
- Closure

III. **The use of different media**
- Anatomically detailed dolls
- Anatomically detailed drawings
- Figure drawing

IV. **Problem interviews**
- Recantation
- Fantastical elements in disclosures
- Very young children

CREATING CHILD FRIENDLY PRACTICES

When working with children

-Always introduce yourself to the child first
-Let the child know what you do in terms that they can understand
-Provide age-appropriate information to the child helps them understand the investigation/prosecution process
-Find out what the child is interested in and talk about it
-Never place your desk between you and the child
-Get down on the child's level (Literally)
-Explain to the child what is and isn't confidential
-Try to interview children alone (away from caretakers)
-Let children know who you are going to talk to
-Encourage the child to speak in their own words
-Keep some crayons and a few toys in your office
-Make some business cards for the kids
-Emphasize safety to the child (if you can)
-Reassure the child that they are not to blame (it helps to ask them what they think is going on)
-Never raise your voice
-Don't make promises about things you have no control over or can't keep

When working on the case

-Involve advocates early in child cases
-Clarify all the roles of the people who will be working with the child
-Get expert feedback on child cases
-Get referrals for mental health counseling as soon as possible
-Assist in meeting emergency financial needs for medical or mental health treatment
-Assist in meeting other emergency financial needs such as shelter, food, clothing, or transportation
-Determine the child's schedule and work with it
-Intervene with the school and other agencies the child may have contact with if they experience threats, intimidation, or other forms of harassment by an offender or others
-Report threats or other acts of intimidation to the proper authorities
-Coordinate with local multi-disciplinary teams to effectively manage a case that involves multiple agencies
-Develop contacts with experts in the field of child abuse
-Develop contacts with your nearest Children's hospital
-Develop contacts with members of local agencies
-Ensure that sexual assault exams are conducted as well as testing for sexually-transmitted diseases

FORENSIC INTERVIEWING OF CHILD VICTIMS

INTERVIEWER

Whoever is most qualified to talk with a child
Degrees are less important than an ability to make a child feel comfortable and able to disclose
Have your game plan and logistics prepared ahead of time

LOCATION

Interview rooms that are child friendly
A quiet place away from the confusion
Child sized furniture if available
Don't interview in an office where you sit behind the desk
Don't interview in a place where there is a chance for interruption or a lot of chaos
Try to interview the child at a time that coincides with their "biological clock"
Put your pager on vibrate
Don't answer the phone during the interview

RECORDING

Sound quality has always been the #1 technical problem
With video, always have a secondary audio backup
Pretest all equipment
Trained interviewers should be used if you record
Mistakes last forever
Every word, gesture, movement can be analyzed
Not a substitute for live testimony
Rarely admissible in court

HOW MANY IN THE INTERVIEW

Multiple people overwhelm and intimidate a child
If it's hard to say to one stranger, imagine how they feel if there several are in there!!
If you have another person in the room, introduce them in the beginning and keep them quiet until the end of the interview
Your assistant can ask a **few** questions to cover **only** some thing you may have missed

EQUIPMENT

Two comfortable chairs that are appropriate for child's age not yours
Small table
Separate monitor room where other parties can observe
Video recorder and back-up audio (preferably in the observation room)
Date and time generator on video equipment
Clock

PROPS

Dolls??Toys??Drawings??Doll House??Anatomical drawings??
Rule #1 don't make the room look like FAO Schwartz
Your props will depend on your game plan

RELIABLE CHILD-FOCUSED INTERVIEWING

The most important element to consider when interviewing children is their developmental status. Children are not a homogeneous group and within similar developmental parameters they can vary in their language, cognitive, social and memory abilities as well as emotional maturity. Therefore, the interviewer must assess the child and mold the interview to the child's stage of development. The use of developmentally sensitive techniques is essential when you want to obtain reliable information from children. The forensic interviewing protocol should incorporate a state-of-the-art research based methodology. A forensic interview allows a person to gather factual information from a child. The interview is divided into several distinct phases through which an interviewer is expected to move in a sequential and organized manner.

RAPPORT BUILDING

*Rapport building is a crucial phase of the interview because it lays the foundation for what is to follow
*Rapport building facilitates an emotional connection between the child and the interviewer
*Developmentally appropriate introductions should be made as well as discussing taping or viewing considerations
*Discuss neutral nonthreatening topics such as school, social contacts, and recreational interests
*Use open-ended questions to elicit information
*Assess child's level of cooperation, body language, and affect

DEVELOPMENTAL ASSESSMENT

*Evaluate child's language and speech
*Adapt your language and vocabulary to fit the child's
*Determine if the child understands prepositions and time
*Body part identification

ASSESSMENT OF COMPETENCY

*This assessment should be conducted for children 8 years old or younger, developmentally disabled victims, or in specific cases where a child's credibility has been questioned

COMPETENCY

Does the child understand the difference between truth and fantasy and appreciate the obligation to tell the truth

Does the child have sufficient "mental capacity" at the time of the incident to observe and record accurate impressions

Does the child have sufficient memory to retain an independent recollection of the observations

Can the child communicate this memory and understand simple questions about the incident

BOLSTERING TO REDUCE SUGGESTIBILITY

*This should be done with all children
*Present guidelines to help the child understand that they are not allowed to guess or approximate their answers
*Explain that some questions may be asked twice but that the interviewer is not looking for a different answer
*All people can be suggestible if questioned inappropriately, coercively, or in a suggestive manner

ELICITING INFORMATION

*Information should be gathered by questioning with the most open-ended techniques that are developmentally possible for the child
*A questioning continuum should be followed when eliciting information
*The types of questions used and information needed are tailored to each individual interview

AGE-INAPPROPRIATE LANGUAGE

Long, complex question
When you were with your cousin in the park that has the lake your mom took you to, what did he do to you?
Passive voice
Were you hurt by him?
Confusing pronouns
What did he do to her?
Double negatives
Didn't mom tell you not to go there?
Complex verbs
It may have been...
Hypothetical
If you want to stop, then tell me.

DEVELOPMENTALLY SENSITIVE LANGUAGE

Several short questions
Where did mom take you that day? What room were you in? What happened at the park?
Active voice
Did she touch you?
Clear use of names
What did Tony do with Kate?
Single negatives
Did Sue tell you not to go there?
Short words
Point to...
Simple verbs
Was it...
Direct
Are you tired? Do you want a break?

CLOSURE

*Allow the child to ask you questions
*If a child has become upset during the interview, this is the time to help them regain their composure
*Give the child an opportunity to express questions, worries, or concerns about the interview
*Thank the child for participating in the interview process rather than for providing a disclosure of abuse
*Dispel any misperceptions that may have arisen during the interview
*Give the child permission to return at a later date if they remember more information

QUESTIONING TYPOLOGY

OPEN-ENDED Type of Question	Definition	MORE CONFIDENCE Example
General	Open-ended inquiry about the child's well-being. It does not assume an event or experience.	How can I help you? How are you feeling today? Is there something I can help you with?
Invitational	Open-ended inquiry that assumes there may be an event or experience.	Can you tell me everything you remember about the park? I heard something may have happened to you, Tell me about it as best you can.
Focused	A question that focuses on a particular topic, place, or person, but refrains from providing information.	Tell me about your dad. Tell me about the daycare.
Follow-up strategies	Strategies that encourage a narrative.	
Facilitative cue	Interviewer gesture or utterance aimed	Uh-huh(affirmative). Anything else? Tell me about that.
Specific question	Follow-up inquiry to gather details about	Where did it happen? What were you wearing? Were any clothes taken off?
Multiple choice	A question that presents a number of alternative responses from which to choose.	Did it happen one time? Two times? Or lots of times? Did it happen in the daytime, night or both?
Suggestive	A question that relies on information not disclosed in the interview.	Do you remember a camera? Did John say anything about telling or not telling?

Direct	A direct inquiry into whether a person committed a specific act.	Did John hurt your pee-pee? Was Jimmy the one who poked you in the butt?
Repeated	Asking the same question two or more times.	Did anything happen to you penis? Do you remember if anything happened to your penis?
Leading	A question that clearly indicates the answer desired.	Isn't it true that Bob put his penis in your mouth? Chester did it, didn't he?
Misleading	A question that assumes a fact is not true, which the child is implicitly or explicitly asked to confirm.	What color hat was Suzy wearing (when she wasn't)? Show me where the doctor touched you (when the doctor didn't touch).
Coercion	Use of inappropriate inducements to get cooperation or information.	If you tell me what daddy did we can go for ice cream. you cannot leave the room unless you tell me what daddy did.

CLOSE-ENDED

LESS CONFIDENCE

Comforter

The doll can be used to provide tactile comfort to the child.

1. Dolls are presented clothed.
2. Dolls are given to the child to hold and freely manipulate.
3. Interviewer can encourage the child to use the doll as support.
4. Attention is not focused on doll's sexual body parts.
5. Interviewer does not initiate or suggest removal of doll clothing.
6. May occur at the beginning/end of the interview.

Icebreaker

The doll can serve as a tool to start communication on the topic of sexuality by focusing the child's attention in a non-leading or threatening manner about sexual issues and sexual body parts.

1. Dolls are used to introduce the topic of sexual body parts, sexual touching, or sexual activity when the topic has not yet been introduced in the context of the interview.
2. The interviewer can make a specific reference about the sexual body parts of the doll or provide an opportunity for the child to undress the doll.

Anatomical Model

The doll can serve as anatomical models for three areas of assessment.

Sexual Knowledge Assessment including child's labels for body parts, understanding of bodily functions, and knowledge of the mechanics of sexual intercourse.

General Knowledge of Sexual Abuse including appropriate and inappropriate touching

Personal Sexual Exposure/Experience including direct questions about possible abusive experiences

1. The doll can be presented dressed or undressed, frequently the doll has been undressed by the child during an earlier part of the assessment.

Demonstration Aid

The doll can serve as a prop to facilitate, clarify, or corroborate the child's disclosure. They can enable a child to "show" rather than "tell" what happened, especially when limited verbal skills or emotional issues interfere with the child's verbal disclosure. The doll can clarify the child's statement after a disclosure of abuse has been made.

1. The interviewer directs the child to use the doll to demonstrate what the child has experienced or observed. The child will be pointing to parts or demonstrating behaviors.
2. The child's actual experience or observation, not their knowledge, is the focus.

Diagnostic Screen/Memory Stimulus

The doll can be used to screen for precocious sexual interest or knowledge and for unusual reactions to parts of the body or sexual stimuli. The dolls may also be useful for triggering the child's memory of possible abusive events.

1. The interviewer provides an opportunity for the child to freely explore and manipulate the dolls while the interviewer observes the child's play, reaction, and remarks.
2. Graphic sexual behavior, unusual emotional responses and suspicious statements by the child are noted and used to guide the focus of the interview with follow-up questions.

Problem Interview Techniques with Anatomical Dolls

General Errors

1. Naming the dolls.
2. Introducing fantasy play or conjecture.
3. Probing or manipulating the doll's sexual body parts.
4. Modeling sexual behavior with dolls.
5. Allowing child to free play.

Specific Errors

Comforter

1. Presenting the dolls unclothed.

Icebreaker

1. Implying sexual abuse prior to a disclosure.

Anatomical Model

1. Failing to accept or use the child's terms for sexual body parts.
2. Being insensitive to child's distress at exposure of doll genitals.

Demonstration Aid

1. Failing to attempt to elicit verbal account first.

2. Making an assumption of nudity.
3. Directing child's demonstration of sexual behaviors before disclosure.
4. Failing to notice child describing doll, not self or perpetrator.

Diagnostic Screen/Memory Stimulus

1. Should not be used in a forensic context.
2. Over-interpreting child's behavior or failing to follow up with clarifying questions.

Everson and Boat (1994)

Understanding Implausible Disclosures and Recantation: A Developmental Perspective

1. Fantastic elements in children's accounts of sexual abuse
    1. Evaluating allegations that contain bizarre, implausible, or fantastic accounts are some of the more difficult forensic and clinical tasks confronting the field today
    2. Recantation is the number one reason for judging a child's report to be false
    3. Improbable elements in a child's disclosure is the second most frequent reason cited for judging a child's report as false
2. Dalenberg (1996) has published the only study of the incidence of fantastic elements in children's disclosures of sexual abuse
    1. Sample size: 644 children aged 3-17 who made disclosures of sexual abuse during videotaped forensic interviews
    2. Gold standard cases (50%)
        1. Perpetrator confession
        2. Conclusive medical evidence of sexual abuse
    3. Questionable cases (50%)
        1. Corroborating evidence for abuse is lacking
    4. Fantastic elements definition: highly implausible or impossible events or gross exaggerations of a plausible events
        1. Fantastic elements: 12 children (2%)
            (1) n=10 (7%) occurred among 3-9 year-olds in the gold standard subgroup made fantastic allegations
                (1) among children who experienced severe abuse (penetration, use of force or threats, repeated abuse) the rate jumps to 15%
            (2) n=2 (1.5%) Occurred among children in the questionable sample
3. Everson (1997) published an article that contributes to the objective analysis of child allegations of abuse by offering 24 possible explanations for such statements
    1. Interaction of ***abusive event*** with ***child characteristics***
        1. Reflection of reality
            (1) Accurate description of reality
        2. Impact of perpetrator manipulation
            (1) Deception to confuse or discredit child
            (2) Drug induced distortions
        3. Trauma or stress-induced process
            (1) Threat incorporation
            (2) Trauma genic misperceptions or memory distortion
        4. Influence of coping mechanism
            (1) Mastery fantasy
            (2) Expression of affect through metaphor or hyperbole
            (3) Misreports by child to deflect blame or deny victimization
        5. Impact of cognitive maturity
            (1) misperceptions or miscommunication due to developmental limitations

(2) Distortion due to attempts to assimilate novel events into existing schemata

2. Interaction of the ***assessment process*** with ***child characteristics***
   1. System response errors
      (1) Distortion due to successive approximations
      (2) Miscommunication due to interviewer error
   2. Influence of interview process
      (1) Impact of leading or suggestive questioning techniques
      (2) Distortion induced by interviewer props
      (3) Confabulation
      (4) Distortion due to interview fatigue
   3. Deception process
      (1) Exaggeration for attention or approval
      (2) Snowballing of an innocent lie
      (3) Deliberate exaggeration or lie
      (4) Fantasy lying
3. Interaction of ***extrinsic influences*** with ***child characteristics***
   1. External source confusion
      (1) Cultural influences
      (2) Cross-tainting
   2. Internal source confusion
      (1) Dream incorporation
      (2) Delusions due to psychotic process

4. Recantation issues
   1. Evaluating recantation as part of a disclosure process

5. Summit (1983) published an article *The Child Sexual Abuse Accommodation Syndrome*
   1. A clinical description of a set of characteristics that were similar in child sexual abuse cases
      1. Secrecy
      2. Helplessness
      3. Entrapment and accommodation
      4. Delayed unconvincing disclosure
      5. Retraction

6. Research studies investigating recantation
   1. Sorenson and Snow (1991)
      1. N=116 cases
         (1) Gold standard
            (1) 80% offender confession
            (2) 20% criminal conviction or compelling medical evidence

      2. Type of disclosures
         (1) 26 % intentional (older children more likely to use this type of disclosure)

(2) 74 % Unintentional/accidental (younger children)

3. Pattern of response to assessment
   (1) 72 % of children initially denied sexual abuse
   (2) 96% disclosed over several interviews
   (3) 22% of the children recanted
   (4) 94% of the recanters reaffirmed

2. Jones and McGraw (1987)
   1. 8% of the children in this study recanted
3. Gonzalez (1993)
   1. 27% of the children recanted
4. Bradley and Wood (1996)
   1. 3% of the children recanted

7. Why Recant
   1. False allegations
      1. 2-4% Crewdson (1998)
      2. Secrecy
      3. Denial
      4. Lack of support
      5. Pressure to recant
      6. Child and family interactions with the system
      7. Intervening events

INTERVIEWING SEXUALLY ABUSED CHILDREN
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Bruises and Fractures: Accidental or Inflicted

Donna Persaud M.D.
UTSouthwestern

Bruises

- Trauma
  - Accident
  - Inflicted
- Other
  - Medical condition
  - Cultural practices

Bruise: Accidental

- Consistent with developmental age of the child.
- Young infants 0-6 months, rarely have bruises
- 9-10months-crawl
- 11-12 months-walk
- 2years-RUN

Bruises: Accidental

- Most falls result in single bruises
- Multiple bruises, involving multiple boy area, require multiple impacts

Bruises Accidental

- "wear and tear" injuries on bumped surfaces.
- Involve frontal place (forehead, nose, chin, palm, elbows, shins)

Bruises: Common Accidental

- Multiple on shins
- "golf ball" to forehead with "black eye appearance"
- Chin split
- Elbows
- Single to few midline back circular

Bruises: Conditions Mistaken

- Mongolian spots
- Bleeding disorder
- HSP
- Birthmarks
- Skin disease
- Impetigo
- Ringworm

*see table 2 *see

Bruises: Inflicted

- Surface marks that betray the weapon used
- Restrain: marks
- Multiple bruises in inaccessible places such as neck, ears, inner thighs, buttocks
- Recognizable patterns such as slap marks on cheeks, adult bite marks

Bruises: Dating

- Charts are imprecise and general guidelines only
- Based on data from adults
- many factors influence the appearance of bruises besides time

Bruises: Dating

- Langlois, Gresham 1991 studied 369 photos where age and origin of injury known.
- Findings:Red, blue, purple, black-not helpful
- Different colors in bruises of same ages
- Yellow consistently > 18 hours

Bruises: Dating

- Stehenson, Bialas 1996
- Studied: 23 white with 35 non -inflicted bruises (1.5-14 days), ages 8m-13 yrs
- Photos observed by 1 , blind to true age
- Recorded colors:
  - fresh<48hours, interm 48-7d, old >7d.

Bruises: Dating

- Accuracy of specific colors
  - Purple, grey, brown-equally if <7d or >7d
  - Blue most-<7d
  - Red-all <7d
  - Yellow, green-all >1d

* Stephenson & Bialas 1996

Bruises: Dating

- Bruises can change color at different rates
- Several Colors in 1 bruise
- Injury >2. Won't be seen as fresh
- 55% correctly estimated
- PE probably better than photos
- red means < 7d
- Yellow, green: >1-2d

Fractures

- Accidental
- Inflicted
- Medical Conditions

Fractures

- Age is critical, single most predictive factor
- Big differences between young infants, early ambulators, verbal children

Fractures: Accidental

- Often single injuries
- Time to present for medical care consistent with expectations based on natural history of the identified injury
- History of symptoms c/w injury
- Corroborating information

Fracture Assessment: Skeletal Survey

- Highest yield first year of life
- Do freely first 2 years of life
- Case selection up to age 5
- Value of "follow up" skeletal survey:
  - identify prior present but unappreciated fxs in healing phase
  - improve dating information
  - document absence of new fxs in safe environment

Fracture Assessment: Other tests

- In Selected Circumstances
  - Bone Scan
  - CAT scan
  - MRI
  - Bone scan with SPECT
  - Ultrasound

Fracture Assessment: Caveats

- Radiologist with experience in pediatric imaging is key
- Quality xrays as important as trained expert
- Early rib fractures may not show up on initial films

Fractures: Accidental

- Toddler's fracture
  - Early walker
  - Distal to mid tibia, spiral
  - Often minumal or no trauma history
  - Caused by low force twisting-child who's foot gets caught and he\she pivots to ground

Fracture: Accidental

- Linear Parietal Non-depressed skull fracture
- Caused by straight low force on to hard surface
- Typical history "fell, seemed fine, days later soft swelling on head"

Fractures: Inflicted

- Young child, no trauma history, otherwise healthy and found with multiple fractures different stages of healing

Fractures: Inflicted

- Posterior fractures
- Metaphyseal (chip, corner, bucket handle)
- Long bone fracture in young infant without a presenting trauma history

Fracture: Posterior Rib

- Highly specific for abuse
- Mechanism is encircling forceful compression of chest
- Not shown to happen in CPR or chest physical therapy

Fracture: Metaphyseal

- Well documented to be highly specific for abuse
- Caused by flinging, jerking motions
- Not shown to be caused by falling

Fractures: Dilemma

- Single shaft fracture in an ambulating pre to early verbal child and "some kind of trauma history"
- This assessment is often complex.
- Fracture type e.g -spiral, oblique or transverse often not particularly useful
- Context of injury, witness observations, physical environment assessment helpful

Fracture Dating

Stage	Peak	Range
Periosteal new Bone	10-14d	4-21d
Soft Callus	14-21d	10-21d
Hard Callus	21-42D	14-90d

Fractures: Conditions Mistaken

- Normal variants
- Obstetric trauma
- Infection
- Bone Disease:Rickets,OI
- Tumor

Fractures: When to R\O OI

- OI= gene mutations in type 1 collagen, clinical and radiological correlates
- 4 Subtypes, type II lethal,
- Increased interest in testing
- 10-15 % with non-lethal OI:missed

Fractures: OI When to Test

- Steiner, Pepin, Byers: J peds 1996
- Reviewed 48 children who had "test for OI"=cultured skin fibroblasts & collagen analysis
- Findings:NI study does not rule out OI
  - fracture pattern not specific for OI, children with OI can be abused, unclear how often OI misdx as abuse.

Fractures: Recommendations for OI Testing

- IF diagnosis uncertain after careful clinical and radiologic evaluation AND no pathognomonic signs of abuse

OI Testing: Not cheap!

- Perform skin biopsy
- Culture fibroblasts
- Transport to special lab
- Collagen analysis

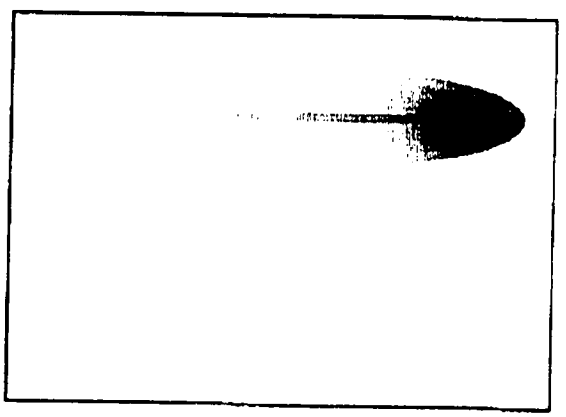

TABLE 1 Injury classifications

Those injuries that, almost regardless of the context of occurrence, have a high likelihood of being due to abuse and shoul always be reported

Intraoral
- Bruised or lacerated sublingual and maxillary frenums in babies
- Bruises or lacerations at the commissures

Bruises
- Recognizable shapes, such as a whip, belt, fist, fingers, buckle, rope, adult teen, slap marks (cheek)
- Circumferential injuries of the wrists, arms, legs, and neck
- Multiple bruises in inaccessible places such as ears, neck, inner thigh, and buttocks
- Any bruising on a very young infant without clear-cut explanation

Burns
- Multiple cigarette burns
- Glove- and sock-pattern liquid burn
- Iron burns on the trunk, back of both hands
- Diaper-area burns
- Bilateral burns to back of hands

Skeletal injury
- Two or more fractures in different stages of healing in a nonambulating child without a history of trauma
- Metaphysical avulsion fractures
- Posterior rib fractures
- Long bone fracture in nonambulating child without a history of trauma

Head injury
- Evidence of shaken infant syndrome
  - Altered level of consciousness
  - Closed head injury
  - Central nervous system hemorrhage
  - Retinal hemorrhages
  - Catastrophic injury explained by routine fall

Injuries that are possibly caused by abuse require careful attention and should generally be reported

Intraoral
- Injuries to tongue and palate in preverbal children

Bruises
- Atypical appearance in preverbal children without explanation of trauma
- Many bruises in different stages of healing
- Bruises over cheeks without obvious patterns
- Black eyes

Burns
- Implement burn on extremity in preverbal children
- Spill, splash injuries to head and trunk of preverbal chil

Skeletal
- Long bone fractures in ambulating but preverbal children

Head trauma
- Subdural hematomas without appropriate history
- Fractures of the skull with suspicions or no history

Injuries that have low specificity for abuse and are usually accidental

Bruises
- Ambulating children
  - Head: "golf ball" – size swelling or bruising to forehead, scratches, bruises to bony prominences, e.g., chin, outer eye, and tip of nose
  - Trunk: isolated single bruises over bony prominence of spine and iliac crest
  - Limbs: multiple scattered bruises without pattern over Shins, extensor surface elbows
  - pattern over shins, extensor surface elbows

Fractures
- Linear parietal skull fracture in ambulating children
- Toddler's fracture: spiral distal third tibia in an ambula child

Head trauma
- Epidural hematoma
- Linear parietal nondepressed skull fractures in older children with short fall history
- Ping-pong fractures in babies

Conditions manifested by unusual skin lesions and burns
- Mongolian spots
- Phytophotodermatitis
- Car seat burns
- Staphylococcal scalded-skin syndrome
- Chicken pox (mistaken for cigarette burns)
- Impetigo (mistaken for cigarette burns)
- Chemical burns
- Epidermolysis bullosae

Conditions manifested by bone abnormalities
- Osteogenesis imperfecta
- Physical therapy (include CPT)
- Toddler's fracture
- Fractures in premature infants
- Congenital syphilis affecting the skeletal system
- Fatigue fractures from exercise
- Cardiopulmonary resuscitation
- Vitamin C or D deficiencies
- Skin and skeletal anomalies associated with chromosomal disorders
- Copper deficiency
- Rickets
- Caffey's disease

Conditions that cause easy bruisability
- Liver disease/Vitamin K deficiency
- Bleeding disorder
- Platelet aggregation disorders

Conditions that cause easy bruisability (Cont'd)
- Folk medicine (coining, cupping, spooning)
- Aspirin toxicity
- Henoch-Schonlein purpura
- Hypersensitivity vasculitis
- Meningococcemia
- Disseminated intravascular coagulation
- Erythema multiforme

Conditions manifested as eye hemorrhages
- Aneurysm
- Motor vehicle accident
- Thoracic compression and hypoxia
- Valsalva effect with subconjunctival hemorrhages
- "Red eye"

Conditions manifested as central nervous system hemorrhages and fluid collections
- Aneurysm
- Brain tumor
- Hemorrhagic disease of newborns
- Folk medicine (fallen fontanelle)
- Benign extra-axial fluid collections of newborns

Self-inflicted injuries
- Depression
- Mental retardation
- Cornelia de Lange syndrome
- Lesch-Nyhan syndrome
- Familial dysautonomia
- Factitious illness
- Temper tantrums
- Head-bangers

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Investigating Physical Abuse and Neglect

presented by

Detective Robert Hugh Farley M.S.
Commanding Officer
Child Exploitation Unit
Cook County Sheriff's Police Department
1401 South Maybrook Drive
Maywood, Illinois 60153
709-865-4875 or FAX 708-865-4818 or Email rhfarley@hotmail.com

at the

1999 Crimes Against Children Conference
Dallas, Texas
August 3, 1999
Sessions 6B and 7B

PHYSICAL AND NEGLECT CHILD ABUSE RECONSTRUCTION

Investigative Techniques

Student Outline Guide

by

Detective Robert Hugh Farley M.S.
Child Exploitation Unit
Cook County Sheriff's Police Department
709-865-4875 or FAX 708-865-4818 or Email rhfarley@hotmail.com

A. Abusive Caretaker Assessment

- Poor parenting skills
- Referral to social services
- Referral to a child protection agency
- Referral to juvenile court
- Referral to criminal court

B. Injury Assessment

- Natural or normal
- Accidental
- Nonaccidental
- Obtain the caretaker's explanation for the "accident" before examining the child
- Is this situation a one time event?

C. Blackened Eyes

- Most everyone has four eyelids
- Are the lower lids blackened vs. the upper lids?
- Are both eyelids on one side of the face blackened?
- Are both eyelids on both sides of the face blackened?
- Bilateral black eyes

D. Neglect Child Abuse Injury Reconstruction

Neglect Child Abuse

- Poor parenting skills vs. intent?
- Medical and dental neglect
- Inadequate clothing and poor hygiene
- Nutritional neglect
- Abandonment and lack of supervision
- Unsafe shelter

Medical and Dental Neglect

- Poor parenting skills vs. intent?

Inadequate Clothing and Poor Hygiene

- Poor parenting skills vs. intent?

Nutritional Neglect

- Poor parenting skills vs. intent?
- Possible failure to thrive

Weight Nutritional Assessment

- 5th % indicates nutritional wasting
- 5th - 10% suggests nutritional wasting
- 95th % indicates obesity

Height Nutritional Assessment

- 5th % strongly suggests nutritional stunting if weight for height is in the 25%
- 5th-10th% suggests nutrititional stunting if weight for height is in the 25th%

Nutritional Chart Calculation

- D.O.B. - June 25, 1995 (7 weeks premature)
- Exam - June 18, 1997 (calculated age - 2 years)
- Corrected age - 1 year, 10 months

Abandonment and Lack of Supervision

- Poor parenting skills vs. intent?

Restraint and Binding Soft Tissue Injuries

Unsafe Shelter

- Poor parenting skills vs. intent?
- Dry clutter
- Wet Clutter

Neglect Prosecution Assessment

- Poor parenting skills vs. intent?
- Is the child's health of life threatened?
- Is there a history of the family refusing help?

E. Emotional Child Abuse

F. Physical Child Abuse Injury Reconstruction

Physical Child Abuse Dynamics

- Causation factors
- Triggering mechanism
- Target children
- Over discipline

Child Abuse Weapon Identification

- Weapon of opportunity
- Favorite family weapon

G. Soft Tissue Injuries

- Most common result of accidental or inflicted injury
- Early recognition prevents more serious cases of abuse

Soft Tissue Injury Identification

- Where is the injury located ?
- Is the location a high risk location?
- How did it occur?
- How many times was the child injured?

Investigation Techniques

- Do you like the child?
- Did you want the child?
- What is the caretakers explanation for the "accident"
- What is the age and developmental skill of the child?

Age and Developmental Skill
0 to 1 Month

- Can't sit or flip by itself
- Head lags when pulled to sit
- Lies with the knees drawn up, arms bent across the chest and head turned sideways

Age and Developmental Skill
1 Month

- Head flops when the body is lifted
- Lies on back with arms and legs extended, head facing the side
- Makes long jerky motions, stretching the limbs, fanning the toes and fingers

Age and Developmental Skill
3 to 6 Month

- Can roll from the stomach to the back
- When pulled to sit, head does not fall back
- Will begin to reach and grasp objects
- Will bear own weight on legs if supported
- When on stomach, can lift head and shoulders looking about

Age and Developmental Skill
6 to 9 Months

- Can roll from the back to the stomach
- When on back , can lift head
- Beginning attempts to crawl or creep
- Sits alone unsupported, for over a minute

- When sitting, reaches forward to grasp without falling

Age and Developmental Skill
9 to 12 Months

- Craws well
- Stands holding on to an object
- Walks, holding onto a hand or furniture
- Can pull to a sitting position
- Can sit steadily for more than ten minutes

Age and Developmental Skill
12 to 18 Months

- Creeps up stairs
- Can stoop and recover an object
- Can get to a standing position alone
- Seats self on a chair
- By 18 months, walks well alone
- Uses a spoon and drinks from a cup

Age and Developmental Skill
18 to 24 Months

- Walks up and down stairs with one hand held
- Jumps with both feet
- Can run, stiffly
- Can hurl or kick a ball

Age and Developmental Skill
2 to 3 years

- Can walk up stairs without hand held
- Can jump from the bottom step
- Can balance on one foot for one second
- Can anticipate the need to urinate or defecate
- If worked with, can toilet self

H. Bruises

- Location
- Distribution
- Number
- Configuration
- Age dating

Accidental Injuries

- Bony prominences
- Knee
- Elbow
- Hands
- Chin
- Forehead
- Nose

Nonaccidental Injuries

- Buttocks
- Thighs
- Arms
- Cheeks
- Stomach or torso

Injury Examination

- Are there injuries one more than one body plane?
- Multiple resolving injuries leave a rainbow effect

Injury Configuration Types

Fixed Objects	**Wraparound Objects**
Paddles	Belts
Coat hangers	Closed end cords
Spoons, handles	Open end cords

Welts from hands

Age Dating of Bruises

Time	**Color**
0- 2 days	Swollen, tender and red
2- 5 days	Blue, purple
5- 7 days	Green
7- 10 days	Yellow
10-14 days	Brown
2- 4 weeks	Clear

Closed Soft Tissue Injuries

- Contusion -the skin tissue is crushed causing a bruise
- Hematoma - a lump developed from a pool a blood collected within the damaged tissue

Open Soft Tissue Injuries

- Abrasion - areas of the body surface denuded by a scrape
- Laceration - Torn or ragged wound or a cut

I. Wound Identification

- Location
- Distribution
- Number
- Configuration ?
- Age dating

Age Dating Abrasions or Wounds

Within several hours Raw surface oozing blood and a clear fluid
After six hours Dry surface and red (depending on the treatment)
Over 24 hours Scabs form

Open and Closed Soft Tissue Injury Reconstruction

- Age dating
- Control marks
- Defense wounds
- Angle of attack
- Submissive position

J. Soft Tissue Injuries from Hands

K. Soft Tissue Injuries from Belts

L. Soft Tissue Injuries from Cords

- Open end cord configurations
- Closed end cord configurations

M. Tests for Easy Bruising

- Blood coagulation studies
- Hemoglobin count
- Platelet count and clotting or bleeding time

N. Physical Child Abuse Investigation Checklist

- Did you ask the questions: natural or normal, accidental and nonaccidental in doing your injury assessment?
- Is this a one time event or a situation repeating itself?
- What causation factors are present?
- What type of triggering mechanisms contributed to the crisis?
- What is the age and developmental skills of the child?
- Is the child a target child or are there target children?
- Was there any delay or hospital shopping involved?
- Are the injuries within the primary target zone?
- What is the location, configuration and distribution of the injuries?
- Are multiple revolving injuries present?
- Was there a weapon of opportunity or a favorite family weapon involved?
- Are the injuries from a hand, a fixed or a wraparound object?
- Is there a identifiable angle of attack?

CONSENT TO SEARCH

I, _____ have been informed of my constitutional right not to have a search made of the premises and/or automobile owned by me and/or under my care identified below without a search warrant. However, knowing my rights to refuse consent to such a search, I hereby authorize _____ and _____ of the Cook County Sheriff's Police Dept. Child Exploitation Unit to conduct a complete search of the premises, garage, storage shed or any structure at the property commonly known as _____

_____

and/or _____ automobile, license _____.
Year and Type of automobile

These officers are authorized by me to take from my premises and/or property and view any videos, photos, magazines, computer, computer discs or any materials which are evidence in the nature of child abuse or child erotica. This written permission is given by me to the above named persons voluntarily and without any threats or promises of any kind, at _____ _____ M on this _____ day of _____, 19 _____. I fully understand that I will be given a receipt for property taken.

Signed _____

Name _____
Printed

WITNESSES:

Signed _____ _____

Name _____ _____
Printed Printed

Authorization for Release of Medical or Confidential Information

I, _____ do hereby authorize

_____
Facility, Agency, Therapist, Etc.

_____ _____
Address City

to release _____
Specific Nature of Information to be Disclosed

for the investigation of _____ _____
Type of Police Investigation Police Report Number

about _____ _____
Name of Patient Date of Birth

to Detective _____ of the Cook County Sheriff's Police Department , **Child Exploitation Unit**, 708-865-4875 or FAX 708-865-4818.

I understand fully the nature of this authorization and further that the above named Detective has the right to view, inspect, copy or xerox any information to be disclosed.

_____ _____
Signature of Patient or Guardian Signature of Witness

_____ _____
Name Printed Name Printed

_____ _____
Date Date

Appendix C: "Drawing Interviews": An Alternative Technique

"Drawing Interviews": An Alternative Technique

By Robert Hugh Farley

In our first child abuse case, over 11 years ago, my partner and I were assigned to investigate the apparent physical abuse of a 5-year-old boy. During our short interview with the victim, we learned that he had been caught playing with matches and was subsequently punished by his mother's boyfriend, who placed the boy's hand on the open flame from a gas stove.

At the conclusion of the interview the boy was transported to the hospital, where he was treated for the burn before being turned over to a protective service worker from the Illinois Department of Children and Family Services.

On the way from the hospital to the Protective Service Office, the worker and the boy stopped at a restaurant for a hamburger. While he was eating, the 5-year-old boy told the worker the hamburger smelled funny—"like my mom's [vagina]." The worker rushed the boy back to the police station, where we finally conducted a lengthy interview. From this interview, it was learned that the victim had been subjected to extensive sexual abuse not only from his mother, but also from the mother's boyfriend. If not for his spontaneous announcement, however, the sexual abuse would have gone undetected, and the court would have returned the boy to the mother.

This incident demonstrated plainly that "simple" cases of physical child abuse are rare. We had thought that, once established from the victim, the interview could be concluded. But experience shows that in all child abuse investigations, a detailed, lengthy, and very sensitive interview of the victim is critical.

In recent years, extensive publicity has been given to the use of anatomically correct dolls for the interviewing of sexually abused children. While it is true that many clinical professionals have had very good results with these dolls, unfortunately, it is also true that a significant number of youth officers across the country have been expected to use the dolls in child abuse interviews despite a lack of training in their proper use.

Drawing Pictures

An excellent alternative for a police officer to use—either in conjunction with or instead of the dolls—is to have the child draw his own pictures. In many cases, using the child's own "drawings," rather than anatomically correct dolls, will provide a more productive interview with the child abuse victim.

Prior to starting the child abuse "drawing interview," the police officer should learn as much as he can about the case. It should be determined when the child last ate or if he is hungry. The interview should never be conducted during the child's regular nap time or when he normally goes to bed for the night.

When starting a child abuse interview, the police officer must first address the victim's fear of retaliation for revealing the circumstances of the abuse or identifying the abuser. This initial action is very difficult for both the victim and the interviewer, since a police officer represents a threat in the sense that he can arrest the abuser.

The interviewing officer should furnish the child abuse victim with a box of crayons, pencils, and several sheets of paper at the start of the interview. If he presents himself to the child as a warm and caring person, the child may think that the drawings are a game, not even realizing that he is being interviewed.

The "drawing interview" should begin with the interviewer asking the victim to write or print his name on a sheet of paper that, depending on the victim's age, is either lined or unlined and colored. This step of the interview will provide the police officer with some idea of the educational and developmental stage of the victim.

The second step is to ask the child to draw a "picture of himself." The child may object at this point, telling the interviewer that he can't draw very well, but he should simply be encouraged to do the best he can.

When the child has finished the drawing, the interviewer can use it to go over the child's name and the locations for the different body parts. The interviewer should begin this portion of the interview by asking the child the color of the hair on the drawing and locations of the eyes, the mouth, belly button, etc. The last questions asked should be the locations and names of the sexual body parts. In some cases, the interviewer may wish to have the child label the body part locations on the drawing.

If the drawing the child has done of himself portrays an unhappy face or scene, the interviewer should then ask, "She doesn't look happy; why is that?"

In the third step, the child is provided with another sheet of paper and asked to "draw a picture of his family." This step is very important as it may provide the interviewer with important information concerning an outsider such as a boyfriend, grandfather, etc., who is living in the family residence or has daily access to the family.

When the family drawing is completed, the child is asked to label all the people in the drawing, including the family pet. The interviewer can then ask such questions as where the various people sleep in the house, which person the child likes the least or the best, etc.

For the final step of the drawing interview, the child is provided with another sheet of paper and asked to "draw what happened." When the drawing is completed, the child is asked to explain the circumstances of the abuse portrayed in the picture. He is asked to label the name of the abuser and the victim and, in cases of physical abuse, asked to identify the instrument of abuse and where it is stored.

As the child completes each drawing, the interviewer must take the time to go over it in detail with the child. If the interviewer observes some portion of the drawing that is unusual, exaggerated or overemphasized, such as the mouth in figure 1, he should ask the child for an explanation rather than making assumptions of any kind.

Of course, the police officer/interviewer, who is typically untrained in art therapy, must remember not to fall into the trap of playing amateur psychologist and attempt to analyze the drawings himself. This job must be left to the professional art therapist.

Conclusions

"Drawing interviews" offer some advantages that the anatomical dolls do not:

- They allow an abused child to express graphically what he may be afraid or unable to express verbally.
- They decrease the child's anxieties during the interview by providing him with a motor activity.
- Drawings of "what happened" will provide written evidence of what actually happened to the child. The drawings may also allow the resurfacing of repressed feelings or facts that normally would not be uncovered in another type of interview.
- Drawings will provide "hard physical evidence" of what the child has related to the police investigator during the interview, making it easier for a police officer on the witness stand to explain the child's version of what happened.
- The paper, pencils, and crayons used in the drawings, if not readily available, can be carried easily by a police officer.

In conclusion, the police officer must remember that the child who has been sexually or physically abused has also been emotionally abused. The "drawing interview" can be conducted in such a manner that it is nonthreatening, nonaccusatory, and, hopefully, nonharmful to an already scarred child.

Figure 1: "Draw Yourself"

This drawing was done by a 14-year-old boy who had been anally and orally sodomized by his stepfather for over 6 years. When the picture was first drawn, there were no arms. When the boy was later questioned by the interviewer about the missing arms, he advised that he had forgotten to put them in, and the arms were then added to the drawing. When questioned about the object depicted in his mouth, the boy said it was a "wanger." Further questioning established that a "wanger" was the stepfather's penis.

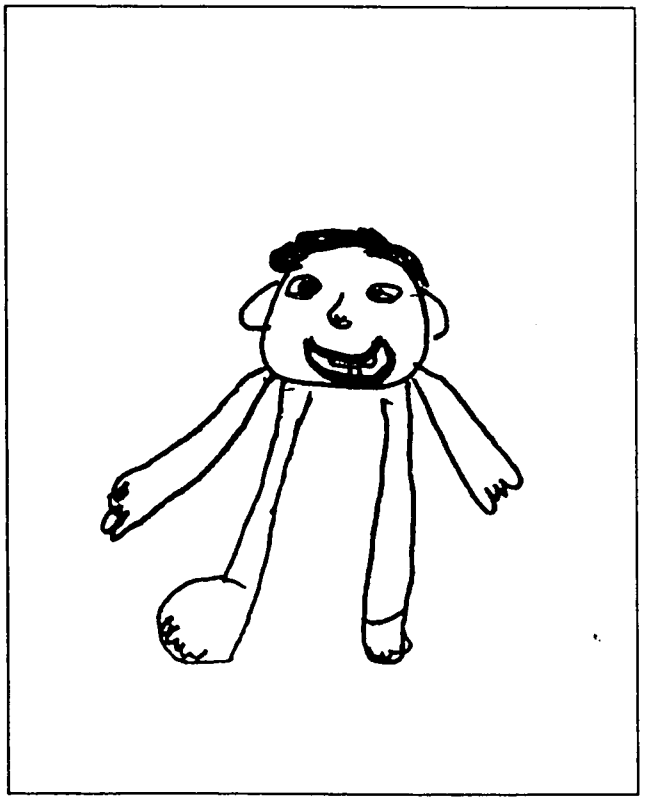


Figure 2: "Draw Your Family"

The purpose of this drawing, done by a 10-year-old-girl, was to identify the other members of the family unit. The girl depicted two "friends" between Mom and Step Dad. When later questioned by the interviewer, the girl advised that "those are Mom's two boyfriends, who visit the house when Step Dad is out driving his truck on the road."

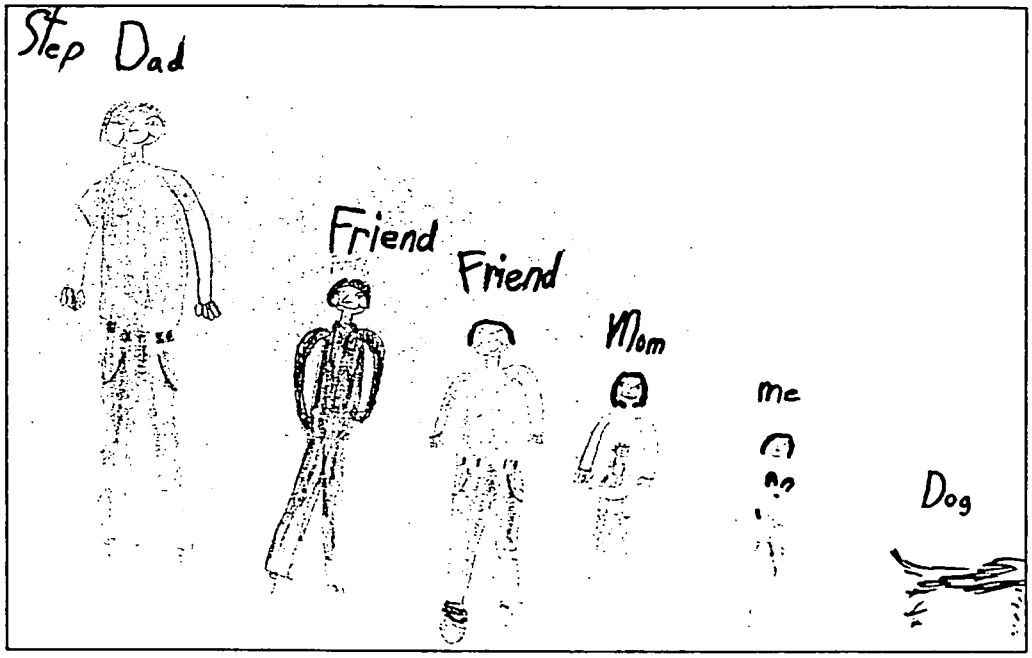
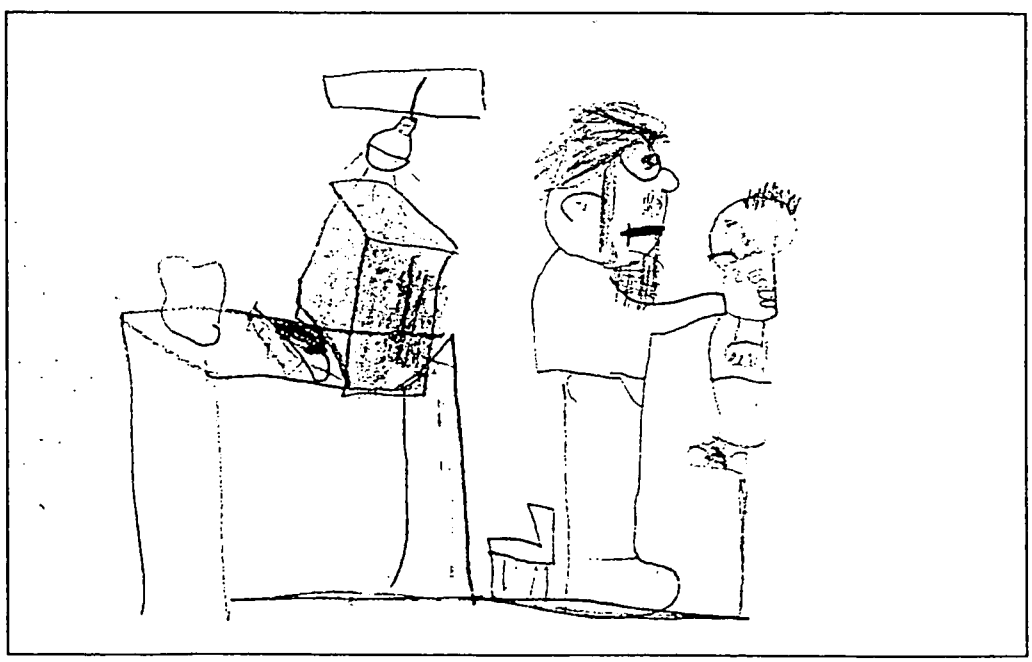


Figure 3: "Draw What Happened"

This drawing was done by an 8-year-old boy who has suffered a history of physical abuse from his stepfather. In this drawing, the boy had knocked over a bag of feed in the basement of the family home. The boy's 6'5" stepfather grabbed him by the neck and, while holding him in the air, choked the breath out of him. Going over the drawing with the interviewer, the boy explained that the shading on his face was when he had turned red and the tear was when he was crying. Note the heavy black line depicting the anger on the stepfather's face. Although the incident had been witnessed by the boy's uncle, the boy later recanted his testimony under pressure from his mother.



U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Recognizing When a Child's Injury or Illness Is Caused by Abuse

Portable Guides to Investigating Child Abuse

Overview

In recent years the public's increased awareness and reports of suspected child abuse have put pressure on law enforcement to improve their investigations of such cases. This was underscored in late 1987 when a New York City toll collector observed a small girl covered with bruises in the rear of a car. The collector radioed the New York State Police, who stopped the car. The child's foster father, an attorney, explained to police that the bruises were accidental, and he was released. A week later, the child was dead from a beating.

Law enforcement personnel frequently must determine whether a child's accident or illness was caused by a parent or caretaker. However, it is often difficult even for medical personnel to discriminate between injuries and illnesses that are accidental and those that are not. The following information can help law enforcement personnel to determine if it is likely that abuse has occurred.

Could This Be Child Abuse?

Investigators must determine whether the explanation for an injury is believable. Police should begin their investigation by asking the caretaker for an explanation of the child's bruises or injuries. This is best done by asking the question: How did the accident happen?

All bruises must be investigated. If bruises are found on two or more planes of a child's body, investigators should be even more suspicious. For example, a child has bruises on his buttocks and stomach. The caretaker's explanation is that the child fell backward in the living room of the family home. This might explain the bruises on the buttocks, but not the stomach bruises. If a discrepancy exists between the reported cause of an injury and the injuries seen, law enforcement personnel should investigate further. They should also keep in mind the following points:

- All other children in the home should be examined for possible signs of child abuse.
- Victims of physical abuse often have been intimidated and will usually support the abuser's version of how their injuries occurred to avoid further injury. They also feel that the abuse was just punishment because they were bad.
- A physical examination of the child in suspected cases of maltreatment must be done and the data recorded precisely.
- Laboratory data should be obtained to support or refute the evidence of abuse.
- If the reported history of an injury or injuries changes during the course of an investigation, or if there is conflict between two adult caretakers as to the cause of injury, the likelihood of child maltreatment increases.
- The demeanor of the child's parents or caretakers is sometimes revealing. For example, the mother's assessment of her pregnancy, labor, and delivery will often provide an insight into her attitude about her child as well as give an indication of whether there is something about the child that is influencing her behavior.

- Investigators should ask questions in an unobtrusive manner; for example:
  - Was this a planned pregnancy?
  - Did you want the baby?
  - Do you like the baby?
  - How did the accident happen?
  - What were you doing just before the accident?
  - Who was at home at the time of the accident?
  - What do you feed the baby? How often? Who feeds the baby?
- Information about a child's birth and his or her neonatal and medical history are critical elements in investigations. Hospital records can confirm or eliminate the existence of birth injuries.
- Any child may be abused, and child abuse occurs in all levels of society. However, there are some factors that increase a child's risk of abuse. These include:
  - Premature birth or low birth weight.
  - Being identified as "unusual" or perceived as "different" in terms of physical appearance or temperament.
  - Having a variety of diseases or congenital abnormalities.
  - Being physically, emotionally, or developmentally disabled (e.g., mentally retarded or learning disabled).
  - Having a high level of motor activity, being fussy or irritable, or exhibiting behavior that is different from the parents' expectations.
  - Living in poverty or with families who are unemployed.
  - Living in environments with substance abuse, high crime, and familial or community violence.

The following are provided to help law enforcement personnel determine which injuries and illnesses in children are likely to be the result of abuse. However, it is also very important for law enforcement to work closely with physicians to determine the nature of all injuries.

Repetitive Accidents

Multiple bruises, wounds, abrasions, or other skin lesions in varying states of healing may indicate repetitive physical assault. Such repetitive accidents or injuries may indicate that abuse is occurring. A careful examination of the circumstances and types of injuries and an assessment of the child and family should be carried out by a professional skilled in family dynamics, usually the social worker investigating a report of suspected abuse. However, a police officer from the juvenile division may in some circumstances be responsible for this, rather than a social worker.

Cutaneous (Skin) Injuries

The most common manifestations of nonaccidentally inflicted injuries are skin injuries. Several characteristics help to distinguish nonaccidental skin injuries from accidental ones, including their location and pattern, the presence of multiple lesions of different ages, and the failure of new lesions to appear after hospitalization. Law enforcement personnel should be sure to obtain a complete history of all injuries from the caretaker.

Bruises

Bruises are due to the leakage of blood into the skin tissue that is produced by tissue damage from a direct blow or a crushing injury. Bruising is the earliest and most visible sign of child abuse. Early identification of bruises resulting from child abuse can allow for intervention and prevent further abuse.

Bruises seen in infants, especially on the face and buttocks, are more suspicious and should be considered nonaccidental until proven otherwise. Injuries to children's upper arms (caused by efforts to defend themselves), the trunk, the front of their thighs, the sides of their faces, their ears and neck, genitalia, stomach, and buttocks are also more likely to be associated with nonaccidental injuries. Injuries to their shins, hips, lower arms, forehead, hands, or the bony prominences (the spine, knees, nose, chin, or elbows) are more likely to signify accidental injury.

Age Dating of Bruises

It is important to determine the ages of bruises to see if their ages are consistent with the caretaker's explanation of the times of injury. Age dating of bruises can often be determined by looking at the color of the bruise. The ages and colors of bruises may therefore show if more than one injury is present. Table 1 shows the ages associated with the colors of bruises.

Table 1

Determining the Age of a Bruise by Its Color

Color of Bruise	Age of Bruise
Red (swollen, tender)	0–2 days
Blue, purple	2–5 days
Green	5–7 days
Yellow	7–10 days
Brown	10–14 days
No further evidence of bruising	2–4 weeks

For example, a 2-year-old boy, not toilet trained, has several yellow-to-brown bruises on his buttocks. The caretaker's explanation for the bruises is that the child tripped in the hallway the day before and fell on his buttocks. This would be suspicious because:

- Children seldom bruise their buttocks in accidental falls.
- Bruises on the buttocks are in the primary target zone for nonaccidental injury.
- The child's diaper (whether disposable or cloth), plastic pants, and clothing would have afforded some protection to his buttocks.
- If the injuries causing the bruises were sustained the previous day, the bruises should be red to purple.

Another child might have both bright red and brown bruises. The caretaker maintains that all of the bruises were the result of a fall that day. However, the bright red color indicates fresh bruises, while the brown bruises are older. The caretaker's explanation is, therefore, suspicious, and separate explanations must be obtained for each bruise.

Bruise Configurations

Bruises will sometimes have a specific configuration. This may enable law enforcement officers to determine whether bruises are accidental or nonaccidental. One of the easiest ways to identify the weapon used to inflict bruises is to ask the caretaker: How were you punished as a child?

The pattern of a skin lesion may suggest the type of instrument used. Bruise or wound configurations from objects can be divided into two main categories: those from "fixed" objects, which can only strike one of the body's planes at a time, and those from "wraparound" objects, which follow the contours of the body and strike more than one of the body's planes. Hands can make either kind of bruise, depending on the size of the offender's hands and the size of the child. Examples of fixed and wraparound objects include:

- Fixed objects: coat hangers, handles, paddles.
- Wraparound objects: belts, closed-end (looped) cords, open-end cords. (Closed-end cords leave a bruise in parallel lines; open-end cords leave a bruise in a single line.)

Natural or Normal Bruising

Injuries inflicted by human hands, feet, or teeth or those inflicted by belts, ropes, electrical cords, knives, switches, gags, or other objects will often leave telltale marks (e.g., gags may leave down-turned lesions at the corners of the mouth). These marks may also help in the investigative process. For example, the size of bite marks may help to determine the biter's approximate age; their shape may help identify whose teeth made the marks. In some cases, however, bruises are acquired innocently, through play and accidental falls, or when a child has a defect in his or her clotting mechanism.

For example, a baby is brought to the hospital with purple bruises on several body surfaces. The parents were unable to provide an explanation other than that the baby "bruised easily." Blood tests later revealed that the baby was a hemophiliac; hemophilia is associated with bruising easily, due to blood clotting problems. There is usually a history of bruising easily in families with such inherited diseases.

Other incidents of "easy bruising" in children can be explained by a low blood platelet count. Multiple bruises can occur in children with leukemia. Diseases causing easy bruising, however, are rare, and inflicted bruises are much more common. The medical diagnosis of clotting disorders requires blood tests and interpretation of those tests by qualified physicians. Therefore, law enforcement officers should try to determine if bruises are the result of an accident or due to physical abuse. Police must also remember never to jump to conclusions and to make a complete investigation of all aspects of suspected child abuse. However, their first duty is to secure the safety of the child quickly.

Mongolian spots (a kind of birthmark) also resemble bruises but can be distinguished by their clear-cut margins, the fact that they do not fade, and their steel gray-blue color. Mongolian spots may be found anywhere on the body (but are typically found on the buttocks and lower back). In addition, they are commonly found in African Americans, Asians, and Hispanics. Investigators should await medical reports when investigating such marks.

Burns

As shown in table 2, certain characteristics of the history, location, or pattern of burns may indicate whether they were nonaccidental.

Table

Distinguishing Accidental

Indications That Burns May Not Have Been Accidental

History

- The burns are attributed to siblings.
- An unrelated adult brings the child in for medical care.
- Accounts of the injury differ.
- Treatment is delayed for more than 24 hours.
- There is evidence of prior "accidents" or an absence of parental concern.
- The lesions are incompatible with the history.

Location

- The burns are more likely to be found on the buttocks, in the anogenital region (the area between the legs, encompassing the genitals and anus), and on the ankles, wrists, palms, and soles.

Pattern

- The burns have sharply defined edges. For example, in immersion burns, the line of immersion gives the appearance of a glove or stocking on the child's hand or foot.
- The burns are full thickness (all of the skin, and possibly muscle and bone as well, is destroyed).
- The burns are symmetrical.
- The burns are older than the reported history indicates.
- The burns have been neglected or are infected.
- There are numerous lesions of various ages.
- The burn patterns conform to the shape of the implement used.
- The degree of the burns is uniform (usually indicating forced contact with a hot, dry object), and they cover a large area.

2

From Nonaccidental Burns

Indications That Burns Are More Likely To Be Accidental

History

- The history of the mechanism of the burns is compatible with the observed injury.

Location

- The burns are usually found on the front of the body. They occur in locations reflecting the child's motor activity, level of development, and the exposure of the child's body to the burning agent.

Pattern

- The burns are of multiple depths interspersed with unburned areas and are usually less severe (such as splash burns).
- The burns are of partial thickness; that is, only part of the skin has been damaged or destroyed.
- The burns are asymmetrical.
- Apparently only one traumatic event has occurred, because the skin injuries are all of the same age.

Poisoning

J.A. Bay's exhaustive review of the world's literature of reported cases of nonaccidental poisoning as a form of child abuse identified certain agents that are commonly used by perpetrators ("Conditions Mistaken for Child Sexual Abuse," in Reece, R.M. (ed.): *Child Abuse: Medical Diagnosis and Management*). The most frequently used agents included barbiturates, psychoactive drugs, tranquilizers, insulin, ipecac, arsenic, laxatives, salt, water, alcohol, marijuana, and opiates. The children poisoned by such agents display a variety of presenting signs and symptoms, but nearly all have major changes in their mental status, ranging from irritability, listlessness, lethargy, stupor, and coma to convulsions. The peak age for *accidental* poisoning is 2 to 3 years, and it is rare under the age of 1 or over the age of 6. The usual history of nonaccidental poisoning is that either the ingestion was not witnessed or that it was administered by a sibling or another child. In addition, the history may change over time.

Head Injuries

Many fatalities from child abuse involve serious head injuries. Subdural hematomas due to child abuse are most common in children less than 24 months of age, with the peak incidence at about 6 months. The signs and symptoms of subdural hematomas may either be nonspecific, including irritability, lethargy, or a disinclination to eat, or there may be more classic signs of raised intracranial pressure such as vomiting, seizures, stupor, or coma. A subdural hematoma associated with a skull fracture is due to a direct impact to the head and ordinarily leaves external marks. It may be associated with shaking the baby violently or with an extreme blow to the head, such as occurs when children are thrown against a hard object.

Retinal hemorrhages strongly suggest whiplash or shaking as the origin of the injury. The presence of bilateral subdural hematomas is also positively correlated with whiplash or shaking. Therefore, law enforcement personnel need to investigate whether these were nonaccidental injuries.

Hair pulling as a means of discipline may be responsible for hair loss or baldness (alopecia).

Eye Injuries

- External eye injuries are so common in children that they are seldom clear-cut evidence of abuse.
- Two black eyes seldom occur together accidentally.
- The "raccoon eyes" associated with accidental and nonaccidental fractures at the base of the skull may look similar to each other, but raccoon eyes from nonaccidental trauma usually are associated with more swelling and skin injury. The history helps distinguish between them.
- Hyphema, the traumatic entry of blood into the front chamber of the eye, may be the result of a nonaccidental injury caused by striking the eye with a hard object, such as a belt buckle. The child will complain of pain in the eye and have visual problems.
- Retinal hemorrhages are the hallmark of shaken baby syndrome and are only rarely associated with some other mechanism of injury.
- Nonaccidental trauma must always be considered in a child under 3 years of age who has retinal hemorrhages or any traumatic disruption of the structures of the globe of the eye (e.g., the lens or retina) or the skin around the eye.

Internal Injuries

- Internal organ injuries are second only to head trauma as the most common causes of death in child abuse.
- Nonaccidental internal injuries usually involve structures below the diaphragm.
- Accidental abdominal injuries usually involve a long fall to a flat surface, a motor vehicle accident or, rarely, are the result of contact sports. Accidental abdominal injuries usually involve older children who are brought to medical attention immediately, whereas children with nonaccidental abdominal injuries will be younger, and a delay in seeking medical attention is more common. Nonaccidental abdominal injuries more commonly involve hollow organs (e.g., the gut and stomach) than accidental injuries, but the liver, spleen, and pancreas can all suffer nonaccidental injury. For some reason, the kidneys are rarely injured.

- Although there are signs and symptoms, in most cases of abdominal organ injury there are no external signs of trauma. This is due to the pliability of the abdominal wall and its ability to absorb trauma without showing bruises.
- Unusual clinical findings may indicate abuse.
- In school-age children, trauma to the pancreas is quite infrequent and usually involves an injury caused by bicycle handlebars or traffic accidents. In infants and toddlers under the age of 3, child abuse must be strongly suspected, since the pancreas is so deep in the abdomen that it is protected from all trauma except blunt force trauma.

Sudden Infant Death Syndrome

Sudden infant death syndrome (SIDS) is the "sudden death of an infant under one year which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Willinger, M., et al., "Defining the Sudden Infant Death Syndrome (SIDS): Deliberations of an Expert Panel Convened by the National Institute of Child Health and Human Development," *Pediatric Pathology* 11:677–684, 1991). SIDS is unexpected, usually occurring in apparently healthy infants ages 1 month to 1 year. Most deaths from SIDS occur by the end of the sixth month, with the greatest number taking place between ages 2 and 4 months. SIDS is the leading cause of death in the United States among infants between the ages of 1 month and 1 year, and is second only to congenital anomalies as the overall leading cause of death for all infants under 1 year of age (National Sudden Infant Death Syndrome Resource Center, 1993).

In sudden, unexplained infant deaths, investigators, including medical examiners and coroners, use the special expertise of forensic medicine (the application of medical knowledge to legal problems) to arrive at a diagnosis. A definitive SIDS diagnosis cannot be made without a thorough autopsy—including microscopic examination of tissue samples and vital organs—that fails to point to any other possible cause of death. Also, if the cause of the infant's death is ever to be uncovered, it will be from evidence gathered during a thorough pathological examination. Often, the cause of an

infant's death can only be determined by carefully collecting and evaluating information from the death scene and conducting forensic tests. Investigators should also carefully review the child's and child's family's history of previous illnesses, accidents, or behaviors. Review of these details may further corroborate what is detected in the autopsy or death scene investigation. Investigators should be sensitive, yet thorough. Criteria for distinguishing SIDS from death caused by child abuse are presented in table 3. The following is a list of key points relative to SIDS:

- SIDS is a diagnosis of exclusion following a thorough autopsy, death scene investigation, and comprehensive review of the child and his or her family's case history.
- SIDS is a definite medical entity and is the major cause of death in infants after the first month of life, with most deaths occurring between the ages of 2 and 4 months.
- SIDS victims appear to be healthy prior to death.
- SIDS currently cannot be predicted or prevented, even by a physician.
- SIDS deaths appear to cause no pain or suffering; death occurs very rapidly, usually during sleep.
- SIDS is not child abuse.
- SIDS is not caused by external suffocation.
- SIDS is not caused by vomiting and choking or by minor illnesses such as colds or infections.
- SIDS is not caused by the diphtheria/pertussis/tetanus (DPT) vaccine or other immunizations.
- SIDS is not contagious.
- SIDS is not the cause of every unexplained infant death.

Table 3

Criteria for Distinguishing SIDS From Fatal Child Abuse and Other Medical Conditions*

Consistent With SIDS	Less Consistent With SIDS	Highly Suggestive or Diagnostic of Child Abuse
An apparently healthy infant fed and put to bed. Found lifeless (silent death). EMS† resuscitation unsuccessful.	Infant found not breathing. EMS transports to hospital. Infant lives hours to days. History of substance abuse or family illness.	History is not typical of SIDS† or there is a discrepant or unclear history. Prolonged interval between bedtime and death.
Peak: 2–4 months (90% < 7 months). Range: 1–12 months	8–12 months	>12 months
Bloody, watery, frothy, or mucous nasal discharge. PM† lividity in dependent areas (portions of the body that are lower—due to gravity, the blood settles). Sometimes	Organomegaly of the viscera (enlargement of the organs). Diagnostic signs of a disease process (by PE†, laboratory tests, x-ray).	Skin injuries. Traumatic injuries to body parts: mucous membranes of the eyelids, fundi (part of the eye opposite the pupil), scalp, inside of the mouth, ears, neck,

there are marks on pressure points (places where a blood vessel runs near a bone, such as where pressure is applied to stop bleeding). No skin trauma. Apparently well-cared-for baby.

trunk, anus or genitals, and extremities. Evidence of malnutrition, neglect, or fractures may also be present.

Prenatal care ranged from minimal to maximal. Frequently, mothers used cigarettes during pregnancy. Some victims were premature or had LBW[†]. Newborns showed minor defects with regard to their feeding and general temperament. Less height and weight gain after birth. Being a twin or a triplet. Possible history of spitting, GE[†] reflux, thrush, pneumonia, illnesses requiring hospitalization, accelerated breathing or heartbeat, (bluish) discoloration of skin due to lack of oxygen in the blood. Usually no signs of difficulty before death.

Prenatal care was minimal to maximal (therefore, it has no significance in distinguishing SIDS from non-SIDS deaths). Child has history of recurrent illnesses and/or multiple hospitalizations ("sickly" or "weak" baby). Previous specific diagnosis of organ system disease.

Pregnancy was unwanted. Little or no prenatal care. Mother arrived late at hospital for delivery, or birth occurred outside of hospital. Little or no well-baby care. No immunizations. Mother used cigarettes, drugs, and/or alcohol during and after pregnancy. Child described as hard to care for or to "discipline." Deviant feeding practices were used.

Table 3 *continued*

Criteria for Distinguishing SIDS From Fatal Child Abuse and Other Medical Conditions*

Consistent With SIDS	Less Consistent With SIDS	Highly Suggestive or Diagnostic of Child Abuse
[illegible] investigation		
Crib or bed in good repair. No dangerous bedclothes, toys, plastic sheets, pacifier strings, or pillows stuffed with pellets. No cords, bands, or other possible means of entanglement. An accurate description was provided of the child's position, including whether there was head or neck entrapment. Normal room temperature. No toxins or insecticides present. Good ventilation, furnace equipment.	Defective crib or bed or inappropriate sheets, pillows, or sleeping clothes. Presence of dangerous toys, plastic sheets, pacifier cords, pellet-stuffed pillows. Evidence that child did not sleep alone. Poor ventilation and heat control. Presence of toxins or insecticides. Unsanitary conditions.	Chaotic, unsanitary, and crowded living conditions. Evidence of drug or alcohol use by caretakers. Signs of a struggle in crib or other equipment. Blood-stained bedclothes. Evidence of hostility, discord, or violence between caretakers. Admission of harm, or accusations by caretakers.
[illegible] infant death		
No previous unexplained or unexpected infant deaths.	One previous unexpected or unexplained infant death.	More than one previous unexplained or unexpected infant death.

No adequate cause of death at PM. Normal skeletal survey, toxicological findings, chemistry studies (blood sugar may be high, normal, or low), microscopic examination, and metabolic screen. Presence of changes in certain organs thought to be more commonly seen in SIDS than in non-SIDS deaths. Occasionally, subtle changes in liver, including fatty change and blood forming in the liver (not a normal site for blood production).	Subtle changes in liver, adrenal glands, and the heart muscle (myocardium).	Traumatic cause of death (IC† or visceral bleeding). External bruises, abrasions, burns. Evidence of malnutrition, fractures, or scalp bruises. Abnormal body chemistry values: Na†, Cl†, K†, BUN†, sugar, liver and pancreatic enzymes, and CPK†. Abnormal toxicological findings.
None.	One.	Two or more. One or more family members arrested for violent behavior.

*Adapted from Reece, R.M. Fatal child abuse and sudden infant death syndrome: A critical diagnostic decision. *Pediatrics* 91(2):423, 1993. Reproduced by permission of *Pediatrics*.

†Abbreviations: BUN, blood urea nitrogen; Cl, chlorine; CPK, creatinine phosphokinase; EMS, emergency medical services; GE, gastroesophageal; IC, intracranial; K, potassium; LBW, low birth weight; Na, sodium; PE, physical examination; PM, postmortem; SIDS, sudden infant death syndrome.

Investigator's Checklist for Use in Suspected Cases of Physical Child Abuse

Far too often police investigating a child's injuries will let their emotions interfere. It should be remembered that the child abuse investigation process, if performed correctly, will ultimately determine which injuries were nonaccidental. The following are some important questions and issues to be considered when investigating a suspected case of child abuse.

- ❑ Begin by asking questions about the child's family history, substance abuse or other environmental factors in the home, and the parents' marital status, employment history, or unrealistic expectations of the child.
- ❑ How could the child's behavior or the caretaker's stress have contributed to the crisis?
- ❑ Could the child do what the caretakers told you he or she did?
- ❑ Is the child a "target" child (a child perceived by the parent(s) as having negative characteristics), or are there target children present?
- ❑ Was there any delay in treatment or was hospital "shopping" involved?
- ❑ What are the locations, configurations, and distributions of the bruises, welts, lacerations, abrasions, or burns?
- ❑ Do the injuries appear to have been caused by the hands or an instrument? Can you determine what instrument might have been used?
- ❑ Are multiple injuries (in various stages of healing) present?
- ❑ Are the injuries within the primary target zone (the back, from the neck to the back of the knees and including the shoulders and arms) and on more than one leading edge (the outside of the arm or leg, etc.) of the body?
- ❑ Can you determine the positions of the offender and the child during the attack?
- ❑ Is there any evidence of attempts to hold the child in a certain position or at a certain angle during the attack? Are there such control marks on the wrists, forearms, or biceps?
- ❑ Was a careful check made for injuries on the head, mouth, ears, and nose?

Contributing Authors

Robert Hugh Farley, M.S.
Detective, Cook County Sheriff's Police Department
Federal Child Exploitation Strike Force
433 West Harrison Street, Fifth Floor
Chicago, IL 60669–2231
312–983–6235 (Strike Force)
708–865–4700 (Cook County Sheriff's Office)

Robert M. Reece, M.D.
Clinical Professor of Pediatrics
Tufts University School of Medicine
Medford, Massachusetts
and
Director, Institute for Professional Education
Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)
399 Boylston Street
Boston, MA 02116
617–587–1500

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Organizations

General

Missing and Exploited Children's Training Programs
Fox Valley Technical College
Criminal Justice Department
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54913–2277
800–648–4966
414–735–4757 (fax)
http://www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for the Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

The National Center for the Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Sudden Infant Death Syndrome

American SIDS Institute
6065 Roswell Road, Suite 876
Atlanta, GA 30328
800–232–7437
404–843–1030 (Georgia)

Association of SIDS and Infant Mortality Programs
c/o The Center for Infant and Child Loss
630 West Fayette Street, Room 5–684
Baltimore, MD 21201
800–808–7437
410–706–5062 (Maryland)

Federal SIDS Program
U.S. Department of Health and Human Services
Office of Maternal and Child Health
Bureau of Maternal and Child Health and Resource Development
Parklawn Building, Room 18A–39
5600 Fishers Lane
Rockville, MD 20857
301–443–6600

The Maryland SIDS Information and Counseling Program
University of Maryland School of Medicine
630 West Fayette Street, Room 5–684
Baltimore, MD 21201
800–808–SIDS
410–706–5062 (Maryland)

National Sudden Infant Death Syndrome Resource Center
2070 Chain Bridge Road
Suite 450
Vienna, VA 22182
703–821–8955, ext. 249

SIDS Alliance
1314 Bedford Avenue
Suite 210
Baltimore, MD 21208
800–221–7437
410–653–8226 (Maryland)

Southwest SIDS Research Institute, Inc.
Brazosport Memorial Hospital
100 Medical Drive
Lake Jackson, TX 77566
800–245–7437
409–299–2814 (Texas)

Other Titles in This Series

Currently there are 10 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below, contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at askncjrs@ncjrs.org.

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

APPENDIX A: SEXUAL EXPLOITATION OF CHILDREN
Student Outline Guide

INSTRUCTOR: Brian J. Killacky
Detective
Bureau of Investigative Service
Area Three Violent Crimes Unit
Chicago Police Department

A. UNDERSTANDING SEXUAL EXPLOITATION

1. Child Pornography
2. Child Prostitution
3. Child Molestation
4. Juvenile Pimping
5. Child Sex Rings
6. Adolescent Offenders
7. Incidental Offenses

B. STATISTICALLY, THIS IS AN UNREPORTED CRIME.
1. Unreported
2. Under reported
3. Not reported at all
4. Delay in the report
5. Lack of Physiological Evidence

C. CHILDREN ARE PERFECT VICTIMS
1. Love and Affection
2. Recognition and reward
3. Selection of Victim
4. Can Be overpowered easily
5. Easily Lured
6. Unaware of Violation
7. Isolation of Effect

D. UNDERSTANDING THE CHILD VICTIM OF EXPLOITATION
1. Psycological Paralysis
2. Lack of Motiviation
3. Deviation from normal behavioral patterns
4. Connection to Delinquent Behavior

E. CHILD PORNOGRAPHY
1. Definition of
2. Types avaliable
3. Why it is used
4. How it is used
5. Manufacture of Child Pornography
6. Home Made Child Pornography
7. Commercial Child Pornography
8. Use of the Computer

F. CHILD MOLESTATION
1. Defining this type of sexual predator
2. Situational
3. Preferantial
4. Juvenile Offender

H. CHILD SEX RINGS
1. Understanding the concepts
2. Types of rings involved
3. Investigative difficulties

I. CHILD PROSTITUTION
1. Definition of
2. Street Prostitution
3. Call Operation
4. House of Prostitution
5. Investigation

J. INCIDENTAL OFFENSES
1. Indecent Solicitation
2. Distribution of Obscene Materials
3. Misdemeanor Related Sex Offenses
4. Harboring a Runnaway
5. Drug Related Offenses
6. Intimidation
7. Communication with a Witness

K. SEARCH WARRANTS
1. Definition
2. Establishing Probable Cause
3. Element of Time
4. Time and Location of Execution

L. ADEQUATE VICTIM PLACEMENT
1. Knowing the system
2. Selection of Placement
3. Avoiding Institutionalization
4. Long Term Placement

APPENDIX B. SEXUAL EXPLOITATION OF CHILDREN INVESTIGATIVE OUTLINE

INSTRUCTOR: Brian J. Killacky
Detective
Bureau of Investigative Services
Area Three Violent Crimes Unit
Chicago Police Depratment

INVESTIGATION OF SEXUAL EXPLOITATION OF CHILDRERN.

1. Becaue the majority of Sexual Exploitation of Children goes unreported in your community, develop an ability to investigative this violent crime Proactively.

2. INVESTIGATIVE INTERACTION ON YOUR DEPARTMENT BETWEEN THE FOLLOWING UNITS IS ESSENTIAL:

A. Patrol Division with Youth, Juvenile, Missing Person, Crimes Against Family Unit,Vice Narcotics and Prostitution.School Officers, D.A.R.E. Officers and Crime Prevention Officers. C.A.P.S. Stratigies should intergrate exploitation of children.

B. Crime Analysis Units should compile information on the following analytical data.

1. Recent Crime Analysis Patterns
2. Child Sex Ring Offenders
3. Indecent Solicitation of Children by strangers luring them.
4. Public Indecency Offenders
5. Prostitution Related Offenses
6. Recent Pennitentary Releases.
7. Automated Fingerprint Identification Systems.
8. Sex Offenders currently on Probation.
9. DNA Anaysis of Offenders.
10. Habitual Sex Offenders Registration Acts.
11. Home Monitoring Information.
12. Updated Photo File of Sex Offenders
13. United States Customs and Postal Inspector Seizure Lists.
14. Offenders Vehicle Information.
15. Current list of all missing persons.

APPENDIX B.
(cont)

SEXUAL EXPLOITATION OF CHILDREN
INVESTIGATIVE OUTLINE

INSTRUCTOR: Brian J. Killacky
Detective
Bureau of Investigative Services
Area Three Violent Crimes
Chicago Police Department

C. INTERAGENCY INTERACTION.

1. City Police with County or Parrish Sheriff on cases of multiple juristiction.
2. County Wide Investigator and Juvenile Officer Meetings to highlight sex abuse and Missing Children Investigations.
3. Involvement of the State Investigative Unit or Attorney General for juristictional differences.
4. Awareness programs for Metro Narcotics Units.
5. Federal Bureau of Investigation
6. United States Postal Inspectors
7. United States Customs
8. ATF.
9. DEA
10. Bureau of Indian Affairs
11. National Center for Missing and Exploited Children
12. Social Service Divisions
13. Cross Reporting on all sex offenses involving children
14. Cross Reporting on all Habitual Runnaways
15. Domestic Violence Programs
16. Juvenile Detention Facilities
17. Adolescent Psychiatric Facilities
18. Runnaway and Homeless Shelter Programs
19. Photo Lab Development Facilities
20. Juvenile and Adult Probation Workers
21. Foster Homes and Shelters
22. School Personnel (pre-school,grammar and High School).
23. Long Term Placement Programs
24. Expand Juristiction of "Hotline"

APPENDIX B.
(Cont)

SEXUAL EXPLOITATION OF CHILDREN
INVESTIGATIVE OUTLINE

INSTRUCTOR:

Brian J. Killacky
Detective
Bureau of Investigative Services
Area Three Violent Crimes
Chicago Police Department

D. PROSECUTION OF THE OFFENDER.

1. Adequate Training must be provided for those who prosecute these cases.
2. Understand the "Vertical Prosecution System"
3. Be aware of changes in the following issues.
   a. age of consent.
   b. age between victim and offender
   c. penetration vs. contact or fondling
   d. extended statute of limitations
   e. amendatory vetos.
   f. Hearsay Exceptions
   g. Timeliness of a search warrant
   h. Pretext Conversational Overhear "one party"vs "two party consent"
   i. Solication, Conspiracy and Attempt
   j. Communication with Witnesses
   k. Intimidation
   l. Relationships between victim, the victims family and the offender.
   M. Misdemeanor Offenses
   N. Conditional Discharge,Supervision and Probation.
   O. Plea Negotiation
   P. Preliminary Hearing vs. Grand Jury
   Q. Victim Witness Programs.
   R. Expert Witnesses.
   S. Felony Review Programs
   T. Conviction Rates
   U. Sexually Dangerous Persons Act
   V. Presentence Psycological Exams
   W. Conditions of Bail or Bond.
   X. Dual Prosecution
   Y. Extended Incarceration
   Z. Conficts of Intrest

SYLLABUS – OPENING REMARKS

I. INTRODUCTION

A. Background of Middlesex Child Abuse Unit

B. Development of a Physical Abuse Protocol

C. Illustrative Cases Pre-Woodward; Commonwealth v. Azar, Commonwealth v. Procopio, Commonwealth v. Haskard

D. Comparisons/differences to sexual abuse cases

II. MATTHEW EAPPEN'S INJURY AND DEATH

A. The 911 call

B. The Emergency Room and Surgery
1. CNS, retinal hemorrhages
2. Cranioectemy after Cat-scan

C. Five days on respirator: no hope of recovery

D. Autopsy: Blunt trauma as cause of death

E. Neuropathology:

F. Pediatric opthamology

G. Child abuse conclusions

III. LOUISE WOODARD

A. Background in Elton, England

B. Experience in the States
1. Prior employment
2. Move to Eappen home
3. Interest in theatre, especially "Rent"
4. Aversion to curfew
5. The Christmas holiday
6. Growing tension in Newton
7. The three days before Matthew's injury
8. Interrogation and arrest for murder
9. Bail issues

IV. THE CASE PRE-TRIAL

A. Discovery begins

B. Polygraph evidence and hearing re: Admissibility

C. Defense requests for DNA: differential diagnosis defense?

D. Reciprocal Discovery: defense witnesses opinions show initial defense theory

E. Dr. Jan Leestma examines Matthew's dura before Labor Day 1997

F. Dura hearing – missing evidence?

G. Defense theory and discovery changes 4 days before trial: the "old-injury and re-bleed theory"

V. TRIAL

A. Commonwealth's Strategy
   1. Strengths and weaknesses of case
   2. Use of visuals

B. The Case-in-Chief
   1. The medical and forensic evidence:
      a. Dr. Ken Mandel, Emergency Room
      b. Dr. Joseph Madsen, Pediatric Neuro Surgery
      c. Dr. Patrick Barnes, Pediatric Radiologist
      d. Dr. Lois Smith, Pediatric Opthamology
      e. Dr. Eli Newberger, Child Abuse Diagnosis
      f. Dr. Gerald Feigin, Medical Examiner

   2. The fact witnesses:
      a. Sgt. Bill Byrnes
      b. The Drs. Eappen
      c. The "Rent" acquaintances
      d. The prior employers
      e. The E.F. Au Pair Manager
      f. Louise's English au pair friend
      g. The Eappens' friends
      h. The Realtor: Saw Matthew the previous Sunday

C. The Cross-Examinations by Defense
   1. Successful (and unsuccessful) attempts at impeachment of Commonwealth's case
      a. Hospital protocol
      b. Retinal hemorrhage evidence
      c. Grand Jury testimony re: force used/needed
      d. Dura issue
      e. Failure of Medical examiner to identify "shaking"
      f. Bias of "medical" witnesses towards "medical" parents

D. The Defense Case-in-Chief and Cross-examination
   1. Dr. Jan Leestma
   2. Dr. Alisa Gean
   3. Dr. Ayub Ommaya
   4. Dr. Thibeault
   5. Dr. Michael Baden
   6. Payment and bias issues; no opthamologist; only one "pediatric" witness

E. The Defendant's Testimony and Cross-Examination
   1. Preparation and strategy for the cross-examination
   2. Too rehearsed? Or effective?

F. Closings
   1. Commonwealth's goal and strategy
   2. Defense strategy

VI. INSTRUCTIONS, VERDICT AND INITIAL SENTENCE

A. The potential conflict issue: E.F. Au Pair's role in the defense and the issue of a "murder" only instruction
   1. Murder and Manslaughter in Massachusetts
   2. The Colloquy with defendant and independent counsel re: omission of manslaughter to the jury

B. The Verdict: 9p.m., October 30, 1997
   Second Degree Murder: "How could you do this to me?"

C. Automatic Sentence: October 31, 1997
   Life with parole eligibility after 15 years

VII. POST-TRIAL DECISIONS

A. Scheduling for Post-Trial Motions: 11/4/99
   Motions for New Trial and to reduce the verdict

B. Decision: November 8, 1997
   1. 10:00 a.m.-Reduction to Manslaughter
   2. 3:00 p.m.-Probation

C. Appeal and Decision: Mass. Supreme Judicial Court

VIII. EPILOGUE

A. "60 Minutes"

B. Tributes to Matthew Eappen

C. What now in Shaken Baby Syndrome Cases?

Conducting "Cyber"Crime Scene Searches

Supervisory Special Agent Don Cavender
Computer Analysis Response Team
FBI Laboratory
Washington, DC
202-324-9310
dlcavender.cart@fbi.gov

Objectives

- What is a Computer Forensic Examiner?
- Training/Equipment
- Pre-search Preparation
- Computer Search Overview/Case Study

Computer Investigative Skills

- Digital Evidence Collection Specialist
  - First Responder
  - 2-3 days training
  - Seize & Preserve Evidentiary Computers/Media
- Computer Investigator
  - Above experience +
  - Understanding of Internet/Networks/Tracing computer communications, etc.
  - 1 to 2 weeks specialized training
- Computer Forensic Examiner
  - Examines Original Media
  - Extracts Data for Investigator to review
  - 4 - 6 weeks specialized training minimum

Services Provided by Computer Forensic Examiners

- Exams
  - Computer and diskette exams
  - Other media - Jaz, Zip, MO, Tape backups
  - PDA's
- On site support of search warrants
  - Consultation with investigators and prosecutors
- Expert testimony for results and procedures

Additional Services

- Recover deleted, erased, and hidden data
- Password and encryption cracking
- Determine effects of code
  - such as malicious virus

Why Consult a Computer Forensic Examiner?

- Computer evidence encountered in all classification of cases
- Review of Digital Evidence is a Forensic Exam subject to procedural review
- Digital evidence is fragile and can be inadvertently damaged, destroyed or altered, rendering it inadmissible in court

Why consult a Computer Forensic Examiner?

- Booting (turning on) an evidence computer will cause system updates
  - Corruption or loss of data, lessens chances of data recovery
- Viewing, copying or printing original files modifies the files and it becomes inadmissible

Computer Forensic Examiner Training

- 4-5 weeks specialized Computer Forensic training
- 6 month to a year for certification
- Commercial training
  - A+ certification
  - CNA/CNE
  - MCSE
- $30,000 to train & equip. a new examiner
- Annual re-certification and commercial training ($5,000)

Other Computer Forensic Certifications

- SCERS - Treasury version of CART
  - also offered to Local LEA through FLETC
- IACIS - LEA non profit association
- Local LEO's
  - State Labs
- Some commercial and academic programs in early development

Computer Forensic Training

- IACIS - International Association of Computer Investigative Specialists - http://www.cops.org/
- Federal Law Enforcement Training Center (FLETC) Financial Fraud Institute - (SCERS Training) http://www.treas.gov/fletc/ffi/ffi_home.htm
- HTCIA - High Technology Crime Investigation Association - http://htcia.org/
- SEARCH Group - http://www.search.org/
- National White Collar Crime Center - http://www.cybercrime.org

Computer Forensic Equipment

- Examination Desktop $3,000
  - Highest performance affordable
  - SCSI, DVD, Super Drive
  - Additional Large Hard Drive $ 500
  - Printer $ 500 - $1500
- Search & Examination Notebook $ 3,000
  - PCMCIA SCSI & Network Cards $ 300
  - Additional Large Hard Drive $ 500
- External Backup (MO, Jaz or Tape Drive) $ 500 - $ 2,000
  - Parallel to SCSI Adapter $150
- CD Writer $ 500
- Forensic Software $ 1,500 - $2,500
- Cables/Adapters $ 200 - $ 300
- Cases $ 150 - $ 300
- PC Tool Kit $ 10 - $ 300
- Media $ 20 - $500 per examination
- Range Total $ 10,000 - $ 15,000 prior to media

Exam Tools

- Examiner should use software and hardware tested and verified for forensic examination
  - Cannot be freely distributed due to licensing
- Examiner may refuse to provide support for procedures or tools outside of forensic protocols

Computer Search Preparation

- Intelligence Gathering/PC Development
- Consult Computer Forensic Examiner
- Type of Search
  - Hardware Seizure (Bag & Tag)
  - Data Seizure (on site backup)
  - Consent Search
- Search Kit

Always attempt to contact a Computer Forensic Exxaminer prior to conducting a computer search

- Investigator contacts examiner while preparing for - PRIOR to search
  - Reasonable belief that computer evidence is on site

What if you can't find an Examiner?

- Do a well documented Bag & Tag Search
- Do not try to do your own exam of the original evidence (just a peek at what might be there)
- Preserve the evidence until the Computer Forensic Examiner can conduct the exam
- Evidence Review will require joint efforts of Investigator and Examiner

Intelligence Gathering

- Complainant Interview
  - Is complainant also potential subject?
- Victim Interview
- Informant Info/Development
  - System Administrator?
- Subpoena/Court Order
- Pretext Telephone Call
- Ruse Visit to Location

What Questions to Ask

- What computers are in use?
  - Hardware (Network?) Software (OS?) How many? Multiple locations?
- How they are being used?
  - Applications
- By whom they are being used?
  - Users & System Administrator
  - Which are subjects
- What is expected o be found on them?
  - Target Evidentiary Data
- Is the subject a publisher?
- Does warrant specify unread email?

Review the Warrant

- Legal Requirement prior to search
- Does it articulate what digital evidence should be encountered?
- Does it specify seizing what may be required for a forensic exam?
- Forensic Examiner may provide expert advice to support probable cause
- Supporting documentation
  - DOJ Guidelines
    DOJ Computer Crime and Intellectual Property Section (CCIPS) - http://www.usdoj.gov/criminal/cybercrime/
    CTC at USA's Office
- Special Timeliness considerations -
    Return of seized evidence

Determine the Type of Search

- Hardware Seizure (Bag & Tag)
- Data Seizure (on site backup)
  - Image or Logical?
  - Requires trained Computer Forensic Examiner(s) on site
- Consent Search

Search vs. Seizure

- Legal necessity
- Practical necessity
- Practical impossibility
- What are you looking for?

Hardware Seizure - What to Seize?

- Storage Media!
- Computer (CPU)
  - Monitor
  - Keyboard
  - Mouse
- Media, floppies, cd's etc.
- Old Drives
- External Drive & Media
  - Corresponding Devices
    - (tape/tape drive, jaz disk/jaz drive)
    - Modem
- Software
- Operating Manuals
- Laptop Power Supply

Bag & Tag Kit

- Cameras
  - Still & Video
- Gloves
- PC Tool Kit
- Labels
  - Color Coding
  - Indelible Felt Tip Marker
- Packing Material
  - Bags & Boxes
  - Packing Material - no peanuts!
  - Anti Static
  - Tape - Shipping & Evidence
  - Rubber Bands
- Evidence Forms

Fingerprint & Trace Evidence

- Determine prior to search
- Evidence Response Team assistance
- Handle with gloves
- Paper Bag & Label
- Image or remove hard drive/media prior to latent print processing

Image or Logical?

- Image - Duplicate Original
  - Best Evidence if original is not maintained
  - Data Recovery
  - Time Consuming
  - Data not readable until restored
- Logical - Content Copy
  - Can best represent network virtual drives
  - No Data Recovery
  - Data in Readable Form

Consent Search

- Has Case Agent submitted an exam based on consent?
  - Review w/Prosecutor, CTC at USA's Office?
    - Obtain Search Warrant?
- Review on-site until PC exists to seize

or

- Image and review after Search Warrant is obtained

Search Operations - Search Steps

- Secure the Location
- Secure the Computers
- Site Survey
- Sketch & photograph site
- Conduct Interviews
- Bag & Tag
  - Shut Down
  - Label Connections
  - Dismantle Equipment
- Data Seizure
  - Shut Down
  - Attach external media
  - Reboot w/ write protection
  - Attach to Network?
- "Hard Copy" Evidence
- Transportation of Evidence
- Storage of Evidence
- Documentation

Secure the Location

- LEOs make safe entry & secure
- Law Enforcement/Individual Safety #1
  - Investigator is responsible for safety of Civilian Examiners/Experts
- Potential for Violence
- Anarchy Files
- Suicide

Secure the Computers

- Move everyone away from the computers
  - "Get your hands off the keyboards!"
- Unplug telephone lines, maybe even the keyboard & mouse connections
- Do not accept subjects offers to "help" you operate the computer
- Be sure the computers are not disturbed while search is on-going

Site Survey

- How many Computers,
- Location
- Type (PC, Mainframe, mini)
- Network
- OS
- Is Data at risk?
- Any processes occurring?

Sketch & photograph site

- Done before anything is disturbed
- Records evidence
- Prevents liability

Photographs & Diagrams

- Photograph
  - Search Site
  - Monitor
  - Connections (back of the computer)
  - Hard Copy Evidence
- Diagram
  - Search Site
  - Computer Connections

Conduct Interviews

- Recruit cooperating persons
- Investigator's discretion
- Take notes / write report
- Get technical details
- Saves time and effort

Subject Interview

- Investigator should include Forensic Examiner in key interviews
  - Subject and Systems Administrator
  - "Geekspeak" translator
- Passwords!
- Associate the Subject to the computer
  - Who uses it
  - For what?/ which programs
  - User ID, screen name, alias, email address

Shut Down

- If it's off, leave it off!
  - Is it in Suspend Mode or Shut Down?
- If it's on
  - Gentle Shutdown
    - Do you recognize the OS?
    - Call for help

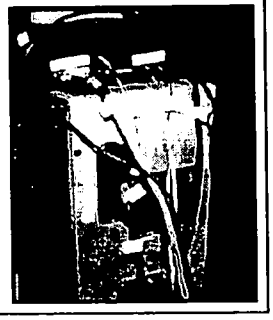
    or
  - Pull the plug
    - photograph screen
    - pull from back of box
    - remove laptop battery
- Detailed Notes

Pulling the Plug - General Guidelines

- Home/Standalone computer
  - usually okay, can lose unsaved data
  - gentle shutdown preferable
- Server/Mainframe computer
  - Don't pull the plug
  - Can cause irreparable damage, may never come back up

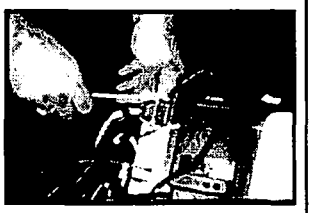
Label Connections (B&T)

- Label ports and corresponding cable
- Label cable connections at both ends
- If not connected - mark it as such (nc, mty)
- Initial external devices and record serial/unique numbers from all devices



Dismantle Equipment (B&T)

- Take all external devices and cables
- Do not attempt to remove just the hard drive for examination
- Seize corresponding media and devices
- Segregate systems



Data Seizure

- Requires Trained Computer Forensic Examiner
- Shut Down
- Attach external media
- Reboot w/ write protection
- Attach to Network?
- All backup done onsite
  - maintain option to seize if required

"Hard Copy" Evidence

- Hand written notes, spiral binders
- Notes near monitor, on/under keyboard, in the trash
- Passwords? Activity logs?
- Computer printouts

Transportation of Evidence

- Carefully Package - original boxes?
- Bubble Wrap/Anti static if available
- No peanuts or excelsior
- Keep it dry
- Avoid shocks
- Avoid magnetic fields

Storage of Evidence

- Start chain of custody ASAP
- Submit to Computer Forensic Examiner ASAP
- Proper evidence storage
  - Secure Location
  - Mark as evidence - do not turn on, do not use!
  - Clean, dry, with AC
    - Evidence Storage specs
  - Proper shipping

Documentation

- Chain of Custody
  - Separate forms for Computer Evidence
- Search/Exam Notes
- Search/Exam Reports

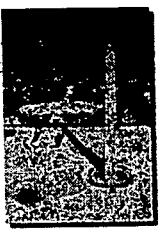
Exam Results -How big?

- One megabyte = 1,000,000 characters
- One megabyte = approx.. 500 pages
- One hundred megabytes = 100 novels
- One gigabyte = 1,000 megabytes
- One gigabyte = 187 feet of paper
- Average Hard Drive = 4 gigabyte

How Big???

- Contents of a 3.2 Gigabyte Hard Drive
- Printed out
- Would build a Stack of Paper as Hi
- The Washington Monument (555 ft

=

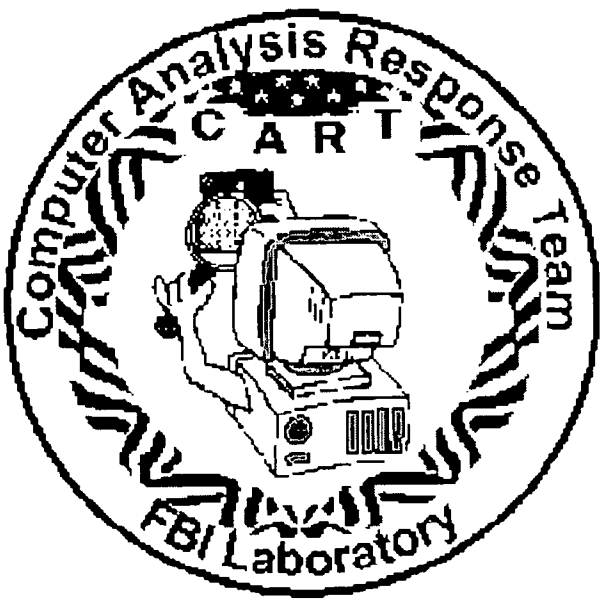


How long?

- 500 pages - 41 minutes (1 meg)
- 50,000 pages - 70 hours (100 meg)
- 500,000 pages - 4 months (1 gig)
- Average Hard Drive - 4 gig
- 2,000,000 pages - 1 1/2 years (4 gig)

FEDERAL BUREAU OF INVESTIGATION

Computer Analysis and Response Team



Conducting Searches in a Computer Environment

COMPUTER ANALYSIS AND RESPONSE TEAM

Conducting Searches in a Computer Environment

935 Pennsylvania Avenue, N.W. / Room 4315
Phone 202.324.9307 • Fax 202.324.9347

Rev. 2/21/97

Disclaimer

This document is designed for training purposes. It provides a framework for learning how to conduct searches in a computer environment. It does not provide any legal advice nor does it make any policy recommendations. Nothing contained in this document should be construed to reflect either FBI policy or procedure.

Federal users are strongly advised to read *Federal Guidelines for Searching and Seizing Computers*, a document published by the United States Department of Justice. This document is neither a summarization of nor a replacement for those guidelines.

State and local users should contact appropriate authorities to determine the application of state and local laws and procedures. Furthermore, all searches and seizures should be conducted in accordance with applicable laws and agency policy.

Introduction

Conducting searches in an electronic environment is a relatively new challenge to law enforcement. While the principles of conducting searches do not change in an electronic environment, new skills and thought processes must be utilized. This guide is designed to be a general approach to the electronic environment. It is neither a substitute for proper investigative techniques, appropriate application of legal principles, nor safe tactical practices. Rather, the electronic aspects of a search have to be woven into the fabric of search execution.

In a classic search scene, the investigator can visually identify the objects which may contain evidence. He or she can view it and make a determination if it is evidence and whether or not to seize it on-scene. Often, this is not the case with electronic evidence.

Because technology changes rapidly, the storage devices for electronic evidence may not be apparent to the investigator. Determining what hardware and software are required to view potential evidence will likely be beyond the expertise of the investigator. Important evidence may be overlooked or damaged if proper seizure and examination procedures are not used.

The Computer Analysis and Response Team has developed this guide to provide investigators with some assistance in dealing with electronic searches. It was written based on the experiences resulting from numerous searches conducted in the field.

This guide includes an overview of the forensic examination process. Hopefully, this will provide investigators with a sense of what methodology is used to examine electronic evidence. A guide for conducting searches is provided to assist the investigator with planning a search that includes electronic evidence. Each United States Attorney's Office has a copy of this document. It provides

excellent legal advice for those operating within the Federal criminal justice system.

Turning Rust Into Evidence

As of this writing, most computers use magnetic media for their permanent storage. This media can be in the form of hard disks, floppy disks, or magnetic tape. What all of these have in common is that they are coated with a metallic oxide. Ferric (iron) oxide, which is the basic component of the coating of these media, and which is usually used in conjunction with cobalt or barium, is commonly called rust. Seizing this media, examining it, developing information from it, and entering it into evidence at trial, is a process called computer forensics. Let's examine this process.

Once a piece of media is obtained, through seizure or other process, it devolves to the government to conduct an examination to determine several things. Does the media contain information which is pertinent to the matter under investigation? If there is pertinent information, is it incriminating or is it exculpatory? How did this evidence come into existence? Who can testify concerning this? There are really four steps to answering these and other questions.

Establishment Of Probable Cause

The case agent is responsible for the establishment of the probable cause to seize material and is responsible for selecting and articulating the legal basis of any seizure. The forensic specialist can assist the case agent by explaining the technical issues and potential problems, providing expertise which can be used in an affidavit, and providing language that will explain technical issues in non-technical language.

One issue which needs to be established and fully articulated is the role that any computer plays in the case. Effectively there are two roles that a computer (and

its storage media) can play in a case. The computer can be an instrumentality of the crime or it can merely be a repository for evidence. In the former case, if it can be shown that the computer was an essential part of the commission of the crime, then it will be much easier to justify to a court the seizure of the computer and media. If the computer is only used as a repository for records, then seizure of the computer may not be approved unless there are articulable reasons that such seizure is necessary. Even then, it is likely that it may be approved only long enough to allow the production of copies.

Seizure

Seizure is the next step in the process. While the case agent may unilaterally seize evidence, there are real advantages to forming a partnership with a forensic specialist. If there are prior consultations, then the volume of evidence may be reduced, the efficiency of the remainder of the process improved and the quality of the evidence increased. It is media which is physically taken. But the media, by itself, usually has no investigative value.

Documentation

The next step in examining the electronic evidence is to document the media. The examiner will conduct appropriate tests to document what is contained in the media. The preliminary tests will reveal the physical characteristics, the manner in which the data is stored, the character of the data, and the presence or absence of hidden or erased data. The examiner refers to this as documenting the media. We will use, as an example, a floppy disk for purpose of this discussion. The examiner determines that the floppy disk was created under the DOS operating system, has some data files, and has an erased file. The product of this part of an examination is "data."

Data is the raw product which, when viewed in the proper light, will have meaning. Data is useless in the absence of either a program which puts the data in a readable format, or at least provides the examiner with an understanding of how the data was created and used. Often, the data will consist merely of a series of numbers and/or characters without apparent meaning. The examiner may or may not be able to identify the program and its data format. It is therefore important for the investigator to determine the identity or at least the types of programs which may be in use by the subject of the investigation. It is the

examiner's challenge to determine what is required to make this data into a usable product which is called information. In this case it is determined that the erased file is a spreadsheet which was created using a program called Lotus 1-2-3.

Examination

Information is data with meaning. To use the spreadsheet analogy, once the Lotus file is examined with an appropriate viewer or loaded into the Lotus program, the rows, columns, figures and formulas become useable by human beings. It is the examination process which turns data into information.

The key to a successful examination is for the investigator and the examiner to set goals for the examination. The investigator has to articulate what the purpose of the examination is, as well as the information which needs to be developed. The goals can be modeled along the lines of the 5 "W's". **Who** may be involved, doing **What**? During what time period (**When**)? Using what software (**Where**)? **Why** is it likely that the evidence is located in this media? And finally, **How** does this relate to the investigation? Examinations are qualitative as well as quantitative processes.

Examiners can conduct a number of different types of examinations on a given piece of media. They can also utilize a variety of tools with different parameters. The type of examination and the tools to be used are chosen based upon the examination goals. It is the sum of these two elements that produce examination results.

$$\text{GOAL} \Rightarrow \text{TYPE EXAM} + \text{TOOLS} = \text{RESULTS}$$

But examination results in and of themselves are still not meaningful. The results must be evaluated and interpreted.

While the significance of a given piece of information can often be judged by the examiner, the investigator will often be able to make a much better judgment of its value. By working together, the investigator and examiner can develop a search strategy that will be both thorough and economical. The examiner and investigator can then explore how the information relates to the case and can determine if the information will be useful as evidence. In the case of our hypothetical Lotus file, if it shows criminal activity, then it may be used as evidence.

Reporting

Information has no legal value until it is actually admitted in trial. It then becomes evidence. The services of the examiner may be required in order to establish the existence of the evidence and the process by which it was developed. In the case above, the examiner can introduce the printed copy of the spreadsheet and testify as to how it was "un-erased" and printed. Prior testimony will be required to show the origin of the evidence. In some cases, the existence of the information may be sufficient as evidence. More commonly, in order to exploit the probative value of the evidence, it is necessary to have the testimony of others who can explain the origin, veracity, or significance of the evidence. In a white collar crime case, it may be desirable to have an employee testify as to how and why the Lotus spreadsheet was created. Alternatively, the services of an auditor may be useful to provide an expert opinion as to the significance of the evidence.

Clearly, both the examiner and the investigator have responsibilities in connection with the examination of evidence. In reality, these responsibilities begin even prior to the search. The following chart summarizes the responsibilities for each party:

	Examiner	Investigator
Probable Cause		X
Seizure		X
Documentation	X	
Examination	X	X
Reporting	X	

By understanding the process and the roles that investigator and examiner each play in the computer forensic process, we will be able to successfully turn rust into evidence.

Before You Begin

There are two issues that need to be addressed in connection with executing search warrants. The first is what kind of a computing environment might be expected. The other concerns where to examine the data in electronic storage. Let's deal with the second issue first.

Where to Conduct Examinations

There are only two places where computer evidence should be examined. One is where it is found and the other is in a laboratory setting. The advantage of conducting full or partial searches on site is that it may allow for less hardware to be seized. This will also help mitigate the defense contention that there was a general seizure. On the other hand, there is rarely sufficient time in which to conduct a full examination of one machine, let alone more than one. If it is essential that all possibilities be exhausted, then a on-site examination should not be attempted. It is generally better practice to conduct a cursory search to determine if the computer is subject to seizure pursuant to the warrant and, if so, to seize it for further laboratory examination.

There are a number of exceptions to this policy. One is in the case of mainframes and minicomputers. Another is in the case of extensive networks which cannot be (or should not be) seized. In these cases, it may be necessary to conduct the search on site, with assistance from cooperative employees or contractor personnel.

Search Environments

There are essentially three environments in which computers operate. How computers are connected and what functions they perform determine how the search may be conducted. It is possible that a search site will contain a composite of these environments.

Stand-alone Computers

A computer can stand on its own. A central processing unit, an input device (such as a keyboard), and an output device (such as a monitor or printer) are required by definition to complete a computer. In addition to these devices, additional devices for input, output, or storage may be present. What defines a stand-alone computer is that it is self contained and is not directly connected to another computer and has its own operating system. A desktop personal computer is the classic example of a stand-alone computer environment. Stand-alone computers are inherently finite. That is, most evidence will be found in one place.

Networks

As we have defined a computer above, it consists of the ability to process information (a central processing unit) and the instructions necessary to do so (an operating system). When two or more computers are electronically connected and can share each other's devices, we call it a network. What is different about a network is that the resources of all of the attached computers constitute a whole. As we shall see, this has a profound effect on search and seizure matters. It is important to note that individual computers attached to the network may be able to function as stand-alone machines. So, to a degree, networks inherit all of the characteristics of the stand-alone environment. They are however, not finite. Information may be found almost anywhere on the network.

Mainframes

In the classic mainframe environment, there is one large computer which has all of the resources. Attached to it are many terminals. These terminals are merely the input (keyboard) and output (monitor) portions of a computer. They do not have the ability to process information. All of that is done at the mainframe, as is any other service which requires a device other than the terminal's keyboard and monitor. The mainframe processes, prints, stores, and directs information to terminals. It is the solitary and central "brain" in the system.

How Does This Apply?

In computer forensics we are normally interested in the storage portion of the computer system where both data and programs are located. This is where we wish to search for evidence. It is important to know where the storage system is in order to conduct a proper search. Let us apply this to the three environments above.

In the stand-alone environment, the storage and operating system are all attached to the computer. Therefore, the search is self-limited. In order to search for evidence on a stand-alone one must have possession and control of the computer. While this is simple enough, there are at least two other issues which need to be taken into consideration. If the entity to be searched has a large number of stand-alone computers, then a large number of potential examinations exist. Consideration should be given to limiting the number of seized and examined computers. This can be done perhaps by evaluating the principal user's relation to the case under investigation. This brings up the issue of probable cause. If there are numerous stand-alone computers, we need to ensure that our probable cause applies to all of the machines or that we limit our search to those to which probable cause applies.

In a network environment, the first problem is to identify where the storage is located. It may be associated with a single computer, often called a file server. It may be associated with each of the attached computers (sometimes called a peer-to-peer network) or both. The type of storage arrangements in use determine what search and seizure procedures are used. To the extent that individual computers permit storage, then the issues identified above are appropriate. When the principal or only storage is in a file server, then it will be necessary to search the file server. This may require both the server and a workstation. It should be noted that the volume of information and potential evidence contained in a network environment is generally an order of magnitude larger than in a stand-alone environment.

Because all storage in a mainframe environment is located with the central processing unit, it follows that the search location is singular. While this is generally true, there is an inherent problem. In a stand-alone environment we can seize the computer and conduct an examination. With a network, we may be able to seize the file server and a single work station in a client/server environment. But due to the nature of mainframes, seizure is not a practical option, except in extraordinary circumstances. Mainframes require physical facilities (electrical and air conditioning) and are always unique. Even though the central processor unit and peripheral devices are standard, their interface to each other is installation dependent. The operating systems are device dependent and often require the services of a programmer, systems engineer, or administrator familiar with the particular installation.

The environment associated with the computers has a major impact on the execution of the search, seizure potential, and human resources needed to successfully conclude a search. It is important that investigators not only understand these issues, but discuss their impact with their forensic specialist.

Planning and Executing Searches in an Electronic Environment

This section was prepared to assist investigators with the planning and execution of search warrants in an electronic environment. As a guide, it does not answer all of the possible questions. It does provide some suggestions that have proved themselves in operational use.

For the purpose of this discussion, we will use the term forensic specialist. By this we mean a person who has received training specifically in the area of computer seizures. This person may be an examiner, crime scene technician, computer specialist, computer crime investigator or any other sworn or civilian employee of a law enforcement agency with the proper knowledge and training.

Pre-Search Procedures

In most searches, the outcome is largely predicated on the quality of the preparation. Preparation prior to the search will enhance the quality of the search and have a significant impact on the quality of the electronic evidence developed after forensic examination.

Intelligence Gathering

There can never be enough information gathered concerning the object(s) of the search. Information that needs to be ascertained includes the type of computer system(s), operating systems, network operating systems, type of storage, location of equipment and storage devices, remote access possibilities and what the computer is used for. This is in addition to the normal tactical questions concerning the physical layout and persons likely to be present at the search site. Intelligence concerning persons with knowledge and/or responsibilities over computer systems is very valuable. If sufficient sources or cooperating witnesses

are not available, consideration should be given to developing them. It is important to begin to set goals for the search and subsequent examination.

Preparation of Affidavit

The following guidance assumes that a judicial warrant will be utilized for the search. If consent or other legal doctrine will be used, a review of the basis and limitations of that doctrine should be undertaken.

Warrants really have two major elements. The first is probable cause to conduct the search. Included within the probable cause are the elements which define the location to search and the items to be searched for. The second is judicial authority to seize items. Based on the intelligence gathered, there should be sufficient probable cause to allow the search for electronic evidence. The services of an experienced computer investigator or forensic specialist may be useful to explain the technical aspects in layman's terms suitable for inclusion in the warrant. Depending on what is found at the search site, it may be necessary to seize hardware not directly associated with the data to be seized. If this can be anticipated, language can be inserted in the affidavit and warrant which will allow seizure of this additional equipment. (The Department of Justice's *Federal Guidelines for the Search and Seizure of Computers* provides excellent advice concerning legal issues and also provides specific language that can be used in affidavits.)

Preparation of Search Plan

A safe and successful search requires that a search plan be organized. Information regarding the electronic environment that was gathered in the intelligence phase should be integrated into the search plan. The forensic specialist should act as an advisor to the principal investigator on technical matters. It must be understood that the principal investigator has authority and responsibility for both the search and seizure. These responsibilities cannot be delegated to, nor should they be assumed by, the forensic specialist.

> **Timing** - When to search is dependent upon two factors. One is the status of the computer system. The other is the presence (or absence) of particular persons. Late night or early morning will likely find the computer systems either down or engaged in off-line functions. As a result, it is likely that there is little danger for loss of data. However, during these same hours, there are likely to be few responsible and knowledgeable employees that can provide technical information to assist the search team.

Manpower - Adequate technical personnel need to be assigned to the search in addition to the general investigative manpower. If intelligence identifies a computer system with which the forensic specialist is not familiar, it may be necessary for the forensic specialist to obtain outside or contract assistance.

A computer crimes investigator or sworn forensic specialist needs to be one of the first persons into the search site. This is to ensure that electronic evidence is not at risk. If the forensic specialist is not sworn, it will be necessary to provide sworn assistance in order to ensure security and enforce compliance in the preservation of the search site.

Logistics - Computer equipment and media can be bulky and require careful moving. Tools, software, labels, evidence tape, blank media and other specialized items are usually required to complete a search. Seized equipment will need to be examined. This normally is not done at the scene. The equipment may need to be transported to a different location than the rest of the evidence. Special packing and transportation may be needed. It is easier to arrange for these needs ahead of time. These requirements need to be coordinated with the forensic specialist.

Review of Warrant Specifics

Once a warrant has been obtained, it is necessary for each member of the search team to review the specifics with respect to each location. These include:

Location to be searched - The location named on the warrant is the physical location which can be searched. It may be determined that computerized data, while accessed from the location searched, is actually located at some other physical location. Legal guidance must be obtained in this situation.

Evidence for which to search - A well-written warrant will authorize the search for evidence in either physical or electronic form. It is important that the non-computer literate searchers recognize potential electronic evidence. At the same time, it is important that the designated computer searchers understand the elements of the case and kinds of evidence likely to be found.

Items authorized to be seized - In addition to the legal aspects, there are practical and forensic reasons to seize things. It may not be possible to

conduct a sufficient examination on scene to determine the location of all the evidence. Conversely, it may not be appropriate to remove an entire computer network from a corporation. Decisions also will need to be made concerning computer related items, such as floppy disks, tape backups, printouts, and papers related to the operation of the computer.

These issues should be discussed by the principal investigator and the forensic specialist prior to the search. A decision does not (and should not) be made prior to entering the premises. However, it will save time and result in a more reasoned decision if the investigator and computer specialist understand the legal and practical issues which they must resolve. It must be understood that more often than not, these decisions will be a compromise.

Initial Search Procedures

There are several critical things that need to be accomplished in the first few minutes of the search execution. It is critical that these steps be taken in order as closely as possible.

Secure Crime Scene

The very first duty of law enforcement upon entering a location is to secure the scene. The government needs to take control of the location and persons therein for several reasons, not the least of which is the safety of the law enforcement officers. It is also necessary for the preservation of evidence. The steps outlined below assume that the scene has been secured insofar as physical and/or environmental threats.

Separate people from computers - Because there may be persons present with the skill and motivation to destroy electronic evidence, immediately separating all persons from any part of a computer system is critical. This should be the responsibility of all sworn members of the search team, not unsworn technical specialists.

Determine if any evidence is at immediate risk - As soon as control of all persons present is accomplished, the forensic specialist should attempt to determine if there is any evidence that is at immediate risk. For example, the process of formatting of a disk or tape destroys data. A determination as to disconnecting the systems present from networks or modems needs

to be made quickly. The possibility that someone may be remotely destroying evidence should be considered.

Stabilize Environment

Once these time-critical tasks are completed, it is important to establish a stable working environment. There are several things that need to be accomplished.

Ensure that computer areas are secured from all parties - Areas of interest for electronic evidence need to be tentatively identified. The search leader should be asked to assign these areas for search by technically qualified persons. Steps should be taken to keep these areas secure until actually searched. *Under no circumstances should non-law enforcement persons be allowed, unescorted, into these areas.*

Determine if computer environment is connected to outside - If not already done, it is important to determine what outside connections may be in place. This is not only important for security reasons, but also to determine if all information is being obtained within the geographic bounds of the location to be searched.

Identify Persons with Computer Knowledge and/or Responsibilities

Identifying persons who should be interviewed by technical personnel can be accomplished by non-technical persons. This should be cross-referenced with the information developed in the intelligence phase. Where feasible, the technical people identified for interview should *not* be interviewed by non-technical persons first (see below).

Conduct Of Search

Once the search scene is stabilized the actual search can begin. The forensic specialist should assign the manpower to most efficiently carry out the search procedures. It will be necessary to get a detailed inventory of the equipment to be searched.

Determine Net Computer Environment

A careful inspection of the search site will allow the forensic specialist to properly execute the search. It will also allow the forensic specialist to advise the search leader as to the situation and estimate the duration of the technical aspect of the search. The inspection should identify the following, at a minimum:

1. Number of CPUs
2. Type of CPUs
3. Location of CPUs and peripherals
4. Type and topology of network
5. Network operating system
6. Size and nature of storage media
7. Existence of back-up media

Photograph and Document Search Site

It is important that the pre-search environment be documented. Not only is it important for legal purposes, but may also serve as a useful reference during the forensic examination of the evidence. At this stage, only general photographs need to be taken. Detailed photographs will be taken at a later stage.

Conduct Interviews of Persons with Knowledge of Computer Systems

Once the technical people have inspected the scene, they are prepared to conduct the interviews of the persons identified as having computer related duties or knowledge. There are several reasons why interviews should only be done at this stage. Forensic specialists are in a position to develop rapport with the interview subjects. Technical people tend to relate to others with similar interests. It is also very easy for them to provide false or misleading information when they believe that their interviewer is not capable of discerning the truth. It is therefore important that they be interviewed by persons who can evaluate their information during the interview. It is also important to conduct the interview before physically accessing or dismantling the computer equipment. Cooperative interviewees may be able to provide valuable and time-saving assistance. It is, after all, their system. Additionally, people who have responsibilities concerning equipment tend to take ownership of these devices. As a result, they tend to be far less cooperative after watching someone dismantle "their" machine.

Determine if On-Scene Examination is Warranted

Depending on the legal, practical, and logistical concerns present, it may be necessary to conduct a examination of the evidence on site. Conversely, if there is a very large volume of material, a limited examination may need to be conducted to eliminate non-pertinent machines and/or media. In most other cases, it is not appropriate to conduct examinations on site.

Evaluate What Evidence/Media Needs to be Seized

The forensic specialist should evaluate the items which are subject to seizure and should make recommendations concerning what to seize. It is necessary to seize those items which will likely contain evidence. However, limiting what is seized to only that which is pertinent will save both the examiner and the case investigator significant time and effort.

Consult Principal Investigator Concerning Seizure

After the above procedures have been accomplished, the forensic specialist needs to consult with the principal investigator and make his/her recommendations. It must be remembered that it is the principal investigator's role to make the final determination. However, the forensic specialist must be able to effectively communicate the situation.

Seizure Procedures

The actual seizure should be performed after all previous steps have been taken. Good seizure practices should be followed.

Operating systems that generally should be shut down via internal commands include Unix, Windows NT and 95, and most types of file servers, such as Novell and Windows NT.

Power Down System - If the computer system is currently running it will be necessary to power down. Depending on which operating system is in use, it may be necessary to shut down the system using the operating system before shutting off the power. Failure to do so can make recovery of some systems difficult or even impossible.

Mark and Initial Items - Before disconnecting or disassembling any computer components, everything should be labeled or tagged, initialed and dated. It is recommended that items associated with a single central processing unit be assigned a single item number with appropriate sub-numbers. If the room in which the computer is seized is given the identifier "F", then a single computer might have the identifier "F-5". The keyboard might be assigned "F-5-1", the monitor "F-5-2" and the central processing unit "F-5-3".

Label All Connectors/Plugs - It is critical that the cabling be documented precisely. There are many non-standard cables. Additionally, there may be multiple combinations which will fit, but do not work correctly. Therefore, all cables which connect items to be seized must be taken. Prior to removal (which will be done later), the cables need to be labeled. This is accomplished by using tape and/or tags to mark each end. A

corresponding tape or mark is placed on the device to which it is connected. Each cable, except power cables, should have two tags or markers - one on each end. Each device should be marked as to where cables are connected. Either a descriptive (ie; LPT1, Serial Port, Monitor connector) or numerical (ie; Port 1, Connector 1) labeling system may be used.

Close-up Photographs - At this point it is very useful to do close-up photography of all the connections between individual pieces of hardware. This will provide a clear exhibit of how the system was connected and labeled. It will also facilitate the reconstruction of the system in a laboratory setting. It should be noted that the examiner often will not have the advantage of being at the search scene.

Dismantle Equipment - Once all of the documentation of the system is complete, disassembly can begin. It is best to work slowly and carefully. Generally, it is better to remove the peripherals first, and then the CPU. Work carefully and do not be in a rush.

Seize Documentation and Media Associated with Seized Machine - Select any documentation that should be taken, as well as any computer related notes or scraps of paper as authorized in the warrant. Be alert to possible passwords written on Post-It/"sticky" notes, scraps of paper, inside covers of manuals, etc. These should of course be seized.

Keep Items from Same System Together - In searches where there are multiple computer systems, it is important to keep items from one system separate from others. If the items get mixed together, it may be difficult to separate them later.

Head "parking" moves the electromagnetic writing equipment inside a disk drive away from the magnetic media. Parking provides some protection for the media, but should never be substituted for careful handling.

Handle Equipment Gently - It is important that computer equipment be handled gently. The condition of the equipment is not known. Any disturbance may loosen connections, which will require difficult troubleshooting. Not all fixed magnetic media is self-parking. It should be assumed that the heads are not parked. Any significant trauma may result in a drive failure.

Evidentiary Procedures

It is important that all post-seizure administrative procedures be properly handled.

Initialing and Dating Seized Items - Each item should be initialed and dated by the seizing person. This will ensure that if a single item is entered into evidence, there will be a solid chain of custody. There is no point in having an examination conducted which cannot result in being admitted into evidence at trial. It is however, acceptable to place floppy disks found in the same location into a single container and submitted as one item.

Packaging - Each item should be packaged in accordance with departmental policy.

Single Machine, Single Seizing Agent - It is more convenient to have a single person act as seizing Agent for a single machine. It will allow one person to authenticate the evidence rather than several.

Evidence Control System - All evidence must be promptly entered into the evidence control system in accordance with applicable rules. It is suggested that evidence be entered into the evidence control system prior to examination.

Report of Search

Documentation of the seizure of the electronic evidence can be accomplished within the report written for the entire search. As an alternative, a separate memo can be written to document the strictly technical aspects of the search.

1.People give to people not causes

2. Effective fund raising depends on strong committed volunteer leadership

3. There must be a sense of urgency to the ask

4. There must be passion to the ask

5. The message must be concise, consistent and compelling

6. The best predictor of a future gift is a good giving experience

7. The ask must be specific as to amount and purpose

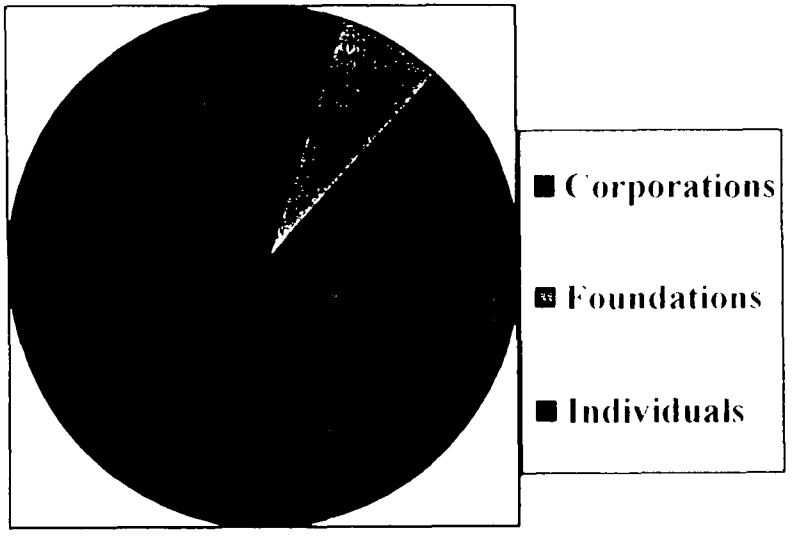
8. Suspects are not prospects

9. Those closest (the board) must give first And at levels that demonstrate commitment

10. There is no single reason why people give

- The board does sets policyand should not be involved in operations
- The board sets strategic direction
- The board establishes and maintains the Mission
- The board provides oversight
- The board ensures that the organization is financially sound

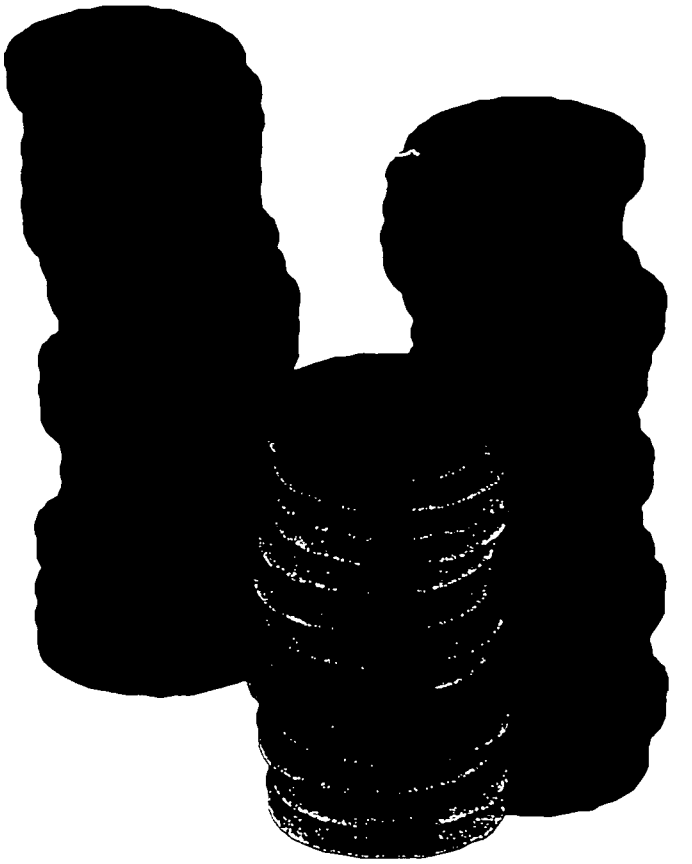
- The board serves as an advocate for the organization
- The board promotes awareness of the organization
- The board member is a fiduciary and must avoid conflicts of interest and acts in the best interest of the organization



Where do funds come from?

- 5% from corporations
- 7% from foundations
- 88% from individuals

- The annual or sustaining gift
- The major or campaign gift
- The ultimate gift



- Operational needs
- Made from discretionary income
- Frequently asked for and given
- Decision made quickly
- Decision rational
- Decision make without professional aid
- Derived from direct mail and special events

- Building and endowments
- 10-25 times annual
- Infrequently asked for and given
- Stop-and-think gift
- Decision becomes emotional
- Takes longer for decision/requires professional assistance
- Personal solicitation

- Used for endowments
- 1,000-2,000 times annual gift
- Once in a lifetime
- Long term relationship
- Very emotional
- Requires professional assistance
- On-going stewardship/personal
- solicitation

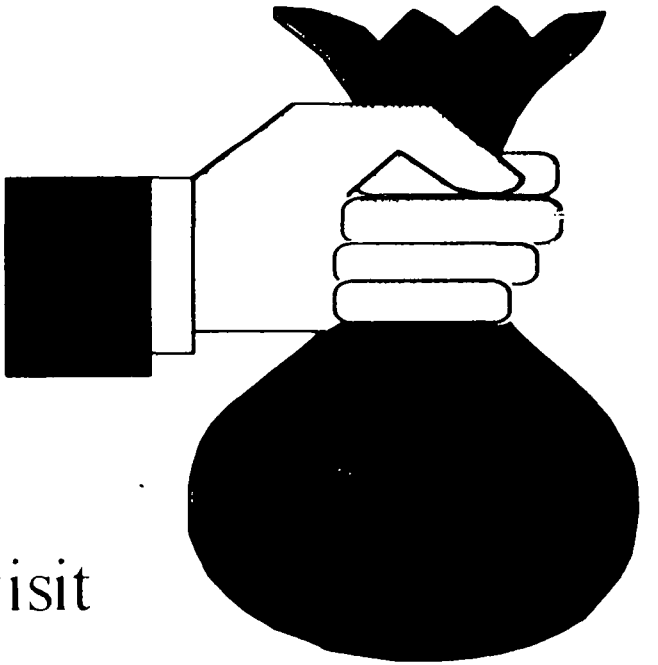
Annual	**Major**	**Ultimate**
Ask 80%	Ask 50%	Ask 20%
Cultivate 20%	Cultivate 50%	Cultivate 80%

- Cultivation events
  - Open houses
  - Parlor meetings
  - Business briefings
- Progressive involvement over time
  - Visit Society headquarters and meet volunteers
  - Briefings with researchers
  - Meet with grateful patients and families
  - Ask for advice

- A small committee who know
- the community is assembled

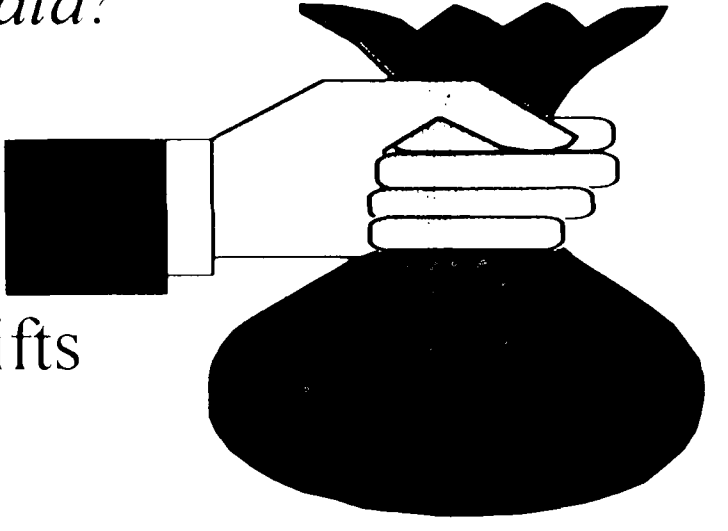
- They review prospects
- (individuals and businesses)
- The suggested amount :
  - Interest in the cause
  - Wealth or giving history
  - Who asks for the gift
- The best solicitor is chosen

- Plan for two visits
- Make team calls
- The ice breaker
- The opening
  - state the purpose of the visit
  - gain attention -- state overarching outcome
  - seek common ground



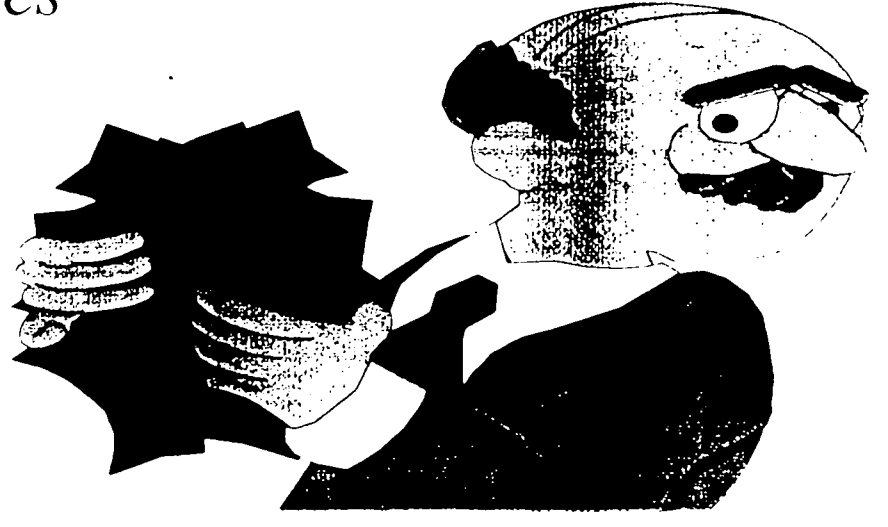
- The ask
  - *"Would you please consider a gift of $--- to be a major underwriter at the Gala?"*

  Pause
- The negotiation
  - use examples of leadership gifts
  - show them the gift table
  - tell them about your own gift



- Use creative redundancy
  - *"Your gift of $---- will be an important leadership gift and will benefit generations of patients and their families"*

- This is a trial close.
- Pause before response.



- Increased market share
- Increased profitability
- Promotion of a new product or service
- Promotion of a positive image
- Counteracting negative publicity/image
- Identification with noble values and causes
- Association with prestigious organizations
- Identification with key demographics
- Improvement of employee welfare
- Improved productivity

- Is the mission easily understood?
- Are its values universally held
- in high esteem or is it controversial?
- Does the charity have high visibility?
- Is the the charity prestigious?
- Has the cause been "legitimized" by celebrities?

Brian J. Killacky
Detective
Area Three Violent Crimes
Chicago Police Department.

1. The purpose of your investigation is to:

a) Establish Corpus Delecti
b) Establish the Criminal Agency
c) Collect Facts Proving or Disproving Guilt.

2. Those who commit crimes of Interpersonal Violence against Children are a heterogeneous group with few shared characteristics. Many times we generally divide these types of violent crimes into:

a). Targeted
b). Incidental.

2. A Child Becomes a Perfect Victim of Interpersonal Violence for the following reasons:

a). Lack of Verbal Capability
b). Unaware of Violation
c). Overpowered and Intimidated Easily
d). Easily lured.
e). Offender/victim relationship.

3. Those responsible for Investigating These Crimes of Violence Against Children must be promoted and selected with the following abilities:

a). Cultivate Information
b). Know the Personal and Property of their jurisdiction.
c). Crime Scene Management
d). Interview and Interrogation Skills.
e). Deal with outside and support agencies
f). High Conviction rate vs. Arrest Rate

Section 3. Cont..

g). Testifying in Court
h). Organization of Investigative Reports
i). Outside Interests.

4. Before walking into the Crime Scene, be aware that many times these crimes were committed through acts of:

a). Violence
b). Anger
c). Power and Control
d). Sexual Gratification
e). Crime of Opportunity
f). Revenge.

5. Detectives and Investigators many times engage in "Profiling".
The Profiling Objective is to provide the Investigator with a Personality Description of the Offender that will aid in the swift identification and apprehension of the offender(s). This is nothing more than an educated guess based on the Detectives:

a). Experience
b). Education
c). Forensic Recognition and Crime Scene Management
d). Intuition (Street Smarts)
e). Analytical Logic
f). Multidisciplinary Approach.

6. The use of "Profilers and Experts" at your Crime Scene:

Your instructor has participated in the Investigation of thousands of Violent Crimes. Before I walk into this Crime Scene I have a solid understanding of Probable Cause.

This can generally be defined as reasonable and prudent information, concerning such facts and circumstances as would warrant a "reasonable man" to believe that a Crime has been committed.

"Expert Knowledge" in this field merely brings the investigation under a more professional scope and expands the focus with an ability to target additional items of evidence that an unskilled investigator would not have located on a systematic basis.

7. Crime Scene:

This type of Investigation usually starts at the point where the body is originally found. Keep in mind that there may be two or more crime scenes in addition to where the body is found. These may include but are not limited to:

a). Where the body was moved from.
b). Where the actual assault leading to the death took place.
c). Where any physical evidence connected with the crime is discovered (this may include body parts or clothing).
d) Primary Crime Scene entry and or exit.
e) The suspect (Clothing, hands and body)
f) The victim (Clothing, hands and body)

Your Primary Crime Scene is generally a Multiple Crime Scene.

8. Crime Scene Arrival:

a). Is the Crime in Progress?
b). Is the Victim in Danger?
c). Is the Offender still at the scene?
d). Who summoned the Police?
e). Was jurisdiction manufactured?

It is axiomatic in police work that the faster the police respond to a crime scene, the greater likelihood of arresting the offender.

Quicker responses in these cases many times is indicative of your Mandated Reporter System and proactive training to the identity of Interpersonal Violence Against Children.

Many of these Investigations are reported:

a). Unconventionally
b) Indirectly
c) Under an inappropriate classification: (Accidental, Missing and Death).
d) Do not develop "Tunnel Vision" upon arrival.

9). Preliminary Investigator at Crime Scene:

a). Did a Crime occur?
b). Identification of Victim.
c). Who has legal Custody of this Child?

9.(cont)

d). Establish Jurisdiction of Corpus Delecti
e). Location of Crime Scenes
f). Protection of Crime Scene
g). Recognition of Crime Scene
h). Identification and Collection of Evidence

10. Evidence at Crime Scenes;

There are several types of Evidence associated with this type of Crime Scene:

a) Prima Facia. Evidence known as Physical Evidence. In itself proves an element of the specific offense.

b). Transfer Evidence Links victim to offender or offender to victim.
Links victim and offender to scene.

c). Reconstructive Evidence:
allows investigators to recreate the crime scene. The most familiar type are crime scene photos and drawings.

d). Hearsay and Outcry. Relevant information received from the victim, witness or offender. This must be relayed to those at crime scene to allow evidentiary potential.

11. Location of Evidence.

a). Point of Entry and exit
Photos of forced entry
Possible fingerprints
Pry Marks
Items touched by offender

b). Where the assault occurred
Semen.
Hair
Blood
Standards fiber and glass
Intra Oral Dental Impressions

c). Outdoor scene
Exact location of assault
Victims clothing
Victim's personal effects

C(cont).

Blood
Semen
Shoe print
Tire tracks
Standards for dirt and gravel

d). Victim and Victims Clothing

Conduct a forensic medical examination at Hospital or M.E. Office to determine:

Injuries
Recovery of physiological fluids

Bed sheets, victim's underclothing or any surface that sexual assault could have occurred on

Look for on these surfaces:

Semen
Blood
Saliva
Bite marks

e). Offender and Offenders Clothing

Often overlooked, especially when offender is in "custody"

Bitemarks
Scratches
Traces of Blood
Transfer evidence such as hair and fiber
Intra Oral Dental Impression.

12. Crime Scene Considerations.

Keep a Good Blend of Practical (Street Smarts) and Scientific(Forensic).
Forensic Investigators need a Trail of Investigative Factors, otherwise they are finished.
A Detective is a Person who can paint a Scene that he or she has never seen.
That's the difference between a Craft and an Art.

The following is a List of Forensic Services to consider in these types of Investigations:

DRUG CHEMISTRY

THIS DISCIPLINE INVOLVES THE CHEMICAL, MICROSCOPIC AND INSTRUMENTAL ANALYSES OF CONTROLLED SUBSTANCES.

TRACE CHEMISTRY

EXAMINATION OF FIRE DEBRIS, EXPLOSIVES, LACHRYMATORS (e.g. mace) AND PRIMER GUNSHOT RESIDUE (e.g. hand swabs).

MICROSCOPY

EXAMINATION OF HAIRS, FIBERS, PAINT, GLASS AND OTHER TRACE MATERIALS.

FORENSIC BIOLOGY

EXAMINATION FOR BLOOD, SEMEN, SALIVA, AND OTHER BODY FLUIDS. COMPARISON OF IDENTIFIED BODY FLUIDS TO KNOWN STANDARDS (VICTIM/SUSPECT) FOR GENETIC MARKER ANALYSIS.

DNA

COMPARISON OF BODY FLUIDS IDENTIFIED ON EVIDENCE ITEMS TO KNOWN STANDARDS (VICTIM/SUSPECT/ELIMINATION) USING RFLP AND /OR PCR ANALYSIS. NO SUSPECT SEXUAL ASSAULT CASES WILL BE ANALYZED AND COMPARED AGAINST THE CONVICTED SEX OFFENDER DATABASE.

FIREARMS

EXAMINATION OF FIREARMS, BULLETS, CARTRIDGES, CARTRIDGE CASES AND DISTANCE DETERMINATION. RESTORE SERIAL NUMBERS FROM ALL KINDS OF METAL OBJECTS.

TOOLMARKS

EXAMINATION OF TOOLMARKS TO SEE IF THERE IS A RELATIONSHIP BETWEEN A PARTICULAR TOOL.

LATENT PRINTS

EXAMINATION OF EVIDENCE FOR LATENT FINGER, PALM, OR FOOTPRINTS, COMPARISON OF LATENT PRINTS TO INKED STANDARDS, AND AUTOMATED FINGERPRINT IDENTIFICATION SYSTEM (AFIS) PROCESSING.

DOCUMENTS

EXAMINATION AND COMPARISON OF HANDWRITING, HAND PRINTING, TYPEWRITING, CHECK WRITING, PRINTED MATERIALS, RUBBER STAMP IMPRESSIONS, ADHESIVES, INKS, PAPER, ALTERATIONS, ERADICATIONS, OBLITERATIONS, TAMPERING, CHARRED DOCUMENTS, PHOTOCOPY PROCESSES, COUNTERFEITS, FOOTWEAR AND TIRE TRACK IMPRESSIONS, AND PHYSICAL MATCHES.

12. (cont) The importance of the Canvass can not be left out when conducting these types of Investigations.

a). Who has custody and intra-family canvass.
b) Social Service Visit and indication reports and their authors.
c) Foster home, whom the child was last with and who drove the child to the hospital.
d) Time appropriate canvass.

13. Conclusion:

Creation of an Investigative file. Your crime scene investigation and reconstruction has been developed to build a layer of protection around the victim. The purpose was to establish:

a) Intent
b) Knowledge
c) Recklessness
d) Negligence
e) Beyond a Reasonable Doubt.

All Discoverable Reports
(Federal, State, local Social Service etc....)

Evidence Analysis

Photographs
(scene, victim and offender)

Statements
(oral or recorded)

Defense Motions.

Impeachment by Omission
Impeachment by Contradiction

213 *MEETING UNTRUE DEFENSES IN SEXUAL ABUSE CASES*

DANIEL ARMAGH
DIRECTOR
American Prosecutors Research Institute

214 HOT TOPICS

- **INTERVIEWING**
- **VIDEO-TAPING**
- **MUNCHHAUSEN SYNDROME BY PROXY (FACTITIOUS DISORDER)**
- **PLETHYSMOGRAPH**
- **RECANTATION**
- **MEDIA BACKLASH**
- **COMPUTER ASSISTED EXPLOITATION**

215 GUIDELINES

- AMERICAN BAR ASSOCIATION RULE 3.8 et. seq.
- NATIONAL DISTRICT ATTORNEY ASSOCIATION
- FACTORS CONSIDERED IN CHARGING - IDEAL v. REALITY

216 PROFESSIONAL EXCHANGE

- WHAT IS THE ROLE OF THE CHILD INTERVIEW SPECIALIST
- PAUL STERN
- BILL WALSH
- APSAC ADVISOR VL 8 # 2

217 GROUND RULES

- **MEET THE DEFENSES FROM THE INCEPTION**
- **ANALYZE THE CASE FOR PROBABLE DEFENSES**
- **DEFENDANT'S STATEMENTS**
- **DEFENDANT'S FAMILY SUPPORT**
- **DEFENSE ATTORNEY'S MOTIONS**

218 CORROBORATION

- STING
- NON - CONFESSION
- CONFESSION
- CORPUS DELECTI
- CALL HIS MOM
- INTERVIEW OTHERS
- ANTICIPATE THE DEFENSE

219 ☐ FANTASY / IMAGINATION

- CHILD (IMAGINATION OR DREAM)
- ADOLESCENT (FANTASY)
- CHILD HAS NO MOTIVE TO LIE
- SEXUAL KNOWLEDGE FROM BOOKS, VIDEOS, OBSERVATIONS OF OTHERS INVOLVED

220 ☐ VERTICAL PROSECUTION

- NUMBER OF INTERVIEWS
- TARGET FOR REASONABLE DOUBT
- COORDINATED APPROACH
- PREVENTS MEETING NEW PROFESSIONAL EVERY TIME
- MULTI-DISCIPLINARY TEAMS

221 ☐ MISINTERPRETATION OF AN INNOCENT TOUCH

- **INTENT IS THE ISSUE**
- **MEDICAL**
- **BATH**
- **VIRGINAL CHECK**
- **WRESTLING**
- **DON'T YOU JUST HATE IT WHEN THAT HAPPENS**

222 ☐ EVIDENCE USED IN ATTACKING DEFENSE

- **SECRECY / THREATS**
- **CHILD DEMONSTRATES IMPROPER TOUCHING**
- **DEFENDANT ADMITS IF TOUCHING IS AS DESCRIBED THEN IT WOULD BE CRIMINAL**
- **TOOLS, PROPS, AND VIDEO CAMERA**

223 ☐ PSYCHOLOGY OF THE INVESTIGATOR

- **BEST OF THE BEST**
- **THINK LIKE A DEFENSE LAWYER**
- **THINK LIKE A PREDATOR**
- **TAKE THE TESTIMONIAL VIEW OF EVERYTHING YOU DO**
- **KNOW YOUR CASE**
- **BE ORGANIZED AND CONCISE**

224 ☐ FANTASY / IMAGINATION

- **SHE'S FANTASIZING ABOUT YOU!**
- **CHILDREN DO NOT FANTASIZE ABOUT INTERCOURSE**
- **EXTRAPOLATE SENSORY DETAILS**
- **TICKLES, TOUCH, TEXTURE, TASTE, SMELL, PAIN, EJACULATION**

- DISTINGUISH VIDEO / GROOMING

225 ☐ MENTAL ILLNESS

- OLDER CHILD
- HISTORY OF MENTAL ILLNESS
- EXPERT TESTIMONY
- EVIDENCE VICTIM IS A GOOD HISTORIAN ABOUT OTHER EVENTS
- THERAPY SESSIONS
- VULNERABILITY

226 ☐ RETALIATION

- STEPFATHER, BOYFRIEND, BABY SITTER, PIMP
- TRYING TO HELP RUNAWAYS
- CHILD "PROSTITUTES"
- USUALLY OLDER CHILD
- AUTHORITY FIGURE
- NOT SOPHISTICATED ENOUGH

227 ☐ RETALIATION

- DESIRED RESULT / ACTUAL RESULT
- FOSTER CARE
- FINANCIAL HARDSHIP
- PAINFUL AND EMBARRASSING EXAM
- LOOSES MOM
- TWELVE STRANGERS / DEMEANOR

228 ☐ CUSTODY DEFENSE

- CONSPIRACY / BRAINWASHED
- CUSTODY AN ISSUE AT DISCLOSURE?
- DIVORCE RECORDS
- WHOM DID VICTIM DISCLOSE TO INITIALLY
- USUALLY NOT SEXUAL ASSUALT LANGUAGE

229 ☐ CUSTODY

- PUBLIC PERCEPTION
- REALITY: 2% OF CASES INVOLVE CUSTODY
- PARENTAL ALIENATION SYNDROME
- MSBP

230 ☐ DEFENSE EXPERTS

- RALPH UNDERWAGER
- RICHARD GARDNER
- WHAT IS THEIR PREVIOUS TESTIMONY?

- **WHAT IS THEIR EXPERT BACKGROUND ?**
- **EDUCATIONAL RELEVANCE?**

231 ☐ SODDI DEFENSE

- DEFINITE ASSAULT
- NO OTHER EXCUSE
- MEDICAL AND FORENSIC EVIDENCE
- SCIENTIFIC EVIDENCE TO EXCLUDE ALL OTHERS
- DEFENDANT ADMITS ABUSE

232 ☐ OFFENSIVE DISCOVERY

- BLOOD TYPING
- DNA
- HLA
- HIV TESTING
- STD
- PHOTO CORROBORATION
- FORENSIC COMPUTER ANALYSIS

233 ☐ SODDI - RAPE SHIELD

- NOTICE
- OFFER OF PROOF
- PREJ. / PROBATIVE
- EXCULPATORY PURPOSES
- TIME FRAME OF OTHER ASSAULT
- CALL OTHER PERSON (S) TO TESTIFY?

234 ☐ SODDI - STD

- TIMING OF SYMPTOMS WITH ASSAULT
- INCUBATION PERIOD
- DEF. MEDICAL RECORDS
- SPONTANEOUS REMISSION

235 ☐ BRAINWASHING

- MULTIVICTIM
- CONSPIRACY OF PROFESSIONALS
- ATTACK YOUR INTERVIEWING PROCESS
- LEADING QUESTIONS
- REWARDS FOR DISCLOSURE
- CONTAMINATION

236 ☐ BRAINWASHING

- EXPERT ON BRAINWASHING

- EXACTLY HOW DOES DEF. SAY THE CHILDREN WERE BRAINWASHED?
- KELLY MICHAELS
- VIDEOTAPING
- ANATOMICAL DOLLS

237 ☐ REASONABLE DOUBT

- INCONSISTENCIES
- DELAYED REPORT
- NO MEDICAL EVIDENCE
- NO EYEWITNESSES
- NO PRECISE DATES
- POOR INVESTIGATION

238 ☐ REASONABLE DOUBT

- VICTIM'S TESTIMONY
- CHILD IS CREDIBLE
- DEMEANOR - NO ONE CAN HAVE DOUBT BASED ON REASON
- IN A FEW SHORT YEARS
- HONOR THE COURAGE
- DEFENDANT IS RESPONSIBLE

239 ☐ *TESTIFYING*

IMPRESSION MANAGEMENT

240 ☐ **PRESENTING YOUR CASE**

- **REVIEW QUESTIONS / TRAPS FROM DEFENSE ATTORNEY**
- **FIND OUT WHAT PART YOU PLAY IN CREATING THE DOMINANT EMOTIONAL THEME FOR THE CASE**
- **ANTICIPATE WHAT EMOTIONAL THEME THE DEFENDANT WILL TAKE**

241 ☐ **PRESENTING YOUR CASE**

- **APPEARANCE IS PROFESSIONAL**
- **TABLE MANNERS ARE IMPORTANT**
- **RELATIONAL COMMUNIATIONS**
- **JURORS ARE ALWAYS WATCHING**
- **LUNCH WITH DEFENSE ATTORNEYS**
- **BE ON TIME**
- **PROFESSIONALLY PACKAGE EXHIBITS**

242 ☐ SCIENCE OF PERSUASION

- **SOCIETAL VALUES**

- DOMINANT EMOTIONAL THEME
- PRIMACY AND RECENCY
- EMOTIONAL CHRONOLOGY
- 65% OF ALL COMMUNICATION IS BODY LANGUAGE
- B.F. SKINNER

243 ☐ ART OF PERSUASION

- TRUST AND CREDIBILITY
- DEMEANOR
- RELATIONAL COMMUNICATIONS
- HOW DOES YOUR TESTIMONY FIT IN THE OVERALL IMPRESSION MANAGEMENT OF THE TRIAL?

244 ☐ FACT BEYOND CHANGE

- TO GET A WITNESS TO TESTIFY AGAINST A FACT THAT IS TRUE BEYOND CHANGE IS THE ULTIMATE IN CROSS-EXAMINATION
- KEEP THE THEORY OF THE STATE'S CASE IN MIND AS WELL AS WHAT THE THEORY OF THE DEFENDANT WILL BE

245 ☐ THREE THINGS

- DEFENDANT CAN TAKE THE 5TH
- HE CAN TELL THE TRUTH ABOUT EVERYTHING
- HE CAN LIE
- HOW CAN WE EXPOSE THE LIE AND WHERE IS IT COMING FROM
- THIS IS ALWAYS A PARADYME FOR POLICEMEN FROM DEFENSE ATTYS.

257 ☐ TESTIFYING: TRAPDOORS AND PITFALLS

- TRAINING AT THE ACADEMY: HOW MANY HOURS ON 1. POLICE REPORTS 2. CHILD EXPLOITATION
- PERSONAL OPINION v. PROFESSIONAL OPINION
- ANSWER THE QUESTION OFFICER, YES OR NO?

258 ☐ TESTIFYING

- TAKE THE QUESTION FROM THE ATTORNEY AND GIVE THE ANSWER TO THE JURY
- POSTURE IS COMMUNICATION
- AVOID COPSPEAK
- DO NOT RAMBLE, ANSWER ONLY THE QUESTION ASKED

259 ☐ TESTIFYING

- YOU DID NOT SEE SARAH RAPED BY ANYONE DID YOU?
- YOU HAVE NO PERSONAL KNOWLEDGE THAT ANYTHING SHE TOLD YOU IS TRUE, DO YOU OFFICER?

- HOW LONG HAVE YOU BEEN A POLICE OFFICER?

260 TESTIFYING

- HOW LONG HAVE YOU INVESTIGATED CHILD ABUSE CASES?
- SHOULDN'T YOU HAVE TAKEN HER TO THE DOCTOR IMMEDIATELY?
- OFFICER, YOU DID NOT TAPE RECORD OR VIDEOTAPE THE INTERVIEW DID YOU?

261 TESTIFYING

- VERBATIM QUOTES AND REPORT IMPEACHMENT
- WHY DIDN'T YOU PUT THIS INFORMATION IN YOUR REPORT?
- WHAT OTHER SUSPECTS DID YOU INVESTIGATE?
- THERE IS NO PHYSICAL EVIDENCE IN THIS CASE IS THERE OFFICER?

262 TESTIFYING

- YOU SUGGESTED THE ANSWERS BY THE TYPE OF QUESTIONS YOU ASKED DIDN'T YOU? WELL WE DON'T KNOW THAT DO WE?
- THE TRUTH IS YOU GOT ALL YOUR INFORMATION FROM THE CPS, MOTHER...

263 TESTIFYING

- ISN'T IT TRUE THAT CHILDREN LIE ABOUT THINGS?
- ISN'T IT TRUE THAT CHILDREN DREAM AND FANTASIZE ABOUT THESE THINGS?
- YOUR AWARE OF SARAH'S REPUTATION FOR LYIING, PROMISCUITY, DISCIPLINE PROBLEMS...

264 TESTIFYING

- IF YOU COULD DO IT ALL OVER...
- YOU WOULD AGREE THIS WAS NOT A PERFECT INVESTIGATION?
- WHAT WERE YOU TRYING TO HIDE BY NOT INCLUDIING IT IN YOUR REPORT? IN YOUR TESTIMONY?

270 TESTIFYING

- TAKE THE QUESTION FROM THE ATTORNEY AND GIVE THE ANSWER TO THE JURY
- POSTURE IS COMMUNICATION
- AVOID COPSPEAK
- DO NOT RAMBLE, ANSWER ONLY THE QUESTION ASKED

272 TESTIFYING

- USE WORDS THAT CONVEY THE FACTS IN EMOTIONALLY COMPELLING WAYS

- **SPEAK LOUDLY AND CLEARLY**
- **DO NOT LOOK TO THE PROSECUTOR OR JUDGE FOR THE ANSWER**
- **DO NOT ARGUE OR LOSE TEMPER**
- **DO NOT LIE**

CHILD ABUSE/NEGLECT

Mary E. Case, MD
Associate Professor of Pathology
St. Louis University Health Sciences Center
Chief Medical Examiner
St. Louis, St. Charles, Jefferson and Franklin Counties

Child abuse as a syndrome was first recognized in the early sixties and was first called the Battered Child Syndrome. It refers to repeated, deliberate physical abuse or neglect of a child. Increasing attention and emphasis has been placed on recognition of the syndrome so that today, physicians who frequently see cases of child abuse are much more cognizant of the syndrome and better able to deal with it appropriately. The classical child abuse syndrome consists of physical injuries which are distributed over time - repetitive. Such cases account for about 70% of fatal cases. Slightly more difficult to detect is the one time abused child. This group accounts for about 30% of fatal cases.

INCIDENCE

Unknown, but abuse is very frequent. About 3-5/100,000 children per year will die from non-accidental injuries. About 2,000 children die each year in the United States from such injuries. Sixty percent of children seen by a physician for an inflicted injury will return with further inflicted injuries. Ten percent will eventually die from such an injury. About 10% of all children seen in emergency rooms have some form of nonaccidental injury. Abuse is the only childhood cause of death to increase in incidence between 1960 and 1990.

AGE

Most of the children are young. 45% are under one year of age. The majority is less than three years old. The average age is 24 months. Under one year of age, abuse/neglect is the 2nd leading cause of death after SIDS.

ABUSER

Parent, boyfriend or consort, babysitter or other sibling. Adult abusers are young, most often in their early twenties. Teenage child bearing has a high correlation with abuse.

SOCIOECONOMIC

Child abuse tends to be more common in the lowest socioeconomic and educational levels. While abusive injuries are seen in all socioeconomic

levels, fatal cases of abuse are most common in the poorer segments.

SEX

No marked difference. Some studies show a slight male preponderance.

POSITION IN FAMILY

Often is the youngest child. Male care-giver is more likely to abuse the youngest. Some mothers may single out a "special" child to be the recipient of abusive actions.

PSYCHOLOGY OF THE ABUSIVE ADULT

Families tend to be isolated. Lack of extended family members to offer emotional and financial support. Family circumstances are commonly unstable. There is usually stress resulting from a number of factors: unstable marriage, single parent with boyfriend or consort, illegitimate or unwanted child. Defect in character rather than I.Q.

MALE: Usually immature, aggressive, impulsive, dominant over the female. More inclined to be abusive when forced into primary care - giver roles; often associated with loss of self-esteem. Child is often not their own. More likely to kill a child than the mother who frequently may inflict less than fatal injuries.

MOTHER: Overstressed, dominated. Most common abuser. May have aggression toward the spouse/boyfriend but acted out on the child.

Alcohol and drugs frequently are involved in the family lifestyle and frequently in the episodes of abuse.

Children who are physically abused may be nutritionally well cared for or there may be neglect of environmental or medical needs. The abusive acts may be precipitated by some exasperating behavior of the child, i.e. crying or soiling the diaper.

THE HISTORY OR STORY

Explanation does not fit the circumstances. No idea how injury occurred - found unresponsive, or feeling poorly last few days.

The injury was self-inflicted - banged head on crib or toy, minor falls, history of clumsiness, easy bruisibility, insensitive to pain. Siblings frequently blamed.

INVESTIGATION OF CHILD ABUSE DEATHS

The investigation of the circumstances surrounding a possible child abuse death is of primary importance. In no other type of death is it so imperative that the medicolegal investigator carry out a proper investigation. Children may be killed in such subtle ways that only by knowing all the circumstances surrounding a death, can the pathologist

adequately proceed to the autopsy and a determination of the cause and manner of the death be made.

Go to the scene as soon as possible, even if the body is no longer at the scene.

NOTE: Position of the body, rigor and livor
Body temperature and time of death estimation
Any attempt to modify the scene
Neighborhood
Home - state of repair, order, sanitary facilities, lighting, heat, cleanliness

TAKE PHOTOGRAPHS !!!!!!!!!!!!

Follow up visits are often necessary to provide additional information as the pathologist begins to make his/her findings available. The pathologist may have questions that require further details. Investigation should determine a number of factors concerning the family.

Type of family structure
Relationships, who lives there, who comes and goes
Economic conditions, where does the money come from
Problems in home, financial, single parent, criminal justice, drugs/alcohol

INTERVIEW - family, neighbors, siblings, others

AUTOPSY - Findings may be contradictory to historical account. At some point, the inconsistencies between the historical account and the autopsy findings must be discussed with the parents. The approach to this aspect of the investigation requires close cooperation among pathologist, investigator and police.

TYPES OF INJURIES

The discrepancy in size and strength between the adult and child is obvious. The adult does not need a weapon or instrument to inflict injuries on a child. Many of the injuries are made by the unaided hand - manual violence. Many of the injuries are those of blunt trauma - contusions, abrasions and less often lacerations. Certain types of violence are quite unique to being effective only against a child - squeezing, shaking, blow from the hand, placing a hand over nose and mouth.

HEAD TRAUMA - Head injuries are the most common cause of death by inflicted injuries and account for 80% of abusive deaths. 95% of these children have subdural hemorrhages. 50% have skull fractures.

Accidental injuries in the home rarely cause fatal head injuries. Injuries comparable to abusive head injuries are seen in motor vehicle accidents and falls from above the first story level.

Skull fractures suggestive of abuse:

1) Multiple or complex fractures
2) Depressed fractures
3) Fracture width greater than 3 mm
4) Growing skull fractures
5) Fractures of more than one cranial bone
6) Nonparietal fracture
7) Associated with intracranial injuries

IMPACT INJURIES - Made by blow to head with fist, foot, or other object or swinging child and striking its head against wall or furniture. Will usually see impact site to undersurface of scalp but not always; 50% will have fractures.

WHIPLASH/SHAKEN CHILD - held by shoulders, chest, or feet and violently shaken. Head of child is poorly supported by weak neck muscles - head whiplashes back and forth.

With either impact or shaking, if significantly injured, the child will be immediately symptomatic with lowered level of consciousness; this will soon be followed by respiratory difficulty and frequently seizures. Pathology of either impact or shaking is same: uni- or bilateral subdural blood over cerebral hemispheres which may be quite small - 3-5 ml - is significant as a marker of brain acceleration; scant subarachnoid hemorrhage over brain; DAI - injury to axonal processes which are stretched and torn or rendered nonfunctional. Maybe able to see axonal retraction bulbs or varicosities. Young infants < 1 year may have contusion - tears - separation of cortex away from underlying white matter. Must remove eyes to see the retinal hemorrhages. Must dissect posterior cervical spine which may reveal fracture of vertebrae, subdural blood of cervical spine, or tears of upper most cervical cord. Epidural hemorrhage in spine is not trauma related.

ABDOMINAL TRAUMA - The second most common cause of death, accounting for 20%, is injury to the abdominal organs. The kidney and spleen are most often injured in accidental, i.e. motor vehicle accident trauma, and are rarely injured by abuse. In contrast, the abused child will most often have injury to the small intestine, especially the duodenum, the mesentery, and the liver.

ASPHYXIA - Infants and children can be easily suffocated by placing a hand, pillow or cloth over the nose and mouth. In children without teeth, may see no marks or may see tiny tears of the inner lips. DO NOT expect to see petechiae in young children. Children up to 5-6 years of age may be strangled manually without leaving marks on the neck externally or internally - simply compressing the very collapsible neck structures may restrict blood flow and breathing. An adult may easily restrict an infant's respiratory excursions of the chest by hands applied to the chest.

SKIN - Non-lethal, very frequently find a variety of injuries, i.e. contusions, abrasions or burns. These may have recognizable patterns and may be of different ages.

Bruises - Contusions

NORMAL - facial scratches in babies from long fingernails
- knee and shin bruises
- single bruise on forehead - toddler
- bruises on bony prominences

INFLICTED - LOCATIONS
- buttocks, back, genital area, face, mouth, neck, chest, abdomen, wrists and ankles.

PATTERNS - hand marks, bite marks, pinch marks, patterned blunt instrument - belt loops, buckles, coat hangers, electrical cords, binding marks at wrists or ankles.

BLUNT SOFT TISSUE TRAUMA - Extensive soft tissue injury to chest, back, head, and extremities can result in blood and tissue fluid loss into soft tissue causing death from blood loss, dehydration, stress cardiomyopathy, and possibly fat embolism.

BONES - Injuries of the bones and joints are frequent (seen in 30%) so that TOTAL BODY X-RAYS SHOULD BE TAKEN ON ALL POSSIBLE ABUSE CASES. Certain bony injuries are almost pathognomonic of abuse since only abusive manipulations or force would injure the bones in certain patterns. In addition to long bone fractures, there may be periosteal hemorrhages or reaction or epiphyseal dislocations. There may be injuries of various ages. Of fractures in abused children, rib fractures are most common followed by humerus followed by femur.

Regarding rib fractures caused by resuscitation, studies have concluded that in the absence of motor vehicle accidents or bone disease, unexplained rib fractures are fairly specific for abuse. Posterior rib fractures in infants result frequently from grasping child around chest.

MOUTH TRAUMA - Injuries to the lips, cheeks, frenulum and teeth are commonly seen in the abused child. A torn frenulum is diagnostic of abuse.

EYE TRAUMA - Large numbers of retinal hemorrhages which extend into the periphery of the retina are quite specific for rotational brain injury. Small numbers of hemorrhages at the nerve root may result from increased intracranial pressure. The eyes should always be removed in suspicious child deaths.

BURNS - May be flame burns, thermal or hot water burns. Particularly when there is a scald burn, the circumstances must be closely investigated. You must go to the scene and re-enact the incident. Take a candy thermometer along to measure water temperatures. Perhaps most scalds are deliberate so be prepared to investigate fully.

BITE MARKS - When seen on a living child are predictors that child will be further abused and will be fatally injured in the future if the abuse is not stopped.

POISONING - Always do toxicological testing for common substances - ETOH, A.S.A. and others if possible. Children have been poisoned by all

types of adult prescription drugs.

PEPPER - may be placed in a child's mouth to stop crying - causes severe irritation of airway and aspiration. May cause death from asphyxia.

WATER INTOXICATION - Forced fluids.

SALT - Pouring salt onto food to punish child or placing in formula. Water and salt require vitreous electrolyte studies to fully appreciate. Sodium > 180 should be considered proof of salt administration.

PRESENTATION AT THE HOSPITAL

Child is brought to medical attention postmortem or in a terminal state. Look for any delay in seeking appropriate medical attention. Children are not usually left unattended for long periods so that any change in their health should be immediately obvious to a reasonable parent. When the child is brought to medical attention, there is usually an explanation given to account for the injuries, i.e. a fall from bed or down the stairs.

TIP - OFFS

1. Inconsistencies between the caretaker's stories. Try to interview them separately so that individual stories may be obtained.

2. Changing stories - The historical account of the injury may change over time as facts are presented to the caretaker that the original account is not consistent with the injuries found at autopsy. New stories may be provided to attempt to "fit" the injuries.

3. Delay in seeking medical attention. Calling other parent or family member to come home rather than 911. Child brought to ER by non-caregiver.

4. Classic injuries.

5. Visits to different hospitals or doctors to hide repetitive abusive patterns.

6. Family profile.

7. Previous abuse of the child !!!!!!!!!! or siblings.

8. Unintentional home injuries are seldom serious. Head injury, rib fractures, lower extremity fractures, and abdominal injuries are usually indicative of child abuse.

CHILDHOOD NEGLECT

Deprivation of nutritional, environmental or medical needs. Infants and

children are totally dependent upon the adult for provision of these necessities. Failure to provide these necessities may result in the death of a child and may then be considered a homicide.

Neglect may accompany physical abuse but not always. Neglect of children which results in death usually involves young infants, under one year old. Families are most often on welfare. Home conditions are very severe - filth, trash, disorder, excrement, infestations, far beyond what may be explained by poverty alone.

Clothing may be soiled. May be rarely or never changed. May actually be stuck to the body with filth. May be inappropriate to size or season.

Skin may show numerous scars from diaper rash or poor hygiene. Parents may attempt to clean child up after death; wash body or change the clothing.

Neglected children usually die from infection. The children frequently have not been taken to well baby visits or immunizations.

HISTORICAL ACCOUNT

Very false - No explanation for the neglect or the fact that the child is dead. Child may be described as being in good health and just suddenly found dead. May be no explanation for the poor nutritional status or very unlikely reason - child said to be a poor eater.....

PROSECUTORIAL APPROACH TO CHILD ABUSE/NEGLECT

Do not reject the possibility of an emotionally repugnant subject - i.e. "someone has killed a child." Forensic pathologists recognize the increasing frequency with which children are dying from inflicted injuries and neglect. The increase is not totally accounted for by better recognition and diagnosis of the problem. There is an actual increasing incidence which is attributed to factors such as: (1) increase in the number of single parent families; (2) increase in stress; (3) drug/alcohol involvement; (4) lack of family members to help young parents.

Children can be killed in very subtle ways. The actual cause of death may not be as evident as we are used to seeing in the adult i.e. gunshot wounds, stab sounds. Defense attorneys frequently deny charges of abuse/neglect by alleging the evidence is "merely" circumstantial. Do not deny reality for the sake of objectivity. Circumstantial evidence is perfectly good evidence. Often to explain why a child has died, the pathologist must refer to the mechanism of death rather than the cause of death. The mechanism of death is the pathophysiologic derangement incompatible with life such as asphyxia. The pathologist may be able to say the child died from asphyxia without being further able to characterize how asphyxia was caused - suffocation, strangulation, exclusion of O2 by a plastic bag, restriction of respiratory excursions of chest, drowning.

Recognize that sufficient scientific literature exists which attests to how accidental versus inflicted injuries occur in children. This is particularly pertinent in regards to head trauma alleged to result from minor

home falls, abdominal trauma from minor home incidents, and hot water scalds.

The dilemma of whom to charge when there are two adults, both of whom deny knowledge of abuse/neglect - charge both. At the very least, one is responsible but both know who is responsible.

Remember that successful investigation of child abuse requires the cooperation of many agencies, the pathologist, police, investigators, social services, and attending physicians and hospitals. The pathologist who performs the autopsy must consider all available information before he makes a final conclusion of cause and manner of death. The final conclusion must sometimes be based on non-anatomic data. The anatomic findings may be nonspecific or totally absent but in circumstances where there is reason for suspicion of an unnatural death, it is better to leave the cause and manner as Undetermined than to attribute such deaths to SIDS or "Unknown Natural Causes".

CHILD ABUSE/NEGLECT

Objectives

1) Identify the common causes of fatal child abuse.

2) Recognize the common patterns of physical injury to children.

3) Develop an understanding of the psychology of the child abuser.

4) Distinguish between acceptable and unacceptable historical accounts of accidental injuries of children.

5) Recognize the indicators and signs of medical neglect of a child.

Children's Trust Fund of Texas
The good we do will last a lifetime.

Shaken Baby Syndrome

and

Abusive Head Trauma

August 4, 1999, 1:00 – 4:30 p.m.

The Shaken·Baby Alliance

Shaken Baby Syndrome/Shaken Impact Syndrome

The term Shaken Baby Syndrome (SBS) and Shaken Impact Syndrome (SIS refer to the signs and symptoms, as well as the clinical, radiographic and sometimes autopsy findings resulting from violent shaking of an infant or young child. SBS/SIS are often used interchangeably, and are synonymous with other descriptive terms used in the earlier scientific literature such as Whiplash Shaken Syndrome and Shake/Slam Syndrome.

HISTORY

In 1946, John Caffey, a pediatric radiologist, described subdural hematomas in association with fractures of the long bones and attributed these to traumatic origins. Subdural hematomas refers to bleeding under the dura mater, the outer membrane covering the brain and spinal cord. The term Shaken Baby Syndrome was coined later to describe infants with subdural hematomas, subarachnoid hemorrhages (bleeding under the inner membrane covering the brain), retinal hemorrhages (bleeding at the back of the eyes), and evidence of healing fractures at the ends of the long bones. This constellation of injuries was observed in many infants in the absence of any evidence of external injuries either to the head or to the rest of the body.

Caffey believed these injuries are attributed to the peculiarities of the infant's head in that it is larger in relation to the body than the adult head, comprising approximately 25% of the total body weight as compared to 10% in an adult. In addition, the infant's weak neck muscles and high concentration of water in the brain substance render them vulnerable to injury due to shaking.

Since Caffey's original paper over 50 years ago, there have been over 200 articles published in peer-reviewed medical and other scientific literature describing the syndrome both generally and specifically with regard to the various lesions seen in the syndrome. A summary of these findings will be presented below.

INCIDENCE

There are no firm statistics regarding the actual incidence of SBS/SIS since there are no central reporting registries to collect these data. However, estimates have been made based on clinical experience and extrapolated figures from hospitals caring for children. Estimates range from annual figures as low as 600 cases per year in the United States to as high as 1400. Until a method for collecting such statistics is established, the true incidence will not be known. It is recognized, however, that it is the most common cause of mortality and accounts for the most long term disability in infants and young children due to physical child abuse. The age of the victims range from the newborn period to 4 years of age. The vast majority of SBS/SIS occur before the infant's first birthday and the average age of the victim is between 3 and 8 months of age.

THE SCENARIO FOR SHAKEN BABY/SHAKEN IMPACT SYNDROME

The usual trigger for shaking a baby is inconsolable crying in the infant. Frustrated by attempts to console the baby, the perpetrator loses control and grabs the infant, either by the chest, under the arms, or by the arms and violently shakes the baby. The time of shaking varies, usually ranging from around 5 seconds to 15 or 20 seconds. It has been estimated by video recordings of a person shaking a doll of approximate size and weight that the number of shakes ranges between 2 to 4 per second. During shaking, the head rotates wildly on the axis of the neck creating multiple forces within the head. The infant stops crying and stops breathing, causing decreased oxygen supply to the body, particularly to the brain. The infant brain, having a much higher water content that the adult brain, is much softer than an adult brain. The absence of myelination, the "insulation" of the nerve cells acquired during development of the nervous system, contributes to the relative softness. These

factors make the brain more gelatinous and during shaking is more easily distorted and compressed within the skull. Shaking and the sudden deceleration of the head at the time of impact does several things:

1. The veins that bridge from the brain to the dura, which is fixed to the inside of the skull, are stretched and, exceeding their elasticity, tear open and bleed, creating the subdural hematoma or subarachnoid hemorrhages or characteristics of the syndrome.

2. The brain strikes the inner surfaces of the skull, causing direct trauma to the brain substance itself.

3. The deeper structures of the brain, the axons, can be broken, shearing off during the commotion to the brain.

4. The lack of oxygen during shaking causes further irreversible damage to the brain substance.

5. Damaged nerve cells release chemicals which add both to oxygen deprivation to the brain and also cause direct further damage to the brain cells.

The combined effect is massive traumatic destruction of the brain tissue, leading to immediate brain swelling and causing enormous increases in the pressure within the skull. This swelling compounds the problem, since swelling causes compression of the blood vessels and decreases the oxygen supply to the brain.

IT IS THESE INJURIES TO THE BRAIN, NOT THE BLEEDING UNDER THE DURA OR THE ARACHNOID MEMBRANES, THAT CAUSES THE SIGNS, SYMPTOMS AND COURSE OF SHAKEN BABY/SHAKEN IMPACT SYNDROME.

Concomitant with the destruction of the brain tissue are other injuries. The most significant of these are the retinal hemorrhages. There are a number of theories to explain retinal hemorrhages in SBS/SIS. One states that they are the result of transmitted pressure within the skull. The argument against this is that retinal hemorrhages occur with much less frequency in infants whose brain injuries are due to accidental causes with similar increased pressures within the skull, such as those resulting from motor vehicle accidents. Another theory is that retinal hemorrhages occur because shaking causes disruption of the layers of the retina. There are 10 layers on the retina, all richly supplied with blood vessels. Proponents of this theory state that when these layers are subjected to the lines of force associated with shaking, they slide across one another, stretching these vessels so that they also shear and bleed.

The retinal hemorrhages seen in SBS/SIS are variable ranging from a few scattered hemorrhages to extensive hemorrhages involving multiple layers of the retina. Retinal hemorrhages seen in other conditions are usually closer to the surface, so-called preretinal hemorrhages, and resolve quickly. Retinal hemorrhages are not seen as the result of cardiopulmonary resuscitation or accidental short falls.

A number of other lesions are variable findings in SBS/SIS. These include skull fractures resulting from the impact when the infant is thrown against a hard or soft surface; fractures of the posterior arcs of the ribs near the spine due to the levering of the fingers of the hands of the perpetrator while holding the baby during shaking; fractures of the clavicles (collarbone); and fractures of the long bones. Long bone fractures are attributed to the flailing of the arms and legs during shaking. Bruising of the skin of the head, face and body may also occur. It is uncommon to see injuries to the bones, interspinous ligaments and muscles of the neck, probably due to the underdevelopment of these structures in the infant. It is also uncommon to see injuries to the spinal cord in cases of SBS/SIS.

SYMPTOMS AND PHYSICAL FINDINGS

Symptoms and physical findings are variable, depending on the length and severity of the shaking and whether the infant was thrown onto a surface. The syndrome can be seen as a continuum from a short duration of shaking with little or no impact, to sever, prolonged shaking and major impact. The resulting signs and symptoms may run the gamut from decreased responsiveness, irritability, lethargy and limpness, - through convulsions, vomiting from increased pressure within the skull, increased breathing rate, low body temperature and low heart rate, - to coma with fixed and dilated pupils – to death. All of these symptoms are caused by generalized brain swelling secondary to trauma with these symptoms beginning immediately after the shaking and reaching their peak within 4-6 hours.

It is important to state that there is no evidence to support the concept that re-bleeding of an older subdural hematoma can result from trivial injury and cause an infant to suddenly collapse and die. The subdural bleeding is only significant in that it is a marker for the traumatic episode to the brain that produces all the clinical signs and symptoms. Even of such a re-bleeding should occur, it does not cause traumatic injury to the brain.

There is no evidence that the findings in SBS/SIS can result from accidental falls in the home, including falls down stairs, off beds or tables, or from caretaker's arms. SBS/SIS results from a violent inflicted injury producing immediate signs and symptoms.

Robert M. Reece, M.D.
Robert H. Kirschner, M.D.

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DIAGNOSING INFLICTED HEAD INJURY

Diagnostic Principles and Practices in Physical Abuse

I. BE PREPARED

A. Hospital Protocol.
Write and adopt a hospital protocol for the management of children with suspected inflicted injuries. Such protocols are necessary in all organized trauma systems that admit children.

B. Community Protocol
Write and adopt a community for assessment of abused children. This may be a lengthy process, however, it will result in improved performance by all agencies.

II. A GENERAL RULE

A. Suspicion of Abuse
Physical abuse is suspected and often definitively diagnosed when an infant or child is brought for care with findings of injury that are not adequately explained by the history given, or with injury findings which stand alone to indicate inflicted injury.

B. Obvious and Occult Cases
In some cases the fact that injuries are inflicted may be evident at a glance, and with one or two questions, however, many cases are not easily recognized and sometimes a very detailed history is necessary.

III. INFLICTED HEAD INJURIES

A. Most Abusive Deaths are from Head Injury
More fatalities and long term morbidity are due to abusive head injury than from any other form of physical abuse.

B. Major Damage Requires Major Events
When a child under 3 years of age comes for medical care with a serious head injury without a readily apparent major trauma history (motor vehicle accident, fall from heights over 10 feet), the chances of this being an inflicted injury are quite high.

C. Epidural Hematoma as an Exception
Epidural hematomas occur when an artery under the skull is torn, usually by a skull fracture. The hematoma grows slowly over a period of minutes to hours and pushes the intracranial pressure up to arterial levels causing severe symptoms and sometimes death often after a lucid interval. The forces required are only those needed to produce linear skull fractures and can consist simply of short falls to hard surfaces. Epidural hematomas are easily recognized using with imaging of the head or at autopsy.

D. Household Accidents
Household accidents very rarely cause head injury death or life-threatening injury in infants and children, but histories of household accidents typically accompany children with fatal inflicted head injury.

IV. COMMON CLINICAL PRESENTATIONS (SEVERE CASES)

A. Discovered Unconscious by Caretaker
This is a very common history that is provided when children with severe inflicted head injuries are brought for care. In these cases no history of injury is given and the child is found to have injuries as a result of medical assessment. In addition (or instead of) being unconscious the child may be discovered convulsing, posturing or even in arrest.

B. Child Became Unconscious
In this variant, the child is described as becoming unconscious before the caretaker's eyes, but not history of injury is provided. If the child is then found to have a serious head injury, it is very likely that the person providing the history is falsifying it.

C. Short Fall Precedes Unconsciousness
In this very common mode, the caretaker reports that the child fell from a bed, a couch, the caretaker's arms or some comparably elevated surface to a floor and become unconscious at some later point in time.

V. REPORTING TO AUTHORITY

Have a protocol, be prepared.
All health providers are mandated reporters, and should report when "reasonable suspicion" exists. Not all reports must be substantiated.
A quick and competent investigation is worth twenty slow ones.
"No one ever died from a conversation." (C.H. Kempe 1962)

VI. ASSESSMENT OF SEVERE AND FATAL CASES

History
Physical and Neurological Exam
Examination of Retina
Imaging
Laboratory
Operation
Autopsy

VII. HISTORY TAKING (INTERVIEWING)

A. Attitude and Approach

1. The history-taker can become ineffective by alienating the informant.
2. Because the child appears to have been abused does not indicate that the person accompanying the child is responsible.

3. History takers should be professional and generally supportive to informants.

B. Investigative and Medical History-Taking

1. As in the case of sexual abuse interviews, the information obtained may be vital to the work of investigators from law enforcement or child protective agencies. It is also vital to the physician who must make a diagnosis and decide whether or not the history explains the injury pathology.

C. Special Elements in the History

1. Who is (are) the informant(s)?
2. When and where is the history given?
3. Open ended questions.
4. Avoid early conclusions.
5. Make a very good written record, preferably dictated immediately and typed later.

D. Psychosocial Factors in the History
Inflicted head injury should usually be diagnosed by medical findings. Over-reliance on social factors and caretakers' apparent attitudes early in the case may be prejudicial, discriminatory, and leads to errors. Note them, and put them aside for later consideration.

VIII. PHYSICAL AND NEUROLOGICAL EXAMINATION BY STAGES

A. Initial assessment: determines need for immediate care and further evaluation, often in the field, continuing in the E.D.
B. Medical diagnostic assessment: is done after child is stabilized and able to undergo studies.
C. Forensic medical consultation: is done as soon as practical.

IX. RETINAL EXAMINATION

Retinal examination is best done by an ophthalmologist with a special interest in trauma using indirect ophthalmoscopy. It is also useful to attempt direct ophthalmoscopy in the E.D. if the pupils are large enough to allow it. Knowing that retinal hemorrhages are present on arrival at the hospital may be forensically important. Many children have visual impairment if they survive and require follow-up by the opthalmologist.

X. IMAGING

A. Chest X-Rays (for emergency care)
A chest x-ray for determination of endotracheal tube position is often done using portable equipment in the E.D., and these films also sometimes show rib fractures when they are closely examined.

B. CT of Head, Abdomen, Chest
The CT of the head is the first study of choice for the child who is unconscious and not yet diagnosed. It should be obtained as soon as the child is stabilized sufficiently

to go to the scanner. If the head CT shows signs of head injury and inflicted injury is now suspected, CT of the abdomen and chest may reveal additional unsuspected injuries.

C. Skeletal Survey
A radiological survey of the entire skeleton is indicated in any child with suspected inflicted injuries, and can often be done on the same trip to the Radiology Department that is made for the head CT. Guidelines describing indications and techniques for these surveys have been published by Kleinman and should be available in the Radiology Department.

D. MRI of Head
Magnetic Resonance Imaging is more sensitive for the detection of thin subdural blood collections and can provide more information about the age of the injury. However, it's use requires a longer period of immobilization than CT and obtaining the study in children on life support carries slightly greater risk. Kleinman's textbook provides detailed recommendations.

E. Follow up studies
Many children will require radiological imaging studies to track changing and healing processes.

XI. LABORATORY

A. Blood Gases
Blood gas analysis is needed for most children who require assisted ventilation or who have been resuscitated. Initial values are useful in determining the duration of prior arrest and can reveal delay in care.

B. Complete Blood Count (CBC)
CBC is required for care, but may also provide the first indication of bleeding in the head when unexpectedly low hemoglobin or hematocrit values are found. Some children with inflicted head injuries have very low values and may need immediate transfusion.

C. Coagulation Screen
A coagulation screen consisting of a platelet count, prothrombin time, partial thromboplastin time and a bleeding time should be done in all cases of suspected inflicted head injury as soon as possible after arrival at the E.D. It is needed both for care and for forensic purposes. Spontaneous bleeding in the head has been reported in cases having severe coagulopathies such as those accompanying leukemia, aplastic anemia, and the hemophilia. However, person with very severe acute brain damage typically develop an acquired coagulopathy. In many cases this will not be present at the moment of presentation, but will develop hours or days later.

D. Blood Chemistries
Assessment of electrolytes and BUN is needed for care, and may also provide clues to delay in care.

E. Enzymes
Determination of AST and amylase values may provide the first indication of an otherwise unsuspected abdominal injury with damage to liver or pancreas, and are needed in all cases of suspected inflicted head injury.

XII. OPERATION

A. Gross Findings
If an operation is needed to remove a large accumulation of blood, the surgeon has an opportunity to obtain important forensic information. (S)he should carefully note the condition of the scalp and skull as he dissects them to determine if bruising or other damage is present. The appearance of the dura, the presence of increased intracranial pressure, the appearance of the blood and the appearance of the brain underlying the blood underlying the blood may provide indicators for the timing of the injury(ies).

B. Specimens for Microscopic Study for Timing
Specimens of tissues involved in injury may be examined microscopically to assess the possible timing of injury. These include scalp, skull, dura and blood clot.

XIII. INTRACRANIAL PRESSURE

Elevated intracranial pressure accompanies brain swelling, and requires treatment. While it is not specific for inflicted head injury, it is important to the understanding of the pathology in the head.

XIV. AUTOPSY

The requirements for the autopsy in cases of suspected inflicted head injury is a subject in itself. Autopsy should be required in all cases of fatal head injury whether intentional or not.

A. Standards to try for:

1. Brain-cutting protocol
2. Neuropathologist with interest in trauma
3. Exam for diffuse axonal injury
4. Careful exam of spinal cord, including exam for d.a.i.

XV. FORENSIC MEDICAL CONSULTATION

Forensic medical consultation is a requirement in any case of suspected inflicted injury at any level of severity that requires medical care. It should be provided by a physician who can demonstrate qualifications from training or experience in this field. Guidelines are under development and may be provided by the American Board of Pediatrics. The components of the consultation are as follows:

A. Review all prior data, meet informants and fill in gaps
B. Coordinate with hospital social work
C. Physical examination with neurological exam as soon as possible
D. Retinal exam by consultant or ophthalmologist
E. Arrange photographic documentation
F. Document, communicate with authorities and testify

XVI. A paradigm for the definition of appropriate or discrepant history in head injury (Hymel, 1998). Two mechanisms for Initial Head Injury Damage

A. Acceleration
Acceleration or deceleration of the head causes movement of the brain, and, if severe, produces shearing injuries, contusional tears and diffuse axonal injury. Many parts of the brain are affected. Consciousness is lost if the sites of consciousness are affected.

B. Contact

C. Brain Swelling (Cerebral Edema and Other Contributors)
Brain swelling may be caused by acceleration damage, by contact damage, by hypoxia, ischemia, infection and other means. In most fatal head injuries, brain swelling is the immediate reason for death. Death occurs when the swelling is sufficient to impede cerebral arterial circulation.

XVII. THE SHAKEN BABY SYNDROME

The Shaken Baby Syndrome (SBS) is diagnosed when an infant or child has a disturbance of consciousness with subdural bleeding, retinal hemorrhages (85%) and some degree of brain swelling. Presenting symptoms often include difficulty breathing, vomiting, convulsions and posturing.

Old or new extracranial injuries are often seen such as bruises on the body or extremities or fractures of the ribs or metaphyses of long bones. External signs of head injury may be present or absent.

The existence of accompanying evidence of contact injury does not exclude shaking as an injury event, but it indicates impact to the head.

XVIII. SHAKING VS. IMPACT

The shortage of reliably witnessed cases makes this issue difficult to resolve. "Confessions" cannot be used as scientific data points. Animal studies are useful for many purposes, but may not provide the definitive answer because of small brain weights. Cadaver studies are mostly unhelpful. Certain motor vehicle events may mimic shaking, and may be useful. Multiply witnessed shaking and "nannycam" recordings may provide the best data points and may eventually resolve this issue.

A. The important practical question is not whether the infant has been shaken or slammed or both.

B. The important question is whether the pathology is due to inflicted injury, unintentional injury or a disease process.

XIX. DETERMINING THE TIME OF THE INJURY EVENT

A. Clinical data is most helpful
A normal, conscious child has not had a fatal head injury in a large majority of cases. Most exceptions are easy to identify from scans or pathology.

B. Imaging can assist in timing

C. CSF color can assist in timing

D. Histology of injury sites can assist in timing

XX. LESS SERIOUS HEAD INJURIES

This is a subject requiring a separate detailed presentation. The following data simply provide some intriguing thoughts about it.

A. Comparative case-fatality rates in a trauma center

1. Unintentional injuries: 2%
2. Inflicted Injuries: 16%

B. Explanation: Unseen and missed cases that recover at home

XXI. UNSEEN AND MISSED CASES

A. Missed cases can be reduced by continuing medical education focused on emergency departments, other primary care settings and organized trauma centers.

B. Unseen cases may be recognized on later medical contacts, but research is needed to improve diagnostic capability.

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Roger E. Haynes
Assistant District Attorney
Dallas County, Texas

The Prosecutor's Goal: Getting the Conviction
Preparation is the key ingredient

Evidence in the SBS case:

Medical

- Ask Questions!
- EMTs, Doctors, Nurses, Radiologist, Opthamologist, Medical Examiner, etc.
- Examine medical records thoroughly.
- Look for statements by caretakers or family about how the injury occurred.
- Look for symptoms of prior abuse.
- Look for:
    * Subdural Hematoma
    * Retinal Hemorrhaging
    * Broken ribs
    * Spiral fractures of long bones
    * Skull fractures
    * Old bruises

  Physical symptoms = Lethargy, Poor Breathing, Seizures, Irritability, Vomiting, Unequal pupil size, Poor Sucking or Swallowing.
- Past medical history.
- Developmental status.

Physical

- Ask Questions!
- Photos of the scene where child was last acting normally.
- Measurements of scene and objects.
- Forensics including trace evidence.
- Seizure of tangible objects.
- Video
- Diagrams
- X-ray, CT scan, MRI

Testimonial

- Ask Questions!
- Family
    * Prior abuse
    * Social history
    * Current situations
- Friends

- Neighbors
- Confessions/statements
    * Common stories
- Time line of childs activity and behavior the last 24 hrs.
- Other siblings.

Defense tactics

- SBS diagnosis of symptoms is inaccurate.
    *it could happen the way D says, the "killer couch"
- Accident - no intent to harm
- Other explanation or diagnosis
    * CPR -- SIDS -- Rebleed -- Shake to Revive
- Expand time frame of injuries -- SODDI

Hurdles

- Often jurors have not heard much about SBS and can be cautious unless properly educated during trial.
- Jurors don't want to believe someone (often a care giver) would shake a child "that" hard.
- Believe our experts not their hired guns.
- Collating Medical, Physical, and Testimonial into layman's terms (A lost juror is a lost case- we need 12, they need 1).
- Giving the jurors a "why"

Motives

- Lost job
- Rocky marriage
- Drug usage
- Financial difficulties
- New to caretaker duties
- Stress

Or combinations of several above.

Jurors are going to have to be educated to understand the mechanics of SBS. Then they are going to need a reason why. Up front preparation on the part of the prosecutor is the best way to make sure that the information is presented in a way that the jury can understand it and subsequently find the D guilty of causing the injury in the only possible way it could have happened.

SBS has a vary unique set of symptoms that when looked at individually may not add up, but when looked at together don't point to anything else.

Shaken Baby Syndrome/Shaken Impact Syndrome

Common Perpetrator Lies: The Dirty Dozen

1. Child fell from a low height (<4 feet), such as a couch, crib, bed or chair
2. Child feel and struck head on floor or furniture, or hard object fell on child
3. Unexpectedly found dead (age and/or circumstances not appropriate for sudden infant death syndrome)
4. Child choked while eating and was therefore shaken or struck on the chest of back
5. Child suddenly turned blue or stopped breathing, and then was shaken
6. Sudden seizure activity
7. Aggressive or inexperienced resuscitation efforts to a child who suddenly stopped breathing
8. Alleged traumatic event one (1) day or more before death
9. Caretaker tripped or slipped while carrying child
10. Injury inflicted by sibling
11. Child left alone in dangerous situation (e.g., bathtub) for just a few moments
12. Child fell downstairs

From: Child Abuse: Medical Diagnosis and Treatment edited by Robert Reece, M.D., Chapter 14: "A Pathologists Perspective" by Robert H. Kirschner, M.D. and Harry L. Wilson, M.D.

Shaken Baby Syndrome Public Awareness Campaign

Shaken Baby Syndrome

Shaken Baby Syndrome (SBS) is a serious condition caused by shaking an infant or child by the arms, legs, or shoulders with or without impact of the head. A baby's brain and blood vessels are not yet developed and their neck muscles are weak, making them vulnerable to whiplash motions. Shaking a young child can cause irreversible brain damage, blindness, cerebral palsy, hearing loss, spinal cord injury, seizures, learning disabilities, and even death.

History of the Campaign

The Children's Trust Fund of Texas (CTF) is a state agency established by the Texas Legislature in 1985 to address the tragedy of child abuse and neglect by focusing on prevention. In 1988, CTF developed a campaign to promote awareness of Shaken Baby Syndrome in recognition of April as Child Abuse Prevention Month. CTF chose to focus on SBS due to the general lack of knowledge of the Syndrome among those who care for children.

Public Service Announcements (PSAs) for television and radio depict the shaking of a flower and compare the damage done to the flower to injuries that can be inflicted on children as a result of shaking. The PSAs were produced in English and Spanish. A brochure called *Shaken Baby Syndrome: The Facts You Need To Know*, available in English and Spanish, has also been used as part of the campaign. The brochure is updated, reprinted and distributed throughout Texas to current and former CTF grantees and a variety of organizations working with parents and other caregivers.

In 1995, CTF served as the lead agency for the state of Texas in a national campaign called "Don't Shake The Baby" developed by the Pueblo County Health Department of Colorado and funded through a grant from the National Center on Child Abuse and Neglect. Materials received through this program were distributed throughout Texas.

Current Campaign

In the 1996, the CTF Request for Proposal included parenting education and children's education programs as well as grants to support Shaken Baby Syndrome awareness. There were four organizations in Dallas, El Paso, Wells, and Snyder that received CTF grants to conduct public awareness campaigns on Shaken Baby Syndrome. These programs distributed CTF materials and materials from the national campaign. Public Service Announcements were released both in these communities and throughout the state in April 1996 in recognition of Child Abuse Prevention Month.

Based on the enthusiasm and success of these four programs and CTF's commitment to community-based initiatives, the CTF Council decided to continue a focus on local awareness campaigns and released a Request For Proposal for the 1997 fiscal year specifically for Shaken Baby Syndrome education. Twenty-two programs in Texas were awarded CTF grants and the four programs funded in 1996 were granted contract renewals to develop local campaigns for the prevention of SBS.

Based on the enthusiasm and success of the Shaken Baby Syndrome campaigns, the CTF Council has continued to renew funding for the grants up to three years. There are currently fourteen SBS programs completing the third year of CTF funding.

1884 Highway 71 West, Cedar Creek, TX 78612
512/303-5061 FAX 512/303-4655 Web Address: http://www.ctf.state.tx.us

Training

Training seminars for CTF grantees have been very successful. Past presentations have included, Dr. Juan Parra, pediatrician and child fatality review team member in San Antonio. Dr. Parra serves on the Children's Trust Fund Texas Council, his presentation focused on SBS from the medical perspective. Another notable presenter was Jacy Showers, a nationally recognized expert on Shaken Baby Syndrome and coordinator of the National Conference on SBS. Her presentation included prevention techniques based on her experiences as the director of the national "Don't Shake The Baby" campaign. Marketing and media experts have also provided training on working with the media and getting your message out in communities.

In April 1998, CTF sponsored eight Texas sites to participate in a national satellite videoconference on the medical implications of SBS. Dr. Randell C. Alexander of the University of Iowa presented the conference with over 300 sites participating. The second National Conference on Shaken Baby Syndrome was held September 13-15, 1998 in Salt Lake City. The Children's Trust Fund of Texas presented on Texas' Prevention Campaign.

In 1999, CTF partnered with the Shaken Baby Alliance to sponsor two regional training seminars on the Shaken Baby Syndrome (SBS). The seminars were held in Fort Worth on February 9-10, 1999 and in Houston on February 10-11, 1999. Nationally recognized presenters addressed the medical, investigative, legal, intervention and prevention challenges facing the tragedy of SBS. Hundreds of participants from Texas to Australia attended the comprehensive training. The participants also included CTF SBS program grantees and local Child Fatality Review Team and state agency representatives. Most participants responded that the training was the best they had ever attended.

What You Can Do

You can help save lives and prevent countless disabilities by spreading the word. Everyone who cares for children must know the dangers of Shaken Baby Syndrome. Innocent lives depend on how quickly we inform the public, so please help the Children's Trust Fund of Texas get the message through. Tell people about the dangers. Shaking a baby can irreversible, lifelong disabilities. Help educate others on the dangers of Shaken Baby Syndrome because, *"the good we do will last a lifetime."*

1999 Shaken Baby Syndrome Awareness Campaign Programs funded by CTF (listed by Regions)

REGION 1 – PANHANDLE PLAINS

Family Support Services Parents, parents to be, grandparents, baby sitters, child care providers, teachers, siblings, media, medical professionals and the court system are all targets for this SBS campaign. Potter and Randall County along with other Panhandle areas are educated through this group's efforts. Presentations are done in all grades of area schools, in childcare centers and in conjunction with Red Cross babysitter training. Program information is distributed to area agencies such as prenatal clinics, children's groups, colleges and prisons. Contact: Rhonda Roden, 1001 South Polk, Amarillo, Texas 79101. Ph. 806/372-3202. **Potter and Randall County**

Giant Steps for Children, Inc. Campaign goal is to educate the community about the dangers of shaking an infant or young child, and engage others in an active effort to spread this knowledge as well. The program reaches people in the community through presentations, media outlets, and special events. Central Texas is their target area, with an emphasis on those of low economic status, female-headed households, and teen parents. Collaborations with hospitals provide valuable opportunities to educate about Shaken Baby Syndrome. Contact: Kim Boyd, P.O. Box 61031 San Angelo, Texas 76906. Ph. 915/659-6900. **Tom Green County**

Parenting Coalition of Brown County, Inc. This campaign works to provide primary prevention to families who are not yet experiencing crisis. Various agencies work with this program to raise awareness about SBS. Adults and children of all ages are targeted and reached in schools, health care centers/clinics, childcare centers and other agencies. Contact: Cathie Lehman, 901 Avenue B, Brownwood, Texas 76801. Ph. 915/646-5939 x301. **Brown County**

REGION 2 - PRAIRIES & LAKES

Central Texas Youth Services Bureau, Inc. The program strives to keep the family together by reduction of incidents in child abuse and neglect. Distribution of SBS awareness materials and counseling for families are important tools in furthering the SBS Public Awareness Campaign. The entire family is served through counseling, education, and meetings provided by this agency. Presentations in schools, social service agencies, hospitals, courts, juvenile justice centers, and community resource groups expose children, youth, families and professionals to the SBS campaign. Contact: Keith Wallace, 204 North East Street Suite A, P.O. Box 92 Belton, Texas 76513-0092. Ph: 254/939-3466. **Bell County**

Child Abuse Prevention Project (CAPP) CAPP focuses on low income families, with emphasis on males and adolescents in Lamar County. Low education levels and high teen pregnancy rates have spurred CAPP to provide information, training, and support to those in their area. Individuals reached through this program benefit by having skills to handle stresses and to intercept abusive situations. Radio spots and billboards are used to relay campaign information in areas where males and adolescents will benefit. Contact: Sharon Eubanks, 136 Grand Avenue Suite B7, Paris, Texas 75460. Ph. 903/737-4346. **Lamar County**

Children First Counseling Center Presentations by this campaign are done in WIC sites, Salvation Army Shelters, at DFW Medical Center, and other facilities in the area. These presentations include abuse prevention information and basic parenting skills; babysitters are also educated in child abuse prevention. Local agencies participate in this SBS campaign in order to provide education, training, and materials. Target groups include low income and teen parents, adolescents and perpetrators of domestic violence. Hispanics, African Americans and Oriental populations make up much of the target group. Contact: Ronna Quimby, 217 West Main Suite 100, Grand Prairie, Texas 75050. Ph. 972/264-0604. **Dallas County**

Lockhart ISD This program provides interactive informational presentations to community organizations and agencies, as well as early childhood programs, elementary student groups, pregnant and teen parents, male students and other at-risk student populations. Lockhart ISD also is a resource for parents, teachers, and caregivers at-risk for shaking an infant or child. Additionally, parent educators are trained in SBS awareness and prevention techniques. Target populations include all genders, ethnic and age groups in the Lockhart area. Contact: Ellen Guckian, 520 Pecos Street, Lockhart, Texas 78644. Ph: 512/398-9879. **Caldwell County**

North Texas SIDS Program (COPC) The focus of this campaign is to reduce infant mortality. Targets of this program are day care providers, CPS workers, social workers, public health workers, and law enforcement. Literature and videos were distributed to schools, churches, and to new and expectant parents. Pregnancy prevention is taught to teens and educational/electronic dolls are used to simulate caring for a baby. This project serves 39 counties in Northeast Texas. Middle and lower income students are the focus of their education and training. Contact: Leslie U. Malone, COPC Administration, 5000 Harry Hines, Dallas, Texas 75235. Ph. 214/648-2796. **Dallas County**

Tejas Council of Camp Fire Boys & Girls Volunteers are trained to deliver and present information on SBS. Information is provided to all Camp Fires groups. After-school Camp Fire programs and teen parents programs are also educated about SBS. Children and adults in McLennan, Bell, Coryell, Bosque, and Falls counties are targeted to receive presentations or printed information on SBS. Contact: Pat McKee, 1826 Morrow, Waco, Texas 76707. Ph. 254/752-5515. **McLennan County**

REGION 3 – PINEY WOODS

Huntsville ISD This campaign focuses on teen parents. Opportunities are provided for teen parents to stay in school and gain skills that will enable them to be successful in the workplace. Specific services include: parenting education classes, child care, transportation for parents and children, prenatal classes for pregnant participants, job skills training and academic tutoring. Some of the populations targeted by this campaign are teens who are pregnant or parenting, other at risk youth/students, WIC recipients, and new mothers. Target areas include Walker, Trinity, Houston, Montgomery and Brazos counties. Contact: Linda Bone, 441 FM 2821 East, Huntsville, Texas 77340. Ph: 409/293-2626 x57. **Walker County**

REGION 5 – SOUTH TEXAS PLAINS

Any Baby Can, Inc. Targets of this campaign include the maternal child health care community and parents, incarcerated parents, at-risk juveniles, staff of agencies addressing child abuse, child care providers, media and middle schools. Literature and presentations are provided to licensed childcare centers and middle schools. Collaboration with colleges who have childcare training programs that could teach SBS prevention is a goal of this group. Contact: Marian Sokol or Katherine Ratcliff, 5410 Fredricksburg Road Suite 104, San Antonio, Texas 78229. Ph: 210/377-0222. **Bexar County**

REGION 6 – HILL COUNTRY

Community Council of Southwest Texas Information packages are distributed by this campaign to participants in the Head Start Program, new mothers, and health care clinics/facilities. Awareness presentations for those involved in WIC programs are also provided. News releases and public service announcements are provided to local media. Collaboration with the school district allows for awareness programs for adolescents. Males are targeted as at-risk and receive educational materials at local activities. Contact: Cindy Rodriguez, P.O. Drawer 1709, Uvalde, Texas 78802-1709. Ph. 830/278-1297. **Uvalde County**

Williamson County & Cities Health District The goal of this campaign is to reduce the number of caregivers at risk of shaking an infant or child. This project is a collaborative, multi-organizational approach, which serves the citizens of Williamson County. Target populations are parents, extended family, siblings, adolescents, daycare providers, baby-sitters and teen parents with a particular focus on male caregivers. SBS materials are distributed to various organizations including schools, churches, hospitals and daycare centers. SBS curriculum is provided for baby-sitting certification courses. Presentations will be given in English or Spanish. Contact: Marge Tripp, 211 Commerce Cove, Suite 109, Round Rock, Texas 78664. Ph: 512/248-3255. **Williamson County**

REGION 7 - BIG BEND COUNTRY

Fort Stockton ISD Pregnant teens and teen parents from the local high school are the focus of this campaign. The students learn about SBS then learn how to teach others about SBS. Students present to various community agencies, such as WIC. Local media is involved in preparing and presenting public service announcements along with the students. Contact: Faye Johnson or Tammy Vick, 400 South Young, Fort Stockton, Texas 79735. Ph. 915/336-4121. **Pecos County**

Roger E. Haynes
Assistant District Attorney
Dallas County, Texas

The Prosecutor's Goal: Getting the Conviction
Preparation is the key ingredient

Evidence in the SBS case:

Medical

- Ask Questions!
- EMTs, Doctors, Nurses, Radiologist, Opthamologist, Medical Examiner, etc.
- Examine medical records thoroughly.
- Look for statements by caretakers or family about how the injury occurred.
- Look for symptoms of prior abuse.
- Look for:
    * Subdural Hematoma
    * Retinal Hemorrhaging
    * Broken ribs
    * Spiral fractures of long bones
    * Skull fractures
    * Old bruises

  Physical symptoms = Lethargy, Poor Breathing, Seizures, Irritability, Vomiting, Unequal pupil size, Poor Sucking or Swallowing.
- Past medical history.
- Developmental status.

Physical

- Ask Questions!
- Photos of the scene where child was last acting normally.
- Measurements of scene and objects.
- Forensics including trace evidence.
- Seizure of tangible objects.
- Video
- Diagrams
- X-ray, CT scan, MRI

Testimonial

- Ask Questions!
- Family
    * Prior abuse
    * Social history
    * Current situations

- Friends
- Neighbors
- Confessions/statements
    * Common stories
- Time line of childs activity and behavior the last 24 hrs.
- Other siblings.

Defense tactics

- SBS diagnosis of symptoms is inaccurate.
    *it could happen the way D says, the "killer couch"
- Accident - no intent to harm
- Other explanation or diagnosis
    * CPR -- SIDS -- Rebleed -- Shake to Revive
- Expand time frame of injuries -- SODDI

Hurdles

- Often jurors have not heard much about SBS and can be cautious unless properly educated during trial.
- Jurors don't want to believe someone (often a care giver) would shake a child "that" hard.
- Believe our experts not their hired guns.
- Collating Medical, Physical, and Testimonial into layman's terms (A lost juror is a lost case- we need 12, they need 1).
- Giving the jurors a "why"

Motives

- Lost job
- Rocky marriage
- Drug usage
- Financial difficulties
- New to caretaker duties
- Stress

Or combinations of several above.

Jurors are going to have to be educated to understand the mechanics of SBS. Then they are going to need a reason why. Up front preparation on the part of the prosecutor is the best way to make sure that the information is presented in a way that the jury can understand it and subsequently find the D guilty of causing the injury in the only possible way it could have happened.

SBS has a vary unique set of symptoms that when looked at individually may not add up, but when looked at together don't point to anything else.

Investigating Fatal Child Abuse and Neglect

Presented by

Lt. Bill Walsh

Youth and Family Crimes Division

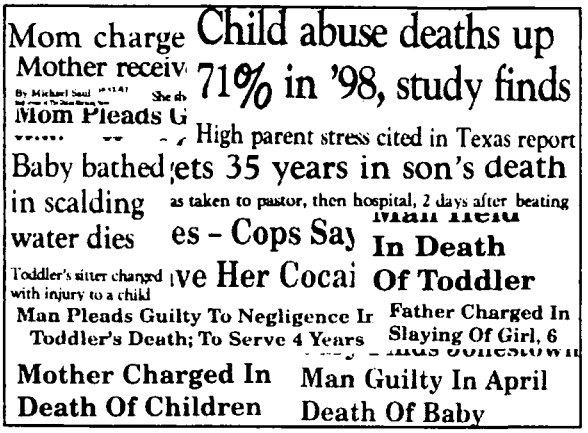
Dallas Police Department

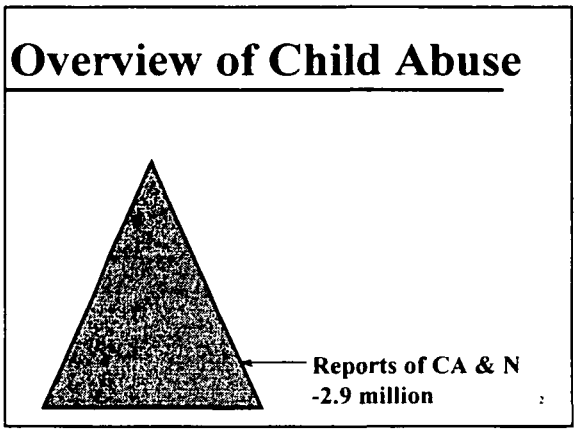
At the

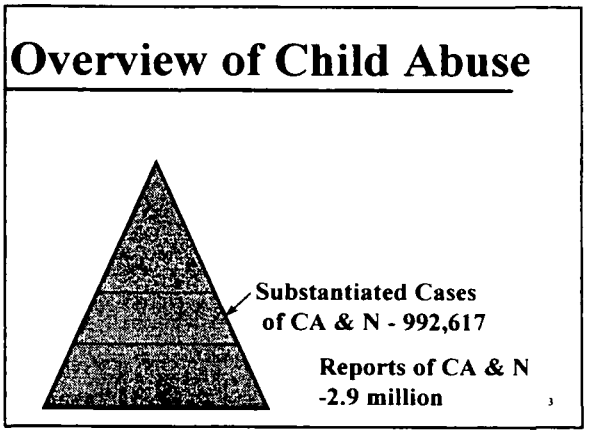
1999 Crimes against Children Conference

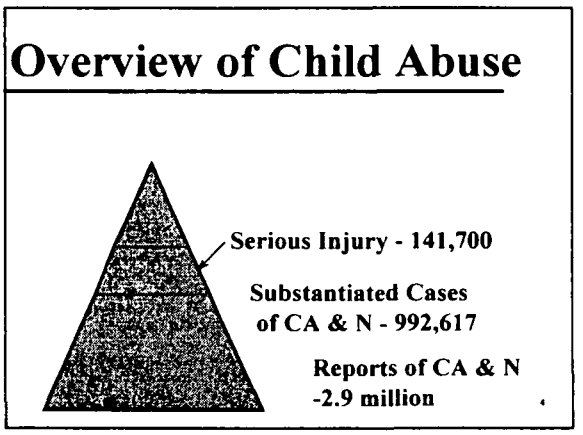
Dallas, Texas

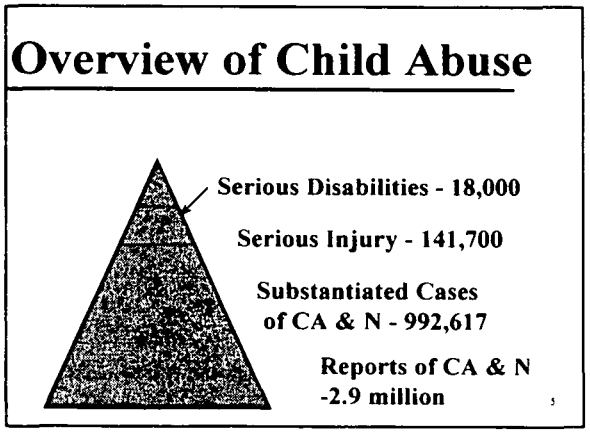
August 4, 1999

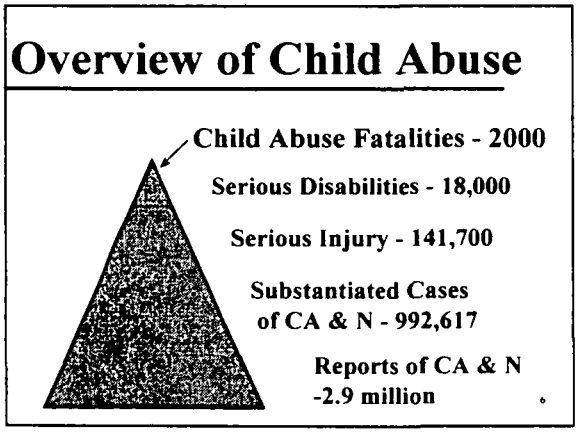

Mom charge
Mother receiv
Mom Pleads G
Baby bathed
in scalding
water dies
Toddler's sitter charged
with injury to a child
Mother Charged In
Death Of Children
Child abuse deaths up
71% in '98, study finds
High parent stress cited in Texas report
ets 35 years in son's death
as taken to pastor, then hospital, 2 days after beating
es - Cops Say
In Death
ve Her Cocai
Of Toddler
Man Pleads Guilty To Negligence Ir
Toddler's Death; To Serve 4 Years
Father Charged In
Slaying Of Girl, 6
Man Guilty In April
Death Of Baby


Overview of Child Abuse
Reports of CA & N
-2.9 million

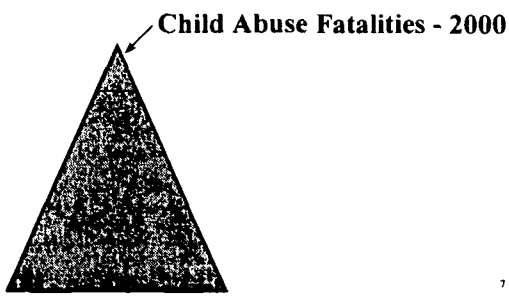

Overview of Child Abuse
Substantiated Cases
of CA & N - 992,617
Reports of CA & N
-2.9 million


Overview of Child Abuse
Serious Injury - 141,700
Substantiated Cases
of CA & N - 992,617
Reports of CA & N
-2.9 million


Overview of Child Abuse
Serious Disabilities - 18,000
Serious Injury - 141,700
Substantiated Cases
of CA & N - 992,617
Reports of CA & N
-2.9 million


Overview of Child Abuse
Child Abuse Fatalities - 2000
Serious Disabilities - 18,000
Serious Injury - 141,700
Substantiated Cases
of CA & N - 992,617
Reports of CA & N
-2.9 million

Overview of Child Abuse



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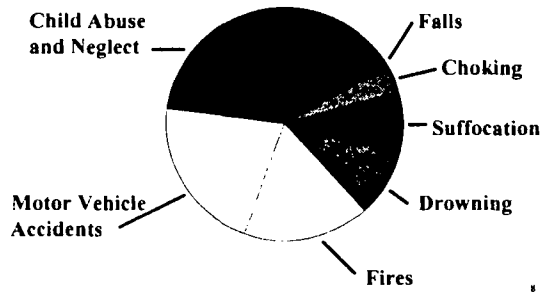
Unexpected Child Deaths



8

Overview of Fatal Abuse

- Estimated that 2000 children die of abuse or neglect per year (some say much higher)
- Approximately 5 children per day
- Of the children that die :
  - 75 % are less than 4 yrs. old
  - 40 % are less than 1 yrs. old

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Table 3
Breakdown of Child Maltreatment Fatalities:
% Distribution by Category

	1995	1996	1997	Average
Prior or Current Contact with CPS	42% (18 states)	40% (20 states)	41% (16 states)	41%
Deaths Due to Neglect	43% (27 states)	43% (28 states)	45% (20 states)	44%
Deaths Due to Abuse	54% (27 states)	52% (28 states)	48% (20 states)	51%
Deaths Due to Neglect and Abuse	3% (27 states)	5% (28 states)	7% (20 states)	5%
Deaths to Children Under Five Yrs. Old	76% (27 states)	78% (25 states)	79% (19 states)	78%
Deaths to Children Under One Yr. Old	37% (27 states)	39% (25 states)	38% (18 states)	38%

1997 50 State Survey by NCPCA

10

Overview of Fatal Abuse

- Child homicide cases are increasing
  - homicide rate for children under 4 yrs. old is at 40 year high (Population Reference Bureau)

11

Child abuse deaths up 71% in '98, study finds

High parent stress cited in Texas report

By Christopher Lee
Austin Bureau of The Dallas Morning News

AUSTIN — The number of Texas children who died because of child abuse or neglect jumped 71 percent in the last year, partly because some parents are overwhelmed by their responsibilities.

That is the finding in a new state study that also called for hiring more children's caseworkers and improving their training so they can better identify children at risk.

A total of 176 children died while being cared for by their parents or others in the last fiscal year, up from 103 the year before, according to the study by the Texas Department of Protective and Regulatory Services.

■ Child abuse deaths. 10A

Nearly three of every four children killed were age 3 or younger. And more than two-thirds were minorities.

The report, obtained by *The Dallas Morning News*, will be released Wednesday, along with a strategy to help child welfare officials better

Please see CHILD on Page 10A.

Fatal Abuse Statistics

- Under reporting or different reporting criteria
  - UCR system, CPS records, death certificates
- Numbers may only reflect cases known to CPS
- Failure to recognize abuse related deaths
  - no autopsy
  - accident vs. neglect
  - neglect vs. criminal neglect

13

Review of DC kids' deaths indicates abuse overlooked

Experts say child deaths often wrongly reported as accidents

Review finds numerous DC kids died from maltreatment, neglect

Nationally, medical professionals have conducted at least three detailed studies of children's deaths from external causes over the last two decades. Each, using data from such differing locales as Chicago, New York City and Missouri, has found that deaths from maltreatment have been underreported by at least 50 percent.

Fatal Abuse Statistics

- Lack of information sharing among agencies
- Improper death investigations
- Professional denial of incidence of fatal abuse

17

Fatal Abuse Statistics

- Child's disappearance may not be known or properly investigated
- Child's body may not be found

18

Fatal Abuse Statistics

- Child's disappearance may not be known or properly investigated
- Child's body may not be found
- Parent's may fabricate child's abduction

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Abduction story fabricated, police say

Oak Cliff man accused of killing, burying his 2-year-old stepson

By Kendall Anderson
Staff Writer of The Dallas Morning News

A 22-year-old Oak Cliff man was accused Saturday of beating to death his 2-year-old stepson, burying the body in rural Hunt County and helping make up a story that the toddler had been abducted.

Juan Tejada was charged with capital murder in the death of Joel Hernandez, whose battered body was unearthed Saturday from a 3-foot-deep grave about 60 miles east of Dallas. Police said he had been dead since at least Tuesday.

"He had on little tennis shoes and a little jogging suit. He was still wearing diapers. . . . Us mamas notice those kinds of things," said Hunt County Justice of the Peace Anita Hunter, who pronounced the boy dead about 9:45 a.m.

Mr. Tejada, whom police described as the common-law husband of Joel's mother, was being held Saturday night in the Law Sheriff's Justice Center. Bail was set at $250,000.

Dallas police were searching Saturday night for Mr. Tejada's brother, Jesus Antonio Tejada, 29. Investigators suspect Jesus Tejada helped bury Joel's body last.

Grim scene in Greenville 18A

Please see BOY on Page 18A.

Increase in Fatal Cases

- Increased professional expertise in all involved disciplines
  - Law enforcement, CPS, Medical, DA's
    - » seminars, articles, media attention
- Increased risk factors for children
  - substance abuse, crack cocaine, economy, family isolation
- More autopsies being conducted
- Increase in Child Death Review Teams

22

Fatal Abuse Victims

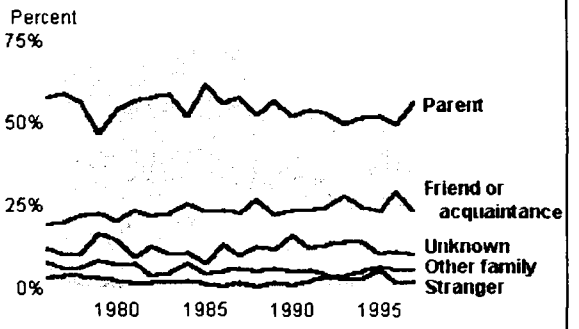
- Physical development
  - much smaller than caretakers
- Unique anatomy
- Lack of verbal skills
- Total dependence on caretaker
  - children must be fed, supervised
- Relative social isolation
  - too young for school, church, sports

23

Homicide trends in the United States

by James Alan Fox, BJS Visiting Fellow & Professor of Criminal Justice, Northeastern University
and
Marianne W. Zawitz, BJS Statistician

Homicides of children under age 5 by relationship with the offender, 1976-97



Offenders

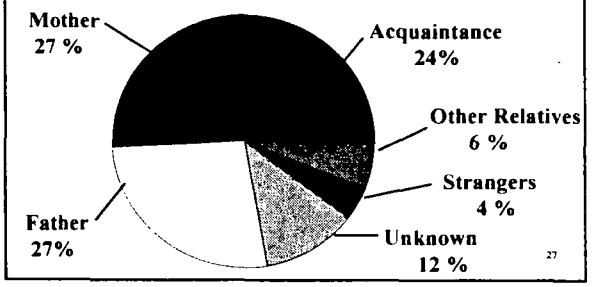
Of all :

- 27% were killed by mothers
- 27% were killed by fathers
- 24% were killed by acquaintances
- 6% were killed by other relatives
- 3% were killed by strangers
- 12% were killed by perpetrators whose relationship was unknown

26

Offenders

Children under age 5 murdered from 1976-97



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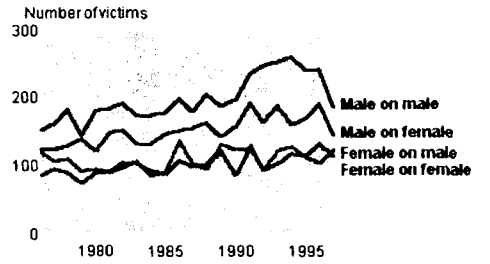
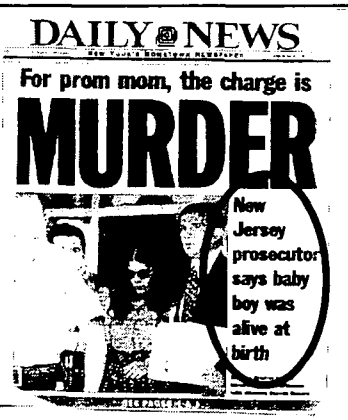
Homicides of children under age 5 by gender of victim and offender, 1976-97



Neonaticide

- Defined as the murder of a child within the first 24 hrs. of life by act or omission
- Usually committed by mother alone
- Child may die from exposure to weather, smothering, starvation, animal attack
  - may or may not have been intended for child to die
- Child usually not physically assaulted
- If child found, burden of proof is to show child was born alive, not stillborn

29



"I was aware of what I was doing when I placed the baby in the bag."

— Melissa Dressler

Woman guilty in baby's death

She tells how she gave birth at prom, disposed of infant

Continued from

SPRINGFIELD, Mo. — In an emotionless and unfaltering voice, a young woman described Thursday how she gave birth in a bathroom at her senior prom last year, killed the baby out of the toilet bowl, wrapped him in plastic bags and dumped him in the trash.

But her parents looked on, 20-year-old Melissa Dressler pleaded guilty to aggravated manslaughter in the baby boy's death, sparing herself a murder trial and a possible life sentence.

She could get up to 15 years in prison at sentencing Oct. 29 and could be out in as little as three with good behavior.

"The baby was born alive," Ms. Dressler told

Girl, 14, accused of killing her newborn

Continued from

ANGLETON, Texas — A 14-year-old Brazoria County girl was arrested Tuesday and accused of capital murder in the death of her newborn baby. The body of the 6-pound, 5-ounce infant was discovered last week wrapped in a plastic bag and left in a trash container behind an auto parts store.

A detention hearing was scheduled Wednesday for the girl, who was believed to have delivered the full-term child early Friday at her home in an upscale subdivision in Pearland, south of Houston.

The preliminary report listed the cause of death as blunt trauma to the head.

The Pearland High School freshman, whose name was not disclosed, was being held at the county juvenile detention center.

The girl, who wore baggy clothing to conceal her pregnancy, gave birth in an upstairs bathroom at her home while other people in the house were asleep, said sheriff's Lt. Steve Ricks.

He said she woke her 21-year-old brother, gave him a plastic bag containing the infant's body and asked him to dispose of it.

Authorities believe the brother drove to the auto parts store and left the bag in the trash bin. The brother was not arrested although he eventually could face charges, Lt. Ricks said.

The girl was described as showing little emotion at the detention center.

"All the family members we talked to were pretty much in shock and dismay that this young lady was pregnant," Lt. Ricks said.

32

Police investigate death of Oak Cliff newborn found in drawer

By Jason Sickles and Dave Michaels

Dallas police are investigating the death of a newborn boy whose body was found Monday, wrapped in towels in a drawer at his mother's west Dallas home.

Authorities learned of the

death about 8 a.m. when a 23-year-old woman went to Parkland Memorial Hospital and asked to see a doctor. The [illegible] for child police when he suspected the woman had killing the child.

"[illegible] questioned her and she admitted that the child was her baby a few hours earlier," said Sgt. Jim Chandler, a police

the woman. She told them the baby was born alive but died a short time later.

An autopsy to determine a cause of death is expected to be performed Tuesday, the city authorities said.

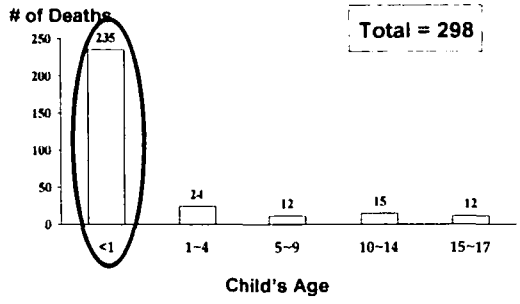
The [illegible] would not be charged [illegible] and remained in custody [illegible] Parkland, authori-

ties said. Police declined to identify the woman. Neighbors said they doubt that the woman should [illegible] the pregnancy and that [illegible] would keep the child.

"I knew her, and I don't think she knew [illegible] baby," said

Please see PEARLY on Page 21A

1997 Dallas County Natural Deaths by Age of the Child



1997 Dallas County Causes of Natural Deaths

Total = 298

◆ Prematurity	98
◆ Congenital anomalies	80
◆ Sudden Infant Death Syndrome	43
◆ Infections	37
◆ Malignancies	19
◆ Cerebral Palsy	3
◆ Other	18

Infanticide

- Defined as the murder of a child within the first year of life by act or omission
- Estimated that @ 40 % of abuse deaths involve infants

Abuse Related Deaths

- **Physical Abuse**
  - **Chronic abuse**
    - » **child abused over time, dies from combination of injuries or a head injury**
  - **Impulsive abuse**
    - » **child dies incident to assault or after a period of time**

37

Neglect Related Deaths

- **Neglect**
  - **Physical neglect**
  - **Medical neglect**
  - **Negligent supervision**

38

Abuse Related Deaths

- **As children get older, the list of possible offenders increases and the causes of death vary**

39

Abuse Related Deaths

CARETAKERS FOR NEWBORNS

Mother (Girlfriend)

TIME

Fathe r (Boyfriend)

40

Abuse Related Deaths

MORE CARETAKERS AS THE CHILD GETS OLDER

Mother Siblings Baby-sitters Daycare Staff

TIME

Fathe r Relatives Friends Neighbors

41

Girl, 12, sentenced in toddler's slaying

She faces up to 20 years for fatal beating

AUSTIN — A 12-year-old girl convicted in the beating death of a toddler will spend up to 20 years in state custody, a jury decided Friday.

The six-man, six-woman jury determined the girl used a deadly weapon in the death of 2½-year-old Jayla Bethea on May 26.

Prosecutors never produced a weapon but told jurors fists and feet could be considered weapons.

Police and prosecutors said the 12-year-old hit Jayla more than a dozen times. The fatal blow, according to a medical examiner, caused her liver to rupture.

Under the sentence, the 12-year-old will first go to a Texas Youth Commission facility. She could be transferred with a judge's permission to prison after turning 18. She also could be kept in the TYC until turning 21.

was not a perfect child but needed no more guidance or supervision than any other youngster.

Gary Cobb, an assistant Travis County district attorney who prosecuted the case, said the girl does need rehabilitation.

"We believe the jury did what was appropriate," he said.

Jayla and four other children were being cared for in an illegal day care operation, according to the Texas Department of Protective and Regulatory Services.

The 12-year-old's grandparents, with whom she and five other grandchildren were living, had applied for state licensing. Their request was denied because of two confirmed cases of child abuse against children living in the home.

No children had ever been re-

Baby bathed in scalding water dies

Toddler's sitter charged with injury to a child

By Al Brunjes

A 21-month-old girl who was bathed in scalding water by a teenage baby sitter last month died this week, police said Friday.

Margo Al-Shabazz suffered second- and third-degree burns over most of the lower half of her body when she was bathed by a 15-year-old sitter, said Detective Don Lenker of the Police Department's child abuse unit. She died early Wednesday in the burn unit at Portland Shriners Hospital.

Hot tap water in the sitter's apartment reached 133 degrees when tested by police the detective said, but he did not know whether the child's bath water was that hot.

Police have charged the baby sitter with injury to a child, a felony, Detective Lenker said. The teen-ager's name is being with-

Margo Al-Shabazz suffered second- and third-degree burns over most of the lower half of her body.

held because she is a juvenile. She has been released to the her parents, he said.

Margo's mother, Shasta Al-Shabazz, 24, was too distraught Friday to discuss her daughter's death. The girl's grandmother said family members are frustrated because they don't know exactly what happened to her.

"We just want to know why, why this girl did this to the baby," said

Please see BABY on Page 8A.

Abuse Related Deaths

NEWBORNS AND INFANTS

Abandonment

TIME

Head Injuries

44

Abuse Related Deaths

AS THE CHILD GETS OLDER

Abandonment Suffocation Burn Injuries

TIME

Head Injuries Abdominal Injuries Negligent Supervision

45

Abuse Related Deaths

- Head injuries are the leading cause of death in infants and the younger children
- Internal injuries are the second leading cause of death, often found in older children

46

Abuse Related Deaths

- Typology
  - Battered Child
  - Impulse or Anger Homicide
  - Punished Child
  - Gentle Homicide
  - Neglect Deaths

47

Fatal Child Abuse vs. Homicide

- Usually no witnesses, or accomplices
  - may have someone who failed to protect, report
- Usually no weapon involved
  - hands, feet, shaking, hot water, starvation, drowning

48

Fatal Child Abuse vs. Homicide

- Usually little physical evidence
  - no fingerprints, DNA, trace evidence
- Difficult to prove intent, motive
  - why would someone hurt a baby?
  - accident?, neglect?, criminal neglect?

49

Fatal Child Abuse vs. Homicide

- Prosecution often depends heavily on medical evidence
  - confusing, technical testimony for jury
  - may involve testimony and opinions of several medical specialists
  - case may be decided by results of the "battle of the medical experts"

50

Fatal Child Abuse vs. Homicide

- Prosecution depends on proving a circumstantial evidence case
  - proving that only the defendant could have committed the fatal abuse
  - Prosecutor must prove guilt *"beyond a reasonable doubt"*
  - Defense only has to convince there is another explanation or another responsible party

51

Fatal Child Abuse vs. Homicide

- Victim may not have external injuries
  - death may appear natural
  - autopsy may not be conducted
  - delay in investigation starting

52

Table 3
Breakdown of Child Maltreatment Fatalities:
% Distribution by Category

	1995	1996	1997	Average
Prior or Current Contact with CPS	42% (18 states)	40% (20 states)	41% (16 states)	41%
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Deaths Due to Abuse	54% (27 states)	52% (28 states)	48% (20 states)	51%
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Deaths to Children Under Five Yrs. Old	76% (27 states)	78% (25 states)	79% (19 states)	78%
Deaths to Children Under One Yr. Old	37% (27 states)	39% (25 states)	38% (18 states)	38%

53

Fatal Child Abuse vs. Homicide

- Investigation complicated by CPS involvement
  - requires coordination and communication between police and CPS
  - different agency missions and goals
  - different decision making processes

54

Fatal Child Abuse vs. Homicide

- Investigation may be conducted by someone unfamiliar with dynamics of child abuse and death investigation
- Deceased child may be moved from the location

55

Battered Child Syndrome

- Repeated acts of intentional trauma inflicted on young children that are clearly identifiable as non-accidental
- Child tends to have injuries about the head, commonly it is the cause of death
- Child may have concurrent evidence of neglect, malnourishment, old injuries
- Battered Child Syndrome evidence is admissible in court
  - Estelle v. Mc Guire, 1991, 112 US 475

56

Battered Child Syndrome

- Often a delay in seeking medical attention
- Caretakers' explanation for injuries is vague, and/or inconsistent
- Caretakers may blame injury on child's clumsiness, other siblings, accident
- Caretakers' history provided to medical staff is not consistent with clinical findings
- Child may or may not be a "targeted child" for abuse

57

Impulse or Anger Homicides

- Sudden, impulsive act of violent assault resulting in fatal injuries to the child
  - Shaking, punching, kicking, throwing
- Aside from fatal injuries, child appears relatively well cared for and normal
- May be a delay in seeking medical attention
- Caretakers' history provided to medical staff is not consistent with clinical findings

58

Impulse or Anger Homicides

- Important to *"lock"* caretakers into their story early in the investigation
- Important that caretakers not be alerted to the implausibility of their story
- Impulse murders may be more common than Battered Child cases
- Offenders very likely to confess if handled properly

59

Two guilty of maiming young boy

Couple face up to life in toilet training case

By Eric Garcia

FORT WORTH — Jurors convicted an Arlington mother and her boyfriend Wednesday on charges that they mutilated the penis of the woman's son during toilet training.

Head Injuries

- Leading cause of death in child abuse cases
- Injuries may not be externally visible
- Child may present clinically with:
  - vomiting, inability or unwillingness to eat
  - coma, shock
  - drowsiness, irritability
- There is no specific diagnostic pattern of inflicted head trauma. Diagnosis is based on the history and the clinical findings.

61

Head Injuries

- A child that has "raccoon eyes" may actually have a head injury at the base of the skull.
- Children's unique anatomy makes them especially vulnerable :
  - relatively large head & brain with high water content
  - more space between brain and skull
  - child's weight
  - undeveloped neck muscles

62

"Red Flag" Stories from Caretakers

- Child was unexpectedly found dead (not consistent with SIDS)
- Child suddenly turned blue and stopped breathing
- Child suffered a sudden seizure event
- Child was hurt by improper CPR
- Child hurt themselves, or hurt by sibling

63

"Red Flag" Stories from Caretakers

- Child was killed falling down the stairs
- Child fell from a low height (< 4 ft.)
- Child fell and struck their head on .....
- Child was hit on head by a fallen object
- Child was choking so caretaker shook/hit the child on the back

64

Case No: 1172-94-0[illegible]JG Page 6

Name: Crawford, Anthony

FINDINGS:

1. Blunt force head injuries:

   a. Multiple contusions.
   b. Left skull fracture with epidural hemorrhage.
   c. Cerebral edema.
   d. Lacerated lip and tongue.

2. Blunt force trunk injuries:

   a. Multiple contusions.
   b. Left posterior rib fractures.
   c. Lacerations of liver, mesentery, and connective tissue with hemoperitoneum.
   d. Congestion of rectal mucosa.

3. Blunt force extremity injuries:

   a. Healing ulcerations of left ankle and heel.
   b. Purple-brown discolorations with superficial abrasions of arms.

65

Case No: 1172-94-0[illegible]JG Page 7

Name: Crawford, Anthony

CONCLUSION:

It is my opinion that Anthony Crawford, a 15-month-old black male, died of blunt force injuries.

MANNER OF DEATH: Homicide.

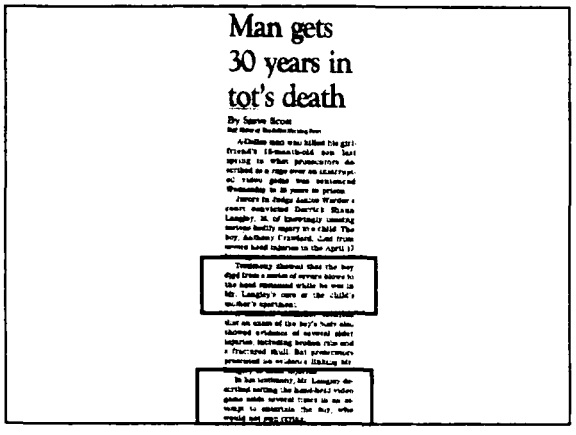
J. M. Gulleyardo, M.D.
Deputy Chief Medical Examiner

TOXICOLOGY:

Blood: Alcohols & Acetone - negative.
Drug Screen - 0.54 mg/l atropine.

Karen F. Ross, M.D.
Medical Examiner

66


Man gets
30 years in
tot's death


Woman
is guilty in
baby death
Life sentence given
in Dallas beating

Fatal Falls

- Dr. Chadwick's trauma center study
  - 317 children <5 yrs.
    - » 7 deaths in 100 children involving falls < 4 ft.
    - » 1 death in 118 children involving falls 10-45 ft.

69

Fatal Falls

- Dr. Chadwick's trauma center study
  - 317 children <5 yrs.
    - » 7 deaths in 100 children involving falls < 4 ft.
    - » 1 death in 118 children involving falls 10-45 ft.

70

Fatal Falls

- Dr. Chadwick's trauma center study
  - 317 children <5 yrs.
    - » 7 deaths in 100 children involving falls < 4 ft.
    - » 1 death in 118 children involving falls 10-45 ft.

71

Fatal Falls

- Dr. Chadwick's second trauma center study
  - 523 children studied
    - » inflicted injuries were excluded
    - » 188 children fell > 10 ft.
    - » longest fall was 40 ft.
    - » no children died

72

Fatal Falls

- Falls < 20 ft. are usually not fatal
- Falls < 4 ft. are very unlikely to cause brain & CNS injury
- Stairways falls do not usually result in life threatening injuries
  - similar to a series of small falls, unless a child is in a walker
- The contact surface does make a difference
  - carpet, wood, concrete, hard object

73

Police overcome hurdles in fatal child-abuse arrest

Suspect tracked to Oklahoma Indian territory

By Stephen Power
Staff Writer of The Dallas Morning News

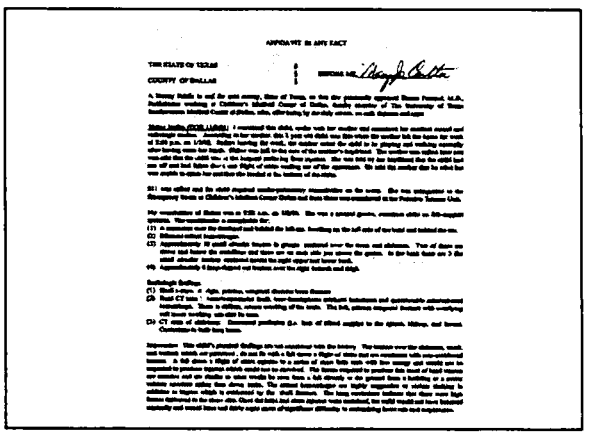
Dallas police had to cross some unusual jurisdictional lines over the weekend to make an arrest in what they believe is the city's first fatal child abuse case this year.

A 20-year-old man suspected of killing his girlfriend's 2-year-old daughter led detectives across state lines and onto Indian territory in Oklahoma on Saturday, only to be arrested and returned to Dallas.

Tom Nakedhead is accused of shaking and beating Shaloe Nolire before fleeing to his grandmother's home near Stillwater, Okla. Police said an autopsy revealed the girl's injuries could not have stemmed from falling down a stairwell, as Mr. Nakedhead reported when paramedics came to their far northeast Dallas home Thursday.

Although police suspected Mr. Nakedhead had fled to Oklahoma, authorities couldn't immediately arrest him because he belongs to the Cherokee Nation, a tribe which has no extradition agreement with Texas. Child-abuse investigators drove more than 230 miles to Stillwater and secured help from the Adair County Sheriff's Depart-

Please see POLICE on Page 14A.



AFFIDAVIT IN ANY FACT

THE STATE OF TEXAS
COUNTY OF DALLAS

BEFORE ME,

My examination of Shiloe was at 9.00 a.m. on 1/8/98. She was a normal grown, comatose child on life-support systems. The examination is remarkable for:
(1) A contusion over the forehead and behind the left ear. Swelling on the left side of the head and behind the ear.
(2) Bilateral retinal hemorrhages.
(3) Approximately 10 small circular bruises in groups scattered over the trunk and abdomen. Two of these are above and below the umbilicus and three are on each side just above the groins. In the back there are 3 flat small circular bruises scattered across the right upper and lower back.
(4) Approximately 8 loop-shaped red bruises over the right buttock and thigh.

Radiologic findings:
(1) Skull x-rays: A right, petrous, temporal diastatic bone fracture.
(2) Head CT scan: Anterior/posterior fresh, inter-hemispheric subdural hematoma and questionable subarachnoid hemorrhage. There is diffuse, severe swelling of the brain. The left, petrous temporal fracture with overlying soft tissue swelling can also be seen.
(3) CT scan of abdomen: Decreased perfusion (i.e. lack of blood supply) to the spleen, kidney, and bowel. Contusions to both lung bases.

7b

Impression: This child's physical findings are not consistent with the history. The bruises over the abdomen, trunk, and buttock which are patterned, do not fit with a fall down a flight of stairs and are consistent with non-accidental trauma. A fall down a flight of stairs equates to a series of short falls each with low energy and would not be expected to produce injuries which could not be survived. The forces required to produce this level of head trauma are massive and are similar to what would be seen from a fall directly to the ground from a building or a motor vehicle accident rather than down stairs. The retinal hemorrhages are highly suggestive or violent shaking in addition to impact which is evidenced by the skull fracture. The lung contusions indicate that there were high forces delivered to the chest also. Once the head and chest injuries were sustained, the child would not have behaved normally and would have had fairly rapid onset of significant difficulty in maintaining heart rate and respirations.

Chest Injuries

- Majority of children with rib fractures are < 2 yrs. old.
- Rib fractures are the most common type of abusive fractures in children
- Posterior (back) rib fractures are the most commonly found
- It is very unlikely that improper CPR is the cause of rib fractures in children

7a

Dallas man convicted of beating his 16-month-old son to death

79

Internal Injuries

- High mortality rates due to delayed medical treatment resulting from:
  - delay in presentation of child
  - inaccurate or false history provided by caretaker
  - inability of child to give information
  - injuries may not be externally visible

80

Man gets 35 years in son's death

7-year-old was taken to pastor, then hospital, 2 days after beating

Children's Anatomy

- Smaller blood volumes
  - hemorrhages are worse
- Internal organs are close to one another
  - *a single impact may injure > one organ*
- Abdominal wall covered by undeveloped muscles and little fat
- The chest has flexible ribs that allows greater compressibility

82

Internal Injuries

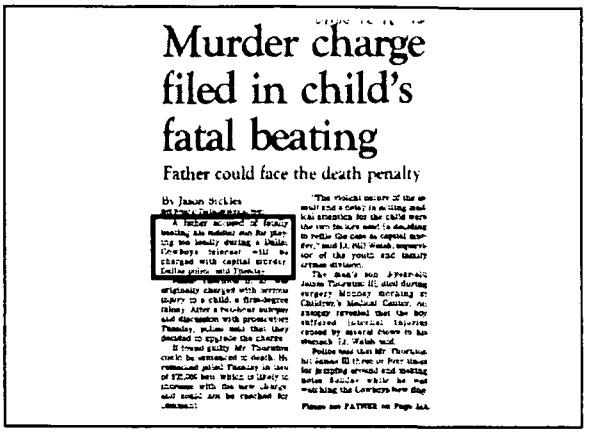
- Caused by:
  - direct impacts
    - » punching
    - » kicking
    - » stomping
  - indirect shearing forces
    - » rapid deceleration of the body
      - child thrown into the wall

83

Internal Injuries

- Second leading cause of fatal injuries
- 40-50 % mortality rate
- May not be externally visible
- Liver is the most commonly injured solid organ due to abuse
- Kidney is the second most commonly injured solid organ due to abuse

84



Murder charge filed in child's fatal beating

Father could face the death penalty

Witnesses say they'd seen defendant hit boy before

20 years given to man in son's beating death

Abdominal Injuries

- Hollow visceral organs can rupture due to compression
  - stomach, intestine
- Intestinal injuries are common abusive injuries
  - especially small intestine
- Small bowel injuries are difficult to diagnose, thus significant morbidity and mortality rates

88

Abdominal Injuries

- Clinical picture
  - vomiting (often bilious)
  - dehydration may occur
  - abdominal pain
  - distended stomach
  - coma, shock
  - peritonitis
  - delayed onset of symptoms (1 hr. to 1 day)

89

Boy, 2, Dies After Blow To Belly; Mother Charged

Fractures

- Fractures suggestive of abuse:
  - multiple fractures
  - fractures of different ages
  - fractures that lack plausible history or explanation
- Fractures commonly due to accidents:
  - clavicle
  - shafts of the long bones
  - linear skull fractures (except in infants)

91

Shaken Baby Syndrome

- SBS is aka Shaken-Impact Syndrome
- Fatal in @ 25 % of the cases
- Child's brain injured from violent shaking
- Rapid acceleration-deceleration forces

92

Shaken Baby Syndrome

- May involve impact to the skull
- Child usually held by upper arms or chest
- Force needed is severe, requires upper body strength

93

Shaken Baby Syndrome

- Medical findings include:
  - Retinal hemorrhages (often bilateral)
  - Subdural or Subarachnoid hemorrhages
  - Cerebral edema (brain swelling)
  - Diffuse axonal injury
    - » shearing of nerve fibers in brain white matter
  - Skull fracture
  - "Black Brain" on MRI or CT scan
  - bruises and other external signs of abuse

94

Shaken Baby Syndrome

- After the assault, there is almost always an immediate change in the child's condition, symptoms include;
  - loss of alertness and/or consciousness
  - inability or unwillingness to eat, vomiting
  - irritability, unresponsiveness, lethargy
  - breathing difficulties
  - coma and or seizures
  - death

95

Mother receives 20 years in toddler's death

96

Neglect

- Most prevalent form of child maltreatment
- Reported that neglect is involved in more than 1/3 of fatal incidents

97

Table 3
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98

Neglect

- Most prevalent form of child maltreatment
- Estimated that neglect involved in 1/3 of fatal incidents
- Neglect is a continuum of care

99

Neglect

- Most prevalent form of child maltreatment
- Estimated that neglect involved in 1/3 of fatal incidents
- Neglect is a continuum of care

Very Best Care — Grossly Inadequate

100

Neglect Deaths

- Neglect is the most frequently reported type of child maltreatment (47%- 65% of reports)
- Neglect is the caretaker's failure to meet the child's needs in terms of food, shelter, medical care or safekeeping.
- In 1997, there were 9 neglect deaths ruled by CPS in Dallas County

101

Neglect

- Physical
  - Inadequate nutrition
  - Inadequate supervision
  - Abandonment
- Medical
  - Failure or delay to seek needed health care
  - Refusal to allow medical treatment

102

Woman admits abandoning babies

By Larry Hartstein

FORT WORTH — A young Arlington woman admitted Tuesday to abandoning two newborn girls in separate incidents, but denied she tried to kill one baby by leaving her outdoors in the cold.

Sabrina Benaissa, 26, pleaded guilty to charges that she abandoned the two girls known as Baby Noel and Baby Chloe.

The case now boils down to whether Ms. Benaissa committed attempted capital murder when she left Baby Chloe inside a plastic bag next to a trash bin on Jan. 23 1996.

"It was a cold act to die," Assistant District Attorney Lisa Ames said in her opening statement to the nine-woman, three-man jury. "She was left on freezing concrete in the middle of

Lead defense attorney Jeff Kearney countered that Ms. Benaissa could have killed the baby in many ways, but did not. She wrapped Chloe in a towel, placed her in a bag insulated with newspapers, and left her next to the trash bin, not in it, he stated.

It's "probably not the way somebody that was thinking properly would have left a baby, but the baby was found," Mr. Kearney said.

He presumed that psychiatric experts would testify that "based on Ms. Benaissa's longstanding mental disorders, she did not have the specific intent to kill that baby."

Ms. Benaissa faces two to 10 years in prison on the two abandonment pleas. If convicted of attempted capital murder, a first-degree felony, she faces a possible life sentence. Mr. Kearney has indicated he will seek a

Attorneys on both sides declined to comment after court, citing a gag order imposed by state District Judge Wayne Salvant.

Ms. Ames, who is prosecuting the case with Assistant District Attorney Rose Anna Sahaas, began her opening statement by talking about the cold.

Noel was found Dec. 28, 1995, in a laundry room that was unheated, that the glass was broken through and wind, a cold wind was whistling through," Ms. Ames said. The baby, wearing only a diaper, was covered by a torn bedsheet and a dirty blanket.

Similarly in 1996, Chloe's body was blue and her temperature had plunged to eight degrees below normal when she arrived at the hospital.

Neglect

- **Subjective determination**
  - **Child and caretaker's age, development, health**
- **May not be a criminal matter unless child is injured or endangered**
- **Community standards must be considered**

104

Neglectful Supervision

- **Failure to properly supervise a child that results in injury or death**
- **Subjective determination**
  - Was it an accident?
  - Was it a preventable accident?
  - Was it neglect?
  - Was it criminal neglect?
  - Should it be prosecuted?

105

Mother, neighbor of kids killed in fire face no charges

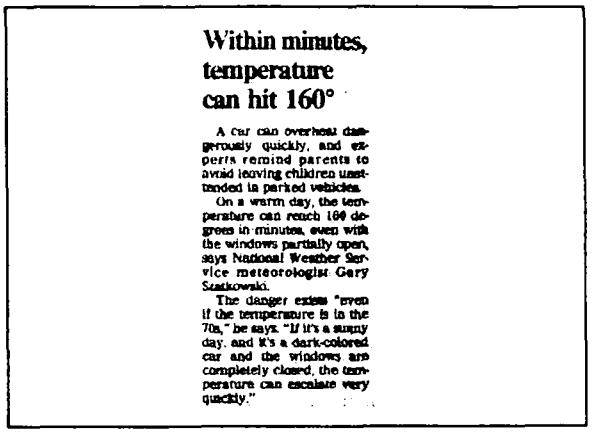
■ The mother of three toddlers killed in a southeast Dallas apartment fire two weeks ago and the neighbor who was supposed to be watching them will not face criminal charges, police said Wednesday. Sgt. Fred Rich of the child abuse unit declined to comment on evidence related to the July 23 deaths of Shakendria Washington, 1; Ayana Scott, 2; and Roderic Lively, 3, but said police consulted the district attorney's office. The children died of smoke inhalation after one accidentally ignited clothing in a rear bedroom of their apartment on Oak Hollow Drive near Elam Road. Their mother, Sharronda Scott, 23, told authorities she left the children in a neighbor's care while she looked for work. The neighbor told authorities she had left the children unattended for about 20 minutes when the fire started.

Mother sentenced in fatal drunken-driving crash

■ **AUSTIN** — A woman who had faced a possible life sentence after her two young daughters were killed in a 1994 drunken-driving accident pleaded guilty to a lesser charge and was sentenced to two years' probation. Shirley Draper had been charged with injury to a child after allowing her daughters to ride with their drunken father. Four days before her trial, Ms. Draper pleaded guilty to reckless conduct and received the maximum punishments of $400, 120 hours of community service and two years' probation. Her case had received widespread attention and raised several legal questions, such as who can be held responsible when a drunken driver puts lives at risk. Police said her ex-husband, Gregory Cook, was on probation for three DWI convictions in Tarrant County and had been drinking the night before the accident happened. He died along with daughters Shauna, 10, and Marissa, 8, when he drove his 1992 Chevrolet Lumina into a wastewater pond north of Wimberley, Texas.

Woman indicted in death of child in hot car

■ **MARKSVILLE, La.** — A woman whose child died after being left alone in a hot car with the windows rolled up has been indicted on a charge of negligent homicide. Lizette Sago, 25, of Simmesport was indicted last week by an Avoyelles Parish grand jury. Police said Ms. Sago left her 15-month-old daughter in her car while she applied for a job Sept. 9 in Bunkie. Ms. Sago parked the car in an unshaded spot and left the windows up, authorities said. When she returned, about two hours later, the infant was unconscious and later died of heat stroke. Ms. Sago told police that she took the infant with her after being unable to find a baby sitter.



Within minutes, temperature can hit 160°

A car can overheat dangerously quickly, and experts remind parents to avoid leaving children unattended in parked vehicles.

On a warm day, the temperature can reach 160 degrees in minutes, even with the windows partially open, says National Weather Service meteorologist Gary Szatkowski.

The danger exists "even if the temperature is in the 70s," he says. "If it's a sunny day, and it's a dark-colored car and the windows are completely closed, the temperature can escalate very quickly."

Manners of Death

- Natural
- Accidental ←
- Homicide ←
- Suicide ←
- Undetermined ←

110

Sudden Infant Death Syndrome

- SIDS is defined as:
  - "The sudden death of an infant under one year of age which remains unexplained after a complete postmortem investigation, including ;
    - » an autopsy
    - » an examination of the scene of death
    - » and a review of the case history "

(NICHHD 1989) 111

Sudden Infant Death Syndrome

- Common history of child being fed, put to bed, appeared normal, found dead next morning
- Cause is still unknown, many theories including risk factors:
  - apnea
  - upper airway obstruction
  - environmental factors (waterbeds, pillows, heat)
  - in-utero influences (increased risk with smoking)
  - sleep position

112

Sudden Infant Death Syndrome

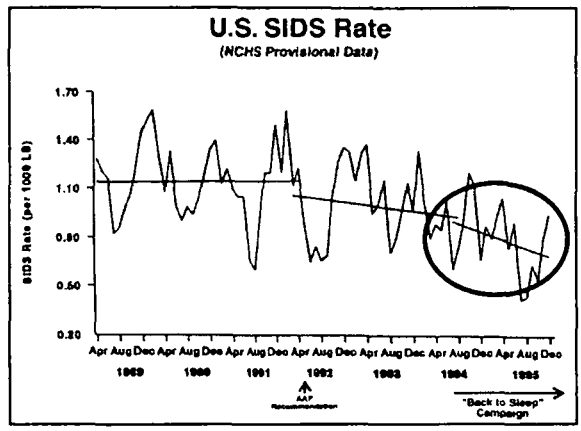
- @ 5,000 SIDS deaths/year
- More frequent in winter months
- More frequent in multiple births
- Male/female ratio: 60-70% / 30-40%
- 90% are less than 6 months old
- Peak incidence at 2-4 months

113

Risk Factors for SIDS

- Sleeping Position
- Environment
- Exposure to Tobacco Smoke
- Complications During Pregnancy
- Premature Birth

114



Physical Characteristics

- Frothy blood-tinged drainage from nose or mouth
- Normal growth/development
- Normal hydration and nutrition
- No sign of external injury

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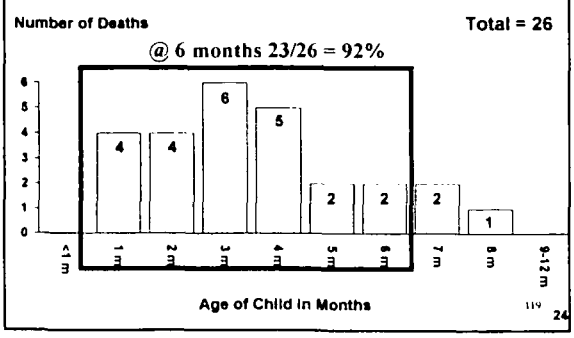
Benefit of the Doubt

- Dr. Harry Wilson's "*Rule of Three*"
  - First sudden unexpected infant death, probably a SIDS event, i.e., a <u>natural</u> death
  - Second sudden unexpected infant death, probably should be ruled as an <u>undetermined</u> death
  - Third sudden unexpected infant death, probably should be considered as a possible <u>homicide</u>

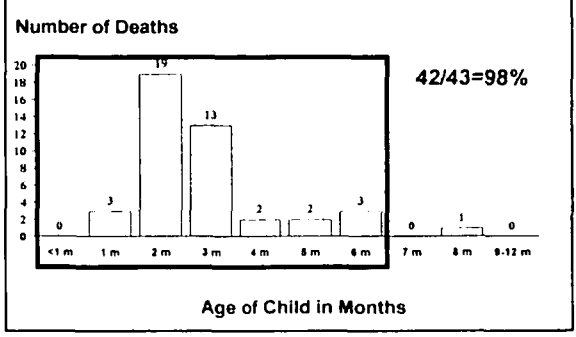
118

1995 Dallas County SIDS Deaths by Age of the Child

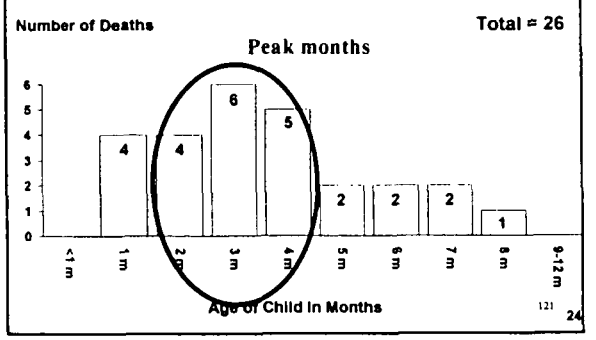


119 24

1997 Dallas County SIDS Deaths by Age of the Child

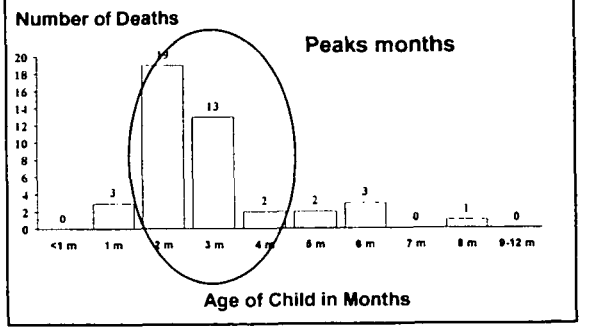


1995 Dallas County SIDS Deaths by Age of the Child

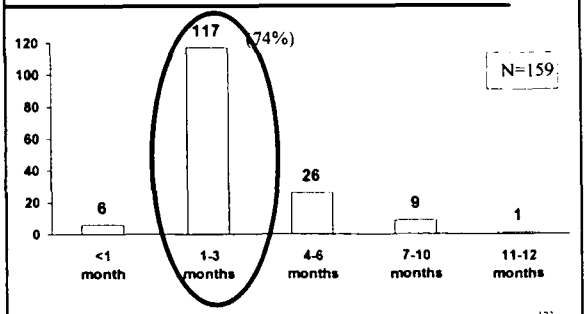


121 24

1997 Dallas County SIDS Deaths by Age of the Child

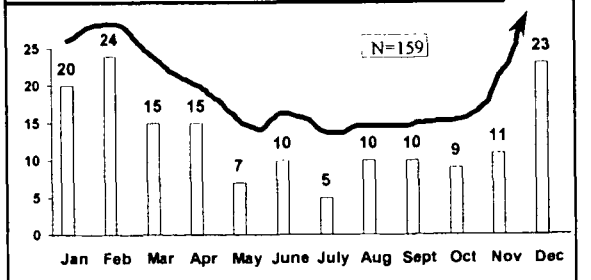


SIDS DEATHS BY AGE



OKLAHOMA NOV. 1991-DEC 1994

SIDS DEATHS BY MONTH



OKLAHOMA NOV. 1991-DEC 1994

SIDS or Homicide?

- Infant older than 6 months of age
- Any signs of smothering
- Previous unexplained disorders affecting the child
- Other unexplained child deaths in the same family
- Suspect confession
- Autopsy rules manner of death as homicide

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DMN 12-6-96

Dying young in Dallas County

1 child slain for almost every week in 1995, report shows

By Barbara Kessler

A child was murdered in Dallas County about every week on average in 1995, according to a report on child deaths released Thursday.

Most of the 49 child homicide victims were killed by abuse from angry caretakers or by gunfire, according to the Dallas County Child Death and Infant Mortality Review Team.

Teenagers and the very young were most vulnerable.

Eleven of the victims, all under age 4, were ruled "child abuse homicides" in which a parent, parent's friend, baby sitter or grandmother killed the child, most often by beating the youth.

In one case, according to the report, "the father's shoe print was clearly evident on the abdomen of his 1-year-old son."

"Children are very vulnerable, but also very demanding and can cause their caretaker to lose their temper," said Dallas police Lt. Dill Walsh.

He explained that young children can be easily injured because they have less body fat protecting their organs and more delicate brains. "So it can be a very dangerous situation," he said.

Lt. Walsh, head of investigations for the family and child violence division and a member of the multi-

Please see MOST on Page 16A.

AP

HOYT: Convicted of killing children

MOM GUILTY: Waneta Hoyt, 48, was convicted Friday in Owego, N.Y., of murdering her five children, whose deaths between 1965 and 1971 had been blamed on sudden infant death syndrome. They were suffocated. The investigation began in 1992 when a prosecutor came across a 14-year-old medical journal article about the deaths. In her confession, later recanted, Hoyt said, "I know something was wrong with me."

Woman charged with killing 8 children

PHILADELPHIA — A 70-year-old woman was charged Wednesday with first-degree murder, accused of suffocating eight of her 10 children starting almost half a century ago.

Marie Noe smothered the children with a pillow or other soft object, District Attorney Lynne M. Abraham said. The children, all of whom were declared healthy at birth and were developing normally, were 13 days to 14 months old when they died over a 19-year period, beginning in 1949.

At the time of the children's deaths, Mrs. Noe said they had died in their sleep. In each case, she was at home alone with the children.

Mrs. Noe's lawyer, David S. Rudenstein, said his client denies the charges. Mrs. Noe has been charged with eight counts of first-degree murder.

"She feels very burdened by these accusations," he said. "She has had to live ... [the] last 30 years with the knowledge that her children passed away. Any mother would be grossly distraught by that."

Her husband, Arthur Noe, who was not at home at the time of the deaths, was not charged. Investigations were continuing, police said.

Neither police nor the district attorney would speculate on a motive for the slayings, though they confirmed the parents had taken out insurance policies on six of the children.

The cases had never been closed, and the prosecutor said the investigation became more aggressive recently because of scientific developments and heightened public interest in unsolved infant deaths.

Mrs. Noe was questioned in March and admitted suffocating four of her children, police said. She could not remember what happened to the other four, police said.

Ms. Abraham said charges were delayed until now because authorities had sought additional evidence.

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Investigating Fatal Child Abuse

- Witness Interviews
- Crime Scene Processing
- Autopsy
- Records check
  - Child Protective Services
  - Law Enforcement
  - Medical
- Suspect Interviews and Interrogations

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Investigating Fatal Child Abuse

- Fatal cases are highly circumstantial
- Burden to prove that defendant had the exclusive opportunity to inflict the child's injuries
- Burden to prove defendant failed to act reasonably in providing care or supervision of child and that failure resulted in child's death

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Investigating Fatal Child Abuse

- Fatal cases often involve complex medical testimony
  - doctors from different specialties testifying
  - "battle of the medical experts"
  - "reasonable doubt"
- Though intent and motive may not be required, the jury may want it

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Crime Scene Search Issues

- Search of residence may requires consent to search or a search warrant
- Scene must be secured until searched
- Crime scene may involve more than one room
- Trashcans should be searched for traces of blood, bloody clothes, hair, dirty diapers, implements used as weapons

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Crime Scene Search Issues

- Scene should be photographed from general to specific
- Refrigerator and cabinets should be searched for food and formula
- General conditions should be noted
  - sleeping arrangements
  - sanitary conditions

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Paramedics

- Name, badge #, shift
- 911 Call (audio recording)
- Observations at the scene
- History given by caretaker
- Written statements
- Copy of run sheet

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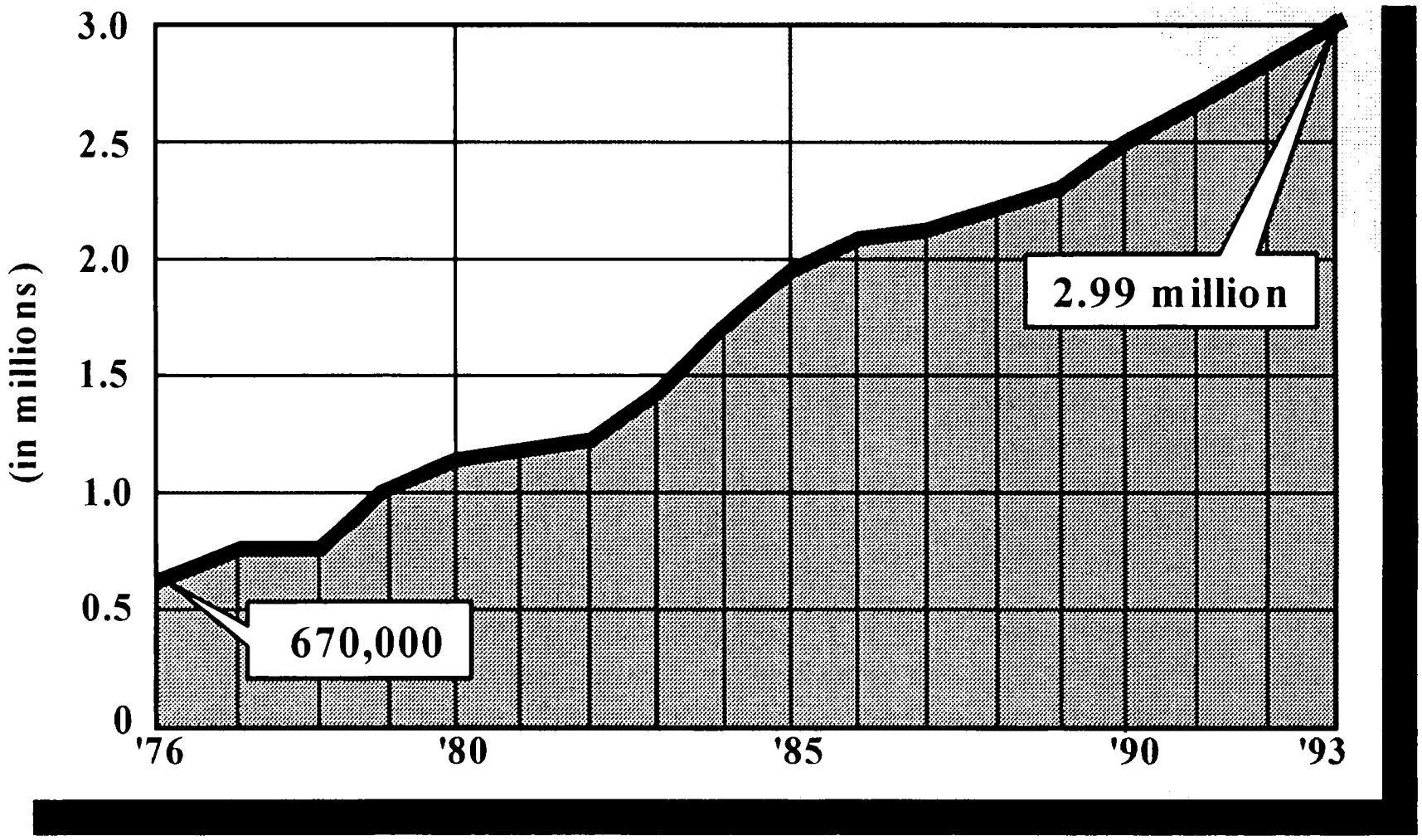
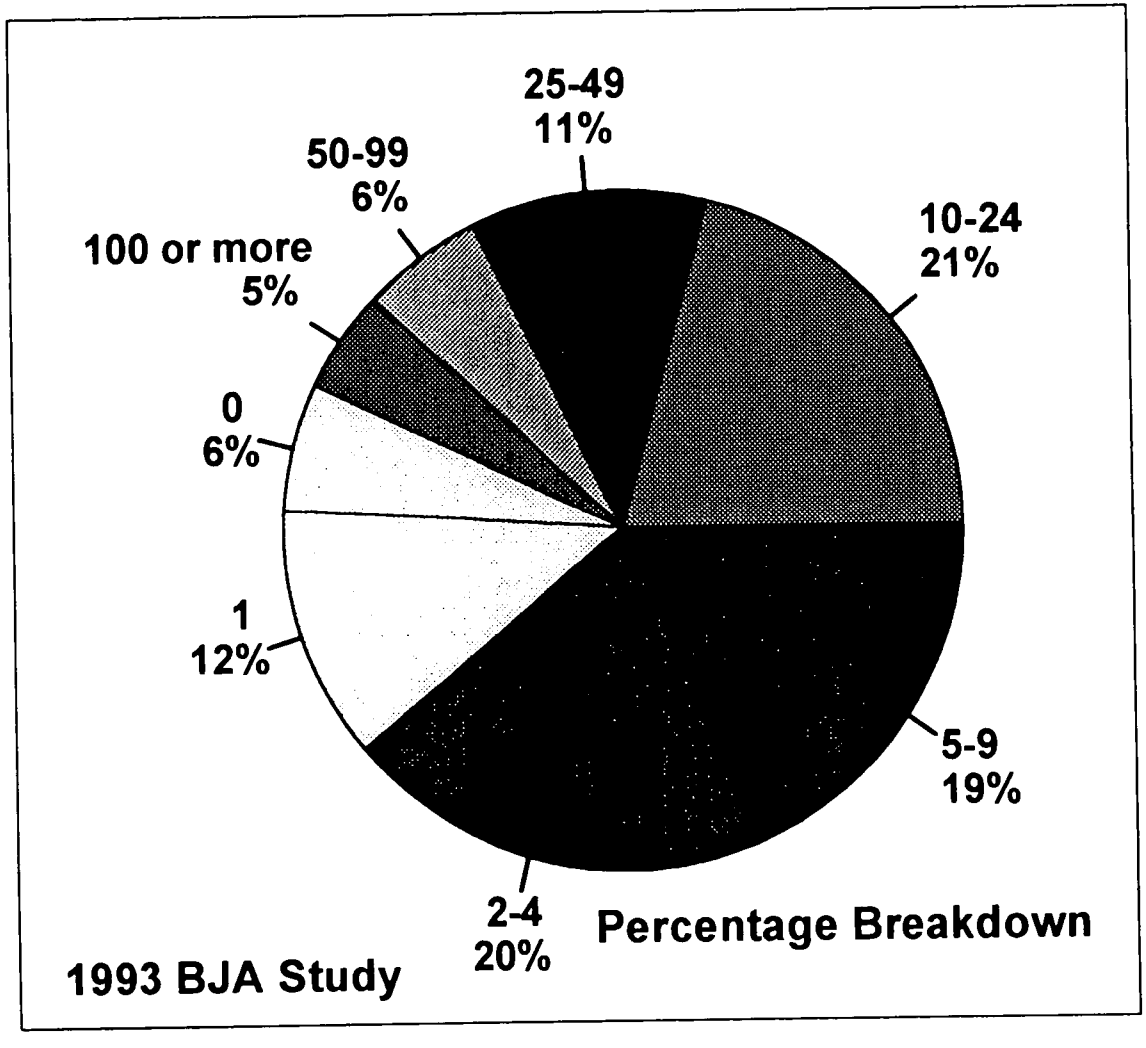
Child Abuse Reports Climb



Law Enforcement Agency Size



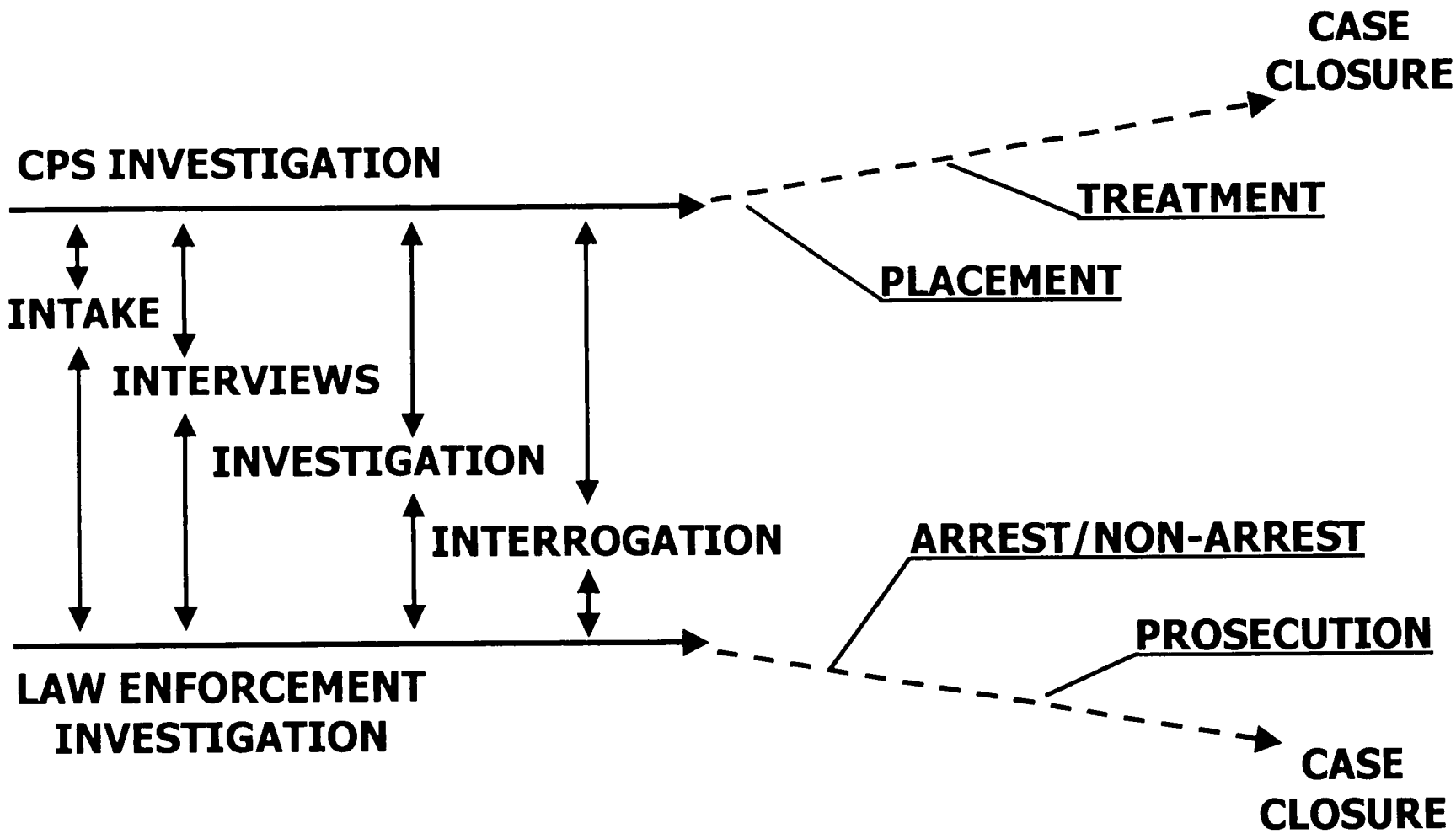
Joint Investigation

An investigation that includes cooperative and collaborative activities from the time of the initial report to case closure by any and all agencies involved in the investigation, information sharing and decision-making

Benefits of Joint Investigations

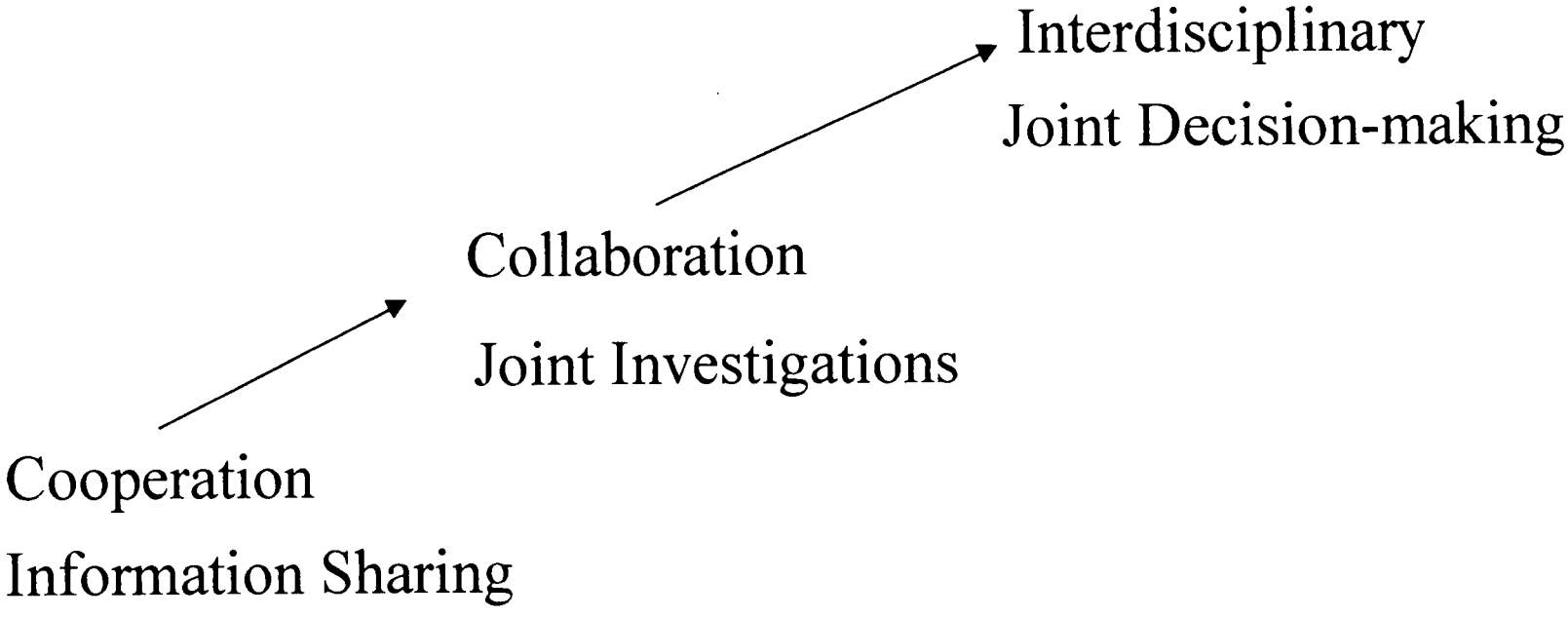
- Improved protection and services to children
- Better understanding of roles and responsibilities
- Enhanced information sharing
- More effective use of limited resources
- Enhanced training
- Reduced burnout

Joint Investigations Fragmented

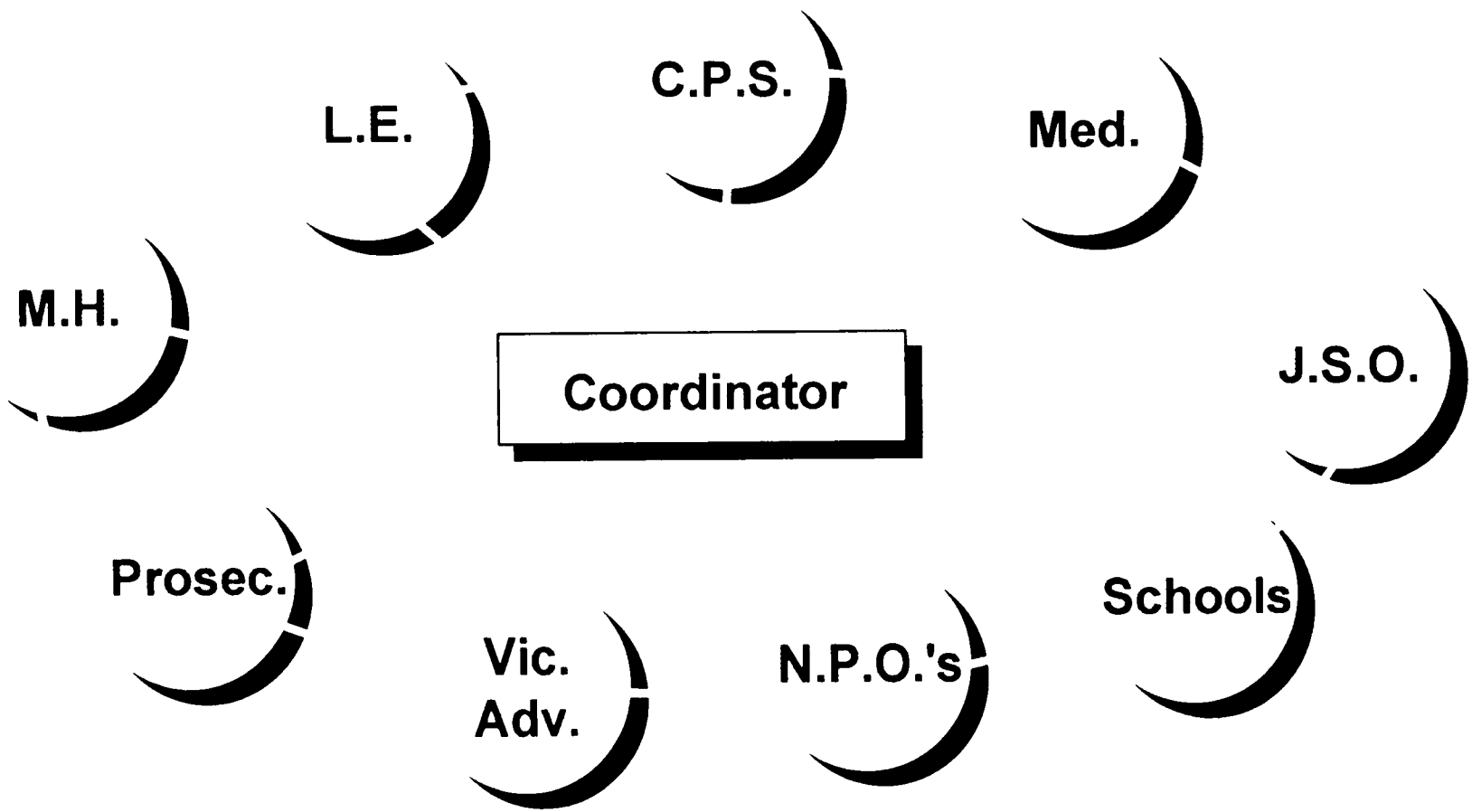


Russ-Huntsville-11

Phases of Team Development



Seacoast Assessment Team



Russ-Huntsville-1

Team Philosophy

- Team Based Child Abuse Investigation

Versus

- Community Based Child Protection Team

Gibrahn
MALE / BORN 1977 / 6'1"/ 230 LBS.

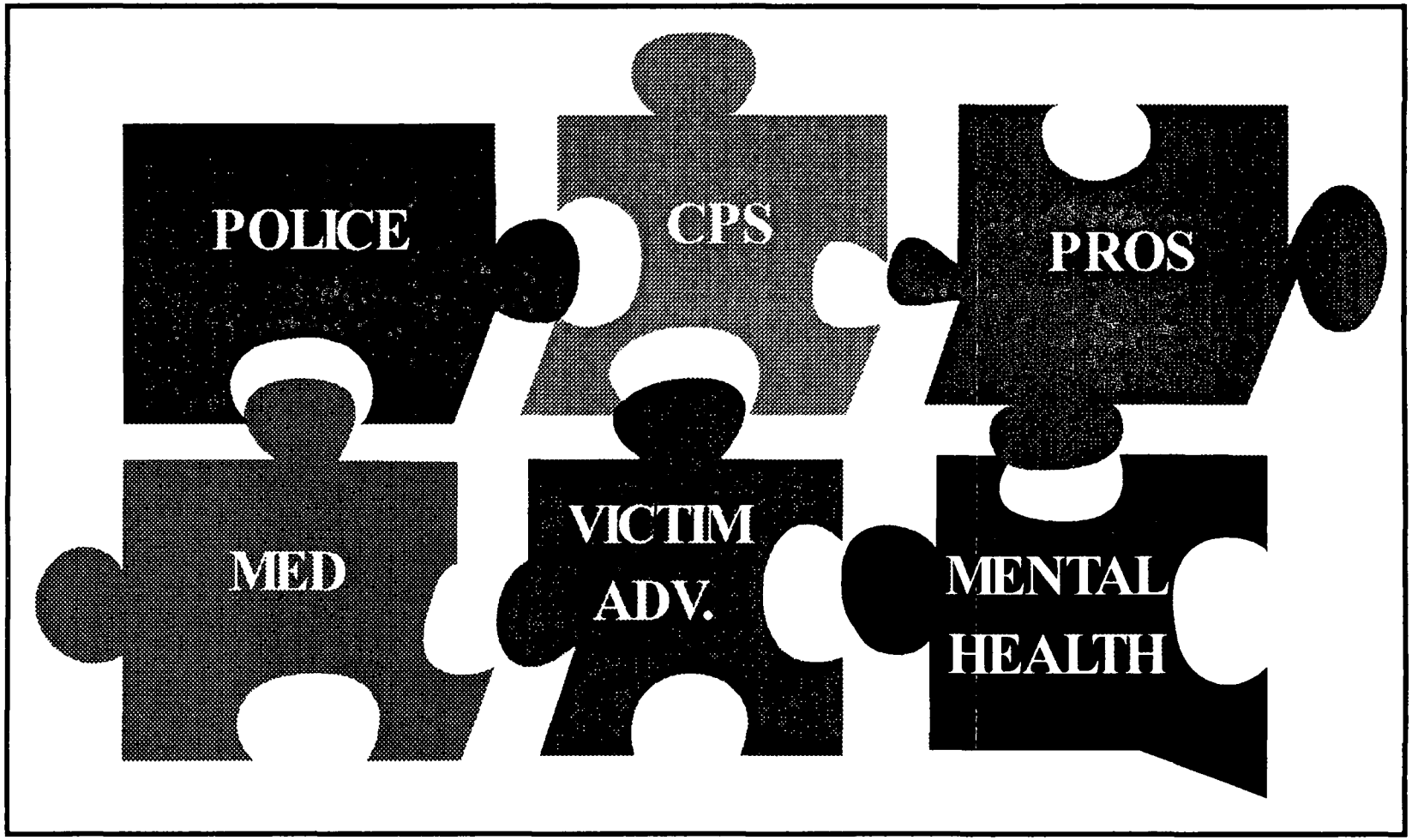
AGENCY	DATE	OFFENSE	DISPOSITION
POL	01/05/88	Shoplifting	Released to Mother
POL	05/16/88	Runaway	Returned to Home
POL	08/02/90	Assault w/Trash Can	J.C. Probation
POL	03/10/91	Runaway	Return from NY C&R
POL	06/30/91	Susp. Sex. Assault	Insufficient Evid.
POL	08/22/91	Shoplifting	Probation
POL	11/20/92	Crim. Mischief (12 cts)	Restit./Counseling
POL	02/26/93	Burglary	Placed Group Home
POL	06/16/93	Runaway	?
POL	08/10/93	Rape	Certified Adult
POL	08/10/93	Robbery	Certified Adult
POL	08/10/93	Attempted Murder	59 to 119 Years

Gibrahn
MALE / BORN 1977 / 6'1"/ 230 LBS.

AGENCY	DATE	OFFENSE	DISPOSITION
POL	01/05/88	Shoplifting	Released to Mother
POL	05/16/88	Runaway	Returned to Home
SCH	02/04/89	Assaulted Classmate	1 Day Suspension
SCH	06/16/89	Assaulted Teacher	5 Day Suspension
SCH	09/21/89	Coded/IEP	KIDS Program
POL	08/02/90	Assault w/Trash Can	J.C. Probation
SCH	11/11/90	Drunk in School	Released to Mother
SCH	12/06/90	Assault. Student on Bus	5 Day Suspension
POL	03/10/91	Runaway	Return from NY C&R
POL	06/30/91	Susp. Sex. Assault	Insufficient Evid.
POL	08/22/91	Shoplifting	Probation
SCH	05/15/92	Weapons Violation	Expelled
POL	11/20/92	Crim. Mischief (12 cts)	Restit./Counseling
POL	02/26/93	Burglary	Placed Group Home
POL	06/16/93	Runaway	?
POL	08/10/93	Rape	Certified Adult
POL	08/10/93	Robbery	Certified Adult
POL	08/10/93	Attempted Murder	59 to 119 Years

Gibrahn
MALE / BORN 1977 / 6'1"/ 230 LBS.

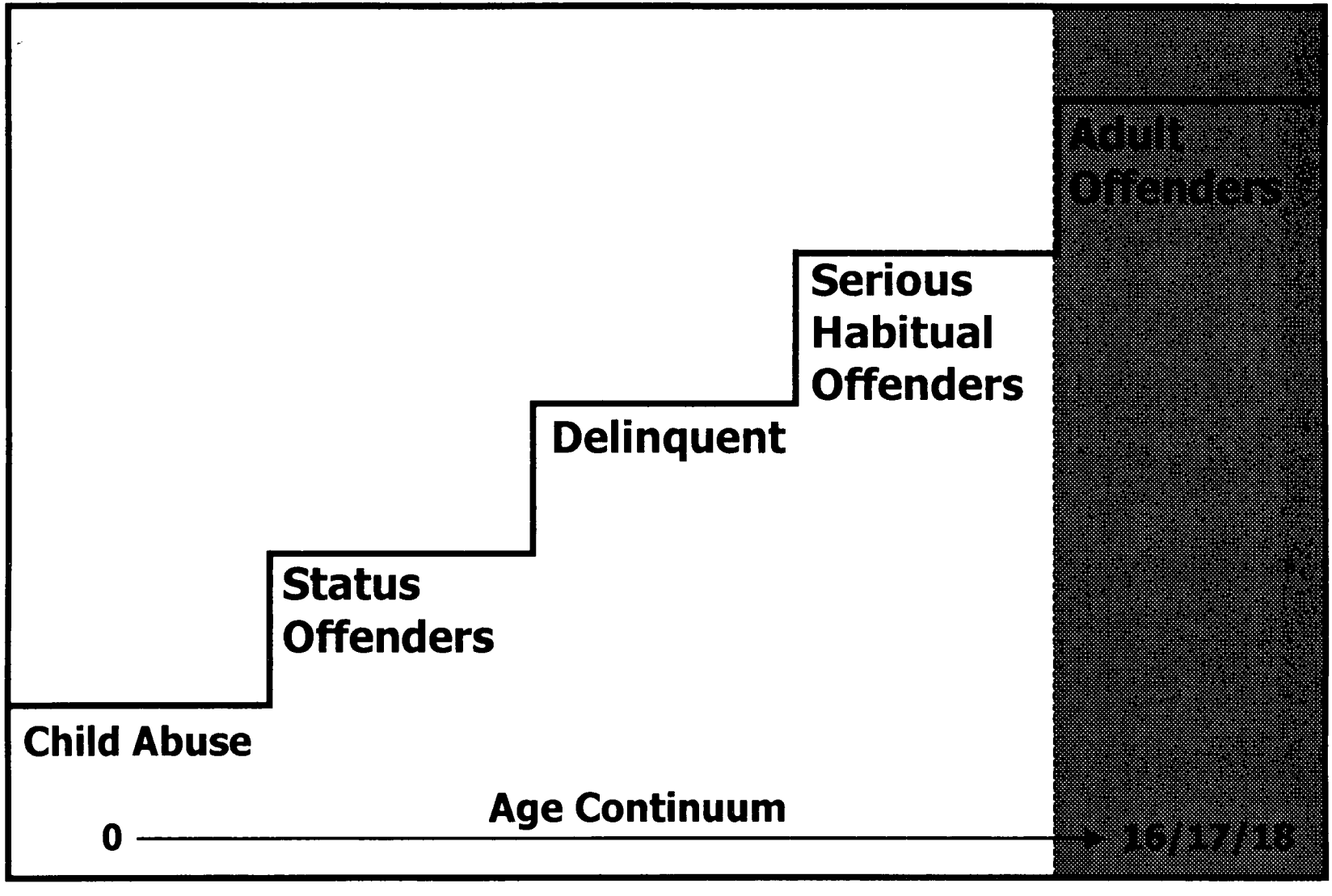
AGENCY	DATE	OFFENSE	DISPOSITION
CPS	06/01/83	Neglect	Unfounded
CPS	04/17/84	Physical Abuse	Offender Removed
CPS	10/07/86	Assaulted Sister	Vol. Family Therapy
POL	01/05/88	Shoplifting	Released to Mother
POL	05/16/88	Runaway	Returned to Home
CPS	08/26/88	Violent at Home	Invol. Hosp.
SCH	02/04/89	Assaulted Classmate	1 Day Suspension
SCH	06/16/89	Assaulted Teacher	5 Day Suspension
SCH	09/21/89	Coded/IEP	KIDS Program
CPS	07/17/90	Uncontrollable/CHINS	Counseling
POL	08/02/90	Assault w/Trash Can	J.C. Probation
SCH	11/11/90	Drunk in School	Released to Mother
SCH	12/06/90	Assault. Student on Bus	5 Day Suspension
POL	03/10/91	Runaway	Return from NY C&R
POL	06/30/91	Susp. Sex. Assault	Insufficient Evid.
POL	08/22/91	Shoplifting	Probation
SCH	05/15/92	Weapons Violation	Expelled
POL	11/20/92	Crim. Mischief (12 cts)	Restit./Counseling
POL	02/26/93	Burglary	Placed Group Home
POL	06/16/93	Runaway	?
POL	08/10/93	Rape	Certified Adult
POL	08/10/93	Robbery	Certified Adult
POL	08/10/93	Attempted Murder	59 to 119 Years


POLICE
CPS
PROS
MED
VICTIM
ADV.
MENTAL
HEALTH

Seacoast Assessment Team Mission Statement

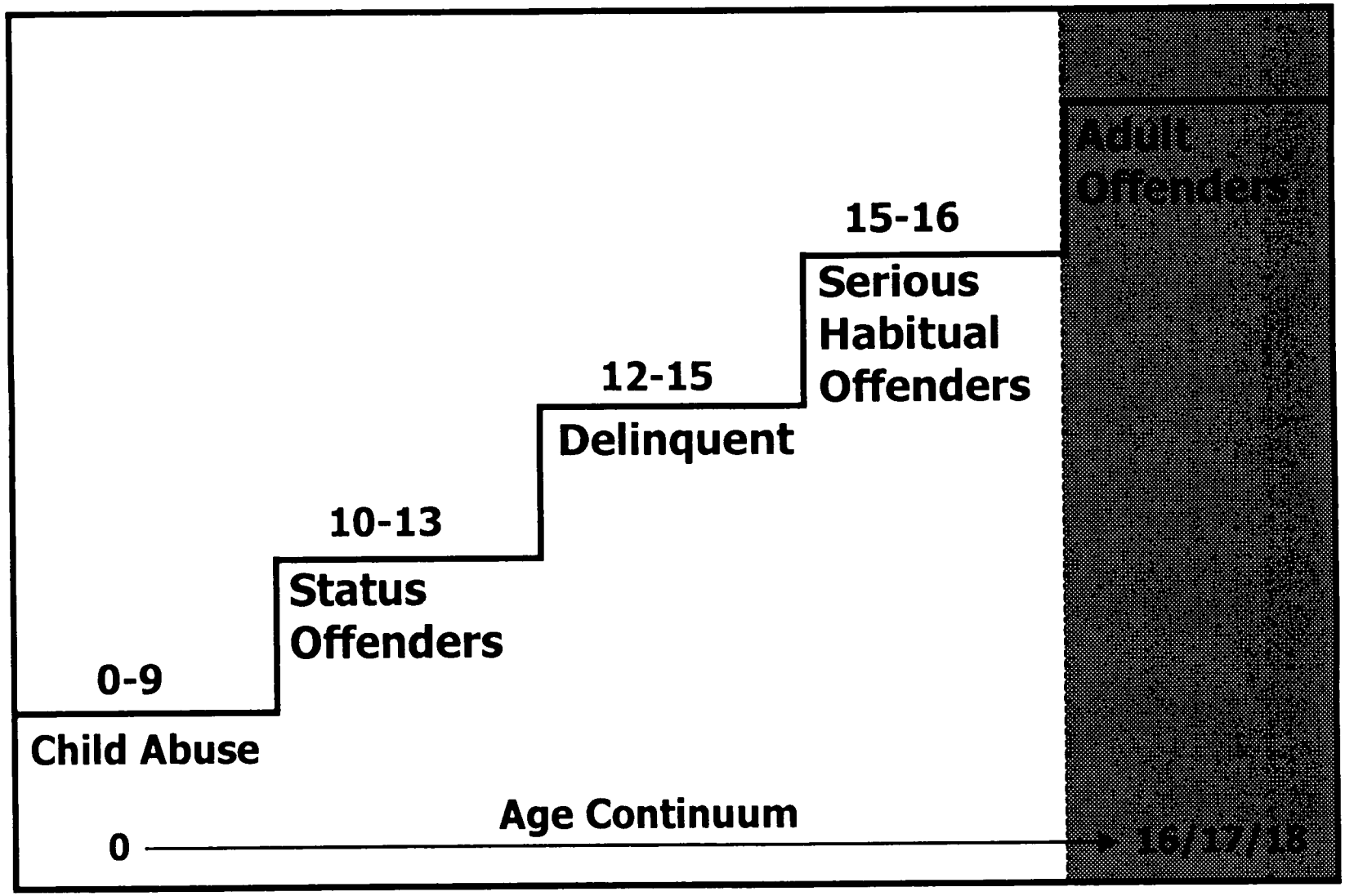
The mission of the Seacoast Assessment Team is to strengthen and protect children, families and the community through an inter-disciplinary team approach which emphasizes early intervention, coordinated investigations and collaborative action plans.

Social / Criminal Evolution



Russ-Huntsville-16

Social / Criminal Evolution



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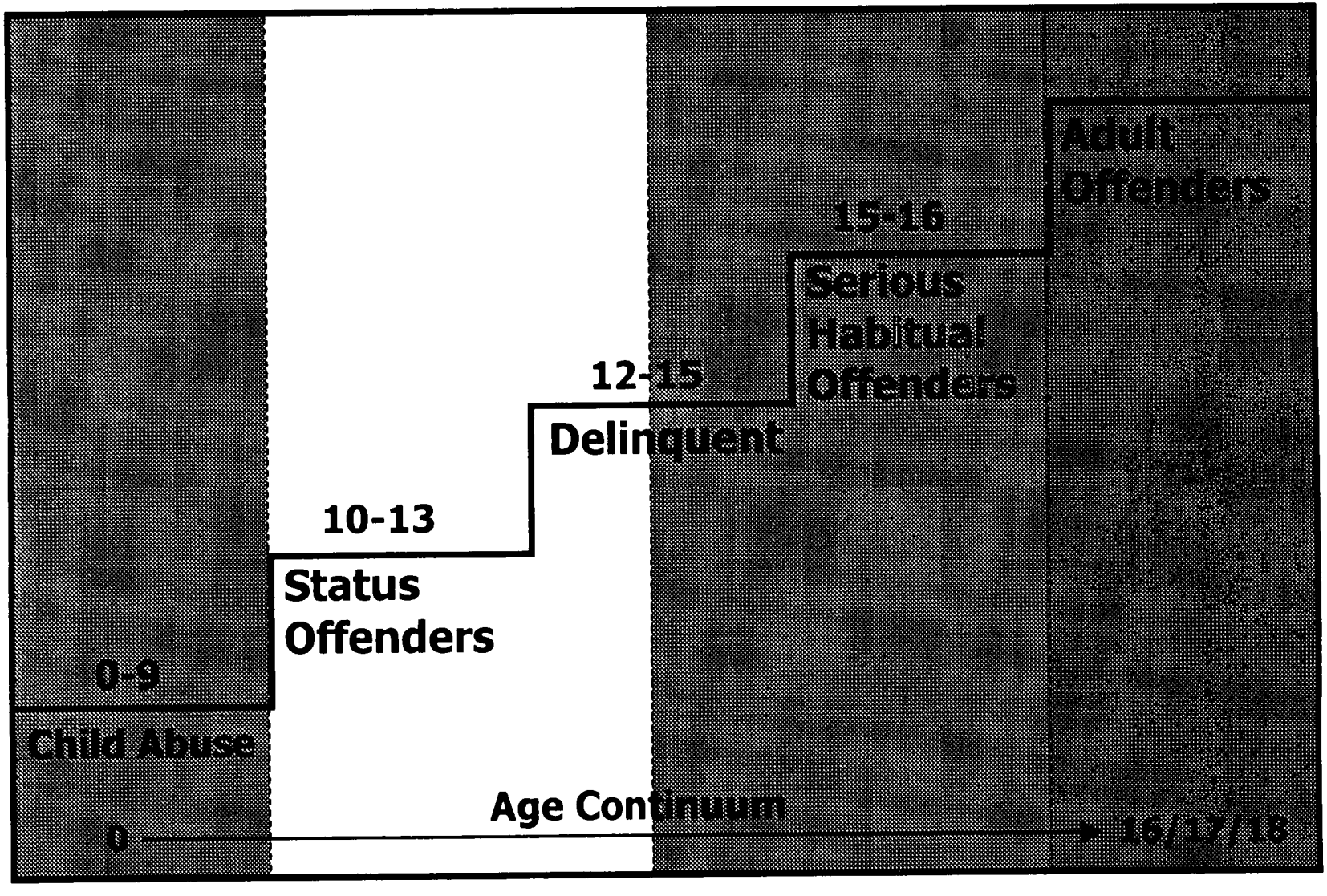
Social / Criminal Evolution



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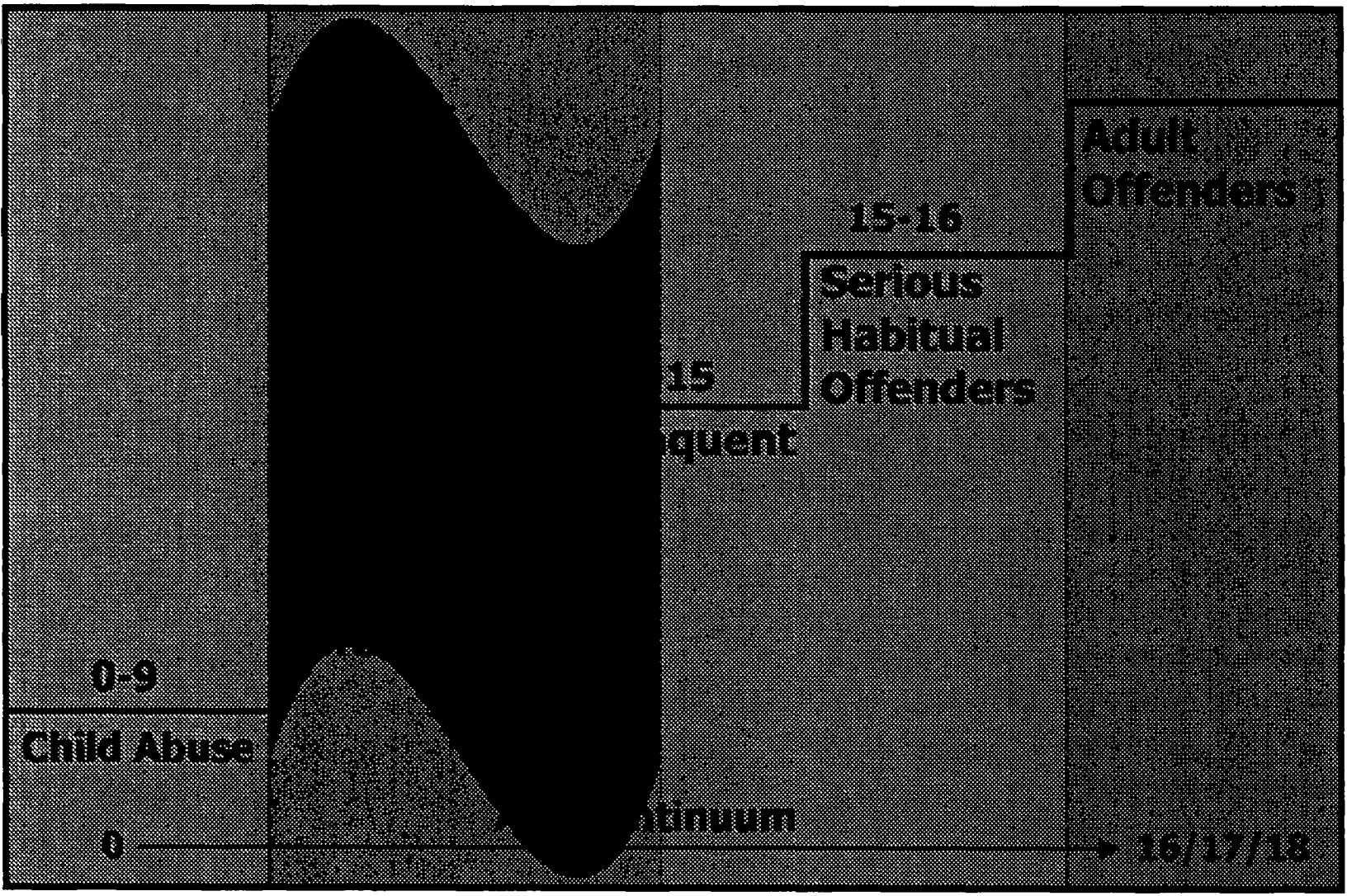
Social / Criminal Evolution



Improved decision-making by better use of information

What's Wrong With Our Current Response?

- Cost to investigate
- Cost to incarcerate
- Human / social cost
- Economic / political cost

Personal Responsibility new Mantra

What Drives Our Resource Allocation

- Special interests/ politics
- Narrow perspective
- What is sexy and new
- Flawed decision-making
  - improper assessment of problem
  - lack of long-range planning
  - knee-jerk reactions
  - inconsistent evaluation

SCHOOL RESOURCE OFFICER

This position was developed for a Police Officer assigned to the Youth Services Section of the Bureau of Investigative Services. They are subject to the duties and responsibilities outlined for all sworn investigative personnel and report to the Youth Services Sergeant. The School Resource Officer (SRO) is primarily responsible for working within the school system to enforce the laws while promoting a safe and drug free environment and building positive relationships between students faculty and the police. The SRO's primary emphasis will be working with older children (grades 6 through 12). The elementary school staff will continue to have the DARE Officer as a resource, however the SRO can assist as the need arises. The EIO must be motivated to work with youth and have the ability to gain the respect of adolescents and teenagers while holding them accountable for their actions. The SRO must have the unique ability to perform the functions of law enforcement officer, educator and counselor while becoming an integral member of the school community.

RESPONSIBILITY:

This jointly funded grant position is a partnership between the Police and School Departments. As such, the Youth Services Sergeant and the Portsmouth High School Principal jointly supervise the SRO. During the school year, this position would coordinate their schedule and receive direction on a day to day basis from the high school principal. The duties set forth below would be primarily carried out in the field with office space at the Portsmouth High School.

GENERAL DUTIES:

It is the duty and responsibility of the SRO to:

1. Promote and maintain a safe and drug free environment within the Portsmouth School System.
2. Enforce the Juvenile Code and the laws of the State of New Hampshire.
3. Place special emphasis upon the enforcement of laws pertaining to:
   - Possession, use and/or sale of controlled substances, including drugs, alcohol and cigarettes
   - Violation of the Truancy Laws
   - Weapons Violations
   - Assaults committed upon or by students
   - Children at risk of self-destructive behaviors, such as suicide
   - Other forms of child victimization, such as child abuse, exploitation and abduction
4. Maintain a direct liaison between the Portsmouth Police Department and the School Community

6. Coordinate various education and prevention efforts (STAR, PRIDE and Scholastic Crimeline), in cooperation with existing programs, such as Peer Leadership and Peer Mediation.
7. Collaborate with existing resources for youth, such as the Clipper Health Center and the Guidance Department to share information, where appropriate, to effectively assess problems confronting today's youth and develop viable plans of action to reduce those problems.
8. Maintain a high profile at various school functions.
9. Maintain regular and close contact with existing Police Department Resources, such as the Patrol Division, the Narcotics Unit, the Youth Advocate and investigative personnel.
10. Attend weekly staff meetings with the Bureau of Investigative Services (BIS) Commander, Captain and Youth Services Sergeant.
11. Build rapport with students and staff while serving as a positive role model within the school community.
12. As a Police Officer assigned to the Bureau of Investigative Services, this investigator will be assigned youth related investigative responsibilities when school is not in session and in extreme situations may be temporarily reassigned a police emergency.

KNOWLEDGE, ABILITIES AND SKILLS:

Thorough working knowledge of the juvenile laws of the State of NH. Skilled investigative and interview techniques. Ability to communicate with a wide range of people. Working knowledge of the NH Criminal and Juvenile Codes. Familiarity with and understanding of the juvenile justice system. Must be able to participate in rigorous physical activities. This position requires good visual acuity, hand-eye coordination and excellent overall fitness.

QUALIFICATIONS:

Currently assigned to the Bureau of Investigative Services or selected for the Special Detail eligibility list. Representatives from the Superintendent of Schools Office, or their designee, will participate in the oral interview portion of the selection process and must find the candidate acceptable. Must successfully complete a probationary period within the Bureau of Investigative Services.

EARLY INTERVENTION OFFICER

The Early Intervention Officer (EIO), coordinates and implements program activities involving persons up to the age of seventeen. They are available to members of the New Heights staff, the school system and the Community for referrals on matters affecting juvenile offenders and youth related problems. The EIO must be motivated to work with troubled youth and possess a great deal of patience, understanding and empathy toward children who exhibit negative and/or self-destructive behavior. The EIO will actively participate in an on going evaluation of the early intervention program.

RESPONSIBILITY:

This grant funded position is supervised by the Youth Services Supervisor and the New Heights Program Director. The duties listed would be primarily carried out the field with office space within the New Heights program.

GENERAL DUTIES:

It is the duty and responsibility of the EIO to:

1. Identify at-risk youth through confidential sources of information, such as police formal and informal contacts, incidents of abuse and neglect, disciplinary or behavioral problems occurring with the school system and referrals from social agencies.
2. Work as an extension of the New Heights staff to plan, organize and implement activities for targeted juvenile offenders who are identified as at risk for future delinquent acts or self-destructive behavior.
3. Work with units within the Portsmouth Police Department, various social agencies and schools to reach out to families with at-risk youth and involve them in the program.
4. Participate in various field trips and adventure based activities where intensive interaction is warranted with the most at-risk youth. Every effort will be made to identify the underlying problems associated with that individual's delinquent or self destructive behavior. Working in conjunction with existing community based resources (Seacoast Assessment Team, YSS Youth Advocate, Rockingham Co. Diversion, DCYF, Clipper Health Center, etc.) the EIO will attempt to coordinate the delivery of services most applicable to the situation.
5. Responsible for transporting youth to various program activities in the 15 passenger van donated to the program. This officer will also be responsible for ensuring that regular maintenance is performed by the dealership on a scheduled basis.
6. This officer will attend weekly staff meetings at New Heights. They will also participate in weekly meetings with the Youth Services Supervisor and the Captain of the Bureau of Investigative Services.
7. Maintain complete and accurate records of program activities. This includes progress reports on participant behavior to determine the overall effectiveness of the services delivered to resolve individual and family problems.

KNOWLEDGE, ABILITIES AND SKILLS:

Thorough working knowledge of the juvenile laws of the State of NH. Skilled in investigative and interview techniques. Ability to communicate with a wide range of people. Working knowledge of the NH Criminal Code. Familiarity with and understanding of the juvenile justice system. Must be able to participate in rigorous physical activities, such as mountain biking, rock climbing and skiing. This position requires good visual acuity, hand-eye coordination and excellent overall fitness.

QUALIFICATIONS:

Currently assigned to the Bureau of Investigative Services or selected for the Special Detail eligibility list. Must complete training in an acceptable outward bound or adventure based training program such as, Project Adventure within the first six months of assignment.

NATURE OF WORK

The purposes of this position are to assist juveniles and their families, frequently at times of crisis, develop the necessary skills, resource allocation and self-discipline to successfully cope with personal circumstances which previously resulted in juvenile criminal activities. These objectives are accomplished by developing, modifying and implementing individualized and tailored case plans, establishing and maintaining effective working relationships with the judges, school instructors and counsellors, police officers, public assistance officials and other social service providers to coordinate the effective application of combined resources and services and personally assessing the results accomplished. This work is subject to review according to the City's personnel plan through observation, reports and the results achieved.

EXAMPLES OF ESSENTIAL JOB FUNCTIONS

1. Meets with referrals from police officers, families in crisis, schools and other agencies.
2. Investigates juvenile cases and gathers pertinent information in matters of truancy, incorrigible behavior, runaway, drug/alcohol offenses, domestic violence, sexual assault, neglect, suicidal behavior, familial crisis offenders and other situations of youth at risk.
3. Is liaison with the courts regarding juvenile petitions, preparing children and families for the court process, presenting family histories and recommending dispositions.
4. Prepares diversion and case plans including guidelines for household rules and curfews. Mediates between family members and the child and provides informal counselling. Monitors progress in school and attends school meetings as requested. Recommends clients for testing and other services.
5. Sets up and monitors community service work and/or restitution. Provides creative consequences as issues arise.
6. Networks with community human service agencies e.g., schools social service, mental health and community resources.

EXAMPLES OF OTHER JOB FUNCTIONS

1. Educates families and local agencies about the juvenile justice system.
2. Serves as support staff and a resource to patrol officers and detectives in juvenile issues.
3. Utilizes the police information systems to develop and maintain incident and individual histories.
4. Prepares juvenile petitions, case reports, confidentiality releases, case management contact forms and juvenile contract agreements for court diversions.
5. Performs other duties and responsibilities as may be assigned.

ENVIRONMENT, WORKING CONDITIONS, PHYSICAL AND MENTAL EFFORT

Work is performed in typical office, school, home, court and juvenile detention environments which may not be handicapped accessible and are subject to other varied environmental conditions. The work is primarily of an intellectual nature but requires the advocate demonstrate strong self-confidence and firm resolve. He/she must be able to hear normal sounds, distinguish sound as voice patterns and communicate through human speech.

REQUIRED KNOWLEDGE, SKILLS AND CAPABILITIES

An incumbent in this position consistently demonstrates a(n)...

1. Thorough working knowledge of the juvenile criminal justice system, the offices and officials responsible for administering the system and of relevant area human service programs, agencies and referral procedures.
2. Ability to quickly identify dominant causes for deviant behavior involving juveniles and to develop and implement case plans which are effective in bringing about corrective actions.
3. A working knowledge of the police information systems and the personal ability to research case information and to document case plans and their implementation using word processing, computers, prepared forms and other manual and automated systems.
4. Strong ability to provide firm, knowledgeable direction to juveniles, family members, police officers and the courts in responding to juvenile issues.
5. Strong personal example to encourage others to provide a high level of service to external and internal customers.
6. Ability to communicate effectively with customers, other employees, City officials and other agencies orally, in writing and by listening in the activities of conversation, discussion, instruction, presentations, notes, memorandum and reports.
7. An ability to establish and maintain effective working relationships with the courts, City and other agencies, other employees and customers.

MINIMUM REQUIRED QUALIFICATIONS

An applicant for this position must have a bachelor of science degree specializing in sociology, psychology or human services and have a basic knowledge of clinical issues in psychology, substance abuse and domestic violence from a recognized college or university. He/she must have three or more years of progressively responsible experience in dealing with troubled children and adolescents or an equivalent combination of training and experience.

(The above descriptions are illustrative. They are intended as guides for personnel actions and are not complete itemizations of all facets of any job.)

1 Failure to Thrive and Neglect

Daniel Armagh
APRI/NDAA

2 *SCOPE OF THE PROBLEM*

- Parents and caretakers are the overwhelming majority of perpetrators in neglect and failure to thrive cases
- At least 2000 deaths *reported* each year
- Professionals are generally poorly trained and not prepared to properly investigate and accurately diagnose these cases
- 18,000 children permanently disabled
- 142,000 children seriously injured

3 *PERPETRATOR PROFILE*

- Majority of perpetrators are fathers/male caretakers - absolute domination of child's environment, including mother
- Most programs target women but do not address domestic violence issues
- Very strong correlation between family violence and FTT or Neglect

4 *PERPETRATOR PROFILE*

- Statistical data on family violence and child abuse
- Battered women are much more likely to abuse their children
- Should we prosecute battered women who abuse or fail to protect their children?
- Feminist perspectives

5 *1.8 - 4 million women are victimized by d.v.*

- *How Violent Are American Families? Estimates from the National Violence Resurvey and Other Studies.* Finkelhor, D., Kirkpatrick, J.T.

6 *Statistical Data on Family Violence and Child Abuse*

- 3.3 - 10 million children witness domestic violence each year.
- *Children of Battered Women.* Jaffe, P., Wolfe, D. (Sage 1990)
- Child Abuse is present is 30 - 70% of families in which there is spouse abuse. The severity of abuse usually parallels the severity of the domestic violence.

7 Massachusetts

- DHSS study revealed that 32% of their child protection cases also involved domestic violence. Hangen, E. D.S.S. *Interagency Domestic Violence Team Pilot Project Data Evaluation - Boston, Mass. Dept. of Social Services.*

8 *Battered Women Abusing Children*

- Mothers are **eight** times more likely to hurt their children when they were being battered than when they were safe from violence. *Lenore Walker (1984)*
- Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate of 1500% higher than the national average. *Physical Violence In*

American Families, Straus, M.A.

9 ☐ *Domestic Violence and Failure to Thrive*

- Children are in nearly 50% of all homes where police respond to domestic violence
- 70% of all women in shelters have children with them, 20% have three or more.
- In 40% of child abuse cases, there is also a battered women.
- Pregnancy is a prime time for the onset of domestic violence, with the abdomen or stomach prime targets.

10 ☐ FTT and Domestic Violence

Testimony before Congress disclosed that nearly 50% of abusive husbands batter their pregnant wives, and that as a result these women are four times more likely to bear low birth weight infants and experience difficulty in post birth maturation if sent back to a hostile environment of domestic violence. *ABA Report on The Impact of Domestic Violence on Children* (1994).

11 ☐ *FTT and Domestic Violence*

Reports suggest that more babies are born with birth defects as a result of the mother being battered than all diseases and illnesses for which we now immunize pregnant women combined. *Chiles, L. Death Before Life: The Tragedy of Infant Mortality. Report of the National Commission to Prevent Infant Mortality.*

12 ☐ *Should Battered Mothers Be Prosecuted for Child Abuse?*

Theories of prosecution against the mother:

- neglect of the child
- direct abuse of the child
- failure to protect the child from harm
- inflicting emotional harm on the child
- failure to report abuse

13 ☐ *FTT Scenarios*

- Being present when the child is abused and failing to intervene
- Failure to seek out medical aid for the child after the abuse
- Leaving the child alone with a known abuser
- Failing to take care of the child's basic necessities of life or emotional well being because abuse is jealous, threatens harm or the child is singled out for abusive treatment

14 ☐ Should we prosecute Battered Women?

- There is no empirical data that battered women are incapable of protecting their children

15 ☐ In Interest of A.D.R., 524 N.E. 2d 487 (ILL. App. Dist.1989)

- ***Father's repeated physical abuse of mother for seven years created injurious***

environment to child's welfare supporting neglect or abuse petition. Court did not need to wait until child became a victim of physical abuse or until repeated beatings caused permanent emotional damage to the child.

16 ☐ In re Theresa "CC", 576 N.Y.S. 2d 937 (1991)

Parental rights of both parents terminated based upon court finding that both had engaged in mutual domestic violence in front of the children for many years impeding the chidren's ability to thrive and develop in the appropriate manner.

17 ☐ State v. G.P., N.W. 2d 477 (Neb. 1990)

Parental rights of non-abusing mother terminated based upon her failure to protect her children from abusive acts by father. Mother claimed a victim of domestic violence and fear prevented her from protecting children or leaving. Court noted the mother returned to abusive environment of her own volition and even after serious abuse of children, stated she would not leave her husband.

18 ☐ *Child Abuse and Feminism*

- Liberal Feminism-until equal
- Radical Feminism-powerless people
- Cultural Feminism-nurturing role of women
- Hedonic Feminism-must first deal with the legacy of violence against women before women can be held responsible.

19 ☐ *Shaken Baby Syndrome*

- Children who are abused by shaking are often neglected for substantial periods of time before medical treatment is sought
- 25% are fatal and the survivors often suffer serious chronic injuries
- Investigators should always be sensitive to acute injuries which have not received appropriate and timely medical attention

20 ☐ *FAILURE TO THRIVE*

- FTT defines children whose growth is significantly under developmental norms established for a child's age and gender
- Organic causes for FTT caused by medical conditions
- Non-organic causes are caused by withholding necessary sustenance. FTT is the developmental outcome for severe malnutrition (starvation).

21 ☐ *FAILURE TO THRIVE*

- Intervention - physicians report a % of FTT to child protective services
- Smaller % of cases are reported to law enforcement: usually advanced stages of malnutrition or dead of related causes.
- MDT pro-active approach can prevent some FTT cases
- Profiling "at risk" families

22 ☐ *NEGLECT*

- Environments which are inappropriate

- Filthy - poor hygiene
- Crack house parties
- Drugs given or accessible by children
- Weapons
- Failure to protect from abuse of various origins

23 CULPABILITY

- Non-criminal culpability from ignorance or poverty
- Exhaustive investigation required to establish type of culpability
- Refer to the appropriate agency and have a follow up protocol

24 CULPABILITY

- Criminal culpability requires evidence that establishes guilt beyond a reasonable doubt that the defendant(s) caused the child's condition due to intentional, knowing, reckless or criminally negligent acts or omissions of "caregivers."

25 SUCCESSFUL PROSECUTIONS

- Thorough investigation
- Professionally conducted and documented interviews of: attending physicians, social services caseworker, medical staff, medical examiner, caregiver(s), family members, neighbors and persons with knowledge of child's life (especially last days)
- Obtaining background assessments - social /medical and prompt scene investigation

26 SCENE INVESTIGATION

- Consent search
- Cooperative state
- Sensitivity but thorough investigation
- Serve search warrant
- Sign consent release for child's medical records
- Release of all children's records

27 SCENE INVESTIGATION

- Relevant (even if peripheral) is important
- age appropriate food in the house?
- milk bottles? cans of formula? mixing instr?
- document and photograph cabinets, counter tops, refrigerators, freshness of foods-both adult and children's.
- used and unused diapers-stools in diapers can indicate infections, last meal, content, last change of diaper-retrieve dirty laundry

28 SCENE INVESTIGATION

- document and photograph presence of pet food in house
- document/ photograph food for adults and other siblings - none for victim
- photograph other children - contrast victim

29 ☐ *VICTIM TREATED DIFFERENTLY*

- Evidence of maltreatment
- no photographs of victim in the home
- no toys for the victim
- photograph of victim at an earlier time
- insurance policy or premiums on victim

30 ☐ *UNDERLYING ORGANIC CONDITIONS*

- Identify organic conditions
- Review and analyze victim's medical records for previous diagnosis for FTT
- Interview physician at onset of investigation and again after reviewing all records
- Train medical staff and physician to ask right questions-document same
- Assess for possible defenses
- Caretakers version corroborate or rebuts medical evidence?

31 ☐ PHYSICIAN INTERVIEW

- Medical examiner or attending physician must be trained in collection of evidence and proper diagnosis
- Plot victim on NCHS chart
- length, weight, head circumference
- FTT = 2 standard deviations below mean for length or weight for age

32 ☐ PHYSICIAN INTERVIEW

- Usually child loses weight first, length second, and head circumference
- Lack of records- victims of FTT have birth weight and weight at referral or death. Physicians reluctant to diagnose FTT on two points.
- Ask for assessment for deviation from normal development - age and gender

33 ☐ PHYSICIAN INTERVIEW

- Most important question-what produced this child's emaciated condition-what is the physician's specific assessment? Document what is said and the basis for their conclusions.

34 ☐ EXCLUDING ORGANIC EXPLANATIONS

- Organic basis? Tests required? If organic, did condition cause emaciation or merely predispose the child against gaining weight?
- Medical history, pre-natal and birth history. Growth history at hospital (24 hrs) and any subsequent admissions
- Feed child in controlled environment and plot growth for a few months-then file

35 ☐ EXCLUDING ORGANIC EXPLANATIONS

- Establish whether malnutrition is acute or chronic
- children rarely are emaciated in a few days.
- Often caretakers will tell you weight lost in last 48 hrs.

- Acute FTT shows signs of emotional deprivation-fetal position, vacant eyes, little response to external stimuli. Document!

36 ☐ *Concluding Questions for Attending Physician*

- What does the physician think of the plausibility of the caretaker's version of the child's feeding history?
- Did parent's actions seem reasonable given the child's condition? Why?
- Criminal charges may be warranted irrespective of organic condition if caretaker failed to get medical attention when child was clearly wasting away

37 ☐ *CARETAKER INTERVIEW*

- Critical - law enforcement if caregiver is willing
- If caretaker invokes, they will probably still answer medical staff questions when child's history is being taken
- Parents/caregivers should be questioned about significant events surrounding conception, rape, pregnancy wanted?

38 ☐ *CARETAKER INTERVIEW*

- Questions concerning prenatal care, child's disposition, feeding and sleeping habits are important.
- Questions about parenting skills are important to determine whether actions were made out of ignorance or intentional, ie, "Did you feed the baby three times a day?" How was the formula mixed? Diluted?

39 ☐ *BIRTH RECORDS*

- Birthing classes? Parenting classes?
- Feeding methods taught?
- Any medical problems that would affect child's development adversely?
- Successful prosecution depends on establishing caretaker had the requisite legal competence and mental state to understand the child was wasting away.

40 ☐ *DEFENSES*

Undiagnosed medical condition:

1. preventable with proper medical care if condition exists at all
2. obvious to a reasonable person child needed medical attention
3. caregiver was legally competent and understood child needed medical attention

41 ☐ *DEFENSES*

Poverty:

1. family too poor to obtain necessary food or medical care
2. look for evidence of money spent on non-necessities: alcohol, drugs, cigarettes, cable t.v., or family received public assistance and had access to resources for the baby.

42 ☐ *DEFENSES*

Ignorance: caregivers were ignorant of basic child feeding and rearing needs.

1. parenting classes
2. raised other children
3. child survived fine for a period of time
4. other evidence supporting competence

43 DEFENSES

Everyone in our family is short-we all grow out of it.

1. Even short children do not waste away
2. Ask physician to adjust chart for premature child.

44 DEFENSES

Child was healthy - lost weight rapidly

1. Thorough medical workup should demonstrate whether malnutrition is chronic or acute
2. Very rare that emaciation occurs rapidly

45 DEFENSES

Transportation - no means to transport the child to medical care or to purchase food.

Investigation may reveal that caregiver had access to free bus tickets or indigent transportation services connected to a medical center or clinic and chose not to use them.

46 AUTOPSY

- Ask medical examiner to determine effects of malnutrition on the ultimate cause of death. Many deaths are classified from natural causes with malnutrition as a secondary cause.
- "But For" test - cases that list cause of death from natural causes with malnutrition as a secondary cause can still be prosecuted if the child would not have died *but for* the complications of malnutrition.

47 AUTOPSY

- Autopsy should document type and condition of food in victim's stomach and intestines to assist in establishing time of death and refute or corroborate caregiver's statement as to when the child was last fed.
- The medical examiner should photograph and note loss of fat tissue and muscle wasting to illustrate the progressive deterioration of the child's condition over time.

48 AUTOPSY

- Calculation of caloric deficit to determine degree of food deprivation. This method was developed by Meade & Brissie, 30 J. Forensic Sci. 1263, (1985) *Infanticide by Starvation.*
- Photographs are critical to proving starvation. Photograph entire body against a non-white background to reduce glare (ABFO Bar - Color)

49 AUTOPSY

- Careful measurements are required both at the time of presentation and at autopsy.

Skin tents and cradle caps should be noted and explained within the context of the child's death.

50 Proving your Case

- Juries are reluctant to believe a parent would starve their child to death
- Prove parents were well aware of child's condition and failed to seek help.
- Impression management of the courtroom.
- Medical and expert testimony - battle of the experts.

Conditions Mistaken for Child Physical Abuse

Abstract

Numerous conditions exist which can suggest an etiology of inflicted injury. Strict adherence to evidence based on diagnosis and consideration of all diagnostic possibilities helps to avoid mistakes. An organ-system approach is outlined here. The medical conditions which may mimic child maltreatment are discussed with an eye toward distinguishing them from inflicted injury.

Learning Objectives

- To identify conditions, disorders and syndromes which may be confused with child abuse
- To differentiate inflicted injury from preexisting medical conditions
- To identify cultural practices which may be confused with child abuse

Outline

I. Cutaneous
   A. Bruising
   B. Burns
II. Intracranial Bleeding
III. Ocular Hemorrhages
IV. Fractures
V. Other

Cutaneous

Bruising

Mongolian spots

Ehlers-Danlos syndrome (India rubber syndrome)

- skin is velvety, hyperelastic and fragile
- minor trauma can lead to ecchymoses.

Erythema multiforme and hypersensitivity vasculitis

Phytophotodermatitis

- exposure to psorlens in the juice of certain plants followed by exposure to sunlight (limes, lemons, figs, parsnip, celery, herbal preparations

Millipedes secretions leading to mahogany colored lesions

Contact dermatitis and allergic reactions (rubber, face masks, surf boards, squash balls, elastic bands in clothing)

Lice (especially crabs) can inject anticoagulant under the skin causing deposit of hemosiderin

Ink paint or dye on the face can mimic bruises or abrasions. Clothing dyes can also look like bruises.

Coagulation disorders

- hemophilia
- von Willebrand's disease
- leukemia
- ITP
- Vitamin K deficiency
- Henoch-Schonlein Purpura

- Cystic fibrosis -malabsorption of Vitamin K
- Bleeding secondary to ingestion of anticoagulant meds or poisons containing anticoagulants

Folk medicine

- coin rubbing (cao gio)
- spooning (quat sha)
- moxibustion
- cupping
- maqua

Burns

Dermatologic disorders

- Phytodermatitis
- Impetigo
- Varicella
- Epidermolysis Bullosa.
- Dermatitis Herpetiformis
- Diaper Dermatitis
- Chillblains
- Drug Eruption
- Mechanical Abrasion
- Chemical Burns
- Staphylococcal Scalded Skin Syndrome
- Accidental burns from car seats etc.

Intracranial bleeding

A. Accidental trauma
B. Coagulation disorders
C. Tumors
D. Vascular malformations
E. Folk medicine (fallen fontanelle-caida de mollera). Baby is held upside down and head dipped into boiling water.

Ocular hemorrhages

A. Periorbital ecchymoses by accident
B. Subconjunctival hemorrhage
C. Retinal hemorrhages
    1. meningitis
    2. coagulopathy
    3. increased intracranial pressure -accidental
    4. compressive chest trauma
    5. severe hypertension
    6. blood dyscrasias
    7. vasculitis
    8. thromboembolic phenomena such as subacute bacterial endocarditis

Fractures

A. Birth injuries - clavicle, humerus, femur
B. Forceful manipulation-overzealous passive exercise, chiropractic or other health care provider

C. Metabolic, genetic and infectious conditions

1. Preterm or very low birth weight babies (neonatal osteopenia
2. Osteogenesis imperfecta
3. Cerebral palsy
4. Osteopenia secondary to nutritional problems, Down's syndrome, chronic pulmonary disease
5. Prostaglandin therapy for patent ductus arteriosus, methotrexate therapy, hypervitaminosis A
6. Metabolic conditions such as Menke's kinky hair syndrome, rickets, scurvy, altered vitamin D metabolism due to drugs like phenobarbital and phenytoin
7. Congenital syphilis
8. Congenital indifference to pain

Other

Hair Tourniquet Syndrome

Alopecia Areata

Hypogammaglobulinemia

MR in parent(s)

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A PROTOCOL FOR THE INVESTIGATION OF CHILD DEATHS FROM SUSPECTED CHILD ABUSE OR NEGLECT IN DEKALB COUNTY

* * *

I. INTRODUCTION

Child abuse is recognized as one of the most tragic and senseless crimes. Unfortunately, the detection of child abuse and the successful prosecution of those who commit these crimes is often difficult due to lack of attention, education and cooperation among law enforcement agencies, prosecutors, social services agencies and health care providers. It is well settled in both theory and experience that the successful detection and prosecution of those who abuse children is best achieved through the participation of all interested agencies at the earliest possible moment. It is with this knowledge in mind that the undersigned agencies have developed this Protocol.

Any investigation into the death of a child must involve the Medical Examiner's Office, the local law enforcement agency, the Department of Family and Children Services, and the District Attorney's Office. Other agencies which possess relevant information including Emergency Medical Services, local hospitals, the DeKalb County School System, the City of Decatur School System, the City of Atlanta School System, the Georgia Council on Child Abuse, the Georgia Center for Children, and the Georgia Bureau of Investigation may be called upon to assist in the investigation in the death of a child. It is imperative that all the appropriate agencies be notified right from the start of the investigation and that all agency representatives continue to coordinate all aspects of the investigation as it progresses. All involved in the investigation of the death of a child should remember that the investigation is collaborative and without cooperation, improper decisions may be made concerning a child's death.

The signing and implementation of this Protocol signifies a commitment by each of us to work together to thoroughly investigate each child death in DeKalb County where there is a possibility that child abuse may be the cause. We each recognize that children are our greatest resource and those who cause harm to them must be held responsible for their actions. We also acknowledge that those deaths which result from accidental or natural causes can at first examination appear to have been the result of some form of abuse or neglect. A thorough review of every case ensures that no act of abuse will go undetected and that no person will be held accountable for acts outside their control.

II. REPORTING

A. Reporting By Professionals Pursuant to O.C.G.A. § 19-7-5.

The following persons are required by law to make a report if they have "*reasonable cause to believe*" that a child has been abused: physicians licensed to practice medicine, interns, or residents; hospital or medical personnel; dentists: licensed psychologists and interns; podiatrists; registered professional nurses and licenses practical nurses; professional counselors, social workers, and family therapists; schoolteachers; school administrators; school guidance counselors, visiting teachers, school social workers, and school psychologists; child welfare agency, i.e., child-caring institutions, child-placing agency, maternity home, family day-care, group day-care or day care center O.C.G.A. § 49-5-12; child-counseling personnel; child service organization personnel; or law enforcement personnel. It should be noted that these persons are not required to prove that a child has been abused, or that they conduct their own investigation to determine if abuse occurred. The standard, "reasonable cause to believe" is broad so as to encourage the reporting of cases where the individual can give a reason to suspect that a child has been abused. Any person who in good faith makes a report of suspected child abuse or neglect is immune from civil or criminal liability. Failure to report child abuse can result in criminal charges.

The law requires that an oral report be made immediately by telephone to the Department of Family and Children Services or its designated agency; or a report may be made to the local law enforcement agency or to the district attorney. The law further requires that if a report is made to the Department of Family and Children Services (hereinafter DFCS), or if DFCS independently discovers such abuse, and there is any evidence or allegation of child abuse, then DFCS must immediately notify the appropriate police authority or district attorney. *supra*.

B. Notification of Suspicious or Unusual Deaths to Medical Examiner Pursuant to O.C.G.A. § 45-16-24

When a person dies in this state as a result of violence; by suicide or casualty; suddenly when in apparent good health; when unattended by a physician; in any suspicious or unusual manner, *with particular attention to those persons 16 years of age and under; after birth but before seven years of age if the death is unexpected or unexplained* (emphasis added);...or after having been admitted to a hospital in an unconscious state and without regaining consciousness within 24 hours of admission,
it shall be the duty of any law enforcement officer or other person having knowledge of such death to notify immediately the coroner or county medical examiner of the county wherein the body is found or death occurs (emphasis added). O.C.G.A. § 14-16-24.

C. Notification of Child Fatality or Near Fatality Pursuant to this Protocol

It is clear that not only best practices demand, but that the law requires, that there be cooperation, communication, and coordination among law enforcement, the county Medical Examiner, DFCS, and the District Attorney when a child dies from suspected child abuse. However, reports regarding death or near death from suspected child abuse come from many different sources. It is imperative that the above agencies have representatives that can be contacted and can contact the other agencies on a 24-hour basis when a call is received. These agencies agree that they will assign a person or persons to receive calls at any time reporting death or near death from child abuse. Telephone numbers will be distributed to local hospitals, emergency medical locations, all law enforcement agencies, and other locations that may need to report a child fatality from suspected abuse.

The reporting agency - the agency that first suspects abuse - will contact the Medical Examiner's office and the appropriate law enforcement agency. (The DeKalb County Department of Public Safety will be contacted if there is a question regarding which law enforcement agency has jurisdiction.) The agency that receives the report will immediately contact the other three agencies. If it is not readily apparent which law enforcement agency has jurisdiction the DeKalb County Police Department will be contacted to represent law enforcement. If they determine that another law enforcement agency has jurisdiction, that agency will be immediately contacted by DKPD to assume the investigation.

III. THE CHILD DEATH INVESTIGATION TEAM

In child fatalities and near child fatalities where child abuse is suspected law enforcement, the Medical Examiner, DFCS, and the District Attorney have legal responsibilities. It is the responsibility of the Medical Examiner to determine the manner and cause of death-was the death from natural causes, accidental, or a homicide; the responsibility of law enforcement to determine if a crime occurred and, if so, who committed the crime; the responsibility of the District Attorney to advise law enforcement regarding sufficiency of the evidence for the issuance of search warrants, to provide subpoenas, to provide legal advise relating to interviewing of witnesses and suspects, and to advise law enforcement regarding what charges, if any, should be filed; the responsibility of DFCS to determine if any surviving children are at risk of harm and to provide shelter for these children. Therefore, it is necessary that these agencies coordinate their investigation in any case where a child has died or is near death from child abuse.

Education, experience and training are essential requirements for persons involved in a child death investigation. Each agency that participates in a child death investigation will involve only these persons with special expertise in the investigation of a child death.

This Protocol signifies the dedication of the Medical Examiner's Office, DFCS, the District Attorney, and law enforcement to a DeKalb County Child Death Investigation Team.

Office of the Medical Examiner

Georgia law requires that the medical examiner conduct a "Medical Examiner's Inquiry" any time a person dies after birth but before the age of seven if the death is unexpected or unexplained; in any suspicious or unusual manner; as a result of violence; suddenly when in apparent good health. A medical examiner's inquiry may include a scene investigation, an external examination, a limited dissection, and an autopsy. O.C.G.A. § 45-16-21; 45-16-24. An autopsy is required if the child is under the age of seven if the death is unexpected or unexplained unless the death was expected or explainable with "a reasonable degree of medical certainty." O.C.G.A. §45-16-27.1. Furthermore, the law states that no one can authorize the removal of the body until the medical examiner's investigation is complete unless authorized by the medical examiner. O.C.G.A. §45-16-29.

It is recognized that although the medical examiner does not have legal jurisdiction of an investigation until there is a death, in many cases hospital personnel, law enforcement, or others are aware that the death of a child is imminent and there is a reason to believe the death may be from abuse. In these cases the expertise provided by the DeKalb Medical Examiner's Office is still essential and they should be notified and included in the investigation as if the child had already expired.

The DeKalb Medical Examiner's Office will establish the Medical Examiner's Child Abuse Death (MECAD) Task Force. The MECAD Task Force is composed of forensic pathologists, investigators, technicians, photographers and support staff. The Task Force is supervised by the Director of the DeKalb Medical Examiner's Office. The purpose of the Task

Force is to work together as a forensic team during the forensic investigation and post-mortem autopsy where an investigation is required pursuant to O.C.G.A. 45-16-24. The Task Force will present its findings to the Medical Examiner for final determination of cause and manner of death. For purposes of this Protocol, the MECAD Task Force will represent the Medical Examiner's Office on the Child Death Investigation Team.

Law Enforcement

Unlike many adult homicides where the issue is not the cause of death, but rather who caused the death, in cases of deaths of children it is not usually readily determinable as to whether the cause of death was accidental, intentional, or natural. Where there is a suspicion that the child may have died from a homicide, law enforcement must immediately begin investigating the case, many times before the final determination from the Medical Examiner. The key to a successful law enforcement investigation is to have well-trained investigators who conduct a thorough investigation early in the case.

Each of the undersigned law enforcement agencies hereby agrees to designate a specially trained law enforcement official to represent their agency on the Child Death Investigation Team. This person will understand child death scene investigation techniques, interviewing witnesses with particular knowledge on how to interview children, interrogating potential suspects in child abuse investigations, and medical knowledge regarding how children die from child abuse. This person will also be available to attend the post-mortem autopsy. Only law enforcement officials with particularized training in this area will represent their agency on the Child Death Investigation Team.

Further, Georgia law provides that a law enforcement officer may take a child into custody if there are reasonable grounds to believe that the child is in "immediate danger from his surroundings and that his removal is necessary." O.C.G.A. § 15-11-17(a)(4). It is the responsibility of law enforcement, working in tandem with DFCS, to determine if there are any surviving siblings or other children that may be in danger and to remove these children for their protection.

District Attorney

The District Attorney hereby agrees to designate specially trained prosecutors and investigators to participate on the Child Death Investigation Team. These individuals will be specially trained on the investigation and prosecution of fatal and near fatal cases of child abuse. The investigators will be available to assist law enforcement with all aspects of their investigation including the interview of witnesses, and execution of warrants. The prosecutors will be available to give legal advice regarding the execution of search and arrest warrants, interviewing of witnesses, interrogation of suspects, issuance of subpoenas, and filing of charges. These individuals will be available to attend the post-mortem autopsy.

The District Attorney further agrees to vertical prosecution in cases of child homicide. This means that a prosecutor will be assigned early to the case and will follow the case through final disposition.

Department of Family and Children Services

In many cases of fatal or near fatal cases of child abuse there are other children in the household. Georgia law provides that DFCS will investigate complaints of child abuse and on the basis of its findings bring the situation to the attention of a law enforcement agency. O.C.G.A. §49-5-8. Also, O.C.G.A. §19-7-5 requires that social services provide to law enforcement or the district attorney the names of the child parents or caretakers, any evidence of previous injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. O.C.G.A. §19-7-5(e).

The DeKalb Department of Family and Children Services hereby agrees that they will provide a representative on the Child Death Investigation Team. This person will be available to interview or assist with the interview of child witnesses and to provide information to the Team regarding any prior incidents or abuse on this child, or any allegations of abuse on this child or other children by the parent or caretaker of the child. DFCS also agrees that this person will be specially trained in the area of child death investigations.

IV. WHERE THE CHILD'S DEATH IS A OTHER THAN A HOSPITAL

If the child is at the scene of death other than a hospital team members from law enforcement and the Medical Examiner's Task Force will respond to the death scene. The Task Force is responsible for the body at the scene. The Task Force will photograph the body as well as other areas and items that may be important to the investigation.

Law enforcement and the Task Force will decide whether DFCS and/or a representative of the District Attorney should be present. The Task Force will coordinate with the Child Death Investigation Team regarding the interviewing of witnesses. These interviews will be written or recorded. Only Team members who are trained regarding child interview techniques will interview any children at the scene. The Task Force will not leave the scene until all witnesses have been interviewed. Each Task Force member will have a "check list" of questions for interviewing witnesses. (See Exhibit A). The Task Force will authorize the removal of the body to the Medical Examiner's Office for further examination and possible autopsy.

If other children present law enforcement and DFCS will determine whether these children should be taken into protective custody.

V. WHERE THE CHILD'S DEATH IS AT THE HOSPITAL

The Medical Examiner's Task Force will meet other members of the Child Death Investigation Team at the hospital. The Task Force will immediately issue a subpoena for all hospital records including x-rays and photographs. As many records as possible should be obtained prior to leaving the hospital. All records not immediately available should be requested within 24 hours. The district attorney's prosecutor will also be available to issue a subpoena if necessary.

The Task Force will interview all available hospital personnel including attending nurses and physicians, emergency room physicians, and social workers. These interviews will be written or recorded.

The Task Force will request that the hospital perform a full-body x-ray of the child. This x-ray will be provided to the pathologist prior to the autopsy. The Task Force will take over the body and be responsible for transporting the body to the Medical Examiner's Office.

If family members or other witnesses are at the hospital the Child Death Investigation Team will determine who will interview these witnesses. Hospital personnel may be requested to conduct some of the initial interviews before interviews are performed by the Child Death Investigation Team. (See Exhibit A.)

The Child Death Investigation Team will determine where the injury took place that caused the child's death, or where the child was last seen before succumbing. The Task Force will respond to the location. Law enforcement will also respond to the seen and other team members depending on the circumstances. A consent to search the premises will be requested. If the occupants refuse the consent to search the district attorney's office will assist in the preparation of a search warrant.

The Task Force will photograph where the child was found before being transported to the hospital. The Task Force will photograph where the injury took place, i.e., bedroom, stairs, crib, kitchen, etc. The Task Force will photograph other areas it determines necessary for assisting the Medical Examiner in making an opinion as to cause and manner of death.

All witnesses that were with the child before the child was transported to the hospital will be interviewed by the Child Death Investigation Team. (See Exhibit A.) Only specially trained interviewers will interview the child witnesses. Law enforcement and DFCS will make a determination if other children should be taken into protective custody.

VI. POST-MORTEM AUTOPSY

Prior to the post-mortem autopsy the members of the Child Death Investigation Team who participated in the investigation will meet with the forensic pathologist. All witness statements, hospital records, photographs, social service records and other information that will

assist the pathologist will be reviewed at this meeting. If the pathologist requests additional information the Team will immediately secure whatever is required by the pathologist.

The Medical Examiner agrees that only forensic pathologists with specialized training in 2the characteristics of death from child abuse and neglect will perform autopsies on children pursuant to O.C.G.A. § 45-16-21; 45-16-27.1. The prosecutor assigned the case as well as the law enforcement representative will be available to observe the autopsy. If possible, the pathologist will let the Team members know the preliminary findings at the conclusion of the autopsy.

VII. INTERVIEW OF ANY POTENTIAL SUSPECTS

If the Medical Examiner has reason to believe that the child died as a result of child abuse and neglect it is the responsibility of law enforcement, with advise from the District Attorney's representative, to conduct the interview or interviews with the suspect. Only law enforcement officials with specialized training regarding the interviewing of suspects in child homicides will conduct these interviews. Law enforcement and the District Attorney's office will collaborate as to whether charges will brought against a suspect for fatal child abuse. Regardless of the decision to file charges, DFCS and law enforcement must make a determination whether other children are at risk.

EXHIBIT "B"

Department of Health and Human Services
Administration for Children and Families

A NATION'S SHAME: FATAL CHILD ABUSE AND NEGLECT IN THE UNITED STATES

A Report of the U.S. Advisory Board on Child Abuse and Neglect

Fifth Report
U.S. Advisory Board on Child Abuse and Neglect
April 1995

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"In the little world in which children have their existence,
Whosoever brings them up,
There is nothing so finely preserved and so finely felt as injustice."
Charles Dickens
Great Expectations

CHAPTER TWO
ADDRESSING SHARED RESPONSIBILITY: CASE INVESTIGATION AND PROSECUTION

CASE INVESTIGATION AND PROSECUTION

When a child dies in America today at the hands of an abusive or neglectful parent, there is too often a lack of accountability on the part of government agencies, front-line professionals, and the perpetrator. Such deaths often fall through the cracks between the many organizations, including law enforcement, medical, judicial, educational, and social service agencies that comprise the child protection system. No mechanisms exist to assure that responsibility is taken within this multiagency system for determining how and why a child dies, or who should be held accountable. As noted by the Congressional Research Service, many law enforcement systems investigate child deaths only if a coroner's autopsy finds the death suspicious; yet coroners do not consistently assure that children are autopsied (Robinson & Stevens, 1992). When autopsies are ordered, they may be incomplete or incompetent.

"Good systems will emerge from well-trained people." — Michael Wald, Deputy General Counsel, DHHS, Board member, ABCAN meeting, Washington., 1994

In short, nobody speaks loudly enough for the children when these tragedies occur. The system created in the United States to ensure that

adult homicides are thoroughly identified, investigated, and prosecuted is failing to serve infants and children who die of maltreatment.

In times past, children were often seen as property. Many police, judges, and prosecutors viewed such deaths as a strictly social problem, not a criminal issue. Today, systemic problems created by those attitudes linger.

The Child Protection System of Mandated Reporters and Agencies

Many of the key agencies that make up the child protection network do not understand their role in abuse and neglect investigation procedures or in assuring a child's safety. The holes in the safety net can easily be seen in the numbers of front-line professionals from education, law enforcement, medicine, and other fields who do not notify child protective service (CPS) agencies about children they suspect of being abused or neglected, even though they are legally mandated to do so.

A recent study found that 69 percent of professionals who suspected abuse did not report it.

Zellman et al (1990) found that 22 percent of these mandated reporters, who include pediatricians, school principals, and day care operators, do not report suspected abuse, citing as top reasons their lack of hard evidence of abuse or neglect—which, in fact, is not required for a report—and their belief that "I can do better than the system." A recent study found that 69 percent of professionals in medicine, law enforcement, and other fields who suspected abuse did not report it to CPS or any other authority (Reiniger et al, 1995). They are often breaking State law.

The ineffectiveness of the mandated reporter system was made clear in 1988 by the National Committee to Prevent Child Abuse's (NCPCA) National Telephone Survey. It found that teachers, who are considered among the most critical members of the system, receive little

education in identifying, reporting, or intervening in suspected child abuse and neglect. Less than half of the teachers had ever attended an inservice workshop on child abuse or neglect. Of those, half believed their instruction was insufficient (McCurdy & Daro, 1988). According to testimony, mandated reporters suffer a "serious knowledge gap" about how and when to report abuse (Reiniger, verbal testimony, 1994).

Such practices among individuals who are supposed to be protecting children become extremely important in light of the number of abused and neglected children who die before anyone alerts a CPS agency. Martinez and Sommer (1988) found that while 40 percent of the children who die from abuse and neglect are under age 1, such children account for only 13.8 percent of abuse cases substantiated by CPS agencies.

"Teachers saw my bruises. They saw what I was going through. I went from an honor student to a kid that didn't have no respect for authority, all of a sudden. Do you understand what I'm saying?"—A Woman of the Family Violence Program, Bedford Hills Correctional Facility, 1994

There even have been cases reported where professionals have sought to protect the perpetrators. Helen Shore, Regional Coordinator, Child Fatality Review Project, Neosho, Missouri, told the Board of a Missouri coroner who wanted to label a case of inflicted suffocation as Sudden Infant Death Syndrome to protect a family's reputation (verbal testimony, 1994).

A few States are making some attempt to address the lack of training for mandated reporters. For instance, California requires 8 hours of training on child abuse and neglect for licensure of family therapists including psychologists and licensed clinical social workers, though not for physicians. Iowa requires 2 hours of training every 5 years for mandated reporters. New York requires 2 hours of initial training for mandated reporters. Any efforts to train mandatory reporters should provide them with skills to recognize the signs of potentially fatal child abuse and to act quickly on their suspicions.

The Role of Child Protective Services

Testimony before this board in 1993 and 1994 indicated a widespread lack of faith in CPS investigative efforts and in CPS' role in detecting or reducing fatalities from abuse or neglect. Many overburdened CPS agencies, although expressly mandated to protect children, "do not see themselves as having a serious role in investigating maltreatment deaths, due to the criminal implications" (Beveridge, verbal testimony, 1993).

"I believe in my heart if CPS had monitored and had me go to counseling with my mother, something might have been done. But if you say you are going to monitor and you don't ever come, and when you decide to come you call me first, that gives me a chance: 'Put on the long sleeves, honey.' Clean up, and all that."— A Woman of the Family Violence Program, Bedford Hills Correctional Facility, June 1994

Many professionals do not trust CPS to conduct thorough investigations of nonfatal abuse or neglect cases before listing them as "unsubstantiated." In cases where children die or are severely injured after CPS investigated and dismissed reports of abuse or neglect, States sometimes take criminal action against CPS workers.

In 1992, 1.9 million reports of abuse and neglect involving 2.9 million children were received by CPS agencies, a figure which includes multiple incidents within some families (NCCAN, 1994). While many States purge unsubstantiated abuse and neglect cases to prevent families from being kept in CPS records, a few States have chosen to keep unsubstantiated cases on file. Many experts argue that retaining unfounded reports allows caseworkers to detect past patterns of abuse when investigating new allegations that a child is in danger (Reininger, verbal testimony, 1994). Today, Child Death Review Teams and police, who routinely review records of deceased children, consider prior reports of unsubstantiated abuse to be potentially important aids in gathering evidence in those States where records are saved (Smith, verbal testimony, 1994).

The Role of Prosecution

Even after a fatality caused by abuse or neglect is recognized and an investigation is launched to identify a perpetrator, the criminal justice system often responds insufficiently. The Board heard the testimony of prosecutors who conceded that charges of child homicides, including heinous cases, are routinely reduced to lesser crimes.

Charges of child homicides are routinely reduced to lesser crimes.

Prosecutors reduce charges or do not charge perpetrators at all because existing murder statutes do not fit many child abuse and neglect fatalities and cases can be difficult to prove in court. For example, most prosecutors have little or no experience with abuse and neglect cases; police often fail to gather sufficient evidence; and autopsies are seldom performed by medical examiners with pediatric expertise. Witnesses are rare aside from the perpetrator because most deaths occur in the privacy of the home, and some juries simply cannot believe that any parent or caretaker would commit such acts upon a child.

> *"The goal must be to prosecute child homicides as aggressively as we now prosecute adult murders. To be successful, the greatest barrier to achieving equal justice must be overcome--the public's disbelief."* — *Ryan H. Rainey, Senior Attorney, National Center for Prosecution of Child Abuse, Los Angeles Focus group, 1994*

In one example of an attempt to anticipate jury disbelief, a Peoria, Illinois, prosecutor waited 7 months to issue a charge of manslaughter against an aunt who killed her baby nephew with a stun gun. Brandon Jordon, age 7 months, died from multiple assaults from a 70,000-volt stun gun. Police say the aunt shot the baby on May 28, 1994, to stop his crying. Authorities were uncertain if they could convince a jury that anyone could commit such a terrible act, and prosecutors delayed charging the aunt while "investigating the effects of stun guns on children" (Staff, *Peoria Journal-Star*, June 30, November 24, November 29, 1994).

A Struggle for States

Several States have tried to address the many troubling issues presented by the flaws in investigating and prosecuting abuse and neglect

deaths. Colorado has established guidelines for the role of CPS, law enforcement, and health professionals when investigating suspicious child deaths. Oregon provides clear guidelines for the specific roles of all professionals involved in death investigatic: : CPS workers are expected to provide case management information and family history to investigators, and police are expected to report witness information and provide scene photographs, physical evidence, and background and suspect information. Health professionals are expected to provide thorough analyses of deaths through autopsies.

"Researchers spend a lot of time investigating how CPS agencies failed when a death occurs, but in most cases CPS was not aware of that family or that child's existence before the death. But somebody, somewhere, was aware."— Jose Alfaro, Director of Research, Children's Aid Society, New York Focus group, 1994

Most experts believe that thousands of families in which a child died in the past decade, whether known to CPS or not, were often well-known to a physician, police officer, probation or parole officer, welfare worker, therapist, or other professional. Indeed, many of these families have multiple problems including drug abuse, domestic violence, unemployment or homelessness that bring them in frequent contact with such agencies. However, few front-line professionals have the training or knowledge to respond to the dangers to children from abuse and neglect.

With such basic, deep-rooted problems, it is not hard to see why the system seems to have fallen into disarray when yet another tragic death of a child is made public in the media. All concerned professionals and agencies must help carry the weight that cannot be borne by CPS alone and become active participants in identifying and reporting abuse and neglect. That effort will hinge, to a large degree, upon a complete rethinking of how we train and guide the people on whom these responsibilities rest.

Provision of Available and Necessary Medical Care to Children

A particularly difficult issue that was brought to the attention of the Board during the preparation of this report, is the issue of religious exemption or religious immunity or deference in cases of medical neglect of children. These phrases have been used to refer to the policies and laws which seek to exempt or immunize parents of children who do not provide available and necessary medical care to a child because of their religious beliefs. This issue involves balancing constitutional guarantees of freedom of religion, parental rights, and societal and governmental responsibilities to protect children from serious harm or death.

The right of a person in the United States to practice his or her religious beliefs is a key principle in our Nation's history and is clearly articulated in the Constitution. Government must not seek to limit that right. However, government has enacted important laws that are designed to protect the health and well-being of children, who because of their very nature are dependent upon their parents for care, nurturing, and protection. Such laws provide for governmental intervention to ensure that a child will have access to available medical care when the child has been harmed, or is at substantial risk of harm. At present, this can be accomplished through the application of child abuse reporting, investigation, and treatment laws in each State.

This issue has been complicated by Federal statutory and regulatory changes that have evolved over the past two decades. The Federal Government became involved with this issue in 1974, following the enactment of the nation's first Federal child abuse statute, the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247, as amended). Regulations implementing CAPTA directed that, in order to receive Federal funds under this new grant program, States had to

construct their civil child abuse statutes in such a way as to ensure that "a parent or guardian legitimately practicing religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian." The regulation went further to indicate that "such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it."

Against a backdrop of heightened awareness and concern about the problem of child abuse and neglect and the desire to take advantage of the financial incentive in this area, most States enacted child abuse and neglect reporting laws that exempted or immunized parents from a finding of negligence if their failure to provide medical treatment was based on religious beliefs. Some States amended their criminal statutes as well, prohibiting prosecution of parents who did not provide medical care for their children, regardless of the outcome.

Throughout the next decade state child protective services expanded and reports of abuse and neglect grew tremendously. In addition, reports of instances in which children became seriously ill, disabled, or died due to a lack of medical treatment came to the attention of CPS agencies, the courts, and the Federal government.

In 1983, the Department of Health and Human Services (DHHS) issued new regulations addressing medical neglect. To continue to receive federal CAPTA funds, States then had to explicitly add medical neglect to their child abuse statutes. In addition, the Department dropped the requirement that States have religious exemption or immunity provisions and clarified that while states may exempt parents from being adjudicated as negligent, the State must have the authority to intervene to protect the child and provide necessary medical care.

In recent years, as the DHHS has continued to review States' child abuse and neglect statues to determine whether they meet the requirements of CAPTA, some States have lost Federal funding and others were influenced to change their laws related to the medical care of children. In 1995, Congress imposed a moratorium on DHHS action with respect to these laws.

Although the Department's policy has been consistent since the issuance of the 1983 regulations—all children are entitled to available and necessary medical care, regardless of the religious beliefs or practices of their parents or guardians—this aspect of the child abuse Federal policy has been the subject of recurrent debate. It has reportedly caused confusion among many child protection agencies regarding their authority to intervene in reported child medical neglect cases if the parent's action or inaction based upon their religious beliefs. In an effort to clarify this issue, some States have added spiritual healers to their list of mandatory child abuse reporters. The courts in various States have interpreted the religious exemption or immunity statutes differently: some have upheld criminal prosecutions of parents whose children suffer serious disability or die as a result of religion-based failure to seek or provide necessary medical care while others have ruled that the States religious exemption or immunity prevents such prosecutions.

Medical professionals and child advocates have voiced increasing concern that continuation of the current policy will endanger more children because children who are at risk of serious harm as a result of a lack of medical treatment often do not come to the attention of medical or child protection professionals until the situation is critical or after the child has died or suffered permanent injury. In addition, there is concern that the current policy undermines the legal responsibility that all parents

have to care for their children and sends a confusing message to parents, spiritual healers, and professionals involved in the child protection system.

It appears that the religious exemption, religious immunity, or deference provisions regarding medical care of children in some State statutes may have created unintended barriers to the provision of timely, necessary medical care for children. After lengthy consideration, the Board is concerned that such an exemption leads people to fail to report cases of inadequate medical care to appropriate authorities. The results have proven to be devastating in a number of widely reported cases.

The reauthorization of CAPTA and the Federal role in child abuse and child welfare programs is under review in the Congress this year. However the Congress may decide these questions, the compelling issue of protecting children who may be denied needed medical care remains. Therefore, the Board recommends that States take action to ensure the protection of all children.

CURRENT ISSUES: TRAINING WEAKNESSES

A RECENT CASE:

The 5-year-old was brought to Lincoln Hospital in the Bronx four times over several months, each time with a different injury: a skull fracture, extensive bruising, cigarette burns on her hands and chest, and severe scalding from hot tapwater. On her final trip, she was DOA. An autopsy revealed that she died from a lacerated liver, the result of being severely punched. When the Medical Examiner collected hospital records, he noticed that a different doctor had seen the girl each time, and the seemingly caring family always gave a history of accidents—a clumsy little girl who put her hands in ashtrays, stepped into scalding water, or fell down a flight of stairs. Each time, the new doctor, untrained in the signs of inflicted abuse, believed the story.—Dr. Michael Baden, New York State Police Medical Examiner's Office, New York Focus group, 1994.

The greatest impediment to creating competence among professionals who respond to child deaths is the lack of specialized training and crosstraining. From the time of death, while a child's body lies motionless on a hospital bed or at home in a crib, to the time of reckoning, when a parent or caretaker is brought before a judge, a lack of expertise on the part of front-line professionals infuses the process with confusion and missed clues.

"We have become experts at finding someone to blame, but somewhere right now, a child is dying at the hands of his/her parent or caretaker, and we don't know how to find them in time."—Yvonne Chase, ABCAN Board member and Deputy Commissioner, Department of Health and Human Services, State of Alaska, ABCAN meeting, 1994

The system is so strained that the question of who harmed a child may never be asked or answered, and in too many cases perpetrators have gone on undetected to harm or kill other children. Sometimes this is due to a lack of crosstraining which is necessary for effective coordination among agencies. It is not unusual for law enforcement to be aware of domestic violence problems in a family, for CPS to know about an allegation of molestation against the mother's boyfriend, and for public health nurses to be tracking an infant in the home suffering from

malnutrition or failure to thrive. Yet more often than not, none of this information is seen in its entirety by any one professional.

Some States are using the knowledge gained from Child Death Review Teams to dramatically improve training and awareness. In Missouri, for example, training developed by experts from Child Death Review Teams is regularly conducted at association meetings of coroners, prosecutors, and others. However, other regions appear to be moving in the opposite direction. In New York City, for example, the child protective training academy is being dismantled and transferred out of the child welfare system. According to Dr. Megan McLaughlin, Executive Director of the Federation of Protestant Welfare Agencies, the critical training of case workers has been made an expendable part of the child protection program (verbal testimony, 1994).

Physicians and Other Hospital Personnel Are Unaware of Abuse Clues

A RECENT CASE:

In Rhode Island, a battered woman appeared at a hospital emergency room with her bruised toddler. None of the doctors or nurses who treated the mother examined the child, and after the woman was patched up, no one thought to notify CPS. Nine months after the mother's visit to the ER, the baby was killed by the same violent boyfriend who had been beating the mother. A member of the Child Death Review Team noted, "The child died essentially because of the failure of an emergency room to identify risk, witnessed through the serious abuse of the mother." —Dr. Richard Gelles, Family Violence Research Program, University of Rhode Island, New York Focus group, 1994.

Several medical examiners testifying before this Board gave detailed accounts of hospital cases where the presence of child abuse or neglect was not ascertained until autopsy. In many cases, the medical

examiners believed the cause of the child's injuries should have been determined, or at least questioned, by those who treated the child in an ambulance, in an emergency room, or in intensive care. Child Death Review Teams have found that because many emergency rooms are staffed by rotating physicians with various specialties, an abused or neglected child might be seen by a physician who is unaware of the health records of children and is unprepared to recognize the symptoms of child abuse or neglect (Minnesota State Department of Human Services, 1991).

Moreover, unknown numbers of children never make it to a medical examiner for autopsy because of a lack of training and awareness among emergency room and intensive care workers, emergency medical technicians (EMT's), and other medical personnel. Often, the true cause of death remains a mystery, and the parent or caretaker is treated as a bereaved victim.

Despite the dimensions of this life-threatening medical crisis, only 400 pediatricians nationally have membership in the American Academy of Pediatrics (AAP) Section on Child Abuse. In States as large and populous as Texas, that translates into less than 10 pediatric specialists, all of whom are on faculty at medical schools (Garcia, 1994 testimony.) Because child abuse is not a defined specialty in pediatrics, it is not required as a rotation during pediatric residency training.

"Doctors, especially younger doctors, want to believe that parents only beat older children. I have to keep telling them, no, they beat babies."—Dr. Margaret McHugh, Child Protection Team, Bellevue Hospital, New York Focus group, 1994

Few Medical Examiners or Coroners Know How to Detect Child Abuse and Neglect

The vast majority of medical examiners and forensic pathologists lack specific training in identifying the cause of a child fatality, and only a handful of medical examiners in the country specialize in autopsies of children. Moreover, although there is a new certification specialty for

pediatric pathology, there is no certification requirement for medical examiners or forensic pathologists who autopsy children.

These problems represent a significant weakness in the system because children succumb to unique and sometimes subtle injuries and maladies from abuse and neglect that are easily missed by an examiner trained to find causes of adult death. Moreover, parental deceit and denial are common. Complicating the situation, 28 States rely upon coroners or justices of the peace who are elected to office based only on the qualifications that they are at least 18 years of age and a resident of that county (CDC, 1993).

"No parent or guardian ever comes in and says 'I've been beating up my child.' They always say, 'The kid fell down, a dog jumped on the kid, a swing hit the kid.' For medical examiners, it is critical to detect the injuries that show the child couldn't have done it to himself."—Dr. Michael Baden, Chief Medical Examiner, New York State Police, New York Focus group, 1994

Most States have very limited funding and do not provide autopsies and death scene investigations for all unexplained deaths, particularly for children. As Gannett's 1990 series showed, "autopsies on children are conducted almost by whim." The series found that four Southern States examined, on average, only 31 percent of dead children, compared with five Western States that autopsy, on average, 54 percent of dead children—the highest national average (Gannett News Service, 1990). Gannett found that, nationwide, one in every 12 SIDS deaths is diagnosed as SIDS without support of an autopsy—a flagrant violation of necessary medical procedure (Lundstrom & Sharpe, 1991). In Pennsylvania, many local coroners are reticent to perform autopsies on any child, and very often do not have the funds or basic training to do so (Carrasco, verbal testimony, 1993). In Texas, if the death of a child younger than age 18 is unexpected, the law requires an autopsy, but a justice of the peace, who may need only be a high school graduate, makes the critical decision on whether the death was unexpected (Evans, verbal testimony, 1994).

This outmoded approach to certifying death has led to problems such as local coroners who refuse to consider abuse as a cause of death because "the parents seemed like such nice people" or "they had an unusually clumsy child," as experts testified before this Board in 1993 and 1994. As a result of these intertwined problems of undertraining and personal reluctance, hundreds, and perhaps thousands, of children die each year from abuse and neglect only to have their deaths misidentified by coroners and medical examiners as being due to natural, accidental, or undetermined causes. Indeed, Child Death Review Teams often find themselves probing issues that a qualified coroner or medical examiner could have already fully addressed.

"the parents seemed like such nice people"

Police Often Are Not Trained to Detect or Deal With Serious and Fatal Child Abuse

Homicide detectives investigate a child's death only when it appears that the death may have been at the hands of another. However, their expertise is usually limited to what they know from investigating adult homicides. Unlike most child fatalities, the unnatural death of an adult is often obvious, and detectives quickly focus on who committed the crime—not on determining whether a crime has even occurred.

If police focus on children involved in domestic violence, child abuse could more effectively be identified.

Retrospective reviews of child fatality cases have discovered too many instances where police had contact with abusive parents or caretakers, but for many reasons failed to assure the child's safety. If investigating police focused on children in families involved in domestic violence and drug abuse, child abuse could more effectively be identified and reported (Minnesota State Department of Human Services, 1991). In addition, the police sometimes fail to identify children who show signs of

neglect, such as being underweight, dehydrated, or in need of medical care. Saving an infant or small child could be as simple as "looking under their shirt or blanket" before leaving the home, as several experts testified.

"The clock starts when a child's death is noted to be suspicious. Law enforcement should be involved and have begun the case evaluation, death scene evaluation, and cleared criminal justice, and CPS records, all within 2 hours."—Capt. John Welter, San Diego Police Department, Los Angeles Focus Group, 1994

There have been a number of improvements within some police agencies recently. The Los Angeles County Sheriff, for example, now requires that investigating officers view the bodies of all living children who are reported to be victims of alleged physical abuse. The policy was instituted in 1992 in response to a case in which a preschooler died after deputies responded to an abuse complaint, but did not look at the child's body as he "slept" under a blanket. Had the deputies looked, they would have discovered extensive injuries to the boy's legs, torso, and arms from being tied down. During Child Death Review Team meetings, Los Angeles City police shared their protocol for inspecting children's bodies, which was soon replicated by the Sheriff's Department. This protocol is now part of the State's Peace Officer Standards and Training.

In addition, Dallas and some other cities now use officers specifically trained in abuse and neglect issues to investigate child fatalities and have created "family violence units" that respond both to child abuse and domestic violence complaints. Because it is critical that police coordinate with other agencies, Dallas CPS workers and child fatality detectives are housed in the same building and respond to deaths in teams. In Des Moines, Iowa, the impetus has come not from the police but from the city's Pediatric Trauma Team, which assures that there is an immediate response to all reports of serious and fatal child abuse by police, juvenile courts and CPS investigators 24 hours per day. However, most improvements in investigation are recent, and no data are available to determine their impact on child deaths from abuse or neglect.

Child Protection Workers Are Often Inexperienced, Undertrained, or Overextended

The NCPCA estimates that about 42 percent of the children who died have had previous or current contact with a CPS agency. Other studies found prior CPS contact with 30 to 45 percent of families in which a fatality occurred. The "prior contact" figure ranges from 17 percent in Colorado to 63 percent in San Diego (McCurdy & Daro, 1988).

The current system is susceptible to too many human errors and flaws. These problems arise from the recent history of child welfare, which has rapidly changed from role of "helper" or "counselor" to "investigator" in order to respond to the burgeoning crises of family violence and family breakdown. Governments have neither consciously acknowledged the cultural changes required within CPS agencies nor addressed the professional training required to make these changes. In some States, child protection workers receive little training to determine the cause of a child's injuries before they result in death or to detect clues that might indicate that a child is in danger.

"It is incongruent and unreasonable to continue to expect poorly trained, low-paid staff to appropriately assess the needs of children and their families."—Megan E. McLaughlin, D.S.W., Federation of Protestant Welfare Agencies, New York Public hearing, 1994

Even well-trained workers cannot function adequately with unmanageable caseloads. While some regions and States do much better than others, in many jurisdictions caseloads are so high that the best CPS can do is take the complaint call, make a single visit to the home, and decide whether the complaint is founded or unfounded. Often, there is no subsequent monitoring of the family.

For example, CPS in New York has reached a saturation point, according to James Cameron, Executive Director, New York State Chapter of the NCPCA (verbal testimony, 1994). In New York, CPS agencies receive over one hot-line call per minute from relatives, neighbors, friends and professionals reporting suspected cases of abuse or neglect. Leah

Harrison (1994), of the Child Protection Center of Montefiore Medical Center in New York, testified that the Center works with the local child welfare agency to protect children. She has found that the agency's staff is unaware of the implications of many medical diagnoses and sometimes makes decisions based on their rules and regulations without taking into consideration the implications of their decisions. Moreover, according to Harrison, many caseworkers lack the resources needed to create an appropriate service plan for the family to ensure a child's safety.

New York is hardly alone. In many cities and States, a litany of child abuse and neglect tragedies have resulted in lawsuits and highly negative press coverage and have created the appearance of widespread professional incompetence. Nevertheless, this Board believes it is a mistake for the public to hold CPS agencies solely responsible for these failures to save children. Placing such a large burden on a single, beleaguered agency is akin to expecting school truancy officers to identify and resolve the complex and persisting problem of urban street gangs.

Multiple Problems Deter the Prosecution of Perpetrators

ONE RECENT CASE:

An Oklahoma mother asked her boyfriend to babysit for her infant girl. While she was gone, the boyfriend became enraged over the baby's crying and violently shook the child until the infant was dead. An autopsy revealed severe brain damage caused by shaking. After the boyfriend's arrest, a photograph of him ran in local newspapers showing him wearing a bill cap popular in Oklahoma that read, "Number One Dad." At his trial, the man admitted he had attacked the child, but the jury found him not guilty. Later, the district attorney (D.A.) was criticized for charging the boyfriend with first-degree murder, since the jury was not able to accept the killing as premeditated.—Barbara Bonner, Verbal testimony, New York focus group, 1994.

Most prosecutors are not specially trained to prosecute child homicides by abuse or neglect. Specialized training and vertical prosecution, in which one attorney carries a case from referral to disposition, are now common in cases of sex crimes against children, but not in cases of child homicides, including fatalities from abuse or neglect.

In addition, judges at all levels have inadequate knowledge about child maltreatment-related fatalities, and too often they are not provided with critical information regarding family history before they impose sentences. Consequently, judges often agree with prosecutors that child homicide defendants should be allowed to plead to lesser crimes. Prosecutors suggest lesser pleas for several reasons: the investigation has failed to provide sufficient evidence to prove the charges beyond a reasonable doubt; the prosecutor lacks the knowledge on how to prove the charges; or there is an absence of a felony murder statute with which to charge the accused for the child's death.

"Prosecutors all over the country will tell you that the easiest murder to get away with is the killing of an infant or small child by a parent or caretaker."—J. Tom Morgan, Atlanta D.A. and ABCAN board member, October 1994.

Prosecutors face major hurdles. Jury members often will not believe that parents and caretakers would seriously hurt or kill children, and the legal system often encounters spouses and relatives who side with perpetrators and delay or cripple investigations. In one Missouri case, the Jackson County prosecutor could not gather enough evidence on the death of a 4-year-old girl because so many of the family's adults had abused the child that no one could determine who inflicted the fatal blow. Surviving siblings and young cousins were threatened into silence and would not testify (Fincham, verbal testimony, 1994).

Despite these many obstacles to prosecution, there are some improvements underway. More perpetrators are being arrested and convicted with information gathered by Child Death Review Teams, the use of more and better autopsies, and extra efforts by concerned physicians. The National Center for Prosecution of Child Abuse deserves recognition for providing nationwide training and consultation for prosecutors in this area.

Yet much more must be done, and we will suggest strategies for change, including dramatically improved training of all front-line professionals, immediate-response joint criminal investigations, and adoption of statutes that allow prosecution of these crimes without the need to prove premeditation.

STRATEGIES FOR IMPROVEMENT: EXPANDING THE EXPERTISE

Broad New Training Efforts for All Front-Line Workers

CPS Training

With CPS increasingly consumed by investigations, CPS managers and line staff are now realizing that a graduate degree in social work alone does not prepare professionals to conduct such investigations and gather evidence related to criminal prosecutions. Some States are considering a dramatic shift that places police in charge of investigating serious cases and high-risk families, thus allowing both CPS and law enforcement to perform the tasks for which they are most skilled.

Some States, such as New Mexico and Connecticut, have enriched their CPS training programs in response to litigation. Alaska has designed and implemented mandatory, competency-based training for all child welfare and child protection workers.

Specialized training for CPS workers should prepare them to become knowledgeable members of Child Death Review Teams. This Board suggests a training model for CPS workers aimed at identifying and preventing serious and fatal abuse and neglect and helping workers assist other agencies in gathering child death investigation information. Such training should include:

- How to identify family strengths as well as risk factors associated with diverse groups and cultures. This would include how to identify normal child development markers via growth charts as well as markers for sufficient language development.

- Cross-training to relate better to other disciplines, with the aim of increasing cooperation among agencies, fostering greater awareness of clues to abuse, and sharing information on fatality cases.

- Training of, and with, community-based workers.
- Training and access to "user-friendly" automated client tracking and case management information systems that can greatly improve access to important information on a family or case.

Beyond training, one important, but problematic requirement must be keeping competent, highly trained people from leaving CPS due to burnout and stress. Low salaries exacerbate this problem. Regular consultation and inservice programs to minimize burnout, preparation for workers dealing with their own emotions after a case results in a fatality, and salaries commensurate with their responsibilities would do much to attract and retain good workers.

"What we need in those intervention and prevention stages is understanding from people like us. If somebody that's sitting next to me has not been through a bit of abuse, how are they going to recognize an abusive situation?"—A Woman from the Family Violence Program, Bedford Hills Correctional Facility, 1994

Medical Training

SHOWING THE WAY:
The University of Oklahoma Science Center is implementing voluntary interdisciplinary training for 180 doctors and other health professionals on child abuse and neglect fatalities. They will be taught how to recognize clinical signs of child abuse and neglect, informed of their obligation to report abuse, and encouraged to work with police and CPS.—Dr. Robert Block, Oklahoma Child Death Review Team, Dallas Public hearing, 1994.

Health care delivery settings, including public and private hospitals and clinics, health maintenance organizations, (HMO's), preferred provider organizations (PPO's) and special children's health programs should provide incentives and significant funding for the development and ongoing training of medical specialists in child abuse and neglect. This commitment should match training in other leading causes of death for children. Such an effort will require public health policymakers to

understand the link between child abuse and subsequent lifetime medical, mental health, criminal, and educational costs of untreated and unrecognized child abuse.

ONE HOSPITAL'S EFFORTS:

Over the past 5 years, the Strong Critical Care Center at the University of Rochester Medical Center, in cooperation with a Child Death Review Team, has produced a series of papers identifying red flags for suspected child maltreatment-related deaths: inconsistent history compared with the physical examinations, history of drug or alcohol abuse, and past history of child abuse or previous involvement with the Department of Social Services. The red flags are now used to train medical staff to spot abuse cases. — Dr. Brahm Goldstein, Associate Professor of Pediatrics, University of Rochester School of Medicine, New York Focus group, 1994.

Increased Use of Immediate Response Joint Criminal Investigations

Joint criminal death investigations have existed at least since the time of Sherlock Holmes and Dr. Watson. For many years, physicians, law enforcement officials and others have informally collaborated to determine the cause and manner of human fatalities. Today, in response to systemwide weaknesses, some cities and counties are creating and training criminal investigation teams that immediately respond to questionable child deaths.

Joint criminal investigation teams differ from Child Death Review Teams in one critical aspect: their mission is law enforcement. They conduct criminal investigations of wrongdoing, rather than retrospective or prospective systemwide reviews of how the child's death happened or could have been prevented.

This Board believes that each team should include, at a minimum, a medical examiner, detective, a CPS caseworker, and a prosecutor.

Protocols should be developed with clear guidelines for the role of each team member from the moment a child's death or impending death is reported. Medical, CPS, criminal histories and other information must be freely shared among all involved.

Because of the hidden nature of many child deaths, the most effective joint criminal investigation teams conduct immediate-response death investigations for all children who die under suspicious circumstances. Prosecutors described to this Board the reluctance to share information between agencies and confusion over roles, problems that are often resolved or greatly decreased by the innovative aspects of team investigations.

"Our efforts have made borderline cases stronger, and strong cases unbeatable. And we ensure that those tragic child deaths that are accidental are accurately characterized as quickly as possible."—Lucinda Suarez, Special Victim's Bureau, Queens County District Attorney, New York Public hearing, 1994

For example, the Los Angeles Police Department's child abuse unit, composed of specially trained child abuse detectives, immediately sends a team to the scene of any suspected child abuse or neglect death. A team, including a prosecutor and coroner's investigator, interviews the parents, visits the hospital, and contacts CPS to determine over the phone whether the family has a history with the agency. The team has even sent the pathologist—day or night—to the death scene to review the child's injuries and witness the evidence. When the team's highly detailed and promptly collected evidence is presented in court, cases are usually prosecuted successfully (Smith, verbal testimony, 1994).

In Queens, New York, an immediate response criminal investigation team has taken the concept a step further, videotaping the death scene to be used as evidence. Such evidence has proved persuasive to juries. The videotape also prevents parents and caretakers from fabricating information or concealing evidence.

Despite these positive results, members of such teams also testified that the work hours are demanding, the pay is the same as colleagues who

do not handle child death investigations, and the burnout level is high. For this reason, jurisdictions should provide incentives for child death investigation team members.

Suspected Child Abuse and Neglect Teams and Other Hospital Efforts

A growing number of hospitals are creating Suspected Child Abuse and Neglect (SCAN) teams responsible for evaluating, reporting, and treating child abuse and neglect and for providing consultation for other hospital staff and other agencies. The core teams include a physician, nurse, and social worker.

"Children are re-molested, re-abused and even die because an untrained medical practitioner, acting without benefit of a specialized SCAN team, did not recognize indicators of a serious or life-threatening injury. Conversely, many families are put through traumatic experiences when their children are inaccurately diagnosed as victims of abuse." —Dr. Astrid Heger, Director, Pediatric SCAN Team Los Angeles Focus group, 1994

SCAN teams build liaisons with law enforcement and fire department EMT's, which provide important contact with "first responders"—those who are first at the scene of a child trauma. Teams may also develop liaisons with home visiting professionals, including public health nurses. This broadens home intervention efforts and provides access to prior medical records from public hospitals and clinics.

Most hospitals do not have SCAN teams. Hospitals with such teams provide varying levels of service depending on whether their team offers primary care or acts as a referral center. We believe every child and family should have access to a "Center of Excellence" for tertiary referral in their region, staffed with trained experts to ensure accurate diagnosis and appropriate treatment. In rural areas, use of telemedicine techniques can enable any SCAN team to consult with a tertiary center hundreds of miles away.

Every child and family should have access to a "Center of Excellence"

AN IDEA THAT WORKS:

Bellevue Hospital's Child Protection Team is made up of representatives from pediatrics, court-appointed special advocates (CASA), substance abuse, and the psychiatric department. It reviews every trauma case admitted, including adult cases where a child is in the home, as well as all cases of domestic violence. Any Bellevue staff member who is unsure about a case may request team review. The team integrates its work with the D.A. The team routinely identifies cases of child abuse and neglect that are missed by hospital physicians and other health professionals.—Dr. Margaret McHugh, Director of Child Protection Team, Bellevue Hospital, New York Public hearing, 1994.

Mandated Autopsies

This Board heard strong agreement from professionals in many disciplines that the single most critical stage in determining the cause and manner of death of an infant or child is the autopsy. Yet here, in an area where the need for professional expertise is so obvious, the system fails dramatically. Few jurisdictions routinely perform autopsies when children die unexpectedly. Among the reasons given are:

- clear guidelines or regulations on when an autopsy should be performed;
- funds;
- competent medical examiner;
- political system in which an elected official decides if an autopsy is needed;
- religious prohibitions both actual and claimed;
- personal reluctance, especially among coroners who may know the family.

Some States and regions are showing the way in this extremely critical area. As of 1992, Kansas appeared to be alone in requiring autopsies of all children who die under suspicious circumstances or of unknown causes (National Center for the Prosecution of Child Abuse, 1994). Georgia requires autopsies of all children age 7 and under, a law which sufficiently captures the high-risk age groups. Curiously, child autopsies have been mandated in the past 5 years in Maine, Nebraska, Oklahoma, Illinois, Iowa, Ohio and Missouri in response to public concern; but, depending on the State, these mandates exclude children who die after age 3, age 2, or age 1 (National Center for the Prosecution of Child Abuse, 1994). Thus most State autopsy mandates do not apply to many children who die from abuse or neglect.

Some localities have chosen to be far more inclusive without waiting for State mandates. For instance, Tarrant County, Texas, (Fort Worth) has adopted a policy requiring that all children who die under the age of 15 be completely autopsied, with microscopy and comprehensive toxicology studies (Peerwani, verbal testimony, 1994). Oregon's medical examiner system reviews all unexplained deaths within 24 hours, and most autopsies are performed by board-certified forensic pathologists (Lewman, verbal testimony, 1994). Missouri provides its Child Death Review Teams with a Certified Child-Death Pathologist Network. Mary Case, Chief Medical Examiner, St. Louis County, notes that prosecutors in Missouri are far more willing to pursue cases because forensic pathologists are much better at presenting evidence to a jury, and attorneys are far more educated about the nature of maltreatment fatalities (verbal testimony, 1994).

"The attitude of rural deputy prosecuting attorneys is that child protection cases are just 'kiddy' cases."—Ed Vandusen, Program Manager, Division of Family and Children's Services, Idaho Dept. of Health and Welfare, Oregon public hearing, 1993

Enhanced Prosecution and Evidence Gathering

Murder is no less a crime because a child, rather than an adult, is the victim.

Murder is no less a crime because a child, rather than an adult, is the victim. Only 21 States have either legislatively delineated child abuse as an underlying felony contributing to felony murder or enacted homicide by child abuse statutes (Rainey, personal communication, 1995). In States without such legislative intent, felony murder charges may not be possible.

Felony murder statutes allow juries to return a verdict of guilty when the prosecutor has proved beyond a reasonable doubt that the defendant intended to commit a felony (i.e., child abuse) which resulted in the homicide. If a defendant is shown to have intended to commit felony child abuse, the defendant may be convicted of murder if the child dies. Elements of the murder such as malice aforethought, premeditation, and intent to kill—which are difficult to prove in child homicide—are not required.

Jurisdictions that have adopted felony child murder or equally effective "homicide by child abuse" laws have experienced increased convictions when prosecuting perpetrators. For example, Oregon differs from the Nation as a whole in that it has a higher rate of criminal prosecution of fatal child abuse cases (approximately 68 percent). "It is possible that Oregon's prosecution rate is higher due to a murder by an abuse statute that passed in 1989. This statute enables prosecutors to charge an alleged offender for a crime that specifically addresses the dynamics often present in child death without requiring proof of intent to murder, a condition seldom provable in child abuse fatalities" (Oregon Department of Human Services, 1993, p. 4). Children in every State deserve a similar level of justice.

CHAPTER TWO RECOMMENDATIONS

This Board has identified a critical need to better educate professionals to identify and respond to fatal child abuse and neglect and to hold perpetrators responsible for their actions. Without a greater understanding among police, physicians, CPS workers, coroners, prosecutors, mandated reporters, and others about the circumstances, red flags, subtleties, systemic problems, attitudes, and obstacles that characterize fatal abuse and neglect cases, innocent children will continue to fall through the cracks in the system. Moreover, if society fails to communicate to parents that child abuse and neglect fatalities must receive the same level of justice as adult homicides, a tacit and dangerous message is sent that such deaths are more acceptable and carry less severe consequences. We therefore recommend:

Recommendation 3: The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

The leadership of DHHS and the Department of Justice (DOJ) should work with professional associations to develop a national strategy to address the dramatic lack of medical, law enforcement, and legal and social service professionals qualified to identify and investigate child abuse and neglect fatalities. This effort should focus on:

- Recruitment and training of more practitioners by offering scholarships or loan forgiveness.

- A review by each discipline of projected training patterns to determine if it can produce enough experts. Each discipline should promote ways to increase expertise via development of continuing education, improvements in school curricula requirements, and inservice training.

- Increasing medical expertise, in particular. This goal should be addressed by the American Medical Association (AMA), National Association of Medical Examiners (NAME), AAP, American Public Health Association (APHA), and others, working cooperatively with

States should include development of: competent forensic medical examiners in every State; training of medical examiners who specialize in pediatric pathology; creation by National Institutes of Health (NIH) of funded medical fellowships in forensic pediatrics as well as forensic pathology, pediatric radiology, and public health/child abuse; enactment by States of a requirement that any doctor in pediatrics, emergency medicine, or family practice complete child abuse training within a short time of licensure; and creation of a study section for child abuse within the NIH.

Recommendation 4: There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.

The Secretary of Health and Human Services and the U.S. Attorney General should utilize funds to improve multidisciplinary training in all disciplines charged with identifying and investigating child abuse and neglect fatalities, with an emphasis on crosstraining where possible. This effort should be tailored to a broad audience including child welfare workers, law enforcement officers, prosecutors, mental health practitioners, physicians, paramedics, EMTs, and others who might work in a front-line capacity.

Regular training should be provided by the National Center for Prosecution of Child Abuse, AAP, NAME, AMA, Society for Pediatric Radiology, American Hospital Association, American Professional Society on the Abuse of Children, American Public Welfare Association, APHA, the Association for Death Education & Counseling, Association of SIDS Program Professionals, National Association of Children's Hospitals & Related Institutions, National Association of Social Workers, National Fetal Infant Mortality Review Program, the National Council of Juvenile and Family Court Judges, the International Association of Chiefs of Police, the International Homicide Investigator's Association, Peace Officer Standards and Training Board, and NCPCA.

Finally, the National District Attorneys Association should develop, with the AMA, joint training for all professionals involved in the identification, investigation, and prosecution of fatalities.

Recommendation 5: States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

All States should create criminal investigation teams either at the local or regional level to investigate any "unexpected child death," as previously defined in this report. The Department of Defense should create teams for the military branches. Indian Nations, DOJ, and Indian Health Service should ensure that such teams operate to review deaths in Indian Country. Each team should, at minimum, include a medical examiner or coroner, law enforcement officer (preferably a child abuse or homicide detective), child protection worker and prosecutor, who work under a protocol that clearly defines each role and allows for effective, confidential sharing of medical, family and criminal histories.

Recommendation 6: States and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) should adopt requirements to assure all hospitals with pediatric services have SCAN teams.

Any hospital with a pediatric unit should be required by the state, military branch, Federal agency, or Indian Nation that oversees its certification to have a SCAN team, including a physician, social worker, and nurse specially trained to evaluate, treat, report, and consult on child abuse or neglect cases. The JCAHO should adopt this requirement. Such teams should interact with investigators and other agencies on abuse/neglect and suspicious injury cases involving children.

Recommendation 7: All States should enact legislation establishing child autopsy protocols. Federal funding for autopsies of children who die unexpectedly should be available under the Medicaid program.

Autopsies should be required, at a minimum, when any child's death is suspected by investigators as being a homicide, suicide, the child was not under supervision of medical personnel at time of death, or the cause of death is not readily determinable. In addition, no cause of a child's death should ever be listed as SIDS without an autopsy, death scene investigation, and clinical review. Such autopsies are also in the interest of parents of SIDS infants, who suffer doubt when an infant dies

suddenly and unexpectedly. To implement this effort, Federal funding for autopsies should be an option under the Medicaid program.

Recommendation 8: States should take steps to ensure that all children have access to available, necessary medical care when they are at risk of serious injury or death.

- Laws protecting children must be applied equally and fairly. All States should ensure that civil child abuse laws include the provision that the failure of parents to provide medical care, when such care is available and necessary to protect a child from death or serious harm, is reportable under the State child abuse and neglect reporting law, regardless of the religious beliefs or practice of the parents. State child abuse reporting laws should not differentiate the handling of possible medical neglect cases based upon the parent's religious beliefs.

- State courts must retain clear authority to order necessary medical care when parents and others, legally responsible for providing medical care, fail to provide it.

- Decisions regarding prosecution of parents who fail to provide available, necessary medical care for their children should be made within each State.

- States should ensure that all health care providers—including spiritual healers who provide health care for payment through public or private insurance reimbursement—are listed as mandatory reporters of child abuse and neglect, thereby involving such providers in training activities that are conducted for mandatory reporters.

Recommendation 9: States should enact "felony murder or homicide by child abuse" statutes for child abuse and neglect. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

Felony murder statutes should specifically include child abuse or neglect felonies as one of the underlying felonies, as in 21 States currently. In some States, an alternate but equally effective law may be "homicide by child abuse or neglect."

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EXHIBIT "C"

Child abuse and the American justice system

Q&A WITH J. TOM MORGAN

The trial involving Louise Woodward, the British au pair charged with the death of 8-month-old Matthew Eappen, pushed more hot buttons than the O.J. Simpson case, if that's possible. Unlike the Simpson case, where the questions centered on the verdict, this case has invoked many questions about the process. DeKalb County District Attorney **J. Tom Morgan** *attempts to answer many of those questions.*

■

Q *Was this case unique in the criminal justice system?*

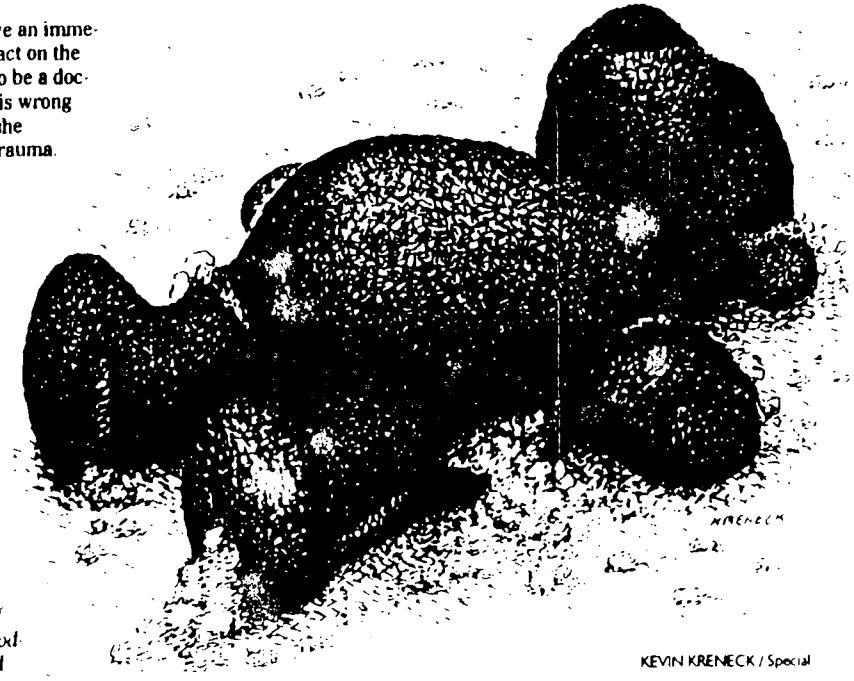
A Unfortunately, no. There are more than 2,000 confirmed deaths from child abuse and neglect each year. Death from child abuse is the leading cause of death for children under age 4. In 90 percent of these cases, a parent or caretaker is charged with the death. Almost all of these cases involve head injuries to the victim. Most of these cases receive little, if any, media attention. If this case involved a mother who worked as a waitress at the local diner and a 19-year-old, next-door baby sitter, it would never have registered a blip on the media radar screen.

Q *Could these injuries have occurred, as the defense claimed, some days before his death?*

A Absolutely not. Matthew Eappen received two types of fatal injuries to the head: blunt force trauma and shaken baby syndrome. Every recognized valid study relating to head [illegible] in children proclaims that injuries such as those sustained by Matthew Eappen would have an immediate and recognizable impact on the child. You would not have to be a doctor to know that something is wrong with your child once he or she received this type of head trauma.

Q *Was Louise Woodward guilty under the law of first- or second-degree murder?*

A Yes. Under our legal definition of murder, if a person intentionally commits an act that takes the life of another without reasonable provocation or justification, then he or she is guilty of murder. A crying baby is not legal provocation or justification for causing the death of a child.



KEVIN KRENECK / Special

Q *Is there another type of murder that Louise Woodward could have been found guilty of?*

A In many states, including Georgia, a defendant charged with the death of another person can be found guilty of felony murder. Felony murder occurs when a person, while committing a felony crime, kills an individual even though there was never any intent to do the killing. Serious child abuse in most states is a felony. If, while committing child abuse, a person kills a child, that person can be charged and found guilty of felony murder. The United States Advisory Board on Child Abuse and Neglect recommended that all the states adopt felony murder statutes so that defendants can be charged with felony murder in these types of cases. Massachusetts does have a felony murder statute, but child abuse in that state is *not* a felony. Therefore, felony murder was not an option for that jury.

Q *Why did the judge not allow the jury to consider manslaughter as an option?*

A The only explicable reason is that the judge did not want Louise Woodward to be found guilty of anything, which was later borne out by his sentencing. Therefore, the judge only allowed the jury to consider the most serious type of murder, which he obviously felt was not warranted by the evidence. It is dangerous for lawyers or judges to second-guess what a jury will do.

Q *Did the judge subvert the jury process in this case?*

A Yes. Judges can, but rarely do, throw out jury verdicts. Judges will throw out jury verdicts or reduce verdicts if they don't like the jury's decision or they do not like the mandatory sentence required by the more serious charge. However, this only applies to guilty verdicts.

In Massachusetts, a judge can reduce the verdict, but the prosecution can appeal the judge's decision. In Georgia, a judge can throw out a guilty verdict in [illegible]rety, but not reduce a verdict. H[illegible], the prosecution cannot appeal a judge's decision to throw out a guilty verdict in Georgia. Disregarding jury verdicts is a way of subverting the jury process and the will of the people. However, judges also have the inherent power to "administer justice" when they feel the law or the jury's verdict is too stringent.

Q *Was the judge's sentence appropriate for the crime?*

A No. The judge obviously did not understand the physical evidence. Pediatricians and forensic pediatric pathologists certainly cringed when they read the judge's ruling that Louise Woodward may have been a little "rough" with Matthew Eappen. In fact, 50 doctors Tuesday sent a letter to news organizations explaining the child's injuries. Matthew's injuries are similar to those of a child's falling two stories onto a concrete surface or being involved in a severe car accident without child restraints.

It is horrible to imagine what this child's last few minutes were like before he lost consciousness.

There are three goals to incarceration: to protect the public from future acts, rehabilitation and retribution. Louise Woodward will probably never commit this type of act again; you don't learn parenting classes in most prisons; therefore, the only purpose for incarceration in this case is retribution.

So what is the life of an 8-month-old worth? Obviously, this judge did not think very much.

Q *Why were our English neighbors so appalled by the jury verdict?*

A First, our criminal justice system is distrusted by most Europeans. Second, most Europeans do not understand or accept the dynamics of child abuse. I have had the privilege of lecturing in Europe to law enforcement officials and prosecutors regarding the investigation and prosecution of child sexual and physical abuse. Their response was, "That does not happen here. It must be unique to America." We are light years ahead when it comes to diagnosing, investigating and prosecuting cases of child abuse.

Q *Is there anything to be learned from this case?*

A We all should realize that this country is woefully unprepared to care for its future — our youngest citizens. An individual must be a certified electrician to work on a house, a certified plumber to fix a toilet, but certified in nothing to care for a child. Child-care providers must not only be available, but trained in all aspects of child caring. How to deal with a crying, colicky baby is a good place to start training those who care for children.

If we spent a fourth on the care of children that we spend on the care of our elderly citizens, cases like Louise Woodward's and the death of Matthew Eappen may not happen with such regularity.

J. Tom Morgan is DeKalb County district attorney and co-author of "A Nation's Shame: Fatal Child Abuse and Neglect in the United States."

RESOLUTION
ON
NATIONAL GUIDELINES
FOR
DEATH INVESTIGATION

WHEREAS, local prosecutors try the vast majority of criminal cases involving deaths in this nation; and

WHEREAS, by virtue of these cases, local prosecutors have the most experience in investigating and prosecuting cases involving the death of a human being; and

WHEREAS, the National Medicolegal Review Panel, under the auspices of the National Institute of Justice, has developed and approved the "National Guidelines for Death Investigation" using only minimal information from local prosecutors; and

WHEREAS, the "National Guidelines for Death Investigation" did not actively call on the expertise, knowledge or support of those most experienced in trying criminal death cases- the local prosecutors of this nation; and

WHEREAS, the "National Guidelines for Death Investigation" is, at best, a cursory treatment of a complex subject, lacking almost any credibility as a reference or investigation tool;

THEREFORE, BE IT RESOLVED, that the National District Attorneys Association, on behalf of all prosecutors of this nation, repudiates the "National Guidelines for Death Investigation;"

BE IT FURTHER RESOLVED, that the Department of Justice is urged to renounce the tract and recall it from public use.

Adopted by the Board of Directors, July , 1998 at Jackson Hole, WY.
98-0_.SUM

1 ☐ ***CHALLENGING EXPERT TESTIMONY REGARDING CHILDREN'S MEMORY AND SUGGESTIBILITY IN COURT***

Brian K. Holmgren

APRI's National Center for Prosecution of Child Abuse

99 Canal Center Plaza, Suite 510, Alexandria, VA 22314 (703) 739-0321

2 ☐ Morison & Greene, *Juror and Expert Knowledge of Child Sexual Abuse*, 16 Child Abuse and Neglect 595 (1992)

Over half the jurors believed children were easily manipulated into making false reports, and were physically damaged by the assault

More than one third believed that allegations frequently prove false, and the typical reaction of the victim would include resistance, crying for help, or escape

20% supported stereotype image of the abuser as a "Dirty Old Man"

4 ☐ *State v. Michaels*, 642 A.2d 1372 (N.J. 1994)

"We therefore determine that a sufficient consensus exists within the academic, professional, and law enforcement communities, confirmed in varying degrees by courts, to warrant the conclusion that the use of coercive, or highly suggestive interrogation techniques can create a significant risk that the interrogation itself will distort the child's recollection of events, thereby undermining the reliability of the statements and subsequent testimony concerning such events."

"We thus agree with the Appellate Division that the interviews of the children were highly improper and employed coercive and unduly suggestive methods. As a result, a substantial likelihood exists that the children's recollection of past events was both stimulated and materially influenced by that course of questioning."

"Accordingly, we conclude that a hearing must be held to determine whether those clearly improper interrogations so infected the ability of the children to recall the alleged abusive events that their pre-trial statements and in-court testimony based on that recollection are unreliable and should not be admitted into evidence."

5 ☐ TAINT HEARINGS FOR CHILD WITNESSES? A STEP IN THE WRONG DIRECTION

John E.B. Myers, 46 *Baylor Law Review* 873 (1994)

6 ☐ *Commonwealth v. LeFave*, Middlesex Superior Court June 12, 1998

"This Court is convinced that the... scientific evidence casting serious doubt on the reliability of the child witness' testimony is newly discovered. The evidence makes clear that there were serious, overwhelming errors committed in the... interviewing of the child witnesss... these errors... rendered the testimony of the child witnesses unreliable, ... There exists a substantial risk that had this evidence been admitted at trial the jury would have reached a different verdict."

"At the new trial the child witnesses will not be permitted to testify because they have been subjected to very serious and repeated impermissible interviewing and investigatory techniques and no independent evidence exists to support their claims. Thus, their testimony has been forever rendered unreliable."

8 ☐ *State v. Kirschbaum*, 195 Wis.2d 11 (Wis. App. 1995)

However, the proposed testimony discussing the procedures and techniques used in pretrial interviews with the victim and how these may have affected the reliability of the child's recollections are subjects with which a lay juror may be unfamiliar.

"Many jurisdictions recognize that young children can be susceptible to suggestive interview techniques and that such techniques can undermine the reliability of a child's account of actual events. See, e.g... *State v. Michaels*..."

"We find the cases from these other jurisdictions persuasive and conclude that... it may be an

erroneous exercise of discretion to deny... permission to hire an expert for testimony on the issue of suggestive interview techniques used with a young child witness."

9 Avenues for Defense Expert Testimony

- Challenges to admission of child's hearsay
- Motions for independent exam of child
- Taint hearings
- Pre-trial motions to admit/exclude expert
- Trial testimony attacking interviews
- General testimony on suggestibility
- Specific attacks on child's statements & testimony
- Evaluations for juvenile & civil court

10 CRITERIA UNDER *DAUBERT*

1. Whether the theory or technique can be or has been tested.
2. Whether the theory or technique has been subjected to peer review or published.
3. Whether the theory or technique has a known or potential rate of error and what it is.
4. The existence and maintenance of standards controlling the technique's operation.
5. Whether the theory or technique is generally accepted in the relevant scientific community.

11 *KUMHO TIRE CO. v. CARMICHAEL*, 119 S.Ct. 1167, 1999 LEXIS 2189 (1999)
Nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert.

12 Expert Testimony on Children's Suggestibility: Should It Be Admitted?
Brian K. Holmgren 10(2) *APSAC Advisor* 10 (1997)

13 Focused and leading questions vary in the degree of their suggestiveness.
What is *leading* and what is *suggestive* are largely in the eye of the beholder.

14 Suggestibility Factors

- → interviewer's mental set
- → stereotypes
- → erroneous suggestions
- → delay
- → intimidating environment
- → repeated questioning
- → form of question
- → secrecy inducements

15 "Suggestibility is an extremely complex, multiply determined phenomenon. Situational factors such as the interview context, the nature of the questions used, and the strength of one's memory of the event in question interact with personality variables to influence the suggestibility of both children and adults." "Therefore, the same individual may be highly susceptible to being misled in one situation, yet highly resistant to being misled in a different situation."
Reed, D.L. (1996). Findings from Research on Children's Suggestibility and Implications for Conducting Child Interviews. 1(2) Child Maltreatment 105-120.

16 *Jeopardy in the Courtroom*
"In short, we urge expert witnesses to review the full corpus of relevant scientific work, describing the magnitude of errors, the inconsistencies within and across studies, and the boundary conditions that might limit any generalization from the science to the case at bar."
"So to repeat, although the literature is skewed toward case studies that entail weaknesses, these

are probably not the most common type of cases."

17 "Although the literature clearly reveals age differences in overall suggestibility, the exact mechanisms involved in producing distortion in young children's reports are still being debated by researchers. Until there is a consensus, nothing like a *Frye* test standard can be met to account for the mechanism by which age differences in suggestibility arise.

Ceci & Bruck, *The Suggestibility of the Child Witness: A Historical Review and Synthesis* (1993)

18 *Reasons For Use Of Leading Questions*
Developmental Capacities Of Children

- Ability to provide information using free recall vs. recognition
- Language skills
- Memory retrieval mechanisms

19 Reasons For Use Of Leading and Focused Questions

1. Protective concerns
2. Psychological dynamics of sexual abuse
3. Developmental considerations (cognitive, linguistic, emotional)
4. Other avenues exhausted
5. False Denials

20 Psychological and Sociological Dynamics of Sexual Abuse

- Adult's abuse of power and control
- Violation of trust
- Delayed and piecemeal disclosure process; inconsistent disclosures
- Threats to silence - fear and secrecy
- Emotional attachment to abuser
- Loss of control and autonomy
- Guilt & shame - repression, denial, avoidance, embarrassment & humiliation
- Isolation, abandonment and specialized treatment

21 *False Allegations and False Denials in Child Sexual Abuse.* Tom Lyon, 1(2) Psychology, Public Policy and Law, 429-437 (1995)

22 *The New Wave in Children's Suggestibility Research: A Critique.* Tom Lyon, 84(4) Cornell Law Review 1004-1087 (1999)

23 Multiple Interviews Or Not ?
Benefits

- May assist child in preparation for court
- Children recall more information
- Reinforces earlier recalled information
- Shortened attention span of children may not allow thorough interview pocess
- Disclosure process in sexual abuse cases frequently necessitates multiple interviews to obtain complete information

24 *False Negatives in Sexual Abuse Disclosure Interviews: Incidence and Influence of Caretaker's Belief in Abuse in Cases of Accidental Abuse Discovery by Diagnosis of STD.*

Louanne Lawson & Mark Chaffin, 7(4) Journal of Interpersonal Violence 532-542 (1992).

25 *False Negatives in Sexual Abuse Disclosure Interviews*

- 28 children ages 3 to menarche presenting to hospital with STD's
- No known prior disclosure or suspicion of sexual abuse
- Only 43% provided any verbal confirmation of sexual contact

- 57% were false negatives
- Caretaker attitude & support was critical variable in the child's disclosure process -children with supportive caretakers disclosed at a rate almost 3.5 times as great as those whose caretakers denied any possibility of abuse
- Aside from the STD many of the abused children presented free from any "suspicious" abuse symptoms, suggesting single interviews and red flags won't identify many hidden victims

26 ☐ *The Diagnosis of Child Sexual Abuse*. Dubowitz, Black & Harrington, 146 American Journal of Diseases of Children 688-693 (1992).

- 28 children with abnormal medical findings indicative of sexual abuse
- 25% provided no verbal information re sexual abuse even to skilled interviewers

27 ☐ *Sexual Abuse Evaluations in the Emergency Department: Is the History Reliable?* Stacy Gordon & Paula Jaudes, 20(4) Child Abuse & Neglect 315-322 (1996).

- 141 kids screened in ER for SA by MDT
- 54% abnormal exams; 10% had STD
- 27% made no ID of perp
- 15% no ID of perp during first interview; 83% of these kids had abnormal exam
- 12% recanted ID after interview
- 30% refused to speak with ER physician; adult had to act as the historian
- The mean ages of the kids recanting or failing to ID perp were significantly lower

28 ☐ *How Children Tell: The Process of Disclosure in Child Sexual Abuse.* Teena Sorenson & Barbara Snow, 70 Child Welfare 3-15 (1991).

- 116 cases of confirmed sexual abuse by plea (80%), conviction (14%) or medical evidence (6%)
- 74% of initial disclosures were accidental
- 72% initially denied abuse
- 78% moved on to tentative disclosures defined as the child's partial, vague or vacillating acknowledgment of abuse
- 70% gave further information over time
- 22% of kids recanted; 92% reaffirmed

29 ☐ *Children's Memories of Physical Examinations Involving Genital Touch: Implications for Reports of Child Sexual Abuse*. Saywitz, Goodman, Nicholas & Moan, 59 Journal of Consulting and Clinical Psychology 682-691 (1991).

- 72 girls, half 5-year-olds, half 7-year-olds
- Girls given physical exam, half included genital examination
- 1/2 interviewed week later, 1/2 after a month
- Children were interviewed using free recall, direct questions, misleading questions, and asked to provide a demonstration of the exam using anatomically correct dolls
- For the genital condition, 78% of the girls failed to disclose vaginal touching in free recall, and 83% failed to show genital touching in the demonstration
- Children who disclosed were younger
- 86% disclosed genital touch for direct question's
- For misleading questions, older children performed better than younger but error rates for all children were low
- Children in the genital condition answered abuse like questions less accurately than children in the non-genital touch condition. However, errors made were more likely to be omissions rather than false assertions

30 ☐ The Effect of Threats on Children's Disclosure of Sexual Abuse. Thomas Lyon, 9(3) APSAC Advisor 9 (1996).

31 ☐ What You Really Need To Know About Memory

Recognition

- Simplest & earliest memory task
- Young children can recognize familiar items as well as adults but have more difficulty with complex stimuli.
- Questions employing recognition allow kids to perform more like adults, but questions are often considered leading or suggestive.
- Multiple choice format for recognition type questions can reduce suggestibility

Free Recall

- Memory strategy most strongly related to age and development.
- Requires memory search for event and descriptive narrative response.
- Questions employ free narrative formats with open ended questions
- Information provided is the most reliable.
- With younger children this format produces quantitatively less information.

32 ☐ "Suggestibility concerns the degree to which children's encoding, storage, retrieval, and/or reporting of events can be influenced by a range of internal and external factors." Ceci 1993

33 ☐ Research Issues

Analog Studies

- ✪ General issues of memory
- ✪ No direct parallel to CSA

Example: staged event studies

Ecological Validity Studies

- o Tries to recreate aspects of CSA
- ✪ Can isolate one or a few aspects

Example: medical exam study

34 ☐ *Federal Rules of Evidence* Rule 403

Relevant evidence may be excluded if it's admission would result in unfair prejudice, lead to confusion of the issues, or result in a trial on collateral matters.

35 ☐ "It is for ordinary minds, and not for psychoanalysts that our rules of evidence are framed. They have their source very often in considerations of administrative convenience, of practical expediency, and not in rules of logic. When the risk of confusion is so great as to upset the balance of advantage, the evidence goes out." Justice Benjamin Cardozo, *Shepard v. United States*, 290 U.S. 96 (1933)

36 ☐ Scientific and expert testimony with their aura of special reliability and trustworthiness... courts the danger that the triers of fact will abdicate (their) role of critical assessment and surrender... their own common sense in weighing testimony. *State v. Batangan*, 799 P.2d 48 (Hawaii 1990)

37 ☐ To a jury recognizing the awesome dilemma of whom to believe, an expert will often represent the only seemingly objective source, offering it a much sought-after hook on which to hang its hat. *People v. Beckley*, 456 N.W.2d 391 (Mich.1990)

38 ☐ We have said it before, and we will say it again, but this time with emphasis -- we really mean it -- *no psychotherapist may render an opinion on whether a witness is credible in any trial conducted in this state. State v. Milbrandt*, 756 P.2d 620 (Or. 1988)

39 ☐ *Frye* Test: Basis for testimony must be sufficiently established to have gained general acceptance in the relevant scientific community

40 *DAUBERT v. MERRELL DOW PHARMACEUTICALS INC.*
509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993)

41 The subject of an expert's testimony must be "scientific...knowledge." The adjective "scientific" implies a grounding in the methods and procedures of science. Similarly, the word "knowledge" connotes more than subjective belief or unsupported speculation.

42 An additional consideration under Rule 702 - and another aspect of relevancy - is whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute.
...whether that reasoning or methodology properly can be applied to the facts in issue.

43 Rule 702's "helpfulness" standard requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility.
...scientific validity for one purpose is not necessarily scientific validity for other, unrelated purposes.

44 The inquiry envisioned by Rule 702 is, ... a flexible one. It's overarching subject is the scientific validity - and thus the evidentiary relevance and reliability - of the principles that underlie a proposed submission. The focus,... must be solely on principles and methodology, not on the conclusions they generate.

45 "Suggestibility is an extremely complex, multiply determined phenomenon. Situational factors such as the interview context, the nature of the questions used, and the strength of one's memory of the event in question interact with personality variables to influence the suggestibility of both children and adults." "Therefore, the same individual may be highly susceptible to being misled in one situation, yet highly resistant to being misled in a different situation."

Reed, D.L. (1996). Findings from Research on Children's Suggestibility and Implications for Conducting Child Interviews. 1(2) Child Maltreatment 105-120.

46 Suggestibility
- Complex & multiply determined
- Situational
- Unique to individual in context
- No simple relationship between age and suggestibility

47 Suggestibility Factors
- interviewer's mental set
- stereotypes
- erroneous suggestions
- delay
- intimidating environment
- repeated questioning
- form of question
- secrecy inducements

48 Psychological Research on Children as Witnesses: Practical Implications for Forensic Interviews and Courtroom Testimony, Myers, Goodman & Saywitz, 27 *Pacific Law Journal* 1-82 (1996)

49 Factors That Vary Across Studies
- Type of recalled event (observations vs. personal experience)
- Form of remembering task (Free recall, recognition)
- Length of delay between event and recall
- Single vs. multiple interviews
- Setting

→ Age of children

→ Type of questions posed to child

50 Limits of Research

→ Cannot replicate circumstances of abuse

→ Cannot replicate circumstances of disclosure

→ Results reported in terms of groups

→ Individual child may not perform as group

→ Statistically significant results vs. important results

→ Results reflect a spectrum of abilities rather than all or nothing

51 JEOPARDY IN THE COURTROOM

". . . [W]e focus disproportionately on [children's] weaknesses, because it is our contention that [these weaknesses] are less well understood by experts and nonexperts. . ." preface at x

". . . [A]lthough we think that there are data that highlight the potential weaknesses of children's reports, we do not think that these data are so consistent as to categorically discredit children from testifying or even to recommend skepticism upon hearing a child's disclosure." page 4

52 Extreme negative opinions about the young child's ability to resist leading questions that have been proffered throughout this century are unwarranted. Assertions from the earlier historical periods, such as '*Create, if you will, an idea of what the child is to hear or see, and the child is very likely to see or hear what you desire,*' are needlessly ungenerous views of children's abilities.
Ceci & Bruck (1993)

53 *Jeopardy in the Courtroom*

"In short, we urge expert witnesses to review the full corpus of relevant scientific work, describing the magnitude of errors, the inconsistencies within and across studies, and the boundary conditions that might limit any generalization from the science to the case at bar."

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Ceci & Bruck, *The Suggestibility of the Child Witness: A Historical Review and Synthesis*

55 "As social scientists whose opinions can influence legal and societal decisions, we have a duty in our presentation to the media and the courts to point out that the problem of suggestibility is circumscribed and complex."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements*. 1(2) Psychology, Public Policy & Law 450 .

56 APA CODE OF ETHICS

- 2.04 USE OF ASSESSMENT IN GENERAL AND WITH SPECIAL POPULATIONS
- *Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies of, and proper applications and uses of, the techniques they use.*
- *Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.*
- 3.03 AVOIDANCE OF FALSE OR DECEPTIVE STATEMENTS
- *Psychologists do not make public statements that are false, deceptive, misleading, or fraudulent, either because of what they state, convey, or suggest or because of what they omit, concerning their research, practice, or other work activities...*

- 7.04 TRUTHFULNESS AND CANDOR
- *In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions. Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.*

57 Arguments Against Relevance

❶ Unless the research protocol replicates the specific facts of the case in total, no expert can relate research findings to the facts of a particular case, or the abilities of a particular child witness.

❷ Research on jurors indicates they already believe children are highly suggestible; experts aren't needed to reinforce this belief.

❸ Highly suggestive interviews themselves undermine reliability in the child's account.

58 *Daubert* Criteria: Theory Tested?

→Little research on children over six

→No base rates for suggestibility factors at different ages of children; generalized reporting of data across age groups

→No research on the emotional component of disclosure & relationship to suggestibility factors

→Little recognition in research of child's initial disclosure and effects on accuracy and memory produced by subsequent suggestive questioning

→Little research on the effects of one or two improper interviews

→Little research on effects of stereotype induction involving a trusted/loved adult

→Little research testing children's resistance to suggestibility factors where children are told they can answer "I don't know/remember"

→No testing on actual abuse populations

59 *Daubert* Criteria: Error Rate?

→Research data not reported by specific age

→Conflicting data

→Suggestibility/reliability gauged by response to target questions; data not reported in terms of overall reliability of information provided

→Effect of confounding variables from tests involving multiple suggestibility factors

→Inability to account for individual differences

→Developmental age vs. chronological age

60 *Daubert* Criteria: Standards?

→ Divergent research methodologies and potential bias of protocols

→ One school focusing on weaknesses in children's memory and impact of suggestibility

→ Other highlighting children's strengths

→ Results reflect objectives of research and methodologies used to test hypothesis

61 *Daubert* Criteria: Standards?

→ No control in research for potential effects of linguistics in questions posed to children

→ Form of suggestive questioning varies across studies including use of forced choice questions

→ Statistically significant results involving insignificant events

→ Participatory vs. observed events

62 *Daubert* Criteria: Acceptance?

- ➔ Discrepant findings within and between studies
- ➔ Acknowledgment of need for further research
- ➔ Disagreement over whether suggestibility leads to erasure of the child's original memory
- ➔ Peer critiques in professional journals
- ➔ Acknowledgment of lack of scientific consensus

63 Cross: The Defense Speaks

- Cross-examination is an opportunity for the lawyer to testify through the witness
- It is not "the greatest legal engine" ever created for discovering the truth
- Jurors pay more attention on cross
- Beware the Trojan horse
- They want to get words for closing
- They're better at it than we are

64 Cross: Be Alert For The Traps

- Discuss likely areas for cross with prosecutor
- What role do you play in case - are you the target or a potential ally?
- The best cross-examinations are subtle - the punch won't be telegraphed
- What's the defense theory and how can it be countered?
- Prepare your responses in advance

65 Cross-Examination

- Do you want the standard burial or the catered affair?
- How well do you parry?
- Is your riposte as sharp as the attorney's thrust?
- Two types of effective questions:
  - The acknowledgment that's deadly
  - The double edged sword

66 Factors Which Influence Suggestibility in Interviews

- Interviewer's mental set - preconceived ideas, lack of objectivity
- Stereotypes about the subject of inquiry
- Erroneous suggestions
- Intimidating environment including the status of the interviewer
- Repeated questions & multiple interviews
- The form of the question (open ended, focused, leading, suggestive, coercive)

67 Cross Questions

Q: The child made a disclosure involving conduct of a sexual nature before you interviewed her?

Q: You were aware of the nature of that disclosure?

Q: You believed it to be a disclosure of sexual abuse?

Q: Your interview was conducted because you suspected the child had been abused?

68 Cross Questions

Q: Do you consider yourself to be an expert in how to interview children?

Q: Do you have any particular professional qualifications for your job of interviewing children?

Q: Are there any educational requirements for this job?

Q: Are there any certification procedures for interviewing children?

69 Cross Questions

Q: Is there a proper "method" or "protocol" for interviewing children?

Q: Did you follow that method or protocol in this case?

Q: Did you deviate at all from that method or protocol in this case?

Q: So it's okay if you do your own thing because you can justify it later, right?

70 Cross Questions

Q: You didn't tape record or videotape your interview with the child, did you?

Q: You didn't record all your interviews with the child, did you?

Q: How many times was the child spoken to that were not recorded?

Q: What was it about this child's story that caused you to record it?

Q: You didn't do that with all the other witnesses did you?

71 Cross Questions

Q: Aren't recordings the only way to ensure the interview was done appropriately?

Q: Aren't recordings the the only way to know for sure if the child's responses were influenced by your questions?

Q: How many rehearsals were done before you recorded the final product?

Q: You don't know how this child was influenced by prior interviews do you?

72 Cross Questions

Q: Children lie don't they?

Q: Children also lie about abuse right?

Q: And children are highly suggestible?

Q: Did you attempt to find out how suggestible this child was?

Q: Did you attempt to find out this child's reputation for honesty?

Q: Were you aware of this child's reputation for lying, delinquency, etc.?

73 Cross Questions

Q: You found no physical evidence to corroborate this child's allegations?

Q: There was no medical evidence of abuse was there?

Q: There were no witnesses to verify this child's claims were there?

Q: And as a trained investigator you looked hard to try and find some additional evidence but didn't right?

74 Cross Questions

Q: You're trained to put all important information in your reports, right?

Q: You didn't document several of these matters that we've just talked about in your reports did you?

Q: You selected the information you wanted to include in your report, yes?

Q: Why didn't you document these other facts you now claim occurred?

75 Cross Questions

Q: If you could do it all over again...?

Q: You would agree this was not a complete investigation?

Q: This wasn't done according to standard procedures was it?

Q: Are you not the least bit concerned that you didn't follow up on...?

Q: You agree it's your responsibility to conduct a competent investigation?

1 ☐ Making the Case Before You Go To Court - Meeting Untrue Defenses In Physical Abuse and Child Homicide Cases

- Brian K. Holmgren
- APRI's National Center for Prosecution of Child Abuse
- 99 Canal Center Plaza, Suite 510, Alexandria, VA 22314 (703) 739-0321

2 ☐ **THE DA'S PERSPECTIVE: ARREST IS NOT THE OBJECTIVE - CONVICTION IS**

- Patience and Finesse
- Verification and Corroboration
- Caretaker explanations are the starting point - thorough investigations establish the true end point
- Doctors make mistakes too - competent investigations supplement the medical opinion - they are not controlled by it
- Law enforcement may have a broader picture than medical personnel because of access to additional information including examination of the scene and statements from additional witnesses
- Many doctors are reluctant to identify abuse or will hedge on definitive identification of injuries as abusive
- Lots of doctors are not specifically trained in identifying child abuse injuries or lack substantive knowledge of this highly specialized area of practice
- See e.g. Carole Jenny, et al., Analysis of Missed Cases of Abusive Head Trauma, 281 JAMA 621-26 (1999). Dr. Jenny reported on 173 children examined at Children's Hospital in Denver between 1990-95 in which abusive head trauma was missed in 31% of the initial diagnosis. The research strongly suggested that the perceived socio-economic status, family dynamics and the stability of the people presenting the child for care were associated with missed diagnosis, suggesting that doctor's perceptions of "nice family values" may lead them to be less suspicious and hesitant to allege abuse.

3 ☐ **Wilbur L. Smith, Abusive Head Injury, 7 APSAC Advisor 16 (1994)**

- "In one series, over 95% of the initial histories supplied by the caretakers of abused children were false. This certainly mirrors our experience."
- "We have received a correct initial history in very few cases, and even in those cases the extent of trauma was minimized. The specious history often features a fall or choking event, rather than the true cause...".
- Serious injuries take serious trauma, and a child with serious head injury who is not involved in an automobile accident or a fall from several stories should be considered a possible victim of child abuse..."

4 ☐ **Difficulties With Abuse Cases**

- Conceptualizing parent as abuser
- Absence of visible trauma - grave internal injuries
- Delayed recognition of crime
- Lack of documentation and scrutiny of caretaker explanations for child's injuries
- Multiple crime scenes: privacy: lack of control
- Establishing requisite "mens rea"
- Multiple potential perpetrators
- Misdiagnosis of abuse by physicians
- Failure of CPS, law enforcement and prosecutors to understand significance of medical findings

- Timing of injuries
- Public perceptions and "backlash"
- Inadequate laws
- Conflicting medical evidence
- Uneducated judiciary
- Defense experts

5 ☐ STRATEGY OF DEFENSE EXPERTS

- To establish other "possibilities" for the child's medical findings
- To suggest possible causes or conditions that were not eliminated
- To substantiate D's claim that shaking was done to revive or wake up child
- To expand the time frame or window of opportunity for the injuries
- To support D's claim of "I didn't know..."
- To challenge the general science and existence of certain types of medical diagnosis

6 ☐ Medical References and Resources:

- Reece, R. ed. (1994). Child Abuse: Medical Diagnosis and Management. Philadelphia, PA: Lea & Febiger.
- Monteleone, J.A. & Brodeur, A.E. eds. (1994). Child Maltreatment: A Clinical Guide and Reference. St. Louis, MO: G.W. Medical Publishing, Inc.
- Ludwig, S. & Kornberg, A.E. eds. (1992). Child Abuse: A Medical Reference. 2d ed. New York: Churchill Livingstone.
- Giardino, A.P. et al. eds. (1997). A Practical Guide to the Evaluation of Child Physical Abuse and Neglect. Thousand Oaks, CA: Sage.
- The Quarterly Child Abuse Medical Update. The Institute for Professional Education, MSPCC, 399 Boylston Street, Boston, MA 02116 ($80 Annually)
- The Pediatric Trauma and Forensic Newsletter, 160 Washington SE, #234, Albuquerque, NM 87108 ($185 Annually, 10 Issues).

7 ☐ Legal References and Resources:

- American Prosecutors Research Institute, National Center for Prosecution of Child Abuse. (1993). Investigation and Prosecution of Child Abuse (2d ed.).
- DerOhannessian, P., Sexual Assault Trials, The Michie Co. (2d ed.1998).
- Stern, P. (1997). Preparing and Presenting Expert Testimony In Child Abuse Litigation: A Guide for Expert Witnesses and Attorneys. Thousand Oaks, CA: Sage.
- Holmgren, B. (1999 forthcoming). Prosecuting the Shaken Infant Case. To appear in Lazoritz, S., ed., The Shaken Baby Syndrome: A Multidisciplinary Approach. Haworth Press
- Parrish, R. (1998) The Battered Child Syndrome: Investigation of Child Physical Abuse and Homicide. United States Department of Justice.
- Lyon, T.D., Gilles, E.E. & Cory, L. (1996). Medical Evidence of Physical Abuse in Infants and Young Children. 28 Pacific Law Journal 93-167.
- Charles A. Phipps, Responding to Child Homicide: A Statutory Proposal, 89 Journal of Criminal Law and Criminology, in press (1999)

8 ☐ **Defense Expert Testimony - Identify Other Causes Not Eliminated**

- Laundry list of other natural or accidental causes
- Osteogenisis imperfecta
- Re-bleed of old injuries producing prior subdural hematoma

- Gluteric acidemia and alagille syndrome
- DTP vaccinations
- Meningitis
- Toxic causes
- Bleeding disorders
- Seizure disorder

9 ☐ **Defense Expert Testimony - Shaking to Revive or Awaken**

- Caretaker admits shaking
- No evidence of additional trauma
- Expert called to support reversal of factual order of events - child found non-responsive or in distress and child mildly shaken by panicked caretaker
- Acceptance of caretaker's explanation

10 ☐ **Defense Expert Testimony - Expand Time Frame for Injuries**

- Difficulty aging bruises, fractures & subdurals
- Delayed onset of symptoms with head and abdominal trauma
- Lucid interval
- Slow bleed - chronic subdural
- See generally, Willman, K.Y. et al., (1997). Restricting the Time of Injury in Fatal Inflicted Head Injuries. 21(10) Child Abuse & Neglect 929-940.

11 ☐ **Defense Expert Testimony - Support Claim of "I Didn't Know"**

- Neglect because parent didn't know any better, low IQ
- People who shake infants are unaware of risks or don't intend to harm
- The child seemed normal afterwards
- I did it before and nothing happened

12 ☐ **Defense Expert Testimony - To challenge the general science and existence of SBS**

- SBS is over diagnosed in the medical field and the darling of the child abuse zealots
- There is no agreement amongst doctors on the mechanism for trauma - whether there must be impact to produce sufficient forces to cause the injuries - since we don't know for sure we can't say in court
- You can't diagnose diffuse axonal injury without microscopic evidence of its existence
- There is no specific set of diagnostic criteria for SBS
- The absence in any given case of: (1) retinal hemorrhages, (2) retinal hemorrhages that are bi-lateral, (3) evidence of impact, and (4) metaphyseal, skull or rib fractures, precludes diagnosis of SBS

13 ☐ **COMMON AND UNTRUE DEFENSES**

- "I didn't know"; "I didn't mean to" (lack of requisite mental state for offense)
- I shook to save or resuscitate child
- Accidental fall, burn or other injury
- SODDI (Paramedic, other caretaker, sibling)
- Alternative medical condition or disease
- Discipline
- Alibi
- Religious exemption

- Cultural norm
- Self inflicted injury
- Poor investigation
- Reasonable doubt
- Intoxication
- Diminished capacity and insanity
- Battered Woman's Syndrome defense to neglect or failure to protect

14 ☐ **MEETING UNTRUE DEFENSES IN PHYSICAL ABUSE & HOMICIDE CASES**

- Prompt investigation with MDT
- Multiple investigators generally required to separate and interview caretakers individually, interview potential child witnesses, secure multiple potential scenes, collect evidence, etc.
- Early involvement of prosecutor with search warrants, presence at autopsy, interviews of witnesses and defendants
- Coordination with hospital and Medical Examiner
- Necessitates thorough understanding of child's injuries - nature, timing, mechanism & clinical course
- Awareness of developmental capabilities of victim
- Analysis of crime scene relative to statements
- Videotaped demonstration by perpetrator of mechanism and force used during shaking
- Establishment of motive evidence
- Discover and investigate "other acts" evidence
- Expert testimony
- Lay testimony supporting expert's
- Focus on histories provided by suspect
- Establish time frames & time line for caretakers relative to when victim well, onset of clinical symptomology, and other methods for timing the injuries
- Other caretakers called to testify they didn't abuse child, including medical personnel
- Testimony involving observations of prior inappropriate caretaking by suspect
- Theme development

15 ☐ **Statutory Interpretation**

- Intent to engage in act vs. intent to produce result
- "Knowing" - subjective vs. objective standard
- "Shaking must be of such force that an independent lay observer would recognize that it is likely to be harmful to the child" Dr. Robert Kirschner
- "There is no disagreement among professionals in the field that the violent shaking, whether or not it is accompanied by an impact, is not a casual act but rather one that would indicate to a rational observer that severe injury was being inflicted on the child." Wilbur L. Smith, Abusive Head Injury, supra.
- "While caretakers may be unaware of the specific injuries they may cause by shaking, the act of shaking/slamming is so violent that competent individuals observing the shaking would recognize it as dangerous..." American Academy of Pediatrics, Committee on Child Abuse and Neglect, Shaken Baby Syndrome: Inflicted Cerebral Trauma, 92 Pediatrics 872 (1993).
- "It matters not that it may have been Janice rather than Roger who struck the child at some

climactic moment. The jury could find that the parents were mutually supportive in their inhumane attitude toward the child and in abusing her physically and that they shared the mindset intrinsic to the crime." Commonwealth v. Lazarovich, 547 N.E.2d 940 (Mass. Ct. App. 1989)

- "Knowingly in child abuse does not refer to the actor's awareness that his action is practically certain to cause the prosecuted result. Instead, knowingly refers to the actor's general awareness of the abusive nature of his conduct in relation to the child, or his awareness of the circumstances in which he commits an act against the well being of the child." People v. District Court, 803 P.2d 193 (Colo. 1990).

16 ☐ **CHARGING - Case Prep**

- Background checks for D and witnesses
- Criminal records for D and witnesses
- Secure information on prior bad acts
- Review prior investigations (DHSS & police)
- Try to gain understanding of dynamics of family
- Obtain written statements from all witnesses
- Consider further use of search warrants and investigative subpoenas
- Obtain medical & treatment records
- Consider appropriateness of videotaped professional interview of any child witnesses
- Have photographs that were taken developed and carefully review
- Review any physical evidence
- Track down prior bad acts witnesses, determine availability and notify of possibility of testifying
- Secure attendance of material witnesses especially those from foreign jurisdictions if non-cooperative
- Insure crime lab analysis completed timely for discovery
- Prepare exhibits and demonstrative aids
- File and brief pre-trial motions

17 ☐ **Potential Motives For Abuse**

- "Motive" in the context of physical abuse and child homicide is unique from motives present in other types of crimes. Generally "motive" is not a purposeful mental state, but instead a risk factor or stressor which may produce reactive and abusive behavior by the child's caretaker. "Motive" in this context is important because it tends to explain why and how the abusive act occurs, although it does not excuse the conduct.
- Offender deliberately sets out to torture or abuse child - the sadistic personality of the offender or their general antisocial personality characteristics explain why they act out violently toward children.
- Triggering event producing anger/frustration (soiling, crying, behaviors of child, adult expectations for child's behavior)
- Child's medical or physical condition which is frustrating for caretaker
- Childcare responsibilities interfering with caretaker's work or recreation
- Alcohol or drug usage by caretaker
- Lack of experience with caretaking; inadequate parenting skills
- Lack of patience with children
- Inappropriate or unrealistic expectations for child's behavior
- Problems in domestic relationship (unexpected or unwanted birth, child care debates, general

discord, caretaking by only one parent, DV)

- Loss of job or unemployment
- Financial difficulties and poverty
- Lack of sleep, exhaustion
- Stress at home or work
- Post partum depression
- Munchausen Syndrome by Proxy

18 ☐ **Dating And Timing Of Injuries**

- Hypothetical for Expert
- Acute vs. Chronic
- Clinical Course of Injury - Symptomology
- Serious & Fatal Injuries vs. Less Traumatic
- CT's and MRI's (MRI can differentiate blood less than 6 hours old and more than 24 hours)(CT can be helpful in distinguishing relatively new - less than 3 days, from old - greater than 7 days)
- Blood samples from subdurals
- Bone Surveys. See generally, O'Connor, J.F. and Cohen, J., Dating Fractures, in Diagnostic Imaging of Child Abuse, P.K. Kleinman, ed., St. Louis: Mosby, Inc. (2d ed. 1998).
- Difficulties With Dating Bruises. See e.g. Schwartz, A.J. & Ricci, L.R. (1996). How Accurately Can Bruises Be Aged in Abused Children? Literature Review and Synthesis. 97(2) Pediatrics 254-57; Stephenson & Bialas, Estimation of the Age of Bruising, 74 Archives of Diseases in Children 53-55 (1996).
- Framing Through Lay Witness Observations of Child's Health
- Prior Medical Records Establishing Presence-Absence of Injury

19 ☐ **Background Investigation - Victim**

- Past medical history including prenatal care, birth records, pediatric records, insurance records, physicians, radiological surveys, pharmacology records, school and daycare records, DHSS records; obtain releases for records early in investigation
- Medical records for siblings
- Determine all prior caretakers
- Documents baseline for comparison to present condition
- Establishes absence or presence of preexisting medical condition
- May establish prior injuries to child (abusive, suspicious, unexplained)
- Establishes continuum of care/lack of care
- May establish prior warnings or education on proper caretaking (e.g., don't shake the child)
- May establish prior concerns of parent (apnea, not eating, colic)
- May establish potential stressors and motives (health condition requiring constant attention, colic, sleeplessness)
- Eliminates potential defenses
- May show child taken to multiple treatment providers to conceal history or avoid suspicion
- Munchausen Syndrome by Proxy established through prior history of medical treatment
- Establish developmental history of child also through D & other caretakers, pediatrician, neighbors & friends, relatives, church members, videotapes and photographs of child
- Want To Establish: Relative size and vulnerability of child to adult; preexisting medical conditions/limitations; general health of child including absence or presence of injuries; ability

to roll, stand, prop, sit, crawl, walk; dexterity of child including ability to support head; ability to grab and manipulate objects

- Measurements of child from fingertips to toes and arm span to establish ability to reach objects

20 ☐ **Background Investigation - Suspect**

- Past employment; residences
- Military history and records. See Thomas F. Boley, Investigative Liason with the Military, 11(2) APSAC Advisor 11-12 (1998) providing information on how to access military records.
- Prior contacts with police; DHSS; court system
- Criminal history including DV, animal abuse and traffic record
- Divorce records and records from family court proceedings
- Employment records; insurance & welfare records
- Prior domestic relationships; history of caretaking of children; paternity; divorce records
- Past history of alcohol or drug abuse
- Develops potential sources for introduction of "other acts" evidence and cross-examination of D and other witnesses

21 ☐ **Background Investigation - Crime Surroundings**

- Complete and certified copy of child's medical records including lab reports, discharge summaries, nurses notes, radiological reports including X-rays, CT's and MRI's, and photos taken by hospital
- D's statements to doctors, nurses, EMT's
- Information supplied to D by medical personnel and others re how injuries caused
- 911 tapes; review for background noises
- Separate interviews of caretakers who had immediate access to child
- Statements from former spouses, relationships
- Interviews of neighbors and friends
- Developmentally sensitive interviews of any siblings as potential victim's and witnesses
- Statements from prior caretakers, relatives, teachers
- Include all other siblings, children of D
- Prior police/CPS contacts with family and residence
- Link D to any prior abuse; establish opportunity to commit prior injuries to child or identity as perpetrator if possible

22 ☐ Crime Scene Investigation

- Child frequently moved; multiple scenes; delays in getting to scene and securing; alteration and D staging
- Expectation of privacy; 4th Amendment issues; no crime scene exception - Mincey v. Arizona, 437 U.S. 385 (1978)
- Admittance to scene via consent to search and search warrant; execute warrant
- Examine, corroborate, refute, seize and preserve; crime scene photos and diagrams
- SIDS component for diagnosis
- Use death-scene investigative checklists for abuse cases as well as homicides
- Search to include all potential scenes; multiple rooms and vehicles; exterior of dwelling
- Search to include trash receptacles and laundry
- Measurements of height of furniture and examination of floor coverings; measurement of highest items in home child could potentially fall from (usually refrigerator or stair landing);

seizure of relevant furniture items

- Instrumentality's of offense (weapons, objects) especially with patterned injuries
- Trace evidence (blood, hair, fibers)
- Motive evidence (soiling, vomitus, illness, colic, messes or spills, monitors or devices for special needs child)
- Life insurance policies on children
- Fingerprints especially for staged crime scene and on instrumentality's
- Evidence of neglect, quality of caretaking
- Baby bottles and baby food containers
- Evidence of drug and alcohol usage
- Medications child taking or deprived of
- Child's clothing, bedding and toys
- Paraphernalia used and discarded by rescue personnel
- Potential poisons and chemicals including salt, alcohol and insulin
- Photos and videotapes of child showing developmental levels
- Childcare books and magazines
- Telephone records
- Be vigilant for anything that looks out of place

23 ☐ **Crime Scene Investigation - BURNS**

- Examine all sources of heat in home: don't limit to sources identified through caretaker's explanation
- Water heater settings: conduct time/temp studies
- Determine if prior complaints re water temperature made to landlord
- Obvious presence of steam when only hot water is on
- Examination of sink or tub including drain
- Eliminate accidental explanations
- Objects (irons, lighters, grates, cigarettes)
- Chemicals (Downey, Draino)
- Trace evidence (skin in drain or on objects, blood on bandages or clothes or blankets, salves used as home remedy)
- Is the appearance, pattern and depth of burn consistent with the history?
- Is the history consistent with time/temp studies and injury pattern? (e.g. presence of splash injuries to support accidental burn, irregular pattern, burns of unequal depth. Clothing worn may alter burn patterns)
- Does the history change or remain consistent?
- Does the history include crying by child after the burn injury?
- Deliberate injuries characterized by:
  - uniform burn depth
  - sharply defined and relatively straight waterline marks in immersion burns
  - stocking or glove patterns
  - absence of classic arrow down patterns when children are held under running water
  - bilateral distribution of scald injuries
  - isolated deep partial or full thickness burns
  - well defined, distinct patterned injuries from hot objects
  - cigarette burns that are full thickness are inconsistent with "accidental touching or brushing" requiring

more time and contact to produce
- simultaneous deep scald burns of the buttocks, perineum and feet
- absence of splash marks
- multiple burns of same or different age
- presence of other non-burn injuries

24 ☐ **Photodocumentation of Child Abuse**

- CT's and MRI's
- Bone surveys: multiple over time
- Photograph child ASAP and on multiple occasions over time: use multiple cameras to ensure photographs turn out
- Body diagrams; location & configuration
- Infrared and blacklight photography. See Michael West & Robert Barsley, Selected Forensic and Physical Evidence Experts, 11(4) NDAA Bull. 8 (1992)
- Color coded photographs; measured injuries: slides vs. 35mm
- Bitemark evidence
- Comparison photographs with patterned injuries and instrumentality
- Bilateral and angled photographs of extremities for comparison of swelling
- Injury reconstruction with dolls
- Videotaped demonstrations by D of mechanism

25 ☐ **Insure Adequacy of Autopsy**

- Radiological survey including MRI for suspected head trauma; "skeletal survey" involving multiple projections rather than "babygram" which is much less discriminating. See Kleinman, P.K., et al., Radiologic Contributions to the Investigation and Prosecution of Cases of Fatal Infant Abuse, 320 New England Journal of Medicine 507-511 (1989); Kirschner, R.H. and Wilson, H.L., Fatal Child Abuse: The Pathologist's Perspective, in Child Abuse: Medical Diagnosis and Management, (R. Reece ed. 1994).
- Tissue samples from fractures and bruises
- Preservation of retinas and optic nerve sheath where hemorrhage or detachment present. (Optic nerve sheath hemorrhages cannot be identified accurately in the living child)
- Toxicological screening (preserve blood samples for additional testing)
- Stomach contents (framing time of death)
- Photodocumentation and injury diagrams
- Coordinate with scene investigation
- Insure history, background information, and results of crime scene investigation provided to ME to assist with determination of cause and manner of death
- Obtain hair and blood samples from victim for comparison with possible trace evidence
- Examination of spinal column and cord, base of brain, and ribs in SBS cases
- Microscopic and dissected examination of bruises to assist in aging injuries
- Reexamination after 24 hours for additional bruises or other injuries
- Eliminate other causes of death or injuries

26 ☐ **INTERVIEWING THE SUSPECT**

- Take your time - delay arrest
- Be non-confrontational early
- Interview independently of other caretakers
- Obtain general information on child and family

- Determine history of prior caretaking of other children
- Information on how other caretakers handled child and general description of quality of caretaking relationship
- Develop sources for records
- Develop time line for days preceding injury or death including child's feeding and sleeping schedule, activities, demeanor, behavior, other caretakers, etc.
- Know the facts and import of medical findings
- Videotaped demonstration of how injuries occurred
- Don't suggest defenses or mechanisms during initial questioning
- Seek elaboration and details. If suspect is not talking about child's behavior, we should be asking for specific details re child's behavior immediately before and after traumatic event (e.g. how child crying, eating and sucking, stretching and moving, playing, tracking of eyes, showing any distress, etc.)
- Potential use of polygraph if no admissions. Be careful of state of mind and mens rea questions.

27 ☐ **Explanation For Injury**

- 95% of initial caretaker histories in abuse cases are false
- Strong evidence of consciousness of guilt
- Necessitates multiple interviews
- Provides identity for abuser
- Independent interviews of caretakers - generally no marital privilege re child abuse
- Interview quickly to obtain initial explanations for injuries before opportunity to collaborate and obtain diagnosis from medical personnel
- Multiple potential sources for prior histories - interview everyone who saw child and spoke with defendant
- Essential component in medical diagnosis
- Single most important source of information
- Source - Caregiver or hearsay; present during event; reason for absence of eyewitness
- History may be based on actual events but sequence may be reversed or altered to alleviate or shift responsibility
- Inexperienced doctors may accept false histories because of reluctance to accuse and lack of training in recognizing abuse injuries
- Lack of concern expressed for child's condition
- Admitted delays in seeking medical treatment
- Denial or admission of clinical symptoms
- Critical condition prompting medical intervention
- Admission regarding triggering event or stressor
- Caretaker's coping mechanisms for stressors and response if unsuccessful
- Inadequate explanation for injury, trivial trauma to explain major injury
- Explanation beyond developmental capabilities
- Explanation of child's post-trauma behavior inconsistent with condition
- Blame shifting to sibling or spouse, doctors, nurses, EMT's
- Changing history when confronted - document information provided to caretaker by medical personnel prompting changes in explanation
- Conflicting explanations by caregivers

- Injury location - configuration inconsistent with claimed mechanism
- Claim injuries self inflicted (head banger, turned on tap water)
- Claim child bruises easily
- Unrealistic expectations for child's "good" or "acceptable behavior (child "wimp" because cried all the time, child wouldn't listen when I told it to do something)
- Teach child lesson or had to discipline child
- Timing of injuries inconsistent with history
- Denial of knowledge of how injury caused
- Other witnesses or knowledgeable persons may also provide false histories because of their own participation, fear of retribution, fear of loss of other children, view loss of D as detrimental to family, denial, acceptance of D's account
- False history or failure to provide critical information to medical personnel during treatment

28 **Common Suspicious Stories - The Dirty Dozen**

- 1. Child fell from a low height such as a couch, bed, crib or chair
- 2. Child fell and struck head on floor or furniture, or hard object fell on child
- 3. Child unexpectedly found dead (age and/or circumstances not appropriate for SIDS)
- 4. Child choked while eating and was therefore shaken or struck on back
- 5. Child suddenly turned blue or stopped breathing, and was then shaken
- 6. Sudden seizure activity
- 7. Aggressive or inexperienced resuscitation efforts to a child who suddenly stopped breathing
- 8. Alleged traumatic event one day or more before death
- 9. Caretaker tripped or slipped while carrying child
- 10. Injury inflicted by sibling
- 11. Child left in dangerous situation (e.g. bathtub) for just a few moments
- 12. Child fell down stairs
- From: Dr. Robert Kirschner and Dr. Harry Wilson, Fatal Child Abuse: The Pathologist's Perspective, in Child Abuse: Medical Diagnosis and Management, Robert Reece, ed. (1994)

29 ## Injuries Produced by SBS

- Contusions to brain, tears to brain tissue, diffuse axonal injury, edema, ICP, atrophy, death
- Mental retardation, cerebral palsy, paralysis
- Subdural and subarachnoid hemorrhage; 90% of kids who die from inflicted head trauma have subdurals vs. 20% of kids who sustain massive accidental head trauma
- Subdurals are a marker for injury to the brain, they are not what causes the child's death: death usually results from edema or from direct trauma to the brain which results in death before edema can occur
- Retinal hemorrhage (often bilateral), retinal detachment and optic sheath injury
  - Not medical consensus on mechanism (ICP, pulling and shearing strain on eye and optic nerve)
  - Bilateral pathognomonic for abuse but may appear in only one eye or not at all
  - CPR not cause (Perloff summary of seven peer reviewed research studies, three of which were single case reports and remainder were prospective studies of consecutive patients receiving CPR or retrospective studies of autopsy findings. Total of 288 children reviewed, only four, 1%, had retinal hemorrhages possibly due to CPR and all were distinguishable form the types of findings seen in SBS cases, e.g. the types of hemorrhages were different or there was no associated brain injury)
  - Research reports indicate present in 25-75% of SBS cases depending in large measure on quality of examination
  - Marker for severe whiplash forces to head

- Retinal Hemorrhages occur in less than 5% of infants with accidental trauma and only in association with a high-energy event and major intracranial injury. (Perloff summary of six peer reviewed research studies involving 291 children injured by accidental means found only three, 1%, with retinal hemorrhages, all were involved in MVA's, two died and the other had cerebral contusions)
- Presence of retinal hemorrhage is strongly suggestive of shaking injury, their absence is non-diagnostic, i.e. it does not exclude shaking as mechanism.

- Blindness
- Damage to upper cervical cord
- Metaphyseal fractures to long bones - high correlation between subdurals and fx's of long bones
- Fractures to skull, cervical column and ribs
- Contusions and abrasions to trunk
- Clinical symptomology
- The combination of retinal hemorrhage, subdural hematoma and cerebral edema are characteristic of SBS, and other potential causes for the co-occurrence of these three symptoms are remote. However, not all of these symptoms need be present for a diagnosis of SBS.
- Clinical symptomology includes: lethargy; extreme irritability; breathing difficulties; gaze disturbances; vomiting; poor sucking or swallowing; bulging or spongy; coma; forehead; unequal size of pupils; bloodshot eyes; seizures; rigidity of extremities.

30 ☐ Shaken Baby Syndrome

- Rapid development of neurological impairment with severe or fatal head injury; decreased level of consciousness or unconsciousness
- Identifies when injury occurred; drastic changes in child's behavior should be readily apparent; narrows class of perpetrators
- Frequent presence of old subdurals, fractures
- High incidence of death
- Injuries may be produced by shaking alone without impact
- Shaking combined with impact produces more rapid deceleration increasing the shearing forces several fold
- Shaking injuries require 10-30 G's of force
- Rotational components to shaking also increase shearing forces
- Not trivial force; equivalent to 50-60 m.p.h..... auto accident or fall from several story building; compare to G forces from roller coaster ride
- Over 50% of fatal shaking involves impact
- Presence of edema, diffuse axonal injury and/or retinal hemorrhages is a clear indication of greater forces
- Many forensic pathologists and pediatric specialists feel that SBS cases involving death or more serious injuries require impact to generate sufficient forces to produce this degree of injury. Other professionals suggest that shaking alone is sufficient. This debate amongst professionals is ongoing but can cloud the issue in the more serious cases where there is not physical evidence of blunt trauma to the head. However, impact against a soft object can increase shearing forces and leave no signs of impact. For a discussion of these issues see DiMaio and DiMaio (1989) Forensic Pathology, p. 323-325, Elsevier Publishing; Duhaime, A.C. et al. (1987) The Shaken Baby Syndrome: A Clinical, Pathological and Biomechanical Study, 66 J. Neurosurg. 409-415; and authorities cited supra under Medical References and Resources.

31 ☐ **Williams, R.A., Injuries in Infants and Small Children Resulting from Witnessed**

and Corroborated Free Falls, 31(10) Journal of Trauma 1350 (1991).

- 106 children under 3 with witnessed and corroborated falls by someone besides caretaker
- Only 3 serious but not life threatening injuries from falls under 10 ft.
- 53 children under 3 with uncorroborated falls
- 18 had severe injuries and 2 deaths from falls under 5 ft.
- Conclusion from study is that children rarely sustain serious injuries from short falls and presence of severe injuries resulting from claimed short falls are highly indicative of abusive trauma

32 ☐ **U.S. v. Gaskell, 985 F.2d 1056 (11th Cir. 1993)**

- Defense argued doctor's demonstration of force necessary to produce victim's SBS injuries using a rubber mannequin was irrelevant and prejudicial
- Defense objection that doll was not similar in size, weight and neck rigidity to victim; more force needed in demonstration to produce head movement on doll than on victim; doctor conceded this on cross
- The conditions of the demonstration were not sufficiently similar to the alleged actions of the D to allow a fair comparison
- A greater degree of force was required to produce the head movement characteristic of SBS in the doll
- Doctor was unable to state the number of oscillations necessary to produce the victim's injuries
- Prosecution failed to establish that either the degree of force or number of oscillations bore any relationship to the D's actions
- By displaying greater force than level required to produce SBS in victim, and by arbitrarily selecting number of oscillations, demonstration tended to implant a strong impression of D's conduct that was not supported by a factual basis
- Generalized demonstrations of mechanisms for trauma which do not purport to demonstrate length of time for shaking or force needed to produce may avoid Gaskell ruling. See e.g. State v. Candela, 929 S.W.2d 852 (Mo. App. 1996).
- Limiting testimony to verbal descriptions of the type of force necessary to produce the injury, including expert testimony that force is "something that any responsible adult would perceive as dangerous." See State v. Ojeda, 810 P.2d 1148 (Idaho Ct. App. 1991).
- Other case law has distinguished Gaskell. See e.g., State v. Powell, 487 S.E.2d 424 (Ga. App. 1997); United States v. White, 1996 W.L. 399973 (A.F.C.M.R. 1996)(upholding doctor's demonstration with teddy bear of force and type of shaking); Roberts v. State, 1997 Ark. App. LEXIS 461 (Ark. Ct. App. 1997)(demonstration of force upheld where defendant did not challenge that force applied was different and it was not used to prove duration of shaking)
- A videotaped demonstration by the defendant of the mechanism and force used during the shaking would permit the expert to comment on the demonstration and offer an opinion whether it is consistent with the type of injuries observed.
- Impact changes force dynamics necessitating inquiry of the defendant regarding presence of impact.
- False histories provided by defendant's compound difficulty in relying on the history as a foundation for an in court demonstration.

33 ☐ **Munchausen Syndrome By Proxy**

- "Munchausen Syndrome by Proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures." Zumwalt & Hirsch, Pathology of Fatal Child Abuse and Neglect, in Child Abuse

and Neglect, 276 (R. Helfer & R. Kempe, eds. 4th ed. 1987)

- "Munchausen Syndrome by Proxy (MSBP) may be defined as the cluster of symptoms and/or signs, circumstantially related, in which: (1) illness in a child is simulated (faked) and/or produced by a parent or someone who is in loco parentis; and (2) the child presents for medical assessment and care, usually persistently, often resulting in multiple medical procedures; and (3) knowledge about the etiology of the child's illness is denied by the perpetrator; and (4) acute symptoms and signs in the child abate when the child is separated from the perpetrator."
- Simulated illness: one that is faked by the perpetrator but does not directly cause harm, the harm is caused by the medical care the child receives as part of the diagnosis or treatment.
- Produced illness: one that is inflicted upon the victim by an act of the perpetrator.
- Rosenberg, D., Munchausen Syndrome by Proxy, in Child Abuse: Medical Diagnosis and Management (R. Reece, ed. 1994).
- Caretaker engages in behavior to gain attention and sympathy for themselves, not child
- Recognized by medical profession as a form of child abuse with potentially severe medical and emotional consequences for child
- Equal distribution of male and female victims; most are infants and toddlers
- May have serial abuse within family although abuse generally confined to one sibling at a time. See Alexander, R.A., Smith, W., and Stevenson, R., Serial Munchausen Syndrome by Proxy, 86 Pediatrics 581 (1990)((estimated 25-35% of cases). Abuse to other siblings may provide strong "other acts" evidence. May have similar presentations with other children tending to show modus operandi and absence of mistake or accident, as well as intent.
- Older children may adopt the false symptoms as their own
- Symptomology in child generally progresses in severity and frequently results in death
- Several basic types of scenarios
  - Exaggerated, false or misconceived medical history or illness
  - Altered laboratory specimens or medical records
  - Assault on child to produce physical signs or symptoms
  - Deliberate poisoning
- Mortality and morbidity rate in latter two scenarios is very high.
- Rosenberg, D.A., Web of Deceit: A Literature Review of Munchausen Syndrome by Proxy, 11 Child Abuse & Neglect 547-563 (1987)(9% mortality); Meadow, R., Suffocation, Recurrent Apnea and Sudden Infant Death Syndrome, 117 Journal of Pediatrics 351-57 (1990)(33% mortality).
- Mean time between onset of symptoms and establishment of a medical diagnosis of MSBP is 15 months, with some cases documenting delay in discovery up to 20 years.

34 **Munchausen Syndrome By Proxy - Common Symptoms and Causes**

- Bleeding from various sites (mother's blood added to specimen, warfarin or phenolphthalein poisoning, use of substances such as cocoa or dyes)
- Neurological symptoms such as drowsiness, apnea, and seizures (lying, poisoning or medications, suffocation)
- Rashes (caustic solutions, phenolphthalein, scratching)
- Fevers (rubbing thermometers, hot water)
- Gastrointestinal disorders, vomiting, diarrhea (lying, ipecac, contaminants in food, laxative poisoning)
- Poisoning (sodium, insulin, feces, medicines)
- Toxicological screening and cultures may provide critical forensic evidence in many types of cases.

- Searches of perpetrator's homes, personal belongings (e.g. handbags or suitcases), and vehicles may produce instrumentality of crimes.
- Extensive review of past medical records needed to make diagnosis. Critical examination of the records is needed since records will contain many improper diagnosis by medical personnel who "buy into" perpetrator's claims.

35 ☐ **Munchausen Syndrome By Proxy - Red Flags of Diagnosis**

- Adapted by Robert Reece from Meadow, R., What Is and What Is Not MSBP?, 72 Arch. Dis. Child. 534-538 (1987).
- 1. Persistent or recurrent illnesses that cannot be explained or are very unusual.
- 2. Laboratory results and physical findings that are at variance with the general health of the child.
- 3. Puzzling symptoms and signs that cause experienced physicians to say they "have never seen a case like it before."
- 4. Symptoms and signs that do not occur when the child is away from the caretaker.
- 5. A caretaker who is particularly attentive in prolonged visiting or living with child in hospital.
- 6. Treatments that are not tolerated (tape or local treatment that produces a rash).
- 7. A caretaker who does not seem as concerned about the child's illness as the medical and nursing staff, or one who meddles and is argumentative about all aspects of treatment.
- 8. Seizures that do not respond to carefully administered anticonvulsants and/or are only witnessed by the caretaker.
- 9. Polymicrobial bacteria, especially with Gram negative organisms
- 10. Atypical episodes of SIDS or claimed "near miss" SIDS. There is no such thing as a near miss SIDS; these are more properly classified as apparent life threatening events and are highly suspicious for abuse.
- 11. A caretaker who has symptoms of MSBP herself or has a borderline personality disorder.

36 ☐ **MSBP - Diagnosis or Defense?**

- Am I bad or am I mad?
- MSBP is not recognized as a specific mental disease or illness under the DSM IV. Instead it is discussed there within the context of Factitious Disorders by Proxy. Disagreement exists on whether this nomenclature of "Factitious Disorders" is a form of mental disorder or simply a nomenclature for a specific type of behavior. The research criteria for Factitious Disorder by Proxy includes "the behavior is not better accounted for by another mental disorder" suggesting the application of this category to MSBP cases is one of default - they have no other recognized mental disorder to ascribe to the behavior.
- No psychological test for MSBP.
- MSBP describes actions of perpetrator, not mental status or psychological profile. It is not a mental health problem of the mother or the child but rather an interactional deceptional problem. (Alexander, R.A.)
- For a discussion of the psychological and definitional constructs of MSBP, see Teresa F. Parnell, Defining Munchausen by Proxy Syndrome, in Munchausen Syndrome by Proxy: Misunderstood Child Abuse, Parnell, T. F. & Day, D. O. (Sage 1998).
- Women often have other attendant psychiatric problems (e.g. borderline personality disorder, dissociative and delusional disorders).
- Abusers may seek to introduce MSBP as a defense based on diminished capacity or non-responsibility/insanity. The extremely premeditated, calculated and deceitful nature of this behavior suggests that such conduct would not satisfy the ALI criteria for "unable to appreciate the wrongfulness of the behavior." However, those supporting its use as a defense

will point to the claimed "compulsive" nature of the behavior under the ALI criteria for "unable to conform conduct to the requirements of the law."

- Prosecutors should strenuously contest inclusion of MSBP as a mental disorder, disease or illness, and avoid suggesting that the perpetrator "suffers" from MSBP, even as support for arguments involving treatment of offenders. The appropriateness of treatment, and its likelihood of success is itself hotly debated. The potential for successful treatment may depend in large measure on the type of classification of behavior by the perpetrator, with those engaging in produced illness being the most dangerous and likely to reoffend, and least responsive to intervention measures.
- MSBP is a recognized medical diagnosis of child abuse
- Prosecutors frequently want to introduce testimony involving MSBP to establish the parent's motive for the abuse, or to provide an explanation for the seemingly bizarre behavior of the abuser.
- For a discussion of the use of MSBP in criminal and civil prosecutions see Robin Wilkinson and Teresa F. Parnell, The Criminal Prosecutor's Perspective, in Munchausen Syndrome by Proxy: Misunderstood Child Abuse, Parnell, T. F. & Day, D. O. (Sage 1998).

37 ☐ **SIDS - Definition**

- "The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and a review of the clinical history" American Academy of Pediatrics (1994). Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities.
- SIDS far more common than infanticide
- 5000-7000 SIDS; 1200-1500 homicides
- SIDS most common cause of death for children between 1-12 months
- 80% occur before 5 months of age, 90% by 6 months, peak 2-4 months
- 60-70% boys, 30-40% girls
- Recent literature suggests less than 5% of apparent SIDS deaths are due to abuse, but precise data are lacking
- In Massachusetts where autopsy rate has been close to 100% for several years, data from Massachusetts SIDS Center show that in 806 sudden, unexpected infant deaths from 1982 to 1990 there have been only 5 cases (0.6%) attributable to fatal child abuse. (Reece) Underscores importance of autopsy as a discriminator.
- More common in winter months
- Higher incidence in multiple births, twins and triplets have rate of incidence 2.5 times greater than single birth child.
- "The appropriate professional response to any child death is compassionate, empathic, supportive, and non-accusatory. At the same time it is vital to discover the cause of death if possible. Unless there is a history of significant antecedent illness or there are obvious injuries, the parents can be told that death appears to be due to SIDS, but that only with a thorough scene investigation, post-mortem examination, and review of the records can other causes be excluded." American Academy of Pediatrics (1994). Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities.

38 ☐ **Distinguishing SIDS from Homicide**

- See generally, Reece, R., Fatal Child Abuse and Sudden Infant Death Syndrome, in Child Abuse: Medical Diagnosis and Management (R. Reece ed. 1994); Reece, Criteria for Distinguishing SIDS from Fatal Child Abuse and Other Medical Conditions.
- Autopsy cannot distinguish death by SIDS from death by suffocation

- Features raising possibility of suffocation or homicide include (1) previous episodes of apnea in same person's presence, (2) previous unexplained medical disorders such as seizures, (3) age at death over 6 months, (4) prior history of abusive injuries to child, (5) prior unexpected or unexplained deaths of other children in family, (6) prior law enforcement or CPS contacts with family especially for violent behavior
- No diagnostic test for SIDS and no known etiology
- Serosanginous nasal discharge seen in approximately 58% of SIDS cases. However, blood has been found on the face of children in a significant percentage of homicide cases. See e.g. Southall study, supra; Truman & Ayoub study not yet published.
- Pathologists diagnose SIDS by exclusion when unable to identify another specific cause for the child's death
- Without a complete autopsy, careful scene investigation, and review of the medical history, SIDS diagnosis cannot be made
- Death should be ruled SIDS when:
- A complete autopsy is done and findings are compatible with SIDS
- No gross or microscopic evidence of head trauma, cervical cord injury, retinal hemorrhage or mechanical asphyxia
- No evidence of trauma on skeletal survey
- Other causes of death are ruled out
- No evidence of current alcohol, drug or toxic exposure
- American Academy of Pediatrics (1994). Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities.

39 ☐ **Kempe, et. al., The Battered Child Syndrome, 181 JAMA 17 (1962)**

- "The Battered Child Syndrome may occur at any age, but in general the affected children are younger than 3 years. In some instances the clinical manifestations are limited to those resulting from a single episode of trauma, but more often the child's general health is below par, and he shows evidence of neglect including poor skin hygiene, multiple soft tissue injuries, and malnutrition."
- "A marked discrepancy between clinical findings and historical data as supplied by the parents is a major diagnostic feature of the Battered Child Syndrome... Subdural hematoma, with or without fracture of the skull...is an extremely frequent finding even in the absence of fractures of the long bones... The characteristic distribution of these multiple fractures and the observation that the lesions are in different stages of healing are of additional value in making the diagnosis."
- Not all of the listed features need be present to make a diagnosis, and the injuries do not need to be in different stages of healing or result from multiple incidents. See Schleret v. State, 311 N.W.2d 843 (Minn. 1981).

40 ☐ **Estelle v. McGuire, 112 S.Ct. 475, 116 L.Ed.2d 385 (1991)**

- Evidence of Battered Child Syndrome Admissible to Prove:
- Intent; Absence of Mistake or Accident; Identity
- Even if the defendant does not raise "accident" as a defense, evidence of Battered Child Syndrome is admissible to prove intent... "The prosecution's burden to prove every element of the crime is not relieved by a defendant's tactical decision not to contest an essential element of the offense."
- Battered child syndrome "exists when a child has sustained repeated and/or serious injuries by non-accidental means...Evidence demonstrating BCS helps to prove that the child died at the hands of another and not by falling off a couch, for example; it also tends to establish that the 'other,' whoever it may be, inflicted the injuries intentionally.

- "When offered to show that certain injuries are a product of child abuse, rather than accident, evidence of prior injuries is relevant even though it does not purport to prove the identity of the person who might have inflicted the injuries."
- "The proof of battered child syndrome itself narrowed the group of possible perpetrators to the (defendant) and his wife...Only someone regularly 'caring' for the child has the continuing opportunity to inflict these types of injuries: an isolated contact with a vicious stranger would not result in this pattern of successive injuries stretching through several months."

Fatal Child Abuse and Sudden Infant Death Syndrome: A Critical Diagnostic Decision

Abstract

Distinguishing between an unexpected infant death due to sudden infant death syndrome (SIDS) and one due to fatal child abuse challenges pediatricians, family physicians, pathologists, and child protection agencies. If child abuse is suspected, the physician must fulfill mandated legal obligations to report the case to the appropriate authorities. Coroners, medical examiners and pathologists have the added responsibility of rendering a medicolegal opinion as to the cause and manner of death.

Learning Objectives

- To review historical inquiries into the Sudden Infant Death phenomena
- To define SIDS
- To describe the clinical presentation of SIDS
- To cite the incidence and epidemiology of SIDS
- To distinguish between SIDS and fatal child abuse
- To describe the role of the autopsy
- To delineate the clinical radiographic study in SIDS
- To identify the importance of death scene investigation to the overall postmortem examination
- To describe criteria for distinguishing SIDS from fatal child abuse and other medical conditions
- To recommend improved practices for determining cause and manner of unexpected infant deaths

Outline

I. Child Protection Needs

II. Historical Background

III. Definition of SIDS

IV. Clinical Presentation of SIDS

V. Incidence and Epidemiology of SIDS

VI. Distinguishing Between SIDS and Child Abuse

VII. Role and Importance of the Autopsy

VIII. Radiographic Studies

IX. Death Investigation: Scene Investigation and Past Medical History

X. Criteria for Distinguishing SIDS from Fatal Child Abuse and Other Medical Conditions

XI. Child Death Review Teams

XII. References

Child Protection Needs

Child protection agencies need to ensure that other children in the home are not at risk. Law enforcement personnel and prosecutors need to proceed if the law has been broken. All agree that the state of our knowledge in this area is incomplete and ambiguity exists in some cases. For everyone concerned, it is necessary and desirable, within the limits of our capability, to know the cause and manner of an infant death. This process requires application of current knowledge, a desire to know the reasons for the deaths, the resources necessary to conduct essential procedures, and the sensitivity and wisdom to perform the task without causing distress to innocent family members.

Historical Background

The history relevant to this presentation is a relatively short one. In the first half of this century, searching for the reasons infants die was the lonely province of a few clinicians, researchers, and pathologists who examined the retrospective traces of infant deaths. Bergman recounts the slow progression of knowledge about sudden unexpected infant death in the pathologists laboratories and morgues where Werne and Garrow and then Adelson and Kinney proposed etiologies for "crib death" other than suffocation. Since the 1950s the pediatric pathologist Marie Valdes-Dapena has been the most consistent researcher, educator, and translator of scientific information about SIDS to the clinical community and the lay public, and her recent review summarizes this material. Parents who had lost their infants began to press the question "Why did my baby die?' forming several grassroots organizations to raise public awareness and stimulate legislative activity to foster research and to provide centers for information and counseling for bereaved parents. Now called the SIDS Alliance, these efforts continue to spur research and greater public understanding of SIDS.

Simultaneously, the issue of child abuse was being confronted by a heretofore denying medical community. In 1946 John Caffey published an account of multiple fractures and subdural hematomas followed in 1953 by Silverman's postulation that these injuries were the result of unrecognized trauma.

Adelson's 1961 paper entitled "Slaughter of the Innocents" added to the factual information about fatal child abuse. In 1962, C. Henry Kempe coined the phrase the "Battered Child Syndrome" and further raised the consciousness of the medical community about the unpleasant truth that infants and children were being physically abused and killed.' The stage was being set for a controversy about death in infancy, its causes, and the possibility of caretakers' culpability for those deaths.

In 1972 a young African-American couple whose infant died suddenly and unexpectedly were charged with criminal neglect. Despite autopsy findings that were consistent with SIDS and no signs of neglect or abuse, the medical examiner indicated that the baby had died of abandonment and neglect. Although the charges were later dismissed, the couple spent six months in jail because of their inability to post bond. But misattribution of death can also occur at the other extreme. An egregious series of lapses and errors of judgment occurred in the case of Mary Beth Tinning, who was charged with smothering her adopted infant daughter. During the inquiry into this death, it was discovered that eight other of her biological children had died and their deaths had been attributed to SIDS or "natural causes." News accounts of this case raised public awareness about the possibility of infant murders' being mistaken for crib death or other medical conditions. It is against this background that the need for an objective and integrated approach to the diagnosis is seen. Whenever an unexplained death occurs in infancy, the question of fatal child abuse must be addressed.

Definition of SIDS

In 1989, the National Institute of Child Health and Human Development promulgated the following definition of SIDS: "The sudden death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history."

Clinical Presentation of SIDS

Typically, SIDS is suspected when an apparently previously healthy baby, usually younger than 6 months of age (peaking between 2 and 4 months of age), is found dead in bed in the early morning prompting an urgent call for emergency help. Emergency personnel respond and initiate cardiorespiratory resuscitation in the home and continue it on the way to the hospital, where the baby is finally pronounced dead. The infant's medical history is usually unremarkable. In many cases a history of a recent routine pediatric visit is elicited. The immediate antecedent history indicates that the baby had been fed his or her usual formula or breast milk and had been put to bed. At varying intervals the parents or other caretaker had checked the baby, who appeared to be normal, but later the baby had been discovered lifeless. No outcry had been heard and the baby had been found in the position in which he had been placed at bedtime or naptime. Evidence of terminal motor activity such as clenched fists may be seen and there may be some serosanguinous, watery, frothy, or mucoid discharge coming from the nose and mouth. The face and dependent portions of the body may have reddish-blue mottling due to postmortem lividity.

Incidence and Epidemiology of SIDS

In the United States approximately 5000 infants succumb to SIDS, annually a rate of about 1.4 per 1000 live births. For white infants, this is a rate of 1.24 per 1000 live births; for African-American infants the rate is 2.26 per 1000 livebirths.

Incidence figures from other parts of the world vary from 0.036 to 6.3 per 1000 livebirths. The role of race and ethnicity are unclear but Kraus and Bultreys, in a careful review of SIDS and socioeconomic status (SES), concluded that the preponderance of evidence suggests a consistent inverse relation between SIDS and SES. But they cautioned that the SES effect may act as a confounder, effect modifier, or intermediate variable.

SIDS has its peak incidence between 2 and 4 months of age. Very few cases occur in the first week of life, and SIDS cases diminish in number after the third month of life. Approximately 90% of SIDS deaths have occurred by 6 months of age." SIDS is seen more often in boys (60% to 70% vs 30% to 40% in girls); it occurs more frequently in the winter months in both the northern and southern hemispheres, suggesting that temperature alone is not a causative factor 16 ; and it is more frequent in multiple births, with twins and triplets having a rate 21/2 times that of singleton babies. The death occurs silently, apparently during sleep.

The absence of a deleterious role of the administration of diphtheria-tetanus-pertussis vaccine has been demonstrated repeatedly. The National Institute of Child Health and Human Development epidemiological study" showed that in 757 SIDS cases there was an increased representation of premature and low birth weight babies and younger mothers; more mothers who smoked cigarettes during pregnancy; more babies who had thrush, pneumonia, and illnesses requiring hospitalization; more subtle neurological abnormalities; and more frequent reports during the neonatal period of tachypnea, tachycardia, cyanotic spells, and vomiting. Autopsy results in this study showed that some of the future SIDS victims had increased extramedullary hematopoeisis, periadrenal brown fat retention, and astroglial ghosis, but these

findings were far from uniform. The study concluded that not one or even combinations of these so-called "risk factors" were powerful enough to be predictive of future SIDS victims.

The issue of recurrent SIDS within a family raises the possibility of genetically determined conditions. It also provokes questions of a forensic nature. In a 14-year study of subsequent siblings of SIDS victims in Norway, and in a Washington State study over 16 years, the SIDS sibling risk was seen to be almost four times that of the SIDS risk among births at large. But when SIDS occurrences among siblings of SIDS cases were compared with those among non-SIDS siblings in maternal age- and birth rank-matched control families, there was no statistically significant difference in SIDS rates or in total infant mortality rates in families with a history of SIDS compared with families with no SIDS. Thus, the notion that having a SIDS baby makes having another more likely was dispelled. With the exclusion from the SIDS statistics of some of the deaths now thought to be due to inborn errors of metabolism, the chances for subsequent SIDS in families seems even less likely.

Distinguishing Between SIDS and Child Abuse

In 1961 Adelson reported on 46 child homicides occurring between 1944 and 1961. Ten children were younger than 1 year of age. Of those, 5 drowned and 3 died of starvation. The causes of death of the other 2 are not described. In 1991 Adelson 21 reported 194 child homicides: 28 occurred before the baby was 1 year old, 16 occurred in infants between I month and 1 year, and 7 occurred between 1 month and 6 months of age. All were fatally and obviously battered. Therefore, in this series, there were no cases likely to be confused with SIDS.

Emery and Taylor described a 24-year period in Sheffield, England (1960 to 1984), during which postperinatal deaths (birth to 2 years) were investigated by gathering information about the death scene, obstetric, and pediatric care, reviewing autopsy findings; and conducting extensive home visits. As a result of this process, accidental suffocation was thought to be the cause of death in 10% of these cases, and the possibility of active

intervention on the part of one or both parents was raised in another 10%, a rate consistently double that of overt child abuse in this age group. Specific data on infants between 1 month and 1 year were not reported.

Suggested etiologies for unexpected infant deaths that have been reported include accidental strangulation, intentional suffocation, and Munchausen Syndrome by Proxy. Deaths in infant twins have also been studied extensively, both from the standpoint of the possible increased risk of death in the twin survivor of a SIDS death, and also to ascertain whether there is increased risk of being abused because of twin status. In 1982, Groothuis and coworkers reported on this latter phenomenon after studying 48 families with twins and 124 single-birth families, matched for hospital of delivery, birth date, maternal age, race, and socioeconomic status. Three control (2.4%) and nine twin (18.7%) families had been reported for maltreatment, with one fatality. Siblings of these twins were reported to have been abused more frequently than the twins themselves, and abuse was limited to the twins in only three families. When analyzing the variables in the families studied, the authors concluded that twin status had the greatest impact on the risk of subsequent child abuse, suggesting that the stress of rearing twins, added to the other elements of childrearing in already marginally functioning families, was a significant determinant for subsequent abuse.

Beal, in her summary of the world's literature concerning the phenomenon of SIDS in twins (1956 through 1988), reported that 6 (1%) of 625 of the surviving twins had subsequently died of SIDS. Data concerning the rate of simultaneous twin SIDS are difficult to interpret, but Beal's estimate, based on published series, is 12 of 637 twin infant pairs, or 2% of all twin sets in which SIDS occurs.

In 1985, Christoffel et al examined 43 unexpected deaths in children brought to Children's Memorial Hospital in Chicago during 1980 to 1981. Nine were due to child abuse and in 3 the correct diagnosis was established only by postmortem examination. In the same journal issue, Kirschner and Stein described 10 cases in which the diagnosis of child abuse was made based on incomplete or erroneous medical observation. Five of those cases were

autopsy-proven cases of SIDS. The recording of the clinical physical examinations had described conditions that were either postmortem changes (e.g., lividity, sphincter dilation), misinterpreted skin markings (mongoloid pigmentation), or a physical finding often seen in SIDS deaths (serosanguinous discharge from nose and mouth). These reports emphasize the need for appropriate evaluation both before and after death, including thorough physical examinations, autopsies, and death scene investigation.

In utero toxic influences have long been suspected as contributing to sudden infant death. Hagland and Cnattingius have reported that cigarette smoking during pregnancy is a highly significant risk factor in the pathogenesis of SIDS. Chasnoff et al found in one study that infants born to mothers who use drugs during pregnancy have a 5- to 10-fold increase in the risk of SIDS. Bauchner et al studied the rate of SIDS in infants of cocaine-abusing mothers and in a control group from the same economic sector and 4.9 and 5.6 per 1000- rates that are consistent with other studies of SIDS rates in lower socioeconomic sectors. Bauchner and Zuckerman appropriately raised questions about study methodology when looking at the high incidence of SIDS associated with in utero drug exposure. They cited the need for accurate measurement of drug use by mothers; control for confounding variables such as cigarette smoking, polydrug use, crowded living conditions, race, low SES, prematurity, and low birth weight; an examination of the relationship between the timing and quantity of exposure of cocaine and the outcome of SIDS; and finally, they questioned the use of SIDS as an outcome measure if there is not strict adherence to the definition of SIDS when death ascertainments are made.

The relationship of substance abuse during pregnancy and subsequent child abuse, if not also controlled for similar variables mentioned above, can be misleading. However, in a study of 100 cocaine-exposed infants and matched control infants followed for 2 years at Rainbow Babies and Children's Hospital in Cleveland, OH, 7 have suffered physical injury, 37 have suffered from neglect, and 21 have been placed in substitute care. The SES-matched control group of non-cocaine-exposed infants has had no instances of abuse or neglect. Wallace found that among- 70 crack-using women with children, 34.3% had the Bureau of

Child Welfare involved in their children's lives as a result of the mother's crack use and the neglect or abuse that followed. Thirty-four percent of the children were placed in substitute care and another 15.7% were being cared for by relatives without formal Bureau involvement. A recent report by Famularo et al showed a strong association between substance abuse and child maltreatment. The rates of fatal child abuse directly attributable to substance abuse are unknown, but logic instructs that a fatal outcome is a natural consequence in a proportion of these reported instances of maltreatment.

There are convincing data that at least in some cases, postpartum depression and other psychiatric disturbances, particularly in mothers who had histories of maltreatment themselves, have led to infanticide.

Role and Importance of the Autopsy

Although the autopsy has not elucidated the etiology for SIDS, and despite often equivocal results, it is still considered the sine qua non in determining the cause of sudden and unexpected death in infancy. But acceptance of this precept is not uniformly embraced throughout the United States even now. In Massachusetts, where the autopsy rate for infants has been close to 100% for several years, the data from the Massachusetts SIDS Center show that in 806 sudden, unexpected infant deaths from 1982 through 1990 there have been only 5 cases attributable to fatal child abuse (0.6%).

In addition to the external findings of postmortem lividity and skin mottling often confused with bruising or other skin lesions, Valdes-Dapena has summarized the major morphological findings. Other less frequent lesions have been described. Evidence that respiratory syncytial virus infection produces life-threatening apneic episodes in infants, reports of unexpected deaths of two infants with respiratory syncytial virus infection, together with autopsies consistent with SIDS have raised, once again, the question of the role of infection-this time of viral infection-as a possible factor in SIDS. Cytomegalovirus inclusion-bearing cells were recovered in the extraneural organs of 4 apparently healthy infants who died

suddenly and unexpectedly; the authors also found glial nodules in the brainstems in each of these infants, causing them to speculate that such lesions could have affected neurons responsible for cardiorespiratory control." Huff reported finding cytomegalovirus cells in 7% of 54 "crib death" babies as opposed to 1.2% of 298 babies who had died of other causes. While these figures are not overwhelming, they do argue for a more careful search for such lesions and elucidation of their significance. Norman and colleagues studied 126 sudden unexplained deaths, excluding those due to accidents, child abuse, poisoning, or other explicable conditions. Of the 126, 86 (68%) were typical SIDS and less than I % of them failed to have intrathoracic petechiae, a putative marker for SIDS whose significance is debated in the literature. Three had infections-granulomatous hepatitis pyelonephritis, and cytomegalovirus-none of which was sufficient to produce death. There were seven known or probable metabolic diseases accounting for a little over 5% of the total. Their belief is that metabolic disease is most likely to be found in families in which there has been more than one child apparently dying of SIDS and in those infants with fatty livers at postmortem examination. The diverse metabolic diseases that can cause sudden infant death include disorders of fatty acid oxidation, organic acids, urea-cycle, amino acids, and carbohydrate metabolism. Current evidence from necropsy studies and from family studies suggests that about 1 in 10 of sudden unexpected deaths in infancy are due to inborn errors of metabolism. Despite the absence of hard data to support this assertion, certain additional steps would add to our knowledge and are recommended for the autopsy: body fluids (urine, blood, vitreous humor, cerebrospinal fluid, bile, and stomach contents) should be obtained and frozen at -80'C; skin samples should be obtained and analyzed; blocks of brain, liver, kidney, heart, muscle, adrenals, and pancreas should be analyzed. Postmortem findings in cases of fatal child abuse demonstrate that the causes of death were injuries to the head or the abdominal viscera, burns, drowning, gunshots, exposure, suffocating, or a combination of these. In contrast to later series, poisoning was not often a factor.

Radiographic Studies

The use of radiographs as an ancillary study in postmortem examinations is routine in most jurisdictions. In most cases where radiographs are used, however, the "babygram" is the standard. Kleinman et al point out that a skeletal survey should be the choice of examination and that properly informed and motivated technologists should be able to obtain high quality postmortem skeletal surveys in most medical examiners offices. The widespread failure to obtain such studies is probably due more to inertia than to actual technical or economic factors. The clinical radiographic study commonly referred to as the "skeletal survey" has been outlined by Kleinman. It consists of numerous projections and is clearly superior to the "babygram" done in most autopsy settings.

Death Investigation: Scene Investigation and Past Medical History

In Adelson and Kinney's 1956 report on 126 infant fatalities, death scene investigations occurred in all but one family. This remarkable adjunct to the postmortem examination was certainly unique at that time and indeed has not been the standard even in the recent past. Smialek and Lambras has observed that by delaying the death scene investigation one may lose accurate documentation of the scene in terms of the environmental risk factors and risk factors associated with sleeping conditions. Prompt interviewing of the discovering caretaker is needed to ascertain details of the infant's situation when first found lifeless. The gathering of information from physicians familiar with the baby and the family and from local child protection agencies should also be accomplished. Stanton and Oakley, reporting on the patterns of illness observed before unexpected infant death, found that 16% of the infants who subsequently died unexpectedly had been previously admitted to a hospital compared with 5.4% of age matched control infants. Nearly half of those who died had been admitted prior to 2 months of age. Child abuse had been diagnosed in 8 of the 71 admitted infants and failure to thrive in 24. The bulk of the other admissions were for infection and loss of consciousness.

In the National Institute of Child Health and Human Development study, to a statistically significant degree, the 757 SIDS babies had more often been sick and had been previously hospitalized. These patterns of illness are important data in the investigation of sudden unexpected infant death.

Taylor and Emery reviewed 65 postperinatal deaths in Sheffield, England, and found that 35 of the infants had had diseases or conditions present before the eighth day of life. Proven nonaccidental injury was seen in two cases, and "gentle battering"- meaning extreme concern in the death review conference because of discrepant histories, social chaos, and a pattern of unusual childrearing practices before death-in three. There were 19 infants certified as "cot deaths" (SIDS).

Criteria for Distinguishing SIDS from Fatal Child Abuse and Other Medical Conditions

	Consistent With SIDS	Less Consistent with SIDS	Highly Suggestive or diagnostic of Child Abuse
History surrounding death	Apparently healthy infant fed, put to bed, Found lifeless. Silent death. EMS resuscitation unsuccessful.	Infant found apneic. EMS transports to hospital. Infant lives hours to days. Substance abuse, family illness.	History atypical for SIDS. Discrepant history. Unclear history. Prolonged interval between bedtime and death.
Age at death	Peak 2-4 mo. 90% <7mo. Range 1-12 mo.	8-12 mo.	>12 mo.
PE and laboratory studies at time of death	Serosanguinous watery, frothy, or mucoid nasal discharge. PM lividity in dependent areas. Possible marks on pressure points of body. No skin trauma. Well cared for baby	Organomegaly of viscera. Stigmata of disease process (PE, laboratory, X-ray).	Cutaneous injuries. Traumatic lesions of body parts (conjunctiva, fundi, scalp, intraoral, ears, neck, trunk, anogenital extremities, malnutrition, neglect Fractures.
History of pregnancy, delivery and infancy	Prenatal care-minimal to maximal. Frequent history of cigarette use during pregnancy. Some future SIDS victims are premature or LBW. Subtle defects in state, feeding, cry neurological status (hypotonia, lethargy, irritability). Less postneonatal height and weight gain. Twins, triplets. Spitting, GE reflux. Thrush, pneumonia, illnesses requiring hospitalization, tachypnea, tachycardia, cyanosis. Usually: No signs of antecedent difficulty.	Prenatal care-minimal to maximal. History of recurrent illnesses. "Sickly" or "weak" baby. Specific diagnosis of organ system disease.	Unwanted pregnancy. Little or no prenatal care. Late arrival for delivery. Birth outside of hospital. Few or no well baby care. No immunizations. Use of cigarettes, drugs/alcohol during and after pregnancy. Baby described as hard to care for or to "discipline." Deviant feeding practices.
Death scene investigation	Crib, bed in good repair. No dangerous bedclothes, toys, plastic sheets, pacifier strings, pellet pillows, No cords, bands for possible entanglement. Accurate description of position with attention to possible head/neck entrapment. Normal room temperature. No toxins, insecticides. Good ventilation, furnace equipment.	Defective crib/bed. Use of inappropriate sheets, pillows, sleeping clothes. Presence of dangerous toys, plastic sheets, pacifier cords, pellet pillows. Cosleeping. Poor ventilation, heat control. Presence of toxins, insecticides. Unsanitary conditions.	Chaotic unsanitary crowded living conditions. Evidence of drugs/alcohol. Signs of terminal struggle in crib, bet, bedclothes or other equipment. Discovery of blood-stained bedclothes. Evidence of hostility by caretakers. Discord between caretakers. Display of violence between caretakers. Admission of harm. Accusations.

Previous infant deaths in family	First unexplained and unexpected infant death.	One previous unexpected or unexplained infant death	More than one previous unexplained or unexpected infant death.
Autopsy findings	No adequate cause of death at PM. Normal: skeletal survey, toxicology, chemistry studies (blood sugar may be high, normal, or low), microscopic examination, metabolic screen. Presence of: large numbers of intrathoracic petechiae; dysmorphic, dysplastic, or anomalous lesions: gliosis of brainstem; sphincter dilation. Occasionally subtle changes in liver, including fatty change and extramedullary hematopoiesis.	Subtle changes in liver, adrenal, myocardium. Few or no intrathoracic petechiae.	Traumatic cause of death (IC or visceral bleeding). External bruises, abrasions, or burns. No intrathoracic petechiae. Malnutrition. Fractures. Subgaleal hematoma. Abnormal body chemistry values (Na, Cl, K, BUN, sugar; liver, pancreatic enzymes; CPK). Abnormal toxicology.
Previous CPS or LE involvement	None	One	Two or more. One or more family member arrested for violent behavior.

Child Death Review Teams

The determination of the cause and manner of death in children has been grossly neglected. Twenty years have passed since Bergman' found that only 25% of sudden and unexpected deaths in the United States had the benefit of an autopsy to establish the cause of death in suspected SIDS cases. It is hoped that a contemporary survey would show a better rate, but even then it must be recognized that the autopsy is only one component of a proper approach in establishing the cause of death. Moreover, death ascertainment should be accomplished in all children younger than the age of 18 years, not just in infants. Because this is such an egregious omission in the conduct of the medical, social, and legal stewardship of our children, momentum has been building to analyze childhood deaths by means of child death review teams. This approach has been superbly described in a series of four manuals prepared by the Child Maltreatment Fatalities Project of the American Bar Association Center on Children and the Law and the American Academy of Pediatrics. The information compiled by means of the detailed investigation suggested in these publications will provide the most reliable determination of cause and manner of death.

If child abuse or neglect is a contributory factor in a substantial proportion of unexpected infant deaths, what should be done to minimize mistakes in the ascertainment of the cause and manner of death? The following recommendations are offered:

1. Accurate history-taking by emergency responders and medical personnel at the time of death and made available to the medical examiner or coroner
2. Examination of the dead infant at a hospital emergency department (Often such babies are taken directly to the morgue, depriving the case of clinical appraisal prior to autopsy.)
3. Protocol postmortem examinations within 24 hours of death, including toxicology and metabolic screening when deemed appropriate in the context of the complete evaluation of the infant's death
4. Prompt death-scene investigation by knowledgeable individuals including careful interviews of the household members
5. Collection of previous medical records from all sources of medical care and personal interviews of key medical providers
6. Detailed collection of medical history from caretakers, using a standardized medical history questionnaire
7. Locally based infant death review teams to review the collected data with participation of the medical examiner or coroner in the review
8. Use of accepted diagnostic categories on death certificates as soon as possible after review
9. Prompt informing sessions with parents when the results indicate SIDS or medical causation of death (High-quality medical examiner's offices inform parents of SIDS cases as soon as the results of the gross autopsy findings are available.)
10. Recognition of all the diagnostic elements comprising the decision about infant deaths (Table)
11. Maintenance of a supportive approach to parents during the death review process
12. Adequate funding of this critical process, both for death ascertainment and for the protection of all infants and children
13. Stimulation and support of more research into the etiology of both SIDS and child abuse.

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Domestic Abuse Top 20 Reasons "Why She Stays"

- Denial & Minimization
- Fear
- Traumatized
- Violence
- No offender-specific treatment
- No monitoring
- No probation or too short
- Limited consequences
- No arrest
- Social institutions

Domestic Abuse Top 20 Reasons "Why She Stays"

- Religion
- Promises to change
- Children
- Post-traumatic Stress Syndrome
- Stockholm Syndrome
- Learned helplessness
- Chronic depression
- Self-blame and low self-esteem
- Isolation
- Money

How to Be a Good Wife

- Have dinner ready. Plan ahead, even the night before to have a delicious meal on time. This is a way of letting him know that you have been thinking about him and are concerned about his needs.
- Prepare yourself. Take 15 minutes to rest so that you'll be refreshed when he arrives. Touch up your makeup, put a ribbon in your hair and be fresh-looking.
- Clear away the clutter. Make one last trip through the main part of the house just before your husband arrives, gather toys, books, etc. Then run a dust cloth over the tables. Your husband will feel he has reached a haven of rest and order.
- Minimize all noise. At the time of his arrival, eliminate all noise of the washer, dryer or vacuum to encourage the children to be quiet. Greet him with a warm smile and be glad to see him.
- Listen to him. You may have a dozen things to tell him. The moment of his arrival is not the time. Let him talk first.
- Make him comfortable. Arrange his pillow and offer to take off his shoes. Speak in a low, soothing and pleasant voice. Have a cool or warm drink ready for him.
- Make the evening his. Try to understand his word of strain and pressure and his need to be home and relax.

Signs

- Jealousy
- Controlling Behavior
- Whirlwind Romance
- Isolation
- Blames Others
- Cruelty to Animals
- 'Playful' Use of Force
- Verbal Abuse
- Threats of Violence and/or Suicide

Why He Stays

- It's Good to be the Dictator
- Violence Works
- No One Knows
- 'My Neighbors Still Like Me'
- Cases Get Dismissed
- Not Held Accountable
- Not Properly Charged
- No EPO or Protective Order Issued
- Low Bond
- It's the Victim's Fault (She Should Have Left)
- Community Does Not Condemn Violence

Self-Assessment of Knowledge About Domestic Violence: A True-False Quiz

- ADULT INJURY IS USUALLY ACCIDENTAL. T/F
- ABUSE VICTIMS REMAIN WITH THE BATTERERS BECAUSE THEY HAVE SERIOUS BEHAVIORAL AND MENTAL HEALTH PROBLEMS. T/F
- A SINGLE ASSAULT DOESN'T CONSTITUTE REAL ABUSE. T/F
- ABUSE USUALLY INVOLVES MUTUAL COMBAT. T/F
- BATTERERS ARE VIOLENT BECAUSE THEY HAVE POOR IMPULSE CONTROL. T/F
- ABUSE VICTIMS NEVER TELL ANYONE ABOUT THE ABUSE. T/F
- THE FIRST GOAL OF INTERVENTION IS TO HOLD THE FAMILY TOGETHER. T/F

Self-Assessment of Knowledge About Domestic Violence: A True-False Quiz

- AN ABUSED VICTIM SHOULD LEAVE IMMEDIATELY. IF SHE DOES NOT, SHE IS NOT READY FOR HELP. T/F
- FEMALE ALCOHOLISM, DRUG ABUSE, DEPRESSION, AND MENTAL ILLNESS ARE MAJOR CAUSES OF ABUSE. T/F
- IF THE CHILDREN ARE NOT IN THE SAME ROOM WHEN THE ABUSE OCCURS, THEY ARE NOT AFFECTED BY IT. T/F
- WOMEN CAN NEVER BE BATTERERS. T/F
- IT'S NOT WORTH THE OFFICERS TIME TO WRITE DOWN WHAT CHILDREN SAY AT THE SCENE. T/F
- THE PROSECUTOR SHOULD DISMISS THE CASE IF THE VICTIM IS NOT GOING TO TESTIFY AT THE TRIAL AGAINST THE ABUSER. T/F

ADAPTED WITH PERMISSION: DOMESTIC VIOLENCE TRAINING PROJECT

Family Violence and Faith

One research study showed that clergy were the second most often sought source for help after the police following the first battering incident. This study also found that none of the women who contacted the clergy found them most helpful.

Another study claims that while the church is the institution most often contacted by battered women, clergy also had the highest negative influence compared to women's groups, psychologists, police, relatives, lawyers, and friends.

(Barnett and LaViolette, 1993)

DPD Family Violence Statistics

	1997	1996	1995	1994	1993
Total Calls	22,433	22,826	23,972	23,616	26,025
Total Offenses	18,811	20,112	20,528	20,506	21,810
Murder	21	15	20	16	43
Sexual Assaults	101	134	157	170	170
Agg. Assaults	2,165	2,248	2,172	2,130	2,573
Assaults	14,697	16,262	16,580	16,447	17,814

Family Violence Statistics in Texas
TCFV

	1997	1996	1995	1994	1993
Family Violence Incidents	181,773	181,443	172,476	163,223	155,767
Women Killed by Intimate male partners	102	116	130	151	161

"The Game"

Terminology from the Subculture
of Pimps and Prostitutes

INTRODUCTION

This manual has been created by the Vice Section of the Las Vegas Metropolitan Police Department.

Most of the terms contained herein have been obtained through interviews with adult and child prostitutes, pimps, and clients of prostitution. Others are taken from an unofficial rap dictionary.

The phrase "The Game", as written on the front cover, is used by pimps and prostitutes when referring to the entire subculture of pimping and prostituting.

The terms in this booklet do not reflect any opinion of the Las Vegas Metropolitan Police Department nor any of its employees and are meant for informational purposes only

This manual is intended for use only by law enforcement personnel.

TERM	DEFINITION
50 (Five Oh)	Police or Vice.
	A
Automatic	When a pimp is out of town in another city, and his prostitute is "working" while he is gone, she is said to be on automatic. This means that she "automatically" goes out to make her pimp money, without him having to tell her anything.
	B
Bag up	To be caught/arrested by the police
Bare Back	Sexual intercourse without the use of a condom
Bend	A prostitute *(She was more than just a bend.)*
Berry	A police car *(The red lights on old police cars looked like a berry.)*
Bitch	The most common term used by pimps when referring to a prostitute.
Bizzo	A girl.
Boo boo head	A whore or deceitful woman.
Bottom bitch	Prostitute who has been with a certain pimp the longest. She is typically the recruiter for the pimp, and is usually the most trusted.
Break a bitch	Phrase used to define the actual act of a pimp taking money from a prostitute.
Break yourself	This is what a pimp tells a prostitute when he wants her money.
Broke luck	Phrase referring to when a prostitute makes money. If a prostitute has turned a trick for money she is said to have "broke luck" for that day.
Buster	Person who tries to act like a pimp, but is not really a pimp.

TERM	DEFINITION
	C
Carpet ho	Prostitute who primarily works hotels
Cat eye	To stare at a woman or man with sexual intention.
Caught a case	When a prostitute or pimp has been arrested and charged with a crime, they refer to that as "caught a case."
Choose	Prostitute having to pick a new pimp. This can be done voluntarily, or by looking another pimp in the eyes. In the latter case, she has now "chosen" that new pimp, even if she didn't want to.
Choosy Suzy	Prostitute who goes from pimp to pimp. She is always "choosing", hence the term.
Chulo	The Spanish word for pimp.
Circuit	All of the "tracks" in the country. When a prostitute works the circuit, her pimp takes her from city to city, or "track to track"; the female will work a certain track until she stops making money, or the "heat is turned up" (police begin to pay too much attention to that prostitute).
Coochie	Vagina
C.R.E.A.M.	Money. An acronym for Cash Rules Everything Around Me.
	D
Daddy	What most pimps are called by their prostitutes.
Date	Can be used to describe the act of prostitution or the client. When a prostitute is with a client, she is said to be "with a date", "on a date", or "turning a date."
Doughski	Money, dollar, etc.
Duck	Black female prostitute.
	E

TERM	DEFINITION
Exit Fee	Money a prostitute has to pay her "pimp" to enable her to leave him. This is usually a high amount so as to dissuade the prostitute from leaving. Most pimps will not let "their prostitute" leave them anyway.
	F
Family	All persons within one pimp's stable (group of prostitutes). If a pimp has three prostitutes working for him, each of the girls is considered family to each other.
Folk	See *Family.*
Flat-backin'	Straight sexual intercourse.
Freelance	A prostitute who works inside a casino or hotel, and approaches clients while they are drinking and/or gambling is said to be "freelancing." This has nothing to do with whether or not the prostitute has a pimp.
Fronts	Money given to the prostitute by the pimp for her to use while she is working. It is usually a small amount, $5 to $20, and is to be used for cab fare, condoms, and drinks (at the bar) for when she is trying to pick up on a client.
	G
Generation	The level of a pimp. If both a pimp and his son are pimps, the son would be called "second generation" pimp.
Get burned	To catch a sexually transmitted disease. *(Specifically refers to the burning sensation caused by gonorrhea when urinating.)*
Golden Shower	An act of prostitution where one of the participants, typically the client, gets urinated on by the other.
Gorilla Pimp	Pimp who resorts to serious brutality to keep his prostitutes working for him.

TERM	DEFINITION
	H
Half n Half	Half sex, half blow job.
Hit-you-on-the-hip	Phrase referring to "paging" someone. Most people carry their pagers on their hips. Example: "If I need you, I'll 'hit ya on the hip'."
Ho	Common title for a prostitute. Typically used by pimps to describe their girls.
Ho cake	Vagina
Ho Vine	The "route" that gossip travels among prostitutes.
Holly	Another term for a ho
Hook	Fake piece of jewelry. This term is used by trick-roll suspects.
Hustler	A person who will basically do anything for money -- sell narcotics, steal, scam, commit acts of prostitution, etc.
	I
In A Minute	(Sometimes "For A Minute") Terms used to describe a length of time, usually a couple of days. Example: My pimp brought me to Las Vegas for a minute.
Izz or Izzn	This is what is added to words to create the language used by pimps and prostitutes. Example: Car would be Cizzar or Cizznar (pronounced Sizar or Siznar), Lick would be Lizzick or Liznick (pronounced Liz zick or Liz nick).
	J
Jakes	The police
Jasper	Lesbian prostitute.
Jenny	Vagina
John	Client of prostitution.

TERM	DEFINITION
..... **K**	
Knocking boots	To have sexual intercourse.
..... **L**	
..... **M**	
Mack	Supposed to be an "upper level" pimp. A Mack will supposedly take money from any female, not just a prostitute (this is according to the Macks arrested so far). *Mack is also an acronym for "Man Acquiring Cash through Knowledge."*
Mark	A client of prostitution.
..... **N**	
..... **O**	
Onetime	Police or vice.
Out-a-pocket	When a prostitute has a pimp, and she looks at another pimp, she is deemed out-a-pocket. She is now subject to the "choosing" rules, as described earlier.
..... **P**	
Party	The act of prostitution. A prostitute may ask a client if he wants to "party."
Peel a trick	Phrase used to describe the act of when a prostitute steals something from her client.
Pimp	Person who persuades, compels, entices, etc., a female to become a prostitute or to continue to commit acts of prostitution. The pimp will take *all* of the money from his prostitutes, and he will commonly have several girls working for him. The pimp will usually have no legitimate source of income. *The term pimp is also an acronym for Provided Income from Managing Prostitutes.*

TERM	DEFINITION
Pimp party	This is when several pimps "unite" to abuse a prostitute either for being disrespectful, trying to leave the "Game" or reporting a pimp to the police. The "pimp party" usually consists of several pimps "gang-raping" the prostitute, beating her, urinating and/or defecating on her, and other forms of abuses.
Pimp stick	Item used by a pimp to beat his prostitute. The item can be any type of weapon; some pimps prefer to use a coat hangar.
Punani	Vagina/sex.
Puta/Puto	Prostitute.
..... **Q**	
..... **R**	
Reckless eye balling	When a prostitute is looking at another pimp, or a suspected pimp, she is deemed to be doing this.
Renegade	Prostitute who does not have a pimp.
..... **S**	
Serve	The procedure of when the newly "chosen" pimp "serves notice" to the old pimp. This is done when the "chosen" pimp takes his "new" prostitute's money (money she earned from the previous night), and gives it to the old pimp. *This is an older custom, and is not used too much anymore. Most pimps will simply verbally "serve" another pimp without a money exchange.*
Square	This is a person who is not involved in the game of "pimpin' and prostitution" and who leads a normal life.
Stable	The amount of prostitutes working for a particular pimp. If a pimp has six girls working for him, he has a stable of six.
Streets	Area that prostitutes offer their trade; the work on the streets is easier and unlike entertainment service or hotel work.
Swan	White female prostitute.

TERM	DEFINITION
Sweatin' a bitch	This is when a pimp goes to the "track" and puts pressure on a prostitute to "chose" him to be her new pimp. It may simply involve following the prostitute, screaming at her, or kidnaping and beating her.
..... **T**	
Track	Certain area of a street in any given city where prostitution can be found.
Trap	Money earned by a prostitute. Called "trap" instead of cash.
Trick	Client of prostitution.
Trick roller	Female/prostitute who steals, either through using deception or drugs, property from male clients after she befriends and either offers or performs sex on him. Most trick roll victims are drugged to the point of unconsciousness, thereby giving the suspect several hours before the victim awakes.
Turn-out	Brand new prostitute; one who was just turned from a normal girl into a prostitute.
..... **U**	
..... **V**	
..... **W**	
Wife-in-law	This is what each prostitute in a pimp's "stable" call each other. A prostitute can only be a wife-in-law to another prostitute when they have the same pimp. In some "stables", wife-in-laws are not allowed to communicate with each other. Many pimps will enforce this rule to keep the prostitutes from unifying against him, and to keep them from knowing how he treats the others.
Woo Woo Woo	Used as an emphasis in statements made by pimps and prostitutes. It has no particular meaning. Example: "The cops said I had this girl working for me, and I beat her, and woo woo woo, before you know it, I was arrested."

TERM	DEFINITION
X	
Y	
Z	

TERM	DEFINITION

TERM	DEFINITION

HOW TO TESTIFY IN CHILD ABUSE CASES

1999 Crimes Against Children Conference
August 5, 1999
Dallas, Texas

Patricia Toth, J.D.
437 E. Lopez Street
Port Angeles, WA 98362
Phone/Fax: (360) 417-5404
PATOTH@olypen.com

I. **Type of Case--Civil vrs. Criminal:** know what type of case testimony will be given in, since it may make a difference in degree of formality and type of testimony allowed

A. Purposes

1. Civil: child protection and family reunification

2. Criminal: protection of the community and criminal accountability

B. Civil Dependency and Neglect Proceedings

1. Cases covered: generally only those involving family member or caretaker

2. Burden of proof = preponderance of the evidence **or** (for termination of parental rights) clear and convincing evidence

3. Petitions generally filed by CPS

C. Criminal Prosecution

1. Child abuse crimes: statutory definitions

2. Status of perpetrator irrelevant to whether charges can be filed unless relationship is an element of the crime

3. Burden of proof = proof beyond a reasonable doubt

4. Charging decisions made by the prosecutor

II. Type of Testimony--Expert or Not

A. Expert vrs. Fact Witness

1. Definition of "expert" testimony: opinion based on scientific, technical or other specialized knowledge

2. Definition of an expert: a person with specialized knowledge, skill, experience, training or education

3. Factual Testimony: any witness testifying about something they did, saw, heard, said, etc., without giving an opinion

4. Is expert testimony necessarily better than "fact" testimony?

   a. Getting your point across without giving an opinion

   b. Using common sense explanations to appeal to the jury

   c. Examples--recantations and delayed disclosure

      (1) Why they occur: child sexual abuse accommodation syndrome

      (2) Strategies when faced with a recantation or delayed disclosure

         (a) Child's explanation

         (b) Expert testimony

         (c) Admissibility of hearsay statements (mainly a consideration with recantations)

            (I) Excited utterances

            (ii) Statements made for purposes of medical diagnosis and treatment

            (iii) Prior testimony

5. Dangers of psychological/mental health expert testimony in child

sex abuse cases

a. Rougher cross-examination

b. Increases chance of reversal

c. Increases chance that defense will call opposing "expert"; result = battle of the experts and loss of focus on child's testimony

d. Could open the door to defense expert examinations of child

B. Types of Expert Testimony

1. Medical testimony

2. Psychological/mental health testimony

a. Behavioral characteristics generally

b. Syndrome evidence

(1) Child sexual abuse accommodation syndrome

(2) Child sexual abuse syndrome--no such thing!

(3) Rape trauma syndrome--post traumatic stress disorder

(4) False memory syndrome

c. Opinion that evidence "consistent with" sexual abuse

d. Opinion that child was abused

e. Explanation for otherwise misleading evidence, e.g., delayed disclosure, recantation, return to abusive situation, etc.

III. General Principles of Effective Testimony

A. Record keeping

1. Maintain complete, accurate, legible and organized records

2. Have clear policies about how and to whom you release records

3. Do not decide how to document child's statements on your own-consult with other professionals who will use the information

B. When you are subpoenaed

1. Read it and determine what child is involved--a criminal subpoena may have only the defendant's name and not the child's

2. Locate and review file before talking to anyone about the case

3. Call the lawyer who subpoenaed you to discuss case

(a) Determine case status and nature of hearing

(b) Ask about expectations of you

(c) Determine when really needed and set up on call arrangement if possible (expect to wait)

(d) Determine what records the lawyer has and supply any others he/she does not already have

(e) Ask what defense challenges are anticipated, including whether a defense expert is expected to testify

(f) Discuss how to handle defense interview, if you are contacted about one

(1) Not in your office

(2) Be prepared

(3) You can set any reasonable conditions on the interview you wish, including time, place and having someone with you--good idea to have someone,

perhaps prosecutor, with you

C. Keep your resume up to date and accurate--defense attorney will see it

1. Send it to lawyer calling you

2. Bring one with you to court

D. Know the most recent relevant literature and make copies of the most applicable available to lawyer calling you

1. *The Advisor*, quarterly newsletter of the **American Professional Society on the Abuse of Children (APSAC)**-national multidisciplinary group of professionals dedicated to improving practice and interagency coordination; (312) 554-0166

2. Child Maltreatment (also a benefit of APSAC membership)

3. International Journal of Child Abuse and Neglect, available as a benefit of membership in the **International Society for the Prevention of Child Abuse and Neglect (ISPCAN)**, (312) 578-1401

4. If cross-examined about a particular article, ask to see it, and then take time to read carefully - - THINK

E. Be careful about use of jargon--choose terms which can be easily understood

F. Act professional and neutral at all times; anyone you pass may be a juror, relative of the child or defendant--**don't** discuss the case anywhere you could be overhead

G. Familiarize yourself with courtroom layout and procedures ahead of time

H. **Always tell the truth**

I. Make sure you hear and understand the question before answering and don't guess; okay to say:

1. "I don't understand the question"

2. "I don't know"

3. "I don't remember"

J. Think about your answer before you speak

1. Pause, take a deep breath and review question in your mind

2. Especially if questions are being fired at you, **pause** and get back control, give prosecutor chance to object

K. Handling objections

1. Stop talking immediately

2. Let the lawyers argue and the judge rule

3. Listen to what lawyer calling you says

4. If unsure whether you can answer, ask

5. Ask for the question to be repeated (everyone always forgets)

L. Don't volunteer information

M. Speak clearly so jury and judge can hear; don't nod/shake head

N. Do not argue with the lawyers or judge--be respectful, reasonable, professional; don't fall into trap of losing your temper

O. Be clear when using visual aids

P. Be careful about estimates, but be confident when called for

Q. Hypotheticals: listen carefully

R. How to handle "just answer yes or no"

S. Don't be defensive about getting paid (if you are)

T. Okay to admit talking to prosecutor before court

U. Referring to notes and records

1. Okay to refresh recollection

2. Anything you use in this way can be examined by the defense

V. After testifying

1. Ask for constructive feedback

2. Watch others testify

3. Learn

IV. ADDITIONAL RESOURCES:

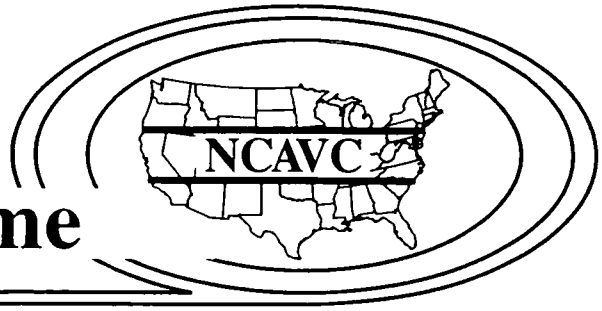
Fox Valley Technical College: 800-648-4966; manages free training courses on many aspects of child exploitation investigation for Department of Justice/OJJDP

Juvenile Justice Clearinghouse: 800-638-8736; call to order free set of *OJJDP Portable Guides to Investigating Child Abuse* (topics include *Interviewing Child Witnesses, Battered Child Syndrome, Photo-documentation, Sexually Transmitted Diseases, Burn Injuries, Law Enforcement Response,* and others)

Clearinghouse on Child Abuse and Neglect Information: (800) 394-3366--offers a wide variety of information related to many aspects of child abuse

U.S. Department of Justice
Federal Bureau of Investigation

National Center For The Analysis of Violent Crime



NCAVC

CRITICAL INCIDENT RESPONSE GROUP
FBI Academy
Quantico, Virginia
JUNE 1998

FBI/DOJ

The Critical Incident Response Group (CIRG)

The Critical Incident Response Group (CIRG) is an FBI field entity located at the FBI Academy in Quantico, Virginia. Established in May 1994, the CIRG was designed to provide rapid assistance to incidents of a crisis nature. It furnishes emergency response to terrorist activities, hostage situations, barricaded subjects, and other critical incidents.

The CIRG is composed of diverse units that provide operational support and training and conduct research in related areas. Expertise is furnished in cases involving abduction or mysterious disappearance of children, crime scene analysis, profiling, crisis management, hostage negotiations, and special weapons and tactics.

The National Center for the Analysis of Violent Crime (NCAVC)

The National Center for the Analysis of Violent Crime (NCAVC), one of the major components of the CIRG, combines investigative/operational support functions, research, and training in order to provide assistance, without charge, to Federal, state, local, and foreign law enforcement agencies investigating unusual, bizarre, or repetitive violent crimes.

Investigative/Operational Assistance

The experienced FBI Special Agents and other professionals who comprise the NCAVC staff provide advice and support in the general areas of Crimes Against Children; Crimes Against Adults; and Threat Assessment, Corruption, and Property Crimes. Typical cases received for services include child abductions or mysterious disappearance of children, serial murders, single homicides, serial rapes, extortions, threats, kidnappings, product tampering, arsons and bombings, weapons of mass destruction, public corruption, and domestic and international terrorism.

The NCAVC staff reviews crimes from both behavioral and investigative perspectives. This criminal investigative analysis process serves as a tool for client law enforcement agencies by providing them with an analysis of the crime as well as an understanding of criminal motivation and behavioral descriptions of the offender. Services provided to law enforcement agencies through this process include the following:

Crime Analysis: The NCAVC staff member reviews the initial crime scene information and preliminary investigative efforts and offers suggestions that may help direct the course of the investigation.

Investigative Suggestions: Certain investigative suggestions and strategies may be offered based on a review of the entire case, focusing particularly on an evaluation of the crime scene and an assessment of the likely offender.

Profiles of Unknown Offenders: By analyzing the details by which a crime was committed, NCAVC staff members can often identify important personality and behavioral characteristics of an offender. Certain crime scenes may reveal behavioral characteristics that give clues about an offender's personality or lifestyle and allow investigators to predict future activity.

Threat Analysis: Communicated threats are evaluated to determine whether the author or caller has the intent, knowledge, or means to carry out any stated or implied threat. A behavioral description of the unknown offender may be provided to assist in identification and apprehension. Known offenders who make threats or who appear to pose a danger may be assessed for potential dangerousness, given appropriate and sufficient background data.

Critical Incident Evaluations: NCAVC staff serve as a resource to CIRG's crisis management, tactical, and on-scene commanders during crisis situations by offering overall behavioral assessment of critical incidents, crime scenes, and potentially dangerous individuals.

Interview Strategies: The NCAVC staff can make suggestions about interview strategies of subjects, suspects, or witnesses, based on a general assessment of the person and an analysis of the crime(s) and behavior exhibited. Suggestions may relate to the most appropriate type of interviewer, desirable approach, and the best environment in which to conduct the interview.

Major Case Management: The NCAVC staff can provide guidance and resources to manage and organize a major multiagency investigation, such as those that occur in child abduction or serial murder cases. Particularly helpful to those investigating the abduction or mysterious disappearance of a child is the *Child Abduction Response Plan* prepared by NCAVC staff with the assistance of and advice from FBI and police investigators who have extensive experience working child abduction cases.

Search Warrant Assistance: Research and experience have shown that certain behavior and personality traits are commonly possessed by specific types of offenders. This information can be particularly beneficial to support affidavits for search warrants.

Prosecutive and Trial Strategies: At the request of the investigating agency or prosecuting attorney, the NCAVC staff may make recommendations regarding possible cross-examination techniques for offenders or witnesses, overall prosecutive theme development, or suggestions for jury selection.

Expert Testimony: NCAVC members have qualified to testify as experts in the areas of criminal investigative analysis, crime scene analysis, violent criminal behavior, and assessment of dangerousness.

Violent Criminal Apprehension Program (VICAP): VICAP is a behaviorally-based crime analysis tool that has been significantly redesigned and structured to address violent crime problems affecting law enforcement agencies. The new system consists of a revised VICAP Crime Analysis Report and a user-friendly computer system designed to enhance crime analysis for specific violent crimes, including solved or unsolved homicides, missing persons, and unidentified dead persons. It is available free of charge to any agency willing to become a part of this effective network of crime analysis.

In addition to the above services, the NCAVC staff can coordinate and obtain other resources to apply to a given investigation. The NCAVC maintains a reference file for experts in various forensic disciplines such as odontology, anthropology, entomology, or pathology. Staff members can coordinate acquisition of special aircraft, tracking or cadaver dogs, or use of the FBI's Evidence Response Team. The NCAVC also works closely with the National Center for Missing and Exploited Children in child abductions and other child victimization cases.

Research

The NCAVC also conducts research into violent crime from a law enforcement perspective. Of primary interest to researchers is how the offenders in the study committed their crimes and how they avoided detection, identification, apprehension, and conviction. The research is designed to gain insight into criminal thought processes, motivations, and behavior. Insights gained through the research are refined into innovative investigative techniques and applied to improve law enforcement's effectiveness against the violent criminal. College undergraduates and graduate students working as interns in the NCAVC provide assistance to the staff in many of the research efforts.

Results of the research are shared with the law enforcement and academic world through publications, presentations, and training, as well as through the application of knowledge to the investigative and operational functions of the Center. Some findings are also useful to incorporate into crime prevention programs. Past and planned research includes studies of sexual homicide, serial rape, child molestation and abduction, bombing, arson, acts using weapons of mass destruction, threatening communications, and serial murder.

Training

The NCAVC staff participates in numerous training functions throughout the year. The NCAVC is represented at major law enforcement conferences such as the International Association of Chiefs of Police and National Sheriff's Association. Staff members take part as attendees and speakers at symposia sponsored by such organizations as the American Professional Society on the Abuse of Children, Academy of Forensic Sciences, International Homicide Investigators Association, American Bar Association, and the Academy of Criminal Justice Science.

Requests for training or presentations by the NCAVC should be made through the local FBI field office.

NCAVC toll-free number: 800-634-4097

Criminal Profiling in Child Abduction Investigations

SSA Mark A. Hilts
CIRG / NCAVC
FBI Academy

Criminal Investigative Analysis

Process of reviewing and assessing the facts of a criminal act, and interpreting offender behavior and interaction with the victim, as exhibited during the commission of the crime, or in the crime scene.

Behavior Reflects Personality

The method and manner in which a crime is committed, relates directly to the personality of the offender.

Cases in which profiling may be useful

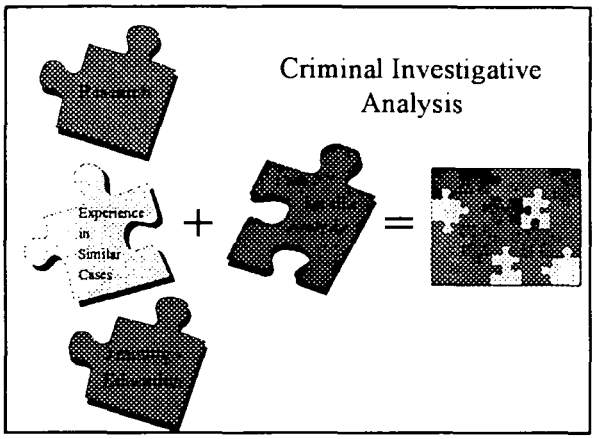
- Homicides
- Sexual assaults
- Child Abductions/Kidnappings
- Bombings
- Product tampering
- Threats

Criminal Investigative Analysis - Products

* Crime Analysis
* Unknown Offender Profile
* Investigative Strategies
* Interview/Interrogation Strategies
* Threat Assessments
* Search Warrant Affidavit Assistance
* Prosecutive Strategies
* Expert Testimony

Profiles do not solve Crimes!

A profile is not a substitute for a thorough, well-planned investigation. Good, fundamental police work solves crimes.



Case Materials for Criminal Investigative Analysis

* Victimology - Complete background information on the victim(s), including physical description, personality, employment, and lifestyle.

Case Materials - Continued

* Reports - Autopsy, laboratory, initial and supplementary police reports.
* Sketches - Crime scene, autopsy sketch
* Photographs - Crime scene, autopsy, victim, aerial

Case Materials - Continued

* Maps - Area map showing all locations pertinent to the crime: victim's residence, place of employment, last known location, crime scenes, recovery sites, other related crimes. Significant geographical or community features

Case Materials - Continued

* Descriptions - Crime scene, general community information
* Media Coverage - Newspaper articles, television coverage

Profiling Concepts

Victimology

*Physical Description
*Lifestyle
*Personality
*Family Friends
*Marital Status
*Employment/Economic Status
*Interpersonal Relationships

Victimology

*Daily Habits
*Criminal History
*Drug/Alcohol Use
*Sexual Habits
*Transportation
*Mental Stability
*Significant Events prior to Crime

Victim Risk Level

* Degree to which the victim contributes or exposes themselves to chance of injury
* Susceptibility to violent crime

High Risk Victim

* Raised expectation that a person is susceptible to violent crime
* Situation or lifestyle has escalated potential victim status

Low Risk Victim

* Minimal expectation of susceptibility to becoming a victim of violent crime
* Situation and /or lifestyle lowers potential victim status

Moderate Risk Victim

* Individual who normally would be considered low risk is engaged in activity that elevates susceptibility towards injury
* Circumstances/location elevate danger

Offender Behavior Characteristics

Offender Risk Level

* Degree to which the offender places himself in jeopardy in order to commit the criminal act

High Risk Offender

* Individual whose lack of planning, control, or poor execution, maximizes his chance of detection
* Due to offender youthfulness/immaturity, mental deficiency, drug/alcohol use, anger, or some combination of these factors

Low Risk Offender

* Offender has minimal expectation of being caught
* Carefully plans offense
* Selects most advantageous time, location, and victim

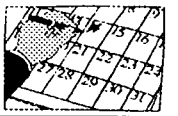
Souvenir / Trophy

* Personal item taken from the victim (Jewelry, clothing, photographs, etc..)
* Enables the offender to relive the crime
* Kept by the offender or given to a significant other person
* May be returned by the offender to the crime scene or grave site

Post Offense Behavior

* Actions taken by the offender following the crime
* Behavior recognizable by others
* Offender recognition through media assistance
* Techniques potentially useful in steering offender towards interjection or mistake

Anniversary Reaction



* Individual's behavior near anniversary of significant event
* Many times occurs around the anniversary of the victim's death, funeral, or date body located
* Offender may visit crime scene, grave site, or attempt contact with victim's family
* Affected by media publicity

Crime Scene Characteristics

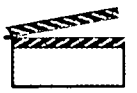
Overkill

* Displayed trauma excessive to that which is necessary to end life
* Suggestive of highly personalized anger
* Victim behavior can affect offender behavior
* Symbolic victim

Undoing

* Attempt by offender to symbolically undo the crime
* Suggests remorse or guilt
* Elevates possibility for noticeable post offense behavior
* Increases possibility of personal association

Staging



* Purposeful alteration of the crime scene
* Done to redirect the investigation away from the offender

Proprietary Interest

* Display of interest or ownership at crime scene
* Protection of personal property
* Sometimes observed at staged crime scenes

Methods of Body Disposal

Dumped

* Little or no effort to conceal the body
* Haste as possible primary objective
* Lack of concern by the offender that the body is quickly located

Concealed

* Concerted effort to ensure body not found
* Delays discovery
* Allows time for distancing

Displayed

* Body is intentionally positioned
* Placement in location where certain to be found
* Positioned to degrade or humiliate the victim, or to shock or offend the person who finds the body

Signature Vs Modus Operandi

Modus Operandi, or Method of Operation

* Technique or means by which an offender commits a criminal act
* Based on learned behavior
* Impacted on by experience, confidence, and mistakes
* M. O. can change - it is not static

Signature

* Ritualistic behavior unnecessary for the successful execution of the crime
* Stems from the offender's fantasy or imagination
* Remains static or fixed. Does not change with time.

Organized
*
Disorganized

Geographic Factors

* Location where victim first approached
* Location(s) of crime scenes
* Body disposal location
* In serial cases, distances between offenses

Time Factors

* Time needed to kill the victim, commit additional acts with the victim, and dispose of the body
* Time of day the crime was committed may provide insight into the lifestyle and occupation of the offender
* In serial cases, time between offenses

Totality of Circumstances

DEFENSE-PROOFING YOUR CHILD INTERVIEWS IN CHILD SEXUAL ABUSE CASES

1999 Crimes Against Children Conference
August 5, 1999
Dallas, Texas

Patricia Toth, J.D.
437 E. Lopez Street
Port Angeles, WA 98362
Phone/Fax: (360) 417-5404
PATOTH@olypen.com

I. Objectivity - - Key Characteristic of the Interviewer

A. An open mind is critical In every interview/investigation--be willing to consider the possibility that an allegation may be false or mistaken

B. Recognize that prior information you have received may not always be correct or complete--don't assume a crime must have been committed and that the suspect is responsible

C. Be open to new evidence and information throughout the interview

D. Your job is not to "validate" abuse, or "get a disclosure," but to elicit accurate information

E. Avoid confirmatory bias

1. Consider alternative explanations for the allegation

2. Ask questions to evaluate other possibilities

3. Explore context surrounding allegation

4. Continue revising hypotheses as new facts emerge

II. Need for Corroboration

A. Common perception is that these cases are almost always "just a child's word against an adult's"

B. Legally, child's testimony alone is enough, if believed, to support a conviction

C. Practically, juries (and judges) want to see more and may be uncomfortable if they perceive case as simply "one on one"

D. Interviewers should think about the investigative interview as an opportunity to elicit information which can potentially lead to other evidence, in addition to child's testimony, which either refutes or supports the suspected crime(s)

III. Role of the Interviewer--Expert or Factual Witness?

A. Expert Testimony

1. Definition of "expert" testimony: opinion based on scientific, technical or other specialized knowledge

2. Definition of an expert: a person with specialized knowledge, skill, experience, training or education

B. Factual Testimony: any witness testifying about something they did, saw, heard, said, etc., without giving an opinion

C. When testifying about an investigative interview with a child, witness/interviewer should be an expert--someone with specialized knowledge and training--giving factual testimony--describing what they did, said, heard and saw, without giving any opinions

D. Not enough to conduct a "good" interview; interviewer must be able to explain and defend interview techniques in court

E. Interviewers concerned about "defense-proofing" the investigative interview with the child must also think about how they can help the child prepare for the trial experience

IV. What To Expect When Testifying About the Investigative Interview With the Child

A. Robust cross-examination

B. Greater judicial scrutiny, both at the trial and appellate levels

C. Good chance that defense will call an opposing "expert" to critique the interview

D. Defense may request a pre-trial "taint" hearing to review suggestiveness of interviewing procedures, and ask that children's ability to recall and testify be deemed "tainted" by unsound interview practices, and that they therefore be prohibited from testifying

1. "Taint" hearing was first required by New Jersey Supreme Court in reversal of conviction in New Jersey v. Kelly-Michaels

2. Prosecutor should object to such a suppression hearing--issue is one of fact to be left up to jury at trial (contact Nat'l Center for Prosecution of Child Abuse, 703-739-0321, for information to use in arguing against the holding of taint hearings)

V. Common Challenges to Interviewing Procedure and Practice

A.. Failure to conduct "blind" interviews

1. Legitimate concern behind this criticism is that interviewer may consciously or unconsciously influence child to confirm what he/she already expects to hear, based on pre-conceived ideas suggested by background information

2. Interviewer must be able to acknowledge awareness of this concern, and show he/she was careful not to assume accuracy of the information, but kept an open mind

3. Interviewer must be able to articulate that proceeding without background information is not optimum investigative practice--that having background is necessary to fully explore alternative explanations for the allegations and thus expose the false accusation, and is necessary to insure that maximum accurate information is obtained from the child

B. Too many interviews

1. Concern here is that repeated interviews reinforce inaccurate account by child; argument is made that only one investigative interview should be done

2. Interviewer should be able to show that number of interviews was

kept to a minimum; helpful if number of different interviewers was minimized

3. Interviewer must be able to explain that sometimes more than one interview is needed for child to trust interviewer and feel comfortable enough to reveal full extent of something which may be frightening, embarrassing

4. Research suggests that repeated within-interview questioning can increase child's suggestibility; repeated interviewing itself is not troublesome if information elicited originally was accurate

C. Interview was not video-taped

1. Defense contends that suggestiveness of interview techniques cannot be fairly evaluated unless interview is videotaped, and that videotaping is recommended as the best practice

2. Interviewer must be able to explain reasons for policy of not video-taping, and show that pertinent interview questions and answers were documented exactly in order to allow an evaluation of the appropriateness of interview techniques

D. Person conducting interview was inexperienced, biased, untrained, etc.

1. Defense challenges ability of interviewer to fairly and skillfully conduct child interviews

2. Interviewer must be able to demonstrate adequate combination of training, experience, skill and objectivity

3. Helpful to show that interviewer was clear that purpose of interview was to investigate with an open mind to determine facts, and not to reinforce previously reached conclusion

E. Interviewer asked "leading" questions

1. Defense often argues that all leading questions in an interview should be avoided, because suggestive and therefore result in unreliable information from child

2. Legitimate concern behind this attack is that leading questions put words in the mouth of the child

3. Be able to explain that specific questions are sometimes more developmentally appropriate with young (especially pre-school age) children than only open-ended questions

    a. Asking only open-ended questions generates least amount of information from young children

    b. When only open-ended questions are used, can lead to errors of omission/false negatives

4. Leading questions, when used, must be used wisely

    a. Make sure child understood that he/she should correct interviewer if something incorrect was said

    b. When needing to be more focused in an interview question, include unlikely information so that child will disagree, correct interviewer, and provide his/her own words

    c. Follow up leading questions with more open-ended questions seeking further details from the child

    d. Importance of additional investigation to verify information generated by more specific questioning

F. Suggestive anatomical dolls were used (inappropriately)

1. Defense argues that doll's body parts are exagerrated and out of proportion, and interviewer uses them to suggest what he/she wants to see or hear, thus causing children to imagine events as a result

2. Interviewer should be able to show that dolls were used appropriately

    a. Only after child had already clearly indicated he/she was sexually assaulted

    b. Only when necessary to clarify what child had difficulty explaining in words

    c. After child was clearly instructed to show only what really happened--words like "pretend" and "imagine" should have

been avoided

VI. Helping Yourself (and the Child) Come Across in Court

A. Beginning the Interview

1. Ask child, "Do you know why you're here today?" or "Has anyone told you anything about our meeting today?"

2. Give simple, appropriate and neutral explanation of your role

3. Avoid indicating you know what the child has told others

4. Be careful discussing 'good touch/bad touch' or similar concepts with value judgments

B. Documentation

1. Determine best way to document the interview in your jurisdiction, and be consistent

2. Document as precisely as possible - - verbatim record of questions and answers can be critical

3. Be careful to document entire interview, not just portion dealing with alleged abusive behavior

4. Explain what you're doing re: documentation to child, whether note-taking, video or audio taping, etc.

5. If taking notes, don't take notes only on abuse issues

6. When interviewer takes notes and types report re: interview afterwards

   a. If original notes are saved, be prepared for defense access to and scrutiny of them

   b. If original notes are discarded after report is prepared, be prepared for cross-examination about 'deliberate destruction' of the notes

   c. Make sure to include even information from interview which

may be 'helpful' to the defense

7. Why note-taking by interviewer is a good idea even when videotaping interview

   a. Provides backup for video record

   b. Allows interviewer to clarify/follow up critical topics during interview

C. Explain <u>and practice</u> ***ground rules*** for the interview with the child

1. TELL THE TRUTH

   a. Determine whether child can demonstrate understanding of truth telling

   b. Obtain child's agreement to tell truth during interview

   c. Be clear that a rule for the interview is no pretending or imagining

2. Tell me if you don't know

3. Tell me if you don't remember

4. Tell me if you don't understand

5. Tell me if I get it wrong (and tell me what's correct)

6. If I repeat a question, doesn't mean your answer was wrong

7. Tell me if you don't want to answer or to talk about it

8. Tell me everything you can remember, because I wasn't there and I don't know what happened

D. Be aware of tendency to rely on focused questions and how difficult to change

1. Check yourself throughout interview: who's talking most? You or child

2. Keep list and practice open-ended questions, for initiating discussion and pairing with leading questions

   a. "Tell me everything you can remember about_____."

   b. "Tell me more about that."

   c. "What happened next?"

   d. "And then what happened?"

   e. "What else do you remember?"

   f. "I'm confused, can you explain that to me again?"

E. Practice having child narrate an event in response to open-ended questions (during rapport building)

F. Don't engage in negative stereotyping

G. Avoid intimidation/coercion

H. Don't encourage imagining

I. Assess child's susceptibility to suggestion

   1. Misleading questions during rapport building/developmental assessment/practice narration

   2. Especially important if child will later testify and be cross-examined

J. Closure/Winding up the interview

   1. "Is there anything else you want to tell me right now?"

   2. "Do you have any questions?"

VII. Helpful References

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