1998 Crimes Against Children Conference

The 10th Annual Conference presented by the Dallas Police Department and the Dallas Children's Advocacy Center

August 17-20 ♡ Hyatt Regency Hotel ♡ Dallas, Texas

Your Name:_____

The 1998 Crimes Against Children Resource Book is dedicated to:

Lieutenant Bill Walsh
Dallas Police Department

To commemorate our 10th Annual Crimes Against Children Conference we would like to honor Lieutenant Bill Walsh of the Dallas Police Department. Lt. Walsh celebrates his 20th anniversary with the Dallas Police Department this year. The last 10 years he has been assigned as Commander of the Investigations Section of the Youth and Family Crimes Division where he has devoted himself to serving the children of Dallas. One of his many accomplishments has been co-founding the Dallas Children's Advocacy Center. This achievement has forever changed the way the City of Dallas responds to child abuse. The Dallas Children's Advocacy Center is a model for the State of Texas. He has devoted much of his personal time serving on various boards, panels and committees to ensure issues of child abuse and neglect are being addressed and improvements made. He has also made quite a reputation for himself as an international speaker and expert on child abuse issues and has presented at many national conferences. In spite of his very busy schedule, he still takes time to speak at local churches, PTA's and civic groups. He is definitely one of a kind. Dallas is fortunate to have this dedicated professional to lead the way in improving our services to the children of this country.

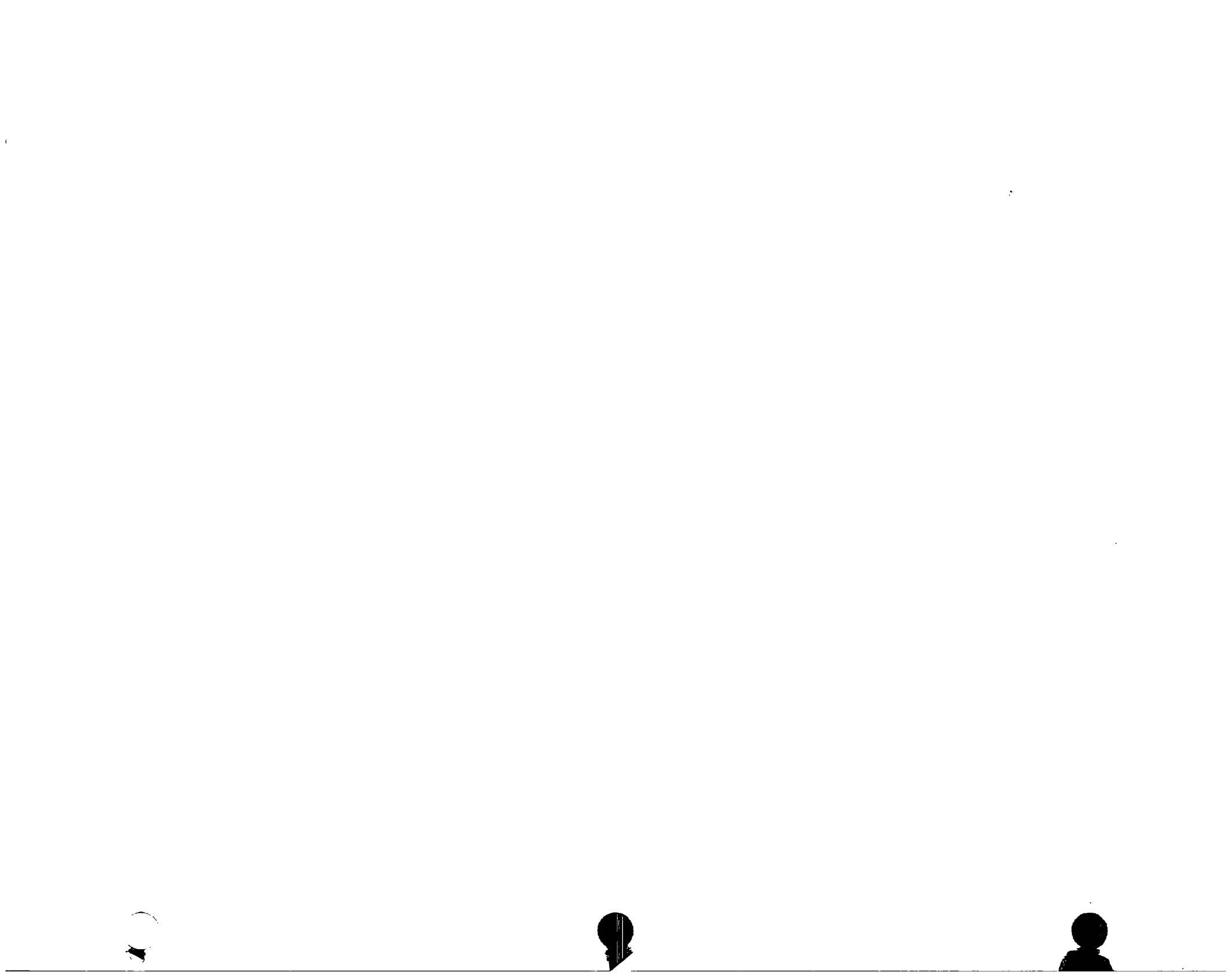


TABLE OF CONTENTS

If the workshop is a repeat, the page numbers will refer you back to the original workshop.
N/A = No materials were submitted by speaker.

10D-11D	Police and CPS: A Team Approach	N/A
10E	Multidisciplinary Team Investigations	431-442
10F-11F	Interviewing Children Who Witness Homicides	443-450
10G-11G	Prosecuting Child Sexual Abuse	N/A
10H-11H	Child Abduction Response Plan	451-480
11E	Expert Panel on Physical Abuse Cases	N/A
DAY 4 - THURSDAY, AUGUST 20, 1998		
12A-13A	Organization and Implementation of a Rural Child Abuse Task Force	481-490
12B-13B	Polly Klaas Case Study	229-230
12C-13C	Darlie Routier Case Study	N/A
12D	Community Response to Child Predators	491-494
12E	Orofacial Trauma/Bite Mark Analysis	495-508
12F	Show Me What Happened: Maximizing Non-Verbal Communication to Clarify Children's Disclosures	509-510
12G	Memory and Suggestibility Issues	511-532
12H	International Child Abductions	N/A
13D	Civil Law for Professionals in Child Abuse Cases	533-558
13E	Expert Panel on Sexual Abuse Cases	N/A
13F	Creating a Safe Place: Assessing the Incestuous Family's Readiness for Reconstruction	N/A
13G	Sexual Abuse: A Child's Perspective	N/A
13H	National Center for Missing and Exploited Children Resources	N/A

STATE OF TEXAS
OFFICE OF THE GOVERNOR

GEORGE W. BUSH
GOVERNOR

June 26, 1998

Greetings:

Welcome to Dallas for the 10th annual Crimes Against Children Conference on August 17-20. Meetings such as this provide a great opportunity to visit with law enforcement and child protective professionals and explore new ideas.

Children are our most precious resource. Families, relatives and communities must provide safe, nurturing environments so that children – the future of the United States – can live fulfilling and productive lives. I commend you for your dedication to eliminating the abuse and neglect of children.

To those from out of town, I know you will enjoy Dallas. From fine restaurants and entertainment to cultural attractions and parks, it has something for everyone.

Laura joins me in sending best wishes for a successful conference.

Sincerely,

GEORGE W. BUSH

POST OFFICE BOX 12428 AUSTIN, TEXAS 78711 (512) 463-2000

The 1998 Crimes Against Children Seminar is co-sponsored by:

Assistance League of Dallas

Children's Advocacy Centers™ of Texas, Inc.

Children's Trust Fund of Texas

Greater Dallas Crime Commission

Hewitt Associates Foundation

IOF Foresters PCA Fund

Missing and Exploited Children's Program
of the Office of Juvenile Justice and Delinquency Prevention

RGK Foundation

Stemmons Foundation

Texas Child Fatality Review Team Project

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

Alamo Children's Advocacy Center

Alliance for Children

Catholic Counseling Services

Child Protective Services

Children's Assessment Center

Children's Medical Center at Dallas

Children's Safehouse of Albuquerque

Collin County Sheriff's Office

Cook Children's Medical Center

Dallas County District Attorney's Office

Dallas County Medical Examiner's Office

Federal Bureau of Investigation

National Center for Missing and Exploited Children

National Children's Advocacy Center

New Jersey State Police-High Technology Crimes Unit

Office for Victims of Crime

Plano Police Department

San Diego County District Attorney's Office

Sonoma County District Attorney's Office

Southeastern Louisiana University

State of North Carolina, First Prosecutorial District Attorney's Office

United States Attorney's Office

United States Department of Justice

United States Department of State
Office of Children's Issues

University of Texas Health Science Center at San Antonio

University of Texas Southwestern Medical Center Dallas

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

Assistance League of Dallas

Circuit City

Dallas Children's Advocacy Center League

Dallas Police Association

Dallas Junior Forum

Destination Dynamics - Dallas, Inc.

Harold's Stores, Inc.

Hyatt Regency Hotel - Dallas

Junior League of Dallas

MJ Designs

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 three specialized squads to respond to crimes against children. They are the **Child Abuse Squad, the Child Exploitation 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:

Child Abuse Squad

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 2751-01-318
POL-00152

Child Exploitation Squad

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, one sergeant 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 **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. This squad began operation in October 1997. In the first seven months, they have made 341 arrests.

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

Dallas Children's Advocacy Center
Their hope is in your vision.

FACTS ABOUT THE DALLAS CHILDREN'S ADVOCACY CENTER

- The Advocacy Center is located in a restored, child-friendly Victorian house at 3611 Swiss Avenue, purchased in 1990 through Community Development Block Grant Funds via the City of Dallas. A three-story addition opened in May, 1997, to accommodate the growing needs of the agency.

- The Advocacy Center is a unique collaborative effort of five public and private agencies charged with treating abused children and bringing their offenders to justice. The five agencies are:

  - Dallas Police Department
  - Dallas County Child Protective Services
  - Dallas County District Attorney's Office
  - Children's Medical Center
  - Department of Pediatrics at the University of Texas Southwestern Medical Center

- Cooperative partnerships have been formed with all 23 law enforcement agencies in Dallas County.

- Case criteria for the Advocacy Center team approach consists of the most severe, complex cases of sexual and physical abuse of children, 14 years of age and younger, residing in Dallas County.

- The Advocacy Center provides therapy for child abuse victims. Children benefit from individual and group counseling programs designed to help them cope with their trauma and prevent further abuse.

- The child abuse caseload now averages about 900 cases a year, exceeding 6,200 children since the agency's inception in 1991. About 30 percent of the total -- approximately 1,900 children-- have received therapy through the center's therapy program.

- The Center strives to break the cycle of violence through education, training and prevention. The Center coordinates local recognizing and reporting child abuse workshops for professionals who interact with children and an annual, national Crimes Against Children Seminar targeting frontline personnel dealing with the investigation and prosecution of child abuse.

- The Advocacy Center provides the leadership, the facility and the funding to make the partnership work. Each agency pays its own personnel, while the agency pays for its staff and related expenses. Currently, there are 19 employees on the Advocacy Center staff and more than 2O personnel from the cooperating agencies headquartered at the Advocacy Center.

- Funding for the Advocacy Center is provided by donations and special events, plus some funding from third party payers and limited state funds. Annual fund-raisers include the *Dallas Cares About Children 5K Run* sponsored by the agency's League, *Bids of Hope* Auction and the *Great Adventure Hunt.*

3611 Swiss Avenue • Dallas, Texas 75204 • (214) 818-2600 • Fax 823-4819

Additional copies of the 1998 Crimes Against Children Seminar 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_____

$35.00 for Single Copies

$25.00 for Two or More Copies

$5.00 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:

Tuesday, August 18, 1998
4:30 - 6:00 P.M.

&

Wednesday, August 19, 1998
4:30 - 6:00 P.M.

Transportation will be provided by the Hyatt Regency Hotel. The bus will transport to and from the Dallas Children's Advocacy Center. See personnel at registration desk for more information about DCAC tours.

1998 Crimes Against Children Conference
Speaker Roster

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)

Sue Austin
Southeast Louisiana University
300 Tchefuncte Oaks
Mandeville, Louisiana 70471
504/845-9594 (Phone)
504/845-9911 (Fax)

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

Lucy Berliner
Harborview Center for Sexual Assault
and Traumatic Stress
325 9th Avenue, Box 359947
Seattle, Washington 98104
206/521-1600 (Phone)
206/521-1814 (Fax)

Arthur Bohanan
Knoxville Police Department
PO Box 3610
Knoxville, Tennessee 37927
423/521-1209 (Phone)
423/421-4124 (Fax)

Tascha Boychuk
Arizona State University, College of Nursing
PO Box 872602
Tempe, Arizona 85287-2602
602/965-7561 (Phone)
602/965-0212 (Fax)

Johnny Rex Buckles
Thompson & Knight, P.C.
1700 Pacific Avenue #3300
Dallas, Texas 75201
214/969-1451 (Phone)
214/969-1751 (Fax)

Connie Nicholas Carnes
National Children's Advocacy Center
106 Lincoln Street
Huntsville, Alabama 35806
205/533-5437 (Phone)
205/534-9616 (Fax)

John Chacón
Children's Trust Fund of Texas
8929 Shoal Creek Boulevard #200
Austin, Texas 78757-6854
512/458-1281 (Phone)
512/458-9471 (Fax)

Cathy Crabtree
Young County Family Resource
and Child Advocacy Center
PO Box 155
Graham, Texas 76450
940/549-9829 (Phone)
940/549-0302 (Fax)

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

Greg Davis
Dallas County District Attorney's Office
133 N. Industrial, LB 19
Dallas, Texas 75207-4313
214/653-3614 (Phone)
214/653-3499 (Fax)

Richard A. Dusak
US Secret Service
1800 G Street, NW
Suite 929
Washington, DC 20223
202/435-5292 (Phone)
202/435-6228 (Fax)

Robert Hugh Farley
Federal Child Exploitation Strike Force
Cook County Sheriff's Police Department
433 W. Harrison, 5th Floor
Chicago, Illinois 60669-2231
312/983-6235 (Phone)
312/294-8968 (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)

Daniel A. Feucht
Fox Valley Technical College
1825 N. Bluemound Drive
Appleton, Wisconsin 54914
920/735-4725 (Phone)

Dana Gassaway
San Diego District Attorney's Office
330 West Broadway #1220
San Diego, California 92101
619/531-3162 (Phone)
619/515-8825 (Fax)

Michael T. Geraghty
New Jersey State Police
High Technology Crimes Unit
Bldg 14 River Road
West Trenton, New Jersey 08628
609/882-2000 x 2555 (Phone)
609/882-3947 (Fax)

Eliana Gil
Inova Keller Center
10396 Democracy Lane
Fairfax, Virginia 22030
703/218-8537 (Phone)
301/869-0621 (Fax)

Dan Goldstein
San Diego District Attorney's Office
330 West Broadway
San Diego, California 92101
619/531-3207 (Phone)

Dawn Hill
The Children's Assessment Center
2500 Bolsover
Houston, Texas 77005
713/986-3453 (Phone)
713/986-3554 (Fax)

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

Linda B. Hooper
Federal Bureau of Investigation
11700 Beltsville #200
Calverton, Maryland 20705
301/586-4519 (Phone)
301/586-4499 (Fax)

Tamara Indest
Southeast Louisiana University
300 Tchefuncte Oaks
Mandeville, Louisiana 70471
504/845-9594 (Phone)
504/845-9911 (Fax)

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

Nancy Kellogg
University of Texas Health Science Center
Alamo Children's Advocacy Center
7130 Highway 90 West
San Antonio, Texas 78227
210/675-9000 (Phone)
210/675-9020 (Fax)

Marcia J. Kesner
Timberlawn Mental Health Systems
6102 E. Mockingbird #477
Dallas, Texas 75214
214/828-4346 (Phone)
214/388-3603 (Fax)

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)

Leah Lamb, D.O.
Child Advocacy Resource & Evaluation Team
Cook Children's Medical Center
801 Seventh Avenue
Fort Worth, Texas 76104
817/885-3953 (Phone)
817/870-7445 (Fax)

1998 Crimes Against Children Conference
Speaker Roster

Nancy Lamb
District Attorney's Office
202 E. Colonial Avenue
Elizabeth City, North Carolina 27909
919/331-4743 (Phone)
919/331-4807 (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)

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

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
1600 W. 7th #616
Fort Worth, Texas 76102
817/336-7135 (Phone)
817/336-7143 (Fax)

Joni L. McClain, M. D.
Southwestern Institute of Forensic Science
Box 35728
Dallas, Texas 75235-0728
214/920-5900 (Phone)
214/920-5908 (Fax)

Doreen E. McGookey
Dallas Police Department
Legal Liaison Division
2014 Main Street
Dallas, Texas 75201
214/670-5471 (Phone)
214/670-4136 (Fax)

Michael Meese
Sonoma County District Attorney's Office
600 Administration #212
Santa Rosa, California 95403
707/527-2100 (Phone)
707/527-2482 (Fax)

Shirley Menard
Alamo Children's Advocacy Center
7703 Floyd Curl Drive
San Antonio, Texas 78284-7951
210/567-5882 (Phone)
210/567-5950 (Fax)

Madaline Merry
Children's Safehouse
PO Box 6573
Albuquerque, New Mexico 87197
505/344-1465 (Phone)
505/342-9466 (Fax)

John E. B. Myers
University of the Pacific
McGeorge School of Law
3200 Fifth Avenue
Sacremento, California 95817
916/739-7176 (Phone)
916/739-7272 (Fax)

Nancy Nayak
National Center for Missing
and Exploited Children
2101 Wilson Blvd. #550
Arlington, Virginia 22201
800/843-5678 (Phone)
703/235-4069 (Fax)

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

Donna I. Persaud, MD
Children's Medical Center
1935 Motor Street
Dallas, Texas 75235
214/640-2870 (Phone)
214/640-6390 (Fax)

Sarah Pickard
Federal Bureau of Investigation
935 Pennsylvania Avenue, NW
Room 4127
Washington, DC 20535
202/324-3665 (Phone)
202/324-2731 (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)

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)

Eric G. Reis
Thompson & Knight, P.C.
1700 Pacific Avenue #3300
Dallas, Texas 75201
214/969-1118 (Phone)
214/969-1751 (Fax)

Lawrence R. Ricci
The Spurwink Child Abuse Program
17 Bishop Street
Portland, Maine 04103
207/879-6160 (Phone)
207/871-5668 (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)

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)

Scotty Sims
Southeast Louisiana University
300 Tchefuncte Oaks
Mandeville, Louisiana 70471
504/845-9594 (Phone)
504/845-9911 (Fax)

Janet E. Squires, MD
Children's Medical Center
1935 Motor Street
Dallas, Texas 75244
214/640-2329 (Phone)
214/640-6390 (Fax)

Patty Villarreal
Alamo Children's Advocacy Center
7703 Floyd Curl Drive
San Antonio, Texas 78284-7951
210/567-5882 (Phone)
210/567-5950 (Fax)

1998 Crimes Against Children Conference
Speaker Roster

Theresa Kern Vo
Catholic Counseling Services
3725 Oak Lawn
Dallas, Texas 75219
214/526-2772 (Phone)
214/526-2941 (Fax)

Susan Waggoner
Child Protective Services
908 Southland Avenue
Fort Worth, Texas 76104
817/335-7172 (Phone)
817/335-8482 (Fax)

Natacha Peláez Wagner
Executive Director
Children's Advocacy Centers of Texas™, Inc.
PO Box 4860
Austin, Texas 78765
800/255-2574 (Phone)
512/441-4331 (Fax)

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

D. A. Watts
Dallas Police Department
2014 Main Street
Dallas, Texas 75201
214/670-5146 (Phone)
214/670-4033 (Fax)

Patty Wetterling
PO Box 639
St. Joseph, Minnesota 56374
320/363-0470 (Phone)
320/363-0473 (Fax)

Charles Wilson
National Children's Advocacy Center
106 Lincoln Street
Huntsville, Alabama 35806
205/533-0531 (Phone)
205/534-9616 (Fax)

Sarah Winkler
Children's Trust Fund of Texas
8929 Shoal Creek Blvd. #S-200
Austin, Texas 78757-6854
512/458-1281 (Phone)
512/458-9471 (Fax)

Julia Coker Wolf
The Children's Assessment Center
2500 Bolsover
Houston, Texas 77005
713/986-3452 (Phone)
713/986-3554 (Fax)

Rick Zomper
Fort Worth Police Department
908 Southland Avenue
Fort Worth, Texas 76104
817/332-5036 (Phone)
817/335-8482 (Fax)

FACULTY AND SPEAKERS

DANIEL ARMAGH

Dan Armagh received his bachelor's degree from the University of Oklahoma in 1980 and his law degree from the University of Oklahoma in 1983. He has been admitted to the bar in Oklahoma and Pennsylvania and has been a prosecutor for 6 years in both states. Prior to becoming a prosecutor, Mr. Armagh was in private practice with emphasis in civil and criminal litigation. Mr. Armagh was an assistant district attorney for Lawrence County, Pennsylvania, where he was in charge of the Sexual Offense Prosecution Unit with emphasis on the prosecution of crimes against children for 4 years. Mr. Armagh joined the staff of the American Prosecutors Research Institute's National Center for Prosecution of Child Abuse as a Senior Attorney in April 1995. Mr. Armagh's duties at the Center include providing intensive training and assistance to prosecutors and other professionals across the country concerning the investigation and prosecution of child abuse. The Center also serves as an authoritative clearinghouse for case law developments, court reforms, trial strategy, the latest research, medical advances, policy development and case management.

SUE AUSTIN, Ph.D.

Dr. Sue Austin is a self-employed Psychologist and Associate Professor of Counselor Education at Southeastern Louisiana University. She has over ten years experience working with victims of abuse. She currently conducts forensic interviews of alleged child sexual abuse cases for the Children's Advocacy Center which utilizes a multidisciplinary team approach. She also conducts evaluations for the courts. She has completed numerous hours of training in working with abuse victims. She teaches a course in assessing and treating victims of child sexual abuse.

CHRISTOPHER R. AVERY

Special Agent Avery is a graduate of the University of Tennessee at Knoxville and holds a Bachelor of Science Degree. Agent Avery has eight years of computer experience involving network, database and system development and deployment in the private sector before joining the FBI. Agent Avery entered the FBI in 1996 and has been assigned to the Innocent Images Initiative.

LUCY BERLINER

Lucy Berliner is a Clinical Associate Professor at the University of Washington School of Social Work, Department of Psychiatry and Behavioral Sciences. She treats children and adults who have experienced violence or trauma, conducts research/evaluation and promotes public policy on behalf of crime victims.

ARTHUR M. BOHANAN

Arthur M. Bohanan is an internationally award winning patented inventor, researcher, lecturer and writer, a Certified Latent Print Examiner, Board Certified Forensic Examiner, Board Certified Questioned Document Examiner and a Fellow of the American College of Forensic Examiners. Also a certified police instructor with over 36 years in the study and practical application of forensics in more than 1000 violent crime scenes. Bohanan is a Police Specialist III, AFIS Manager and Senior Forensic Examiner with the Knoxville Police Department. He conducts research at the University of Tennessee Hospital and "Body Farm," with the FBI, RCMP and Virginia Division of Forensic Services. A consultant and instructor for the Office of Juvenile Justice and Delinquency Prevention/National Center for Missing Children and a specialist with the National Disaster Medical System's DMORT 4 Nuclear, Biological and Chemical Decontamination Unit. He received an "Honorary Doctorate of Science and Technology" (May 1998) from the International Hall of Fame, Atlanta, sponsored by the Inventors Club of America for "Dedicated research involving fingerprint analysis and identification and recovery of missing children."

TASCHA BOYCHUK, Ph.D., RN

As a forensic interviewer, Dr. Boychuk has interviewed over 1500 children reporting sexual or physical abuse. During the past five years her focus has shifted to children who witness homicide. She serves as an interviewer and consultant for law enforcement investigating homicides where children are witnesses.

JOHNNY REX BUCKLES

Johnny Rex Buckles is an associate in the tax practice group at Thompson & Knight, P.C. in Dallas, Texas. He received his Juris Doctorate degree, *cum laude*, from the Harvard Law School, where he served for two years as a member of the Harvard Law Review. Mr. Buckles received his Bachelor of Science degree with a major in Accounting from Oklahoma State University. Mr. Buckles practices primarily in the areas of nonprofit and tax-exempt organizations, including the process of incorporation, obtaining recognition of federal income tax exemption from the Internal Revenue Service, compliance, and tax controversy. He is a member of many professional organizations, including the American Bar Association, the State Bar of Texas, and the Dallas Bar Association. He currently attends Dallas Theological Seminary on a part-time basis in pursuit of a Master of Arts degree in Biblical Studies.

CONNIE NICHOLAS CARNES, MS, LPC

Connie Nicholas Carnes is the Clinical Director for the National Children's Advocacy Center, Huntsville, Alabama. Ms. Carnes directs the Intervention Services Program of the NCAC and serves as clinical liaison to the Madison County Multidisciplinary Team. She has thirteen years of therapy experience and has focused her practice on children for the past eight years. She is a executive board member for the Alabama Professional Society on the Abuse of Children and speaks and writes extensively on child abuse issues.

JOHN CHACÓN

John Chacon is a graduate of the University of Texas at El Paso with degrees in Social Work, Psychology and Military Science. He is a national certified consultant for Family Development Resources, Inc. for more than ten years and former therapeutic social worker for the El Paso Center for Children for four years.

CATHY CRABTREE

Cathy Crabtree is the Executive Director of the Young County Family Resource and Child Advocacy Center located in Graham, Texas. She has held this position since the initial development of this small, rural CAC in the Fall of 1992. Ms. Crabtree, a graduate of West Virginia University, is also a founding member of the Children's Advocacy Centers of Texas, Inc. Board of Directors and serves as chairman of the Standards Committee.

ROBERT CUMMINGS

Robert Cummings has been a Dallas Police officer for 13 years. He is currently assigned to the Sex Offender Apprehension Program (SOAP) where he tracks and monitors registered sex offenders.

GREG DAVIS

Greg Davis served as an Assistant District Attorney from 1977 to 1982. After 10 years in private practice, he rejoined the Dallas County District Attorney's Office in 1992. He is a Chief Felony Prosecutor in the Capital Murder Division where he tries death penalty cases. To date, he has obtained four death sentences, including Darlie Routier, only the seventh woman to be sent to Texas' death row.

RICHARD A. DUSAK

Richard Dusak received his Bachelor's degree from Millersville University of Pennsylvania in 1973. In 1974 he became employed as a Uniformed Division officer with the US Secret Service and was involved in the protection of the White House complex and Foreign Missions. In 1976, he transferred to the Special Investigations and Security Division, now the Forensic Services Division. In this position, he trained and qualified as a Forensic Document Examiner and was responsible for representing the Secret Service as an expert witness in criminal cases. He currently holds the position of Senior Document Analyst and supervise the Automated Recognition Section of the Forensic Services Division. He serves as liaison to federal, state and local law enforcement in crimes against children and represents the Secret Service on the Federal Agency Task Force for Missing and Exploited Children.

ROBERT HUGH FARLEY

Robert Hugh Farley is a 24-year veteran of the Cook County Sheriff's Police Department in Chicago, Illinois. As a Detective, he has 22 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, child exploitation and child prostitution in an undercover, proactive capacity. As a nationally recognized expert, consultant, author and instructor in child abuse investigative techniques, he has trained thousands of police officers and professionals throughout the United States and Canada. As a result of his training curriculum, the child abuse investigative techniques he developed have been implemented by hundreds of police departments, child protective agencies, child advocacy centers and prosecutors throughout North America and Europe.

BYRON FASSETT

Sergeant Byron Fassett has been with the Dallas Police Department for 17 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 14 detectives and is divided into 2 teams, the Investigations Team and the SOAP (Sex Offender Apprehension Program) 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 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.

DANIEL A. FEUCHT

Daniel Feucht has a Bachelor of Business Administration Degree and an Associate of Arts Degree in both Police and Fire Science Technology. Dan has more than 20 years of experience in law enforcement. He achieved and retired with the rank of Sergeant from the Appleton, Wisconsin Police Department. During his tenure with the Department, he was assigned to the Investigative Service Unit as a Property/Evidence Control Officer in the Identification Section. His responsibilities included property and evidence management, evidence management principles, techniques and applications training for in-house field evidence technicians, fire department, ambulance, hospital and other police jurisdictional personnel. He trained police school liaison officers, Department of Social Services and hospital personnel on sensitive crime evidence management. Dan developed and implemented policies and procedures on evidence and property management for the Appleton Police Department accreditation process and assists other police jurisdictions with major crime scene management. Dan has extensive training in the field of crime scene technology. He developed and implemented various training programs statewide. Since 1986, he has been a certified instructor for Fox Valley Technical College. In addition to conducting in-services and specialized training on crime scene technology, he teaches with the Police Academy and at the academic level. Dan is a member and certified crime scene analyst with the International Association for Identification (IAI). He has been an active member with the Wisconsin Association of Identification (WAI) since 1980 and served as president during the 1994-95 term. Dan is a consultant and instructor for the Office of Juvenile Justice and Delinquency Prevention/National Center for Missing and Exploited Children.

DANA GASSAWAY

Dana Gassaway has been in law enforcement for the past 26 years. He spent 21 years on the San Diego Sheriff's Department, with the last 10 years as a detective in the Sheriff's Child Abuse Unit. At both the Sheriff's Department and the District Attorney's Office, he is responsible for the investigation of both physical and sexual abuse of children. He has specialized in conducting pro-active investigations into the sexual exploitation of children. Investigator Gassaway has provided training to law enforcement, child protective services personnel and prosecutors throughout the United States. He is the past president of the San Diego Child Abuse Investigator's Association and past member of the board of directors of the American Professional Society on the Abuse of Children. He is currently on the board of the California Professional Society on the Abuse of Children.

MICHAEL T. GERAGHTY

Detective Sergeant Geraghty is a 12 year member of the New Jersey State Police. He is past president of the High Technology Crime Investigators Association, Northeast Chapter.

FACULTY AND SPEAKERS

ELIANA GIL, Ph.D.

Dr. Eliana Gil is the Coordinator of the Abused Children's Treatment Program at Inova Keller Center in Fairfax, Virginia. She is also Director of the Starbright Training Institute for Child and Family Play Therapy which provides comprehensive clinical training programs on the assessment and treatment of child abuse and neglect, as well as play therapy theories and application with children and families. Dr. Gil has a private practice in Rockville, Maryland and she is a Registred Play Therapy Supervisor, a Registered Art Therapist, a licensed Marriage, Family, Child Counselor, and a Certified Family Therapist who received her doctorate in family therapy from the California Graduate School of Family Psychology in San Rafael, California. She served on the Boards of Directors of the American Professional Society on the Abuse of Children and the National Resource Center on Child Sexual Abuse for several years and is currently President of the Association for Play Therapy. Dr. Gil is an adjunct faculty member at George Washington and Virginia Tech Universities where she teaches play and family therapy courses. Dr. Gil has written numerous materials on child abuse and related topics, including: *Outgrowing the Pain: A Book for and About Adults Abused as Children; United We Stand: A Book for Individuals with Multiple Personalities; The Healing Power of Play: Therapy with Abused Children and Outgrowing the Pain Together: A Book for Spouses and Partners of Adult Survivors.* Her most recent books are *Treating Abused Adolescents: Systemic Treatment for Families who Abuse; Play in Family Therapy; Sexualized Children: Assessment and Treatment of Sexualized Children who Molest*, co-authored ith Dr. Toni Cavanagh Johnson; and *Someone in my Family has Molested Children: A Book for Kids Whose Mom, Dad or Relative Molested Children*, co-authored with Dr. Jeffrey Bodmer-Turner. Dr. Gil is a well-known lecturer, author, and clincian and has been a frequent quest on local and national TV and radio shows. She is bilingual and bicultural, originally from Guayaquil, Ecuador.

DAN GOLDSTEIN

Dan Goldstein has spent seven years prosecuting cases in the area of family protection. Currently, Mr. Goldstein is assigned to the Family Protection Division of the San Diego County District Attorney's Office where he prosecutes child abuse and domestic violence crimes. Prior to becoming a prosecutor, Mr. Goldstein was employd as a Santa Barbara County Paramedic and training officer for 10 years. It was during these years he became committed to prosecuting abusers of all types. Mr. Goldstein obtained his undergraduate degree fro the University of California at Santa Barbara while he worked full-time as a paramedic. He attended Whittier College School of Law where he graduated magna cum laude. Mr. Goldstein began his career as a prosecutor with the San Diego City Attorney here he primarily prosecuted child abuse and domestic violence crimes before accepting a position with the District Attorney in 1993. Dan has lectured extensively on issues involving family protection. He is a technical advisor to the California District Attorneys Association and has lectured throughout the country on domestic violence prosecution and child abuse. Dan has also lectured at several health care symposiums on issues of child abuse and domestic violence. During his career he has successfully prosecuted many high profile cases, including Sally McNeil for the murder of her husband, Mr. California; Mario Rushing for the murder of Tamara S. and her unborn fetus; Daniel Moriarity, the chairman of the the University of San Diego's Psychology Department for threats against his wife and Ivan and Veronica Gonzales, who became the first married couple in California to receive the death penalty after they were convicted of torturing and murdering their four year old niece.

DAWN HILL

Dawn Hill received her Masters of Social Work from the University of Houston in 1994. She holds an undergraduate degree in Psychology from Southwest Texas State University. Dawn is licensed as an Advanced Clinical Practitioner in the state of Texas. She has worked and trained in the area of child sexual abuse and incest since 1988. She developed and supervised the interviewing/videotaping program at the Children's Assessment Center. She is currently a therapist whose responsibilities include: providing individual, group and family therapy services, court testimony, community training, case consulatation and crisis services.

MARK A. HILTS

Mark A. Hilts is a Supervisory Special Agent with the FBI's National Center for the Analysis of Violent Crime. He has been in law enforcement for over 17 years and for the last three years has been assigned to the FBI's Child Abduction and Serial Killer Unit. Prior to joining the FBI, Agent Hilts spent six and a half years as a police officer wih the Plano, Texas Police Department.

FACULTY AND SPEAKERS

LINDA B. HOOPER

Linda Hooper is a graduate of San Jose State Univesity in California and holds a bachelor of science degree in Criminal Justice. Mrs. Hooper held several positions in the criminal justice field prior to entering the FBI in 1984 as a Special Agent. Mrs. Hooper has served in both the Portland Division and the Washington Field Office working violent crimes and gang homicides. In January 1995, Mrs. Hooper was promoted to supervisor in the Violent Crimes Unit, Violent Crimes and Major Offender Section in the Criminal Investigative Division at FBI Headquarters where she was the Program Manager of the Innocent Images National Initiative as well as the Kidnapping Coordinator. In January 1997, Mrs. Hooper was promoted to squad supervisor in the Baltimore Division where she supervises a squad devoted to working the Innocent Images National Initiative.

TAMARA INDEST

Tamara Indest is Executive Director of CASA Services, Inc. and the Children's Advocacy Center for Tangipahoa, Livingston, and St. Helena parishes in Louisiana. She is responsible for overseeing the work of the Program Coordinators of both the CASA and the Children's Advocacy Center. Tamara provides community education and awareness to daycare workers, educators, child protection workers, juvenile probation officers, CASA volunteers and board members, judges, attorneys, civic organizations and the community at large on child abuse and neglect issues. She has recruited, trained and supervised community volunteer advocates for abused and neglected children in State custody since 1994. She is responsible for procuring funding and has received approximately $600,000 from various funding sources. Tamara has a degree in criminal justice and is currently working on a master's degree in counseling.

MICHAEL V. JOHNSON

Detective Mike Johnson is a founding member and child abuse investigator for the Collin County Children's Advocacy Center, and was named their 1996 "Child Advocate of the Year." A child abuse detective with the Plano Police Department since 1986, Mike also served on Senator Florence Shapiro's Blue Ribbon Committee where he was instrumental in formulating the now instated, "Ashley's Laws." He currently serves on the advisory board for the Junior League of Plano and has also served on the Board of Directors for the National Network of Children's Advocacy Centers and the advisory board for the Education and Training Division of Child Protection for the Children's National Medical Center in Washington, D.C. He speaks at federal, state and local programs focusing on child abuse, and lectures citizens' groups and other police organizations on child abuse issues.

NANCY D. KELLOGG, M.D.

Dr. Nancy Kellogg is an Associate Professor of Pediatrics and the Medical Director of the Alamo Children's Advocacy Center. She has worked full time in child abuse since 1988, evaluating over 4500 children and teens and testifying in over 450 cases. She has authored many articles and book chapters including one regarding anogenital symptoms and signs confused with sexual abuse.

MARCIA J. KESNER

Marcia Kesner is Director of Admissions, Consultations and Evaluations at Timberlawn Mental Health Systems in Dallas, Texas and a therapist in private practice. She has conducted over 3000 assessments on individuals, couples and families. She has previously worked for the Dallas Police Department, Dallas County District Attorney's Office and Dallas County Mental Health and Mental Retardation.

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.

NANCY LAMB

Nancy Lamb has been a prosecutor in northeastern North Carolina since 1984. A major portion of her career has been and is currently devoted to the prosecution of child abuse cases. She joined the staff of the North Carolina Department of Justice as an Assistant Attorney General for one year, on special assignment to the criminal division as a prosecutor in the Little Rascals day care cases in Edenton, North Carolina. Nancy received her undergraduate degree from Appalachian State University in 1977 and her law degree from Wake Forest University in 1982. Nancy is on the training faculty for the Southern Regional Children's Advocacy Center, operated by the National Children's Advocacy Center in Huntsville, Alabama. She travels throughout the 17 state southern region to assist and train others in establishing child-focused programs that promote coordination among agencies involved with child abuse victims. She is President of the North Carolina Professional Society on the Abuse of Children, the state chapter affiliate of the American Professional Society on the Abuse of Children (APSAC). Nancy was elected to APSAC's Board of Directors in 1996 and to the Executive Committee in 1997 where she serves as co-chair of the Professional Education Committee. For the past six years, Nancy has provided training on child abuse topics at both state and national conferences. Additionally, she is a frequent lecturer for the American Prosecutors Research Institute's National Center for Prosecution of Child Abuse.

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 assigned to the Missing and Exploited Children Task Force at the FBI Academy in Quantico, Virginia. He is a founding member of the Board of Directors of the American Professional Society on the Abuse of Children (APSAC) and is currently a member of the APSAC Advisory Board. He is also a member of the US Interagency Task Force on Child Abuse and Neglect and the Boy Scouts of America Youth Protection Expert Advisory Panel. Mr. Lanning is 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. He has lectured before and trained thousands of police officers and criminal justice professionals.

DAN LESHER

Dan Lesher has been a Dallas Police officer for approximately 17 years. For the last 10 years he has been assigned to the Child Abuse Squad where he investigates cases of physical and sexual child abuse involving family members, including child fatalities.

JORGE MARTINEZ

Jorge Martinez is a native of Chicago, Illinois and a graduate of Loyola University of Chicago. Mr. Martinez served for eight years in various positions as a sworn police officer on the Skokie, Illinois Police Department. He was appointed as a Special Agent with the Federal Bureau of Investigation in 1988. Mr. Martinez has served in the Chicago

and Washington field offices working violent crimes, property crimes, gang crimes and crimes on government reservations. In June 1996, Mr. Martinez was promoted to supervisor in the Violent Crimes and Major Offenders Section in the Criminal Investigative Division at FBI Headquarters where he was the Manager of the Innocent Images National Initiative. In March 1998, Mr. Martinez was promoted to squad supervisor in the Baltimore Division where he supervises a second squad devoted to working the Innocent Images initiative.

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

Special Agent McCall was appointed to the FBI in November 1990. He was assigned to the Dallas Field Office in March 1991. He was appointed to the Evidence Response Team (ERT) in Ausgust 1991 and made Team Leader in September 1992. He is currently serving as Coordinator.

JONI L. MCCLAIN, M.D.

Dr. McClain is currently a medical examiner at the Southwestern Institute of Forensic Sciences in Dallas, Texas. She is board certified in anatomic, clinical and forensic pathology. She is a member of the Dallas County Child Death Review Committee at the Dallas Children's Advocacy Center. She has lectured to many agencies on child abuse.

DOREEN E. McGOOKEY

Doreen McGookey is an Assistant City Attorney for the City of Dallas. Her duties include rendering legal advice to the Dallas Police Department. She received her B.A. from Austin College in 1986 and her J.D. from Baylor Law School in 1989.

MICHAEL MEESE

Michael Meese, a sergeant with the Petaluma Police Department, was the lead investigator in the Polly Klaas case. His involvement in the case began within an hour of the crime and lasted throughout the trial. His responsibilities included daily supervision of the investigative activity, interviewing the suspect, and assisting in the preparation for and presentation of the case at trial. Mr. Meese works as a Criminal Investigator for the Sonoma County District Attorney's Office in Santa Rosa, California. He earned a master's degree in public administration from the University of San Francisco. Mr. Meese teaches various law enforcement subjects through the Santa Rosa Junior College to managers, supervisors and peace officers. He is an Assistant Professor at a private college where he facilitates courses in ethics.

SHIRLEY W. MENARD

Dr. Menard has been working with abused children for the past 20+ years and specifically with sexually abused children for 4 years. She is an Associate Professor teaching graduate nursing students and medical students. Dr. Menard is a researcher, practitioner and teacher with many articles and presentations to her credit.

MADALINE MERRY

Madaline Merry is a Child Interview Specialist at the Children's Safehouse in Albuquerque, New Mexico. She has conducted more than 600 forensic interviews and has additionally facilitated over 1500 interviews as a member of the multidisciplinary team. She is a master's level art therapist who attained her degree in 1995 at the University of New Mexico. Her clinical experience includes group and individual work with adult and child sexual trauma survivors and their families.

JOHN E.B. MYERS

John E.B. Myers, J.D. is Professor of Law at the University of the Pacific, McGeorge School of Law in Sacremento, California. He has authored and co-authored numerous books, book chapters and articles on the subject of child abuse and neglect. He is a frequent speaker at conferences and training sessions, having made more than 200 presentations in the US, Canada and Scotland. John is on the faculty of the National Judicial College, the National Council of Juvenile and Family Court Judges and the National Center for Prosecution of Child Abuse.

NANCY NAYAK

Nancy Nayak is the Assistant Director of the International Division of the National Center for Missing and Exploited Children (NCMEC). Since joining NCMEC in October 1996, she has assisted in developing NCMEC's role as a respected national resource in international abduction issues. She also manages incoming cases of international parental abductions under the Hague Convention for the Department of State. She has a master of arts degree in international politics from George Mason University and a bachelor of arts in international studies and in history from Thomas More College in Crestview Hills, Kentucky.

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.

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.

SARAH PICKARD

Before going to work for the FBI, Ms. Pickard worked for the sheriff's department in North Georgia for 11 years and in 1979, attended the FBI's National Academy. Ms. Pickard went to college at night and earned a bachelor of science degree in criminal justice while working at the sheriff's department. In May 1982, Ms. Pickard returned to the FBI Academy for new agent training following which she reported to her first assignment in the Atlanta Division. Following assignments in the Honolulu and New York Divisions. She was promoted to Supervisory Special Agent in March 1989 and transferred to FBI Headquarters where she worked in the Office of Professional Responsibility, the FBI's equivalent of an internal affairs unit, and also served as an Assistant Inspector. In October 1993, she transferred to the FBI's Springfield Division where she supervised 15 agents and 9 local and state police officers working a variety of crimes in 27 counties. In May 1997, Ms. Pickard was promoted to Unit Chief and returned to FBI Headquarters where she oversees the Offices of Crimes Against Children and Indian Country Investigations in the Special Investigations and Initiatives Unit.

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.

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.

ERIC G. REIS

Eric Reis is an attorney in the Dallas office of Thompson & Knight, P.C. He graduated with honors from the University of Texas School of Law, where he served as Associate Editor of the Texas Law Review and as Chairman of the Legal Research Board. He received his undergraduate degree from Harvard University. Mr. Reis is a member of the Tax Section and the Real Property, Probate and Trust Law Section of the American Bar Association. His practice focuses primarily on estate planning, charitable gift planning and tax exempt organizations.

LAWRENCE R. RICCI

Lawrence R. Ricci, MD is board certified in Pediatrics and Emergency Medicine. He is a full time specialist in the evaluation and treatment of abused children as director of the Spurwink Child Abuse Program in Portland, Maine. The Child Abuse Program is a statewide referral center for Maine children and Dr. Ricci over the past 10 years has evaluated and treated over 3000 children for abuse concerns. Dr. Ricci has served on a number of state and national child abuse committees including Chair of the Maine Child Death/Serious Injury Review Panel and Chair of the Section on Child Abuse for the American Academy of Pediatrics. He is director of the Annual Colby College Child Abuse Conference and the Annual Spurwink Northern New England Conference on Child Maltreatment and has developed and presented numerous child abuse workshops throughout Maine and around the country to social workers, mental health professionals, legal professionals and medical professionals. He testifies frequently in court and has published widely.

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 has been with the National Center for Missing and Exploited Children (NCMEC) since 1990, first as the Supervisor of the Case Analysis Unit, then as Director of the Exploited Child Unit since November 1996. Prior to joining NCMEC, Mr. Rodriguez was a Detective (retired) with the Metropolitan Police Department in Washington, DC, where he was assigned to the Intelligence Division. Mr. Rodriguez was detailed to the FBI from March 1985 to June 1990 as an Intelligence Liaison Officer working on Chinese Organized Crime. Mr. Rodriguez has been a guest lecturer at the University of Maryland, the FBI Academy (Quantico, VA), the British Senior Police College (Bramshill, England) and several law enforcement conferences and symposiums speaking on the issues of missing children and child sexual victimization.

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

Commander Brad Russ has been a senior instructor for the Department of Justice, OJJDP since 1986. He has provided training to thousands of child protection professionals including law enforcement officials, child protective services workers, prosecutors, judges, and individuals from a wide range of human service agencies. Commander Russ is a 19 year veteran who currently heads the Bureau of Investigative Services for the Portsmouth, New Hampshire Police Department. Commander Russ was one of the original founding members of his state's first full child protection multidisciplinary team in 1983. The team has expanded its role and still operates today as a national model, not only for child protection, but also to develop early intervention and community based collaborative strategies to assist children and their families. 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.

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.

SCOTTY SIMS

Scotty Sims is Program Coordinator for the Children's Advocacy Center in Tangipahoa, Livingston, and St. Helena parishes in Louisiana. She coordinates the duties of the multidisciplinary team which investigates, assesses and prosecutes child sexual abuse cases. Prior to becoming Coordinator, Scotty worked with children through the Louisiana Science and Arts Center for one year. She assisted in the establishment of the Hospice Foundation in Tangipahoa and worked for many years as a Hospice volunteer with children dealing with grief and death. Scotty will complete her master's degree in counseling from Southeastern Louisiana University in December 1998.

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.

PATTY VILLARREAL

Patty Villarreal has worked with abused children for many years and along with her work with sexually abused children, she also works with Shaken Baby Syndrome. She is an associate professor teaching family nursing. She was also the director of the Neonatal Nurse Practitioner Program at the University of Texas Health Science Center at San Antonio. Ms. Villarreal is also a researcher and teacher with many articles and presentations to her credit.

THERESA KERN VO

Theresa Kern Vo, Ph.D., is a licensed psychologist. She is a frequent speaker on issues related to child abuse and neglect and stress management. She is the Clinical Director of the Dallas Crisis Team which provides CIS debriefings for law enforcement, fire and other emergency service personnel. She is a trainer with the Southeast Regional Children's Advocacy Center. She is the Administrator of CCS and has a private practice where she specializes in work related stress.

SUSAN WAGGONER

Susan Waggoner has been a CPS investigator for 8 ½ years. The last four years she has been in the TIP (Teamed Investigation Project) unit. This unit is housed in the Alliance for Children Advocacy Center. It teams serious physical and sexual abuse investigations, along with child deaths with the Fort Worth Police Department.

NATACHA PELÁEZ WAGNER

Natacha Peláez-Wagner has served as the Executive Director for Children's Advocacy Centers of Texas™, Inc. (CAC TX) since its inception in November 1995. In this capacity, she manages funding contracts for the 35 children's advocacy centers in the state and coordinates training and technical assistance resources for them as well. Prior to coming to CAC TX, Ms. Peláez-Wagner was Coordinator of the Community Justice Council in Travis County for three years. In this position, she coordinated and facilitated myriad multidisciplinary teams, committees and working groups whose aim was to address the community's response to crime and develop innovative programs dealing with specific criminal justice issues. Prior to moving to Austin, Ms. Peláez-Wagner served as Executive Director of the Crime Victim Foundation in Phoenix, providing financial assistance and support services to victims of violent crime. Ms. Peláez-Wagner's areas of expertise include community mobilization, organization and outreach, training, program development, formation of collaborative partnerships and group facilitation. She also has extensive experience in the development of culturally appropriate outreach and service delivery procedures and bilingual materials to Hispanic communities.

FACULTY AND SPEAKERS

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.

D.A. WATTS

Detective Watts has been with the Dallas Police Department for 28 years. The last 15 years he has been assigned to the Homicide Unit. Currently, he is assigned to the Cold Case Squad.

PATTY WETTERLING

Patty Wetterling is the mother of Jacob Wetterling, who was abducted at gunpoint on October 22, 1989. Jacob is still missing. Since Jacob's abduction, Patty has become a nationally recognized educator on the issue of child abduction and sexual exploitation. She serves on the Board of Directors for the National Center for Missing and Exploited Children and is a consultant with the Office of Juvenile Justice and Delinquency Prevention. She is a co-author of the newly published "Family Survival Guide" and had the honor of addressing the National Missing Children's Day Ceremony in Washington DC with Attorney General Janet Reno. Throughout her efforts to raise public awareness on child abduction, Patty has never stopped searching for her son. She has never given up hope.

CHARLES WILSON

Charles Wilson, MSSW is Executive Director of the National Children's Advocacy Center in Huntsville, Alabama. He was previously Director of Family Services for the State of Tennessee. Mr. Wilson has published numerous articles in the field of child abuse and is co-author of the book, "Team Investigation of Child Sexual Abuse." He is past president of the American Professional Society on the Abuse of Children and currently serves on the board of the Alabama Network of Children's Advocacy Centers. He is a nationally and internationally recognized speaker on child abuse issues.

SARAH WINKLER

Sarah Winkler has served at the Children's Trust Fund of Texas for ten years in child abuse and neglect prevention program and public education design and management. She also serves on several statewide committees to plan and implement human service delivery systems in communities across the state, as well as provide oversight for statewide research initiatives regarding child abuse and neglect prevention.

JULIA COKER WOLF

Julia Coker Wolf received her masters degree in family therapy at the University of Houston at Clear Lake in 1991. She holds an undergraduate degree in psychology from Scripps College. Julia is licensed as both a Licensed Professional Counselor and a Licensed Marriage and Family Therapist in the state of Texas. She is also an LPC approved supervisor. Julia has worked and trained in the area of sexual abuse and incest since 1991. Her work at The Children's Assessment Center in Houston includes supervising the Family Reunification Treatment Program, providing individual, group and family therapy services, court testimony, community training, case consultation and crisis services.

RICK ZOMPER

Rick Zomper has been a Fort Worth police officer for 12 years, assigned to the Crimes Against Children Unit as a detective for 5 years. He has been assigned to the Alliance for Children Center since its opening in February 1995.

Investigative Case Management

I. Introduction

A. In this class we will review a systems response to Missing and Abducted Children
   1. Child Abduction Homicide Characteristics
   2. Policy and Supervision Issues
   3. Framework for Managing a Child Abduction
   4. Major Case Management Responsibilities
   5. Information Management/Lead Tracking Systems
   6. Child Abduction/Recovery Practical Exercise

II. Child Abduction Homicide Research

A. Washington State Attorney General's Office preliminary results drawn from:
   1. 577 cases in 46 states (1971-1995)
   2. 621 victims (77% female/23% male)
   3. All size state, county and local law enforcement
   4. All geographic areas represented

B. Case selection criteria
   1. Victim under 18 years
   2. Victim is murdered
   3. Body is recovered
   4. Case handled as an abduction
   5. Parental child abuse excluded

C. Police involvement began as:

1.	MISSING PERSON	58%
2.	DEAD BODY	23%
3.	ABDUCTION	9%
4.	RUNAWAY	9%

D. Victim Gender Differences

1.	MALE	24%
2.	FEMALE	76%

E. Victim Age Groups

1.	1-5	9%
2.	6-9	21%
3.	10-12	21%
4.	13-15	28%
5.	16-17	21%

F. Victims as Targets
   1. Younger males are more apt to be victimized than older males
   2. Older females are more apt to be victimized than younger females

G. Time Delay in Reporting
   1. 60% of cases over 2 hours lapsed before police were notified of missing child
   2. The older the child the greater the delay

H. Time victim alive after abduction
   1. 44% of cases victim dead within 1 hour
   2. 74% of cases victim dead within 3 hours

I. 22% of victims were still alive when reported missing

J. 42% of victims were dead before they were reported missing

K. Time is of the Essence
   1. Mobilize all resources immediately
   2. Information dissemination critical
   3. No geographic limits/turf issues
   4. Think outside the box

III. Policy and Supervision Issues

A. Pre-Planned Critical Incident Response
   1. Policy and Procedural Guidelines for:
      a) Telecommunications
      b) First Responders
      c) Street Supervisors
      d) Notification of Investigations (BIS)
      e) Involvement of additional resources

B. Front-end vs. Reactive Management
   1. Policy and Procedure Development
   2. Guidelines
   3. Checklists
   4. Roll call and department-wide training
   5. Mock disaster training
   6. Consistency and accountability

IV. Child Abduction Policy

A. Purpose
   1. Guide activities of responding units
   2. Manage complex and protracted investigations

3. Establish a framework
4. Allow flexible or partial application
5. Should be reviewed annually and tested

B. Case Guidelines for Investigative Commanding officer
1. Establish contact with on-scene supervisor
2. Obtain synopsis of incident
3. Determine location of command post
4. Establish double perimeter
5. Patrol outer/CID inner
6. Crime scene processing only
7. Media and public outer perimeter

C. Initial Briefing Participants
1. On Scene Supervisor
2. 1st Responding Officer
3. Patrol Supervisor
4. CID Personnel
5. Crime Scene Personnel
6. Other agencies (as appropriate)

D. Initial Briefing
1. Determine actions prior to arrival
2. Ascertain facts known at time
3. Determine lead agency/unit
4. Assign lead investigator
5. ID representative's from other agencies
6. Determine specific role
7. ID and assign assist agency lead
8. Determine need for additional investigator
9. Assign investigator as recorder
10. Assign tasks (pre-numbered MCI form)
11. CID Commander assigns investigator and administrative supervisor
12. Determine chain of command
13. Assign investigator to crime scene(s)
14. ID Areas for witness interviews (secure)
15. Stress importance of:
    a) Slow things down
    b) Don't get caught up in excitement
    c) Team work
    d) Communication (yo-yo)
    e) No tunnel vision
16. Keep lead investigator informed
17. No investigative assignments for supervisor
18. All information funnels through supervisor
19. Assign investigator to victim(s)/family
20. Provide CP with list of personnel

21. Brief P.I.O or department designee
22. Utilize pre-numbered lead sheets
23. Determine need for additional resources:
    a) Clerical/sworn personnel
    b) K-9 units/air support
    c) Civilian volunteers
    d) Federal/state resources
    e) Office space
    f) Phone banks/special numbers
    g) Computers/copy and fax machines
    h) Administrative supervisor to coordinate

E. End of 1st Day Briefing Participants:
1. All CID personnel assigned
2. Crime scene unit personnel
3. Representative's from participating agencies
4. Public information officer (PIO)
5. Command staff
6. Prosecutor's office

F. Purpose of 1st Day Debriefing
1. Discuss investigative progress
2. Describe tracking system/leads
3. Stress accuracy/thoroughness
4. Confidentiality outside work group
5. Opportunity to brainstorm

V. Major Case Management Responsibilities

A. Investigative Supervisor
1. Regular reports to CID Commander
2. Updates progress/status
3. Ensures compliance with procedures
4. Charts assigned personnel
5. Radios/frequency
6. Cell phones/beepers
7. Cars/special equipment
8. Distribute copies
9. Reviews leads, establishes priorities
10. Makes assignments
11. Classifies information status (lead sheets)
12. Reviews data base printouts
13. Coordinates and attends briefings
14. Responsible for investigator security

B. Administrative Supervisor
   1. Reports to CID Commander
   2. Attends daily briefings
   3. Responsible for administrative support
   4. Coordinate/training and briefing of:
      a) Call takers
      b) Clerical staff
   5. Establish proper paperwork flow
   6. Responsible for quality control:
      a) MCI follow-up forms
      b) Supports lead sheets
      c) Master log sheets
      d) Binders/files etc.

C. Lead Investigator
   1. Coordinates and supervises investigation
   2. Crime scene properly managed
   3. Evidence properly collected/maintained
   4. Evidence properly submitted/returned
   5. Reviews and assigns leads
   6. Reviews and classifies completed lead sheets
   7. Coordinates/manages all follow-up/leads:
      a) Suspect interviews
      b) Polygraphs
   8. Search warrants
   9. Keeps prosecutor's office informed
   10. Responsible for master file security

D. Crime Analyst
   1. Reports to lead investigator
   2. Develops database system
   3. Provides training and coordinates data entry
   4. Provides liaison with lead sheet manager
   5. Regularly prints requested reports
   6. Conducts quality control of data

E. Lead Sheet Manager
   1. Reports to administrative supervisor
   2. Leads forwarded to supervisor
   3. Maintains master log of all leads
   4. Maintains files for leads classified as:
      a) No value
      b) Investigative
      c) Active/Inactive

F. Call Taker
1. Completes MCI Form
2. Completes background investigative query
3. Preserve tapes of phone calls
4. Notify supervisor of "hot" leads

G. General Points
1. Designate a conference area in command center
2. Set-up separate room for phone calls
3. Staff hotline 24 hrs. a day
4. Install caller ID and record all phones
5. Assign liaison to each assist agency
6. Pair investigator with assist agency person
7. Utilize Crime Analyst as scene recorder
8. Utilize Crime Analyst to record daily briefings
9. Assign Investigator to brief roll calls
10. Consider completing VICAP Forms
11. Limit distribution of database printouts
12. Stress importance of team work and communication

VI. Information Management

A. Information Management
1. Centralization of information
2. One person or section responsible
3. System for storing and retrieving information
4. Automated or Manual (card system)
5. Visual aids
6. Flow charts
7. Time lines
8. Graphs (analytical correlation)

B. Information Evaluation
1. One person accountable for
2. Maintenance
3. Evaluation
4. Developing reports
5. Dissemination analysis
6. Roll call bulletins

C. Flow of Information
1. Everyone responsible for information input
2. Information must be available to all investigators
3. Regular briefings essential
4. Especially with multiple jurisdictions
5. Garbage in-Garbage Out (GIGO)

D. Standardized Information Procedures
   1. Utilize standard forms
   2. Missing Child Form
   3. Lead sheets and Tip/Hotline Forms
   4. Uniform narrative and summary reports
   5. Uniform Case Tracking Reports

E. Tracking Tips & Leads
   1. Requires a procedure
   2. Specifically designed forms
   3. Helps with flood of information
   4. Prioritize and assign
   5. Ensures follow-up/accountability
   6. Consider telephone recording
   7. E-911 or Caller ID (Fast Trak)
   8. Train call takers

F. Case File Contents
   1. CAD Log
   2. Teletypes
   3. MV and Record Checks
   4. Global/Local Checks
   5. Database searches re:
      a) Previous incidents
      b) Suspects fitting MO
   6. Tapes of phone/radio traffic
   7. Phone messages
   8. Copies of all initial reports
   9. Copies of any court orders
   10. Custody
   11. Temporary placement
   12. Domestic orders
   13. All taped interviews
   14. Witness Statements
   15. Vehicle Canvass
   16. Neighborhood Canvass
   17. Include people not at home
   18. Crime scene reports
   19. Photographs
   20. Evidence Log
   21. Search Warrant/Return
   22. Lab submittal slips
   23. Lab reports
   24. Photos/video of child
   25. Flyers/bulletins
   26. Press releases

27. Newspaper articles
28. TV coverage
29. VICAP report
30. Suspect profile
31. Polygraph results
32. Off-line searches
33. CPS records
34. Medical/Dental records
35. School records
36. Assist agency reports/records
37. Crime Stopper Bulletins
38. Legal paperwork
39. Warrants/UFAP
40. Affidavits
41. Civil Proceedings
42. Suspect Records
43. Employment
44. Criminal (verify with prints)
45. Nexis/Lexis search
46. Professional Licenses
47. Fed Parent Locator Service
48. Postal records
49. Credit check

VII. Practical Exercise

S320196

PRO ACTIVE
SEXUAL ABUSE INVESTIGATIONS

1988 CRIMES AGAINST CHILDREN CONFERENCE

AUGUST 16 - 20, 1998
DALLAS, TEXAS

INSTRUCTOR: DANA GASSAWAY

I. History of proactive investigations in child sexual exploitation

II. Planning the operation

- A. Agencies to be involved
- B. Funding
- C. Manpower

III. Type of operation

- A. Advertisement
- B. Correspondence
- C. Computers
- D. What to use as bait

IV. Undercover meets

- A. Security and officer safety
- B. Selecting an undercover officer
- C. Recording the undercover meeting

V. Special problems

- A. Equipment failure
- B. Follow-up in other jurisdictions
- C. Search warrants

Reprinted from the Law Enforcement Quarterly

PROACTIVE INVESTIGATIONS

By: Dana Gassaway

Typically when one thinks of proactive investigations in law enforcement, undercover narcotic investigations comes to mind. Most people are aware that police agencies routinely conduct covert undercover operations in order to identify drug traffickers and users in addition to seizing their narcotics. Most of the public is aware that police seize the offenders' money and the fruit of any illegal activity. It is also common knowledge that law enforcement agencies attempt to infiltrate organized crime syndicates in an effort to gather evidence of crimes being committed by individuals who are members of such organizations. Also, after successfully capturing the bad guys, undercover operations have been publicized by the police thus making the public more aware.

When investigating sex crimes committed against children, the public rarely thinks about proactive investigations. The same is true of most law enforcement officials. If you were to ask any police officer about the types of undercover operations he is familiar with, most often you would hear about the Narcotics or Organized Crime Units. If it were suggested to conduct undercover investigations in cases involving the sexual exploitation of children, both the public and most of law enforcement could not

begin to explain how such an operation could be conducted.

The goal of any proactive investigation is to identify criminal offenders and prosecute them for crimes they have committed. A product of these investigations may be illegal drugs or the proceeds from the sale of the drugs. In proactive investigations involving the sexual exploitation of children the goals are the same. An attempt is made to identify perpetrators and seize child pornography. A more important goal is to identify victims of child molest and sexual exploitation.

Among professionals who are involved with children who have been molested, it is common knowledge that many times these children do not report their victimization. When the child does not report the crime, the perpetrator usually goes undetected. If the perpetrator is a preferential molester, he will most likely continue to victimize other children until he is reported to the authorities. The proactive investigation attempts to get the perpetrator to reveal his illegal activity and to identify current and past victims. Additionally, many preferential molesters produce and collect child pornography. They will often trade or sale portions of their collections with other molesters, thus propagating the spread of child pornography.

The task for the investigator is to gain the trust of the molester so the molester will confide in him about his illegal activity.

Most might think this task would be extremely difficult to accomplish. Usually the molest occurs in secret and remains hidden by both the victim and the perpetrator. Normally the perpetrator would be the last person to discuss his activity. Society views child molesters with such disdain, it is rare for a molester to speak with anyone about his desire to molest children.

To gain the trust of the molester, the investigator can assume the role of another child molester. Child molesters often need validation for their activity. For that reason they sometimes join underground organizations such as NAMBLA, (North American Man Boy Love Association). Membership in these types of groups allows these individuals to meet one another and receive the organization's publications. Communication with another known child molester is another way to receive validation for their activity with children. By becoming a "child molester," the investigator may be able to gain the trust of an offender and learn about past crimes and the identity of victims.

In the 1970's and early 1980's there were many publications that catered to pedophiles. Some of these were, PAN (Pedo Alert News), Magpie, (the Journal of the Pedophile Information Exchange), Wonderland, (Newsletter of the Louis Carroll's Collectors Guild) and the CSC Newsletter (Childhood Sensuality Circle). Pedophiles would place personal ads in these publications in an effort to meet other pedophiles. Some members of law Enforcement recognized these

publications as a way to correspond with those who advertized in them. Taking it one step further, Officers placed their own advertisements in the publications and began corresponding with those who replied. Today nearly all of these types of publications are no longer in circulation which resulted in the elimination of a valuable resource for law enforcement.

Currently the best resource for such law enforcement advertisements is in an adult contact publication. Frequently, advertisements in these publications are placed by persons who are looking for a sexual partner. Most ads are sexually explicit and many contain photographs of the advertiser. When law enforcement places ads for undercover sting operations in publications such as "Swingers Digest," care must be taken in the wording of the ad. If the ad is written in a manner that it is obvious the advertiser is interested in child pornography or molesting children, the publisher will not print the ad. The ad should have more than one meaning to the reader. For example, the following ads were used in past undercover operations.

NAVY COUPLE, WELL TRAVELED, SEEKS PERSONS WITH LIBERAL ATTITUDES ABOUT FAMILY FUN AND PHOTOGRAPHY PLEASE BE DISCREET

WHITE MALE APPROACHING MIDDLE AGE BUT RETAIN YOUTHFUL FANTASIES. COLLECTORS OF THE UNUSUAL AND HARD TO FIND.

I AM PROFESSIONAL, DISCREET, SANE AND THINK YOUNG.

The hope for the police officer is those persons responding to the ad will interpret it as being placed by someone interested in child pornography. The term "family fun" can have different meanings, one of which is incestuous relationships. "Family fun" used with "photography" could suggest pornography. The second advertisement suggests someone who is interested in children and is a collector of child pornography.

It is suggested that the investigator place their advertisement in several publications to maximize the response. Once the ad is answered, the investigator must be prepared to devote the time necessary to follow through on the answers received in response to the ad. As the response to these types of advertisements can be overwhelming. One officer received over 70 letters one week after his advertisement was published. Answering these letters and beginning a correspondence can be time-consuming.

Not all letters need to be answered if the response from the ad is such that the writer indicates an interest in other subjects. When writing a return letter, the investigator must take care not to suggest any specific acts or crimes. Entrapment is always an issue in these types of operations. To avoid entrapment it is wise to allow the suspect to suggest any illegal activity. Once the suspect has suggested some type of illegal activity, the

investigator can respond by mirroring the suspect's suggestions. There is nothing wrong with asking if he has a "collection" or if he has had any experiences as it relates to molesting children, but encouraging the suspect to send you child pornography is the same as asking him to commit a crime.

Many times the investigator will be asked to send child pornography to the suspect. Although in most jurisdictions it is legal while conducting an investigation for the police to send child pornography in the mail, several questions must be answered before doing so. Has the pornography being sent been published commercially? The use of photographs seized by law enforcement in completed investigations only serves to re-victimize the depicted child. It could be extremely embarrassing if photographs were placed into evidence and a member of the court or jury knew the child or even worse was the child in the photographs. Additionally, it may turn out that photographs used by the police are much more explicit than those seized from the suspect. This may not set well with a jury or the court. Once the investigator sends pornography to the suspect, all control over it is lost. The subject may reproduce it and send copies to other persons. It is suggested that investigators not send any pornography to a suspect unless it is absolutely necessary and then only if the pornography has been commercially reproduced.

The investigator should consider NOT sending any child pornography.

Instead, the use of photographs of nude children which do not meet the legal definition of pornography can have the desired effect when sent to a suspect.

Once correspondence had been initiated, an attempt should be made to identify the suspect. Many times he will be using an assumed name, a post office box, a private mail box service, or a combination of the three. The United States Postal Inspector can be a great resource to the investigator in identifying the holder of a post office box or private mail box.

If the suspect states he has molested a child or is currently molesting a child, every attempt should be made to identify the victim. Holding out for the suspect to send child pornography may only lead to a child being further victimized.

It is not unusual for the suspect to want to meet with the investigator before revealing specific criminal acts or exchanging pornography. The investigator should be prepared for this. Once the suspect trusts the undercover officer, he often reveals incriminating information which can lead to his arrest. Care should be taken in the setting up of any undercover meeting to ensure officer safety and to facilitate the use of hidden video and/or sound equipment to record the meeting. In selecting the location of the meeting, care should be given to officer safety, and toward making the suspect feel comfortable in the surroundings.

This will greatly enhance the possibility of obtaining incriminating information.

To make any undercover operation successful, the participation of other agencies should be considered. The combining of several agencies' resources greatly enhances the operation's chances for success. The United States Postal Inspector should always be included in the event the suspect sends illegal material through the mail. The assistance of the state police or state bureau of investigation can be invaluable in serving search warrants and conducting follow up investigations in jurisdictions other than your own. The prosecutor should also be consulted to assure that legal requirements are being met. The prosecutor can also be a resource in assisting in preparing search and arrest warrants.

These types of undercover operations have proved extremely successful in the past. The Southern California Regional Exploitation Unit, a multi-agency task force in San Diego, has identified, arrested and convicted over 104 individuals as a result of an ongoing undercover operation. Given adequate resources, operations such as these can continue to be a valuable method for law enforcement to identify victims and their perpetrators.

Sex Offender Apprehension Program *(SOAP)*

Presented by

Lt. Bill Walsh

Dallas Police Department

1998 Crimes Against Children Conference

Dallas, Texas

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.

Child Victims

- Children are "perfect victims"
- They are often too trusting
- They often desire attention and affection
- They often desire material things
- They are often curious about sex
- They often defy their parents
- They are often not viewed as credible witnesses

3

Dynamics of Sexual Abuse

- Almost always occurs in private
- In the majority of cases, there is no medical evidence
- In most cases, child "knows" the offender
- Child may not want the offender punished

4

Disclosure Process

- Some children tell promptly
- Some children delay disclosing
- Some children give partial and/or progressive disclosures
- Some children never tell
- Some disclosures occur accidentally
- Some disclosures are initiated by others

5

Offenders

- Majority of sex offenders have victimized children
- Numerous victims in their lifetime
- High rate of recidivism
- Convicted sex offenders do not go to prison for life
- Sex offenders are highly motivated to commit sex crimes

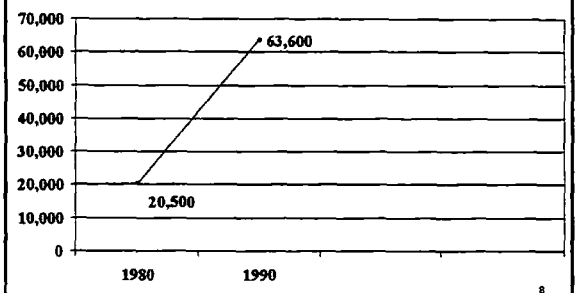
6

Sex Offenders

- Convicted convicted sex offenders are going to reside in your community (sex offender registration laws
- Number of convicted sex offenders is on the increase
- Sex offenders are often very transient
- Sex offenders have the potential for ever escalating violence

7

Sex Offenders in State Prison



8

Sex Offenders in State Prison

- Percentages
  - 1980 - 6.9 %
  - 1994 - 9.7 %
- 10 states have prison populations in which sex offenders comprise 20% or more of the inmates

9

SOAP Program

- Pro-active approach
- Zero tolerance philosophy
- Multi-agency team approach
  - Law enforcement
  - Probation
  - Parole
  - Courts
  - Community

10

SOAP Program

- Strict enforcement of sex offender registration law
- Greater scrutiny of sex offender's compliance with conditions of probation and parole
- Investigation of information of from the community

11

SOAP Team

- Dallas Police Department (5)
- Dallas County Sheriff's Department (3)
- Dallas FBI
- Dallas County Community Supervision
- Texas Parole Department

12

ALAMO CHILDREN'S ADVOCACY CENTER

ORGANIZATIONAL HISTORY

The Social service system in our communities more often resemble a complex maze of agencies rather than a logical, efficient and effective system, There are three agencies with the official responsibility for the investigation of child sexual abuse - Child Protective Services, District Attorney and Law Enforcement.

This leads to repeated interviews of the child at different locations. In San Antonio a child could be examined and question as many as eight times by different agencies in separate locations. It is no wonder that families lose faith in the system. The investigative process has the unintended effect of victimizing the child and their family.. It is devastating for the child to have to wait for a physical examination in a emergency room along with other trauma victims. And the child and their family should not have to contend with aloof and unresponsive bureaucrats.

In recognition of these problems there has been a national movement to establish organizations that will do the following:

1. coordinate the investigation of the allegation of child sexual abuse
2. provide emergency counseling services to the child and family
3. undertake the physical examination of the child
4. provide education and training for professionals and the community
5. conduct support programs for the child and the family
6. provide long term counselling for the child and family

These services are provided in a child friendly facility that minimizes the trauma to the child. There organizations are named **CHILDREN'S ADVOCACY CENTERS** (CAC). A precondition to be established as a CAC is an interagency agreement between the critical stakeholders in the investigation and intervention of sexually abused children, i.e. the police, the prosector's office, child protective services, a children's hospital or pediatric services.

The **ALAMO CHILDREN'S ADVOCACY CENTER (ACAC)** is the outgrowth of a community based task force established to study the complex problem of child sexual abuse. ACAC was started in 1992 as a collaborative effort between the San Antonio Police Department, Child Protective Services, Bexar County District Attorney, the Alamo Council of Governments and the University Health System and the University of Texas at San Antonio. While ACAC was established in part by government agencies, it is an independent, private non-profit organization.

THE ALAMO CHILDREN'S ADVOCACY CENTER: AN INTERDISCIPLINARY MODEL OF CARE FOR ABUSED CHILDREN

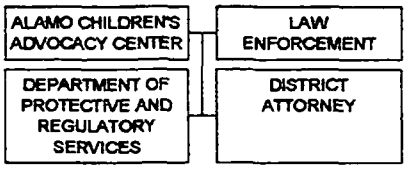
presented by:
SHIRLEY W. MENARD, RN, PH.D., CPNP, FAAN
and
PATTY VILLARREAL, RN, MS, FAAN

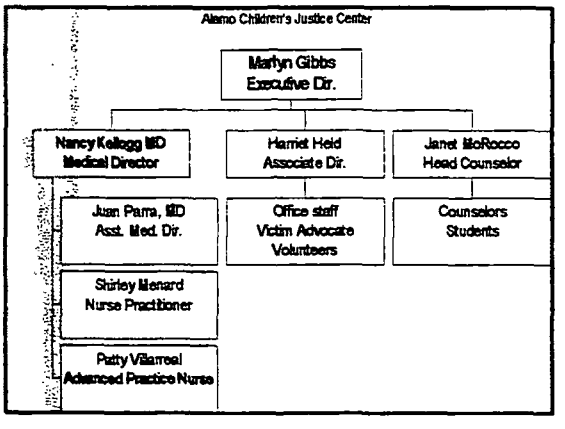
The University of Texas Health Science Center at San Antonio, Department of Family Nursing Care and The Alamo Children's Advocacy Center

THE CENTER

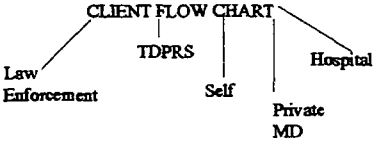
- Alamo Children's Advocacy Center
  - Dedicated to meeting medical and emotional needs of sexually abused children.
  - One of few Centers providing comprehensive care.
  - Design is specifically for children.
  - Equipped with latest technology.
  - Liason with members from law enforcement, Child Protection, and District Attorney's Office.

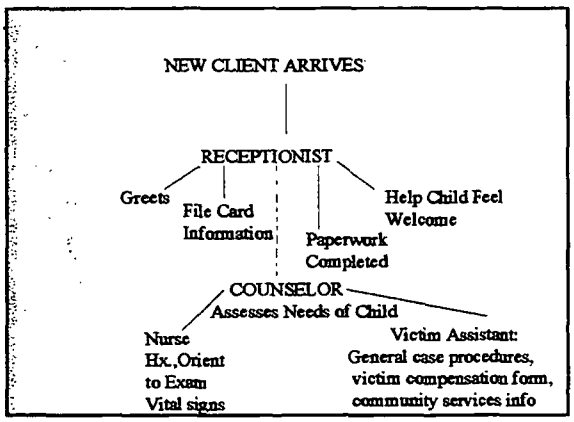
THE ALAMO CHILDREN'S JUSTICE CENTER

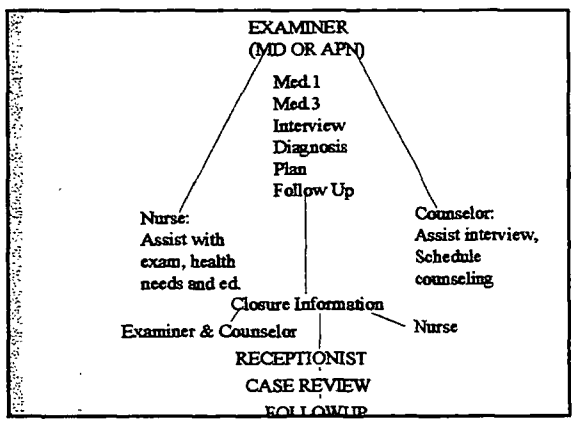




THE ALAMO CHILDREN'S ADVOCACY CENTER

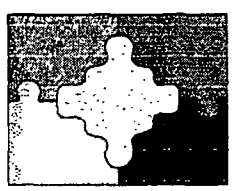






ROLE OF ADVANCED PRACTICE NURSES

- Interview
- Examine
- Diagnose
- Treat
- Follow-up
- Testify
- Research



CHILD SEXUAL ABUSE

- SEXUAL - SEXUAL CONTACT, INTERCOURSE, OR CONTACT WITH A CHILD INCLUDING PORNOGRAPHY. FAILURE TO PROTECT.
- INCEST - SEXUAL ABUSE WITHIN THE CONTEXT OF THE FAMILY

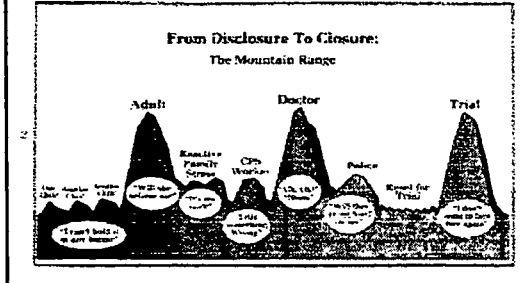
DETECTION OF CHILD SEXUAL ABUSE

- Behavioral changes
  - withdrawal
  - depression
  - sexual acting out
  - school grades
  - interpersonal relations
  - difficulty sleeping
  - nightmares

- Physical
  - eating disorders
  - stomach aches
  - headaches
  - dysuria
  - bowel changes
  - vaginal discharge
  - pain

HISTORY

- Background Information:
  - Family Dynamics
  - Level of Child's Cognitive Function
  - Level of Child's Emotional Coping
  - Concerns of Family and Child
  - History of Previous Abuse
  - History of this Abuse
  - Medical History



Interview of Child

- Initial Non-Directive Approaches
- Mid-Interview
- Closure

PHYSICAL EXAMINATION

- General Examination
- Genital Examination
- Collection of Specimens
- Culposcopy and Photography
- Diagnosis
- Treatment Plan
- Documentation

TREATMENT PLAN

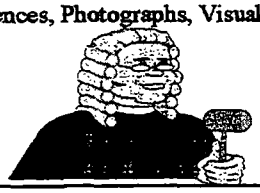
- Treat for any diagnosed STD's
- Counseling recommended for all children
- Follow-up as needed
- Education/Court School
- Referrals for other problems
- Coordination with other agencies

TESTIMONY OF APN

- Criminal Court
- Juvenile Court
- Family Court
- Civil Court
- Depositions
- Affidavits

PREPARATION FOR TESTIMONY

- Educational Background and Training
- Pertinent Points of Specific Case
- Areas of Expert Testimony
- References, Photographs, Visual Aids



General Tips for Testifying

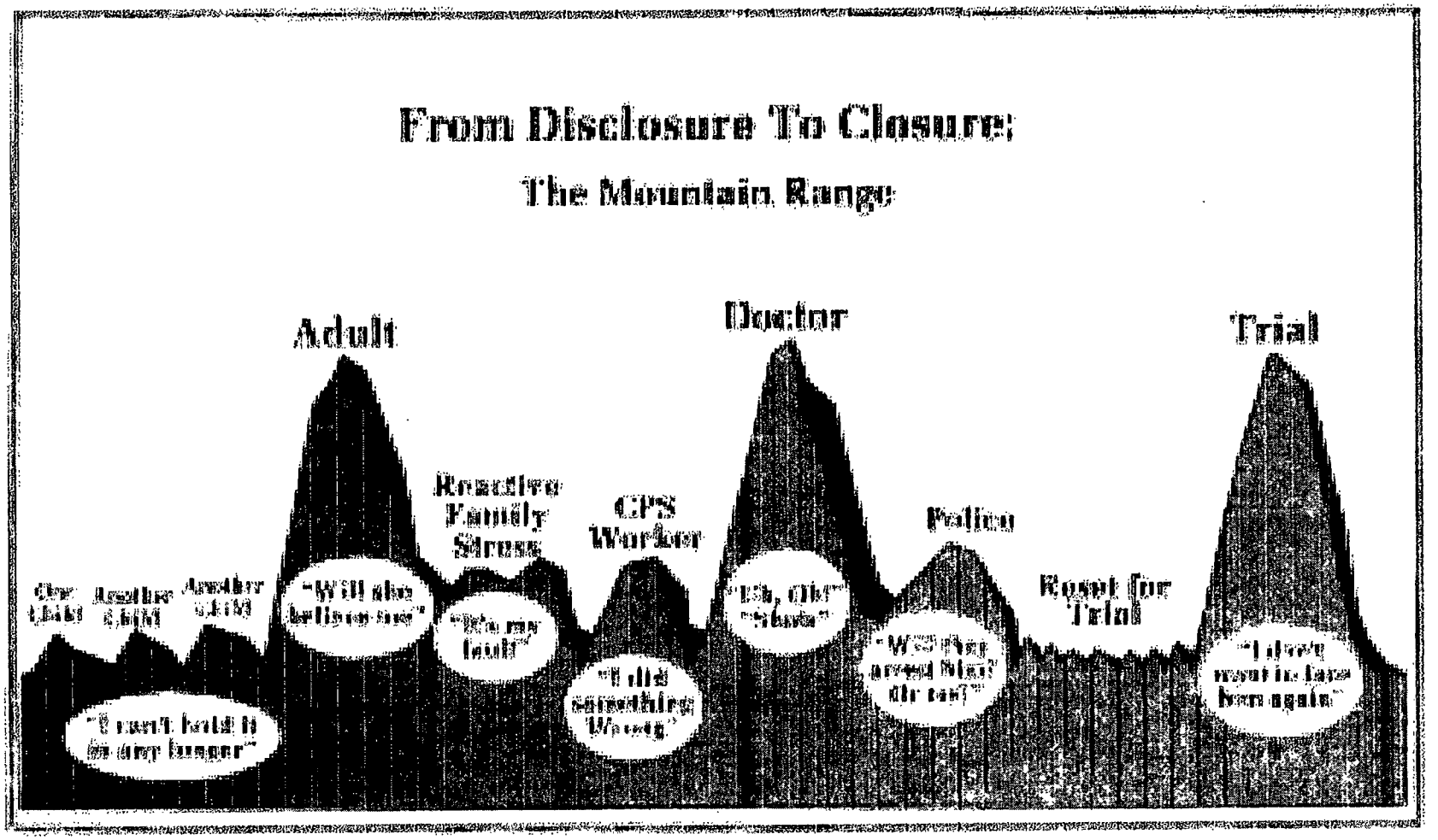
- Be objective, not defensive
- Be impartial and treat each attorney with the same demeanor
- Be Concise and Precise
- Questions: Repeat, Rephrase, Define, and Separated

Continued

- Speak loudly and in layman's terms
- Dress professionally
- Tell the Truth!!!
- Say "I don't know" when appropriate

STANDARDS OF CARE

- AMERICAN NURSE'S ASSOCIATION
  - Code for Nurses
  - Standards of Maternal and Child Health Nursing Practice
- INTERNATIONAL ASSOCIATION OF FORENSIC NURSES
- BOARD OF NURSE EXAMINERS
- STATE AND NATIONAL LAWS


From Disclosure To Closure:
The Mountain Range
Adult
Doctor
Trial
Protective Family Stress
CPS Worker
Police
Report for Trial

It's Not a Social History:

Guidelines for Forensic Interviews in Allegations of Child Sexual Abuse

Sue Austin, Ph.D.

Psychologist

&

Associate Professor of Counseling

Southeastern Louisiana University

Hammond Louisiana

Tamara Indest, B.A.

Executive Director

Children's Advocacy Center

Tangipahoa, Livingston & St. Helena Parishes

Louisiana

Scotty Sims, B.G.S.

Program Coordinator

Children's Advocacy Center

Tangipahoa, Livingston & St. Helena Parishes

Louisiana

It's Not a Social History:
Guidelines for Forensic Interviews in Allegations of Child Sexual Abuse

Sue Austin, Ph.D., Tamara Indest, B.A., Scotty Sims, B.G.S.

Definitions:

Social History - provides a unique historical portrait of the children's, parents' and families' lives; **may** include information such as:

- a history provided by the child, parents, teachers and other relatives
- genetic factors and medical history
- interaction of environmental and biological factors
- a comparison of the child's behavior in relation to the norm
- developmental tasks, i.e., social skills, motor skills, communication skills, self-help skills, interpersonal skills of the child
- educational and intellectual functioning
- description of situation, frequency, duration and intensity of problem behaviors
- effect of behaviors on family members and others
- motivation for change
- perceptions of the family members concerning themselves, others and the environment
- family characteristics including: communication styles, values, roles, decision-making style, involvement with the child, interactional patterns, conflict resolution, commitment to the family's goals and values, etc.
- intervention plan and treatment goals

Forensic Interview: purpose is to provide an opportunity for an objective opinion by referral sources, i.e., child protection, law enforcement, judicial system, etc. in order to determine:

- whether the child was abused
- whether the child's report of the abuse is credible
- whether the child is at risk for further abuse
- what steps need to be taken to protect the child

A MODEL FOR INTERVIEWING IN CASES OF CHILD MALTREATMENT

The very sensitive nature of child sexual abuse and allegations of abuse mandates involvement of several disciplines with differing goals and opinions about how those goals should be reached. Because of this, a multidisciplinary model is recommended for interviewing children who have alleged abuse or who are suspected of having been abused. The Children's Advocacy Center is the ideal coordinator and facilitator of the interviewing center because of their unique ability to remain neutral and to advocate for the best interest of the child without regard to policies and procedures of a specific agency. The following steps are guidelines for establishing a multidisciplinary interview center:

Establishing the multidisciplinary interview center:

1. Select an individual to serve as the Director of the center who will oversee daily operation of the center.
2. Obtain the support of the local Prosecuting Attorney, as well as the Sheriff or Police Chief and Director of Protective Services prior to beginning the center.
3. Establish a policy making team consisting of members of the community, as well as representatives from each of the disciplines.
3. Sign an interagency agreement allowing the various agencies to share information about a case.
4. Establish a policy with the various agencies mandating participation by all investigative agencies in the multidisciplinary interview center.
5. In order to establish a sense of ownership by everyone involved, solicit the support of direct service workers, as well as superiors by inviting them to assist in developing a protocol for conducting the interviews.
6. Contract with or hire at least one (preferably several) forensic interviewer who is specially trained in forensic child interviewing.
7. If at all possible, send teams consisting of several members of each discipline to the OJJDP training, which is an excellent source of team building and clarifying the center's vision, mission and protocol.
8. Provide the director and interviewers with extensive start-up and ongoing training in the needs of investigative agencies, child development and forensic interviewing.
9. Provide training in forensic interviewing techniques for all members of the team in order to encourage understanding of and cooperation with the interview process.
10. Obtain a child-friendly setting for conducting the interviews.
11. Establish a mid-level multidisciplinary team consisting of representatives from the prosecuting attorney's office, law enforcement, mental health, medical and child protection to review each case on a monthly basis in order to ensure that the case is tracked until completion, including further investigation, litigation, provision of appropriate services and follow-up. In addition, this team should offer feedback concerning benefits and problems associated with the operation of the center. The meeting should be scheduled at a specific time each month and held at a neutral site.
12. A data collection and tracking system should be established at the center in order to provide statistics to the various agencies, as well as to the judicial system and funding sources and to provide appropriate case management.

The Referral and Interview:

1. An individual reporting an allegation of child sexual abuse should **ideally** contact the Director of the Center who will then notify the multidisciplinary team members and set up the interview. Child protection or law enforcement may be the first contact and would then notify the Center who would coordinate the interview.
2. The interview should be set up as soon as possible, preferably on the same day of the disclosure prior to any other interviews. In any case, no other interviews should be conducted prior to the multidisciplinary team interview with the exception of a brief interview by child protection in order to maintain the safety of the child.
3. It is in the best interest of the process to have the non-offending parent and the child transported to the interview by a third-party such as child protection, law enforcement, etc.
4. The family should be introduced to the members of the team and made to feel comfortable by a child advocate or counselor who will also provide support following the interview.

5. Everyone, including the child will be informed that the interview will be videotaped. A protective order to insure confidentiality of the videotape should be issued by the court.
6. Family members will remain in another room away from the interview rooms.
7. Members of the team should remember the sensitive nature of the case, as well as the feelings of the victims and their families and maintain professional conduct at all times.
8. Representatives of the various disciplines will coordinate their informational needs and communicate those to the interviewer prior to the interview.
9. Members of the team will observe the interview (which will be videotaped) on a TV monitor and make notes of any discrepancies in the information or additional information needed.
10. Observers will inform the Center Director of any additional information needed so that the questions can be conveyed to the interviewer through an earphone.
11. Immediately following the interview, the members of the team will coordinate the investigation and offer feedback to the interviewer for improving interviews.
12. The team should also consider the child's and non-offending parents' needs for additional mental health, medical and other support services and make appropriate referrals.

Conducting the Interview:

1. The interviewer must state:
   a. the time, date and place of the interview.
   b. the full name of the child and interviewer.
2. Briefly assess the child's development level and understanding of concepts.
3. Briefly assess the child's understanding of morality.
4. Explain to the child that it is okay to say they do not know the answer or to say they do not understand the question. Also explain that you may be asking the same question more than once and it does not mean they should change their answer.
5. Allow sufficient time for the interview while remaining sensitive to the needs and readiness of the child.
6. Discuss the lack of confidentiality, especially with older children. Inform them that the videotape may be used in court.
7. Refrain from pressuring, coercing or reinforcing the child into responding in a particular way.
8. Ask open-ended questions when possible. Avoid leading questions.
9. Follow up on everything the child says by using prompts and asking for details.
10. Assess whether the child is responding in a manner to please the interviewer.
11. Without putting words into the child's mouth, model that it is okay to use explicit language that would not be permitted elsewhere. Determine the child's words for various body parts and use those.
12. With reluctant children, allow the child to use drawing or writing to show or tell what happened.
13. Use common events to establish a time frame.
14. Use developmentally appropriate language.
15. Use names rather than pronouns.
16. Use short, simple, direct questions and sentences.
17. Determine if the child has been told to say something or whether the child has been told not to disclose.
18. Leave the child with a feeling of accomplishment and appreciation.
19. End the session with an assessment of the child's ability to seek help in a future incident.
20. Discuss with the child briefly the possibility of talking to a counselor about the abuse.

Specific Interviewing Techniques and Practice -- available during presentation

Problems, Concerns and Suggestions for Implementing an Interview Center -- Question and Answer Period

U.S. Department of Justice

Federal Bureau of Investigation

Agency Description

The Federal Bureau of Investigation (FBI) exercises its jurisdiction and investigative responsibilities pursuant to Federal statutes addressing various crimes against children, including kidnaping and sexual exploitation. Federal law defines children as minors under the age of 18, often referred to as "children of tender years." FBI investigations involving crimes against children generally include violations of Federal statutes relating to child abuse, sexual exploitation of children, interstate transportation of obscene material, computer pornography, interstate transportation of children for sexual activity, parental kidnaping, and violations of the Child Support Recovery Act. In some instances, the RICO (Racketeer Influenced and Corrupt Organizations) statute also may apply. While some of those Federal violations may not necessarily involve the sexual abuse or sexual exploitation of children, such as violations of the International Parental Kidnaping Act, the FBI pursues any child victimization offense within its lawful jurisdiction, often coordinating those investigations with other Federal, State, and local agencies.

Cases related to the sexual abuse and exploitation of children and other crimes against children are given high priority within the FBI. All available and necessary FBI resources are used during these investigations, and each case is aggressively prosecuted. Nonfamily abductions, often referred to as stranger abductions, receive immediate attention. Particular attention is also given to investigations involving organized criminal activity, commercialized child prostitution, and the manufacture and distribution of child pornography. The transmission and exchange of child pornography through computer bulletin boards are aggressively investigated as an insidious form of child sexual exploitation.

The FBI also investigates allegations of sexual assault in Indian country, including the investigation of child abuse and the sexual exploitation of children. The FBI addresses these sensitive investigations by participating with other professionals in a multidisciplinary team approach that enlists the expertise of investigators, social workers, clinical psychologists, victim-witness coordinators, and Federal prosecutors.

Services

Investigative Services and Support

FBI Headquarters. On January 20, 1997, a new unit and two new offices were

established within the Violent Crime and Major Offenders Section, Criminal Investigative Division, at FBI Headquarters. These entities, the Office of Crimes Against Children (OCAC) and the Office of Indian Country Investigations (OICI), are managed within the Special Investigations and Initiatives Unit (SIIU), and became operational during March 1997. Staffed by Supervisory Special Agents and Support professionals, the entities were established to specifically focus on crimes against children and crimes in Indian country. The OCAC addresses all crimes under the FBI's jurisdiction that in any way involve the victimization of children, providing program management and field wide investigative oversight of those critical FBI operations. Likewise, the OICI addresses crimes in Indian country, providing program management and investigative oversight of those sensitive FBI operations. The SIIU, OCAC and OICI work closely with FBI field offices, other FBI components, and various other entities to provide and coordinate operational support to more effectively address crimes against children.

FBI Field Offices. Individual FBI field offices throughout the country serve as the primary point of contact for persons requesting FBI assistance. Special agents assigned as Crimes Against Children Coordinators use all available resources--including investigative, forensic, tactical, informational, and behavioral science--in the investigation of crimes against children. The special agents coordinate their investigations with appropriate local law enforcement agencies, as well as with Federal or State prosecutors. Upon receiving notification that a child has been abducted, FBI Evidence Response Team personnel may be assigned immediately to conduct the forensic investigation of the abduction site and any other appropriate areas, while other special agents typically join law enforcement personnel in coordinating and conducting the comprehensive neighborhood investigation that is vital to the resolution of these cases. A Rapid Start Team may also be deployed immediately to begin the overwhelming task of coordinating and tracking the investigative leads, which often number in the thousands during protracted child abduction investigations. Special Agents will also coordinate child abduction investigations with the National Center for Missing and Exploited Children (NCMEC) and other entities to make full use of all available resources.

SPECIAL INVESTIGATIONS AND INITIATIVES UNIT
OFFICE OF CRIMES AGAINST CHILDREN

- To ensure that the FBI will continue to dedicate appropriate resources to investigate crimes against children (CAC), the Office of Crimes Against Children (OCAC), an entity within the Violent Crimes and Major Offenders Section at FBIHQ, was established to consolidate management of all FBI investigations involving the victimization of children. The OCAC is staffed by four Supervisory Special Agents (SSAs) and three Program Analysts (PAs) and was created specifically to focus on CAC operations, policies, training and related initiatives. The OCAC works closely with the Child Abduction and Serial Killer Unit (CASKU) and other FBI components to support the efforts of all FBI field divisions. The unit assumed oversight of all FBI CAC matters in December, 1997.

- Child victimization crimes under FBI jurisdiction include kidnaping, child abduction, interstate child prostitution, interstate/international travel to engage in an illegal sexual act with a minor, child pornography transported interstate and distributed electronically via the computer through the Internet and online services, physical and sexual child abuse on government lands, domestic and international parental kidnaping, and violations of the Child Support Recovery Act.

- It is anticipated that the efforts of the OCAC will lead to substantial increases in the timely notification of child abductions to the FBI, rapid deployment of FBI resources when a child abduction occurs, the number of victimized children safely returned, the identification and prosecution of offenders, and the number of incidents in which the victimization of children are stopped.

- In 1998, an additional SSA and PA will be detailed from the OCAC to the National Center for Missing and Exploited Children (NCMEC) to enhance the NCMEC's working relationship with various FBI components and to strengthen interagency efforts to more effectively address CAC matters. The additional personnel will establish strong liaison between the NCMEC and FBI field offices and Legats to ensure immediate access to various NCMEC resources. Utilization of these important resources will ensure the most effective FBI response to child abductions and international parental kidnapings.

- To further enhance the FBI's role in CAC matters, each field division has designated two Special Agents as CAC coordinators. These agents investigate and/or coordinate division CAC matters, act as a point of contact for state and local agencies involved in CAC, and coordinate and provide training to state and local law enforcement. The CAC coordinators receive specialized training developed by the OCAC at the FBI Academy in Quantico, VA.

- CAC coordinators will maximize FBI resources and expertise by working with state, local, and other federal agencies to establish multi-agency resource teams consisting of law enforcement, investigative, prosecutive and social service professionals. The CAC resource teams will be capable of effectively investigating and prosecuting incidents that cross legal and geographical jurisdictional boundaries and enhance the interagency sharing of intelligence and information. The composition of each CAC resource team will be fluid and unique to the field office it serves. The capabilities of team members can be drawn upon to support investigation in virtually every CAC case in which the FBI becomes involved.

- The OCAC is developing protocols for processing the child abduction (CA) flagging mechanism in the Missing Person File of the National Crime Information Center (NCIC). This flag alerts NCMEC and CASKU via an NCIC computer message of cases in which the investigating agency has reason to believe that a child is missing under suspicious circumstances and/or that the child is believed to be in a life-threatening situation. Once alerted, NCMEC, CASKU, and FBI field offices respond accordingly. Policies developed by OCAC will ensure 24-hour monitoring of the CA flags by the FBI's Strategic Information and Operations Center (SIOC) and appropriate responses.

- The OCAC is working to develop an effective investigative protocol for the handling of international parental kidnaping matters. The OCAC and other members of the Federal Agency Task Force for Missing and Exploited Children, which include components of the Departments of Defense, Education, Health and Human Services, Justice, and Treasury; NCMEC; Interpol; and U.S. Postal Inspection Service, are studying the complex international legal, investigative, logistical, cultural, and Hague Convention issues related to these investigations to improve communication among agencies and education of victim parents.

- The OCAC is significantly involved in the FBI's development of a national sex offender registry and tracking mechanism, which was legislatively mandated by the Pam Lynchner Act of 1996. This law provides for the nationwide registration and tracking of convicted sex offenders who have committed certain sex offenses against minors.

- The OCAC and other members of the DOJ Working Group on Child Support Enforcement are discussing an initiative to develop and implement a prototype program ("The Border Initiative") along the Texas/Mexico border aimed at increasing child support collections from American citizens and foreign nationals in default of their child support obligations.

- The OCAC participates in a DOJ working group studying initiatives with respect to international trafficking of women and children.

1998 Crimes Against Children Seminar

Children's Advocacy Centers : A True Collaboration Working For Our Children

Presented by: Cathy Crabtree, Executive Director - Young County Family Resources and Child Advocacy Center

Natacha Peláez - Wagner, Executive Director - Children's Advocacy Centers™ of Texas, Inc.

I. Overview - Natacha Peláez - Wagner
- National
- State

II. Steps to Establishing a CAC - Cathy Crabtree
- Needs Assessment and Identifying Community Leadership
- Developing Interagency Agreement and Protocols
- Selecting a Model to Fit your Community
- Generating Startup and Continuation Funding

III. Funding, Training and Technical Assistance Resources Available for CAC Development - Natacha Peláez - Wagner

IV. Question/Answer Period

Children's Advocacy Centers™ of Texas, Inc.

Fact Sheet

- Children's Advocacy Centers (CAC's) are safe, child-friendly places where child abuse cases are investigated and handled in a coordinated manner without subjecting victims to repeated interviews in multiple locations.

- CAC's bring together the numerous entities involved in the investigation and prosecution of child abuse cases. CAC's coordinate the professionals in the fields of law enforcement, prosecution, medical and mental health, and child protective services to facilitate the healing process for child victims and the effective prosecution of their perpetrators.

- Most CAC's are tax-exempt non-profits with 501 c3 status.

- Texas has the largest number of CAC's in the country. The first CAC in Texas was developed in Amarillo in 1989.

- Currently there are 35 centers across the state.

- Children's Advocacy Centers of Texas™, Inc., an association of CAC's, is responsible for assisting and supporting the development, growth and continuation of CAC's in the state of Texas through training, technical assistance and funding.

- CAC of Texas has developed minimum standards for centers and provides orientation and training workshops for communities interested in starting centers.

- A goal of CAC of Texas is to encourage the continued involvement of community-based groups and individuals in supporting existing and developing centers at the local levels.

06/04/98

TEXAS FAMILY CODE LANGUAGE
CHAPTER 264

SUBCHAPTER E. CHILDREN'S ADVOCACY CENTERS

Section 264.401. DEFINITION. In this subchapter, "center" means a children's advocacy center.

SECTION 264.402. ESTABLISHMENT OF CHILDREN'S ADVOCACY CENTER.

(a) On the execution of a memorandum of understanding under Section 264.403, a children's advocacy center may be established by the participating entities.

(b) A center may be established to serve two or more contiguous counties.

SECTION 264.403. INTERAGENCY MEMORANDUM OF UNDERSTANDING.

(a) Before a center may be established under Section 264.402, a memorandum of understanding regarding participation in operation of the center must be executed among:
(1) the division of the department responsible for child abuse investigations;
(2) representatives of county and municipal law enforcement agencies that investigate child abuse in the area to be served by the center;
(3) the county or district attorney who routinely prosecutes child abuse cases in the area to be served by the center; and participates in child abuse investigations or offers services to child abuse victims that desires to participate in the operation of the center.
(4) a representative of any other governmental entity that participates in child abuse investigations or offers services to child abuse victims that desires to participate in the operation of the center.

(b) A memorandum of understanding executed under this section shall include the agreement of each participating entity to cooperate in:
(1) developing a cooperative, team approach to investigating child abuse;
(2) reducing, to the greatest extent possible the number of interviews required of a victim of child abuse to minimize the negative impact of the investigation on the child; and
(3) developing, maintaining, and supporting, through the center, an environment that emphasizes the best interests of children and that provides investigatory and rehabilitative services.

(c) A memorandum of understanding executed under this section may include the agreement of one or more participating entities to provide office space and administrative services necessary for the center's operation.

SEC. 264.404 BOARD; ADMINISTRATION OF CENTER

(a) The executive officer or board of each participating entity executing a memorandum of understanding that established a center under this subchapter shall appoint a member to serve on the governing board of the center.

(b) A governing board member serves at the pleasure of the appointing executive officer or board.

(c) Service on a center's board by a public officer or employee is an additional duty of the office or employment.

Sec. 264.405. DUTIES A center shall:

(1) Assess victims of child abuse and their families to determine their need for services relating to the investigation of child abuse.

(2) Provide services determined to be needed under Subdivision (1)

(3) Provide a facility at which a multidisciplinary team appointed under Section 264.406 can meet to facilitate the efficient and appropriate disposition of child abuse cases through the civil and criminal justice systems; and

(4) coordinate the activities of governmental entities relating to child abuse investigations and delivery of services to child abuse victims and their families.

SEC. 264.406 MULTIDISCIPLINARY TEAM.

(a) A center's board shall appoint a multidisciplinary team to work within the center to review new and pending child abuse cases for the purposes of coordinating the activities of entities involved in investigation, prosecution and victim services.

(b) A multidisciplinary team may review a child abuse case in which the alleged perpetrator does not have custodial control or supervision of the child or is not responsible for the child's welfare or care.

(c) A multidisciplinary team shall consist of persons who are involved in the investigation or prosecution of child abuse cases or the delivery of services to child abuse victims and their families.

(d) A multidisciplinary team shall meet at the call of the board. The board shall call a meeting of the multidisciplinary team if:
(1) a new child abuse case is received; or
(2) a pending child abuse case requires attention.

(e) At each meeting, the multidisciplinary team shall discuss each active case and the actions of the entities involved in investigation, prosecution, and victim services.

(f) When acting in the member's official capacity, a multidisciplinary team member is authorized to receive information made confidential by Section 40.005, Human Resources Code, or Section 261.201 or 264.408.

SEC. 264.407 LIABILITY

(a) A person is not liable for civil damages for a recommendation made or an opinion rendered in good faith while acting in the official scope of the person's duties as a member of the multidisciplinary team or as a board member, staff member or volunteer of a center.

(b) The limitation on civil liability of Subsection (a) does not apply if a person's actions constitute gross negligence.

SEC. 264.408 USE OF INFORMATION AND RECORDS;CONFIDENTIALITY AND OWNERSHIP

(a) The files, reports, records, communications, and working papers used or developed in providing communica tions, and working papers used or developed in providing services under this chapter are confidential and not subject to public release under Chapter 552, Government Code, and may only be disclosed for purposes consistent with this chapter. Disclosure may be to:

1. the department, department employees, law enforcement agencies, prosecuting attorneys, medical professionals, and other state agencies that provide service to children and families; and
2. the attorney for the child who is the subject of the records and a court-appointed volunteer advocate appointed for the child under Section 107.031.

(b) Information related to the investigation of a report of abuse or neglect under Chapter 261 and services provided as a result of the investigation is confidential as provided by Section 261.201.

(c) The department, a law enforcement agency, and a prosecuting attorney may share with a center information that is confidential under Section 261.201 as needed to provide services under this chapter. Confidential information shared with or provided to a center remains the property of the agency that shared or provided the information to the center.

(d) A videotaped interview of a child made at a center is the property of the prosecuting attorney involved in the criminal prosecution of the case involving a child. If no criminal prosecution occurs, the videotaped interview is the property of attorney involved in representing the department in a civil action alleging child abuse or neglect. If the matter involving the child is not prosecuted, the videotape is the property of the department if the matter is an investigation by the department of abuse or neglect. If the department is not investigating or has not inves tigated the matter, the videotape is the property of the agency that referred the matter to the center. If the cen ter employs a custodian of records for videotaped interviews of children, the center is responsible for the custody of the videotape. A videotaped interview may be shared with other agencies under a written agreement.

(e) The department shall be allowed access to a center's videotaped interviews of children.

SEC. 264.409 ADMINISTRATIVE CONTRACTS.

The department may contract with a statewide organization of individuals or groups of individuals who have expertise in the establishment of operation of children's advocacy center programs. The statewide organiza tion shall provide training, technical assistance, and evaluation services for local children's advocacy center programs.

SEC. 264.410 ELIGIBILITY FOR CONTRACTS

(a) A public entity or nonprofit entity is eligible for a contract under Section 264.410 if the entity:

1. has a signed memorandum of understanding as provided by Section 264.403;
2. operates under the authority of a governing board as provided by Section 264.404;
3. has a multidisciplinary team of persons involved in the investigation or prosecution of child abuse cases or the delivery of services as provided by Section 264.406;
4. holds regularly scheduled case reviews as provided by Section 264.406;
5. operates in a neutral and physically separate space from the day-to-day operations of any public agency partner;
6. has developed a method of statistical information gathering on children receiving services through the center and shares such statistical information with the statewide organization and the department when requested;
7. has an in-house volunteer program;

8. employs an executive director who is answerable to the board of directors of the entity and who is not the exclusive salaried employee of any public agency partner; and
9. operates under a working protocol that includes a statement of:
    A. the center's mission;
    B. each agency's role and commitment to the center;
    C. the type of cases to be handled by the center; and
    D. procedure for case reviews.

(b) The statewide organization may waive the requirements specified in Subsection (a) if it determines that the waiver will not adversely affect the center's ability to carry out its duties under Section 264.405. Any waiver that is granted must be identified in the written contract with the center. If a request for a waiver is denied, an appeal of the decision may be made to the department's executive director, who may reverse the decision. If the executive director approves a request for a waiver on appeal, the statewide organization shall contract with the center and shall include the waiver in the contract.

TEXAS STANDARDS FOR CHILDREN'S ADVOCACY CENTERS

To be recognized by Children's Advocacy Centers™ of Texas, Inc. as a children's advocacy center program, CAC staff, volunteers, board of directors, and public agency partners must comply with the following minimum standards:

1. A CAC program must have a mission and purpose in keeping with mission and purpose of the National Network of Children's Advocacy Centers.

2. A CAC program must be affiliated with Children's Advocacy Centers™ of Texas, Inc. and must abide by all reporting and evaluation requirements of Children's Advocacy Centers™ of Texas, Inc. and the Texas Department of Protective and Regulatory Services.

3. A CAC program shall be an inclusive organization whose staff, board members, and volunteers reflect the children they serve and their community in terms of gender, ethnicity, and cultural and socio-economic backgrounds.

4. A CAC program operates under the auspices of a nonprofit 501(c)(3) board of directors or under 501(a) of the code. Total board of director memberships may not include a disproportionate number of public agency staff.

5. A CAC must operate in a neutral and physically separate space from the day to day operations of any public agency partner.

6. Before a children's advocacy center may be established, an interagency agreement must be entered into by local Child Protective Services, local law enforcement agencies and by the county and/or district attorney who routinely prosecutes child abuse cases in the area to be served. It is strongly recommended that a representative of the local medical community who actually participates in the collection of forensic evidence also sign the interagency agreement with the public agency partners.

7. The interagency agreement at a minimum must include the following assurances:
   - development of a cooperative, team approach to investigating child abuse;
   - reduction to the greatest extent possible of the number of interviews required of a victim of child abuse to minimize the negative impact of the investigation of the child;
   - the development, maintenance, and support through the center, of an environment that emphasizes the best interests of children and that provides investigative and rehabilitative services.

8. A children's advocacy center must hold multidisciplinary staffings on new and pending child abuse cases at regularly scheduled intervals. The multidisciplinary team shall consist of persons who are involved in the investigation or prosecution of child abuse cases or the delivery of services to child abuse victims and their families.

9. A CAC must develop a method of statistical information gathering on children receiving services through the center. These statistics must be shared with Children's Advocacy Centers™ of Texas, Inc. and the Texas Department of Protective and Regulatory Services when requested.

10. A CAC must make referral to and/or provision for appropriate therapeutic treatment programs for child victims and non-offending family members.

11. A CAC must make referral of child victims to appropriate medical providers for assessment and treatment as indicated.

12. A CAC must develop an in-house volunteer program.

13. Children's advocacy centers must have malpractice and/or liability insurance for the facility and staff.

CAC STAFF

14. Minimum staffing requirements must include the hiring of a paid executive director who is answerable to the board of directors. The executive director must not be the exclusive salaried employee of any public agency partner.

15. New CAC executive directors must receive training as approved by Children's' Advocacy Centers™ of Texas, Inc.

16. A CAC program may not employ applicants if they have been convicted, or have prior charges, or have charges pending for a felony or misdemeanor involving a sex offense, violent act, child abuse or neglect, or related acts that would pose risks to children or the CAC program's credibility. Criminal record checks shall be completed on all CAC staff.

CAC VOLUNTEERS

17. A CAC direct service volunteer is of majority age, 18 years or older, in the state and has successfully passed screening requirements which include a written application, personal interview, written references, and criminal records check, and has proof of current auto liability insurance and a current driver's license if licensed driver. CAC volunteers under 18 years of age may assist in day to day operational tasks as long as they do not provide direct services.

18. A CAC volunteer does not become inappropriately involved in a child's case by engaging in activities which jeopardize the safety of the child, the integrity of the program, or activities which are likely to result in conflict of interest or expose the program or volunteer to criminal or civil liability.

19. A CAC volunteer respects the right to privacy of clients by keeping information that would identify CAC clients confidential.

DEFINITIONS OF
CHILDREN'S ADVOCACY CENTERS OF TEXAS, INC.

MISSION STATEMENT

The mission of Children's Advocacy Centers of Texas, Inc. is to promote, assist and support the development, growth, and continuation of Children's Advocacy Centers in the State of Texas.

TYPES OF CHILDREN'S ADVOCACY CENTERS IN TEXAS

- Facility Based Model Operated by Independent Nonprofit Board
- Facility Based Model Operated by Umbrella Nonprofit
- Youth Services Model/Comprehensive Victim Service Model
- Medical Model

MINIMUM REQUIREMENTS TO OPERATE AS A TEXAS CAC

At a minimum, the following criteria must be met in order for a community agency to qualify as a legitimate CAC model:

- interagency agreement signed by law enforcement, Child Protective Services and the District Attorney's office
- coordinated investigations of child abuse conducted by law enforcement and Child Protective Services child friendly and noninstitutional setting to be used for child centered investigative interviews conducted in accordance with agreed interagency protocol
- neutral and physically separated space from the day to day operations of any public agency partner
- multidisciplinary staffings held at regularly scheduled intervals
- development of a method of statistical data collected on children receiving services through a children's advocacy center
- referral to and or provision for appropriate therapeutic treatment programs for child victims and non-offending family members
- referral of child victims to appropriate medical providers for assessment and treatment as indicated
- development of an inhouse volunteer program
- affiliation with the Children's Advocacy Centers of Texas, Inc.

DESCRIPTION OF TEXAS CHILDREN'S ADVOCACY CENTERS

In order to maintain neutrality and community involvement, Children's Advocacy Centers must be operated under the auspices of a nonprofit 501(c)(3) Board of Directors or under
501(a) of the Code, whose total membership does not include a disproportionate number of public agency staff.

STAFFING

Minimum staffing requirements must include the hiring of a paid executive director who is answerable to the Board of Directors. The executive director must not be the exclusive salaried employee of any public agency partner.

All Texas CAC models must meet these minimum requirements, and conform to the legal description and staffing pattern.

INTERAGENCY AGREEMENT

Community based advocacy centers are required to enter into interagency agreements with their public agency partners - Child Protective Services, local law enforcement agencies and the District Attorney's Office. The interagency agreement at a minimum must include the following assurances:

- to develop a cooperative team approach to the investigation of child abuse and neglect.
- to reduce to the absolute minimum the number of interviews the child abuse victim must participate in, so as to minimize "revictimization" of the child.
- to support the founding, development, and continuation, of a neutral "child friendly" environment where both the investigation of the abuse and/or rehabilitative services are offered to the victim child and nonoffending family members.

It is strongly recommended that a representative of the local medical community who actually participates in the collection of forensic evidence also sign the interagency agreement with the public agency partners.

EXAMPLES OF TEXAS CHILDREN'S ADVOCACY CENTER MODELS

1. Facility Based Model Operated by an Independent Nonprofit Board
   Facility based models conform to all the previously stated minimum criteria.
   Two distinguishing characteristics are that:
   a. all of the building is used for CAC activities, and
   b. frequently, public agency partners are housed on site.

2. Facility Based Model Operated by Umbrella Nonprofit Board
   In some communities, existing nonprofit boards, which govern a variety of community related programs, develop a children's advocacy center.
   CAC's that develop in this manner meet all of the minimum requirements. Distinguishing characteristics include:
   a. a housing separate from other programs that the umbrella Board of Directors administers, and
   b. the appointment of an advisory board that has the authority to make day to day decisions affecting the operations of the CAC guide public relations and fundraising decisions.

3. Youth Services/Comprehensive Victim Model
   In some communities, it may not be possible to establish an advocacy center that is a "stand alone' facility. Two factors which most commonly contribute to the difficulty in establishing a "facility based" model are:
   a. a relatively small number of annual reports of child abuse in a county (less that 500 reports) or
   b. large geographic areas with relatively sparse population and financial resources.
   A CAC model that has developed in response to these factors is a nonprofit "Victim Services/Youth Services Center" which offers a child advocacy center program as part of its comprehensive services. The Victim Services/Youth services Center model meet all of the Texas CAC minimum requirements. Distinguishing characteristics include:
   a. a paid executive director who spends a proportionate amount of her time directing the activities of the child advocacy center component of the "Victim Services/Youth Services program, and
   b. a nonprofit board of directors which oversees the child advocacy center program in addition to other services offered through the center.

4. Medical Model

In some communities, the children's advocacy center has evolved in association with a medical institution or medical school. The Medical Model meets all of the Texas CAC minimum requirements. Distinguishing characteristics include:

a. typically the CAC is located on the medical institution campus and
b. frequently the sexually abused child's disclosure interview is conducted by medical staff prior to the medical examination.

PROGRAM COMPONENTS

"Deciding what to put on the menu."

MEAT –

* *Child interviews*
* *Case staffings*
* *Coordinated Investigations*

POTATOES –

* *Medical exams/services*
* *Mental Health services*
* *Volunteer Program*
* *Professional Training*

DESSERT –

* *Court school*
* *Trial accompaniment*
* *Child Fatality Review Teams*
* *Crime Victim Compensation services*
* *Prevention and community education programs*
* *Domestic Violence programs*
* *At-risk youth programs (mentoring, tutoring, etc.)*
* *Adult sexual assault services*

ASSESSING NEEDS IN YOUR COMMUNITY

"Look back before you move forward."

WHAT IS HAPPENING WITH CHILD ABUSE CASES NOW?

* ***How many?***
* ***Who is involved?***
* ***What is the process?***

WHAT IS HAPPENING TO CHILD ABUSE VICTIMS NOW?

* ***How many times are child victims interviewed?***
* ***Is interviewer appropriately trained?***
* ***Are specialized medical exams/services available?***
* ***Are mental health services available and accessible?***
* ***Are child victims/witnessed prepared for court appearances?***
* ***Who accompanies kids in court?***
* ***Is there follow-up with victims and families after disposition?***

WHAT IS THE PROBLEM THAT NEEDS TO BE FIXED?

* ***If you can't identify "WHAT" the problem is, you can't answer questions like "WHY" start a Center; "WHO" will be involved, and "HOW" it should be developed and implemented.***

IDENTIFYING LEADERS IN YOUR COMMUNITY

"Who will save the Frog Hospital?"
Agencies, Activists and Angels

*** IDENTIFYING PARTNER AGENCY STRENGTHS AND WEAKNESSES**

- *Supervisors*
- *Front lines*

*** IDENTIFYING POWER AND INFLUENCE IN THE COMMUNITY**

- *Governmental*
- *Private sector*

*** IDENTIFYING SOURCES OF FINANCIAL SUPPORT**

- *Individuals*
- *Businesses*
- *Community organizations*
- *Local foundations*

DEVELOPING INTERAGENCY AGREEMENTS AND PROTOCOLS

"The foundation for the future"

INTERAGENCY AGREEMENT

* *Why have one?*
* *What should it say?*
* *Who should say it?*
* *Who should sign it?*

WORKING PROTOCOLS

* *How do they differ from the Interagency Agreement?*
* *What should it say?*
* *Who should say it?*
* *Who should sign it?*

KEEPING IT CURRENT

* *When to review?*
* *What to revise?*
* *Who's still on board?*

SELECTING A MODEL

"The framework for today and tomorrow."

*** FACILITY-BASED MODEL (Operated by Independent Nonprofit Board)**

- ** All of the building is used for CAC activities*
- ** Partner agency staff frequently housed on site*

*** FACILITY-BASED MODEL (Operated by Umbrella Nonprofit Board)**

- ** Housing separate from other programs umbrella administers*
- ** Appointment of a CAC governing board with the authority to make day to day decisions affecting operations of the CAC guide public relations and fund raising decisions.*

*** YOUTH SERVICES/COMPREHENSIVE VICTIM SERVICES MODEL**

- ** Paid executive director who spends proportionate amount of time directing activities of CAC component.*
- ** Nonprofit board of directors which oversees the CAC program in addition to other services offered through the Center.*

*** MEDICAL MODEL**

- ** Typically the CAC is located on the medical institution campus.*
- ** Larger focus on medical component*

GENERATING START-UP AND CONTINUATION FUNDING

"How to foot the bill."

IDENTIFYING LOCAL FUNDING SOURCES

* *Foundations*
* *Businesses*
* *Community Organizations*
* *United Way*
* *Service Organizations*
* *Special events*
* *Local government/partner agencies*
* *Individuals*

CONTACTING AND INFLUENCING LOCAL FUNDING SOURCES

* *Board recruitment*
* *Generating contacts*
* *Establishing rapport*
* *Local publicity*

Forensics and Crimes Against Children

The purpose of this training is to provide a brief overview of this one week forensic aspects of criminal investigations course as it relates to crimes against children.

Specific areas of forensic capabilities as it relates to crimes against children will be identified as key elements for the first responding officers/investigators to understand and be better prepared to identify, collect and preserve evidence with modern forensic science applications.

The overall basic training is geared toward the areas of identification, collection and preservation of evidence related to the advancements in forensic technology. Some specific areas of training will be crime scene management issues/factors, photography, DNA, interagency-protocols, evidence collection and fingerprint technology.

This training is not to convert law enforcement officer's/investigator's into forensic scientists, but rather orient them to the capabilities of modern forensics and to translate that capability into the best investigative practices from the investigations inception to its conclusion.

SKIN MANIFESTATIONS OF ABUSE

Prepared by: Donna Persaud, M.D.

General Principles

Skin= largest organ in human body therefore skin manifestations of abuse numerous diverse
Skin can be seen by both medical and non-medical personnel

Determination of Accidental vs Inflicted Injury

For all types of injuries, the diagnosis of abuse is based not only on physical, radiographic, and laboratory findings, but also on knowledge of the epidemiology and risk factors of abuse as well as the history provided. The following is a listing of the injury features commonly used to distinguish accident from abuse.

1. *Location:*

    a. Normal childhood trauma:
        Elbows, knees, shins, outer thighs, circular bruises over the spine, forehead, other "bony prominences"

    b. Inflicted injury:
        Padded areas: buttocks, cheeks , genitalia,
        Inaccessible areas: earlobes, neck, inner thighs, trunk

2. *Presence of recognizable patterns*: The following injuries most times will indicate abuse.

    Human hand-grab (oval bruises in groups),pinch marks, slap marks = Linear bruises alternating with clear spared areas
    Object imprints-whips, doubled electric cords, belts, coat hangers, board, fly swatter, paddles, hairbrush
    Restraint marks-encircle extremity, neck, gag marks-both sides mouth
    Multiple bruises- different ages in inaccessible locations

3. *Inconsistency between history and injury:*

    Delay in seeking medical attention beyond what would be reasonable, given the expected clinical course of the injury.

    Insufficient trauma explanation: large differences between the amount of force needed for the particular injury and the type of trauma incident described.

4.*Inconsistency between clinically determined age of injury and historical accounts*

Comparing the clinically estimated age of a bruise to the described age is critical to many child abuse assessments. However, dating of injuries is a rather inexact science. The following limitations should be kept in mind when making evaluations; depth, location and skin complexion may potentially affect the time of appearance and color of a bruise. Making assessments from photographs may be limited by light availability and technique.

Guide to color changes seen in bruises over time

0-2 days	Swollen ,tender
0-5 days	Red, blue, purple
5-7 days	Greenish
7-10 days	Yellowish

10-14 days	Brown, normal tint, fading
2-4 wks	Cleared

Moritz and Henriques 1947

5. Inconsistency between history and developmental capability of child

The appropriateness of the scenario can be judged by considering the developmental capability of the child.

6.Suspicious Circumstances-

Significant or remarkably patterned injury (e.g. bilateral injury) without witness and a preverbal child.

7.Conditions that may be mistaken for abuse

Normal childhood trauma
Bleeding disorder-low platelets, leukemia
Birthmarks- Mongolian Spots 80% of black children, tend to remain stable in color over days and weeks whereas bruises change more rapidly.
Cultural practices-Cio gao or coin rubbing to the back
Blood vessel inflammation- Henoch-schonlein purpura by palpable lesions over the lower extremities and buttocks. There are other features which help to distinguish this condition from non accidental trauma such as pain in the abdomen, swelling and pain of the joints and evidence of kidney disease.
Photodermatitis-citrus juice on skin deposited by hands of an adult during regular care. Chemicals react with sun causing skin marks that match fingertips.
Contact Dermatitis
Impetigo

8.Uncertainties

At times it may be impossible to say whether bruises are accidental or non accidental. In such cases the history must be interpreted in the light of the observed bruises, the past medical history, the developmental history, the presence or absence of other injuries and any laboratory data. In cases where the cause of the bruises cannot be determined, care should taken to document the history and injuries accurately for future reference should a pattern emerge. Correlation with social factors may be needed to determine future risk of abuse.

A. Burns are caused by application of thermal energy to the skin and subcutaneous structures.

1)Dry or liquid contact
2)Conversion of electrical chemical or microwave energy to thermal energy
3)Flame

B. Factors affecting injury depth, extent and configuration

Agent creating burn
Temperature of agent
Length of time thermal energy applied to skin
Depth of skin at site of burn
Age of child
Clothing

The history of events, child clothing at the time of the incident , child's development , and other minute details should be compared with the observed injury to determine plausibility.

C. Burn classification:

1)First degree \ superficial

Involves only the superficial layer of the epidermis and is characterized by redness of the skin only.

2)Second degree \superficial partial

Extends into the dermis, producing blistering and skin loss

3)second degree \deep partial thickness

Painful but sensation may be impaired. Heal more slowly and leave residual scarring.

4)Third degree \deep thickness

Entire dermis and appendages damaged, variable penetration to subcutaneous tissue. No sensation as sensory endings destroyed. Heal with scarring and require grafting

5) Fourth degree.

Beyond subcutaneous tissue to joint and bone.

Relationship of Time to Temperature -to produce Second Degree Burn in An Adult

Temp (C)	Temp (F)	Time (SECS)
48.9°	120°	300s
54.4°	130°	30s
60.0°	140°	5s
65.0°	150°	1.5s

*Moritz and Henriques 1947

D. Important Considerations:

Clothing can hold heat to skin longer

Skin of palm and soles thicker and more resistant to burning.

E. Patterns of Inflicted Burns

Immersion-characterized by sharply demarcated edges and paucity of splash marks, flexion creases and apposing skin surfaces spared. Symmetry is also another clue.

Inflicted Contact-geometric pattern that duplicates object, depth of burn greater and geometric imprint may be more complete if child held against hot object as opposed to accidental contact-however an implement at very high temperatures might create a clear object impression in accidental contacts. Curling iron burns are becoming increasingly common, distinguishing accidental from non accidental is not always straightforward. The developmental capability of the child and the site of the burn are important factors to consider.

Splash -may be inflicted or accidental method of assessment for determining whether accident or abuse is as described for inflicted contact burns.

BURN SEQUELAE

Deep burns and in particular immersion burns, have tremendous potential for cosmetic disfigurement and long term functional impairment. It is imperative that all agencies involved in the coordination of care for the child who has sustained a significant burn, do their best to ensure that follow up wound care is received.

SKELETAL MANIFESTATIONS OF ABUSE

·Inflicted bone injury can present as:

-common fractures

-"chip" and "bucket handle" metaphyseal fractures

-multiple fractures at different stages of healing

-repeated fractures to same site

-subperiosteal bleeding

·The entire clinical presentation which includes the history, physical examination and radiological findings is considered when making a diagnosis of abusive bone injury. Significant injury of accidental nature should present with a history of significant trauma with details given immediately. After the fact explanations that cannot be verified (especially if the child is nonverbal) and changing stories are unsatisfactory methods of justifying a significant injury and tend to support the diagnosis of abuse. Some fractures however are so rare in accidental trauma that they almost always indicate abuse.

-*Specific fractures*

·metaphyseal-epiphyseal fx in < 2 year old

·rib, sternum

·scapula

·medial and lateral clavicle

·vertebral body and spinous process

-*Highly suggestive fractures/patterns*

·multiple: bilateral, symmetric

·repetitive, different ages

·associated non-skeletal injury: intracranial, visceral

-*Concerning*

·hands and feet

·complex fracture line of skull

-*Nonspecific fractures*

·long bone shaft (diaphyseal)

·midshaft of clavicle

·simple linear skull fracture

Note: highly suggestive, concerning and nonspecific injuries may increase in significance when a history of trauma is absent or when history is inconsistent with the injury or history is not medically believable given the child's developmental abilities.

Timing of Skeletal Trauma

History

Very young infants (under 4 months) have limited ability to move around therefore, impairments in function due to fractures may go unnoticed. In addition, swelling may not be immediately obvious especially over "chubby" areas like the thigh and arm. Infants cry and fuss a lot due to a fracture but still need very careful physical examination to determine the site of injury because the signs can be so subtle. It happens sometimes that other causes are sought for fussiness until the fracture is discovered. Therefore, timing of fractures in pre ambulating infants by observation alone is not straightforward.

Ambulating children are a little easier. For example, following a complete shaft fracture of a long bone there may be failure to move the extremity or if it is a lower limb, failure to walk. Occasionally however, a child may cry briefly following the trauma event, then fall asleep perhaps after being picked up immediately following the trauma incident. Any impairment goes unnoticed-until the child wakes up! This is different than the child who is said to have gone to sleep but appeared completely normal and then wakes up with a fracture.

Radiology

It takes an average of 10 days for long bone and ribs to show signs of healing. Metaphyseal - epiphyseal fractures as well as skull fractures do not follow the same healing process and are therefore not amenable to easy dating by radiographic appearance. Complete healing of fractures is most rapid in the youngest infants with an average duration of 2 months.

When there are multiple bone injuries, radiologists may not always be able to say whether bony injuries occurred all at once or at different times, especially if different bones are involved.

.Indications for skeletal survey include:

- *under 1 year*: any suspicious injury/physical abuse, neglect, failure to thrive, or if another child in the home has been physically abused.
- *under 2 years*: any evidence of physical abuse.
- *2-5 years*: frequency of occult skeletal injury decreases therefore studies are selective.
- *> 5 years*: complete skeletal survey is rarely indicated, occult fractures are rare.

Use of Repeat Skeletal Surveys

Repeat skeletal surveys may be performed for the following reasons:

Very young infants with a single fracture thought to be due to abuse -: Repeat x rays can be done to detect other fresh fractures which may be present though not apparent at the initial radiological evaluation. Such injuries can become visible on later films when new bone deposition occurs during the healing process. The typical time for follow up xrays is about 2 weeks after the initial survey.

Extensive fractures on first skeletal survey-: Follow up films to demonstrate normal healing of bone and the absence of new fractures in a changed environment. This would be strong evidence in favor of an environmental \ non-accidental cause of injury and against bone disease or fragility of the child as a cause of injury.

Conditions that may be Mistaken for abuse

·*Innocent trauma*-

1.Toddler fracture:

Distal tibia oblique fracture in an early ambulating child (typical age 11-18 months). Will present with failure to bear weight and usually no trauma explanation. Initial x rays may be negative. On follow up films there is periosteal reaction._

·*Normal variants-*

Physiologic periosteal reaction- in infants' bones may be confused with injury; symmetric periosteal reaction (new bone formation) occurs along the long bone shafts in healthy infants appearing at 2-3months and resolving by 8 months, without other signs suggestive of abuse. Good radiologists with experience at viewing pediatric x-rays should be able to distinguish these cases.

Congenital Abnormality-these create peculiar radiographic appearances that may mimic fracture. They do not change over time. Clinical correlation and expert radiologist reading can usually distinguish these as different than trauma.

Other Explanations that may be considered as causes of bony injury

·*Birth trauma* may result in fractures of clavicle or humerus. Any fracture which does not have signs of healing at 14 days should not be attributed to birth trauma. The presence of new onset soft tissue swelling overlying the fracture and symptoms in a baby would indicate a new trauma event. Rib fractures very rarely result from birth trauma.

·*Bone Disease-*

Medical causes of "soft bones which break easily" are readily recognizable syndromes, radiographic patterns, or rare congenital defects. Usually there is a family history of bone disease as well as other associated findings in the infant.

Probability of mild type IV of Osteogenesis Imperfecta with white sclera, normal hearing, normal dentition, negative family history and no wormian bones is estimated to be 1:1,000,000 to 1:3,000,000.

Can genetic testing " rule out bone disease"?- No it can't. Bone disease should be clinically and radiologically apparent, gene testing would then be confirmatory. The circumstances should not be suspicious in bone disease. An approach to the possibility of bone disease is to consider whether the physical findings, medical history, radiological findings and circumstances of the injury are consistent with child abuse or other clinical condition.

References

Skin Manifestations of Abuse

1. Richardson AC, Cutaneous Manifestations of Abuse in *Child Abuse: Medical Diagnosis and Management.* Edited by Robert M. Reece, Lea & Febiger, 1994.
2. Schwartz AJ, Ricci LR.How Accurately can bruises be aged in abused children literature review and synthesis. Pediatrics;97:254-257.1996.

Skeletal Manifestations of Abuse

1. Kleinman PK, Marks SC, Blackbourne B, The metaphyseal lesion in abused infants: A radiologic-histopathologic study. *American Journal of Roentography.* 1986 :146:895-905.
2. Kleinman PK, Marks Jr SC, Richmond JM, Blackbourne BD, Inflicted skeletal injury: A postmortem radiologic-histopathologic study in 31 infants. AJR 165:647-650.1995
3. Caffey J, Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentography.* 1946:56:163-173.
4. Kempe CH, Silverman FN, Stelle BF: The battered child syndrome. 1962:181:17-24.
5. Kogutt MS, Swischuk LE, Fagan CJ, Patterns of injury and significance of uncommon fractures in the battered child syndrome. *American Journal of Roentography,* 1974:121,143.
6. Taitz LS. Child abuse and osteogenesis imperfecta.(letter) *Br Med J* 1987;295:1082-1083.
7. Ablin DS, Greenspan A, Reinhart M, Grix A. Differentiation of Child abuse from Osteogenesis Imperfecta. *AJR* 1990 154: 1035-1046.
8. Merten et al; Skeletal Manifestations of Child abuse, in *Child Abuse:Medical Diagnosis and Management.* Edited by Robert M. Reece, Lea & Febiger, 1994.

The Children's Assessment Center

. . . an advocacy center for children

Child Sexual Abuse: A Family Treatment Program

Julia Coker Wolf, MA, LPC, LMFT
Registered Sex Offender Treatment Provider

Dawn Hill, LMSW-ACP

Crimes Against Children Conference
August 17, 1998
Dallas, Texas

The Children's Assessment Center

. . . an advocacy center for children

FACT SHEET

5100 Southwest Freeway
Houston, Texas 77056
(713)599-5687
(713)599-5930 FAX

In 1997, The Children's Assessment Center served over 5,000 sexually abused children and their families by fulfilling its mission to protect children by providing co-housing, coordination, agency collaboration and the use of the multi-discipline team approach in prevention, assessment, investigation, referral for prosecution and treatment of child sexual abuse.

As a program of Harris County Commissioners' Court, The Center represents a true partnership between the public and private sectors for the most effective services delivery to children and families. Currently housed in the Children's Protective Services Building at 5100 Southwest Freeway, The Center will move in early 1998 to a $10 million, 53,000- square-foot, state-of-the-art facility specifically designed to provide an environment that will meet each child's need for warmth, support and protection.

The Children's Assessment Center is a member of the National Network of Children's Advocacy Centers and part of a national movement to create child-friendly intervention systems for sexually abused children. Harris County is the largest metropolitan area to serve sexually abused children in this innovative manner. The Center is also the largest program of its kind in the nation.

The Center houses professionals from ten partner agencies, which include law enforcement, medical school, psychological/psychiatric school, and governmental investigative entities all with the common goal of protecting children. The following agencies collaborate with The CAC to provide comprehensive, coordinated team respons[illegible] child sexual abuse victims in Harris County:

- Child Advocates, Inc.
- Harris County Children's Protective Services
- Harris County Attorney's Office
- Harris County District Attorney's Office
- Harris County Sheriff's Office
- Hermann Hospital
- Houston Police Department
- Texas Department of Protective and Regulatory Services
- Interfaith Ministries/Youth Victim/Witness
- University of Texas Health Science Center

The Children's Assessment Center substantially benefits child sexual abuse victims and families by offering the following:

- One child friendly location
- On site medical and clinical assessments
- Joint training for all professionals and volunteers
- Elimination of repetitive interviews of children by offering co-housing of all disciplines and team staffings of all cases
- Quality, coordinated assessment and planning by professionals to insure the success of recovery by children and families

OUTLINE

I. INTRODUCTION OF SPEAKERS

II. CHILDREN'S ASSESSMENT CENTER

III. RATIONALE FOR DOING THIS TYPE OF WORK

- Self development occurs in the context of important relationships
- Incest occurs in a family context and disrupts and distorts the family relationships, therefore, family treatment is indicated.
- Child protection and/or legal interventions do not necessarily end relationships
- Importance of family relationships before, during, and abuse end relationships

IV. REFERRAL CRITERIA

- All family members' intellectual functioning must be at a level that permits them to actively participates in all treatment modalities
- No family members can suffer from chronic substance abuse
- The victim child must express a desire t reunify the family
- The non-offending parent must express a desire to reunify with the family
- The alleged perpetuator must not be in complete denial of the sexual offense (s), verbally commit to treatment, and must express a desire to reunify with the family
- Only Biological or established step-parent/paramour relationships

V. TEAM APPROACH TO INTAKE AND TREATMENT

- Multiple perspectives - why impt.
- Sharing the intensity of doing this type of clinical work
- Respect for each other and open communication reduces splitting by clients

VI. STAGE 1: ASSESSMENT AND PREPARATION FOR TREATMENT

- Join the family system
- Assessment of substance abuse and addiction
- Enhancement of client motivation
- Clinical assessment of family functioning and structure
- Confrontation of family denial
- Definition of the problem of incest with the family
- Determination of the treatiability of the family system for reunification
- Coordination with protection agencies regarding goals for the family (Qualls)
- Establishment of a therapeutic contract with the family

VII. STAGE 2: ACTIVE TREATMENT

- Confront denial, minimization, and other cognitive distortions
- Reduce maladaptive belief systems, behavioral patterns, and family interactions
- Enhance adaptive beliefs, behavioral patterns, and family functioning
- Reinforce existing family strengths
- Develop individual and family relapse prevention plans
- Assess therapeutic gains with the family

VIII. STAGE 3: REUNIFICATION TREATMENT

- Implementation of individual and family relapse prevention plans
- Integration and generalization of therapeutic gains
- Initiation of family reunification through graduated reintroduction of the alleged perpetrator into the family

IX. AFTERCARE

- Monitoring
- Assessment of additional treatment needs and referral

X. CASE PRESENTATION

- Genogram and description of family and referral to CPS
- Treatment history prior to FRP
- Treatment to date

The Children's Assessment Center

... an advocacy center for children

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. FRP

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, the offender must be the one who leaves the home, not the child, until reunification occurs.

Overall, any dysfunctional family patterns resulting from 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.

THE CHILDREN'S ASSESSMENT CENTER
FAMILY TREATMENT PROGRAM

STRUCTURE OF PROGRAM

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, the offender must be the one who leaves the home, not the child, until reunification occurs.

TREATMENT PLAN

INTAKE

All family members will attend the intake appointment. The alleged offender will not have contact with any children in the family during the intake appointment.

The intake will be conducted by a multi-disciplinary team consisting of therapists and a representative from CPS.

During the intake appointment, children, the alleged offender and the non-offending partner will all be interviewed individually and by different team members.

A substance abuse screening (MAST) will be given to each adult and adolescent in the family.

After meeting with all family members, the team will meet, discuss the family situation and decide if the family is appropriate for treatment in the Family Treatment Program. The team will prepare an initial treatment plan including assignment of therapists and treatment modalities, any necessary outside referrals, referrals for psychologicals, etc. Finally the team will present the treatment plant to the parents. If the parents agree to the plan, initial appointments will be arranged and CPS will be notified that the family is accepted into treatment. If the family does not agree with the proposed plan or is deemed

not appropriate for treatment at this time, they will be referred back to CPS for alternative treatment options.

ATTENDANCE

Successful completion of the program requires regular attendance of all family members. Three unexcused absences by any family member will result in the family being unsuccessfully terminated from the program, followed by referral back to the CPS caseworker for case review.

Clients must arrive on time for all therapy session. Arrival more than 14 minutes late will result in cancellation of that session. Cancellations are to be made prior to a session. However, if clients are unable to cancel prior to a session, they should call and explain their absence as soon as possible.

TREATMENT PLAN

1. Treatment modalities for the family will be tailored to each family's needs. The primary therapist on the case will conduct all individual therapy with the victim child, individual therapy with the non—offending parent, family therapy and couples therapy. Family members will also participate in group therapy.

2. The alleged perpetrator will be assigned to a therapist, other than the primary therapist, for individual therapy and will also particular in group therapy. The alleged perpetrator will begin participating in family therapy when the group, individual and family therapists deem it appropriate.

3. Individual therapy with siblings, grandparents or other adjunct family members can be conducted by any team member.

4. Stages of treatment will be tailored to each family needs.. However, the following describes an overview of Family Treatment Program stages, in general.

5. Stage I, assessment and preparation for treatment, will last a minimum of 4-12 weeks during which a combination of individual, couples and family therapy will be used to treat the family. The goals of stage 1 are as follows:

    a) Join the family system
    b) Assessment of substance abuse and addiction
    c) Enhancement of client motivation
    d) Clinical assessment of family functioning and structure
    e) Confrontation of family denial
    f) Definition of the problem of incest with the family
    g) Determination of the treatability of the family system for reunification
    h) Coordination with protection agencies regarding goals for the family

i) Establishment of a therapeutic contract with the family

6. Stage 2, active treatment, will last a minimum of 40-52 weeks during which a combination of individual , couples, family and group therapy will be used to treat the victim child, non-offending parent, offender and siblings. The goals of stage 2 are as follows:

a) Confront denial, minimization and other cognitive distortion.,
b) Reduce maladaptive belief systems, behavioral patterns, and family interaction
c) Enhance adaptive beliefs, behavioral patterns and family functioning
d) Reinforce existin family strengths
e) Develop individual and family relapse prevention plans
f) Assess therapeutic gains within the family

7. Stage 3, reunification treatment, will last a minimum of 16 weeks, during which a combination of family and group therapy will b e used. Family therapy will continue for all family members. Offenders will continue in group therapy. The goals of stage 3 are as follows:

a) implementation of individual and family relapse prevention plans
b) Integration and generalization of therapeutic gains.
c) Initiation of family reunification through graduated reintroduction of the offender into the family

8. Stage 4, aftercare, will monitor the success of the family reunification through family and individual therapy if needed. The offender will continue in group treatment for at least another 6 months to 1 year. Goals of stage 4 are as follows:

a) Monitoring of therapeutic gains
b) Assessment of continued child safety
c) Assessment of additional treatment needs, and referral

9. Weekly therapeutic team staffings will be held to assess progress and develop changes in treatment planning. Throughout treatment, going communication between therapy team members and CPS caseworkers will occur. Therapists will provide caseworkers with a written summary of each family's progress every three months.

10. The following are the treatment goals:

a) Offender:

1) Make a full disclosure of all offenses. An objective measure to monitor this disclosure, such as a full disclosure polygraph may be used. Assume responsibility for the abuse. Offenders must take responsibility for child sexual abuse without minimizing, externalizing or projecting blame onto others. Manipulation and denial are major behavioral overlays of the offense and the response to discovery.
2) Develop and implement a detailed relapse prevention plan. Disclose to the non-offending partner all offenses and the details of his/her relapse prevention plan.
3) Obtain improved parenting, stress management and problem solving skills.

b) Non-offending partner/spouse

1) Will fully believe the abuse occurred and have an understanding of the dynamics of child sexual abuse.
2) Will understand the thinking errors of the offender
3) Will exhibit improved assertiveness skills if needed
4) Will develop improved parenting skills and address any parenting problems
5) Will develop appropriate nurturing parent/child relationships
6) Will not blame the victim
7) Will agree to live with any restrictions placed on the offender (such as not bathing any children in the family) after reunification occurs.

c) Victim:

1) Child will not feel responsible for the abuse
2) Child will feel safe in the home
3) Child can express the effects of the abuse to offender and non-offending partner (if of the age to do so)
4) Child has the ability to share concerns with the non-offending parent and feels the non-offending parent can and will protect him or her.

d) Sibling(s)

1) Will not blame the victim for the abuse or family separation
2) Will be able to identify and express their feelings about the loss change of the family
3) Will feel safe and demonstrate the ability to share concerns with the non-offending parent

e) Couple

1) Develop increased and improved communication with each other
2) Develop more equal power distribution in the family
3) Develop joint and consistent parenting approach
4) Improved sexual relationship

Overall, any dysfunctional family patterns resulting from 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.

INCARCERATION TDC----

ONE YEAR $14,235.00

INCARCERATON JUVENILE DETENTION----

ONE YEAR $36,500.00

PSYCHIATRIC HOSPITALIZATION----

TWO WEEKS $5,040.00

One adult, 3 children AFDC & Foodstamps----

ONE YEAR $7,908.00

General Information Concerning The Innocent Images Initiative

- Since 4/97, the Innocent Images national initiative has conducted 58 presentations to local/state law enforcement officers and/or prosecutors; a total of over 3,000 attendees.

- Since March 5, 1997, the statistical accomplishments of the Innocent Images national initiative include:

  62% increase in the number of search warrants executed;
  50% increase in the number of indictments obtained;
  57% increase in the number of arrests;
  45% increase in the number of convictions;
  48% increase in the number of informations obtained.

- The focus of the Innocent Images initiative continues to be identifying those individuals who are willing to travel for purposes of meeting a juvenile for sexual purposes; those who manufacture or produce child pornography; and those who upload ("post") child pornography onto the Internet or on-line services.

- Approximately 95 percent of "Innocent Images" cases involve cases outside the State of Maryland; where the central operation is located. There are currently 55 FBI field offices assisting and conducting investigations as a result of the Innocent Images UCO.

- Issues such as encryption, search and seizure, and the privacy act have been continually raised in the Innocent Images investigation and resolved by CID; in consultation with the Baltimore Division, Office of General Counsel, and the Child Exploitation and Obscenity Section, DOJ.

- Beginning in April 1998, the Innocent Images staff at the Maryland Metropolitan Office at Calverton will be staffed by 23 Special Agents and 43 support employees.

- The FBI's Los Angeles and Houston Divisions are currently conducting on-line child pornography/child sexual exploitation investigations as part of the Innocent Images national initiative. Other offices, such as McAllen, Texas (targeting Spanish speaking subjects); and Orlando, Florida are expected to go on-line in the near future.

INNOCENT IMAGES

Online Child Pornography/Child Sexual Exploitation Investigations

The FBI's Response to Online CP/CSE investigations

While investigating the disappearance of a juvenile in May 1993, FBI agents and Prince George's County, Maryland, Police detectives identified two suspects who had sexually exploited numerous juvenile males over a 25 year period. Investigation into the activities of the suspects determined that adults were routinely utilizing computers to transmit images of minors showing frontal nudity or sexually explicit conduct and to lure minors into engaging in illicit sexual activity. Further investigation and discussions with experts, both within the FBI and in the private sector, revealed that the utilization of computer telecommunications was rapidly becoming one of the most prevalent techniques by which some sex offenders shared pornographic images of minors and identified and recruited children into sexually illicit relationships. Based on information developed during this investigation, the Innocent Images investigation was initiated, in 1995, to address the illicit activities conducted by users of commercial and private online services as well as the Internet.

The central operation and case management system for all FBI online CP/CSE investigations is located at the Maryland Metropolitan Office at Calverton, Baltimore Division. The Innocent Images field supervisor and investigative personnel work closely with the Innocent Images program manager at FBI Headquarters in investigative, administrative and policy matters involving the initiative. All FBI field offices forward copies of text and images obtained in all online CP/CSE investigations to the Baltimore Division for incorporation into the Innocent Images case management system. The Innocent Images initiative provides for a coordinated FBI response to a nationwide problem by collating and analyzing information and images obtained from numerous sources and avoids duplication of effort by all FBI field offices.

The FBI's national initiative focuses on individuals who indicate a willingness to travel for the purpose of engaging in sexual activity with a juvenile; producers of child pornography; and major distributors of child pornography (defined as one who appears to have transmitted a large volume of child pornography via computer on numerous occasions to numerous other subscribers), in violation of the following Sections of Title 18 of the United States Code:

- Section 2251- Sexual Exploitation of Children/Selling or Buying of Children
- Section 2252 - Sexual Exploitation of Minors
- Section 2253 - Criminal Forfeiture

- Section 2423(b) - Interstate Travel with Intent to Engage in a Sexual Act with a Juvenile.

The FBI and the Department of Justice (DOJ) review all files and select the most egregious subjects for prosecution.

The FBI has taken the necessary steps to ensure that the Innocent Images national initiative remains viable and productive through the use of new technology and sophisticated investigative techniques, coordination of the national investigative strategy and a national liaison initiative with a significant number of commercial and independent online service providers. Innocent Images has been highly successful. It has proven to be a logical, efficient and effective method to identify and investigate individuals who are using the Internet for the sole purpose of sexually exploiting children.

The Beginning of Innocent Images

During the early stages of Innocent Images, a substantial amount of time was exhausted on commercial online service providers which provide numerous easily accessible "chat rooms" in which teenagers and pre-teens can meet and converse with each other. Through the use of chat rooms, children can chat for hours with unknown individuals, often without the knowledge or approval of their parents. Investigation revealed that computer-sex offenders utilized the chat rooms to contact children as a child does not know whether he/she is chatting with a 14 year old or a 40 year old. The chat rooms offer the advantage of immediate communication throughout the United States and provide the pedophile an anonymous means of identifying and recruiting children into sexually illicit relationships. The FBI has investigated more than 70 cases involving computer-sex offenders traveling interstate to meet juveniles.

The investigative operation involves undercover agents (UCAs) subscribing to various commercial online service providers, the Internet and various bulletin board systems (BBBs) utilizing fictitious screen names and engaging in real-time chat or E-mail conversations. UCAs do not "surf the net" and all areas of online service providers or the Internet are predicated prior to FBI entry. Predication can be by citizen complaint; complaint by an online service provider; or self-predication by virtue of title, i.e., alt.pedophilia.sex, alt.children.sex, alt.boys.sex., alt.girls.sex. Each undercover contact conducted over the computer is handled as a consensually monitored telephonic conversation. All contacts between UCAs and potential subjects are captured and archived on electronic media, to include, all conversations and images downloaded to the UCAs.

The Innocent Images investigation demonstrated the need for a mechanism to track subject transactions and to correlate the seemingly unrelated activities of

thousands of subjects in a cyberspace environment so the Innocent Images case management system was developed which has proven to be an effective system to archive and retrieve the information necessary to identify and target priority subjects. All relevant data obtained during an undercover session is loaded into the Innocent Images structured and full text retrieval case management system by Intelligence Research Specialists (IRSs). The IRSs update, review and analyze the information contained in the case management system on a daily basis to identify priority subjects. Once an individual has been targeted as a potential or priority subject, subpoenas are issued to the relevant online service providers to obtain all available identifying information. A subject is given a priority status based on any indication that he/she is a preferential child molester or is willing to travel for the purpose of engaging in sexual activity with a minor. Once a subject has been targeted for investigation, an IRS prepares a lead packet for the appropriate FBI field office. The packet contains copies of all evidence collected by the FBI, to include, UCA chat and session logs, relevant investigative reports, all electronic conversations between the UCA and the subject and all illicit images uploaded to the UCA. The lead packet is sent to the appropriate field office for further investigation and presentation to the U.S. Attorney's Office for prosecutive action.

The Progression of the Innocent Images Initiative

Innocent Images has expanded to include investigations involving newsgroups, Internet relay chat and fileservers.

Internet Newsgroups

A great deal of child pornography is regularly posted on Internet newsgroups which are electronic bulletin boards to which anyone with an Internet Service Provider (ISP) and news access can post messages, with or without attachments (sometimes taking the form of pornographic images). Anyone with an ISP can access newsgroups and download any posted messages and/or attachments. From an investigative standpoint, subjects who post to newsgroups are extremely difficult and labor intensive to investigate because it is hard to identify who they really are. Unlike online service providers, such as America Online, there are no unique screen names associated with each account. Each time a subscriber signs on with an ISP, he can assume any identity he wants but, through consultation with persons who are extremely proficient on the Internet, Innocent Images personnel have discovered a way to identify persons who post child pornography to newsgroups.

Internet Relay Chat (IRC) Channels

IRC channels are similar to chat rooms. They are places on the Internet where people can go to communicate with people who have similar interests. The

communications are real time, just like telephone calls or face to face communications. The threat that they pose to children is similar to the threat posed by chat rooms. IRC channels can be dedicated to any topic including the trading of child pornographic images or the recruitment of children into illicit sexual relationships. The difference between IRC channels and chat rooms is that subscribers, to online service providers providing chat rooms, have unique and traceable screen names assigned to them. IRC users can assume any screen name they want and change it at any time they want. They can assume one identity during one IRC session and another identity during another IRC session just minutes or hours later which makes identifying and tracking IRC users much more difficult.

File Servers ("FServes")

Fserves are a feature of IRC channels. An IRC user can set up an fserve that allows other users to access and download files from particular directories on his hard disk. It is a mechanism that child pornography collectors are using to build their collection. Fserves enable computer users to program their computers so that visitors can download a certain number of bytes in exchange for uploading a certain number of bytes. In other words, it is an automated, computer programmed, trading system. The person who sets up the fserve (the host) can establish the parameters of the trading. He can restrict the visitor to certain directories on his hard disk. He can give the visitor a credit of a certain number of bytes or no credit at all. Once the visitor uploads the minimum number of bytes, he can download a preset number of bytes, selecting from the file names listed on any of the directories made available by the host. Most often, a host programs his computer and leaves it on in his absence. The trading is then done automatically by his computer using the parameters the host previously established. Identifying people who establish fserves is done in the exact same way as identifying other users of IRC channels.

The Growth of Innocent Images

The Innocent Images initiative has been "franchised" to the FBI's Los Angeles Division and it is anticipated that other FBI field offices, located at strategic locations around the country, will eventually operate Innocent Images franchise operations. The well-defined administrative and operational protocols established by the Baltimore Division will greatly assist in the expansion of the Innocent Images initiative by other FBI field offices. All of the franchised field offices will operate in close coordination with the FBI's Baltimore Division, FBIHQ and the Child Exploitation and Obscenity Section (CEOS), DOJ.

For further information concerning Innocent Images....

Contact:

Supervisory Special Agent (SSA) Linda B. Hooper
Supervisory Special Agent (SSA) George Martinez
Innocent Images
Maryland Metropolitan Office at Calverton
Baltimore Division
Telephone (301) 586-4519
Facsimile (301) 586-4499

SSA Jack Boyle
Program Manager
Special Investigations and Initiatives Unit
Office of Crimes Against Children
FBIHQ
935 Pennsylvania Avenue, NW
Room 4127
Washington, D.C. 20535
Telephone (202) 324-2681
Facsimile (202) 324-2731

1998 Crimes Against Children Seminar

Innovations and Creative Approaches in Developing Children's Advocacy Centers

Moderator : Natacha Peláez - Wagner, Executive Director, Children's Advocacy Centers™ of Tx, Inc.

Presenters: Cindy Alexander, Clinical Supervisor, Dallas CAC
Debra Brown, Executive Director, Hope House, (San Angelo)
Roxanne Carter, Executive Director, The Bridge CAC (Amarillo)
Andra Chamberlin, Program Director, CAC of Midland
Betty Dickerson, Executive Director, Midland Rape Crisis Center
Sandra Martin, Executive Director, Travis County CAC (Austin)

I. Mobile Services - Cindy Alexander

- Forensic Interviews and Case Staffings - Roxanne Carter
- Therapy - Cindy Alexander

II. Adding Programs Beyond the Core - Debra Brown

III. Working Successfully Within Another Organization - Andra Chamberlin and Betty Dickerson

IV. Creative Utilization of Volunteers - Sandra Martin

V. Question and Answer/Discussion

RURAL OPERATIONS TO SERVE MULTIPLE COUNTIES

I. Choosing Mobile Service

- The Bridge was established to provide services to the top 26 counties of the Texas Panhandle. Satellite offices were opened and then closed due to overhead that exceeded funding possibilities within small rural towns.

- Our rural interviewer averages 15 interviews per month this number continues to grow as the rural investigators and prosecutors become accustomed to the procedure.

Tip: Put the policies you will use into the hands of each and every coordinating agency employee that you will work with. Each time a new worker is hired, mail that person your policies for interviewing to help control misunderstandings.

II. How It Works

- A camera, monitor and custom carrying cases were designed and built to withstand the day-to day maneuvering.

- Sites are established in rural regions to utilize for interview rooms. Often the space used will be property owned by a church. In one town, a church has a house that is used only for Sunday School class space and during the weekdays which is made available for interviews video-taped by The Bridge.

- Rural Children's Protective Services caseworkers and Law Enforcement investigators contact our interviewer and she travels to the site region. The interviewer travels with all of the needed materials and upon arrival, sets up the site.

Tip: Be flexible. Every site we use is completely different. Find out where the empty rooms are in your site area are and find a way to make them work. We recommend 3 rooms to be available: family, interview, and observation.

III. How It Is Funded

- The Bridge receives some United Way funding from one of the largest of the rural towns we provide services for.

- Primarily, the rural program is funded through a grant from the Victim's of Crime Act. This is a great way to use this money because the local Council of Governments usually covers a regional area and they like to fund programs that provide services to that whole region.

Tip: Don't be afraid of innovations for your rural service. A rural program in North Carolina was recently given funding to purchase a Recreational Vehicle to use as a mobile unit.

JOB DESCRIPTION

POSITION TITLE: Rural Interviewer/Facilitator

SUPERVISOR: Managing Interviewer/Facilitator

BASIC FUNCTION: Coordinates rural case management and directs child abuse cases from initiation to adjudication with all disciplines involved.

RESPONSIBILITIES:

1. Regular reporting of case status to the Managing Interviewer.
2. Schedules rural interviews for The Bridge, taking responsibility of notifying proper authorities of scheduled interviews.
3. Conducts interviews of alleged victims of child abuse as well as child witnesses and makes appropriate referrals for needed services, including crime victims assistance.
4. Coordinates execution of forms necessary to the interview process.
5. Facilitates monthly rural case reviews in the central rural counties of the Texas Panhandle.
6. Testifies in court regarding interviews as needed.
7. Performs speaking engagements and public education programs at the direction of the Managing Interviewer.
8. Is available for after hour interviews if needed.
9. Assists with the client intake procedure including making family comfortable during the interview process.
10. Performs any and all activities to support the mission of the organization and ensure advocacy in the communities served.

CHILDREN'S ADVOCACY CENTER OF TOM GREEN COUNTY, INC.

Core Components:

- **Videotaped interviews**
- **Team staffings**
- **Therapy referrals for victims**

Programs Added:

- **Therapy referrals for non-offending family members**
- **Social services referral program**
- **Volunteer component - special needs**
- **Community education**
- **Child Fatality Review Team**
- **Voice for Victims**
- **Court accompaniment**
- **Court School**
- **CASA (Court Appointed Special Advocates)**

Programs Under Research:

- **Expansion of services to surrounding out counties**
- **Training institute**

Children's Advocacy Center of Midland
A program of Midland Rape Crisis Center

Policy and Procedure Manual

Multidisciplinary Team Operations

Multidisciplinary Team Protocols

Table of Contents

Revised Wednesday, June 03, 1998

Section 1

Multidisciplinary Team Protocols

Agency Role Description

A. **Law Enforcement** - The role of law enforcement in investigating allegations of child abuse is that of an objective fact finder. It is law enforcement's responsibility to determine if a crime has occurred, gather and preserve evidence that will prove the allegation, and apprehend and bring the individual responsible to court.

B. **Texas Department of Protective and Regulatory Services** - The primary goal of the TDPRS in child abuse allegations is to protect children at risk of abuse in their homes. Through principals outlined in the Texas Family Code and TDPRS regulations, this goal is met through investigation of the allegations, assessment of the family's strength and needs, and provision of services as needed to the child and family.

C. **District Attorney** - The role of the District Attorney is to evaluate the results of investigations by law enforcement or TDPRS personnel in terms of general prosecution; to provide guidance to law enforcement and TDPRS personnel during the course of their investigation when such guidance is sought; and to prosecute appropriate cases in the District Courts of Midland County, Texas.

Section 2

Multidisciplinary Team Protocols

General Procedures

The following is a description of the process taken from the initial report and referral of a child sexual abuse or designated physical abuse case to disposition.

1) Report is received by TDPRS - CPS, Law Enforcement, or District Attorney's Office.

2) An investigator from TDPRS - CPS, Law Enforcement, or District Attorney office conducts an initial assessment interview.

3) If further investigation is warranted, the investigating agency will contact the CAC to schedule a forensic interview. Interviews can only be scheduled by TDPRS-CPS, Law Enforcement, or District Attorney's office. The CAC will not accept referrals from any other party.

4) The child is brought to the CAC of Midland for a forensic interview by either a non-offending parent, legal guardian, law enforcement officer, TDPRS staff person, or prosecutor. Upon arrival, the child and family are met by a CAC staff person or Family Greeter.

5) All forensic interviews will be conducted by the CAC interviewer. In unique circumstances, an interview may be conducted by a TDPRS staff person or law enforcement officer. The interview may be observed by prosecutors, law enforcement personnel, or TDPRS personnel.

6) While the forensic interview is taking place, the accompanying family member is required to remain at the CAC office.

7) The investigating agency must be present at the time of the scheduled interview or the interview will be canceled.

8) It is important that all involved parties show up at the scheduled time. The interview will begin on time with the referring agency present. Please remember that your questions and input are crucial to the interview; therefore, it is vital that the referring agency personnel be present throughout the entire interview.

9) No defense attorneys will be allowed to watch an interview or review a video/audio tape unless they are accompanied by a member of the District Attorney's office having jurisdiction of the case.

10) CAC of Midland will keep all original video/audio tapes on site. The tapes will be maintained in a locked facility. A copy of the video/audio tape will be available to the law enforcement agency or TDPRS - CPS investigating the case if a receipt is signed. Multidisciplinary team members are welcomed to review tapes at the CAC facility.

11) The investigating agency may visit/interview accompanying family members at the time the child is being interviewed.

12) If warranted and not previously done, the investigating agency or the CAC of Midland may schedule a medical/sexual assault exam.

13) No alleged perpetrators will be allowed at the CAC except by written order of the court having jurisdiction of the case.

14) The cases will be scheduled for case review at the next multidisciplinary team meeting. The purpose of the review is to assess the needs of the child and family involved. The team should consist of the CAC of Midland Program Director, an officer from the appropriate law enforcement agency, a TDPRS staff person, a representative from the District Attorney's office, and if needed, other parties associated with the case. The team should be prepared to discuss evidence and statements gathered, plus any identified needs of the child and family. In addition, the team may recommend follow-up counseling or medical treatment.

15) All efforts will be made to coordinate each step of the investigative process to minimize the number of interviews the child is subjected to. Should more than one interview be necessary, every effort will be made to have the same staff person who conducted the initial interview conduct all subsequent interviews.

16) As the case processes through the judicial system, the case will be staffed at the multidisciplinary team review as needed.

Section

3

Multidisciplinary Team Protocols

How to Schedule an Interview

A. All referrals for interviews should come from one of the following team agencies: TDPRS, Midland Police Department, Midland County Sheriff's Office, or the District Attorney. If time if available, the CAC of Midland will accept referrals from law enforcement or TDPRS - CPS from surrounding counties. The CAC of Midland will not accept referrals from any other party.

B. All forensic interviews will take place at the CAC of Midland, 500 North Loraine, Suite 1096, Midland, Texas.

C. No alleged perpetrators will be allowed at the CAC of Midland except by written order of the court having jurisdiction in the case.

D. The minimum time period for an interview is 2 hours.

E. If more than one child is to be interviewed during the same scheduled time, allow an extra hour for each additional child.

F. To request an interview appointment:

1. Contact the CAC of Midland forensic interviewer.
2. Request date/time.
3. Provide complete information when scheduling. The information needed includes:
    - Incident Number
    - Investigator's Name
    - Child's name, age, birth date, ethnicity
    - Parent's names, address
    - Type of abuse, location
    - Date of disclosure

- Was a medical exam conducted? If so, who was the SANE or MD, when did the exam take place, and what was the diagnosis?

- Have there been previous referrals involving the alleged victim, family, or perpetrator? If so, when and what was the nature of the report?

J. Any professional involved with the investigation may observe, via the monitor, as the interview is conducted. Parents or guardians are not allowed to view the interview as it is being conducted. If the parents request to observe/listen to the video/audio tape after the interview is completed, permission must be granted by the prosecuting agency. If the case will be involved only in the civil courts, permission must be granted by the TDPRS supervisor. No defense attorney will be allowed to observe an interview or view/listen to a video/audio tape unless accompanied by a member of the District Attorney's office.

K. Once the interview is completed, the representative from the investigating agency will sign for a copy of the video/audio tape. The CAC of Midland will keep the original tape/s on site. TDPRS - CPS has made the decision that case workers will not take a copy of the tape without the supervisor's approval.

Scheduling an Interview After Normal Working Hours

A. If a team agency needs to schedule an interview after normal working hours, the CAC interviewer can be reached by calling the Midland Rape Crisis Center hotline at 682-7273. The answering service will page the interviewer and have the interviewer contact the team member.

B. If the interviewer is not available, all team member agencies have key cards to the building and a key to the CAC. Team members can conduct their own interviews, if necessary. Instructions for using the video/audio equipment is placed next to the equipment. Please inform the on-call Midland Rape Crisis Center staff member, via the hotline, that you will be using the facility.

Section

4

Multidisciplinary Team Protocols

Multidisciplinary Team Staffings and Post-Case Review Procedures

A. The purpose of the team staffings is to assess the needs of each investigation and the needs of the child and family involved.

B. The CAC Program Director will send out written notification to all team members of the scheduled staffings (the second Tuesday of each month at 9:30 AM). This notification will include a list of all cases to be reviewed.

C. Cases to be staffed will include all interviews conducted at the CAC since the last MDT meeting, cases that are actively under investigation by law enforcement or TDPRS - CPS, and other cases as determined by MTD members.

D. Any team member can put a case on the staffing list. A case to be reviewed does not have to involve a child that has been interviewed at the CAC. Be prepared to give the following information when scheduling a case to be staffed. This information must be in the CAC office a week before the staffing.

- Child's name, age, birthdate, ethnicity
- Type of abuse
- Sexual assault exam date, SANE or MD
- Team members involved in case

E. The Victim Service Coordinator will attend the staffings and will address any follow-up that needs to be made with the children and families. The MDT case database will be updated each month as new information is provided. Each team member will receive an updated printout once per month.

Section
5

Multidisciplinary Team Protocols

Confidentiality of Records

The CAC of Midland will adhere to SEC. 264.408 USE OF INFORMATION AND RECORDS; CONFIDENTIALITY AND OWNERSHIP in the Texas Family Code as stated below.

A. The files, reports, records, communications, and working papers used or developed in providing communications, and working papers used or developed in providing services under this chapter are confidential and not subject to public release under Chapter 552, Government Code, and may only be disclosed for purposes consistent with this chapter. Disclosure may be to:

   1. the department, department employees, law enforcement agencies, prosecuting attorneys, medical professionals, and other state agencies that provide service to children and families; and

   2. the attorney for the child who is the subject of the records and a court-appointed volunteer advocate appointed for the child under Section 107.031.

B. Information related to the investigation of a report of abuse or neglect under Chapter 261 and services provided as a result of the investigation is confidential as provided by Section 261.201.

C. The Department, a law enforcement agency, and a prosecuting attorney may share with a center information that is confidential under Section 261.201 as needed to provide services under this chapter. Confidential information shared with or provided to a center remains the property of the agency that shared or provided the information to the center.

D. A videotaped interview of a child made at a center is the property of the prosecuting attorney involved in the criminal prosecution of the case involving a child. If no criminal prosecution occurs, the videotaped interview is the property of attorney involved in representing the department in a civil action alleging child abuse or neglect. If the matter involving the child is not prosecuted, the videotape is the property of the department if the matter is an investigation by the department of abuse or neglect. If the department is not investigating or has not investigated the matter, the videotape is the property of the agency that referred the matter to the center. If the center employs a custodian of records for videotaped interviews of children, the center is responsible for the custody of the videotaped. A videotaped interview may be shared with other agencies under a written agreement.

E. The department shall be allowed access to a center's videotaped interviews of children.

Section

6

Multidisciplinary Team Protocols

Conflict Resolution

A. Each member of the multidisciplinary team will respect the opinion and beliefs of the other team agencies involved. If conflict or disagreement arises as to the investigation, interview, or follow-up during the course of the case, all efforts will be made to resolve the conflict in a professional manner.

Section

7

Multidisciplinary Team Protocols

Policy for Outside Counties

A. The CAC of Midland will provide, to the ten counties under Midland CPS jurisdiction, services for interviewing sexual and/or severely physically abused children. These interviews will be videotaped according to established procedures. Audio tapes will be done at the request of the referring agency.

B. All cases must be referred by law enforcement, Child Protective Services, or the District Attorney's Office.

C. All children to be interviewed must be accompanied by a law enforcement official or TDPRS staff person.

D. Midland County child abuse cases take priority at the CAC of Midland.

E. The referring agency, if outside Midland County, must bring two (2) blank video tapes and two (2) blank audio tapes, if needed.

F. Referring law enforcement officials or TDPRS - CPS staff persons may conduct their own interviews at the CAC of Midland.

G. There is no charge to outside counties for the use of the facility, equipment, or the forensic interviewer.

H. If the CAC of Midland's forensic interviewer conducts the interview and is subpoenaed, it is requested that the referring agency reimburse mileage at $0.28 per mile and any miscellaneous expenses incurred while traveling.

Section 8

Multidisciplinary Team Protocols

Medical Protocol for Child Sexual Assault Exams

Pediatrician's Protocol for Responding to Allegation of Sexual Abuse of a Child Under Age 13

A. For obviously acute injuries that require immediate attention or if the alleged abuse occurred <72 hours prior to presentation and physical evidence may be obtainable:

1. Notify child's private physician.
2. If child is a patient at the Community Clinic, notify the pediatrician who is on call.
3. If the child has no physician, notify the pediatrician who is on call.

B. For alleged abuse that is not acute (abuse occurred >72 hours prior to presentation):

1. Notify child's private physician who can arrange for exam time, etc.
2. If the child is a clinic patient, notify Drs. Ballesteros or Medina.
3. If child has no physician, notify the pediatrician who is on call and that pediatrician will be responsible for arranging the exam.

C. Exam site (office or ER) is left to the individual physician. However, in an acute situation be aware of "chain of custody" for the evidence box (rape kit).

D. If problems arise with pediatric response to this issue, please notify the chief of pediatrics.

Note: This protocol was developed by the pediatricians in Midland in 1996 and is under revision.

Section

9

Multidisciplinary Team Protocols

Therapy Referral Protocol

- If a child has been interviewed at the Children's Advocacy Center of Midland, the CAC can make a referral to Center's for Children and Families for therapy for the child and non-offending family members.
- CAC staff must send a completed referral form to Centers, along with a copy of the intake form, synopsis, and release of information signed by the parent or guardian of the child.
- On the referral form, list all family members that are eligible for therapy.
- The parent or guardian is responsible for calling Centers and scheduling therapy sessions.
- CAC of Midland will pay for the therapy for the child and non-offending secondary victims.
- If TDPRS will be opening services which include therapy, CAC of Midland can make an emergency referral and pay for the first four sessions. This can be done if the child needs to be seen in therapy as soon as possible. After the first four sessions, TDPRS will began paying for the therapy.

Section
10

Multidisciplinary Team Protocols

Partner Agency Agreement

The undersigned representatives of the multidisciplinary team agencies in Midland County, Texas agree to the policy and procedures of the Children's Advocacy Center of Midland as outlined in this manual.

Al Schorre — Date
District Attorney
142nd Judicial District
Midland County, Texas

Elaine Leonard
TDPRS
Program Administrator
Region 9

Alane Edwards — Date
Executive Director
Centers for Children and Families

Sgt. B. J. Land — Date
Crimes Against Persons
Midland Police Department

Sgt. Terry Cowin — Date
Midland County Sheriff's Office

Andra K. Chamberlin — Date
Program Director
CAC of Midland

Margaret Robinson, R.N.
Memorial Hospital and Medical Center
Vice President of Patient Services

MEMORANDUM OF UNDERSTANDING

CHILDREN'S ADVOCACY CENTER OF MIDLAND
AND
MIDLAND RAPE CRISIS CENTER

PREMISE:

The Children's Advocacy Center of Midland (CAC) has been developed as a program under the umbrella of the Midland Rape Crisis Center (MRCC) a 501(c)3 non-profit charitable organization under the regulations of the Internal Revenue Service.

PURPOSE:

That in doing so, the needs of the community will be served while promoting the efficient use of administrative services, grant funds, and donor contributions of an established non-profit agency.

AGREEMENTS:

1. That the CAC will operate as a program under the umbrella of the MRCC and exist under the authority of the MRCC Board of Directors which has final responsibility for MRCC and CAC operations. The mission and purpose of the MRCC shall support the mission and statutory duties of the CAC as contractually required by the CAC of Texas, Inc.
2. That the CAC program will have its own program board responsible for CAC operations. The CAC Program Board Chair, the MRCC Executive Director, and one representative from each team member agency will be responsible for the hiring of the CAC Program Director. The CAC Program Board, along with the MRCC Executive Director will be responsible for termination, as well as acceptance of any resignation from the CAC Program Director. Joint supervision will be provided by the MRCC Executive Director and the CAC Program Board Chair. The MRCC Executive Director will supervise and evaluate the administrative duties and performance of the CAC Program Director and will notify and keep the CAC Program Board Chair informed relative to the working relationship with the CAC Program Director. The CAC Program Director will coordinate administrative matters with the MRCC Executive Director.
3. The CAC Program Director will be responsible for the hiring, supervision and termination of CAC staff. All CAC staff positions must be approved by the CAC Program Board and the MRCC Board of Directors. If a staff member shares duties between the CAC and the MRCC, both the CAC Program Director and the MRCC Executive Director will supervise that position. The CAC Program Director and all employees will adhere to the MRCC personnel policy and the contents of this Memo of Understanding.

4. That the CAC Program Board will include the immediate past president of the MRCC Board of Directors, plus one other member of the MRCC Board as designated by that Board. The CAC Program Board Chairman will serve as a voting member of the MRCC Executive Committee and the MRCC Board of Directors. If the CAC Program Board Chairman is unable to attend the MRCC Executive Committee meeting or the MRCC BOD meeting, he will designate another CAC Program Board Member to attend in his place. The Treasurer of the MRCC Board of Directors will also serve as the Treasurer of the CAC Board
5. That the CAC program will facilitate a multidisciplinary team to review new and pending child abuse cases for the purpose of coordinating the activities of Child Protective Services, law enforcement, District Attorney's Office, medical profession, and other entities involved in the investigation, prosecution and delivery of victim services.
6. That the CAC Program Advisory Board, with approval from the CAC Program Board, will establish policy and procedures which will govern the operations of the CAC program as they relate to forensic interviewing of children and the multidisciplinary team operations.
7. That the CAC Program Board will provide conflict resolution between agencies that comprise the multidisciplinary investigative team; and assure adherence to the Texas Department of Protective and Regulatory Services grant guidelines and other grants received. The CAC Program Director will coordinate administrative matters with the MRCC Executive Director. The CAC Program Director will jointly report to the CAC Program Board and the MRCC Executive Director. The CAC Program Director and all employees will adhere to the MRCC personnel policy and the contents of this Memo of Understanding.
8. That the MRCC accounting records of all funds, grants, and other financial data relating to the CAC Program will be available to the CAC Program Board; and a physical property inventory of the CAC will be maintained by the MRCC.
9. That the MRCC will provide administrative services for the CAC program, including accounting and fiscal management, distribution of funds, and grant writing. All funds donated directly to the CAC will be spent on CAC functions and operation costs. The CAC Program Director will assist in grant writing and fundraising activities.
10. That the MRCC Board of Directors will assume the major responsibility of private sector fundraising for the CAC Program. However, the CAC Program Board should be prepared to assist in these efforts. If the CAC Program Board elects to conduct a fundraising event and anticipates raising more than $5,000, they will seek approval from the MRCC Executive Committee and the MRCC Executive Director. All funds raised solely by the CAC Program Board will be spent on CAC functions and operation costs as directed by the CAC Program Board. The CAC Program Director will coordinate fundraising with the MRCC Board and the MRCC Executive Director.
11. That the CAC Program Board will approve the yearly budget for the CAC. After approval by the CAC Program Board, the budget will be submitted to the MRCC Board of Directors for final approval. The CAC Program Director can make grant adjustments within grant guidelines.
12. The CAC program will share in the cost of building occupancy (rent factor), maintenance and repairs proportionate to its access to office space and common

areas, plus share in the cost of equipment, maintenance and repairs proportionate to its use by CAC staff.

13. The CAC program will maintain a separate physical address, telephone number, and share a proportionate cost of communication equipment.
14. MRCC Board members and staff, CAC Program Board members, persons representing governmental agencies and volunteers will adhere to appropriate ethical conduct in maintaining the confidentiality and security of all programs.
15. Conflict Resolution - The CAC Program Board and the MRCC Board will resolve areas of conflict between the two boards in the following manner: The MRCC Board President, the CAC Program Board Chair, the MRCC Executive Director, the CAC Program Director, and the four agency heads (Police, Sheriff, District Attorney, and Child Protective Services) or their designees, will meet to resolve any conflict or problem involving the two boards. The suggested resolution will be submitted to each respective board for approval. If the Boards are unable to resolve the issue, final authority will rest with the MRCC Board of Directors.
16. Conflict of Interest - The CAC Program Director and all CAC employees will adhere to the MRCC personnel policy regarding conflict on interest.
17. Strategic Plan - The CAC Program Board Chair will appoint a Long-Range Planning Committee of three to five CAC Program Board Members to develop long range planning for the CAC with an emphasis on setting goals and policy. The CAC Program Board Chair or representative, CAC Program Director, and the MRCC Executive Director will attend the committee meetings. The Long-Range Planning Committee will submit proposals first to the CAC Program Board for approval. Approved proposals from the Long-Range Planning Committee will then be presented to the MRCC Board of Directors for approval. After approval by both boards, the CAC Program Board will be responsible for following through to implement strategic plans.

Linda George MRCC President	Brian Carney CAC Program Chair
Date	Date

VOLUNTEER OPPORTUNITIES

Family Greeters

- Welcome the families and guide them into waiting/playing areas
- Provide information packets/intake form/evaluation
- Supervise/play with children
- Assist counselors, investigators and families as needed
- Monitor play areas

CAP Support (Medical Examination)

- Welcome the families and guide them into waiting/playing areas
- Supervise/play with children
- Assist in examination as needed
- Monitor play areas

Court School

- Assist Program Coordinator with Court School presentation
- Play games/exercises/role play
- Supervise children
- Assist with mock trial

SibCare

- Supervise children
- Plan activities/projects for children not in group therapy
- Assist counselors as needed

Rainbow Room

- Helping maintain daily operations of the room
- Provide assistance to visitors/caseworkers throughout the day
- Assist with inventory, donations and special projects

Adopt-A-Caseworker

- Provide presentations for businesses and organizations
- Follow up and monitor "caseworker adoptions"
- Support the Community Partners program through special projects

Follow-up/Case-tracking

- Phone protective parent to offer assistance and see how child is doing
- Provide information and referral
- Inputting completed data for casetracking system

Fund Raising/Special Events

- Assist with CAC fund raising projects
- Help with administrative aspects (data entry, follow-up phone calls, etc.)

Yard/Maintenance

- Mow, edge lawn
- Clean gutters, rake & pick up leaves, trim hedges
- Other grounds-keeping duties as needed

Administrative

- Answer phones/reception
- Take messages, schedule interviews
- Photocopying and filing
- Word processing
- Assist with projects placed in volunteer box

Janet Squires, M.D.
"Conditions Mistaken for Child Abuse"

Associate Professor of Pediatrics
University of Texas Southwestern Medical Center
Director of General Pediatrics, REACH Program
Children's Medical Center of Dallas

Sexual Abuse: Medical Evidence

- Most children who have been sexually abused have normal or nonspecific genital exams.
- Medical evidence depends on an experienced clinician documenting findings of trauma or infections (recent or ongoing trauma, healed trauma, sexually transmitted diseases).
- Recognizing abnormal genital findings assumes that normal genital findings in nonabused children are known and used as the standard for comparison.

Genital Findings in Non-Abused Girls

Genital findings
Erythema of the vestibule (56%)
Periurethral bands (50.6%)
Labial adhesions (38.9%)
Lymphoid follicles on the fossa navicularis (33.7%)
Posterior fourchette midline avascular areas (25.6)
Urethral dilation with labia traction (90.5%)
Urethral dilation with the supine separation (79.3%)

Hymenal findings
Mounds (33.8%)
Projections (33.3%)
Septal remnants (18.5%)

Intravaginal findings
Vaginal ridges (90.2%)
Rugae (88.7%)

Unusual findings * (<5%)
Posterior fourchette friability
Anterior hymenal clefts
Notches of the hymen
Hymenal septa
Vaginal discharge
Foreign body

** The major concern in a study of this type is the lack of certainty about whether the sample contains only non-abused children. The children were screened for behavioral indicators but were not interviewed. (From McCann et al., 1990.)*

- Definitive medical proof of child sexual abuse includes only those findings which occur exclusively in abused children and are not seen in nonabused children. Some findings [e.g. irritation, superficial trauma] may corroborate a history of abuse but are not in themselves definitive proof.
- Sample classification of physical findings for sexual abuse
  - Normal findings: does not rule out sexual abuse
  - Nonspecific findings: associated with sexual abuse but may also be seen in nonabused children
  - Concerning or suspicious findings: while not definitive, are concerning for abuse and would corroborate a history of sexual abuse
  - Specific findings: while not definitive, findings most likely caused by sexual abuse, and strongly corroborates a history of sexual abuse
  - Definitive findings

Sexual Abuse: Child History

- The recognition of sexual abuse is most commonly dependent on an outcry from the child (followed by comprehensive investigation of allegations which includes objective, thorough and well-documented interviews).
- The reliability of the history of the very young child is often questioned.
- The medical exam can corroborate a history of abuse. A normal medical exam can never totally eliminate the concern of abuse.
- The "dreaded" scenario:
  - preschool-aged girl reports to a caregiver "so-and-so touched me down there and it hurt"
  - the physical findings show marked irritation from nonspecific prepubertal vulvovaginitis
  - typical social details include:
    - divorced parents who dislike each other and the child visits two homes
    - child in a day care center

Medical Conditions Mistaken for Child Sexual Abuse

Accidental straddle injuries
Accidental impaling injuries

Nonspecific vulvovaginitis and proctitis ("bubble bath irritation")
Diaper dermatitis/yeast infections
Other physical irritants (diaper chemicals, powder, sand, fleas)

Group A strep vaginitis and proctitis
Other infections (pinworms, shigella)

Foreign bodies
Labial adhesions
Lichen Sclerosis et atrophicus

Urethral prolapse
Congenital hemangiomas or skin markings

Anal fissures
Neurogenic patulous anus
Symptoms of inflammatory bowel disease (ulcers)
Symptoms of chronic constipation (e.g. Hirschsprungs' disease)
Anteriorly displaced anus

Janet Squires, M.D.
"Conditions Mistaken for Child Abuse"

Associate Professor of Pediatrics
University of Texas Southwestern Medical Center
Director of General Pediatrics, REACH Program
Children's Medical Center of Dallas

Physical Abuse: Injuries: Accidental or Inflicted?

- Most explanations given for trauma or burns involve child-initiated accidents.
- Caregivers rarely volunteer history of abusive behaviors.
- For infants with injuries, siblings or other young children are often blamed.
- Knowledge of normal child development and behavior is necessary to assess accuracy of history.

  Sample motor skills:

  - 3-4 months (roll over)
  - 6 months (sit alone)
  - 9-10 months (crawl fast)
  - 11-12 months (walk)
  - 2 years (run fast)

- Immobile infants rarely have bruises.
- Most falls result in single bruises.
  - multiple bruises, involving multiple body areas, require multiple impacts.
- Children are forward moving and frontal explorers.
  - "wear and tear" injuries are on bumped surfaces.
  - most accidents involve the frontal plane (esp. forehead, nose, chin, palms, elbows and shins).
  - injuries to the buttocks, genitalia, abdomen, back and sides, especially sides of face, are often inflicted.
- Burns are commonly caused by accidents, but approximately 10% of all burns are caused by abusive caregivers (4% - 28% in various studies).

continued, next page

Sample of Accidental Burn Injuries
0-4 Years of Age (1989)*

Burn Source	Estimated No. of Children^
Irons	11,745
Hair curlers and curling irons	11,362
Hot water	10,495
Cigarettes/pipes/cigars/tobacco	6,468
Ranges, not specified	5,423
Household products/caustics/drain cleaners/ammonia/oven cleaner	3,155
Gasoline and gasoline cans	2,832
Electrical wiring/outlets/ receptacles/extension cords	2,814
All other ovens	2,690
General home or room fires*	1,592
Light bulbs	1,410
Electric and gas ranges	1,116
Fireworks	1,002
Microwave ovens	817
Cigarette or pipe lighters	713
Hair dryers	368
Matches	209

Type of Heating Unit	Estimated No. of Children^
Home radiators	8,925
Fireplaces (all types)	7,174
Kerosene or oil heaters	4,151
Heating systems, not specified	3,948
Coal or wood-burning stoves	2,941
Water heaters	347

* Estimates based on U.S. Consumer Products Safety Commission: National Electronic Injury Surveillance System: Product Summary Report, National Injury Information Clearinghouse, Washington, DC, 1989.
^ In U.S. hospital emergency departments; does not include deaths at the scene that never arise at emergency departments.

Physical Abuse: Folk/Cultural/Religious Well-Intentioned Practices

- Cultural practices: examples
  - Cao Gio: rubbing coin or spoon heated in oil on ill child's rib, spine and neck.
  - Cupping: applying hot glass or suction to areas over the trunk and back.
  - Caida de Mollera (fallen fontanelle): attempting to elevate the sunken fontanelle by holding child upside down.

- Folk medicine practices
  - many "home remedies" can be beneficial and most do not cause harm (e.g. herbal teas), but there are exceptions

- Religious practices: examples
  - withholding life-saving treatments (e.g. blood products)
  - delay in seeking medical care while anticipating supranatural intervention

- Some cases are difficult: pit well-meaning parents against modern medical practices (note: must be sure parents have intent to act in child's best interest).

- Medical conditions
  - every doctor's DREAD; mistaking a medical condition for child abuse.

Medical Conditions Which Can Be Mistaken for Physical Abuse

Conditions Manifested by Unusual Skin Lesions/Burns
Mongolian spots
Phytophotodermatitis
Car seat burns
Staphylococcal scalded skin syndrome
Chickenpox (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 Prematures
Congenital syphilis affecting the skeletal system
Fatigue fractures from exercise
Cardiopulmonary resuscitation
Vitamin C or D deficiencies
Skin/skeletal anomalies associated with chromosomal disorders
Copper deficiency
Rickets
Caffey's disease

Conditions Which Cause Easy Bruisability
Liver disease/Vitamin K deficiency
Bleeding disorder
Platelet aggregation disorders
Folk medicine (coining, cupping, spooning)
Aspirin toxicity

Conditions Which Cause Easy Bruisability (cont'd)
Henoch-Schonlein Purpura
Hypersensitivity vasculitis
Meningococcemia
Disseminated intravascular coagulation
Erythema maltiforme

Conditions Manifested as Eye Hemorrhages
Aneurysm
Motor vehicle accident
Thoracic compression and hypoxia
Valsalva effect with subconjunctival hemorrhages
"Red eye"

Conditions Manifested as CNS Hemorrhages/Fluid Collections
Aneurysm
Brain tumor
Hemorrhagic disease of the newborn
Folk medicine (fallen fontanelle)
Benign extra-axial fluid collections of newborns

Self-Inflicted Injuries
Depression
Mental retardation
Cornelia DeLange syndrome
Lesch-Nyhan syndrome
Familial dysautonomia
Factitious illness
Temper tantrums
Head-bangers

FUND RAISING PRESENTATION

THE 10 VERITIES OF FUND RAISING

1. People give to people and not causes

2. The effectiveness of fund raising depends on strong committed volunteer leadership

3. Those closest (the board) must give first and at levels that demonstrate commitment

4. There must be a sense of urgency to the ask

5. The message, why they should give, must be concise, consistent and compelling

6. The best predictor of a future gift is a good giving experience

7. There must be passion to the ask

8. The ask must be specific as to amount and purpose

9. The best predictor of giving is a history of giving- suspects are not prospects

10. There is no single reason why people give to charity but many and an individual giver may have many motivations e.g. altruism, civic responsibility, recognition, perceived benefit, tax implications, reciprocity, religious conviction, family or cultural tradition.

THE NATURE OF GIFTS

- the annual or sustaining gift
- the major or campaign gift
- the ultimate gift

GIFT CHARACTERISTICS

ANNUAL	MAJOR	ULTIMATE
operational needs	building, endowment	endowment
made from discretionary income	10-25 times annual	1,000-2,000 times annual
frequently given	infrequently given	once in a lifetime
frequently asked for	infrequently asked for	asked for once
decision made quickly	stop-and-think-gift	long term relationship
decision rational	decision becomes emotional	very emotional (deeply involved)
decision made without professional assistance	takes longer for decision may require professional	longer still and complex requires professional
direct mail special events	personal solicitation • direct mail for prospect acquisition • special events for cultivation	on-going stewardship personal solicitation

CULTIVATION-ASK RATIO

ANNUAL	MAJOR	ULTIMATE
Ask 80%	Ask 50%	Ask 20%
Cultivate 20%	Cultivate 50%	Cultivate 80%

THE ISSUES- THE CHOICE OF FUND RAISING TECHNIQUE

FIRST ORDER

How much?	How much money is needed?
How quickly?	How fast do you need the money
How much help?	Is there a staff, active and effective volunteers

THE TECHNIQUES

Direct mail

Grants

Special events

Face to face asks

Campaigns

Corporate joint promotions

SECOND ORDER

How much competition?

What is the comfort level with the specific techniques?

What is the fund raising expertise of staff?

What is the local environment?

THE TEN STEPS OF A MAJOR GIFT PROGRAM

1. Development of the message that will convince prospects to become donors.

2. Development of the materials that will convey the message.
   - brochure
   - video
   - custom proposal

3. Identification of sources for donor prospects.
   - grant directories
   - alumni lists
   - prospects identified by volunteers and staff

4. Planned opportunities to meet these prospects.
   - special events
   - athletic and cultural events
   - parlor meetings (presentations to an invited group in a host's home)

5. Progressive involvement (cultivation) of prospects with the organization.

6. Evaluation of the prospect's ability to give.
   - interest in the organization
   - wealth

7. Development of a strategy for the solicitation.
   - as a part of campaign or person by person
   - face-to-face, mail, phone
   - who makes the call

8. Solicitation of the donation.

9. Recognition of the gift.
   - prompt acknowledgment
   - named gift opportunities
   - creative tangible recognition (children's art rather than a plaque)
   - endowed funds

10. A program of continuous communication with the donor-gift stewardship.

THE IDEALIZED ROLE OF THE BOARD MEMBER

The 4 W's

- Wealth
- Wisdom
- Work
- Wallop

The 5 I's

- Integrity
- Intelligence
- Influence
- Investment
- Involvement

The 7 Deadly Sins

- membership without attendance
- acceptance without commitment
- affiliation without passion
- meeting without participation
- decision without integrity
- identification without giving
- involvement without advocacy

Board's concern is why things are done, staff how things are done

SEXUAL EXPLOITATION OF CHILDREN

Brian J. Killacky
Detective
Area Three Violent Crimes
Chicago Police Department

(CAE) Sexual Exploitation of Children (Revised). Instructional Outline.

This unit of Instruction will give the Investigator a foundation of investigative skills to identify and protect sexually exploited children in their juristiction as well as building a solid criminal investigative case against the sexual predator.
Topics to be discussed are Victimology, a Proactive Investigative Approach, the development and use of Search Warrants, Sexual Predators, Child Pornography, Child Sex Rings and Adequate Victim Placement for the child victim of this type of violent crime.

The following is an outline of this instructional block.

1. A Comprehensive look at Sexual Exploitation.

2. Understanding the Sexually Exploited Child Victim.

3. Understanding and Implementing a Professional Investigative Approach in Sexual Exploitation Cases.

4. Using Search warrants in Sexual Exploitation Cases.

5. The Investigation of Child Molesters.

6. The Interrogation of the Child Molester.

7. Child Pornography.

8. Child Sex Rings.

9. Adequate Victim Placement.

(CAE) Sexual Exploitation of Children.
(revised)

1, SEXUAL EXPLOITATION:

A Graphic Illustration of Interpersonal Violence Described by Some As Sexual Abuse.

Child Pornography	First degree Murder
Child sex Rings	Mass Murder/Serial Murder
Child Prostitution	Criminal Transmission of HIV
Juvenile pimping	Delivery of Controlled Substances
Kidnaping	Harboring a Run away
Harmful Material	Public Indecency
Mann Act Violations	Computer Related offenses
Contributing to delinquency	Curfew and truancy Violations
Indecent Solicitation of a Child	Lewd Calls and Letters.

2. SEXUALLY EXPLOITED CHILD:

A Child is a Perfect victim of this form of Violent Crime for the following reasons:

Lack of Verbal Capability	Easily Lured
Lack of Recall	Easily Drug dependant
Unaware of Violation	Easily Impressed
Overpowered and Intimidated Easily	

Other reasons that make a Child a Perfect Victim:

Offender victim are biologically related.
Offender lives with victim
Offender has legal access.
Offender has lured victim into "wanting to be with the offender".

The vast majority of this type of Violent Crime Perpetrate Against Child goes:
Unreported
Not Immediately Reported
Unconventionally Reported.

Question: During the last five Investigations your agency investigated involving sexual exploitation of a child, what was the time between the sexual activity and the time the child made an outcry?

(CAE)

There is a Multitude of reasons for this delay:

Offender Transfers the Blame.	Financially dependant on Offender
Peer Pressure	Delinquent Background
Parental pressure	Transient Family
Jurisdictional Problems	Lack of Physiological Evidence

Sexually Exploited Children many times develop Psychological Paralysis.
Internalizes vs. Externalize.

This Child many times slips into:

Delinquent Acts	Habitual Run away
Status Offenses	Suicide
Chemical Dependancy	Prostitution

3. CONDUCTING SEXUAL EXPLOITATION INVESTIGATIONS:

The purpose of your investigation is to:

Establish Corpus Delecti
Establish the Criminal Agency
Collect Facts Proving or Disproving Guilt.

(ie.) Flight 800
OKC Bombing.

Those assigned to Sexual exploitation Investigations must have the following abilities:

Cultivate Information
Know Personal and Property of your jurisdiction
Crime Scene Management
Interview and Interrogation Skills as well as knowing the difference between the two.
Deal with outside and support agencies
High Conviction vs.Arrest Rate
Testifying in Court
Investigative Format in reports and Investigative Case File.
Objectivity and Outside Interests.

Sexual Exploitation Investigators Must Be Able to:

Establish the approximate date and Time of Offense.
Location of Offense and Appropriate Jurisdiction
(CAE)

(Cont)

Victim Identification
Age of Victim vs. Age of Offender.
Statute of Limitations
Property Identified, recovered and Evidence Analysis.

CRIME SCENE RECOGNITION:

Your Primary Crime Scene is Generally a Multiple Crime Scene.
Outcries and evidence begins and continues to the following locations:

Photo Labs
Adolescent Psyc. unit
Suspects Residence
Red Light Districts
Anonymous Letters and Calls
Abortion Clinics
Out of State Notifications
Juvenile Detention Facilities
Property Recovered on Search warrants
"Information for Police" Calls
Computer Data Bases
Medical Examiners Office
Emergency Rooms
Runaway Shelters
Confession of Incarcerated Offender
(prior to outcry of Victim)
Vacated or evicted property recovered.
Motel/Cabin/Water craft/Aircraft/RR Train
Greyhound Bus..
Out of Country Crime Scene.

Because most investigations are delayed or originally unreported, do not forget to attempt to build a layer of protection around your child victim through Crime Scene recognition and Evidence Potential:

Prima Facia Evidence:	Physical Evidence. In itself proves an element of the offense.
Transfer Evidence:	Links victim to offender or offender to victim. Links victim and offender to scene.
Reconstructive Evidence:	Investigative Reconstruction of scene. (Photos etc,)
Hearsay and Outcry:	Relative Information to build upon.

The following is a list of Forensic Services to consider in your Sexual Exploitation of Children 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.

(CAE) Cont.

Keep a good blend of Practical (Street Smarts) and the Scientific (Forensic).
Forensic Investigators need a trail of Investigative Factors, if not they are finished.
A Detective is a Person who can paint a scene that he or she has never seen.
That the difference between a Craft and an Art.

4. SEARCH WARRANTS:

Grounds for a S.W.	Upon the written complaint of any person under oath or affirmation which states facts sufficient to show probable cause and which particularly describes the place or the person or both to be searched and the things to be seized.
Issuance of a S.W.	All search warrants but show the exact location to be searched as well as the date and time of issuance. All must be signed by a judge or magistrate. All states have a time requirement between when the document is signed vs. the time of actual execution,

Expertise in a Search Warrant:

Your instructor has participated in hundreds of Search warrants in his career that have been based on Probable Cause developed during the particular investigation as opposed to the "Expertise of the Officer Applying for the Warrant".

Probable Cause can be generically 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.

Regarding a Search warrant, the reasonable and prudent man could also believe that evidence of that specific offense could be found in a particular place within a Reasonable Time:(refer to Brinegar vs. United States 338 US 160 (1949)..

"Expert Knowledge" in the field of Sexual Exploitation merely brings the investigation under a more professional scope and expands the focus to additional questions asked of the victim and the ability to target additional items of evidence that an unskilled investigator would not have located on a systematic basis.

No Matter what your educational qualifications are, how many seminars you attended, how much specific literature you have read or how many individuals you have arrested, do not make this the basis for your establishment of Probable Cause.

(CAE) Cont:

Avoid "Fill in the Blank" Search warrants dealing with this type of offense>
Boilerplate Clauses are likely to be Invalidated.(People vs. Frank 38 Cal.3d 711,728 (1985)

ESTABLISH YOUR PROBABLE CAUSE NOT YOUR INDIVIDUAL EXPERTISE:

EXECUTION OF SEARCH WARRANT RECOMMENDATIONS:

Maintain Surveillance of Location or Person to be searched.
Victims many times have ties to offender.

Suspects have burned items, flushed items and buried items in the backyard while under surveillance.
Tore up items and placed them in neighbors trash container.
Drive to another location and conceal them.
Delete analytical info from the computer
Offenders "tipped off" by Victims or their parents!
Offenders have received calls from members of law enforcement.

Have complete and accurate description of residence:
Sky Scrapers
Townhouses
Lofts
Apartment Complex
Subdivided residences
Mobile Home Parks

Verify Actual occupant
Numerical Addresses
Actual Space occupied or under authoritative control of suspect

Check Analytical Information from the following Agencies to support residency or occupancy:
Law Enforcement and Social service records
Someone who has been in residence
Utility Companies
Dept of Motor Vehicles
Post office or local Mail carrier
Municipal and Tax records

Time Of Execution of Search warrant:
Non Confrontational Time of Execution
Time where more information may be obtained:
Examples of Execution:
The offender in bed with a Child
The offender viewing Child Porno

(CAE) Cont.

Check For Firearms through ATF and Gun Reg.
Concentrate on items described.
Be aware of Sexual devises used on the victim.

Victims Clothing
Victim Photographs
School Books
Victims Personal Belongings
Diaries
Calender of Events
Victims Names and TXs
Victims school and medical records
Evidence of Victims date of Birth

Photograph the Search warrant Crime Scene.:

Shows Background of Child Porno
Photo point of entry
Photo all items inventoried prior to removal.

Please refer to Attached regarding Computer Related items to be seized in computer related crimes involving Sexual Exploitation of Children.

5. THE INVESTIGATION OF CHILD MOLESTERS.

Any Person who engages in illegal sexual behavior with a Child is a Child Molester.
During the last seventeen years of Violent Crimes Investigation, your instructor has heard the Term "pedophile" used in connection with all forms of Child Molestation.
IN DSM III (Diagnostic and Statistical Manual of Mental Disorders) of

the American Psychiatric Institute , pedophile is classified as a "Paraphilia" which is one of many psychosexual disorders. This is a diagnosis that can only be made by Qualified Psychologist and Psychiatrists. "Paraphilia" is a practice or fantasy upon which a person is dependant upon for sexual arousal. It may not be harmful or illegal.

Not all pedophiles are Child Molesters and not all child molesters are pedophiles.

Child Molesters are a heterogeneous group with few shared characteristics apart from a predilection for deviant sexual behavior..
There is no infallible profile of the "typical Child Molester". And folks, there is no "Typical Child Molester".

Four Primary Areas Making a Complete Profile:
Crime Scene Reconstruction
Offenders Personality Description
Offenders Post Offense Behavior
Interviewing and Investigative Strategies

Profiling Objective:
To Provide the Investigator with a Personality Description of the offender that will aid in swift identification and apprehension.
A Profile is nothing more than an educated guess- based on the investigators:

Experience
Education
Forensic Recognition
Intuition (Street Smarts)
Analytical Logic
Multidisiplinary Approach

For Classroom purposes, there are two types of Child Molesters:

A. Situational
B. Preferential

A. Situational:

(CAE) Cont:

Does not Have a true preference for a Child
Will attack: Senior Citizens
Prostitutes
Homeless and Street Children
Mentally Incapacitate People
May be involved in Home Invasion/Armed Robbery and Res. Burglary.
More of an Incidental type of Offender vs. Targeted.

Much More Likely to Kill the Victim.
Drifter and Loner.

Investigative Difficulties:

No true fixation for a specific age and sometimes sex of victim.
Establishment of Primary Jurisdiction hinders Investigation
Investigators fail to recognize potential forensic evidence and M/O.

B. Preferential Offender:

True Preference with children
Erotic Imagery and sexual fantasies focus on children
Multiple Victims
Will go to great lengths to seduce a child
Understands "Love and Affection, Recognition and Reward"
Gravitates to Legal Access via Vocation or Volunteer association
Mary or date to gain access
Few Problems with the law because of Victim Selection (Profile)
Inner circle of friends are younger

Investigative Difficulties:

Establishing Jurisdiction
Dates of Occurrences
Types of Illegal Sexual Behavior
Lack of Supportive Evidence
Victim or Victims Family Obstructs your investigation.
Statute Of Limitations prevents Prosecution
Inadequate Investigative Skills of Law Enforcement

(Cae) Cont:

6. Interrogation of the Preferential Child Molester

Prior to In Custody, analytical information and supportive information should be obtained.

Do Not Do Separate agency Interrogations

Custodial vs. Non Custodial Interrogations.

"Over Involved" Investigator Tunnel Vision in full force.

Keep weapons out of sight and reach.

Search suspect.

Allow to shift blame.

Communicate at offenders level.

Reinforce consentual aspects of case

Childs age, Date of Birth, age in School.

Photograph of Child or shown pornography.

Do not show shock or emotion.

Date of Offenses.

Consent to Search.

Gifts or items.

Establish Intent, Knowledge, Recklessness or Negligence

Aware of "Illegal Sexual Behavior" of respective state.

Aggravating Factors: Age of Victim
Biological Relationship or custodial care
Mental State of Child

Additional Victims, Offenders or times of offenses.

Is There anything that you would like to add to this discussion?

(CAE) Cont.

7. Child Pornography

Definition
Types
Reasons for: Personal Sexual Gratification
Lower Inhibitions
Blackmail Victim
Medium of Exchange
Monetary Gain

Home Made
Commercial
Computer Generated.

8. Child Sex Rings:

Child Sex rings can be one of the following in your community:

Multiple Victim/ One Offender.
Preferential Offender
Monetary Gain
Love and Affection
Operates for years
May use older victims to "recruit" younger child victims
Child Pornography
Incidental Offenses

Game Rooms/ Teen Drop in Centers/ local 24 Hr Restaurant/Museums/Amusement Parks
Non Alcoholic Dance and Social Gatherings
Parks and Forest Preserves
Nature Centers
Teen Record Shops
Train Stations/Bus Stations/ Airports.

Single Victim/Multiple Offender
Labeled as Professional Victim.
Offender meets child, Passes to another molester.

Multiple Victim/Multiple Offender
Meeting place common to adults and children.

(CAE) Cont>

9. Adequate Victim Placement:

The more professional and Proactive, the more you identify victims in your respective area. Example Reactive Narcotics Unit vs. Proactive.

Most important aspect of your investigation, the identification, classification and placement of the child victim of this violent Crime called Sexual Exploitation.

Previous Victims:
Murdered and Tortured by Sex Offenders and Serial Killers
Child Victims as Suicide Victims.
Become Drug Addicts

12

Commit Violent Crimes

High Risk Intervention Victims require secure placement who will run from treatment.

Long Term Placement
Adolescent Psyc. Hospital

PHYSICAL AND NEGLECT CHILD ABUSE INJURY RECONSTRUCTION TECHNIQUES

Detective Robert Hugh Farley, M.S.
Cook County Sheriff's Police Department
Child Exploitation Unit
1401 S. Maybrook Drive
Maywood, IL 60153
(708) 865-4875 or Fax (708) 865-4818

Physical and Neglect
Child Abuse Injury Investigative Techniques

A. Abusive Caretaker Assessment
- Poor parenting skills
- Referral to Social Services or give the parent advice
- 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
- Four eyelids on most everyone
- Lower lids vs. upper lids blackened?
- Both eyelids on one side of the face blackened?
- Both eyelids on both sides of the face blackened?
- Bilateral black eyes

D. Neglect Child Abuse Injury Reconstruction

Poor parenting skills vs. intent?

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?

Weight nutritional assessment
- 5th percent indicates nutritional wasting
- 5th–10th percent suggests nutritional wasting
- 95th percent indicates obesity

Height nutritional assessment
- 5th percent strongly suggests nutritional stunting if weight for height is the 25th percent
- 5th–10th percent suggests nutritional stunting if weight for height is 25 percent

Nutritional chart calculation
- D.O.B.—June 25, 1995 (7 weeks premature)
- Exam—June 18, 1997 (Calculated age—2 years)
- Correct 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?
- Wet clutter
- Dry clutter

Neglect prosecution assessment
- Poor parenting skills vs. intent?
- Is the child's health or life threatened?
- Is there a history of the family refusing help?

E. Emotional Abuse

F. Physical Child Abuse Dynamics
- Causation factors
- Triggering mechanism
- Target children
- Over discipline

Child abuse weapon identification
- Weapon of opportunity
- Favorite family weapon

Soft tissue injuries
- Accidental
- Nonaccidental

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?

Physical child abuse investigative techniques

- Do you like the child?
- Do you or did you want the child?
- Caretaker's explanation for the "accident"
- 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 knees drawn up, arms bent across chest, and head turned sideways

1 month
- Head flops when body is lifted
- Lies on back with arms and legs extended and head facing the side
- Makes long jerky motions, stretches limbs, fans toes and fingers

3 to 6 months
- Can roll from stomach to 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

6 to 9 months
- Can roll from back to 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

9 to 12 months
- Crawls well
- Stands holding onto object
- Can pull to sitting position
- Walks, holding onto hand or furniture
- Can sit steadily for more than 10 minutes

12 to 18 months
- Creeps up stairs
- Can stoop and recover an object
- Can get to standing position alone
- Seats self on a chair
- By 18 months, walks well alone
- Uses spoon and drinks from cup

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

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

G. Bruises
- Location
- Distribution
- Number
- Configuration
- Age dating

Accidental injuries
- Bony prominences
- Knee
- Hands
- Elbow
- Chin
- Forehead
- Nose

Nonaccidental injuries
- Buttocks
- Thighs
- Arms
- Cheeks
- Stomach or torso

Injury examination

- Are the injuries on more than one body plane?
- Multiple resolving injuries-rainbow effect

Injury configuration types

Fixed objects	**Wrap–around objects**
Coat hangers	Belts
Handles	Closed end cords
Paddles	Open end cords
Welts from hands	

Age dating of bruises

Time	**Color**
0 - 2 days	Swollen, tender, 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 of blood collected within the damaged tissue

Open soft tissue injuries

- Abrasions-areas of the body surface denuded by a scrape
- Laceration-torn or ragged wound or cut

H. Wound Identification
- Location
- Distribution
- Number
- Configuration?
- Age dating

Age dating of abrasions or wounds

Within several hours	Raw surface oozing blood and a clear fluid
After 6 hours	Dry surface, red (depending on the treatment)
Over 24 hours	Scabs form

I. 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. Forensic Photography in Child Abuse Cases
- Black and white
- Color
- Exemplar vs. color chart
- Video
- X-rays
- Black light or woods lamps
- Ultraviolet-short or long wave

* Additional information on this topic can be found on pp. 5-47 of the manual *Child Abuse and Exploitation Investigation Techniques*, U.S. Department of Justice, 1995.

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 right to refuse consent to such a search, I hereby authorize _____ and _____, of the Child Exploitation Strike Force, to conduct a complete search of the premises and property commonly known as _____ and/or automobile, license # _____. These officers or agents are authorized by me to take from my premises and property any letters, papers, videos, photos, computer disk s, or materials which is evidence in the nature of child abuse. This written permission is given to me to the above named persons voluntarily and without any threats or promises of any kind, at _____ _____M on this _____ day of _____, 19___. I further understand that I will be given a receipt for property taken.

Signed _____

Name _____

Witnesses:

Signed _____ _____

Name _____ _____

Agency _____ _____

MICHAEL F. SHEAHAN
SHERIFF

WILLIAM J. BURKE, JR.
CHIEF

COOK COUNTY SHERIFF'S POLICE DEPARTMENT
1401 SOUTH MAYBROOK DRIVE
MAYWOOD, ILLINOIS 60153
TELEPHONE: (708) 865-4700

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____
(facility, agency, therapist, etc.)

_____ _____
(address) *(city)*

to release _____
(specific nature of information disclosed)

about _____ _____
(name of patient) *(date of birth)*

for the purpose of _____
(purpose or police report case number)

to Detective Robert Hugh Farley of the Cook County Sheriff's Police Department, Federal Child Exploitation Strike Force, 433 W. Harrison, 5th Floor, Chicago, IL 60669, 312-983-6235.

I understand fully the nature of this authorization and further that the above named Detective has the right to inspect, copy, or Xerox the information to be disclosed.

_____ _____
Date Signature of Patient

_____ _____
Witness Parent or Guardian

S021D97

CRIMES AGAINST CHILDREN CONFERENCE 1998

Workshop: Investigation of Multi-Victim/Offender Cases
Presenter: Lucy Berliner

KING COUNTY SPECIAL ASSAULT NETWORKING AGREEMENT

STATEMENT OF PURPOSE

This agreement sets forth the system for cooperative investigation between King County law enforcement agencies, the Office of the Prosecuting Attorney, and the Department of Social and Health Services's Division of Children and Family Services (DSHS/DCFS). The intent of this agreement is to provide a working protocol for the investigation of cases where children have suffered injury or death as a result of abuse and neglect, or have been subjected to sexual abuse. Protocol for responding effectively and systematically to adult victims of sexual assault is also addressed. Additionally, it is intended that this agreement promote interagency cooperation, sharing of information and coordination. This agreement does not apply outside of King County.

COOPERATING AGENCIES

Office of the Prosecuting Attorney/Special Assault Unit - Adult/Juvenile
Department of Social and Health Services/Division of Children and Family Services
King County Police/Special Assault Unit
Seattle Police/Special Assault Unit
Other Municipal Police Departments within King County
Office of the Attorney General/Seattle SHS Division
Victim Advocacy Organizations
Abused Deaf Women's Advocacy Services (ADWAS)
Eastside Sexual Assault Center for Children (ESACC)
Harborview Sexual Assault Center (HMC-SAC)
King County Sexual Assault Resource Center (KCSARC)
Seattle Rape Relief (SRR)

11.94

"No contact order" - A "no contact" order between the victim and alleged offender will be sought in all cases where charges are filed. "No contact" includes no supervised contact. Violations should be reported to the prosecutor's office for revocation of bond proceedings. In general, in the case of conflicting or overlapping court orders, the most restrictive order about contact should be followed.

Filed case - The Screening Unit Senior Deputy will assign a deputy at the time charging documents are prepared. The assigned deputy prosecutor will be the contact for the victim, detective, advocate, etc., from that time forward. Exception - The detective may request assignment of a prosecutor at the outset of the investigation when the detective anticipates the need for ongoing legal advice or case consultation.

C. *Notification of Case Decision by Prosecutor's Office*
Procedure - A prosecutor, after receiving a completed investigation from law enforcement, shall notify the victim, any person the victim requests, law enforcement and the local office of CPS (if involved) of the decision to charge or decline to charge a crime **within 5 days of making the decision**. [RCW 26.44.030 (6)] Statutory Referral Only cases will be returned by the prosecutor to the proper law enforcement agency.

D. *Notification of Guilty Plea*
Procedure - The prosecutor will notify the victim and law enforcement, prior to a guilty plea, when that plea will result in a reduced charge.

V. MULTIPLE VICTIM AND MULTIPLE OFFENDER CASES INVOLVING CHILDREN

A. ***Definition*** - These cases involve referrals where abuse may be occurring in a setting where many children may be at risk or where many individuals may be offenders. This includes any case where a victim indicates the possibility of a group of offenders with a high degree of cohesiveness and membership control.

B. ***Specialized Response*** - Special treatment of these cases is required (i.e. systematic and coordinated initial response in the investigation and prosecution) for the following reasons:

- The children and parents are likely to know and communicate with each other and potentially contaminate the individual reports.
- These cases often involve very young children who may have limitations in their capacity to recall and describe multiple acts of abuse and may be more vulnerable to threats and intimidation.
- Children subjected to extreme forms of intimidation or abuse in groups by trusted authority figures may be more fearful of reporting. Additionally, they may only tell gradually over time, in fragments, in very secure settings, or with significant prompting.
- It is inherently difficult to accurately recall specific, separate acts/incidents where they involve many occurrences, with different individuals, over time.

C. ***Procedure***

Initial response by law enforcement

- Immediate referral to supervisor of law enforcement investigative units.
- Supervisor assigns a single investigator to coordinate the case.
- Investigator identifies representatives from other relevant systems (E.g., victim advocates, CPS, day care licensing and prosecuting attorney) to respond.
- Investigative team decides on case approach and creates documentation system.
- Investigator designates one person as media contact if necessary.
- Prior agreement upon information to be disclosed is made.

Investigation by law enforcement

- Identify all possible victims.
- Arrange for interviews through the Prosecutor's office utilizing their protocol.
- Interview as many victims and witnesses as possible as close in time as possible - RUSH.
- Explore with victims all other possible victims and suspects at initial interview.
- Elicit from parents any information regarding possible victims and suspects.
- Investigate ALL allegations thoroughly.
- Use surveillance, search warrants, criminal records checks, evidence collection, lab analysis, etc., as required.
- Interview all suspects and obtain a statement.

Response to victims

- Set up a forensic medical evaluation as soon as possible with one of the specialized sexual assault medical providers, including colposcopic exam, drug/toxicology screen when indicated. It is preferable in cases involving multiple victims, that medical exams be obtained at the same facility.
- Therapy - Therapists <u>will not</u> conduct investigative interviewing or act as agents of the criminal justice system. Unless the child makes spontaneous disclosure, there should not be contact between the investigator and therapist/counselor.

Response to parents and/or guardians

- Identify the group of involved parents or guardians of the victims.
- A team is designated to attend a meeting with this group to provide specific instructions regarding the following:
  - Therapy/counseling for children - the issues that will be addressed and who provides.
  - Group support network with ground rules regarding interaction between group members. For the good of the case, it is necessary that there be no identification of issues or specific details discussed. In addition, group participants will be aware that team members will be present during support meetings.
- Discussion of the incident(s) should not be initiated by adults with the child.
- Document and notify law enforcement of any disclosure.
- Document and notify parents and guardians of the way the "System" works regarding the case. Provide them with a knowledge base of how the case will be responded to and the timelines to anticipate.
- Advise parents not to conduct investigative activities on their own.

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 <u>cool</u> 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.

REFERENCES

1. Purdue GF, Hunt JL: Child abuse-An index of suspicion. J Trauma 28: 221, 1988.
2. Lenoski EF, Hunter KA: Specific patterns of inflicted burn injuries. J Trauma 17:842, 1977.
3. Deitch, E.A., Staats, M.: Child abuse through burning. J. Burn Care Rehab., 3:89-94, 1982.
4. Moritz, A.R., Henriques, F.C.: Studies of thermal injury II. The relative importance of time and surface temperature in the causation of cutaneous burns. Am. J. Path., 23:695-720, 1947.

PROSECUTION OF FATAL CHILD ABUSE

Dan Goldstein
Deputy District Attorney
San Diego County

Without doubt, Child Abuse Homicides are the most challenging cases a prosecutor will ever face. Many cases can go unrecognized. Explanations of accident, natural causes, Sudden Infant Death Syndrome (S.I.D.S.), and lack of knowledge, are heard more often with child abuse homicides than with other killings. This is due to a number of reasons including, but not limited to: the relationship of the victim to the offender, which will cause some family members to minimize, while other family members will consider anything less than a first degree murder a loss; media attention focused on your case magnifying the issues; and public perception, i.e., juries, judges, and even law enforcement officials may have built in biases causing them to believe the killing was an accident, discipline out of control, or feel some type of sympathy for the offender, causing an erosion of your charge of murder.

Often a defendant will claim the other caretaker did the killing , but it was in reaction to frustration, stupidity, drug and alcohol abuse or duress. Thus, child abuse homicides present both as "who done its", and "what is its". A prosecutor must be well versed in the law of homicide and evidence to effectively prosecute these killings. The prosecutor must be able to understand and articulate the dynamics of child abuse and the importance of prior acts of violence.

A prosecutor must be able to recognize the numerous complex medical issues present in all child abuse homicides. Dating injuries, identifying a perpetrator, and ruling out an accident or S.I.D.S, requires a prosecutor to mesh the fields of medicine with the criminal justice system and to build a case that will be understandable to a jury.

The nature of interfamilial homicides also presents numerous issues that a prosecutor must overcome. Initial recognition that the death is in fact a homicide is hampered by late reporting, inaccurate - whether honest or dishonest - histories, crime scene destruction, fear of retaliation, and bias on the part of family members who cannot or will not believe that a loved one would kill a child in their family. Additionally, siblings

and/or children of the offender will often be the only witnesses to the events, creating enormous stress and tension within the family. Further, it is not uncommon to see the issue of domestic violence raised as a defense of duress, lack of reporting, or failure to aid.

Lastly, unique to child abuse cases is the battle for sympathy. At first blush one would assume anyone who would hurt a child deserves the harshest of punishments. However, a review of the many child abuse homicides prosecuted over the last decade reveals juries, judges, and the media often sympathize with the offender to some degree due to the nature of the relationship to the victim, lack of education, destruction of the family unit, and the unbelievable quality of child homicides.

The goal of this presentation is threefold:

- Create an understanding of the evidence that must be acquired during the investigatory phase of a child abuse homicide to present and win the case before a jury.

- Obtain a working knowledge of medical evidence from a prosecutorial perspective.

- Employ effective trial strategies in child abuse homicides to hold the abuser accountable.

CHILD ABDUCTION AND SERIAL KILLER UNIT

In an effort to combat two of the most serious violent crime problems facing the nation today, FBI Director Louis J. Freeh created a specialized unit to focus on investigations of child abduction and serial homicide. These crimes are among the most difficult to resolve and require the immediate dedication of significant resources. The Child Abduction and Serial Killer Unit (CASKU), located near the FBI Academy, provides immediate operational assistance to federal, state, and local law enforcement agencies involved in these important and complex investigations.

The unit's primary responsibility is to provide immediate investigative support through violent crime analysis, technical and forensic resource coordination, and application of the most current expertise available in matters involving the abduction or mysterious disappearance of children and cases of serial or mass murder. CASKU's efforts are directed toward supporting the investigative agencies in recovering the victim(s) and fully resolving the child abduction or serial murder case.

CASKU Special Agents provide the following services:

- profiles of unknown offenders
- crime analysis
- investigative strategies
- interview and interrogation strategies
- behavioral assessments
- trial preparation and prosecutive strategy
- expert testimony
- coordination of other resources, including the use of the FBI Evidence Response Teams and FBI Laboratory services

The unit can also assist in coordinating the deployment of Rapid Start, a computerized major case management support system. Additionally, CASKU maintains a close working relationship with the National Center for Missing and Exploited Children and can help in arranging use of their resources, such as age enhancement of photographs and poster distribution.

The FBI's Violent Criminal Apprehension Program (VICAP) works closely with CASKU and provides automated support. The VICAP data base contains reports submitted by participating law enforcement agencies on certain violent crimes. The information can be used in linkage and analysis of multiple, serial cases.

CASKU also shares expertise and insight gained from case experience and research with law enforcement agencies through training and publications.

CASKU can be contacted directly at 540-720-4700 or through your local FBI office.

MISSING AND EXPLOITED CHILDREN'S TASK FORCE

The Missing and Exploited Children's Task Force (MECTF) was created by the Morgan P. Hardiman Task Force on Missing and Exploited Children's Act of the 1994 Crime Bill. Its purpose is to coordinate federal law enforcement resources to assist state and local authorities in investigating the most difficult cases of missing and exploited children.

The Task Force includes at least two members from each of the following agencies:

- Federal Bureau of Investigation
- Bureau of Alcohol, Tobacco, and Firearms
- Drug Enforcement Administration
- U.S. Postal Inspection Service
- U.S. Customs Service
- U.S. Marshals Service
- U.S. Secret Service

As legislated by Congress, the FBI manages the Task Force, which is collocated and works closely with the FBI's Child Abduction and Serial Killer Unit. The Unit Chief of CASKU also serves as Chief of the MECTF.

The Task Force efforts focus on major offenders who have demonstrated a desire to abduct children. The Task Force performs investigative, analytical, and other functions as necessary to identify unsolved cases for which those offenders may be responsible. The Task Force function is not to take a leadership role in the investigations, but to provide advice and technical assistance and to make available the combined resources of the above agencies in child abduction cases.

The Attorney General has assigned an attorney to provide legal guidance, as needed, to members of the MECTF.

Both the Child Abduction and Serial Killer Unit and the Missing and Exploited Children's Task Force have a very close working relationship with the National Center for Missing and Exploited Children. The intention of this marriage of agencies is to provide optimum expertise and resources immediately whenever a child becomes a kidnap victim.

The MECTF can be contacted directly at (540) 720-4760.

CHILD ABDUCTION AND SERIAL MURDER

THE PROBLEMS

Child Abduction

Statistics vary regarding the incidence of child abduction. The issue is a complex and sometimes confusing one, in that there is no mandatory reporting to a central agency, and definitions of "abduction," "missing," and even "child" differ from jurisdiction to jurisdiction.

In the 1984 Missing Children's Act (P.L. 98-473), Congress mandated that the Office of Juvenile Justice and Delinquency Prevention (OJJDP) conduct national incident studies to determine statistics about "missing children," including "stranger abductions" and "parental kidnappings." Called the National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART), they provided the first estimates derived from comprehensive scientific investigation. All NISMART estimates were for 1988.

The project, begun in November 1987, consisted of six studies. The three that related directly to the issue of abducted children included:

- A telephone survey of nearly 35,000 households to determine the incidence of abducted, runaway, thrownaway, lost, or otherwise missing children.
- A study of records in a national sample of 83 law enforcement agencies to find the number of nonfamily abductions.
- An analysis of 1976-1987 FBI homicide data to estimate how many children may have been murdered in the course of stranger abductions.

NISMART developed two definitions for nonfamily abductions:

Legal Definition included an incident involving:

- The coerced and unauthorized taking of a child into a building or vehicle, or a distance of more than 20 feet; or
- The detention of a child for more than an hour; or
- The luring of a child for the purpose of committing another crime.

A **Stereotypical** abduction was defined as an incident that *in addition to meeting the legal definition criteria* involved abduction by a stranger whereby:

- The child is gone overnight; or
- The child is killed; or
- The child is transported a distance of 50 miles or more; or
- The child is ransomed; or
- The perpetrator evidences an intent to keep the child permanently.

NISMART estimates the following statistics for nonfamily child abductions for 1988:

- 3,200-4,600 legal definition abductions
- 200-300 stereotypical abductions
- Many of these children have been assault victims, and upwards of 100 have been projected as murder victims

Because there is no legislative mechanism in place for mandating the reporting of these cases to the FBI, in many situations the resources of the Bureau are not utilized to effect the safe return of the victims or to identify and apprehend the perpetrators.

Serial Murder

A central reporting agency or collection point for data on serial murder does not exist. The FBI captures murder statistics through voluntary submissions from police departments through the Uniform Crime Reporting system. That system, however, is not designed to indicate which offenses might be part of a series and the responsibility of one offender. For example, the murders committed in different states by one offender would be reported as separate incidents by agencies within each jurisdiction.

The FBI uses the following definitions for multiple murder:

Mass: four or more victims at one location within one event.

Serial (spree): killings at two or more locations with no cooling-off time period between murders. Time interval between killings can be minutes or days. Characterized by ongoing high excitation level and often involves fugitive status.

Serial (classic): two or more killings committed as separate events, usually, but not always, by one offender acting alone. Crimes may occur over a period of time ranging from hours to years. Quite often the method is predatory/stalking, the motive is psychological, and the offender's behavior and the physical evidence observed at the crime scenes will reflect sadistic, sexual overtones.

The incidence of homicide in the United States has risen from 8,600 in 1961 to 23,305 in 1994, with the rate per 100,000 citizens going from 4.7 to 9.0 in that time. Clearance rates of murders have fallen from 93.1% in 1961 to 64% in 1994. (See table on next page for annual figures from 1981-1994.)

Homicides in the United States (reported)		
Year	**Estimated #**	**% Clearance**
1981	20,053	72
1982	21,012	74
1983	19,308	76
1984	18,692	74
1985	18,976	72
1986	20,613	70
1987	20,096	70
1988	20,675	70
1989	21,500	68
1990	23,438	67
1991	24,703	67
1992	23,760	65
1993	24,526	66
1994	23,305	64
1995	21,326	65

Other facts about murder in the United States include:

- The percentage of murder victims under the age of 18 has risen from 7.65% (1,452 victims) in 1985 to 11.42% (2,521 victims) in 1994.
- As determined through media searches (there are, at present, no official law enforcement statistics), the number of multiple murderers (mass and serial) operating each year rose from 51 to 101 during the years 1970-1984.
- The number of classic serial killers operating each year rose from 43 in 1970 to 81 in 1984, as determined through searches in the media.
- There is a high degree of transiency among serial killers, often creating crime scenes hundreds of miles apart.

Clearance rates for murders have changed drastically because the dynamics of the crime have changed significantly. Thirty or forty years ago, generally the murderer and murder victim were connected--relatives, neighbors. acquaintances. Today, many more murders are perpetrated between strangers. Of those cases reported to the Uniform Crime Reporting system in 1994, more victims were listed as strangers or of unknown relationship to the offender than were listed

as having a known relationship (relationship categories of victim to offender are husband, wife, mother, father, son, daughter, brother, sister, other family, acquaintance, friend, boyfriend, girlfriend, neighbor, employer, employee).

With no known connection to the victim, mobile and cunning offenders are, in many cases, getting away with murder. Many consciously cross jurisdictional lines or commit crimes or dispose of bodies in rural areas. The killers' perceptions are often that agencies in different jurisdictions fail to communicate and connect the crimes and that small agencies are unprepared to deal effectively with complex, bizarre crimes.

The Child Abduction and Serial Killer Unit and other components of the FBI seek to provide vital resources to assist the law enforcement community recover victims and fully resolve the crimes.

RAISING MONEY LEGALLY:
SELECTED ISSUES IN FUND RAISING

Johnny Rex Buckles and Eric G. Reis
Thompson & Knight, P.C.
1700 Pacific Avenue, Suite 3300
Dallas, Texas 75201
(214) 969-1700

August 19, 1998

SELECTED ISSUES IN FUND RAISING

Johnny Rex Buckles and Eric G. Reis

Charities must consider a number of factors in planning, implementing, and conducting a program of fundraising. First, the charity must respect direct statutory limitations on fundraising, including federal, state, and local restrictions on gambling. Second, the charity must consider indirect limitations on fundraising, including the tax implications (for both the charity and donor) of a particular fundraising method. Finally, the charity may be constrained by provisions in its governing instrument (i.e., its Articles of Incorporation) or by donor restrictions on the use of funds. This outline describes a few of the issues and problems that arise in each area.

I. Direct limitations on fundraising.

The most important direct limitations on fundraising involve bingo, raffles, and other games of chance.

A. Texas Bingo Enabling Act.

1. Bingo must be specifically authorized by each locality. Except where authorized, it is illegal.

2. Bingo operators must be licensed by the Texas Lottery Commission. The fee for this license is based on annual gross receipts.

3. Prizes may not exceed certain limits per game and per occasion.

4. The net proceeds of any game must be devoted exclusively to charitable purposes.

5. Bingo is subject to a gross receipts tax, a bingo rental tax, and a fee on prizes.

6. Bingo operators must maintain separate accounts for bingo funds, file reports with the Texas Lottery Commission, and satisfy other requirements.

B. Texas Charitable Raffle Enabling Act.

1. Most charities that have been in existence for at least three years qualify to hold a raffle.

2. A charity may not hold more than two raffles per calendar year and may not hold more than one raffle at a time.

3. The charity may not pay for television, radio, newspaper, or other advertisements in mass media, and may not promote the raffle statewide.

4. The prize may not be money and may not have a value of more than $50,000 (unless the prize is donated by a third party).

5. Each ticket must list the name and address of the charity, the price of the ticket, and a general description of any prize that is worth more than $10.

C. Federal law.

Federal law allows section 501(c)(3) organizations to conduct bingo and other games of chance, provided that no part of the gross receipts inure to the benefit of any private shareholder, member, or employee.[1]

II. Indirect limitations on fundraising.

The most important indirect limitations on fundraising are imposed by federal tax law. Improper fundraising practices may result in adverse tax consequences for the donor, the charity, or both.

A. Soliciting and acknowledging donations.

1. Substantiation of charitable contributions. The charity must provide each donor with a "contemporaneous written acknowledgment" of any contribution of $250 or more, or the donor's tax deduction will be disallowed.

   a. Written acknowledgment. The acknowledgment must contain the following information:

      (1) the amount of cash and a description (but not a statement as to value) of any property other than cash contributed;

      (2) whether the donee organization provided any goods or services (defined as cash, property, services, benefits and privileges) "in consideration for" any donated property;

      (3) a description and good faith estimate of the value of any goods or services provided to the donee (other than intangible religious benefits) in consideration for the donated property; and

[1]Unless otherwise indicated, all section references are to the Internal Revenue Code of 1986, as amended.

(4) a statement that the donee organization provides intangible religious benefits, if applicable. "Intangible religious benefit" is defined as "any intangible religious benefit which is provided by an organization organized exclusively for religious purposes and which generally is not sold in a commercial transaction outside the donative context." I.R.C. § 170(f)(8).

b. Contemporaneous. The acknowledgment must be "contemporaneous." This requirement will be met if the taxpayer obtains the acknowledgment on or before the earlier of the date the taxpayer files a return for the year in which the contribution was made, or the due date (including extensions) for filing such return. I.R.C. § 170(f)(8)(C).

c. Token benefits. Small items and token benefits to donors that have insubstantial value may be ignored for substantiation purposes. In 1998, items are considered to have insubstantial value if:

(1) the payment occurs in the context of a fundraising campaign in which the charity informs patrons how much of their payment is a deductible contribution, and

(2) either (i) the fair market value of all the benefits received in connection with the payment is not more than 2% of the payment, or $71 (in 1998, adjusted for inflation), whichever is less, or (ii) the payment made by the patron is $35.50 (in 1998, adjusted for inflation) or more and the only benefits received in connection with the payment are token items (*e.g.*, key chains or mugs) that bear the organization's name or logo and that (in the aggregate) cost the charity no more than $7.10 per donor (in 1998, adjusted for inflation).

d. Membership benefits. Annual membership benefits offered to a taxpayer for a payment of $75.00 or less per year may also be disregarded for substantiation purposes, so long as the benefits consist of:

(1) certain rights and privileges (such as free or discounted admission to the organization's facilities or events, free or discounted parking, preferred access to goods or services, and discounts on purchase of goods or services); and

(2) admission to events during the membership period that are open only to members of the donee organization and for

which the organization projects that the cost per annum (excluding allowable overhead) is within the limits established on "low cost articles" under § 513(h)(2) (i.e. $7.10 in 1998, adjusted for inflation).

e. Payroll deductions. Contributions made through payroll deductions may be substantiated by (i) a pay stub, W-2 or other document provided by the employer showing the amount withheld from wages, and (ii) a pledge card or other document prepared by the charity stating that it does not provide goods or services in exchange for any contribution made by payroll deduction. Treas. Reg. § 1.170A-13(f)(11)(i).

f. Split interest gifts. Substantiation is not required with respect to contributions to split interest trusts (such as charitable remainder annuity trusts or unitrusts), but is required with respect to contributions to pooled income funds. The contemporaneous written acknowledgment need not include a good faith estimate of the donor's income interest in the pooled income fund. Treas. Reg. § 1.170A-13(f)13.

g. Penalties. A donee that knowingly provides false written substantiation to a donor may be subject to penalties for aiding and abetting the understatement of tax liability.

2. Disclosure of "*quid pro quo*" contributions. If a charity solicits or receives a "*quid pro quo*" contribution in excess of $75, additional rules apply.

a. "*Quid pro quo*" defined. A "*quid pro quo*" contribution is a "payment made partly as a contribution and partly in consideration for goods or services provided to the payor by the donee organization." Intangible religious benefits are not included. I.R.C. § 6115(b).

b. Written statement. The charity must provide a written statement that:

(1) informs the donor that the amount of the contribution which is deductible is limited to the excess of the amount of money and the value of other property contributed by the donor over the value of the goods and/or services provided to the donor by the donee organization; and

(2) provides the donor with a good faith estimate of the value of the goods and/or services provided to the donor by the organization. I.R.C. § 6115(a).

c. Raffles. The IRS contends that the purchase of a raffle ticket is not a *quid pro quo* donation. *No* portion of the purchase price is deductible, because the purchase price equals the benefit received by the buyer (regardless of whether the buyer actually wins a prize).

d. Unused tickets. Donors who cannot or do not wish to attend a fundraising event or who do not wish to receive other consideration should be advised that they must actually return the ticket or other consideration in order for the entire amount of their payment to be treated as a charitable contribution. Mere failure to attend the event or to utilize the other items provided is not sufficient.

e. Penalties. If a charity fails to provide the *quid pro quo* disclosure, it is subject to a fine of $10 for each failure to disclose to each donor, up to a maximum penalty of $5,000 per mailing or fundraising event. No penalty will be imposed if the charity can show the failure to disclose was attributable to a reasonable cause. I.R.C. § 6714.

3. Additional requirements for gifts of property. The donor must take additional steps to secure a tax deduction for donations of property rather than cash.

a. Property gifts of $500 or less. A donor who makes a gift of property and claims a deduction of $500 or less must have a receipt from the charity and a reliable written record of certain information concerning the property.

b. Property gifts over $500 but under $5,000. A donor who makes a gift of property and claims a deduction over $500 but under $5,000 must have a receipt from the charity and a reliable written record of certain information concerning the property, *and* must also complete Part 1 of IRS Form 8283, which requires the donor to disclose certain information.

c. Property gifts over $5,000. If a donor contributes property (other than publicly-traded securities) for which a charitable deduction in excess of $5,000 is claimed, the donor must (1) complete Form 8283, (2) obtain a "qualified appraisal" of the property, (3) attach a

fully completed appraisal summary to the tax return in which the deduction is first claimed, and (4) maintain certain records. The requirements for a "qualified appraisal" are beyond the scope of this outline.

B. Withholding taxes from prizes given to "donors."

1. Charities are not required to withhold taxes from bingo winnings. I.R.C. § 3402(q)(5).

2. Other gambling winnings may be subject to withholding if the winnings exceed $5,000. I.R.C. § 3402(q)(3).

3. If winnings are subject to withholding, a flat 28% rate applies.

C. Payment of Wagering Tax and Special Occupational Tax.

1. A charity which sponsors a raffle or other gambling activity may be required to pay a tax of 0.25% on all "wagers" authorized by state law. I.R.C. § 4401(a). The tax increases to 2% for activities that are not authorized by state law.

2. A charity which sponsors a raffle or other gambling activity may also be required to pay a special occupational tax, and may be required to register with the District Director of the IRS. I.R.C. §§ 4411, 4412.

D. Unrelated Business Income Tax.

1. Definition. Income of a charity is unrelated business taxable income ("UBTI") if (1) the income is generated by a "trade or business," (2) the trade or business is "regularly carried on," and (3) the trade or business is not substantially related to the charity's exempt purposes.

2. Exceptions. Certain activities generally will not generate UBTI:

   (a) Volunteers. A trade or business conducted by volunteers will not generate UBTI.

   (b) Convenience of Patrons. Business conducted for the convenience of the organization's members, students, patients, officers, or employees will not generate UBTI. For example, a tax-exempt hospital will not receive UBTI from its cafeteria.

   (c) Donated Goods. The sale of donated property will not generate UBTI.

(d) Bingo and Raffles. Proceeds of a bingo game will not be UBTI if all wagers are placed, all winners are determined, and all prizes are distributed in the presence of everyone who participates in the game. The game must also be authorized by state and local law, and cannot be an activity which is ordinarily carried out on a commercial basis.

(e) Dividends, interest, royalties, and rents. In general, dividends, interest, royalties, and rents do not constitute UBTI. However, UBTI may arise in situations where the charity is more than just a passive recipient of investment income, as explained below. In particular, the charity cannot provide services to the payor.

3. Special situations.

(a) Affinity credit cards and insurance endorsements. Charities often receive income by allowing their name to be used by credit card companies or insurance companies. In return, the charity receives a percentage of the income generated by the credit card or insurance product. The IRS has argued that such arrangements generate UBTI. However, courts have generally found in favor of the charity, as long as the charity does nothing more than lend its name to the activities of the for-profit company. *See, e.g., Sierra Club Inc. v. Commissioner*, 86 F.3d 1526 (9th Cir. 1996); *Mississippi State Univ. Alumni, Inc.*, 74 T.C.M. (CCH) ¶ 458 (1997).

(b) Rental of mailing list. With limited exceptions, a charity may rent its mailing list to another charity without generating UBTI. Renting a mailing list to a for-profit company may generate UBTI.

(c) Sponsorships. In general, the provision of advertising by an exempt organization in return for payments from a sponsor constitutes an unrelated trade or business. However, mere "acknowledgment" of a contribution does not constitute advertising. Distinguishing between acknowledgments and advertisements is difficult. However, Congress has provided a statutory safe harbor for "qualified sponsorship payments" received after December 31, 1997. Such payments do not constitute UBTI.

(1) Definition. A "qualified sponsorship payment" is a payment made in exchange for the charity's use or acknowledgment of the sponsor's name, logo, or product lines.

(2) Limitations.

(a) No advertising message. The use or acknowledgment may not include "advertising," which includes "messages containing qualitative or comparative language, price information, or other indications of savings or value, an endorsement, or an inducement to purchase, sell, or use" the sponsor's products.

(b) No contingent payments. A qualified sponsorship payment cannot be contingent on the level of attendance at or public exposure of an event.

(c) No periodicals. The safe harbor does not apply if the sponsor is entitled to acknowledgment in a charity's regularly scheduled publication, unless the publication is distributed in connection with a specific event.

(d) No trade show activities. The safe harbor does not apply to payments made in connection with convention or trade show activities.

4. Allocating payments. Agreements between charities and their donors or sponsors should specify what portion of each payment is for each item or service provided by the charity. Although this allocation may not be respected by the IRS, it provides a basis for excluding at least part of each payment from UBTI.

III. Donor restrictions.

In soliciting and receiving donations, a charitable organization may be required or encouraged to follow certain restrictions or non-binding preferences imposed or otherwise expressed by donors with respect to the use of donated funds. This poses unique problems. Discerning the donor's intent may be difficult, and following that intent may be impossible. A few of the problems in this area are discussed below.

A. **Identifying Secondary Beneficiaries.** Both taxable donors (individuals and business corporations) and tax-exempt charitable foundations often desire that a charity receive a donation and apply it for the benefit of certain designated individuals or charities which are members of the charitable class benefitted by the grantee organization's operations. The designation of such "secondary beneficiaries" presents a host of potential legal problems under federal tax law.

1. Ensuring Income Tax Deduction for Charitable Contributions by Taxable Donors. The income tax deduction for charitable contributions is unavailable to a donor who conditions its gift to charity on the charity's agreement to use the donation exclusively to benefit a specific individual or small group of individuals named and selected by the donor. However, the deduction generally will not be denied under this rule if the donor merely expresses a non-binding preference that the charity benefit a named individual, as long as the individual is a member of the charitable class benefitted by the charity's operations and the charity exercises actual control over the use of donated funds. Special considerations apply where a charity first selects named individuals to benefit from an upcoming fundraising campaign and then seeks support for these individuals.

2. Facilitating Private Foundations' Grant-making. Private foundations generally prefer to make grants to charities which receive broad public support, for grants to such organizations are not subject to the burdensome "expenditure responsibility" rules imposed on private foundations by Section 4945. Similarly, private foundations often prefer to make grants that ultimately benefit individuals to organizations which serve the needs of such individuals (rather than to the individuals directly). If a private foundation makes a grant to a public charity and requires the charity to transfer donated funds to another organization or an individual, the private foundation will be deemed to have made a grant directly to the ultimate beneficiary. Generally, a public charity must make the selection of persons or entities to benefit from grant funds completely independently of the private foundations making the grants in order to ensure that the private foundations will be deemed to have made their grants directly to the initial grantee.

B. Identifying Purposes. Once funds have been received by a charity, it must determine how these funds will be used. Donor expectations as to the general use of funds may be more important than one might initially think.

1. Charter Purposes. Texas case law supports the position that the charter purposes of an organization (i.e., the purposes clause in the Articles of Incorporation of a Texas nonprofit corporation) result in the impression of a charitable trust upon all donations received by the charity. A charity must use all donated funds in furtherance of its charter purposes. Failure to do so subjects the charity to a lawsuit by the Attorney General of the State of Texas. Thus, even if a charity does not expressly state the purposes that will be furthered with money received in a fundraising campaign, the charity is bound to use the donated funds in furtherance of its charter purposes.

2. Designated Divisions. Under the common law, if a charity receives a donation that is restricted to a particular program or division operated by the charity, it must use such donated funds to further the designated program. Under this rule, it has been held that a check made payable to a designated division of a charity (rather than to the charity itself) is a valid gift to the charity for use in the designated division.

Child Neglect

Abstract:

Child Neglect is the most frequently reported form of child maltreatment, constituting 47-65% of all reports. Child Neglect is associated with numerous long term effects. The incidence and warning signs of postpartum neglect will be reviewed. Risk factors for Failure to Thrive will be elaborated upon. Principles of intervention will be presented.

Learning Objectives

- To define forms of child neglect
- To delineate the incidence of child neglect nationally
- To identify the long term effects of child neglect
- To identify risk factors for failure to thrive
- To describe principles of intervention for neglect
- To list questions helpful in evaluating medical neglect.

Outline

I. Defining Child Neglect

II. Incidence of Child Neglect

III. Serious Long Term Effects

IV. Warning Signs of Postpartum Neglect

V. Failure to Thrive

VI. Principles of Intervention

VII. Medical Neglect.

Defining Child Neglect

Definition: failure to meet the child's needs in terms of:

- Food
- Clothing
- Shelter
- Medical Care
- Safekeeping
- Nurturance
- Education

Incidence of Child Neglect

The most frequently reported form of child maltreatment

- 47-65 % of reports
- 49% of substantiated reports (contrasted with 21 % for physical abuse, 11 % for sexual abuse)
- Only 6 % of research papers in Child Abuse and Neglect were on neglect ('93)
- Nearly half of child fatalities result from neglect

Serious Long Term Effects of Neglect

Failure to Thrive

Cognitive Disorders

Poor social skills

Increased criminal behaviors

Warning Signals of Postpartum Neglect

Substance Abuse

No Prenatal Care

Avoidance of Newborn

Fetal Alcohol Syndrome or Drug Withdrawal

Maternal Depression or Psychosis

Retarded Mother with no Help

Previous Child Abused or in Foster Care

Baby Born Outside of Hospital in Unusual Places

Failure to Thrive (FTT)

I. Definition:

A condition in which a child's growth deviates from the norms for the child's age and sex. The Proximate cause of this growth failure is malnutrition, either primary or secondary.

II. Risk Factors:

The most common and most pervasive risk factor is economic deprivation.

Family risk factors

Parental competence factors (Belsky)

- Parental resources, especially
- Early developmental experiences and personality
- Parental mood disturbances and/or adjustment problems affect the quality of the mother-child interaction and hence the outcomes of the children.

Child Characteristics, such as temperament, physical health and illness

- Lethargic listless children evoke less responsive behavior from parents.
- Biologic risk factors such as prematurity, low birth weight or early childhood illnesses may disrupt infant behavior, intensify family stress, engender early separation from the mother.
- Immature and abnormal oral-motor behavior, deficient signaling of needs during mealtimes may contribute.
- Once deficient growth and nutrition begin, irritability and inconsistent social responsiveness contributes to parents' inability to respond appropriately.

The family and social context of parent-child relations, including the parents' relationship to one another, family social networks and resources, employment, and community resources.

- Lower economic levels
- Higher family stress
- Less extended family supports

- Greater social isolation

III. Medical issues in the evaluation of failure to thrive

A. Familial factors

- Consanguinity
- Developmental delay
- Potentially growth-retarding familial illnesses such as cystic fibrosis, lactose intolerance
- Short height of both parents, patterns of familial short stature with the possibility of malnutrition or deprivation in their backgrounds
- Identification of psychosocial stressors, such as illness in a family member, serious mental illness, substance abuse, history of eating disorders or developmental impairment

B. Perinatal factors

- Prematurity or LBW
- Intrauterine growth retardation
- Prenatal exposure to legal psychoactive drugs (caffeine, nicotine, alcohol)
- Prenatal exposure to illegal psychoactive drugs (marijuana, cocaine, opiates)
- Exposure to STD's including HIV
- Exposure to other maternal infections during pregnancy

C. Postnatal medical factors

Almost all severe and chronic childhood illnesses can cause growth failure. The mechanisms for this growth failure may be due to enzymatic, endocrine, and metabolic reasons, but include nutritional and psychosocial reasons. A common myth is that growth during hospitalization separates the "organic" from the "non-organic" causes of FTT. The use of "organic" and "non-organic" as adjectives has been challenged since all FTT is a combination of factors leading to malnutrition and cannot be neatly separated on the basis of underlying organic system disease. Growth during hospitalization represents the child's complex needs being met by a team of highly trained medical personnel, and

lack of growth at home usually represents that these needs cannot be met by overwhelmed parents unless they are given large amounts of assistance. The medical conditions to be considered are countless, but the most common categories are those which interfere with caloric intake or retention. These include:

- Infections
- Gastrointestinal conditions (chronic non-specific diarrhea, gluten-sensitive enteropathy, gastro-esophageal reflux, Cystic fibrosis, and lactose intolerance)
- Parasitic infestations
- Urinary tract infection
- Renal tribular acidosis
- Untreated dental problems
- Large tonsils
- Recurring otitis media and sinusitis
- Human immunodeficiency virus
- Lead Poisoning

IV. Medical Management

A. Longitudinal, ongoing care

B. Nutritional evaluation and treatment

C. Anthropometric assessment, emphasizing accuracy of measurements and consistency of conditions of measurement, using growth charts to plot the measurements. Weight for age, the most powerful predictor of mortality, provides a composite measurement of past and present growth and nutrition reflecting both current and past insults. Depressed height for age is considered a manifestation of the cumulative effects of chronic malnutrition. In contrast, depressed weight for height indicates acute and recent nutritional deprivation. Children at highest risk are those who have depressed weight for height and height for age, representing acute malnutrition superimposed on a chronic problem.

D. Psychologic Assessment

A wide range of testing is used in the comprehensive assessment of failure to thrive (see table).Assessment of intellectual development will reveal the impairment of FTT on learning potential of children. Assessment of social and affective responsiveness will detail those areas in need of intervention. Assessment of the family environment using the Home Observation for Measurement of the Environment (home) Inventory will show the areas in which help can be given to the family.

V. Dispositional Decisions

A cooperative venture between an interdisciplinary team and a family which has a child with failure to thrive will most often result in a good outcome. In a small percentage of cases, the child will be found to be at risk because of the family's inability or unwillingness to persevere in the management regimen. Children with FTT who are referred to child protective agencies fall into two broad categories: those whose safety requires placement and those in less severe jeopardy whose caretakers require protective monitoring and support to comply with the treatment plan. When placement is carried out, the foster parents must be selected carefully, and assurance must be obtained that they can carry out the treatment plan.

Principles of Intervention

Assessment and treatment of contributors
- Depression
- Substance Abuse

Education about nutrition

Education about programs (WIC, etc)

Addressing medical conditions and access problems

Supportive therapy to mothers

Safety measures

Housing and Poverty

MEDICAL NEGLECT

I. Non-compliance with medical recommendations

A. Neglect only if actual or probable harm exists

Ex. A two year-old infant has not yet received her 15 month and 18 month immunizations and on two occasions follow-up appointments for ear infections were not kept. She has otherwise been in good health and appears well.

Ex. Donna is an 8 year-old with severe reactive airway disease. She has been hospitalized 16 times, including 5 admissions to the Pediatric Intensive Care Unit. She was seen last week and potent medicines were prescribed (steroids and beta agonists). She did not receive these medications and now is in significant respiratory distress in the Emergency Department.

B. Neglect only if significant benefit from treatment is probable.

Ex. Seven year-old Mike has twice received chemotherapy for a rhabdomyosarcoma. The prognosis is grim but there is a new experimental protocol. When this is raised, his parents refuse any further chemotherapy.

C. Neglect even if a single or rare event

Ex. A father is bathing his one year-old infant and the phone rings. He leaves the infant for about a minute and returns to find him face down in the water and not breathing. The child is rushed to the hospital and is successfully resuscitated and recovers.

D. Neglect even if a good reason or excuse exists

EX. An eight year-old girl with a congenital abnormality of her urinary tract has had repeated urinary tract infections with progressive damage to her kidneys. She has only received her prophylactic antibiotics intermittently. The girl's mother complains to the social worker about how much the medicine costs and her inability to pay for them.

II. Delay or failure to seek health care

A. The problem is not recognized

EX. John is s 6 month-old infant. His father is surprised when shown how John's growth has plateauxed. His description of how he mixed the formula reveals gross overdilution. He seemed to be "doing great" according to father.

B. The problem is recognized, but the parent thinks there is no treatment or solution for it.

EX. Larry is a 7 year-old who reveals his bedwetting during a routine visit. He describes his sister teasing him about it in front of other kids at school and now "everybody knows". His mother mentions that she stops him drinking liquids after 6 PM, but thought that was the only solution for it.

C. The problem is recognized, but the response is inappropriate

EX. Lee is a 6 week-old infant of Vietnamese parents with a 2-day history of fever and vomiting. He has several lesions on his chest resulting from coining.

D. The problem is recognized, but there is no access to care

EX. Melissa is a diabetic 11 year-old child admitted to the hospital in diabetic coma. She had received good care until recently when her mother lost her job and her health coverage. Mother states that "I knew there was no way I could pay those bills, and I didn't think they'd see Melissa".

E. The problem is recognized but the parents thought it would get better without medical care.

EX. Georgia is a 3 year-old girl brought to the emergency department with cellulitis of the calf. She had burned herself when she touched a curling iron last week. Her parents felt it was improving until "we noticed that red streak today".

III. Refusal to allow health care

A. Mistrust of the medical care system

Ex. John is an 11 year-old boy who has been sad and withdrawn over the last year since his parents separated. He is in the custody of his mother who reports that "John is OK". His school performance has deteriorated sharply and he has few friends. His mother refuses any recommendation for counseling or psychotherapy, saying "I don't believe in that stuff'.

B. Religious exemption

Christian Science Cases

1979 Michael Schram-Age 12-Peritonitis secondary to ruptured appendix

1986 Amy Hermanson -Age 7- Diabetes mellitus

1987 Ian Burdick -Age 15- Diabetes mellitus

1989 Ian Lundman -Age 11 - Diabetes mellitus

1979 Ronald Rowan -Age 11- Aspiration asphyxiation secondary to intractable vomiting

1981 Kris Ann Lewin -Age 13- Bone cancer

1984 Shaunty Walker Age 4- Meningitis

1988 Ashley King Age 12-Bone cancer

1986 Robyn Twitchell- Age 2- peritonitis secondary to volvulus

1984 Natalie Ripperger Age 8 months- meningitis

1992 Andrew Wantland -Age 12- Diabetes mellitus

Deaths in Charismatic Sects

Child Inc (Children's Healthcare Is A Legal Duty, Inc., Box 2604, Sioux City, IA 51106, Phone 712-948-3500) has tracked deaths of children after medical care was withheld on religious grounds in seventeen sects during the past decade. Causes of death include diarrhea, dehydration, blood poisoning, gangrene, diabetes, abdominal obstructions, a Wilm's tumor and many infectious diseases.

The press has reported more than a hundred preventable death in Faith Assembly since this church was founded in the mid-1970's. The great majority are children and mothers in childbirth. Faith Assembly children have died of treatable conditions in Iowa, Michigan, Wisconsin, Illinois, Missouri, Indiana, Ohio, Kentucky, Louisiana and other states.

Five babies died near Sioux Falls, S. Dakota, in unattended home deliveries advocated by End Time Ministries.

Roger and Dawn Winterbone, members of Faith Tabernacle Church in Philadelphia lost five children to pneumonia over a nine-year period, but reiterated their intention to withhold medical care from their surviving children.

Survivors:

Carolyn Hyatt - deaf from repeated bouts of otitis media due to withheld treatment with antibiotics. The state (California) allowed her parents to adopt two more children after she became deaf.

Paul Michener - Ohio - Four inch leg disparity secondary to untreated burn.

Kim Scheck - Maryland - Pulmonary scarring secondary to untreated infections as a child. Died at age 44 of congestive heart failure and cor pulmonale.

Sue McLauglin - North Dakota - Hypothyroidism diagnosed at birth- untreated - final height 4'2 inches. No information on mental development.

Duane Siegemnann - Illinois- Lost sight in injured eye that went untreated after the injury.
Vaccine-preventable diseases

3 youths in Christian Science families died in 1985 from measles in the Principia Schools for Christian Science in the St. Louis area. In 1994 Christian Science youth at Principia started a measles epidemic that spread to more than 200 children, including many outside the religious community.

1982- Debra Kupsch - age 9 - diptheria - died.

1972 - Epidemic of polio in Christian Science boarding school, leaving 11 children with paralysis.

1991- Philadelphia had 492 cases of measles and six deaths among children of the Faith Tabernacle Congregation and the First Century Gospel Church.

IV. Non-compliance for Other Reasons

Case Report

JB is a 5 1/2 year-old white boy who is the product of full-term pregnancy and with a birth weight of 5 pounds 5 ounces. There is no record of placental characteristics, but it is known that mother smoked during- pregnancy. The child was admitted to a local hospital because of continued failure to thrive, weighing 29 1/2 pounds on admission, and gaining to 31 pounds over the weekend.

The past medical history of this child indicates that he has been seen and evaluated at three major tertiary pediatric centers and at least one local hospital in which a Failure to Thrive team from one of the tertiary care centers has a regular clinic. The child has had a typical infection/malnutrition cycle because of otitis media. He has never been anemic. His psychological evaluations have shown him to be functioning at a 3 1/2 year-old level cognitively, has a speech acquisition delay, but socially he is engaging and plays well, except that he is disruptive in class at Headstart. The teachers at Headstart have reported that he complains that his mother doesn't feed him. He has no gross or fine motor problems. His height, weight and head circumference have all always been below the 5th percentile.

Mother has a long history of psychiatric disorder. She is said to have been very thin as a child. The diagnoses of manic-depressive disorder, and of character disorder have been raised. At one point mother sued a doctor for not having given JB his immunizations on time. She has said she wants to go "on Oprah" to talk about failure to thrive. She also has many somatic complaints. Father is only minimally involved.

What diagnostic possibilities should be considered?
What other questions should be asked?
Should a report to CPS be filed?
What management should occur?

Questions to Ask When Evaluating Medical Neglect

1. Is there risk of substantial harm as a result of the action (inaction)?

2. Is there evidence of substantial harm as a result of the action (inaction)?

3. Why did the parents (caretakers) not seek care or "comply" with the advice?

4. How did the medical system attempt to engage the caretakers (parents) in providing for the child's medical needs?

5. What are the potential benefits of medical care/advice?

6. What are the potential risks of medical care/advice?

7. What was the expected outcome (by the parents) without medical care?

8. What was the expected outcome (by the care providers) without medical care?

9. Were the parents aware of that expected outcome? Did they believe that to be the outcome?

10. Was the poor outcome related causally to the parental omission, or were there intervening factors involved in that outcome?

Examples of "Non-compliance"

1. The mother of three generally healthy middle-class children, one of whom has had numerous diagnoses of otitis media, alternately seeks "traditional" pediatric care with homeopathic care. She comes frequently to the pediatrician for "a look in the ears", asked for an opinion as to whether there is an infection, then checks with her homeopathic doctor (not a pediatrician) as to his opinion. She accepts a prescription for antibiotics from the pediatrician, but does not get it filled unless the child complains of pain or runs a fever. This approach to treatment went on for over a year. Finally she decided the child needed PE tubes and a T&A, a course of action recommended to her by the pediatrician over I year previously. Since the surgical procedure, the child has not had another ear infection. He has no hearing loss.

Is this neglect?

2. A 6 year old boy is diagnosed with acute lymphocytic leukemia at a large tertiary care teaching hospital with a distinguished reputation. When chemotherapy was explained to the parents, the father refused preferring to take the child out of the country for Laetrile treatment.

This was one of the counter-culture's "natural" remedies for leukemia at the time. The child underwent treatment with laetrile but after a period of time, the child succumbed to his disease.

Is this neglect?

3. The third pregnancy of a 30 year-old mother is delivered at home by a lay midwife. The mother's first 2 children had been born in a hospital uneventfully but some misuderstandings about the children's well-being had developed and the relations between the father and the hospital deteriorated after the last delivery and he decided that his wife should deliver at home.

The child developed neurological signs of stupor, vomiting and then coma at age 3 weeks. She was brought to the local hospital and transferred to a tertiary care center when a CT scan showed a subdural hematoma. There were no retinal hemorrhages and no other signs of bleeding. Bleeding and clotting studies were abnormal.

Father was very confrontational in the hospital, interfering with PICU personnel as they attempted to carry out the treatment of the child. As the history developed, it turned out that the lay midwife and other providers had not given the baby Vitamin K and the bleeding was attributed to this omission.

Was this the reason for the SDH?

If it was, is this medical neglect?

Was the father's insistence on home delivery a culpable offense?

4. The children of a prominent chiropracter in a small community brings his children to the local pediatrician, but refuses adamantly to have any immunizations for his children, based on his "scientific opinion" that the risks of immunization outweighed their benefits.

Is this neglect?

Should this family be reported to CPS because of medical neglect?

The Sequestered Ones: A Family With Five Children Isolated From Society.

The report reveals how child abuse and child neglect may not always adhere to traditional measures of evaluation. We describe in detail the physical, developmental, behavioral and social effects in five siblings, 11 months to 7 years of age, who for personal and religious reasons were conceived, delivered, and reared without any contact with the outside world.

Remarkable lacunae in social skills speech, interpersonal relationships, and motor development (including peculiar locomotion) were documented using photos and videotapes to establish baseline data with which future progress could be compared.

A facile prognosis for these children and their parents cannot be derived from present standards of medical and psychological assessment, nor is there any convenient method to assess what may have transpired without active intervention or what deleterious effects our intervention may have on the future development of these five children.

DF is a 21 month old Black female brought to the Emergency Room because of vomiting, drooling and dysphagia. Mother, a 27 year old single parent with an older daughter, said that she had had several girl friends to her apartment for a birthday party the night before. She had gotten up around 7:00 AM, fed DF and later in the morning both had gone back to bed for a nap. Mother awoke around 3:00 PM to find DF vomiting, very red in the face, and holding a cup of unknown brownish liquid with ashes in it left behind by one of the guests of the previous night.

On examination, the child's lips were swollen and red and the tongue showed numerous white lesions. The hard and soft palates had several similar white plaques. She had no respiratory distress and there were no findings on examination of the lungs. Initial laboratory data are normal (CBC, electrolytes, blood sugar, calcium phosphorus, BUN, creatinine, arterial blood gases, CBC and clotting studies). Toxic screen of blood and urine were sent. Examination under anesthesia showed burns of the lingual surface of the epiglottis, swollen arytenoids, normal vocal cords and a burn at the cricopharyngeal level of the esophagus, in addition to the already described burns of oral and pharyngeal surfaces. Later esophagoscopy showed strictures at this level and a gastrostomy was done for feeding.

The brown-liquid in the cup was sent for analysis and showed a strongly alkaline pH and was thought to be consistent with lye (sodium hydroxide). No other substances were detected.

The urine screen on DF was returned as (+) for cocaine.

Further social history from mother revealed that although she denied having knowledge of any drug use at the party, later she found that 2 of her guests were free-basing cocaine and the lye was the base they were using.

DF has been in the hospital for almost 2 months and is only now *slowly* gaining weight. Most of her intake is being delivered per gastrostomy tube. She will be placed in substitute care voluntarily by her mother, who continues to be depressed and guilty about what happened to her daughter.

Bibliography
Child Neglect

Belsky, J.: Child maltreatment: An ecological integration. Am. Psychol. 35:320, 1980.

Belsky, J., rovine, M., and Taylor, D.G.: The Pennsylvania Infant and Family Development Project: The origins of individual differences in infant-mother attachment: Maternal and infant contributions. Child Dev. 55:718, 1984.

Benedict, M., and White, R.: Selected perinatal factors and child abuse. Am. J. Public Health 75:780, 1985.

Crittenden, P.M.: Maltreated infants: Vulnerability and resilience. J.Child Psychol. Psychiatry 26:85,1985.

Drotar. D.: The family context of nonorganic failure to thrive. Am. J. Orthopsychiatry, 61:23, 1991.

Drotar. D., et al.: Early psychological outcomes in failure to thrive: Predictions from an interactional model. J. Clin. Child Psychology 14:105, 1985.

Dubowitz, H.: Pediatrician's role in preventing child maltreatment. Pediatr. Clin. North Am. 37:989,1990.

Egeland, B., Stroufe, L.A., and Erickson, M.: The developmental consequences of different patterns of maltreatment. Child Abuse Negl. 7:459, 1984.

Erikson, M.F., Egeland, B., and Pianta, R.: The effects of maltreatment on the development of young children. In Child Maltreatment. Edited by D. Cicchetti and V. Carlson. Cambridge, Cambridge University Press, 1989.

Galler, J.R.: The behavioral consequences of malnutrition in early life. In Nutrition and Behavior. New York, Plenum Press, 1984.

Garbarino, J., and Sherman, D.: High-risk neighborhoods and high-risk families: The human ecology of child maltreatment. Child Dev. 51:188, 1980.

Helfer, R.E.: The Neglect of our children. Pediatr. Clin. North am. 37:923, 1990.

Jaudes, P.K., and Diamond, L.J.: Neglect of chronically ill children. Am.J. Dis. Child. 140:655, 1986.

Kadushin, A.: Neglect in families. In Mental Illness, Delinquency, Addictions, and Neglect. Edited by E.W. Nunnally, C.S. Chilman, and F.M. Cox, Newbury Park,CA, Sage, 1988.

Olds, D.L., et al.: Preventing child abuse and neglect: A randomized trial of nurse home visitation. Pediatrics, 78:65, 1986.

Parker, S., Greer, S., and Zuckerman, B.: Double jeopardy: The impact of poverty on early child development. Pediatr. Clin. North Am., 35:1227, 1988.

Zuckerman, B.: Drug-exposed infants: Undestanding the medical risk. In Future of Children: Drug Exposed infants. Los Altos, CA, Center for the Future of Children, 1991.

Bibliography
Failure to Thrive

Altemeier, W.A., et al.: Prospective study of antecedents for non-organic failure to thrive. J.Pediatr. 106:360, 1985.

Barrett, D.E., and Frank, D.A.: The Effects of Undernutrition on Children's Behavior. New York, Gordon and Breach, 1987.

Belsky, J.: The determinants of parenting: A process model. Child Dev. 55:83, 1984.

Crittenden, P.M.: Nonorganic failure to thrive: Deprivation or distortion. Int. Ment. Health J. 8:51, 1987.

Drotar, D., Malone, C.A., and Negrav, J.: Environmentally based failure to thrive and children's intellectual development. J. Clin. Child Psychol. 10:236, 1980.

Drotar, D., et al.: Maternal interactional behavior with nonorganic failure to thrive infants: A case comparison study. Child Abuse Negl. 14:41, 1990.

Frank, D.A., and Zeisel, S.H.: Failure to thrive. Pediatr. Clin. North Am., 35:1187, 1988.

Kotelchuck, M.: Nonorganic failure to thrive: The status of interactional and environmental theories. In Advances in Behavioral Pediatrics. Vol. 1. Edited by B.W. Camp. Greenwich. Jai Press, 1980.

EVIDENCE RESPONSE TEAMS

Federal Bureau of Investigation

by Special Agent A. Todd McCall, Team Leader

Dallas Division

- Introduction
  - -Questions are welcome at any time.

- History of the Evidence Response Team (ERT) Concept.
  - Created by Los Angeles Division for 1984 Summer Olympics.
  - First test 1988 crash of Pacific Southwest Airlines commuter jet
  - Dallas Division ERT created in August, 1991
  - Mandated that all Divisions have ERT by Director Louis Freeh, October, 1994

- Major Case impact of ERT
  - World Trade Center Bombing, February, 1993
  - Branch Davidian Compound Fire, April, 1993
  - Oklahoma City Federal Building Bombing, April, 1995
  - Centennial Park Bombing, 1996 Summer Olympics, Atlanta
  - TWA Flight 800 Disaster, July, 1996
  - Middle East Bombings

- Focus of the ERT is NOT the so-called major case.
  - The purpose and primary focus is the local investigation.

- Child abduction/murders in which ERT has made an impact.
  - Ashley Estelle, Plano, Texas
  - Polly Klaas- near San Francisco, California
  - Lisa Rene, Arlington, Texas and Pine Bluff, Arkansas
  - Infant abduction/murder, Pottsburo, Texas
  - Amber Haggerman, Arlington, Texas
  - Sarah Patterson, Granbury, Texas

- What makes the ERT concept successful?
  - ALL VOLUNTEERS.
  - Team concept.
  - Training.

- Other benefits of the ERT.
  - Direct contact/connection with the National Center for the Analysis of Violent Crime.

ERT Presentation - Page 2

- Structure of an ERT and responsibilities of each member.
  - -A Team consists of up to eight members.
    - -Team Leader
    - Photographer/Photo Log Preparer
    - Sketch Preparer
    - Evidence Recorder/Custodian
    - Evidence Recovery Personnel
    - Specialists

  - The search as a process
    - Preparation
    - Approach Scene
    - Initiate Preliminary Survey
    - Evaluate Physical Evidence Possibilities
    - Prepare Narrative Description
    - Depict Scene Photographically
    - Prepare Sketch/Diagram of Scene
    - Conduct Detailed Search
    - Record and Collect Physical Evidence
    - Conduct Final Survey
    - Release Scene

  - ERT Documentation
    - Administrative Worksheet
    - Narrative Description
    - Photographic Log
    - Diagram/Sketch
    - Evidence Recovery Log
    - -Latent Print Lift Log

- Questions and Answers period

- Conclusions

BASIC ISSUES IN GRANTS

Grants seem to have an almost mystical_attraction to the non-profit world. Imagine people can give us large sums of money based upon what we write to them

• We are not required to face them and directly ask them for a contribution.

• We do not have to recruit armies of volunteers to conduct our tournaments, dances and thons

• We do not have to create and lease mailing lists, design catchy envelopes to grab attention, hassle with printers and designers and spend big bucks not knowing what the return mail will bring us.

• Instead, we can sit down, by ourselves, with our word processor and discuss that which we are most familiar with -our organization and its needs.

• Well intentioned board members believe that hundreds of thousands of dollars are there for the taking.

• Special event weary organizations look to grants as their salvation.

• And agencies dependent upon government funding look upon foundation and corporate grants as diversifying their fund raising.

On the other hand ,the experienced and overwhelmed grant seekers,

• Are frustrated by the onerous conditions ,insufficient funds, the short deadlines and the length of the proposal all a part of government grant making.

• They are confused by the unpredictable and often impenetrable world of the private foundation.

And they are dismayed by the intense competition, shifting priorities and small yield of corporate grants.

What is the reality? Some where between these extremes. What then is the upside of grants- the benefits. What is the downside of grants- the costs.

The Good News:

• the payoff can be tremendous hundreds of thousands of dollars- and yes even small organizations can get big grants

• costs, when compared to other types of fund raising, are very low

• there is no dependence on volunteer labor as in special events or people of affluence or influence as in major gifts- just you and the typewriter

• for the successful grant writer there is no greater sense of personal/professional achievement

The Bad News

• if you are indiscriminate in your applications the turn down rate will be very high

• you lose some control over your destiny as you meet the priorities of funding sources

• if your need is for basic operations of your organization grants may not be your best option

• commercial information sources create a false sense of confidence - that you can rely upon them as an exclusive source of information

It is my hope that I can provide, to you, today, a balanced evaluation of grants. Some practical advice that can help demystify the process.

Time constraints preclude an in-depth discussion on all the facets of grants. Therefore ,rather than limit this discussion to only a single aspect of this vast topic, I think the greatest utility will be to provide a series of quick hints on several topics

Caveat can not generalize easily because of great variety of grant makers.

- Federal
- State
- Corporate
- National foundations
- Community foundations
- Regional with medium staffs
- Small with small staff

- Boutique
- Small with no staff largest # of foundations

General Considerations

1. For operational support we are better off with major gifts from individual donors

- individuals provide 86% of donations
- their gifts are generally unrestricted

2. In general grant makers prefer new projects rather than to provide operational support

3. For capital needs use a campaign

4. For PR combined with fund raising use special events

5. If we seek project support many grant makers (small and corporations) dollar range of giving will not be sufficient

6. Many intimidated by large foundations-but best advice is to maximize return it takes no more time to write 50,000 than 5,000 or 500,000 than 50,000

Accurate Information

- Federal Register
- State agency mailing lists
- Directories
- Grantor publications

1. If a foundation has no staff or written guidelines they are not geared to review unsolicited proposals we must treat them as a major donor and cultivate the decision maker

2. Therefore, computer searches or directories indiscriminately list grant makers which really are major donor prospects

3. Even if the foundation has a staff who makes the decision the board or staff

4. Government grant makers often have hidden or unclear agendas

5. Before you send in a proposal read and meet with or at least talk on phone to grantor(even government)

- if won't meet what are your chances
- test ideas
- get current priorities
- won't waste their and your time
- establishes person to person relationship
- many provide technical assistance
- visit in pairs

The Right Approach

1. Do we write a proposal and find the right source or find a source and write the right proposal?

- it is their money and they set the rules
- each has a very different philosophy
- what is their view of state of art

2. Innovative proposals need to use the language of demonstration grants

3. Corporations give to further some corporate purpose such as generating favorable publicity or cultivating a specific demographic group. What do they consider "enlightened self interest" at this moment

4. Make certain your request in $ falls within their range

Format and Writing

1. Cover letter should be brief, unless proposal is a letter

2. Provide only what they want if they are interested they will ask for a fuller proposal or explanations

3. It is the great idea that will sell a proposal even from a small agency The format you use highlights the idea.

4. Government grants tell you what format and style is almost irrelevant

5. Write to your audience. There are many grant makers and they differ. Use different styles depending on their attributes:

- sophistication
- technical expertise
- time available to review

Organizational Credibility

1. Personal contact single most effective way to establish credibility

2. Letters are perceived as self serving and are not effective unless grant requires proof of support

3. Use academics for evaluation and project design include their resumes

4. Cite investment (prior grants) of others

5 .Cooperation with another agency is both creative and enhances credibility

6. Pilot ploy, a narrow window between operational support and a project to fully develop that which you are doing on a pilot basis

- disguises operational needs
- shows some expertise

Evaluation

1. Most projects can be evaluated on basis of two questions:

- did it go up or down
- were they happy

2. To avoid confusion of project objectives and methods ask can we measure it by one of the above, if yes we have an objective if no it is a method

Budget

1. Do the numbers add up

2. If matching required do you show it through existing expenses rather than new dollars

3. Have you shown organization's matching to demonstrate commitment

4. Is your argument to continue at end of project credible and does budget justify it:

- revenue generator
- fund raising
- self-liquidating

5. Does the grantor permit carry over or budget shifting if not you need a tight budget

6. Are you showing direct and indirect expenses correctly

This workshop will present as a case study the Polly Klaas kidnap and murder case. Polly Klaas, a twelve-year-old, was kidnaped from the bedroom of her home where she was playing with two of her friends as her mother and sister slept in an adjoining bedroom by Richard Allen Davis, a paroled career criminal.

The investigation involved a partnership of federal, state and local agencies. Following a grueling two-month investigation, Davis was identified as the primary suspect. Davis ultimately made damaging statements and led investigators to the location where he had secreted her body.

Davis' arrest did not end the cooperative investigative efforts. The Federal Bureau of Investigation aided the Sonoma County District Attorney's Office in preparation of trial exhibits while investigators continued to track leads, locate witnesses, and account for Davis' activities since his release from prison.

This presentation will cover the investigative steps which led to the arrest of Davis, subsequent follow-up investigative activities, trial preparation, the trial and the lessons learned during the investigation.

The Use of Search Warrants to Corroborate the Victim's Statement in Child Abuse and Sexual Exploitation Investigations.

Presented By

Sergeant Byron A. Fassett
Child Exploitation Squad
Youth and Family Crimes Division
Dallas Police Department
Dallas, TX 75201
(214) 670-4978
FAX (214 670-4982

Most would agree that crimes against children are some of the most difficult cases encountered by investigators for a multitude of reasons. They routinely have no real physical or medical evidence, no witnesses, and a victim who may be viewed as less credible than the adult defendant. The end result of this is a case, if it goes to court, that ends up as a "swearing match" between the victim and the suspect. In some cases this can be avoided by the investigator through the proper use of search warrants to corroborate the victim's statement and enhance the investigation for prosecution. Search warrants are investigative tools that are routinely under-utilized in child abuse investigations.

I. Role of Search Warrants in Criminal Investigations.

II. Role of the Search Warrant in Child Physical and Sexual Abuse Investigations.

III. Practical Uses of Search Warrants in Child Abuse and Sexual Exploitation Investigations.

IV. Practical Considerations for Executing the Search Warrant

V. Writing the Probable Cause Affidavit (Narrative)

VI. Useful Hints on Writing Probable Cause Affidavits

a. Determine what evidence you are looking for in chronological order of the event and list as items to be seized. Use this as a outline for the narrative. Write the facts as they occurred in chronological order.

b. Each item listed to be seized should be justified in the narrative.

c. Do not summarize excessively.

d. Avoid excessive abbreviations and police jargon.

e. If you state such and such happened, state how or why you know it happened.

f. Do not state conclusions without giving the reasons or facts leading to that conclusion.

g. If you mention a person's name, state the person's role in the offense or their relationship to the suspect (victim, owner, friend.)

h. Tell the magistrate about your training and experience in child abuse investigations.

Useful Hints on Writing Probable Cause Affidavits (CONT.)

I. Tell how the suspect was identified. Specify:

1. photo line-up;

2. fingerprint identification;

4. eyewitness who knows suspect by virtue of being: relative, neighbor, employer;

J. Establish credibility of witnesses and informants mentioned in probable cause affidavit

K. Do not use narrative from prosecution report as executed search warrant affidavits are public record, prosecution reports are not.

Head Trauma in Child Abuse

Abstract

There is more mortality and morbidity from non-accidental head trauma than from any other single cause of child physical abuse. Intracranial injury is found in 60% of inflicted injury deaths (Weston). Short falls (under four feet) lead to no serious or life-threatening injuries. (Helfer, Hobbs, Billmire, Kravitz). Seventy percent of children with abusive head injuries also have skeletal injuries. Shaken baby syndrome (SBS) and shaken impact syndrome are specific entities with characteristic signs, symptoms, and physical findings and abnormalities on imaging studies. Head trauma in children, therefore, warrants special attention. Causality must be carefully determined.

Learning Objectives

- To differentiate abusive from non-abusive head injuries
- To identify the types of scalp injuries associated with abuse
- To differentiate simple from complex fractures of the calvarium
- To identify mechanisms of intracranial bleeding
- To define and describe Shaken Baby/Shaken Impact Syndrome
- To differentiate abusive and non-abusive mechanisms of retinal hemorrhages and their significance
- To compare CT and MRI for use in diagnosing head injuries

Outline

I. Introduction

II. The Scalp

III. Fractures of the Calvarium

IV. Intracranial Bleeding

V. Shaken Baby/ Shaken Impact/ Whiplash Syndromes

VI. Shaken Impact Postulation

VII. Retinal Hemorrhages

- Incidence
- Differential diagnosis
- Mechanisms of production
- Significance

VIII. Imaging Modalities- Advantages and disadvantages

IX. Bibliography

Introduction:
Head Injuries

More fatalities and long term morbidity are due to abusive head injury than from any other form of physical abuse. The types of abusive head injuries range from asymptomatic swelling through mild to moderate bruising, skull fracture, to intracranial bleeding and diffuse axonal shearing injury and brain swelling resulting in stupor, coma and death.
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.

Data Collection

While a seriously head-injured child is being evaluated and treated medically, it is crucial for a detailed, analytical- but not challenging or accusatory- history to be obtained from the caretakers. The person collecting the history should ideally be someone with experience in child abuse cases and one who does not have immediate responsibility for the medical treatment required by the child. it is the rule that abusing parents will tell a misleading story about how the "accident" happened and are sometimes quite inventive in describing the event. Thus, the skill of interviewing becomes an important foundation on which to build the diagnostic formulation. Gentle probing, with inquiries and request for clarification on questionable portions of the history- sometimes called "the Columbo approach" often will elucidate the mechanism of injury and show discrepancies in the history.

The history of the pregnancy, labor and delivery, neonatal course, as well as a history of family diseases is important, with particular attention to bleeding and clotting disorders, neurological diseases, metabolic and bone disease, or other genetic conditions of the family. This comprehensive evaluation will save returning to the caretakers for missing data as the case ages. The past medical history of the child, including previous injuries and serious illnesses or hospitalizations, along with a review of systems should be obtained. Exploration of the social milieu with attention to the living arrangements and the relationships of household members should be done.

The physical examination of the child with a head injury runs the risk of ignoring less urgently compromised organ systems. Bleeding visceral organs are the most glaring and potentially disastrous omissions, but overlooking cutaneous injuries can deprive the diagnostician of important clinical data because of the fleeting nature of these injuries. Likewise, inspection of the oral cavity looking for intraoral lesions is important as is a search for hidden head lesions under the hair. The neck should be carefully inspected for signs of injury (strangulation, hand or finger bruising). The presence of bruises on the back, thighs, or in the perineum should also be noted. Photodocumentation of such injuries is highly desirable.

The examination of the fundi is of utmost importance. This should be carried out ideally by pupillary dilation and indirect ophthalmoscopic inspection, but in lieu of that capability, by direct opthalmoscopy. Although retinal hemorrhages are the most common finding in child abuse, other lesions may also be seen. These include retinal detachment, optic nerve injury and cupping of the optic nerve secondary to raised intracranial pressure. Although retinal hemorrhages are not pathognomonic of inflicted head trauma, they are present in a high percentage of abuse cases and not present in most accidental head trauma, and are seldom seen in children who had undergone cardiopulmonary resuscitation.

Laboratory Studies

Children with head trauma severe enough to be admitted to the hospital should also have laboratory studies to support diagnoses of associated trauma in other organ systems, to anticipate hematologic and biochemical alterations sometimes attendant to head trauma, and also to seek for the manifestations of their neurological status. These studies are displayed in Table I

Table I

CBC with morphology, serial hematocrits

Serum electrolytes, BUN, creatinine, serum and urine osmolality

Urinalysis

Liver function studies (AST, ALT, alkaline phosphatase)

Serum and urinary amylase

Creatine phosphokinase (CPK)

Cultures of blood, urine, cerebrospinal fluid (if safe to perform lumbar puncture)

PT, PTT, platelet count

Stool for blood

Arterial blood gases

Imaging Studies

In most instances of moderate to severe head injury, the first imaging modality should be CT scanning without contrast since it is readily available in most hospitals and can be performed safely with life support systems operating during the procedure. Bone windows should be employed along with the standard scan. Plain radiographs of the skull will usually show existing skull fractures better than CT. Magnetic resonance imaging (MRI) is ordinarily used as a confirmatory test rather than an initial one due to the longer scan times and need for life support, but MR gives superior detail in showing parenchymal changes and smaller subdural hemotomata.

CT scans of the abdominal viscera are valuable when liver function studies show elevation of the transaminases and/or there is reason to believe hepatic damage is present. Likewise, if splenic or renal tearing is suspected, CT will delineate these injuries(See Abdominal Trauma, below).

Skeletal surveys are recommended in serious head trauma in children under the age of 3 years since the diagnosis of abuse may be made or supported if unsuspected or occult traumatic injuries are found in other parts of the appendicular skeleton. Such accompanying skeletal fractures are seen in roughly half of the cases of abusive head injury. Posterior rib fractures are present in some cases of shaken infants and can be demonstrated either with bone scintigraphy for fresh fractures or with follow-up thoracic films in 10- 14 days to see callus formation at the site of these fractures.

The types of injuries in serious abusive head injury include skull fractures, subdural or subarachnoid bleeding, cerebral edema, diffuse axonal shearing injuries, parenchymal tears and contusions, and injuries to the cervical spinal cord. The shaken baby syndrome (shaken-impact syndrome) occurs in babies, usually under one year of age but described in children as old as 2 years of age, and consists of violent shaking and/or shaking plus impact. Recent data have supported the concept that shaking and impact by throwing the child against a surface and resultant deceleration are the responsible forces producing the subdural hematoma, diffuse axonal shearing and consequent cerebral edema leading to raised intracranial pressure. Whether shaking alone or shaking plus impact are required to cause the damage is being debated, but the clinical picture is one of neurological devastation resulting in death in 27% and long term neurological morbidity in the majority (57-65%) of the survivors.

The Scalp

Injuries to the scalp include ecchymoses, lacerations, abrasions, subgaleal hematomas, and alopecia secondary to hair-pulling.

Fractures of the Calvarium

Simple:

- Linear -- not crossing suture lines parietal (vast majority) less than 2 mm separation

Complex:

- Linear -- crossing suture lines
- Branching or stellate
- Comminuted (isolated fragments of bone), depressed (comminuted with bone fragment impinging on the brain), compound (overlying laceration), diastatic

Intracranial Bleeding

Mechanisms:

Shearing of bridging veins connecting cerebral surface and dural sinuses. Once bleeding begins, accumulating volume of blood tears other veins, accompanied by underlying parenchymal edema and bleeding into brain matter.

Shaken Baby / Shaken Impact Syndrome

Age Range:

- in older literature, birth to four years
- in recent literature, one month to 24 months
- mean age: 5.8 to 7.8 months

Signs and Symptoms:

- respiratory distress
- irritability
- lethargy
- hypotonia
- seizures
- coma
- vomiting, poor feeding
- hypothermia

Shaken Impact Postulation (Duhaime)

- 48 cases of SBS were studied
- Of these 48 cases, 62.5% had clinical evidence of blunt trauma to the head (bruising, skull fracture)
- All 13 fatal cases showed postmortem evidence of blunt trauma

Using a model with a strain gauge measuring forces during shaking, Duhaime was unable to demonstrate enough force from shaking to account for the extent of damage seen in clinical cases of SBS. She concluded that shaking alone was not sufficient to cause the extensive damage and postulated that this damage is caused by

shaking plus impact of the head against a surface. The deceleration of the brain impacting on the inner surface of the skull was therefore thought to be responsible for the variety of brain lesions seen in this condition.

In 1992, Duhaime reported on 100 children under 2 years of age studied prospectively for head injury. The age range was 11 days to 2 years, with the mean age being 9.0 months. The study consisted of a description of the elements of the accident or injury. This description included the when and the how, the distances, surfaces and objects involved in the event, the immediate and delayed reactions of the victim, and how the victim was handled after the accident. The evaluation consisted of a complete physical examination as well as a radiological evaluation, which involved:

- - skull radiographs;
- - CT or MRI ;
- - skeletal survey, selected on clinical or historical grounds;
- - bone scans when skeletal surveys were equivocal.

In addition, funduscopic exams and a social evaluation screening were performed.

Results of this study:

Mechanism of Injury	Number
Falls	73
<4 feet	34
>4 feet	21
Downstairs	10
Downstairs in walker	8
Motor Vehicle Accidents	9
Impact by moving object	2
Assault (admitted)	2
No history	14
Total	100

Injury Types: Concussion

Soft tissue injury only	32
Skull Fracture	43
Epidural Hematoma	3
Intradural Hemorrhage	22

In the same study, there were 24 children in whom inflicted injuries were identified. The histories in these cases fell into three categories:

1. fall from less than 4 feet
2. admission of assault
3. no history at all.

The types of injuries in these 24 children were as follows:

craniofacial soft tissue	2
linear or depressed skull fracture	7
multiple, basilar, stellate fractures	2
subdural hemorrhage	13
retinal hemorrhage	9
positive skeletal survey	9
deaths	3

Duhaime's conclusions:

1. Short falls rarely, if ever, cause significant brain injury.
2. Greater biomechanical forces lead to more significant injuries.
3. Subdural hematomas are uncommon as the result of accidental injuries.
4. Subdural and subarachnoid bleeding are common in inflicted injury.
5. Retinal hemorrhages are overwhelmingly more common in inflicted injuries (9 out of 10).

Retinal Hemorrhages

- - Occurs in 75% of abusive head trauma.
- -84% of all retinal hemorrhages occur as a result of abuse.
- -Occur exclusively in children under 4 years of age.
- -Seizures often are seen in association with retinal hemorrhages.
- -Retinal hemorrhages are venous in origin.

Differential diagnosis of retinal hemorrhages:

- Vaginal delivery
    - * occur in 40% of children delivered vaginally -
    - * these resolve usually within 10 days with no residuals -
    - * mechanism of injury thought to be thoracic squeezing and change in intracerebral pressure producing sparse numbers of foci of bleeding
- Bleeding disorders
- Vasculopathies – arteriovenous malformations (A.V.M.).
- Increased intracranial pressure
- Meningitis
- Cardiopulmonary resuscitation (rarely)
- Accidental head trauma (rarely)

Possible Mechanisms of Retinal Hemorrhage

- Increased pressure on chest causing increased hemodynamic pressure
    - (Purtscher's retinopathy)
- Increased ICP due to subdural / subarchnoid bleeding
- Central vein obstruction secondary to swelling of the optic nerve
- Internal splitting of retina (traumatic retinoschisis) caused by tractional forces transmitted from the vitreous humor which oscillates violently as the head is shaken

Retinal Hemorrhages and Accidental Trauma

Fifty children under 20 months of age were studied (Alario et al.) and the following mechanisms were described:

- 26 fell down stairs (52%)
- 15 fell from heights greater than 4 feet (30%)
- 4 fell from heights greater than 10 feet (8%)
- 2 impacts from moving objects (4%)
- 3 unrestrained MVA (6%)

Findings:

- 10 had isolated neurologic abnormalities
- 14 had uncomplicated skull fractures
- 6 had intracranial bleeding
- none had retinal hemorrhages

Comparison of CT and MRI in Head Injuries

Advantages of CT:

1. delineates SAH better than
2. better imaging of calvarial injuries
3. ease of performance in unstable patients

Advantages of MRI:

1. better in subacute and chronic cases
2. better for deep cerebral injuries
3. able to determine age of extracerebral fluid
4. will detect smaller subdural hematomas

Bibliography

Alexander RC, Sato Y, Smith W et at. Incidence of impact trauma with cranial injuries ascribed to shaking. Amer J Dis Child 1990; 144:724-726.

Aoki N, Extracerebral fluid collections in infancy: Role of magnetic resonance imaging in differentiation between subdural effusion and subarachnoid space enlargement. J Neurosurg, 1994; 81:20

Billmire ME, Myers PA. Serious head injury in infants: accident or abuse? Pediatrics 1985;75:340-42.

Budenz DL, et al. Ocular and optic nerve hemorrhages in abused infants with intracranial injuries. Ophthalmology, 1994;101:559

Caffey J. On the theory and practice of shaking infants. Amer J Dis Child 1972; 124:161-169.

Caffey J. The whiplash shaken infant syndrome: Manual shaking by the extremities with whiplash-induced intracranial and intraocular breedings, linked with residual permanent brain damage and mental retardation. Pediatrics 1974;54:396-403.

Chiaveillo C, Christoph R, Bond GR. Stairway-related injuries in children. Pediatrics, 1994;94:679

dos Santos A, Pindaro, J et al. Extradural hematomas in children. Pediatrics Neurosurg, 1994;21:50

Duhaime AC et al. The shaken baby syndrome. A clinical, pathological and biomechanical study. J Neurosurg 1987;66-.409-415.

Duhaime AC, et al, Crush injuries to the head in children. Neurosurgery, 1995; 37: 401

Duhaime AC et al. Head injury in very young children: Mechanisms, injury types and ophthamological findings in 100 hospitalized patients younger than 2 years of age. Pediatrics 1992;90: 179-185.

Duhaime AC et at: The shaken baby syndrome: A misnomer? J Pediatr Neurosci 1988;4: 66-86.

Elner SG et al. Ocular and associated systemic findings in suspected child abuse: a necropsy study. Arch Ophthalmol 1990;108:1094-1101.

Fisher H, Allasio D. Permanently damaged: Long-term follow-up of shaken babies. Clin Pediatr, 33:696

Gilles E. Abusive head injury in children: A review. Western State University Law Review. 1993;20:335-378.

Gilliland MGF, Luckenbach MW, Are retinal hemorrhages found after resuscitation aftempts? A study of the eyes of 169 children. Am J Forensic Med Pathol. 1993-. 14:187

Gilliland MGF, Luchenbach M. Are retinal hemorrhages found after resuscitation attempts? A study of the eyes of 169 children. Amer J Forens Med Pathol 1993; 14:187-192.

Goetting MG and Sowa B. Retinal hemorrhage after cardiopulmonary resuscitation in children: an etiologic reevaluation. Pediatrics 1990; 85:585-588.

Guthkelch AN. Infantile subdural hematoma and its relationship to whiplash injuries. BMJ 1971;2:430-431.

Hahn YW, Taimaondi AJ, McLone DG et al. Traumatic mechanisms of head injury in child abuse. Childs Brain 1983;10:229-241.

Hiss J, Kahama T, The medicolegal implications of bilateral cranial fractures in infants. J Trauma, 1995; 38-32

Johnson DL, Braun D and Friendly D. Accidental head trauma and retinal hemorrhage. Neurosurgery 1993;33:231-235.

Kanter RD. Retinal hemorrhage after cardiopulmonary resuscitation or child abuse? J Pediatr 1986; 108:430-432.

Levitt CJ, Smith WL and Alexander RC. Abusive Head Trauma. In Reece RM (Ed). Child Abuse: Medical Diagnosis and Management. 1994; Malvern, Pa. Lea and Febiger.

Ludwig S and Warman M. Shaken baby syndrome. A review of 20 cases. Ann Emerg Med 1984;13:104-107.

Lyons TJ, Oates RK. Falling out of bed: A relatively benign occurrence. Pediatrics, 1993; 92:125 rich AM et al, Head trauma in children with congenital coagulation disorders. J Pediatrics Surg, 1994; 29:28

Merten DF, Osborne DRS, Radkowski MA and Leonidas JC. Craniocerebral trauma in the child abuse syndrome: radiological observations. Pediatr Radiolog 1984; 14:272-277.

Meservy CJ, Towbin R, McLaurin RL et al: Radiographic characteristics of skull fractures resulting from child abuse. AJR 1987; 149:173-175.

Munger CE, Peiffer RL, Bouldin TW et al. Ocular and associated neuropathologic observations in suspected whiplash shaken infant syndrome. Am J Forens Med Path 1993; 14:193-200.

Munger CE, et al. Ocular and associated neuropathologic observations in suspected whiplash shaken infant syndrome. Am J Forensi Med Pathol, 1993; 14:193

Nashelsky MB, Dix JD. The time interval betweer, lethal shaking and the onset of symptoms: A review of the shaken baby syndrome literature. Am J Forens Med Pathol, 1995-, 1 6:154

Ommaya AK. Whiplash injury and brain damage: An experimental study. J Amer Med Assoc 1968;204:285.

O'Sullivan MG et al, Acute subdural haematoma secondary to ruptured intracranial aneurysm: Diagnosis and management. Br J Neurosurg, 1994;8:439

Ramundo M, et al, Clinical predictors of computed tomography abnormalities following pediatric brain injury. Pediatr Emerg Care, 1995; 1 1:1

Reiber GD, How far must children fall to sustain fatal head injury: Report of cases and review of the literature. Am J Forensic Med Pathol, 1993;14:20

Rosenberg N et al. Retinal hemorrhage. Pediatr Emerg Care, 1994; 10:303

Sato YS, Yuh WTC, Smith WL et al. Head injury in child abuse: Evaluation with MR imaging. Pediatr Radiology 1989;173:653-657.

Smith WL et al. Magnetic resonance imaging evaluation with neonates with retinal hemorrhages. Pediatrics 1992;89:332.

Thibault LE and Gennarelli TA. Biomechanics of diffuse brain injuries. In: Proceedings of the Fourth Experimental Safety Vehicle Conference. New York. American Association of Automotive Engineers, 1985.

Vance BM. Ruptures of surface blood vessels on cerebral hemispheres as a cause of subdural hemorrhage. Arch Surg 1950;61:992-1006.

Wilkinson WS, Han DP, Rappley MD et al: Retinal hemorrhage predicts neurologic injury in the shaken baby syndrome. Arch Ophthalmol 1989; 107:1472-1474.

Yamashima T, Friede RL. Why do bridging veins rupture into the virtual subdural space? J Neurol Neurosurg Psychiatry 1984;47: 121-127.

FORENSIC EVALUATION WHEN SEXUAL ABUSE IS SUSPECTED
1998 Crimes Against Children Conference
Dallas, TX
August 18, 1998

Presented by:
Connie Nicholas Carnes, MS, LPC
Charles Wilson, MSSW
National Children's Advocacy Center, Huntsville, AL

****

AGENDA

1:00-2:30 **Children's reluctance to disclose**
The Controversies and Research Basis, Continuum of Interventions
Referral Criteria, Protocol Design
Interviewing Non-Offending Parents
Developmental Assessment
Social and Behavioral Assessment

2:45-4:30 **Touching knowledge and body parts vocabulary**
Abuse focused, non-leading interviewing
Cognitive Interviewing/Narrative Elaboration
Evaluating the Disclosure for credibility
Pilot Research Project outcomes

****

Overview of the training---The Forensic Evaluation process

1. Children's reluctance to disclose
2. Continuum of interventions with sexually abused children
   - Forensic Interview
   - Forensic Evaluation
   - Forensically Sensitive Therapy
   - Traditional Therapy
3. Purposes of Forensic Evaluation
   - Determine if abuse occurred and by whom
   - Gather forensically sound facts for the use of CPS, Law
   - Enforcement and prosecution
   - Allow child to disclose over time in a non-threatening environment
   - Gather information on the child's psychosocial functioning in order to make treatment recommendations and to form professional opinions on the reliability of the disclosure
4. Why are children referred for Forensic Evaluation?
   - No disclosure, but the presence of behavioral or other indicators strongly suggest victimization
   - Full nature and extent of abuse not disclosed at initial investigative interview
   - Information gained in initial investigative interview needs further clarification

5. NCAC Forensic Evaluation Protocol
    - NOP interview
    - Developmental Assessment and Rapport Building
    - Social and behavioral assessment
    - Touching knowledge, Body Parts terminology
    - Abuse focused/non-leading questions or Cognitive interviewing (Depending on age)
    - Body Safety, prevention education, closure

Understanding and Interviewing Non-offending Parents

1. The Non-Offending Parent's role in the investigation and in the child's reactions
2. Common Reactions of Non-offending parents
    - Disbelief or rationalization
    - Anger and/or rejection of the child
    - Rejection by the child
    - Ambivalence toward or support of the accused parent or family member
    - Concern about economic considerations
    - Denial and confusion with their own issues
3. Building a Bridge to the Non-offending parent
    - Anticipate her experience before you see her
    - Remember: She is in shock
    - Imagine yourself in her shoes
    - Don't blame her
    - Normalize her responses
    - Respond selectively and purposefully to what she says
    - Support and acknowledge her strengths
    - Acknowledge her divided loyalties
    - Ask her to tell you what it would mean to her if it were true

Developmental Assessment

1. The components of a developmental assessment
2. Tools to obtain the information you need regarding the child's developmental level

Social and behavioral assessment

1. The Achenbach and Friedrich scales
2. The components of social and behavioral assessment.
    - The child's view of their family/support system
    - The child's self esteem and self understanding
    - The child's understanding of and management of feelings.
    - About secrets and rules
3. Tools for use in social and behavioral assessment.

Assessment of touching knowledge and body parts terminology

1. Assessent of touching knowledge
2. The Touch Continuum
    - --Developed by Sandra Hewitt
    - --informal clinically based abuse screening technique

3. Body parts inventory
4. Use of anatomically detailed dolls
5. APSAC guidelines
6. Standardized and free style drawings

Abuse focused, non-leading interviewing of children

1. Reasons for using abuse focused questions
   - There are many topics you need to learn about
   - Free recall memory is not well developed in young children, you need to provide the retrieval cues
   - Children from abusive families may not perceive maltreatment as out of the ordinary—unless you ask specifically
   - Children are reluctant to talk about abuse due to coercion not to tell, attachment to the abuser or general lack of trust
2. Preparing the child for a series of questions
   - Tell them you will be asking lots of questions
   - Be sensitive to the child's vulnerability to coercion
   - Give explicit permission to the child to say they do not understand you or correct you, and to say they do not know
   - Provide the "rules" for the interview setting

Cognitive Interviewing and Narrative Elaboration

1. The Cognitive Interview Procedure
2. The Narrative Elaboration Procedure

Body Safety and Prevention activities

1. Rationale for using these activities
2. Tools to use for education on Body Safety and Prevention

Evaluating the Disclosure for credibility

1. Evaluating the credibility of a child's statements, behaviors and emotions during a Forensic Evaluation

Reporting the results

Pending Research

National Children's Advocacy Center

Protocol for Forensic Evaluation

The NCAC originated in 1985 in Huntsville, Alabama. The Madison County Multidisciplinary Team in Huntsville reviews and decides cases involving child sexual abuse and severe physical abuse. Evidence is collected through medical examinations by physicians, investigative interviews by law enforcement and CPS, and related investigative work by all members of the team. In most cases, these efforts yield adequate information for decision making on prosecution and child protective issues. In 26% of the cases, however, something more is needed by the team. In these cases, the child was unable or unwilling to freely disclose abuse during the investigative interview; in these cases, there is a need for extended Forensic Evaluation of the child.

Thus, forensic evaluation is conducted with a specific subset of children in which initial investigative results are unclear. Elliott and Briere (1994) also identified this unique subset of children. In a study examining the outcomes using their forensic evaluation model, they placed children into categories described as abused, nonabused and "unclear abuse history." Their evaluation consisted of at least one child interview, a medical examination, an interview with the non-offending caregiver, and an assessment of the child's distress using the Briere Trauma Symptom Checklist for Children. Elliott and Briere recommended a more extended series of interviews in the absence of external evidence and caution that cursory interviews with children may increase the likelihood of false negatives by truncating a potentially more complete and valid disclosure. Other research also supports a more comprehensive evaluation. Faller (1996) notes that a more comprehensive model is not subject to the criticism, especially in court, of the simpler models, and that it allows the evaluator to access multiple sources of data for better decision making.

Part of the underlying rationale of extended forensic evaluation for this subset of children is the research that shows that children who have been sexually abused are often reluctant to disclose the abuse to investigators due to intimidation, fear, shame or guilt. Some children require more time and trust in the interviewer to feel comfortable with fully disclosing sensitive facts about abuse.

The children in this particular subset are referred by the multidisciplinary team to the NCAC intervention program for forensic evaluation when: 1) the child does not disclose abuse to investigators, but exhibits behaviors or other indicators strongly suggestive of victimization, 2) the extent or nature of abuse is not disclosed by the child during the initial investigative interview by Law Enforcement/DHR, or 3) when the information gathered in the initial investigative interview needs further clarification. The purposes of the Forensic Evaluation are:

- To determine the likelihood of whether or not the child has been abused, and to identify suspected perpetrators.
- To gather forensically sound facts necessary for child protection and law enforcement officials to understand what, if anything, has happened.
- To allow the child to disclose over time in a non-threatening environment and to assess the extent and nature of the alleged abuse.
- To gather information regarding the child's social and behavioral functioning in order to make treatment recommendations.

Prior to beginning the evaluation, information on the case from Law Enforcement, DHR, and Medical staff is collected and reviewed. Following is an outline of the procedure used in conducting forensic evaluations. Each session will be the subject matter of subsequent chapters in this manual.

Session 1: The first interview is conducted with the primary caregiver that has not been alleged to have abused the child (to be called non-offending parent, or NOP, for the purposes of this protocol). Information is gathered on family history and dynamics, in order to facilitate evaluation and treatment (if needed) of the child and to develop a recommendation for involvement of the NOP in the disclosure and /or recovery process. Assessment of behavioral functioning of the child is obtained using the Child Behavioral Checklist (Achenbach, 1988) as well as clinical data. The checklist is completed by the non-offending parent and any other significant care providers, as well as any teachers involved with the child. Assessment of any sexual behaviors exhibited or reported by the child is accomplished by using the Child Sexual Behavior Inventory (Friedrich,1990) and other clinical information. This checklist is also completed by caregivers and teachers involved with the child. If the child is at least 8 years old, the Trauma Symptom Checklist (Briere,1996) is administered at the completion of the evaluation.

****Note**: The second and remaining clinical sessions are done with the evaluator and child present. The NOP is only involved in the sessions when input is needed, and the evaluator would never do the actual assessment work with the child in the presence of the NOP.

Session 2. The second session is devoted to developmental assessment and rapport building with the child. The evaluator explains her role as someone who helps children, and expands upon this as deemed appropriate for the individual child. Developmental assessment is focused on the following areas:

- Speech and language
- Measurement/time
- Social relatedness (overly friendly/withdrawn)

- Knowledge of DOB, address, city/state of residence
- Basic concepts of first, last, always, beside, before, inside, outside, etc.
- Number concepts
- Kinship (family members/who is considered in family)
- Perspective taking (ability to take a perspective other than one's own)
- Knowledge of color
- Vocabulary and knowledge of feelings (limited/moderate/extensive)
- Exhibits understanding of truth versus lie

This information is gathered within the context of a session using art and play techniques, (i.e. checking the child's ability to count the number of crayons in the therapist's hand). No specific or focused efforts are made to draw out abuse specific information at this initial session.

****Note**: The evaluator gauges the time for specific questioning regarding the abuse allegations based upon the child's comfort level in the therapeutic setting. If a spontaneous disclosure occurs as the child's comfort level increases, or at any point in the process, the therapist employs investigative interviewing techniques and methodologies to gather specific details regarding the disclosure. Evaluators are trained to use non-leading questioning procedures, and the Cognitive Interview technique is employed when appropriate to allow the client to produce a step by step narrative description. These techniques are built into the protocol for sessions 5-7, however, sometimes children make spontaneous disclosures for no apparent reason in earlier sessions, and the evaluator moves into the investigative interviewing mode when this happens.

Session 3. The third session continues to focus on rapport building with the added goal of social and behavioral assessment. The evaluator uses developmentally appropriate play and art therapy techniques, and/or paper and pencil exercises to begin to explore the child's self understanding, self esteem and perceptions regarding their support system or lack thereof. Note: The evaluator concentrates on assessing the social and behavioral functioning of the child during these initial sessions, but social and behavioral functioning continues to be observed and monitored throughout the Forensic Evaluation process.

Session 4. During the fourth session, the evaluator introduces materials to facilitate discussion about good, bad and secret touching, remaining keenly aware of the comfort level of the child. Other activities, such as the "Touch Continuum" are used to allow the child to comfortably talk about types of touching. A body parts inventory may be introduced at this point, if it is appropriate for the child. The inventory can be done with anatomical drawings or dolls. Regular dolls or anatomically detailed dolls are used

depending on the child and situation. Anatomically detailed dolls are to be used with caution, and only when absolutely needed, strictly following the guidelines for use of the dolls established by APSAC.

Sessions 5 through 7. During sessions 5, 6 and 7, the evaluator employs abuse focused, but non-leading questioning techniques to attempt to learn more about the child's experiences. Abuse focused child interviewing techniques are employed to gather information regarding such topics as family violence, substance abuse, care routines (i.e. bathing, eating), environment, people, sexual abuse and discipline. Addressing these issues is done over a series of sessions with play and art activities interjected as needed to maintain the child's comfort level. If the child is 6 or older, and some disclosure is made, the evaluator employs the Cognitive Interviewing technique to obtain detailed narrative descriptions of events. The Narrative Elaboration procedure (Saywitz et al., 1996) is employed to cue children to elaborate on participants, setting, actions and conversation/affective state existing during the alleged events.

Session 8. At the eighth session, the evaluator changes the focus to body safety and prevention education regardless of whether or not a disclosure has been made. Also during this final session, the evaluator does closure work with the child, including summarizing the Forensic Evaluation experience and preparing the child for the next step (therapy or conclusion of clinical involvement). Closure is completed at this session.

During the process of evaluation, any new information pertaining to the abuse allegations is immediately relayed to the appropriate team members for follow up. The NCAC form entitled "New Disclosure Alert" is completed immediately upon obtaining new information on the case and is faxed to the appropriate member(s) of the investigative team.

Interviewing tools considered appropriate for use during the Forensic Evaluation process include, but are not limited to:

- Markers and drawing paper
- Puppets (used as communication tools and avoiding fantasy play)
- Dollhouse
- Anatomically Detailed dolls (used only when there has already been a disclosure and there is a need to be able to show as well as tell)
- Regular dolls
- Drawings with and without anatomically detail

Upon completion of the Forensic Evaluation, the therapist collates and summarizes all collaborative information relevant to the case which may include, but is not limited to, reports from: Law enforcement agencies, DHR, medical professionals, family members, day care or school, and the National Crime Information Center for inclusion in the final report. The evaluator uses the NCAC Disclosure Credibility Desk Guide for decision making on the likelihood of abuse having occurred.

A written report is then prepared for the multidisciplinary team. The Forensic Evaluation report includes abuse disclosure or non-disclosure, disclosure examination, reactions and consequences of the alleged abuse, summary of family issues, summary of collaborative reports and treatment recommendations.

The Evaluator

The professionals who conduct Forensic Evaluations should possess characteristics similar to those defined in the APSAC Practice Guidelines on Psychosocial Evaluation of Suspected Sexual Abuse in Children (APSAC, 1997). The following characteristics are defined in the guidelines:

1. The evaluator should possess a graduate level mental health degree in a recognized discipline (e.g. psychiatry, psychology, social work, nursing or child development) or be supervised by a professional with a graduate level degree.
2. The evaluator should have professional experience assessing and treating children and families, and professional experience with sexually abused children. A minimum of two years of professional experience with sexually abused children is expected; three to five years are preferred for forensic evaluators. If the evaluator does not possess such experience, supervision is essential.
3. The evaluator must have had specialized training in child development and child sexual abuse. This training should be documented in terms of formal course work, supervision, or attendance at conferences, seminars, and workshops.
4. The evaluator should be knowledgeable about the dynamics and the emotional and behavioral consequences of sexual abuse experiences. The evaluator should be familiar with the professional literature and with current issues relevant to understanding and evaluating sexual abuse experiences.
5. The evaluator should be familiar with different cultural values and practices that may affect definitions of sexual abuse, child and/or family comfort with the evaluation process, child and/or family willingness to provide complete and accurate information, and the evaluator's own interpretation of responses.
6. The evaluator should have experience in conducting forensic evaluations and providing expert testimony. If the evaluator does not possess such experience, supervision is essential.

7. The evaluator should approach the evaluation with an open mind to all possible responses from the child and all possible explanations for the concern about sexual abuse. The evaluator should recognize that all sources of information have limitations and may contain inaccuracies. In forming an opinion, the evaluator should consider plausible alternative hypotheses.

Early Findings Using the Forensic Evaluation Protocol

The NCAC Forensic Evaluation protocol was initially designed as a 12-session model. Two purposes guided its design. First, children need a sense of safety and a pace without pressure to provide information that adults can use to protect the child and prosecute the offender. Second, evaluators must obtain the information in a forensically sound manner. After implementation of the model for one year with 24 children, disclosure patterns were examined. For the purposes of that analysis, a disclosure was defined as any piece of new sexual abuse information which significantly contributed to the evaluator's ability to assist the team to confirm or disconfirm the suspicion of abuse. The pattern of disclosures obtained from the first 24 children supported the Sorenson and Snow (1991) finding that some children tend to disclose over time. However, it was also determined that in 100% of the cases, new disclosures which were obtained occurred during the first 8 sessions. Those disclosures obtained from the ninth to the twelfth session were enhanced reports of detail, rather than new reports of information. Due to these findings, the number of sessions of the model was decreased from 12 sessions to its present eight-session format. In a pending larger cross-site research project, we will vary length of evaluations between eight and four sessions to assess the effects of the pace on eliciting useful information. Comparison of the 4 and 8 session formats is illustrated below:

Comparison of Forensic Evaluation Protocols

4 & 8 Week Versions

	4 Week Version	8 Week Version
1	NOP Interview Collect Achenbach & Friedrich Data	NOP Interview Collect Achenbach & Friedrich Data
2	Developmental Assessment. Rapport Building Psychosocial Assessment	Development Assessment/ Rapport Building
3	Inventory of Touching knowledge, Body Parts vocabulary. Abuse focused, non-leading questions and/or Cognitive Interview (depending on age).	Psychosocial Assessment
4	Abuse focused, Non-leading questions or Cognitive Interview to fill in information gaps. Clinical closure.	Inventory of touching knowledge and Body Parts vocabulary
5		Abuse Focused, Non-leading questions or Cognitive Interview (depending on age)
6		Abuse Focused, Non-leading questions or Cognitive Interviewing continues
7		Fill in information gaps
8		Body Safety & Prevention Education Clinical Closure.

Child Molesters: A Behavioral Analysis

For Law Enforcement Officers Investigating Cases of Child Sexual Exploitation

December 1992
Third Edition

Kenneth V. Lanning
Supervisory Special Agent

Behavioral Science Unit
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia

5. Collection of Child Pornography and Erotica

Law enforcement investigations have verified that pedophiles almost always collect child pornography or child erotica. *Collection* is the key word here. It does not mean that pedophiles merely view pornography: They save it. It comes to represent their most cherished sexual fantasies. They typically collect books, magazines, articles, newspapers, photographs, negatives, slides, movies, albums, drawings, audiotapes, videotapes and equipment, personal letters, diaries, clothing, sexual aids, souvenirs, toys, games, lists, paintings, ledgers, photographic equipment, etc.—all relating to children in a sexual, scientific, or social way. Not all pedophiles collect all these items; their collections vary in size and scope. Factors that seem to influence the size of a pedophile's collection include 1) socioeconomic status, 2) living arrangements, and 3) age. Better educated and more affluent pedophiles tend to have larger collections. Pedophiles whose living or working arrangements give them a high degree of privacy tend to have larger collections. Because collections are accumulated over a period of time, older pedophiles tend to have larger collections. Pedophiles with the economic means are converting more and more to videotape systems. They are even converting their books, magazines, photographs, and movies to videotape. For less than $1,000, a pedophile can have his own video camera and two video records, which give him the capability to produce and duplicate child pornography and erotica with little fear of discovery.

Situational Child Molesters might also collect pornography but not with the high degree of predictability of the Preferential Child Molester. In addition, child pornography will comprise a small percentage of the total collection of the Situational Child Molester. In the child pornography collected by Situational Child Molesters, the children might be dressed up (stockings, high heels, makeup) to look like adults. The morally indiscriminate child molester might collect pornography or erotica of a predominately sadomasochistic theme but probably will not save the same material year after year. The sexually indiscriminate individual is most likely to have an extensive collection; however, the vast majority of it will not be child oriented. His material might display a wide variety of sexual activity and perversions, with child pornography being only one small portion. The law enforcement investigator should always consider the possibility that any child molester might collect child pornography or erotica; however, it is almost a certainty with the Preferential type. Because true child pornography is not easy to obtain, some pedophiles have only child erotica in their collections. Because it represents his sexual fantasies (age and gender preferences, desired sexual acts), the collection of any child molester should be carefully examined and evaluated.

Previous research conducted with Carol R. Hartman and Ann W. Burgess identified four kinds of collectors: 1) "closet," 2) "isolated," 3) "cottage," and 4) "commercial." The "closet collector" keeps his collection a secret and is not actively involved in molesting children. Materials are usually purchased discreetly through commercial channels. The "isolated collector" is actively molesting children as well as collecting child pornography or erotica. Fear of discovery overrides his need for active validation and causes him to keep his activity a secret between only himself and his victims. His collection may include pictures of his vic-

tims taken by him as well as material from other sources. The "cottage collector" shares his collection and sexual activity with other individuals. This is usually done primarily to validate his behavior, and money or profit is not a significant factor. Photographs, videotapes, and "war stories" are swapped and traded with other child molesters (and sometimes, unknowingly, with undercover investigators). The "commercial collector" recognizes the monetary value of his collection and sells his duplicates to other collectors. Although profit is an important motive, these individuals are usually active sexual molesters themselves.

With the exception of technical child pornography (see discussion below), the primary producers, distributors, and consumers of child pornography in the United States are child molesters, pedophiles, and sexual deviants. Child pornography is not a multi-billion dollar industry run by organized crime or satanic cults.

Child Pornography

What the pedophile collects can be divided into two categories: child pornography and child erotica. *Child pornography* can be behaviorally (not legally) defined as the sexually explicit reproduction of a child's image—including sexually explicit photographs, negatives, slides, magazines, movies, videotapes, and computer disks. In essence, it is the permanent record of the sexual abuse or exploitation of an actual child. In order to be legally child pornography, it must be a visual depiction (not the written word), or a minor (as defined by statute), which is sexually explicit (not necessarily obscene, unless required by state law). Child pornography, by itself, represents an act of sexual abuse or exploitation of a child and, by itself, does harm to that child.

Child pornography can be divided into two subcategories: commercial and homemade. *Commercial* child pornography is that which is produced and intended for commercial sale. Because of strict federal and state laws today, there is no place in the United States where commercial pornography is knowingly openly sold. In the United States it is primarily a cottage industry run by pedophiles and child molesters. The commercial child pornography still being distributed in the United States is smuggled in from foreign countries—primarily by pedophiles. The risks are usually too high for the strictly commercial dealer. Because of their sexual and personal interests, however, pedophiles are more willing to take those risks. Their motive goes beyond just profit. Commercial child pornography is still assembled and is much more readily available in foreign countries. United States citizens, however, seem to be the main customers for this material. Some offenders collect their commercial child pornography in ways (*e.g.*, photographs of pictures in magazines, pictures cut up and mounted in photo albums, names and descriptive information written below, homemade labels on commercial videotapes) that make it appear to be homemade child pornography. If necessary highly experienced investigators and forensic laboratories could be of assistance in making distinctions between homemade and commercially produced child pornography.

Contrary to what its name implies, the quality of homemade child pornography can be as good if not better than the quality of any commercial pornography. The pedophile has a personal interest in the product. *Homemade* simply means it was not originally produced primarily for commercial sale. Although commercial child pornography is not openly sold anywhere in this country, homemade child pornography is continually produced,

swapped, and traded in almost every community in America. Although rarely found in "adult" bookstores, child pornography is frequently found in the homes and offices of doctors, lawyers, teachers, ministers, and other apparent pillars of the community. There is, however, a connection between commercial and homemade child pornography. Sometimes homemade child pornography is sold or winds up in commercial child pornography magazines, movies, or videos. The same pictures are reproduced and circulated again and again. With rapidly increasing frequency, more and more of both commercial and homemade child pornography is in the videotape format. This actually increases the odds of finding child pornography in any investigation.

It is important for the law enforcement investigator to realize that most of the children in prepubescent child pornography were not abducted into sexual slavery. They were seduced into posing for these pictures or videos by a pedophile they probably know. They were never missing children. The children in child pornography are frequently smiling or have neutral expressions on their faces because they have been seduced into the activity after having had their inhibitions lowered by clever offenders. In some cases their own parents took the pictures or made them available for others to take the pictures. Children in pubescent or technical child pornography, however, are more likely to be missing children—especially runaways or thrownaways being exploited by morally indiscriminate pimps or profiteers. In contrast to adult pornography, but consistent with the gender preference of most preferential child molesters, there are more boys than girls in child pornography.

In understanding the nature of child pornography, the law enforcement officer must recognize the distinction between *technical* and *simulated* child pornography. The Child Protection Act of 1984 defines a *child* as anyone under the age of 18. Therefore, a sexually explicit photograph of a 15-, 16-, or 17-year-old girl or boy is *technical* child pornography. Technical child pornography does not look like child pornography, but it is. The production, distribution, and, in some cases, the possession of this child pornography could and should be investigated under appropriate child pornography statutes. Technical child pornography is an exception to much of what we say about child pornography. It often is produced, distributed, and consumed by individuals who are not child molesters or pedophiles; it is openly sold around the United States; and it more often portrays females than males. Because it looks like adult pornography, it is more like adult pornography.

On the other hand, sexually explicit photographs of 18-year-old or older males or females are not legally child pornography. But if the person portrayed in such material is young looking, dressed youthfully, or made up to look young, the material could be of interest to pedophiles. This is *simulated* child pornography. Simulated child pornography looks like child pornography, but it is not. It is designed to appeal to the pedophile but it is not legally child pornography because the individuals portrayed are over 18. This illustrates the importance and sometimes the difficulty in proving the age of the child in the photographs or videotapes. Particularly difficult is pornography portraying underage children pretending to be overage models pretending to be underage children.

Unlike child erotica, child pornography requires a child to be victimized. A child had to be sexually exploited to produce the material. Children used in pornography are desensitized and conditioned to respond as sexual objects. They are frequently ashamed of their portrayal in such material. They must deal with the permanency, longevity, and circulation of such a record of their sexual abuse.

Some types of sexual activity can be repressed and hidden from public knowledge; child victims can imagine that some day the activity will be over and they can make a fresh start. Many children, especially adolescent boys, vehemently deny their involvement with a pedophile. But there is no denying or hiding from a sexually explicit photograph or videotape. The child in a photograph or videotape is young forever and the material can be used over and over again for years. Some children have even committed crimes in attempts to retrieve or destroy the permanent records of their molestation.

Child Erotica (Pedophile Paraphernalia)

Child erotica is a broader and more encompassing term than child pornography. It can be defined as any material, relating to children, that serves a sexual purpose for a given individual. Some of the more common types of child erotica include toys, games, drawings, fantasy writings, diaries, souvenirs, sexual aids, manuals, letters, books about children, psychological books on pedophilia, and ordinary photographs of children. Child erotica might also be referred to as *pedophile paraphernalia*. Generally, possession and distribution of these items does not constitute a violation of the law.

For investigative purposes, child erotica can be divided into the categories below.

Published Material Relating to Children Examples of this include books, magazines, articles, or videotapes dealing with any of the following areas:

Child development	Sexual disorders
Sex education	Pedophilia
Child photography	Man-boy love
Sexual abuse of children	Personal ads
Incest	Detective magazines
Child prostitution	"Men's" magazines
Missing children	Nudism
Investigative techniques	Erotic novels
Legal aspects	Catalogs
Access to children	Brochures

Listing of foreign sex tours, guides to nude beaches, and material on sponsoring orphans or needy children provide them with information about access to children. Detective magazines saved by pedophiles usually contain stories about crimes against children. The "men's" magazines collected may have articles about sexual abuse of children. The use of adult pornography to lower inhibitions is discussed elsewhere in this book. Although the possession of information on missing children should be carefully investigated to determine possible involvement in abduction, most pedophiles collect this material to help rationalize their behavior as child "lovers," not abductors. Personal ads include those in "swinger" magazines, video magazines, and newspapers, and may mention "family fun," "family activity," "European material," "youth training," "unusual and bizarre," "better life," and so on. Erotic novels may contain stories about sex with children but without sexually explicit photographs. They may contain sketches or drawings. Materials concerning current or proposed laws dealing with sex abuse; arrested, convicted or acquitted child molesters; or investigative techniques used by law enforcement are common.

Unpublished Material Relating to Children Examples include items such as the following:

Personal letters	Telephone and address books
Audiotapes	Pedophile manuals
Diaries	Newsletters and bulletins
Fantasy writings	Directories
Manuscripts	Adult pornography
Financial records	

Directories usually contain information on where to locate children. Newsletters and bulletins are distributed by pedophile support groups, such as the North American Man-Boy Love Association (NAMBLA), the Lewis Carroll Collector's Guild, and any other similar group. Manuscripts are writings of the pedophile in formats suitable for real or imagined publication. Ledgers and financial records might include canceled checks used to pay victims or to purchase pornography or erotica.

Pictures, Photographs, and Videotapes of Children Examples include children found in the following:

Photography, art, or sex education books
Photography albums and displays
Candid shots
Photocopies of photographs or pictures
Drawings and tracings
Poster and paintings
Advertisements
Children's television programs or videos
Cut-and-paste pictures
Digitally encoded images on computer or CD-ROM disks

Cut-and-paste involves creating new pictures by cutting and pasting parts of old ones. Seized videotapes should always be viewed or scanned in their entirety because a variety of material, including hard-core child pornography, could be on any one tape. Some pedophiles cut out pictures of children from magazines and put them in albums as if they were photographs. Visual images of children can be on computer and CD-ROM disks (which resemble audio CDs).

Souvenirs and Trophies Examples may include mementos of children, listed below:

Photographs
Articles of clothing
Jewelry and personal items
Audiotapes
Letters and notes
Charts and records

Photographs collected by pedophiles are often labeled or marked. Charts and records might include astrology or biorhythm charts. Audiotapes, letters, and notes collected for souvenir purposes are usually from past child victims and discuss what the two did together and how much the victims like the offender. Personal items could even include victims' fingernails, hair, or underwear.

Miscellaneous This category can include items used in courting children:

Computers and peripheral equipment
Sexual aids
Toys, games, and dolls
Costumes
Child- or youth-oriented decorations
Video and photography equipment
Alcohol and drugs

Costumes include those worn by the offender and by the children.

Motivation for Collection

It is difficult to know with certainty why pedophiles collect child pornography and erotica. There may be as many reasons as there are pedophiles. Collecting this material may help pedophiles satisfy, deal with, or reinforce their *compulsive*, persistent sexual fantasies about children. Some child erotica is collected as a substitute for preferred but unavailable child pornography.

Collecting may also fulfill needs for *validation*. Many pedophiles collect academic and scientific books and articles on the nature of pedophilia in an effort to understand and justify their own behavior. For the same rea-

son, pedophiles often collect and distribute articles and manuals written by pedophiles in which they attempt to justify and rationalize their behavior. In this material pedophiles share techniques for finding and seducing children and avoiding or dealing with the criminal justice system. Pedophiles get passive validation from the books and articles they read and collect.

Pedophiles swap pornographic photographs the way boys swap baseball cards. As they add to their collections, they get strong reinforcement from each other for their behavior. The collecting and trading process becomes a common bond. Pedophiles get active validation from other pedophiles, some victims, and occasionally from undercover law enforcement officers operating "sting" operations. Fear of discovery or identification causes some pedophiles to settle only for passive validation.

The need for *validation* may also partially explain why some pedophiles compulsively and systematically save the collected material. It is almost as though each communication and photograph is evidence of the value and legitimacy of their behavior. For example, one pedophile sends another pedophile a letter, enclosing photographs and describing his sexual activities with children. At the letter's conclusion he asks the receiver to destroy the letter because it could be damaging evidence against him. Six months later police find the letter—carefully filed as part of the pedophile's organized collection.

Some of the child pornography and erotica collected by pedophiles is saved as a souvenir or trophy of the relationships with children. All child victims will grow up and become sexually unattractive to the pedophile. In a photograph, however, a 9-year-old child stays young forever. This is one reason why many pedophiles date and label their pictures and videotapes of children.

The need to validate their behavior and to have souvenirs of their relationships are the motivations most overlooked by investigators when evaluating the significance of the pornography and erotica collections of pedophiles.

Use of Collection

Although the reasons why pedophiles collect child pornography and erotica are conjecture, we can be more certain as to how this material is used. Study and police investigations have identified certain criminal uses of the material.

Child pornography and child erotica are used for the sexual arousal and gratification of pedophiles. They use child pornography the same way other people use adult pornography—to feed sexual fantasies. Some pedophiles only collect and fantasize about the material without acting out the fantasies, but in most cases the arousal and fantasy fueled by the pornography is only a prelude to actual sexual activity with children.

A second use of child pornography and erotica is to lower children's inhibitions. A child who is reluctant to engage in sexual activity with an adult or to pose for sexually explicit photos can sometimes be convinced by viewing other children having "fun" participating in the activity. Peer pressure can have a tremendous effect on children; if other children are involved, the child might be led to believe that the activity is acceptable. When the pornography is used to lower inhibitions, the children portrayed will usually *appear* to be having a good time.

Books on human sexuality, sex education, and sex manuals are also used to lower inhibitions. Children accept what they see in books, and many pedophiles have used sex education books to prove to children that such sexual behavior is acceptable. Adult pornography is also used, particularly with adolescent boy victims, to arouse them or to lower inhibitions.

A third major use of child pornography collections is blackmail. If a pedophile already has a relationship with a child, seducing the child into sexual activity is only part of the plan. The pedophile must also ensure that the child keep the secret. Children are most afraid of pictures being shown to their friends. Pedophiles use many techniques to blackmail; one of them is through photographs taken of the child. If the child threatens to tell his or her parents or the authorities, the existence of sexually explicit photographs can be an effective silencer.

A fourth use of child pornography and erotica is as a medium of exchange. Some pedophiles exchange photographs of children for access to or phone numbers of other children. The quality and theme of the material determine its value as an exchange medium. Rather than paying cash for access to a child, the pedophile may exchange a small part (usually duplicates) of his collection. The younger the child and the more bizarre the acts, the greater the value of the pornography.

A fifth use of the collected material is profit. Some people involved in the sale and distribution of child pornography are not pedophiles; they are profiteers. In contrast, most pedophiles seem to collect child erotica and pornography for reasons other than profit. Some pedophiles may begin nonprofit trading, which they pursue until they accumulate certain amounts or types of photographs, which are then sold to commercial dealers for reproduction in commercial child pornography magazines. Others combine their pedophilic interests with their profit motive. Some collectors even have their own photographic reproduction equipment. Thus, the photograph of a child taken with or without parental knowledge by a neighborhood pedophile in any American community can wind up in a commercial child pornography magazine with worldwide distribution.

Characteristics of Collection

Important The pedophile's collection is usually one of the most important things in his life. He is willing to spend considerable time and money on it. Most pedophiles make no profit from their collections. After release from prison, many pedophiles attempt to get their collections back from the police. The new state and federal laws banning its mere possession will most likely prevent the return of the child pornography. But unless denial is made a condition of treatment, probation, or parole the child erotica may have to be returned.

Constant No matter how much the pedophile has, he never has enough; and he rarely throws anything away. If police have evidence that a pedophile had a collection five or ten years ago, chances are he still has the collection now—only it is larger. This is a very significant characteristic to consider when evaluating the staleness of information used to obtain a search warrant.

Organized The pedophile usually maintains detailed, neat, orderly records. There are exceptions, but the collections of most pedophiles are carefully organized and maintained. As will be discussed, some pedophiles now use computers for this purpose.

Permanent The pedophile will try to find a way to keep his collection. He might move, hide, or give his collection to another pedophile if he believes the police are investigating him. Although he might, he is not likely to destroy the collection: It is his life's work. In some cases he might even prefer that the police seize it and keep it intact in an evidence room where he might retrieve at least some of it when released from prison. One offender is known to have willed his collection to a fellow

pedophile. Another offender knowing he would never get his child pornography back, still went to the prosecutor's office to put his magazines in covers and dividers so it would not be damaged.

Concealed Because of the hidden or illegal nature of the pedophile's activity, he is concerned about the security of his collection. But this must always be weighed against his access to the collection. It does him no good if he cannot get to it.

Where pedophiles hide their collections often depends on their living arrangements. If living alone or with someone aware of his preference for children, the collection will be less well concealed. It might be in a trunk, box, cabinet, bookcase, or out in the open. The child pornography might be better hidden than the erotica. If living with family members or others not aware of his activity, it will be better concealed. The collection might be found behind a false panel, in the duct work, under insulation, and so on. The collection is usually in the pedophile's home, but it could be in an automobile or a camper, at his place of business, in a safety deposit box, or in a rented storage locker. The most difficult location to find is a secret place in a remote rural area. The investigator should search any area that is under the control of the offender.

Shared The pedophile frequently has a need or desire to show and tell others about his collection. He is seeking validation for all his efforts. The investigator can use this need to his advantage by showing interest in the collection during any interview of a pedophile. The offender might appreciate the opportunity to brag about how much time, effort, and skill went into his collection.

Use of Computers There is a modern invention that is of invaluable assistance to the pedophile: the computer. It could be a large computer system at his place of business or a small personal computer at his home. It is simply a matter of modern technology catching up with long-known personality traits. The computer helps fill their need for organization, validation, souvenir records, and to find victims.

Law enforcement investigation has determined that pedophiles use computers to organize their collections and correspondence. Many pedophiles seem to be compulsive record keepers. A computer makes it much easier to store and retrieve names and addresses of victims and other pedophiles. 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.

Many pedophiles communicate with other pedophiles. Now, instead of putting a stamp on a letter or package, they can use their computer to exchange information. Pedophiles can use their computers to locate individuals with similar interests. The computer may enable them to obtain active validation with less risk of identification or discovery. Like advertisements in "swinger magazines," electronic bulletin boards are used to identify individuals of mutual interest concerning age, gender, and sexual preference. For instance, in the December 1983 issue of the North American Man-Boy Love Association (NAMBLA) bulletin, a member from Michigan proposed that NAMBLA establish its own electronic bulletin board. The pedophile may use an electronic bulletin board to which he has au-

thorized access, or he may illegally enter a system. The pedophile can also set up his own or participate in other surreptitious or underground bulletin boards.

The pedophile can also use the computer to troll for and communicate with potential victims with minimal risk of being identified. Adolescent boys who spend many hours "hacking" on their computers are at particularly high risk of such contacts. The child can be indirectly "victimized" through the transfer of sexually explicit information and material or the child can be evaluated for future face-to-face contact and direct victimization.

Pedophiles 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.

The pedophile can now use a computer to transfer, manipulate, and even create child pornography. This is a small problem that will soon be a big problem. Computer software and hardware is being developed so rapidly that the potential of this problem is almost unlimited. The ability to manipulate digital visual images may make it difficult to believe your eyes when viewing child pornography. Recent television commercials show Elton John singing with a visual image of Louis Armstrong and Paula Abdul dancing with a visual image of Gene Kelly. Soon visual images of computer generated "children" engaging in sexually explicit conduct may call into question the basis for highly restrictive (*i.e.*, possession, advertising, etc.) child pornography laws. It would be hard to argue that child pornography is the permanent record of the abuse or exploitation of an actual child, if no real child is involved. Only obscenity laws may apply to such material.

Police must be alert to the fact that any pedophile with the intelligence, economic means, or employment access might be using a computer in any or all of the above ways. As computers become less expensive, more sophisticated, and easier to operate the potential for abuse will grow rapidly. If the risks of trafficking in child pornography do not remain high, the pure profiteers may even return.

The Role of Law Enforcement

Police should not expect to find child pornography or erotica in all or even most child sexual abuse cases. It can be found in intrafamilial cases. It is most often found in cases involving Preferential Child Molesters (pedophiles) and Sexually Indiscriminate Situational Child Molesters. Investigators can always attempt to get a warrant to search based on reliable case specific information that a particular suspect possesses child pornography or other evidence of criminal behavior. Probable cause to believe that a suspect is a preferential type offender can be used to supplement and strengthen such case specific information to further justify a search for child pornography or to justify the expansion of the scope of a search to include child erotica. In order to do this, however, the affidavit for the search warrant *must* set forth the probable cause to believe that the suspect is a Preferential Child Molester or offender (not just a child molester) and set forth expert opinions concerning traits and characteristics of such offenders. In addition, it is the author's opinion that probable cause to believe that an individual is a Preferential Child Molester constitutes probable cause to believe he has a child pornography/erotica collection.

During any investigation of child sexual abuse, the possible presence of child pornography and erotica must be explored. For law enforcement officers, the existence and discovery of a child erotica or child pornography collection can be of invaluable assistance to the investigation of any child sexual abuse case. Obviously, child pornography itself is usually evidence of criminal violations. The ledgers, diaries, letters, books, and souvenirs that are often part of a child erotica collection, however, can also be used as supportive evidence to prove intent and for additional lead information. Names, addresses, and pictures of additional victims; dates and descriptions of sexual activity; names, addresses, phone numbers, and admissions of accomplices and other pedophiles; and descriptions of sexual fantasies, background information, and admissions of the subject are frequently part of a child erotica collection.

Child erotica must be viewed in the context in which it is found. Although many people might have some similar items in their home, it is only the pedophile who collects such material for sexual purposes as part of his seduction of and fantasies about children. Many people have a mail-order catalog in their home, but only a pedophile has albums full of children's underwear ads he clipped and saved from past catalogs.

Child erotica must also be evaluated in the context in which it is found. The law enforcement investigator must use good judgment and common sense. Possession of an album filled with pictures of the suspect's own fully dressed children probably has no significance. Possession of fifteen albums filled with pictures of fully dressed children unrelated to the suspect probably has significance. Possession of his own children's underwear in their dresser probably is normal. Possession of a suitcase full of little girl's underwear probably is suspicious. Possession of a few books about child development or sex education on a bookshelf probably has no significance. Possession of dozens of such books together in a box probably is significant.

Most people have photographs of children somewhere in their homes, and many people also possess photographs of naked children. Under most state statutes and the current federal law, pictures of children portraying simple nudity are not generally considered sexually explicit or obscene. The federal law requires at least "lascivious exhibition of the genitals or pubic area" to be considered sexually explicit and therefore to constitute child pornography. How then can an investigator evaluate the possible significance of nude and nonsexually explicit photographs of children found during a search in the possession of a suspected offender?

Some visual depictions of children are clearly always child pornography. The conduct portrayed is so sexually explicit that the visual depiction stands on its own. This might include a photograph of a man inserting his erect penis in a young girl's vagina. Some visual depictions of children are never child pornography. The activity portrayed does not meet the legal threshold of being sexually explicit conduct no matter how the offender used the material. This might include hundreds of underwear ads from store catalogs that an offender collected for sexual arousal. Such material might, however, constitute child erotica and be of evidentiary value.

A major problem today is that some visual depictions of children may or may not be child pornography depending on the totality of facts. Looking only at the visual depiction of the child does not resolve the issue. What is the difference between simple nudity or art and

what the law describes as lewd or lascivious exhibition of the genitals or pubic area? In a series of appellate decisions including *U.S.* v. *Dost*, 636 F. Supp. 828 (S.D. CAL. 1986) *aff'd sub nom.*; *U.S.* v. *Wiegand*, 812 F. 2d 1239 (9th Cir.), *cert. denied*, 484 U.S. 856 (1987); *U.S.* v. *Arvin*, 900 F. 2d 1385 (9th Cir. 1990) *cert. denied*, 111 S.Ct. 672 (1991); and *U.S.* v. *Cross*, 928 F. 2d 1030 (11th Cir. 1990) *cert. denied*, 112 S.Ct. 594 (1991), and 112 S.Ct. 941 (1992) the courts have attempted to provide some guidelines. Any investigator or prosecutor dealing with child pornography should carefully read these and other decisions.

It is the author's opinion that the essence of these decisions is that the material in question must be evaluated in context on a case-by-case basis. When the totality of facts are known, the author has never seen a case where there was any doubt whether a visual depiction of a child was simple nudity (*i.e.*, innocent family photographs, work of art, medical research, etc.) or lascivious exhibition of the genitals. Those claiming there is a doubt are often attempting to cover up sexual exploitation of children by creating a smokescreen to confuse the issue. The author knows of no investigator or prosecutor in the United States with so little work that they would use child pornography laws to try and convict normal parents who simply have photographs of their nude, young children or true professionals who utilize this material in a professional way.

The real dilemma is that on one hand the courts rule that borderline material should be evaluated in context and on the other hand judges rule the context material is inadmissable because the prejudicial value outweighs the probative value.

The following criteria are offered for the evaluation of such photographs. As used here, the term *photograph* includes any visual depiction (negatives, prints, slides, movies, videotapes, computer images).

How They Are Produced Because photographs are well taken and have artistic value or merit does not preclude the possibility that they are sexually explicit. Because someone is a professional photographer or artist does not preclude the possibility that he has a sexual interest in children. The lascivious exhibition of the genital or pubic area is characteristic of the photographer or collector, not the child, to satisfy his voyeuristic needs and sexual interest.

Pedophiles are more likely to use trickery, bribery, or seduction to take their photographs of children. They sometimes photograph children under false pretenses, such as leading them or their parents to believe that modeling or acting jobs might result. Some offenders even hide and surreptitiously photograph children. One pedophile hid above the ceiling of a boys' locker room and photographed boys through a moved ceiling tile. Many pedophiles even collect photographs of children who are complete strangers to them. They take these pictures at swimming meets, wrestling matches, child beauty pageants, parks, parades, rock concerts, and other events open to the public. These photographs are usually of children of a certain age and gender.

Pedophiles are also more likely to take and possess photographs that focus on certain parts of a child's anatomy of particular sexual interest to a certain offender. In some photographs the children may be involved in strange or bizarre behavior, such as pretending to be dead or simulating unusual sex acts. In one case, a pedophile photographed young boys with painted bondage-like markings on their bodies. If commercially produced, the way the photographs were advertised is important in evaluating their significance.

Investigators should make every effort to determine the circumstances under which recovered photographs were taken in order to evaluate their investigative significance as

child erotica. Any photograph that can be linked to abuse or exploitation has a greater chance of being found sexually explicit by the courts. The sequence in which the photographs were taken, which can sometimes be determined from the negatives, can be an important part of the evaluation. Recovered videotapes must be listened to as well as observed to evaluate their significance.

How They Were Saved Volume is a significant factor here. Pedophiles are more likely to have large numbers of photographs of children. One pedophile had 27 large photo albums filled with pictures of children partially or fully dressed. They are more likely to have their photographs carefully organized and cataloged and mounted in binders or albums. These may be photographs they cut out of magazines, catalogs, or newspapers. Sometimes sexually explicit captions are written above, below, or on the pictures.

Photographs are frequently marked with the children's names and ages and the dates taken. Sometimes they are also marked with the children's addresses, physical descriptions, and even the sexual acts they performed. Most people who have photographs of their naked children or grandchildren save them as a small part of a wide collection. The pedophile who collects photographs of children is more likely to have hundreds of such photographs together, and all the children portrayed will be of the same general age. There will be few, if any, photographs of these same children when they are older. The pedophile offender is also more likely to have enlargements or carefully arranged groupings of these photographs—even arranged on the wall as a kind of shrine to children. Some material may be placed where child victims will have easy access to it.

Investigators should carefully document the context in which such recovered photographs were maintained by the offender. Prosecutors must ensure that jurors understand that the pedophile's collection of photographs of naked children is not an ordinary one.

How They Were Used Pedophiles often use these photographs to help seduce and lower the inhibitions of children. Pictures of naked children could be used to convince children to remove their clothing. Investigators should attempt to determine how the offender used such material in his interaction with children. In addition, investigators should attempt to determine if the offender sold or traded this material.

Few police officers would ignore or fail to seize sexually explicit child pornography found during a search. But, over and over again, officers ignore and leave behind the child erotica. Although not as significant or damaging as child pornography, child erotica is valuable evidence of intent and a source of valuable intelligence information. The finding of child erotica might also influence bail, a guilty plea, and the sentence eventually imposed.

The investigative experience of many law enforcement officers dealing with pornography is often limited to commercial pornography distributed by individuals motivated by monetary profit. The direct connection between the pornography and the sex crimes is rarely a factor in these kinds of cases. In an investigation narrowly focused only on the pornography or obscenity violations, officers might have legal problems justifying the seizure of child erotica (pedophile paraphernalia) found when executing a search warrant or consent to search. In an investigation more

broadly focused on child pornography and its role in the sexual exploitation of children by child molesters, however, officers should recognize the evidentiary value of child erotica. If the facts of the case justify it, this relationship between child pornography and the sexual exploitation of children should always be set forth in the affidavit for a search warrant. Both the child pornography and the child erotica should be seized as evidence when found in such cases. Child pornographers are often child molesters. The photograph of a fully dressed child may not be evidence of a pornography violation, but it could be evidence of an offender's sexual involvement with children. If there is doubt about the legality of the seizure of child erotica, the presence of such material should be noted and, if possible, it should be photographed or videotaped (without sound).

Every effort should be made to attempt to identify the children, even those fully dressed, in photographs or videotapes found in the possession of a pedophile. This is especially true if these items appear to have been produced by the offender himself. Each of these children is a potential victim of sexual abuse. This identification must be done discreetly in order to avoid potential public embarrassment to the children, whether or not they were victimized. Sometimes the pedophile makes the identification unbelievably easy by labeling his photographs with names, descriptions, addresses, dates, and even sex acts performed.

Possession of numerous books, magazines, articles, or newspaper clippings about the sexual development and abuse of children or about pedophilia in general can be used as evidence of intent at a subsequent trial. It is very difficult to disprove the claim of a wrestling coach that his touching was legitimate athletic training or the claim of a teacher that his or her touching was normal healthy affection. This difficult task can be made easier if police have seized a child erotica collection that includes items such as a diary or fantasy writings describing the sexual stimulation experienced when touching a child to demonstrate a wrestling hold or when fondling a student.

Dating Skin Trauma Is What We Were Taught Right?

Lawrence R. Ricci, MD, FAAP
The Spurwink Child Abuse Program
Portland, Maine

Hamlet, act III, scene ii William Shakespeare

Hamlet: Do you see yonder cloud that's almost in the shape of a camel?

Polonius: By the mass, and 'tis like a camel, indeed.

Hamlet: Methinks it is like a weasel.

Polonius: It is backed like a weasel.

Hamlet: Or like a whale?

Polonius: Very like a whale.

The Cross-examination

Attorney:	Do you see yonder red bruise that's no more than 12 hours old?
Expert:	'Tis less than 12 hours old, indeed.
Attorney:	Methinks it is yellowed like a 24 hour old bruise.
Expert:	It is colored like a 24 hour old bruise.
Attorney:	Or like a 2 day old bruise?
Expert:	Very like a 2 day old bruise.

How accurately can bruises be aged in abused children? Literature Review and Synthesis.

Schwartz S, Ricci LR

Pediatrics. 1996;97:254-257

The courtroom and bruises

- When did the bruise occur? (Who did it?)
- Is the age of the bruise consistent with or inconsistent with the stated history? (Is the reporter truthful?)
- Are there multiple ages of bruises and hence multiple episodes of trauma? (What's the level of risk to the child?)
- How precisely can bruises be aged?

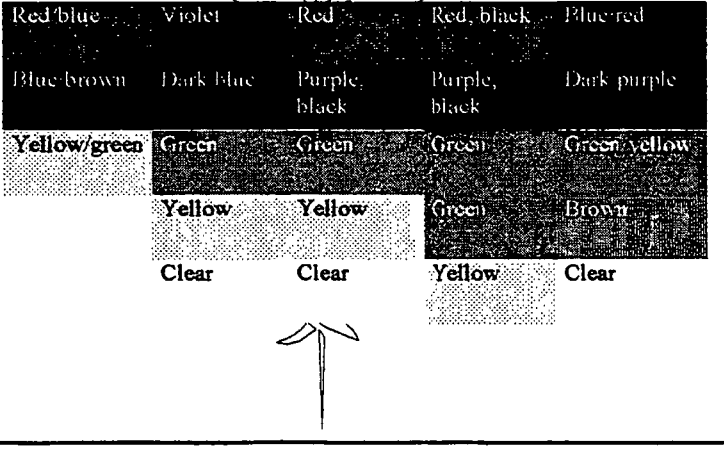
Color/age chart

Color	Age
Red, blue	0-5 days
Green	5-7 days
Yellow	7-10 days
Brown	10-14 days
Clear	2-4 weeks

Where did this and other charts come from?

Are they scientifically based?

Older pathology texts



Estimation of the age of cutaneous contusions in child abuse.

Wilson, EF
Pediatrics. 1977;60:750-752.

Texts where charts are cited

- Brodeur AE, Monteleone JA, *Child Maltreatment*. St Louis: GW Medical Publishing Inc;1994:6.
- Richardson AC. Cutaneous manifestations of abuse. In Reece RM, ed. *Child Abuse Medical Diagnosis and Management*. Philadelphia: Lea & Febiger;1994:169.
- Schmitt BD. The child with nonaccidental trauma. In: Helfer RE, Kempe RS, eds. *The Battered Child.* 4th ed. Chicago: University of Chicago Press;1987:192.
- Ludwig S. Child abuse. In: Fleisher GR, Ludwig S, eds. *Textbook of Pediatric Emergency Medicine*. 3rd ed. Baltimore: Williams & Wilkins;1993:1432.
- Farmer Keil M. Child abuse. In: Joy C, ed. *Pediatric Trauma Nursing*. Rockville, MD: Aspen Publishers Inc;1989:221.

Wilson (1977)

"Since estimation of the age of a contusion is difficult and imprecise at best, the physician should state that the appearance of a contusion is consistent with its being so many days old rather than stating categorically that it is exactly so many days old."

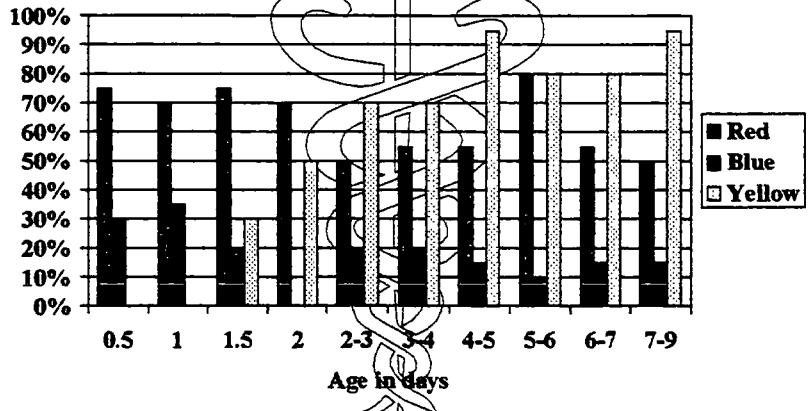
Law, science and the expert witness

- Frye v United States (1923): "...the thing from which the deduction is made must be sufficiently established to have gained general acceptance..."
- Daubert v Merrell Dow Pharmaceuticals (1993)
  - The theory or technique can and has been tested.
  - Testing involved peer review and publication.
  - Error rate is known.
  - General acceptance in the scientific community.

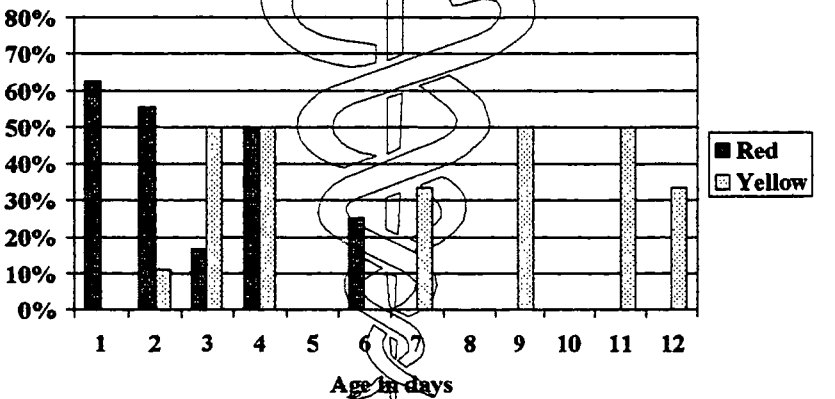
Factors affecting bruise color

- True color
  - Extent of bleeding
  - Location of injury
  - Depth of injury
- Apparent color
  - Skin complexion
  - Ambient light
  - Photographic distortion

Langlois and Gresham (1991)

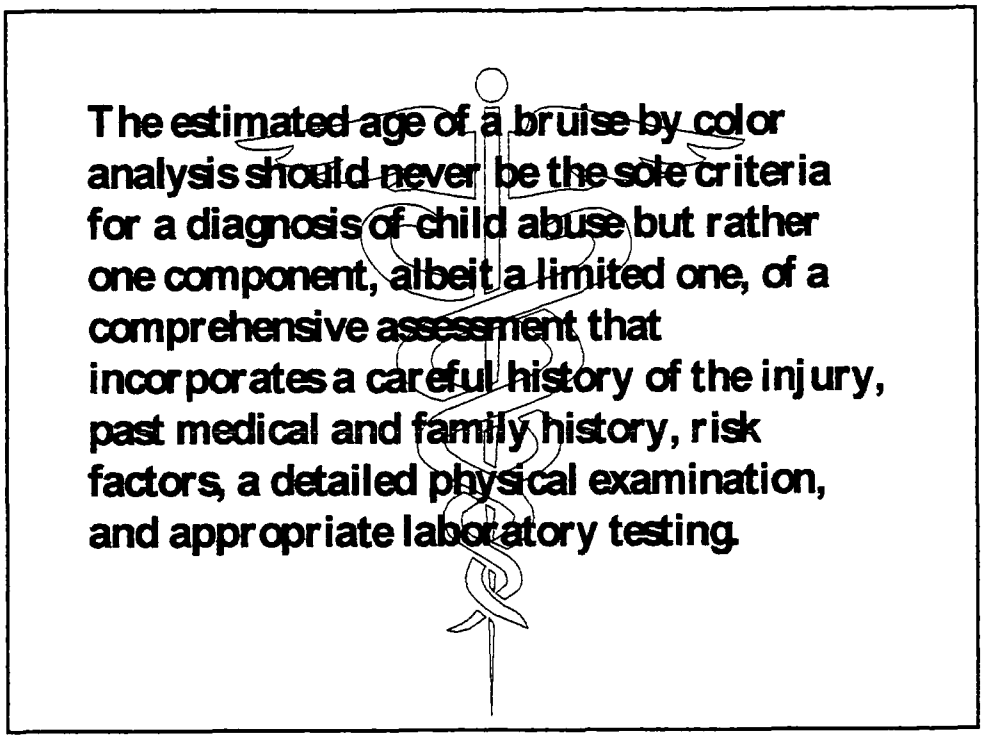


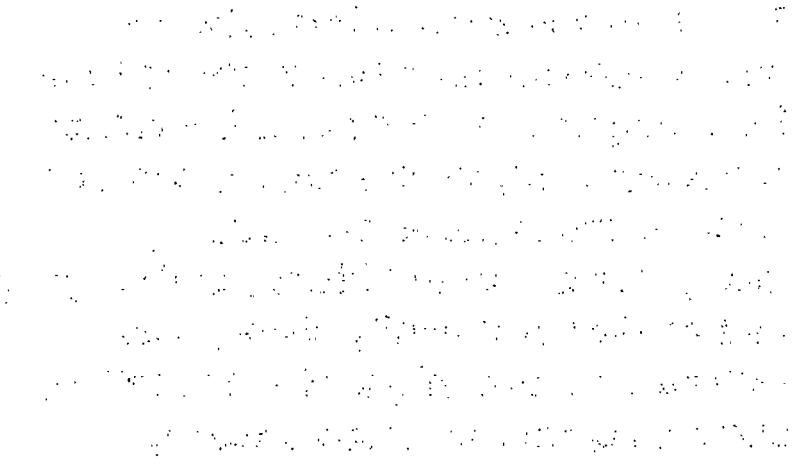
Stephenson and Bialas (1996)



What can be said about color?

- Bruises may be fresh if only red is present and older if yellow is present.
- Preemptively note in reports and testimony the limits of bruise color analysis.
- Use the phrase "consistent with" cautiously.
- Accurately describe the size, shape, location, and color of each bruise in writing, drawing, and photographs.


The estimated age of a bruise by color analysis should never be the sole criteria for a diagnosis of child abuse but rather one component, albeit a limited one, of a comprehensive assessment that incorporates a careful history of the injury, past medical and family history, risk factors, a detailed physical examination, and appropriate laboratory testing.



Children's Trust Fund of Texas

The good we do will last a lifetime

Workshop: Shaken Baby Syndrome
Wednesday, August 19
8:00 - 9:30am

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. 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. ThePSAs were produced in English and Spanish. A brochure called *Shaken Baby Syndrome: The Facts You Need To Know* was also developed in English and Spanish as part of the campaign. The brochure has been reprinted annually 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. CTF received free materials including posters, bumper stickers, and a video and information card on what to do when a baby is crying. These materials were distributed throughout Texas.

Current Campaign

In the 1996 funding cycle, four organizations in Dallas, El Paso, Wells, and Snyder 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. Twenty-two programs in Texas were awarded CTF grants and four programs funded in 1996 were granted contract renewals to develop local campaigns for the prevention of SBS.

Training seminars have been held in Austin in September 1996, and January, 1998 for CTF grantees. Dr. Juan Parra, a pediatrician and child fatality review team member in San Antonio, who serves on the Children's Trust Fund of Texas Council, presented information on SBS from the medical perspective. Jacy Showers, a nationally recognized expert on Shaken Baby Syndrome and coordinator of the National Conference on SBS, provided training on prevention techniques

based on her experiences as the director of the national "Don't Shake The Baby" campaign, and marketing and media experts provided training on working with the media and getting your message out in communities.

The first National Conference on Shaken Baby Syndrome was held November 10-12, 1996 in Salt Lake City and the second National Conference will be held on September 13-15, 1998 in Salt Lake City. The Children's Trust Fund of Texas will be a presenter. In April, 1998, CTF sponsored eight Texas sites to participate in a national satellite video conference on the medical implications of SBS. The conference was presented by Dr. Randell C. Alexander of the University of Iowa and over 300 participated in the eight Texas sites

1997-98 Shaken Baby Syndrome Awareness Campaign Programs funded by CTF (listed by Regions)

Panhandle Plains - Region I

Child Advocates
Wichita Falls, TX
Janet Booher
Community Recruiter
817/766-0552

Family Support Services
Amarillo, TX
Charmaine Keller
Director of Education
806/372-3202

Giant Steps for Children, Inc.
San Angelo, TX
Rachel Barry
Executive Director
915/659-6900

Parenting Coalition of Brown County, Inc.
Brownwood, TX
Cathie Lehman
SBS Campaign Supervisor
915/646-5939, ext. 301

*Scurry Community Services
Snyder, TX
LuAnn Grice
915/573-3508

Prairies and Lakes - Region 2

Central Texas Youth Services Bureau, Inc.
Belton, TX
Keith Wallace
Executive Director
817/939-3466

Child Abuse Prevention Project
Paris, TX
Sharon Eubanks
Executive Director
903/737-4346

Children First, Inc. dba, Children First Counseling
Grand Prairie, TX
Maxine Nobbman
Education Coordinator
214/264-0604

*Dallas Children's Advocacy Center
Dallas, TX
Sandra Cobb
Program Coordinator
214/818-2600

Education and Social Services at Townview Magnet School
Dallas, TX
Carey Martin
Child Related Cluster Coordinator
214/944-2102

Lockhart ISD
Lockhart, TX
Joan Schlaht
Assistanct Director
512/398-5276

Dallas County Hospital District
Dallas, TX
Leslie Malone
SIDS Program Manager
214/648-2769

Tejas Council of Camp Fire Boys and Girls, Inc.
Waco, TX
Pat McKee
Executive Director
817/752-5515

Piney Woods - Region 3

Huntsville ISD
Huntsville, TX
Linda Bone
Teen Parenting Coordinator
409/293-2626, ext. 57

Gulf Coast - Region 4

Rusk School Health Promotion Project
Houston, TX
Odilia Méndez
Child Advocate
713/227-5160

South Texas Plains - Region 5

Any Baby Can, Inc.
San Antonio, TX
Marian Sokol
State Executive Director
210/737-9119

Hill Country - Region 6

Austin Travis County Health and Human Services
Austin, TX
Rick Schwertfeger
Supervisor
Chronic Disease & Injury Prevention
512/473-4274

Community Council of Southwest Texas, Inc.
Uvalde, TX
Cindy Rodriguez
Director of Elderly Services
210/278-6268

Williamson County & Cities Health District
Georgetown, TX
Marge Tripp
Public Health Supervisor
512/248-3255

Big Bend Country - Region 7

*Child Crisis Center
El Paso, TX
Deborah Benedict
Program Coordinator
915/533-2311

Fort Stockton ISD
Fort Stockton, TX
Faye Johnson
Principal, Butz School
915/336-4121

* First CTF funded SBS Sites

Continuing Education

By Lori Jackson, MSN, RN, and Catrina L. Miller, RRT

Recognizing the symptoms of shaken baby syndrome

In some households, child abuse is a common occurrence. In others, it may be a one-time loss of control that ends in tragedy. In one form of child abuse that is often unrecognized, parents or other caregivers violently shake infants, usually out of frustration or rage over their incessant crying. Whether this abuse occurs many times or just once, it can result in shaken baby syndrome (SBS), which may cause severe brain damage or death.

SBS can be difficult to diagnose because there are no external signs of abuse. Healthcare workers need to recognize the importance of early recognition of SBS and prompt treatment of life-threatening intracranial hemorrhages and cerebral edema. Proper documentation, reporting, and preventive interventions are equally important.

A variety of social and environmental risk factors may predispose a parent or caregiver to violently shake an infant. (See "Risk factors of child abuse.") Risk factors such as poverty, unemployment, or alcohol and drug abuse can increase parental stress. People under stress from such risk factors may be more prone to impulsive and aggressive behavior.[1]

Victims of SBS are most often between the ages of 3 weeks and 15 months, and the majority of those are under 6 months old.[1,2] Some of these infants cry for no apparent reason; colicky infants in particular tend to cry more often and be more sensitive, irritable, and difficult to soothe than average babies. This may leave a parent feeling frustrated, angry, and inadequate.[3]

Many parents who would never hit their child may think shaking is a less violent approach. Even experienced parents can be driven to the point of shaking their child for as long as he or she persists in crying. In some cases, parents use shaking as a form of discipline for misbehavior.

The perpetrators of this type of child abuse vary from biologic parents to other caregivers and older siblings. Early studies suggested that women were most often perpetrators of fatal child abuse, but recent data suggests that male caretakers are at greater risk to abuse infants.[2] Male perpetrators (fathers, stepfathers, mothers' boyfriends) outnumber females slightly more than 2-to-1, and biological fathers are perpetrators 37 percent of the time.[2] A large and previously unrecognized group of perpetrators are female baby sitters, at 17.3 percent.[2]

Infants are considerably more vulnerable to injury when shaken than older children. The brain and blood vessels in an infant are highly susceptible to whiplash injuries. An infant's head makes up approximately 10 percent of his or her total body weight compared with 2 percent in an adult, and the neck muscles are very weak during the first year of life. The combination of weak neck muscles and a lack of strong head control mean that during shaking, energy cannot be absorbed by the neck muscles or by avoidance. Additionally, the infantile brain is softer and less myelinated than older brains, and the vasculature of the central nervous system is thin and friable.[3] Soft cranial sutures and open fontanels leave more room to exacerbate tearing and shearing forces, so even a slight whiplash motion can stretch the brain and its blood vessels.[2]

The primary mechanism of SBS injury is the movement of the brain within the skull. Injury results from a cycle of rapid and repeated acceleration and deceleration of the head as it is thrown back and forth, resulting in a disconjugate movement of the brain and skull.[4] The head undergoes high-energy rotational forces as well as whiplashing motion during shaking.[4,5] The rotational forces lead to tearing of the vessels that bridge between the meninges and the skull, resulting in subdural hematoma.[1,4] Bruising of the brain occurs at the site of initial impact, then as the brain hits the other side of the skull.

Studies have proved a strong association between subdural hematoma and abuse.[5] Subdural hematoma is by far the most frequently seen cause of death in infants with SBS. Research also suggests that violent shaking causes extreme increases in intraocular and intracranial venous pressure, resulting in retinal hemorrhage, another classic sign of SBS.[3]

Clinical findings in SBS cases

The clinical presentation of a shaking injury may or may not suggest abuse. Often the child has no signs of other types of abuse. A recent report indicated that of 59 children with subdural hemorrhage, only 29, or about half, also had significant additional injuries such as retinal hemorrhage, patterned bruising, and rib and long bone fractures.[3]

In most cases, there are no external signs of head trauma. Parents or caregivers seldom mention shaking and often withhold information. Explanations given in response to questions tend to be inconsistent, or parents may claim only to have played roughly with their child or to have shaken the child while trying to perform CPR.[3] When the caregiver's answers do not explain the child's condition, SBS should be suspected.

The most common symptom on arrival in the emergency department is respiratory difficulty or apnea. Respiratory distress without stridor or adventitious lower airway sounds should alert medical personnel to look for a central cause.[3] Often infants with these symptoms are hypothermic. Other signs of shaking may include seizures or posturing; patterned bruising on the upper arms, thorax, or ankles and feet; and rib fractures. The anterior fontanel may be enlarged or bulging, or the head circumference may be greater than the 90th percentile for the infant's age.[3]

SBS is difficult to diagnose because the clinical findings are often vague and a reliable history of how the injury occurred is hard to obtain. Many differential diagnoses must be excluded. (See "Differential diagnoses.")

The diagnostic evaluation of SBS is based upon the signs and symptoms noted during examination. Diagnostic tools include a complete ocular fundoscopic exam, skull radiography, and computed tomography or magnetic resonance imaging (MRI).

A health professional should be suspicious if the infant's clinical presentation, age, and CT scan or MRI results suggest SBS.[6] Radiographic findings that suggest head trauma and an absence of external injuries taken together suggest shaking. To make a definitive diagnosis, a fundoscopic retinal exam plus a CT scan or an MRI of the head are essential.[6]

Fundoscopic examinations should be done on all infants for whom SBS is suspected; such exams can identify retinal hemorrhage, a classic sign of SBS that may give early clues about intracranial injury.[6] Retinal hemorrhages are present in 50 percent to 80 percent of SBS cases.[7] Although retinal hemorrhages often indicate SBS, they may exist in a variety of other circumstances including vaginal delivery, spontaneous subarachnoid hemorrhage, systemic hypertension, intracranial hypertension, thoracic or abdominal trauma, abusive head trauma, bleeding disorders, vasculopathies, increased intracranial pressure, and birth trauma.[8] Experts disagree on whether CPR can cause retinal hemorrhage.[8,9,10]

Idiopathic retinal hemorrhage occurs in up to 40 percent of newborns delivered by normal vaginal delivery.[11] It is rarely seen in cesarean deliveries, but there is a threefold increase in retinal hemorrhage in infants delivered by vacuum extraction.[12] Most idiopathic retinal hemorrhages disappear during the first week of life, but may be seen as late as six weeks after delivery.[11] In contrast, retinal hemorrhage in abused infants can persist for 10 years or more.[13]

The CT scan generally is the first diagnostic tool used in suspected cases of SBS,[5,6] but CT scans of the head may yield initial false-negative results, especially in the early stages of cerebral edema. A normal CT scan does not automatically rule out SBS. Serial scans may be needed to document intracranial injuries.[5,6]

An MRI is often used as a supplement to CT scans, because an MRI has a greater imaging potential, is more sensitive, and can detect old and new injuries.[5,10] An MRI provides a better contrast study to detect smaller subdural hemorrhages. However, the MRI of the infant brain has limitations because of the brain's lack of myelin and the high fluid content.[7]

An X-ray skeletal survey of long bones, skull, spine, and ribs may be performed to detect periosteal tears associated with SBS. It may also help identify old and new fractures that indicate ongoing abuse.[5,6] High resolution cranial ultrasound can provide a view of shearing injuries and subdural and subarachnoid fluid.[5]

Lumbar puncture is indicated to rule out sepsis in infants with nonspecific symptoms such as vomiting and lethargy. SBS should be suspected if the cerebrospinal fluid remains bloody as it is collected.[5]

Management of injuries

The treatment of SBS begins with early recognition and prompt medical management of the intracranial hemorrhage and life-threatening cerebral edema.[3] A multidisciplinary approach is used to maintain ventilation, oxygenation, and perfusion.

Risk factors of child abuse

- Alcohol/substance abuse,
- child with disabilities,
- child left with many caregivers,
- delay in seeking care,
- domestic violence,
- financial difficulties,
- history of abuse during abuser's own childhood,
- inadequate knowledge of child's basic needs and development,
- inappropriate affect of the caregiver,
- infant with "difficult temperament" or colic,
- lack of family support,
- mental illness or depression,
- parental youth and immaturity,
- pattern of increased severity of injuries over time,
- relationship tensions and difficulties,
- social-situational stress,
- "triggering" situation precipitating loss of control by caregiver, and
- unrealistic expectations of the child.

SOURCES: "Shaken baby syndrome: a nursing perspective," by E.M. Chiocca, 1995, Pediatric Nursing, 21(1), pp. 33-38; and "Physical abuse of children: an update," by A.P. Sirotnak and R.D. Krugman, 1994, Pediatrics in Review, 15(10), pp. 394-399.

OBJECTIVES

Upon completion of this article, you will be able to:

- describe information that health professionals need to document and report shaken baby syndrome (SBS) and other child abuse;
- identify the signs of SBS based on history, clinical findings, and diagnostic evaluations;
- discuss the social and environmental factors that place certain families at risk for SBS; and
- list three topics of preventive education.

Earn 1 contact hour—#505A

Obtain 1 contact hour by completing the exam and order form on page 13.

Intubation may be needed to treat apnea and bradycardia. Hyperventilation and the administration of osmotic agents to decrease cerebral edema are futile because the necrotic edema associated with SBS does not respond well to these measures.[3]

Emergency surgery may be necessary to evacuate intracranial hematomas and to avoid further intracranial hemorrhage, edema, herniation, and death. Three days of postoperative closed external drainage is recommended in such cases.[6] If secondary hydrocephalus develops, a ventriculoperitoneal shunt may be required. The use of steroids to decrease cerebral edema in these infants is controversial.[6]

Monitoring and management of elevated intracranial pressure (ICP) is crucial; lack of treatment can lead to decreased cerebral blood flow, poor cerebral perfusion, tissue necrosis, and death.[6] Diuretics and fluid restriction may decrease ICP. A barbiturate coma may be used to decrease ICP although this practice is controversial.[6] Anticonvulsants are used to control seizures.

Nurses should focus on restoring physiologic equilibrium and preventing neurologic sequelae. (See "Possible results of shaken baby syndrome.") Interventions include assessing the infant's airway, breathing, and circulation; assisting with intubation if needed; monitoring oxygen saturation and providing oxygen as needed to promote optimal cerebral tissue perfusion; frequently assessing vital signs; assessing systemic perfusion; monitoring fluid and electrolyte balance; inserting a nasogastric tube for vomiting; assessing and documenting seizure activity, using seizure precautions; and administering anticonvulsants. Nurses should also care for the shunt; monitor ICP levels and elevate the head of the bed 30° to decrease ICP; minimize environmental stimulation; perform frequent and complete neurological assessments, because an infant's level of consciousness is the most sensitive indicator of neurologic status (a standardized scale such as the Glasgow Coma Scale is recommended); and obtain a thorough history from the caregiver seeking medical attention for the infant.[14]

The prognosis of an SBS patient depends largely on the severity of the shaking injury. One third of infants have little or no sequelae. One-third experience permanent and serious injury such as brain damage, developmental delay, blindness, paralysis, seizures, mental retardation, or visual defects. One third die.[4,5,6] Mortality and morbidity are high in infants who are comatose when they arrive for care.[5]

In other cases, such as habitual shakings, the injuries may not be evident until the child enters school, when learning difficulties, delayed motor skills, and visual or hearing impairments are often discovered. One physician suggests that undetected shaking injuries may be responsible for many cases of idiopathic mental retardation.[7]

Documentation of child abuse

Healthcare providers are legally and ethically responsible for reporting suspected child abuse to a child protection agency. Laws passed by all states in the 1950s forbidding the abuse of children made it a criminal offense to fail to report suspected abuse. The laws also protect health professionals from criminal and civil liability when they make a report in good faith.[15] Health professionals should be familiar with state law and institutional policies regarding suspected child abuse.

Compiling a history of what happened to an infant is the crucial first step in differentiating unintentional from intentional trauma. Health professionals should ask questions about the family milieu and be alert for discrepant histories, a cardinal feature in the diagnosis of intentional trauma. Because not all victims of abuse have visible injuries, nurses should look for subtle nonverbal cues, such as under-reaction to pain or treatment.[6]

A detailed medical history focusing on the care and supervision of the infant, the onset of symptoms, and the possible mechanism of injury should be followed by a careful investigation by social services. The presence of another health professional during the physical assessment supports the examiner and adds credence to the observations and later interpretation of the physical and behavioral findings.[16]

If nurses or other health professionals find an injury, they should document its location, shape, color, and measurements. A body diagram can be helpful; however, injuries should also be documented with photographs.[16]

If an infant has experienced acute trauma, especially involving brain injury, a careful history of feeding, sleeping, and behavior patterns for the 24 to 48 hours before the child arrived for care can be helpful. Infants rarely eat or act normally after significant brain hemorrhage.[2]

Health professionals should carefully document parent-child-practitioner interactions in the medical record, objectively documenting the behaviors that lead to the conclusion.[15,16] These observations will have legal value if child protection proceedings become necessary. All observations should be documented clearly and legibly in the medical and social services record.

The Federal Child Abuse Prevention and Treatment Act, passed in 1974, requires all states to develop a child-protection system and all healthcare workers to report child abuse. Although state laws vary, physicians, nurses, and others who examine or treat children should consider themselves "mandated reporters" under the law.[15] (A mandated reporter is required by law to report suspected child abuse.) State laws also stipulate the manner of reporting, usually specifying that the child protection services agency in the child's county of residence or a central state reporting system receives the report. The report should include information such as the child's name, address, and whereabouts; the name and address of the parent or caretaker; and a detailed description of the nature and extent of the presenting injuries. The report should also include the parents' or caretakers' description of the injury, the person responsible for the injury (if known) or the name of the person caring for the child at the time of the injury, a statement indicating why child abuse is suspected, and any additional information that may help establish the cause of the injury or provide assistance for the child.[17]

Reports should be submitted as soon as possible after the injury is observed. Some states require that reports be made within 24 hours.[17]

Methods of prevention

Most cases of SBS could be prevented with appropriate knowledge, understanding, and interventions. Studies in the United States show that between 25 and 50 percent of the public do not know of the danger of shaking infants.[6]

Babies are shaken because their caregivers handle stress poorly and do not know about appropriate infant care and a child's normal development and behavior. But there are ways to educate caregivers and prevent abuse. Counseling teaches methods of recognizing and reducing stress. Parenting classes offer suggestions for discipline and information about normal growth and development, thus increasing parents' confidence in their child-rearing skills. Support systems such as parental hot lines and organizations can help new families and those at risk for child abuse. With the help of such resources, parents can learn more about child development to avoid unrealistic expectations and find out where to call for help before abuse occurs. If these resources do not prevent abuse, temporary foster placement is an option.

Child abuse prevention campaigns have been aimed at young, single pregnant women because they can face stress and abusive relationships. However, prevention campaigns must also target male caregivers and the rising number of female baby sitters who are perpetrators of SBS. Many times, baby sitters are as young as 11, with little experience in handling the frustrations of child care. They are unfamiliar with normal child development and behavior and do not possess the techniques to reduce their stress during an infant's "crying crisis."

If parents and caregivers learn to understand infants' needs and react to them appropriately, the number of shaken babies will be drastically reduced. Public awareness of the dangers of shaking infants, self-control techniques, and resources to call on are essential for prevention of SBS. For the healthcare team, the importance of early identification of child abuse, particularly the hidden clues of SBS, cannot be overemphasized. Prompt and thorough assessment can speed the medical interventions needed to save an infant's life.

Critical care nurse Lori Jackson, MSN, RN, has worked at Rockford Memorial Hospital in Rockford, Ill., for seven years and is the neonatal clinical nurse specialist for the Level 3 NICU.

Catrina (Tina) Miller, RRT, is a registered respiratory therapist and perinatal/pediatric respiratory care specialist. She has worked at Rockford Memorial Hospital for nine years and is a member of the neonatal air/ground transport team.

Differential diagnoses

Symptoms of SBS may also be caused by one of the following:

- anemia,
- apnea episodes,
- central nervous system infections,
- electrolyte disorders,
- failure to thrive,
- hydrocephalus,
- intrauterine subdural hematoma or neonatal subdural hematoma caused by birth trauma,
- meningitis,
- metabolic disturbances,
- rupture of a congenital aneurysm,
- seizure disorders,
- shock,
- strangulation,
- sudden infant death syndrome,
- thrombocytopenia,
- motor vehicle accident during which an infant was not restrained in a car seat, and
- viral syndromes.

SOURCE: "Shaken baby syndrome: a nursing perspective," pp. 35-36.

Possible results of shaken baby syndrome

- Blindness or eye trauma,
- brain damage,
- death,
- delay in normal development,
- fractures or dislocations,
- hydrocephalus,
- impaired motor and sensory skills,
- mild to severe retardation,
- seizures, and
- spinal injury, paralysis, or spasticity.

SOURCE: "Shaken baby syndrome: a nursing perspective," p. 37.

REFERENCES

1. Coody, D., et al. (1994). "Shaken baby syndrome: identification and prevention for nurse practitioners." *Journal of Pediatric Health Care, 8*(2), 50-56.
2. Starling, S.P., Holden, J.R., & Jenny, C. (1995). "Abusive head trauma: the relationship of perpetrators to their victims." *Pediatrics, 95*(2), 259-262.
3. Ludwig, S., & Warman, M. (1984). "Shaken baby syndrome: a review of 20 cases." *Annals of Emergency Medicine, 13*(2), 104-107.
4. Shugerman, R.P., et al. (1996). "Epidural hemorrhage: Is it abuse?" *Pediatrics 97*(5), 1-5.
5. Carty, H., & Ratcliffe, J. (1995). "The shaken infant syndrome." *British Medical Journal, 310*(1), 343-345.
6. Chiocca, E.M. (1995). "Shaken baby syndrome: a nursing perspective." *Pediatric Nursing,* 21(1), 33-38.
7. Caffey, J. (1974). "The whiplash shaken infant syndrome: manual shaking by the extremities with whiplash-induced intracranial and intraocular bleedings, linked with residual brain damage and mental retardation." *Pediatrics, 54*(4), 396-403.
8. Duhaime, A.C., et al. (1992). "Head injury in very young children: mechanisms, injury types, and ophthalmologic findings in 100 hospitalized patients younger than 2 years old." *Pediatrics, 90*(2), 179-185.
9. Smith, W.L., et al. (1992). "Magnetic resonance imaging evaluation of neonates with retinal hemorrhages." *Pediatrics, 89*(2), 332-3.
10. Sirotnak, A.P., & Krugman, R.D. (1994). "Physical abuse of children: an update." *Pediatrics in Review, 15*(10), 394-399.
11. Budenz, D.L., et al. (1994). "Ocular and optic nerve hemorrhage in abused infants with intracranial injuries." *Ophthalmology, 101*(3), 559-564.
12. Plantes, J.T., & Schaal, P.C. (1971). "Retinal hemorrhage in the newborn: an attempt to indicate and explain its cause and significance." *Ophthalmologica, 162,* 213.
13. Aron, J.J., et al. (1970). "Ocular signs in the syndrome of Silverman." *Annales d'oculistique, (French) 203*(5), 495-503.
14. Vernon-Levett, P. (1994). "Commentary on intended vs. accidental head injury in critically injured children." *AACN Nursing Scope in Critical Care,* 1(1), 13.
15. Rhodes, A.M. (1987). "The nurse's role in reporting child abuse." *Maternal Child Nursing, 12*(5), 315-319.
16. Middleman, R., Middleman, H., & Wefil, C. (1987). "What child abuse really looks like." *American Journal of Nursing,* 91155-1158.
17. Rhodes, A.M. (1987). "Identifying and reporting child abuse." *Maternal Child Nursing, 12*(6), 399.

This article is classified as Type I continuing education for Texas for RNs and LVNs and may be used to fulfill th CE requirements. Social workers may use these cour to meet their CE requirements. Our sponsor numbe CS1237. Occupational therapists who wish to receive credit for this article should contact the Texas Boarc Occupational Therapy because Texas requires OTs have home study material preapproved.

MEDICAL, INVESTIGATIVE, LEGAL, INTERVENTION & PREVENTION CHALLENGES

THE SECOND NATIONAL CONFERENCE ON SHAKEN BABY SYNDROME

SEPTEMBER 13-15, 1998
LITTLE AMERICA HOTEL
SALT LAKE CITY, UTAH

CONFERENCE REGISTRATION

If more than one person from your agency is registering for this conference, please use a separate form for each person.

Make checks payable to and mail or FAX registration form to:

The Second National Conference on Shaken Baby Syndrome
2955 Harrison Blvd., Suite #102, Ogden, Utah 84403
Phone (801) 393-3366 • FAX (801) 393-7019
E-Mail capcente@ix.netcom.com

Name _____ Title _____

Institution Affiliation _____

Business Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-Mail _____

Discipline: *(please check one)*

☐ Physician ☐ Law Enforcement ☐ Psychology
☐ Nurse, Medical ☐ Social Work ☐ Other_____
☐ Legal ☐ Prevention / Education

Registration cost is $325. After August 15, $375

☐ YES! I want to attend the social event at the Deer Valley Mountain Resort on Monday, September 14. I have enclosed an additional $45 to cover the costs of the event. (Refer to page 1 for description.)

☐ YES! I want to RSVP for the Pre-Conference Prevention Institute. I understand there is limited space available and I will be receiving confirmation in the mail. (Refer to page 1 for description.)

I have enclosed my check for $_____ (Please include the participant's name on the check stub.)

I want to charge my costs to my: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

Cardholder's name _____

Signature _____

Card Number _____ Exp. Date _____

For special billing or purchase order requests call (801) 393-3366.

Registration Deadline, August 15, 1998

Children's Trust Fund of Texas (CTF)

CTF MATERIALS DISTRIBUTION/INFORMATION REQUEST FORM

NAME OF PUBLICATION	QUANTITY
Shaken Baby Syndrome Brochure, English	
Shaken Baby Syndrome Brochure, Spanish	
CTF Shaken Baby Syndrome Campaign Fact Sheet with funded programs	
Cassette Tape: Shaken Baby Syndrome-Radio Public Service Announcement	
Video: Shaken Baby Syndrome- Public Service Announcement	
Shaken Baby Syndrome Community Action Guidebook	
Child Abuse Prevention Month Kit, 1997	
Child Violent Death in Texas	
Children's Trust Fund of Texas Biennial Report	
Children's Trust Fund of Texas Brochure	
Children's Trust Fund of Texas - Creating Partnerships with Communities Video	
Family PRIDE Brochure	
State Child Fatality Review Team Committee Brochure	
Parents Checklist, English	
Parents Checklist, Spanish	
Poster-A Beginning	
Poster-Prevention Works	
Quality of Life Community Workbook (1994)	
Statewide Child Survey, Executive Summary, 1997	
Statewide Child Survey, Full Report, 1997	
Texans Attitudes, Executive Summary, 1996	
Texans Attitudes, Full Report, 1996	

PLEASE PRINT

A physical address not PO Box is needed if ordering several publications.

NAME: _____

Agency: _____

Address : _____

City _____ State ____ Zip code _____

Phone No.: _____ Fax No.: _____

Please send to: Children's Trust Fund of Texas, 8929 Shoal Creek Boulevard, Suite 200, Austin, TX 78757-6854, phone 512/458-1281, fax 512/458-9471, inquiries@ctf.state.tx.us. Please visit our Web Site at http://www.ctf.state.tx.us

J:\inforeq\request.doc

Nonfamily Abduction

I. Introduction

A. Definition of nonfamily abduction

B. Statistical overview

II. Initial Response to Nonfamily Child Abduction Cases by Law Enforcement

A. Law enforcement components

1. First responder

2. Supervisor

3. Investigative team

B. Initial approach

1. Importance

2. Attitude

C. Case stages

1. On scene

2. Follow up

a. short term

b. long term

3. Recovery

4. Trial

III. Responsibility of the First Responder

A. Immediate activity prior to arrival at scene

1. Be observant

2. Copy complete description of child and suspect

B. Immediate activity upon arrival at scene

1. Contact complainant—confirm nature of call

2. Confirm description of child/suspect/vehicle—rebroadcast

3. Request and direct backup units

4. Conduct a thorough search of residence

5. Safeguard scene

6. Secure clothing worn by child (bed sheets)

7. Stay with parent and do thorough interview

8. Establish perimeter

9. Enter child into NCIC

10. Establish a staging area away from family/scene

11. Notify a supervisor

IV. Supervisor Responsibility

A. Uniformed supervisor upon arrival at scene

1. Debrief first responder

2. Select command post site

3. Coordinate search/personnel needs

4. Appoint a scribe

5. Contact and brief investigative team

B. Investigative supervisor upon arrival at scene

1. Assume overall responsibility for investigation

2. Coordinate resources with uniformed supervisor

3. Coordinate with public information officer

4. Act as spokesperson for investigative team

5. Ensure activity log is maintained

6. Confirm establishment of command post

V. Responsibility of Primary Investigator

A. Collect original supplemental reports

B. Remain with reporting party

C. Coordinate with patrol and secondary investigators to ensure complete search

D. Obtain a complete description of child

1. Prepare a (flyer) bulletin

E. Ensure victim is entered in NCIC

F. Send teletypes

G. Set up phone trace and recorder

H. Determine availability of medical and dental records

I. Obtain hair sample of:

1. victim

2. parents/family

3. pets

J. Obtain teeth impressions, fingerprints

K. Compile complete list of friends and relatives

L. Coordinate with other agencies, units (i.e.,. Sex Crimes) for address, M.O. of known sex offenders

M. Interview immediate family in depth

N. Monitor all incoming/outgoing phone calls

O. Keep phone line open

P. Note identification of everyone present

Q. Remain at residence with parents

R. Determine if any unusual strangers or prowlers have been seen in the vicinity

S. Explain to parents what is being done

VI. NCIC Off-Line Log Search

A. Case studies

B. Video/slides

VII. Responsibility of Secondary Investigator

A. Supervise search of external areas

B. Contact prosecuting attorney for search warrants

C. Record all license plate numbers in area

D. Search vehicles leaving scene

E. Run registration checks on all cars

F. Conduct follow-up interviews of friends, classmates, etc.

G. Direct evidence collection

H. Produce/distribute missing person poster

I. Coordinate civilian search teams

J. Identify and question persons who frequent the area

1. electric meter readers

2. gas company employees

3. newspaper carriers

4. postal workers

5. lawn service employees

6. maintenance workers

7. taxis

K. Conduct door-to-door canvass if not done by patrol force

L. Obtain map of the area

M. Use police vehicle P.A. system if applicable

N. Follow up on leads provided by primary investigator

VIII. Case Studies

A. Court disposition

IX. Practical Exercise (Group)

A. Handout

B. Video

C. Flipchart

D. Discussion/review

Missing Person's Call Out Questionnaire

INC # _____ Start Time _____ Date _____

Call Received Time _____ Date _____

Requested by _____ Call Sign _____

Field Supervisor _____ Call Sign _____

Missing Person's Name _____ DOB/Age _____ / ____

Missing From _____

Missing How Long _____

Reporting Person _____

Prior Missing Reports Y_____ N_____ How Many _____

Medical Conditions _____

Mental State _____ Diagnosed Y_____ N_____

Hazard to Self _____ Others _____

Reason for Missing _____ Picture Available Y_____ N_____

Vehicle Involved: Make _____ Model _____ Year _____ Plate _____

Additional _____

Possible Destination _____

Number of Witnesses _____

In the Company of _____

Relationship _____

Radio Channel _____ Command Post Y_____ N_____ Location _____

Comments _____

_____

_____

Missing Person Detail Call Out Policy

I. The Missing Persons Team

The team will normally consist of one (1) sergeant and two (2) missing persons detail detectives. Additional detectives will respond, if necessary.

II. The Sergeant

A. Oversees the duties of the missing persons detectives to ensure that all applicable provisions of this policy are followed.

B. Coordinates with the patrol supervisor to ensure the most efficient use of manpower and the complete coverage of each portion of the investigation.

C. Recommends initiation of Phase 3 and/or Phase 4 to unit lieutenant if the investigation becomes complex, extended, or additional resources are required.

D. Coordinates with the public information officer to ensure the timely flow of accurate information in order to enlist the cooperation and support of the citizens in the community.

E. Keeps department staff advised of developments of situation at all times.

F. Ensures a log is kept on all information gathered.

G. Establishes command post away from scene.

H. Ensures unit lieutenant is advised and updated on incident. In his/her absence, notification will be made to the G.I.B. commander.

III. The Primary Investigator

A. Responsible for the collection of the original departmental report (if completed by a patrol officer) and the preparation of his/her report, and the collection and distribution of all supplemental and related reports.

B. Assigned to remain with the complainant at a location as close as possible to the scene of the disappearance, wherever telephone and radio communications are available.

C. As quickly as possible, do the following and verify the completion of each task with a check mark.

☐ 1. Receive a verbal report from patrol division.

- ☐ 2. Coordinate as necessary with patrol and the secondary investigator to ensure a complete search.
- ☐ 3. Obtain complete physical description; D.O.B.; social security number; driver's license number; AKAs; scars; marks; tattoos; physical deformities; date, time, and place last seen; clothing description; possible destinations; information on physical or emotional problems; and photo if available.
- ☐ 4. Bluebook and broadcast.
- ☐ 5. Enter into NCIC—report hand-carried to G.I.B. desk sergeant.
- ☐ 6. Compose and send any necessary teletypes.
- ☐ 7. Determine availability of fingerprints, dental charts, and medical records.
- ☐ 8. Obtain samples of the victim's hair.
- ☐ 9. Obtain samples of family members hair.
- ☐ 10. Obtain the family's fingerprints.
- ☐ 11. Obtain samples of hair from family pets.
- ☐ 12. Seal off victim's bedroom.
- ☐ 13. Coordinate with the sex crimes detail to obtain names, addresses, and M.O.s of known sex offenders in the area.
- ☐ 14. Obtain list of friends and relatives.
- ☐ 15. Note the identities of everyone present.
- ☐ 16. Question all family members individually.
- ☐ 17. Question friends in the immediate area.
- ☐ 18. Question schoolmates or business associates in the immediate area.
- ☐ 19. Provide tape recorder and instructions for its use to family for recording phone calls.
- ☐ 20. Monitor incoming calls—find out who called and why. Note conversation.
- ☐ 21. Ask family to keep phone lines open as much as possible.
- ☐ 22. Question family members about victim's potential enemies, former spouses, etc.

☐ 23. Determine if strangers or prowlers have been noted in area of residence, school, or work.

☐ 24. Determine any recent criminal activities or suspects in area.

☐ 25. Account for victim's clothes, car, medications, cash, credit cards, and weapons.

☐ 26. Remain with complainant until released by missing persons supervisor.

a. Continue the follow-up to case completion if the investigation enters phase 4.

b. Have trap and trace put on telephone.

IV. Secondary Investigator

A. Will coordinate with primary investigator and detail sergeant to ensure a rapid and thorough search of the home and immediate area.

B. Will coordinate with patrol and make recommendations as to the following being completed.

☐ 1. Immediate search of home.

☐ 2. Perimeter established.

☐ 3. Sealing of the area.

☐ 4. Identify and note all vehicles and drivers in perimeter. Search trunks of vehicles leaving.

☐ 5. Run registration checks and stolen checks on all vehicles present.

☐ 6. Identify and note all subjects in area on foot.

☐ 7. Ensure systematic search of area includes the following:

☐ a. Attic

☐ b. Sheds

☐ c. Basements

☐ d. Dumpsters

☐ e. Crawl spaces

- ☐ f. Laundry and recreation rooms
- ☐ g. Vacant apartments and buildings
- ☐ h. Air support for search of roof tops and extend areas
- ☐ i. Swimming pools and other bodies of water
- ☐ j. Dive team advised if area contains canal or mini-lake environment
- ☐ k. Canine team or blood hound
- ☐ l. Body dog, if necessary
- ☐ m. Search of open fields
- ☐ n. Hazards such as abandoned refrigerators, junk cars, sewers, etc.
- ☐ o. Play areas used by children such as tree houses, etc.

☐ 8. Provide briefing information for precincts, night detectives, community relations silent witness

☐ 9. Coordinate with unit sergeant and field supervisor on need for assistance from:

- a. Other law enforcement agencies
- b. Civilian search and rescue units

☐ 10. Identify and question the following individuals who frequent the area:

- a. Gas company employees
- b. Delivery persons
- c. Phone company employees
- d. Sales personnel/canvasses
- e. Electric company employees
- f. News carriers
- g. Letter carriers
- h. Lawn service employees

i. Security personnel

j. Maintenance workers

☐ 11. Identify and question all neighbors

☐ 12. Conduct door-to-door search on apartment complex and/or neighborhood areas

☐ 13. Obtain map of area—either hand-drawn or apartment type. Map should include the following:

a. Where victim was last observed

b. Police perimeter

c. Location of police personnel

14. Attempt to locate victim by using the listed off-site resources.

☐ a. Victim's job

☐ b. School

☐ c. Known friends

☐ d. Former spouses

☐ e. Suspected enemies

☐ f. Creditors

☐ g. Relatives

☐ h. Former neighbors

☐ i. Bureau of Records and Identification check of the following:

☐ 1) Victim/suspect file on principals

☐ 2) Stolen/recovered vehicles and bicycles in area

☐ j. Radio supervisor for related calls and suspicious persons/vehicles in area

☐ k. M.V.D. and driver's license checks as needed

- ☐ l. Phone company trap and trace
- ☐ m. Doctor's office or hospital checks
- ☐ 15. Check taxi companies and Dial-A-Ride for recent pick-ups in area
- ☐ 16. Teletypes, bulletins
- ☐ 17. NCIC entry
- ☐ 18. Ensure copy of original D.R. taken to G.I.B. desk sergeant
- ☐ 19. Utilize police vehicle public address systems, if applicable
- ☐ 20. Coordinate above items with primary investigator after search of area has been completed

V. Victim (if located)

A. Notification will be made to the field supervisor and missing persons supervisor as soon as possible

B. Interview victim:

1. Completed by primary investigator
2. Establish if crime occurred
   a. Notification made to appropriate detail
   b. Stand by with victim until appropriate detail arrives

VI. Equipment

A. Each detective's vehicle should be equipped with the following equipment and clothing:

1. Turn-out boots
2. P.D. Class B—with P.D. T-shirt or jumpsuit uniform with cloth badge, name tape, and P.D. patches
3. P.D. issue ball cap
4. P.D. "raid jacket" for inclement weather
5. Collapsible "entrenching tool" type shovel

6. Crime scene tape

7. Detailed maps of county

B. Each sergeant should also have:

1. A water cooler of a size sufficient to meet the needs of a 3-man team for at least 12 hours in hot weather

2. One evidence kit

3. Copies of G.I.B. manual (section missing persons detail call out policy)

4. Tape recorders with phone jack and ear piece

S320D96

Interview Techniques

Course Content

- Interviewing victims of sexual abuse
- Interviewing missing and exploited children
- Interviewing adolescent runaways

Interview Consideration

I – Intrusive
F – Fear
A – Anxiety
G – Guilt
E – Embarrassment

Dynamics of Disclosure

1. Mandatory
2. Stranger

ANGER

Decision making is affected by <u>consequences</u> and a child's <u>perception of our reaction</u>.

Developmental Considerations

- Egocentric
- Chronological versus developmental
- Visual reasoning
- Attention span
- Questioning children
- Needs of the child

Phases of an Interview

1. Preparation and setting
2. Rapport and assessment
3. Structure and empowerment
4. Transition and inventory
5. Focus memory and free recall
6. Questioning protocol and tools
7. Overcoming reluctance and anxieties
8. Closure and connections

Preparation and Setting

- Interviewer
- Interview setting
- Case preparation

Interviewer

- Knowledge and comfort level with children
- Perspective and objectivity
- Child advocate vs. shining knight
- Needs of child vs. case

Interview Setting

- Neutral and private location
- Room design and equipment
- One person or lead interviewer
- Role of support person
- Documenting the interview

Case Preparation

- Interdisciplinary teams
- Cooperation and information collection
- Develop an investigative strategy
- Immediate interview pitfalls

Interviews to Conduct First

- Reporting party
- Person first disclosed to
- Family members
- Friends of the victim
- Teachers and caretakers

Rapport and Assessment

- Separation and introductions
- Ice-breaking and engagement
- Gradual and supportive approach
- Neutral and nonthreatening activities
- Two-way conversation and assessment
- Trust and rapport building essential

Structure and Empowerment

- Preparation for questioning
- Setting a structure
- Providing options

Transition and Inventory

- Why are you here today
- Transitional props
- Freehand drawings
- Anatomical inventory
- Don't exceed competency level

Focus Memory and Free Recall

1. Discuss child's environment
2. Reconstruct circumstances of abuse
3. Free recall of events
4. Cognitive interview techniques

Questioning Protocol and Tools

- Specific question phase
- Important questions to ask
- Who, what, where, and how
- When is harder for kids
- Careful of why questions
- Five types of questions

Five Types of Questions

1. General
2. Focused
3. Multiple choice
4. ?'s req. yes/no answers
5. Leading questions

Overcoming Reluctance and Dealing With Emotions

- Gradual progression/chip away.
- Gently impress importance.
- Probe for secrets and threats.
- Discuss fears of disclosure.
- Reflective listening.
- Demonstrate understanding and concern.
- If stuck, narrow focus.
- Be creative/adjust approach.
- Navigating a ship in uncharted waters.
- Know when to quit.

Closure and Connections

- Maintain rapport regardless of outcome.
- Reinforce not to blame/done nothing wrong.
- Encourage questions.
- Don't violate trust/unauthorized promises.
- End with a neutral and fun activity.
- Establish connection with victim/witness advocates.

Conceptual Model of C.S.A. Interviews

1. Preparation and setting
2. Rapport and assessment
3. Structure and empowerment
4. Transition and inventory
5. Focus memory and free recall
6. Question protocol and tools
7. Overcoming reluctance and anxieties
8. Closure and connections

Interviewing the Older Child

- Determine child's perception of you and of law enforcement officers.
- Assess degree of trust present in child.
- Establish an alliance with child.
- Determine what is in it for the child.
- Allow the child some control and power over the interview.
- Ask the child his/her opinion of what should happen.
- Discuss options and possible outcomes.
- Don't act like the perpetrator and attempt to intimidate the child.
- Tell the child what services are available to him/her.

Opening Questions/Statements

- "How do you want or wish to be helped?"
- "I would like to understand what's been going on in your life."
- "My job is to try and help keep you out of danger and protect you from people who want to abuse and hurt you."

Understanding the Adolescent Runaway

- The teen does not feel valued by family or society.
- Most come from dysfunctional families.
- Family life is stressful and unhappy.
- Teen is given little support, time, or attention by family and teachers.
- Anger, conflict, and dissatisfaction are prevalent.
- The teen learns to cope through suppression of emotions/feelings.
- Learns street survival through criminal acts.
- Enhances their perception of being an outcast in society and family life.
- Most abuse drugs and alcohol.
- Most have been beaten and/or sexually abused.

Adolescent Runaway's Self-Perception

- Most see themselves as:
  - Trustworthy
  - Easy going
  - Strong
- Most would not change who they are.
- Believe friends/classmates think highly of them.

- Emotionally unhappy with their lives.
- Frequently nervous, worried, and afraid.
- Feel different from most people.
- Feel betrayed and remain isolated.

Dealing With the Adolescent Runaway

- Attend to teen's physical needs first.
- The amount of time that the teen has spent on the street equals his/her difficulty in communicating.
- Youth must not feel threatened.
- Allow the teen some decision making opportunities.
- Questioning causes defensiveness in the youth.

Interviewing the Adolescent Runaway

- Runaways tend to blame themselves.
- Youths interpret searching questions as attacks on their views.
- Stress that your intention of the interview is to learn what happened and assist the teen.
- Use levity and understanding versus confrontation.
- Males are especially reluctant to admit to any sexual exploitation.

PERSPECTIVES OF CHILD ABUSE

JONI L. MCCLAIN, MD
MEDICAL EXAMINER
SOUTHWESTERN INSTITUTE OF FORENSIC SCIENCES
DALLAS, TEXAS

HISTORICAL PERSPECTIVE:

1946 Dr. Caffey wrote his landmark article reporting his observations of a common association of subdural hematomas and abnormal x-ray changes suggestive of trauma in long bones.

1961 Dr. Henry Kempe first used the term "Battered Child Syndrome".

INCIDENCE

1.5 - 2.0 million children are at risk for serious injury or death each year.

Several thousand children are estimated to die each year of non-accidental trauma.

The most common age at risk is 1 month to 6 years.

Half of all the deaths are below 1 year of age.

Males slightly outnumber females in the incidence of abuse.

BLUNT FORCE INJURIES

TERMINOLOGY:

ABRASION: Scraping of the skin with removal of the superficial layers. Indicates an area of impact. Some abrasions are patterned. If the abrasion shows a pattern, it is possible to sometimes match the object that produced the injury with the pattern.

LACERATION: Tearing of the skin produced by blunt trauma. Classically, a laceration shows "tissue bridging".

BLUNT FORCE INJURIES (continued)

CONTUSION (BRUISE): Hemorrhage into the skin, tissues under the skin, or both. May have a pattern. Different colors of bruises generally indicate that the trauma occurred at different times.

FRACTURES: Broken bones
Types: depressed, comminuted, spiral, etc.

POSTMORTEM CHANGES

RIGOR MORTIS: The stiffening of the body after death due to the muscles of the body becoming hard as a result of chemical changes within the muscle fibers.

LIVOR MORTIS: Purple discoloration of the skin due to the settling of the blood into the dependent parts of the dead body.

Colors of livor mortis

Purple: Normal
Cherry-red: Carbon monoxide intoxication
Red-pink: Cyanide
Refrigeration
Green: Hydrogen sulfide

INVESTIGATION OF CHILDHOOD DEATHS: Questions to ask.

1. Scene Investigation

a. Where was the body found?
Note any rigor mortis, livor mortis
Note the temperature of the body (warm or cold)
Photograph the scene

b. What is the condition of the home?
Check the cleanliness, environmental hazards, drugs, adequate food, insects, temperature of the residence, etc.

c. What is the condition of the other siblings?

d. Who was taking care of the child?

e. Who is living in the house? Stepfather? Boyfriend?

f. What happened to the child?
Separate interviews of the caretakers and siblings may be beneficial

INVESTIGATION OF CHILDHOOD DEATHS: QUESTIONS TO ASK (CONTINUED)

g. What is the past medical history of the child? Colicky? Cries a lot? Health problems?

h. Have there been any reports filed on the household for suspected child abuse?

i. If the child was taken to the hospital, was there a delay in getting treatment?

j. Have other children died? If so, what was the cause of death?

MEDICO-LEGAL AUTOPSY

All suspected child abuse cases are ideally autopsied by a medical examiner (forensic pathologist).

The autopsy consists of a complete and thorough examination of the deceased including examination of the clothing, full body x-rays, photographs, diagrams, toxicology, and histology. Collection of trace evidence if needed is also performed at the time of the autopsy.

Incisions are made over the back, buttocks, and lower extremities looking for injuries.

Photographs are taken of the injuries. Routine photographs of the entire body are also obtained.

CORRELATION OF FINDINGS AT AUTOPSY WITH THE INVESTIGATIVE FINDINGS

1. Does the story fit with the autopsy findings.

2. Could this be an accidental death?

3. Was this a single, impulsive incident or have there been many episodes of abuse?

4. Is the death due to natural causes?

PERSPECTIVES OF CHILD ABUSE

SPECIAL TYPES OF INJURIES SOMETIMES SEEN IN CHILD ABUSE

TORN FRENULUM - due to a slap, punch, or jamming a bottle in the mouth, or shearing stress applied when the nose is pinched and the mouth is covered.

SPIRAL FRACTURES OF LONG BONES- due to a twisting motion

ACCIDENTAL CONTUSIONS vs INFLICTED CONTUSIONS

Accidental contusions are due to bumps and falls and are generally located over the bony prominences such as the forehead, chin, elbows, knees, and shins.

Inflicted contusions are generally over the buttocks, back, thighs, genitalia, earlobes, neck, and cheeks.

ARTIFACTS

Tight clothing on the skin may cause indentations on the skin that can simulate ligature strangulation.

Mongolian spots are hyperpigmented areas in the buttock region or back that may resemble bruises.

Marks from cardiopulmonary resuscitation may resemble inflicted blunt trauma.

Birth trauma must be ruled out from inflicted trauma.

Postmortem insect activity or animal activity must not be mistaken for inflicted trauma.

INFANTICIDE

Definition: The murder or killing of an infant soon after its birth.

Infanticide
- -most commonly committed by the infant's mother
- -smothering and strangulation are the most common methods (this type of death may leave little or no injury on the body); the pathologist should closely check the body for small abrasions, contusions, or conjunctival petechiae.
- -correlate findings at autopsy with the account of the history by the mother and witnesses.

PERSPECTIVES OF CHILD ABUSE

Infanticide (continued)

-the mother may need to be examined by an obstetrician for signs of a difficult delivery that could explain the death.

Questions in infanticide deaths:

1. Was the child born alive?

If food is found in the stomach, this is an indication that the child was born alive. Air in the lungs or intestines may be due to resuscitation or decomposition and does not always indicate the child was born alive. Foreign material in the distal airways of the lungs may be valuable if the child was born alive into a toilet and aspirated debris.

2. Was the child viable?

Correlate the birth weight and height with gestational age. Is the birth weight and height compatible with life? Are there any congenital birth defects? Is the fetus macerated? If the fetus is macerated, this indicates that the child was dead in the uterus.

PROBLEMS WITH INFANTICIDE DEATHS

In dealing with infanticide deaths, identification may become the main problem. The infant may never be identified, especially if it is dumped in a public location. Attempts to locate the mother can be made by surveying emergency rooms for women who have recently delivered a baby. Also serology and DNA specimens can be obtained from the infant for later comparison to the suspected mother.

CHILD NEGLECT

The pathologist must differentiate between intentional starvation versus a natural disease process. Other types of child neglect include depriving a child of medical treatment. An example would be a child dying of a ruptured appendix because the family refused to seek medical attention on religious grounds.

The overall condition of the home should be assessed by the investigator. In cases of suspected starvation, the house should be examined for the amount of food in the house.

PERSPECTIVES OF CHILD ABUSE

SEXUAL ABUSE

Bite marks on the child, especially in the genital region are suggestive of child abuse. A sexual assault kit should be obtained to check for sperm or seminal fluid. Venereal disease in a child indicates abuse. The pathologist or pediatrician should check for injuries to the genitals or anus. Correlate the findings with the history of what happened to the child.

"SHAKEN INFANT SYNDROME"

Many pathologists no longer use this term as a cause of death on a death certificate. At the Southwestern Institute of Forensic Sciences in Dallas, we prefer to use terms such as Craniocerebral trauma, Head Injuries, Blunt force injuries of the head, etc. as the cause of death.

Classically, the injuries associated with the term "Shaken Infant Syndrome" include the following: Retinal hemorrhage, subdural hemorrhage &/or subarachnoid hemorrhage. There may be little or no external injuries noted on the child.

In the majority, if not all of the cases of this type investigated by SWIFS, evidence of blunt trauma to the head consisting of a bruise or subscalpular hemorrhage is detected. This does not eliminate shaking as occurring. However, it indicates that the head has impacted or been impacted by some object.

BURNS

Accidental burns are generally asymmetrical and random. They commonly occur on the front of the body or on the hands. They are poorly demarcated and may have a splash type pattern.

Inflicted burns are commonly symmetrical in a hand, glove, or sock pattern. There may be a dip or immersion pattern over the buttocks or lower extremities.

Branding type burns may occur with curling irons or cigarettes. These burns are generally over the back, arms, or buttocks.

SCALDING INJURIES (Temperatures of water or other liquids)

150 degrees fahrenheit will produce a 2nd degree burn in 1-2 seconds.

140 degrees fahrenheit will produce a 2nd degree burn in 3 seconds.

130 degrees fahrenheit will produce a 2nd degree burn in 30 seconds

SCALDING TYPE INJURIES

The investigator should check the hot water tank temperature as well as the faucet set-up and temperature of the water from the faucet in injuries due to scalding water.

RADIOLOGY

A radiologist may be useful in assessing any pre-existing trauma to the bones. Radiology is also useful in dating bone injuries, assessing metaphyseal fractures of the long bones due to rough handling and violent shaking. Subperiosteal hemorrhages of the bone due to twisting or wringing of the long bones can be detected. Also rib fractures can be assessed.

SUMMARY OF TREATMENT GUIDELINES IN WORKING WITH ABUSED CHILDREN: OUTLINE

INTRODUCTORY REMARKS

The common denominator in CAN cases is the potential for traumatic impact

Each child has unique response and factors affecting impact (including age, chronicity and severity of abuse, environmental factors including protection and safety; personality and biological factors)

Children make idyosincratic meaning of the event at the time, and may later make cognitive reevaluations

Trauma must be resolved: Closure and disengagement

Children have conflicting drives to achieve mastery and control, and to deny, suppress and avoid difficult (overwhelming) emotions. Therefore, the therapist must gauge therapy posture based on the child entering, and continuing, in treatment.

Few treatment outcome studies; some therapy techniques easier to measure than others (See Finkelhor and Berliner, 1995).

BASIC ISSUES: Summary of research findings re. common symptomatology

See Kendall-Tackett, Williams & Finkelhor (1993): No *profile* of sexually abused children exists. Some symptoms seem to appear with greater frequency:

Fear and anxiety: Hypervigilance and hyperalertness

Depression: Withdrawal, flat affect

Aggressive sexual behaviors, or "Traumatic Sexualization," (Finkelhor & Browne, 1985)

The differentiating effects based on type of abuse have not been empirically proven. Many symptoms (including above) can be found in children who are physically abused, neglected or emotionally maltreated. These symptoms, and others, are not conclusive of abuse, but they suggest that an assessment consider the possibility. In addition, other research findings include:

Aggression: Destructive of property (Attacks as primary defense)

Problems in development of *self*: Self-image, esteem problems; increased sense of vulnerability and futility

Problems in identity formation: Kegan and Coopersmith note that the following must be present to form (positive) identity: attainment of love, feelings of significance, a sense of virtue, and mastery, power and control.

THEORETICAL MODELS

Friedrich (1995) notes that most current work with abused children and their families use three primary models: traumagenic factors (as per Finkelhor), information-processing (as per Burgess and Hartman); and PTSD models(in other words, trauma theory). He suggests adding three other important theoretical frameworks: attachment theory, (emotional and behavioral) dysregulation theory, and theories of self-perception and development. This combination appreciates both individual impact and family context.

Gender Differences: (Friedrich, 1995)

Sexual abuse of boys more often accompanied by physical abuse

Male children more externalizing (Challenge to deal with dysregulation while recognizing internal distress)

The earlier a pattern of aggression is developed, more likely boys will have difficulties with law as they get older

Language acquisition and verbal expression (key in developing social skills and self-control) are not as rapid in boys (Implications for treatment)

Problem sexual behaviors more likely more frequent treatment issue for boys. More or less unique to boys are confusion/anxiety over sexual identity; inappropriate attempts to reassert masculinity; and recapitulation of victimizing experience.

THE PHENOMENOLOGIC EXPERIENCE — ASSESSMENT

Assessment of symptoms: Intent and what it seeks to address

Family assessment: Environmental safety, ability and willingness to provide appropriate care and protection. A focus on safety first.

Criteria for accepting into treatment (Friedrich, 1990): Therapy most effective when 1)there is ongoing support by primary caretaker; 2)child has a sense of safety; 3)child's therapy concurrent with system change; and 4) the therapy is goal oriented

Need for family therapy and therapy beyond the symptom reduction phase- expected participation of caretakers: Observer role

Format of therapy: child, parent-child, family (talk about symptom reduction)

Critical evaluation issues: suicidality and danger to others; self-injury; gender-identity issues; killing animals; dissociation. Likewise important to assess for resilliency issues, strengths, and the possibility of stress-resistant personalities (differentiating from suppression or other defensive mechanisms).

CULTURALLY-SENSITIVE ASSESSMENT AND INTERVENTIONS

Definition of culture from multidimensional approach. Culture: "...sets of shared world views, meanings and adaptive behaviors derived from simultaneous membership and participation in a multiplicity of contexts such as rural, urban, or suburban setting; language, age, gender, cohort, family configuration, race, ethnicity, religion, nationality, socioeconomic status, employment, education, occupation, sexual orientation, political occupation, migration and stage of acculturation." (Falicov, 1996, p.375). Falicov suggests therapeutic conversation and curiosity, respect of diversity and commonalities, avoidance of "superior/inferior" judgements.

When working with abused children and their families, it is important to assess the family's culture, neither over- nor under-emphasizing the role of culture in patterns of maltreatment. It is also useful to explore obstacles to self-disclosure (that is, whether introspection and verbal expression are more or less valued or encouraged); the acceptability of help-seeking behaviors both within and across cultures; who the accepted helpers are within cultures and what the acceptable healing rituals are. It is likewise important to understand the family's view of their culture's development vis a vis oppression and exploitation — this history may create an understandable difficulty with trust and willingness to ask or receive from a mainstream culture. Regarding family violence and sexuality, these topics are more or less charged in different cutlures and may create a barrier to effective discussion of necessary topics. The level of acculturation may create divisions among family members or may provoke maladaptive attempts at control of children.

Assess/provide culturally-sensitive intervention (intake); goal-setting; therapy format; requests for participation of extended family members; type of therapy interventions used; tools and props; interactions with community agencies; invitations to community helpers; confidentiality; use of verbal contracts or written contracts; fee negotiations; framework for advancing therapy goals.

GOALS OF THERAPY

Address specific behavioral symptoms within context of symptom reduction followed by additional work on underlying issues:

Re. symptoms: Identify useful intent, support intent, not mechanism, make substitutions by finding alternatives

Allow and encourage opportunities for control and mastery avoiding power struggles

Improve self-concept and self-confidence (usually enhanced by opportunities for control and mastery)

Encourage exploration of relational issues (attachment, dependency, trust) and encourage rehearsal of new behaviors designed to elicit positive responses. Promote affiliation with peers

Allow and promote individual avenues of self-expression (art, crafts, song, poetry, movement, sand, etc.)

Provide a safe holding environment that elicits feelings of safety and trust: Encourage a reparative process: Be cautious of over-identification with victim role

Coping strategies for pre- and post-abuse issues promoting increased sense of control

Resolution of trauma: Make meaning of the experience; achieve closure

Orientation to future: Reality-based hope and optimism

TREATMENT OF CHOICE

Play Therapy: Natural and self-healing; releases tensions; allows child to compensate in fantasy for real or perceived hurts; self-discovery of adaptive behaviors; way to communicate/express; cathartic; symbolic resolution of fears, worries, concerns, joys, wishes, conflicts; helps assimilate stressful experiences; allows child active vs. passive role; opportunities for mastery and growth.

Definition by Nancy Boyd-Webb: Psychotherapeutic method, based on psychodynamic and developmental principles, intended to relieve the emotional distress of young children through a variety of imaginative and expressive play materials such as puppets, dolls, clay, board games, art, and miniature objects.

Directive and non-directive therapies

Non-directive therapist active observer; believe that play uncovers unconscious conflicts and desire; interprets; analyses the transference; gives child positive regard; accepts the child unconditionally.

Directive therapists observe, ask the child to describe, suggest motivations or feelings (wonder outloud); focus on child's affect and behavior; become part of the play; set limits; stimulate confrontation of issues; direct the play suggesting themes and activities.

The use of directive and nondirective approaches when working with abused and traumatized children

The need to be equally versed in both approaches

The ability to shift with the child

Answering the question *"Why am I doing this, with this particular child, at this stage of the treatment?*

FUNCTIONS OF PLAY THERAPISTS

"Play therapist not only helps bring about relief of clinical symptoms but also works toward removal of impediments to the child's continuing development so that the prospects for the child's future growth are enhanced." Enzer

Functions include: To develop a therapy alliance; Help the child with understanding; Link understanding to feelings; Recognize advantages/disadvantages of defenses; Work through defenses; Find modes of expressing affect; Assist with coping strategies and social skills.

USE OF PLAY THERAPY WITH ABUSED CHILDREN

Gneeral play therapy models: Psychoanalytic, structured, relationship, behavioral, group, expressive

Choosing appropriate toys and setting up a play therapy room

Basic "stations" in play therapy with abused children:

Art therapy (includes easel, paints, pens, markers, crayons; clay; collage materials; building materials; crafts) Art materials provided on continuum of fluid to resistive.

Puppet therapy: With or without "stage," male and female puppets, animals, and puppets with universal symbolic meanings: "benevolent," and "malicious," vulnerable and fierce; dominant and compliant — culturally-diverse. (Mouths signal communication)

Sandworld therapy: Wet and dry sandtrays, containers for water play, miniatures representing all forms of life, multicultural symbols, religious symbols and so forth.

Safety corner: Pillows, large boxes, hiding place, capes, masks, shields, self-protection

Nurturing and healing: Cooking utensils, play-dough for making food, or food; bathing materials, towels, blankets, diapers, baby bottles, medical kit, medical equipment.

When you do not have a play therapy room, it may be necessary to carry a tote bag with selected play therapy materials. These may also come in handy if you are going on an interview or home visit. I suggest the following materials for a "basic" play therapy bag:

Small doll house with family members (young and older, big and small), as well as an animal family (for example, a bear or rabbit family); Paper and crayons, pencils and markers; Puppets which are both fierce and friendly, maybe 4; A baby doll, nursing bottle, bath-tub, crib, and blanket; Soldiers and superheroes; A mask, sunglassess and telephone.

Assist child with expressive modes and dynamic movement: Comfort with physical sensations and pleasure (walking, running, throwing and catching balls); physical control (dancing, skating, martial arts, tai-chi movement). Activity groups (camping, exploring, climbing, ropes), as well as groups designed to increase children's self-esteem and give opportunities for affiliation. There are some wonderful new programs designed to give children opportunities to develop nurturing relationships with other living things, such as vegetable and gardening projects, and working with animals (both farm and domestic).

Story-telling and the use of metaphors.

Relationship-building and transference/countertransference issues.

Issue of "continuous" therapy and the clinical role.

Play therapy, as well as art and sandworld therapy must be observed in content and process.

GOAL ORIENTED TREATMENT

Make sure you make treatment plans based on 1)Identifying specific goals; 2) Defining goals in behavioral terms which are measurable; 3)Deciding which format and type of therapy will best advance specific goals; 4)Designing or selecting specific play therapy techniques that promote the goal. The use of Goal Attainment Scaling (Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive mental health programs. *Community Mental Health Journal, 4,* 443-453) In addition, the use of psych instruments (both abuse-specific and generic) may help you measure symptom reduction.

THEORIES THAT GUIDE TRAUMA-SPECIFIC WORK

I expand the PTSD model to include a broader view of trauma impact as individualized: the individual may or may not experience trauma impact. The first issue therefore is to assess (and not assume) the level of damage.

Identify and respect defensive strategies: When they are no longer needed they will relax some

The issue of disclosure: Set a context, don't collude with denial, and watch for the child's natural way of exposing self to necessary material. On occassion, clinicians will need to facilitate "Tickle the defenses" Whitaker.

Respect the child's pacing.

TRAUMA-SPECIFIC WORK

Definition of trauma: A trauma is a non-normative, sudden, and unexpected event which overwhelms the person's perceived ability to cope, producing heightened arousal, and a debilitating sense of loss of control.

Impact of trauma: chronic PTSD responses, a sense that the person continues to live in the climate of the trauma; helplessness and vulnerabiilty. Interferes with developmental growth and functioning.

Consensus about trauma resolution: conscious (or unconscious -symbolic) working-through

Explain concept and method to parents and child; allow child to pace work

Purpose:

* Help child recall event: Pairs safe/unsafe

* Help child assimilate experience: Build from what's available

* Sequence/order the event

* Understand/intervene with idiosyncratic meaning (particularly vis a vis "abuse-dominated view of self" Michael White)

* Help child express emotion (discharge affect) verbal or nonverbal

* Give new information/ Discuss "transformation" and coping strategies then and now

* Provide witnessing (reality check)

Detailed trauma resolution work is not necessary with everyone — some children and adults achieve resolution of trauma in their own unique ways, using internal and external resources. This work is done after a strong therapy relationship is underway and when the child has a stable sense of self, coping strategies and support systems in place. The therapist takes care to avoid flooding and obtains supervision and consultation when necessary. This work can elicit strong countertransference responses which must be addressed. In addition, this work is counterindicated for individuals with a fragile ego, lack of internal or external resources, or who show signs of decompensation. Children often do this work through post-trauma play or addressing specific PTSD symptoms.

POST-TRAUMATIC PLAY OR ACTION:

Post-traumatic play is qualitatively different from generic play. Not all traumatized children use post-trauma play spontaneously on in the therapy room. Sometimes, it may be appropriate to encourage the child's use of post-trauma play, since most of the time it seems to have positive effects. Some children who do not use post-trauma play to process trauma material, may engage in behavioral reenactments instead.

It is important to note that post-trauma play can result in negative results for children and should be monitored closely. In particular, if children's symptoms seems to exacerbate and persist (as oposed to "peaking" which may be associated with processing), it may be necessary to intervene in the play.

Post-trauma play may be a way that the child is exposing him/herself to incrumental levels of affect in order to develop coping strategies and affect tolerance. It may be akin to *gradual exposure* and may therefore be effective in that it desensitisizes the child to feared material.

Partial list of characteristics of Post-Traumatic play (Terr, 1983)

Literal, repetitive, rigid, non-spontaneous, fixed, undynamic, no change

Positives: Matches previously unsafe memory with safe outcome

Can help child move through/towards resolution

Intent: Mastery

Negatives: Can reinforce feelings of victimization; helplessness

With same outcome, the child may experience increased vulnerability; increased symptoms

Observe/document the process of post-traumatic play

Talk to parents/caretakers about child's functioning outside therapy

Intervening with morbid, undynamic post-traumatic play

Types of intervention:

Physical movement; Break physical paralysis

Verbal sequencing—Not interpretation

Movement within play

Ask for characters to have voices

Assign roles to child within play
Videotape—show back—pause, forward, reverse, etc.

SELECTED BIBLIOGRAPHY ON WORKING WITH ABUSED CHILDREN

Araji, S. K. (1997). *Sexually aggressive children: Coming to understand them.* Thousand Oaks,CA:Sage Publications

Araoz, D. L. & Carrese, M. A. (1996). *Solution-Oriented brief therapy for adjustment disorders: A guide for providers under managed care.* NY: Brunner/Mazel

Anthony, J. (Ed), & Cohler, B.J., (1987) *The invulnerable child.* NY:Guilford Press

Bray, M. (1992). Poppies on the rubbish heap: Sexual abuse, the child's voice. Canongate Press Pl., 14 Frederick Street, Edinburg, England

Brooks, B., & Siegel, P. M. (1996). *The scared child: Helping kids overcome traumatic events.* NY:Wiley & Sons

Burgess, A. W. & Hartman, C. R. (1993). Children's drawings. *Child Abuse and Neglect*, 17, pp.161-168.

Cabe, C. N. (1991). *Working through the pain: A guide to group treatment for the adolescent male surivor of childhod abuse.* Rainbeau counseling and research center, 147 East Aurora Rd., Northfield Center, OH 44067

Cantwell, H. (1988) Child Sex Abuse: Very Young Perpetrators. *Child Abuse and Neglect* 12:579-582.

Cattanach, A. (1993). *Play therapy with abused children.* Jessica Kingley Publishers: London.

Ceci, S.J., Toglia, M.P., Ross, D.F., (1987) *Children's eyewitness memory.* NY: Springer-Verlag

Chetnik, M. (1989). *Techniques of child therapy: Psychodynamic strategies.* NY: Guilford Press

Combrick-Graham, L. (Ed), (1989). *Children in family contexts: Perspectives on treatment.* NY: Guilford Press

Cooper, S. & Wanerman, L. (1977) *Children in treatment: A primer for beginning psychotherapists.* NY: Brunner/Mazel

Cunningham, C. and MacFarlane, K. (1988) *Steps to healthy touching. KIDSRIGHTS, Mount Dora:FL.*

Cunningham, C. & MacFarlane, K. (1991) *When children molest children: Group treatment strategies for young sexual abusers.* Safer Society Press, Orwell:VT

Deblinger, E. & Heflin, A.H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach.* Thousand Oaks, CA: Sage Publications

Deblinger, E. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 5, 747-752.

Deblinger, E. (1992). Child sexual abuse. In: A. Freeman & F. Datilio (Eds.). *Comprehensive casebook of cognitive therapy.* Plenum Press:NY.

Donovan, D.M. & McIntyre, D. (1990). *Healing the hurt child: A developmental-Contextual approach.* W.W.Norton:NY

Finkelhor, D. , (Ed.) (1986) *A sourcebook on child sexual abuse.* Sage Publications: CA

Finkelhor, D. & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. *J. American Academy of Child and Adolescent Psychiatry,* 34(11): 1408-1423.

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541

Friedrich, W.N. (1995). *Psychotherapy with sexually abused boys: An integrated approach.* Sage Publications: CA

Friedrich, W.N. (1993). Sexual victimization and sexual behavior in children: A review of recent literature. *Child Abuse and Neglect,* 17, pp. 59-66.

Friedrich, W.N. (1990) *Psychotherapy of sexually abused children and their families.* NY: W.W.Norton

Friedrich, W. and Luecke, W. (1988) Young school-age sexually aggressive children. *Professional Psychology Research and Practice* 19,2: 155-164.Garbarino, J., Stott, F.M., et al (1990) *What children can tell us.* SF: Jossey-Bass.

Garbarino, J., Guttmann, E., Seeley, J.W.,(1986) *The psychologically battered child.* NY: Jossey-Bass.

Gil, E. (1996). *Treating abused adolescents.* Guilford Press:NY

Gil, E. (1994). *Play in family therapy.* Guilford Press:NY

Gil, E. (1991). *The healing power of play: Therapy with abused children.* NY:Guilford Press.

Gil, E. & Johnson T.C. (1993). *Sexualized children: evaluation and treatment of sexualized children and children who molest.* Launch Press: Rockville, MD.

Greenspan, S.I. (1981) *The clinical interview of the child.* NY: McGraw-Hill.

Hartman, C. R. & Burgess, A. (1993). Information processing of trauma. *Child Abuse and Neglect,* 17, pp.47-58.

Ho, Man Keung (1992). *Minority children and adolescents in therapy.* Sage Publications, Newbury Park:CA.

Hunter, M. (1990) *Abused boys: The neglected victims of sexual abuse.* Lexington:MA, Lexington Press.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* Lexington:New York.

James, B. (1989). *Treating traumatized children: New insights and creative interventions.* Lexintgon,MA: Lexington Books.

Johnson, T. C. (1989) Female child perpetrators: Children who molest other children. *Child Abuse and Neglect* 13,4: 571-585.

Johnson, T. C. (1988) Child perpetrators, Children who molest other children: Preliminary Findings. *Child Abuse and Neglect* 12:219-229.

Johnson, K. (1989). *Trauma in the lives of children.* Claremont:CA, Hunter House.

Johnson, T.C. (1989) Children who molest other children: A treatment program. *Journal of Interpersonal Violence* 4:185-229.

Kalff, D.M. (1980). *Sandplay.* Santa Monica:CA, SIGO Press.

Karp, C. L., & Butler, T. L. (1996). *Treatment strategies for abused children: From victim to survivor.* Thousand Oaks, CA: Sage Publications

Kempe, C.H. & Helfer, R. (1980) (3rd ed.)*The battered child.* Chicago: University of Chicago Press.

Kendall-Tackett, K. A., Williams, L.M., Finkelhor, D. (1993). The impact of sexual abuse on children: A review and ssynthesis of recent empirical studies. *Psychological Bulletin,* 113, 1, pp.164-180.

Lanktree, C. B. & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. *Child Abuse and Neglect, 19*, 9:1145-1155.

MacFarlane, K., Waterman, J. et al (1986) *Sexual abuse of young children.* NY: Guilford Press.

Mandell, J.G. & Damon, L. et al (1990) *Group treatment for sexually abused children.* NY: Guilford Press.

Monahon, C. (1993). *Children and trauma: A parent's guide to helping children heal.* Lexington:NY.

Myers, J. B. (1987). *Child witness law and practice.* NY: Wiley & Sons.

O'Connor, K. J. (1991) *The play therapy primer: An integration of theories and techniques.* Wiley:NY.

Orbach, I. (1988) *Children who don't want to live.* NY: Jossey/Bass.

Pearce, J. W. & Pezzot-Pearce, T. D. (1997). *Psychotherapy of abused and neglected children.* NY:Guilford Press.

Porter, E. (1986) Treating the young male victims of sexual assault: Issues and intervention strategies. Orwell, VT: Safer Society Press.

Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective.* NY: Guilford Press

Putnam, F.W. (1993). Dissociative disorder in children: Behavioral profiles and problems. *Child Abuse and Neglect,* 17, pp.39-45.

Pynoos, R. S. and Eth, S. (1986). Witness to violence: The Child interview. J. of the American Academy of Child Psychiatry, 25(3), pp.306-319.

Rogers, A. G. (1995). *A shining affliction: A story of harm and healing in psychotherapy.* NY:Penguin Books

Rubin, L. (1997). *The transcendent child: Tales of triumph over the past.* NY: Basic Books

Seligman, M. & Darling, R. B. (1997). *Ordinary families, special children: A systems approach to childhood disability* (2nd Edition), NY: Guilford Press

Schaefer, C.E. (Ed) (1988) *Innovative interventions in child and adolescent therapy.* Wiley Series on Personality Processes, Wiley & Sons: England.

Schaefer, C.E. & O'Connor, K.J. (Eds) (1983). *Handbook of play therapy.* NY: Wiley Press.

Selman, R.L. & Schultz, L.H. (1990). *Making a friend in youth: Developmental theory and pair therapy.* University of Chicago Press:Chicago,IL.

Sgroi, S. (1989) *Vulnerable populations.* (Volume I) Lexington:NY.

Sgroi, S. (1990) *Vulnerable populations.* (Volume II) Lexington:NY.

Shirar, L. (1996). *Dissociative children: Bridging the inner and outer worlds.* NY: Norton.

Silberg, J. L. (1996). (Ed.) *The dissociative child: Diagnosis, treatment, and management.* Lutherville, MD: Sidran Press

Singer, D. (1993). *Playing for their lives: Helping troubled children through play therapy.* The Free Press:NY

Stosny, S. (1995). *Treating attachment abuse: A compassionate approach.* NY: Springer

Terr, L. (1983). Play therapy and psychic trauma: A preliminary report. In C. E. Schaeffer and K. J. O'Connor (1983). *Handbook of play therapy.* pp.308-320, NY: Wiley.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry.* 148:1, pp. 10-20.

Terr, L. (1990) *Too scared to cry.* NY: Harper & Row.

Vargas, l. A. & Koss-Chiono, J. D. (1992). *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents*. Jossey-Bass: SF,CA

Waterman, J., Kelly, R., Oliveri, M. K., McCord, J. (1993). *Behind the playground walls: Sexual abuse in preschools*. Guilford Press:NY

Webb. N.B. (Ed.)), (1991). *Play therapy with children in crisis: A casebook for practitioners*. Guillford Press:NY.

Wester, W. C. & O'Grady, D. J. , (Eds.), (1991). *Clinical hypnosis with children.* Brunner/Mazel:NY.

Wiehe, V.R. and Herring, T. (1991) *Perilous rivalry: When siblings become abusive*. Lexington Books:NY.

Wiehe, V.R.,(1990) *Sibling abuse: Hidden physical, emotional and sexual trauma*. Lexington:NY.

Yates, A. Psychological Damage Associated With Extreme Eroticism In Young Children. (1987) *Psychiatric Annals* 4,17: 4.

Wolfe, D. (1991). *Preventing physical and emotional abuse of children.* Guilford Press:NY.

RESOURCES

MY UPS AND DOWNS (CARD GAME), $28.45/SET
7849 Ute Highway Longmont, Colorado 80503

MONSTER THERAPY: A MATTER OF CONTROL. Written by Sandra Ballester, Psy.D. and Frederique Pierre, LCSW, 2930 W. Imperial Hwy., Ste.506, Inglewood, CA. 90303

PROJECTIVE STORYTELLING CARDS Northwest Psychological Publishers, P.O.Box 494958, Redding, California 96049-4958

FEELING CARDS Communication Skillbuilders, P.O.Box 279, Kalispell, MT 59903

LET'S TALK ABOUT TOUCHING: A Therapeutic Game. Toni Cavanagh-Johnson, Ph.D., 1101 Fremont Avenue, Ste. 104, South Pasadena, CA 91030

THERAPEUTIC STORIES TO HEAL ABUSED CHILDREN Psychological Associates of Oxon Hill, 6178 Oxon Hill Road, Ste 306, Oxon Hill, MD. 20745, (301) 567-9297

THE BIRD AND THE BUTTONS: HEALING STORIES FOR CHILDREN
by Leah Subotnik, 316 Jordan Street, Nevada City, CA 95959.

UNIQUITY: Books, therapeutic toys, videos. Write for a catalog. P.O.B. 6, Galt, CA 95442 (800)521-7771

CULEBRA DESIGNS: Custom-made playthings for children's therapy. 630 East 9th Street, No.16, NY, NY 10009 (212)473-3002

THERAPLAY PRODUCTS: Books, play therapy materials, videotapes, and therapeutic toys. (Portable sandtray and portable playhouse.) P.O. Box 761, Glen Ellen, CA 95442 (707) 938-3074

PLAYROOMS: Miniatures for sand therapy and sandtrays. P.O. Box 2660, Petaluma, CA 94953 (707) 763-2448

AT-RISK RESOURCES: Innovative products for educators, counselors, parents and children. 645 New York Avenue, Huntington, NY 11743. 1-800-99-YOUTH.

KID'S COURT, INC. 7949 47th Court, Kenosha, WI 53142-2046

SAFER SOCIETY FOUNDATION, INC: Specializing on books on sex offenders (young & adult), P.0.BOX 340, Brandon, VT 05733 (802)247-3132

EMPOWER THE CHILDREN: VIDEOS FROM THE J.GARY MITCHELL FILM CO., POB 2438, Sebastopol, California 95473-2438 (800)301-4050

VIDEO TAPES: EVALUATION OF SEXUALIZED CHILDREN AND CHILDREN WHO MOLEST AND TREATMENT OF SEXUALIZED CHILDREN AND CHILDREN WHO MOLEST: Conversations with Dr. Eliana Gil. Contact: J.Gary Mitchell Film Co., 1313 Scheibel Lane, Sebastopol, CA 95472 (800)301-4050.

THE SELF-ESTEEM BOOKSTORE: 4607 North Woodward, Royal Oak, MI 48073 (810) 549-0511. 1-800-251-8336

OAK HILL SPECIALTIES: Quality hand-crafted specialty furniture for the sandplay professional. Beautiful sandtrays, shelves for miniatures, a travel sandtray. POB 152, Cloverdale, CA 95425 (1-800-615-4155)

"TRAVEL TRAY" Weighs 18 lbs. with sand. Portable sandtray complete with figures. POB 30174, Walnut Creek, CA 94598 (510)937-4449 ($325 each)

CREATIVE THERAPY STORE (WPS). 12031 Wilshire Blvd., Los Angeles, CA 90025-1251

ROSE TRAVEL KITS: (PLAY THERAPY TRAVEL KITS) 102 Foster Ranch Rd., Trinidad, TX 75163 (1-800) 713-2252

FANCY FIGURINES: SANDPLAY MINIATURES. Hard to find specialty items. 4201 Willow Park Drive, Orlando, FL 32835 (407) 291-6436

ANNA'S TOY DEPOT: 2401 So. Lamar, Austin, TX 78704 (1-888) 227-9169

SELECTED BIB ON CHILD/FAMILY THERAPY

Andreozzi, L. L. (1996). *Child-centered family therapy.* Wiley & Sons: New England

Ariel, (S.) (1992), *Strategic Family Play Therapy.* Wiley & Sons: England

Combrinck-Graham, L. (Ed.) (1989). *Children in Family Contexts.* Guilford Press: NY.

Figley, C. R. (Ed) (1989) *Treating Stress in Families.* Brunner/Mazel: NY.

Friedrich, W.N. (1990) *Psychotherapy of Sexually Abused Children and Their Families.* W.W. Norton:NY

Gardner, R.A. (1972) The Mutual Storytelling Technique in the Treatment of Anger Inhibition Problems, *International Journal of Child Psychiatry,* 1 (1): 33-64

Guerney, B. (1964), Filial Therapy:Description & Rationale, *J.of Consulting Psychology* 28,(4):304-310

Gil, E. (1994). *Play in family therapy.* Guilford Press:NY.

Irwin, E.C., Malloy, E.S. (1978), Family Puppet Interview, *Family Process,* 17: 179-191 Reprints:Eleanor Irwin, Dept. of Psychiatry, U.of Pittsburg, Pittsburg, PA 15213

Kaplan, L. & Girard, J.L. (1994). *Strengthening high-risk families.* Lexington: NY.

Karen, R. (1994). *Becoming attached.* Warner: NY.

Maddock, J.W. & Larson, N.R. (1995) *Incestuous families.* Norton: NY.

Montalvo, B. & Haley, J. (1973), In Defense of Child Therapy, *Family Process.* 12, (3): 227-244

Schaefer, C. and Carey, L. (1994). *Family play therapy.* Jason Aronson: NY.

Scharff, D.E. & Scharff, J.S. (1987) *Family therapy with very young children,* In: Scharff & Scharff, *Object Relations Family Therapy,* (p.285-307) Jason Aaronson:NJ

Trepper, T.S. and Barrett, M.J. (1989). *Systemic Treatment of Incest: A Therapeutic Handbook.* Brunner/Maze:NY

Wachtel, E.F. (1994). *Treating troubled children and their families.* Guilford Press: NY.

Zilbach, J.J. (1986), *Young Children in Family Therapy.* Brunner/Mazel:NY

ART THERAPY

Burns, R.C. (1987). *Kinetic-house-tree-Person drawings.* Brunner/Mazel:NY.

Burns, R.C. & Kaufman, S.H. *Kinetic family drawings.* Brunner/Mazel:NY.

Cohen, B. M., Barnes, M. M., & Rankin, A. B. (1995). *Managing traumatic stress through art.* Sidran Press: Lutherville,MD.

Cohen, B. M. & Cox, C. T. (1995). *Telling without talking.* Norton: NY.

DiLeo, J.H. (1973). *Children's drawings as diagnostic aids.* Brunner/Mazel:NY.

DiLeo, J.H. (1983). *Interpreting children's drawings.* Brunner/Mazel:NY.

Furth, G. M. (1988). *The secret world of drawings: Healing through art.* Sigo Press, Boston:MA.

Kaufman, B. and Wohl, A. (1992) *Casualties of childhood: A developmental perspective on sexual abuse using projective drawings.* Brunner/Mazel:NY.

Kellogg, R. (1970). *Analyzing children's art.* Mayfield Publishing: Palo Alto, CA.

Kwiatkowska, H.Y. (1967) Family Art Therapy. *Family Process* 6:37-55.Linesch, D. (1993). *Art therapy with families in crisis: Overcoming resistance through nonverbal expression.* Brunner/Mazel:NY

Linesch, D. G. (1988). *Adolescent art therapy.* Brunner/Mazel:NY

Malchiodi, C. (1998). *Understanding children's art.* Guilford Press:NY

Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes.* Brunner/Mazel:NY

Oster, G.D. & Gould, P. (1987) *Using drawings in evaluation and therapy.* Brunner/Mazel:NY

Peterson, L. W. & Hardin, M. E. (1997) *Children in distress: A guide for screening children's art.* W.W. Norton: NY

Rubin, J. A. (1987). (Ed.) *Approaches to art therapy: Theory and technique.* Brunner/Mazel:NY

Rubin, J. A. (1984). *Child art therapy: Understanding and helping children grow through art.* Second Edition. Van Nostrand Reinhold:NY.

Wohl, A. & Kaufman, B. (1985). *Silent screams and hidden cries.* Brunner/Mazel:NY

SAND THERAPY

Ammann, R. (1991). *Healing and transformation in sandplay: Creative processes become visible.* Chicago, IL: Open Court Publishing

Bradway, K. & McCoard, B. (1997). *Sandplay—Silent workshop of the psyche.* New York: Rutledge

Bradway, K., Signell, K. A., Spare, G. H., Stewart, C. T., Stewart, L. H., Thompson, C. (1981, 1990). *Sandplay studies: Origins, theory & Practice.* Boston, MA: Sigo Press

Chevalier, J. & Gheerbrant, A. (1996). *Dictionary of symbols.* NY: Penguin Press

Cirlot, J. E. (1971). *A dictionary of symbols.* New York: Barnes & Noble

De Domenico, G. (1988). *Sand tray, world play: A comprehensive guide to the use of the sand tray in psychotherapeutic and transformational settings.* 1946 Clemens Road, Oakland, CA 94602

Dundas, E. (1978). *Symbols come alive in the sand.* Aptos, CA: Aptos Press

Kalff, D. (1980). *Sandplay: A therapeutic approach to the psyche.* Boston, MA: Sigo Press

Mitchell, R. R. & Friedman, H. S. (1994). *Sandplay: Past, present and future.* New York: Routledge

Ryce-Menuhin, J. (1992). *Jungian sandplay: The wonderful therapy.*London: Routledge

Weinrib, E. L. (1983) *Images of the self.* Boston, MA: Sigo Press

CROSS-CULTURAL ISSUES

Canino, I.A. & Spurlock, J. (1994). *Culturally diverse children and adolescents: evaluation, diagnosis and treatment.* Guilford Press:NY.

Costantino, G., Malgady, R.G., & Rogler, L. H. (1985). *Cuento therapy: Folktales as a culturally sensitive psychotherapy for Puerto Rican children.* Hispanic Research Center, Fordham University, Monograph No. 12, Waterfront Press, Maplewood, NJ.

Cirillo, S. & Diblasio, P. *Families that abuse: Diagnosis and therapy.* W.W.Norton:NY.

Ho, M.K. (1992). *Minority children and adolescents in therapy.* Sage: Newbury Park:CA.

Ho, M.K. (1987). *Family therapy with ethnic minorities.* Sage:Newbury Park:CA.

Korbin, J. (Ed.) (1981). Child abuse and neglect: Cross-cultural perspectives.U. of California Press, Berkeley, CA.

Sue, D.W. & Sue, D. (1990). Counseling the culturally different: Theory and practice. Second Edition. Wiley & Sons:NY.

Ting-Tooney, S. & Korzenny, F. (1991). *Cross-cultural interpersonal communication.* Sage:Newbury Park:CA.

Tseng, W.S. & Hsu, J. (1991). *Culture and family: Problems and therapy.* Haworth Press:NY.

Vargas, L.A. & Koss-Chioino, J.D. (Eds.), (1992). *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents.* Jossey-Bass:S.F., CA.

FORENSIC INTERVIEWS OF CHILD WITNESSES

Cecci, S. J., Toglia, M.P., & Ross, D.F. (Eds.), (1987). *Children's eyewitness memory.* New York: Springer-Verlag.

Doris, J. (Ed.) (1991). *The suggestibility of children's recollections.* Washington, DC: American Psychological Association.

Garbarino, J., Stott, F.M., et al., (1989). *What children can tell us.* San Francisco: Jossey-Bass.

Goodman, G.S. & Bottoms, B.L. (1993). Child victims, child witnesses: Understanding and improving testimony. New York: Guilford Press.

Horowitz, A.N. (1992). *The clinical detective: Techniques in the evaluation of sexual abuse.* New York: W.W.Norton.

Myers, J.E.B., (1987). *Child witness: Law and practice.* New York: Wiley Law Publications.

Myers, J.E.B., Bays, J., Becker, J., Berliner, L., Corwin, D.L., Saywitz, K.J. (1989). Expert testimony in child sexual abuse litigation. *Nebraska Law Review*, Vol. 68, 1-2: University of Nebraska.

Schetky, D. & Green, A., (1988). *Child sexual abuse: A handbook for health care professionals.* New York: Brunner-Mazel.

_____(1993). *Child victims as witnesses: What the research says.* Newton, MA: Education Development Center.

Steward, M.S., Bussey, K. Goodman, G.S., Saywitz, K. J. (1993). Implications of developmental research for interviewing children. *Child Abuse and Neglect,* 17, pp.25-37.

PLAY THERAPY SELECTED BIBLIOGRAPHY

Freeman, J., Epston, D., Lobovits, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families.*NY:W.W. Norton

Gil, E. (1991). *The healing power of play.* NY: Guilford Press

Gil, E. (1994). *Play in family therapy.* NY: Guilford Press

Greenspan, S. I. (1981). *The clinical interview of the child.* NY: McGraw Hill

Hughes, J. N. & Baker, D.B. (1990). *The clinical child interview.* NY: Guilford Press

Kaduson, H. G., Cangelosi, D., & Schaefer, C. (Eds.), (1997). *The playing cure: Individualized play therapy for specific childhood problems*. NY: Aronson

Kaduson, H., & Schaefer, C. (Eds.), (1997). *101 favorite play therapy techniques*. NY: Aronson

Knell, S. M. (1995). *Cognitive-behavioral play therapy*. NY: Aronson

Landreth, G. (1991). *Play therapy: The art of the relationship*. Muncie, IN: Accelerated Development Publishers

Landreth, G. L., Homeyer, L. E., Glover, G., and Sweeney, D. S. (1996). *Play therapy interventions with children's problems: Case studies with DSM-IV diagnoses*. NY: Aronson

O'Connor, K. J. & Ammen, S. (1997). *Play therapy: Treatment planning and interventions - The Ecosystemic Manual and Workbook*. NY: Wiley

O'Connor, K. J. (1991). *The play therapy primer: An integration of theories and techniques*. NY: Wiley

O'Connor, K. J. & Schaefer, C. E. (Eds.), (1994). *Handbook of play therapy: Volume II, Advances and innovations*. NY: Wiley

Schaefer, C. E. (Ed.), (1993). *The therapeutic powers of play*. NY: Aronson

Schaefer, C. E. & Cangelosi, D. M., (Eds.), (1993). *Play therapy techniques*. NY: Aronson

Schaefer, C. E. & O'Connor, K. J. (Eds.), (1983). *Handbook of play therapy*. NY: Wiley

Singer, D. (1993). *Playing for their lives: Helping troubled children through play therapy*. NY: Free Press

Vargas, L. A. & Koss-Chiono, J. D. (Eds.), (1992). *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents*. San Francisco, CA: Jossey Bass

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. NY: W. W. Norton

PROFESSIONAL RESOURCES

For Play Therapy Training Resources, contact:

Association for Play Therapy, % California School of Professional Psychology, 5130 Ea. Clinton Way, Fresno, CA .93727-2014 (209)-253-2278.

For Art Therapy Training Programs, contact:

The American Art Therapy Association, 1201 Allanson Road, Mundelein, IL 60060, 847-949-6064.

For Sand Therapy information, contact:

Sandplay Therapists of America, P.O.B. 4847, Walnut Creek, CA 94596 (310) 607-8535. Web page: www.sandplayusa.org e-mail: sta@sandplayusa.org

For information about Storytelling, contact:

National Storytelling Association, POB 309, Jonesborough, TN 37659; 615-753-2171

To contact Eliana Gil, Ph.D.: P.O.Box 5629, Rockville, MD 20855, 301-869-0469; emgil@earth-link.net

PROSECUTING DOMESTIC VIOLENCE

Dan Goldstein
Deputy District Attorney
County of San Diego

Violence within the family or domestic violence, has attracted a great deal of attention in the media and within our society over the past decade. Consequently, public prosecutors are being asked to do more and more in domestic violence prosecutions. The reality though is public prosecutors have been at the forefront of the attack on domestic violence for years. It has been through the prosecution of domestic violence that society has become more aware of its ramifications. Not only is it imperative that we as prosecutors hold abusers accountable, but we must direct our efforts towards stopping the violence and protecting the children in these battering relationships.

Effective prosecution of domestic violence requires utilization of multi-disciplinary resources. From providing battered woman services to counseling for the abusers, victim advocates, probation officers, and mental health care professionals, all play important roles in stopping the violence. However, the ultimate responsibility for holding batterers accountable rests with law enforcement.

Because of this, it is imperative that prosecutors and local law enforcement agencies be well versed in the evidentiary issues which present themselves during these trials. This means not only conquering legal issues, but also, the acquisition of dependable evidence. This includes detailed report writing, spontaneous statements, prior complaints, medical records, family court documents, and the offender's interrogation. Additionally, we must always recognize the political and sociological complexities of the domestics violence case; i.e., the myths and misconceptions regarding the victims and offenders of domestic violence.

Often, victims of domestic violence recant or refuse to testify. A prosecutor must do more than show the victim is a liar. Of course, the cooperative victim also presents just as many dilemmas. Many times they are seen as vindictive, angry, or rejected. It is up to the prosecutor to show these are expected reactions in a battering relationship.

During this dialogue we will identify and create solutions to the following issues:

- The prosecutors role in disabusing the jury of the myths and misconceptions of the battering relationship;

- Approaches to dealing with the hostile or recanting victim;

- Effective cross- examination of the batterer;

- Trial tactics and ways to empower your jury so they will stop the violence.

US SECRET SERVICE FORENSIC INITIATIVE for MISSING and EXPLOITED CHILDREN

1. **1995 Crime Bill**

- **Mandated Forensic/Technical Assistance**
- **State and local agencies**
- **Federal agencies**
- **Hardiman Task Force**

2. **Why the Secret Service?**
   - **Unique Forensic Technology**

3. **Forensic Information System for Handwriting**
   - **National Database**
   - **Digitize-Search & Retrieval**

4. **Automated Fingerprint Identification System**
   - **Printrac-Morpho-NEC**
   - **Multi-state connectivity**

5. **International Ink and Watermark Library**
   - **On-line Libraries**
   - **Age determination**

6. **Other Services Offered**
   - **Polygraph Assistance**
   - **Graphic and Photographic Support**
   - **Computer-aided Age Progression and Regression**

7. **How to request services in Missing and Exploited Children cases.**

Children's Trust Fund of Texas

The good we do will last a lifetime

Workshop: Children's Trust Fund Community Initiatives
Wednesday, August 19
9:45 - 11:30am

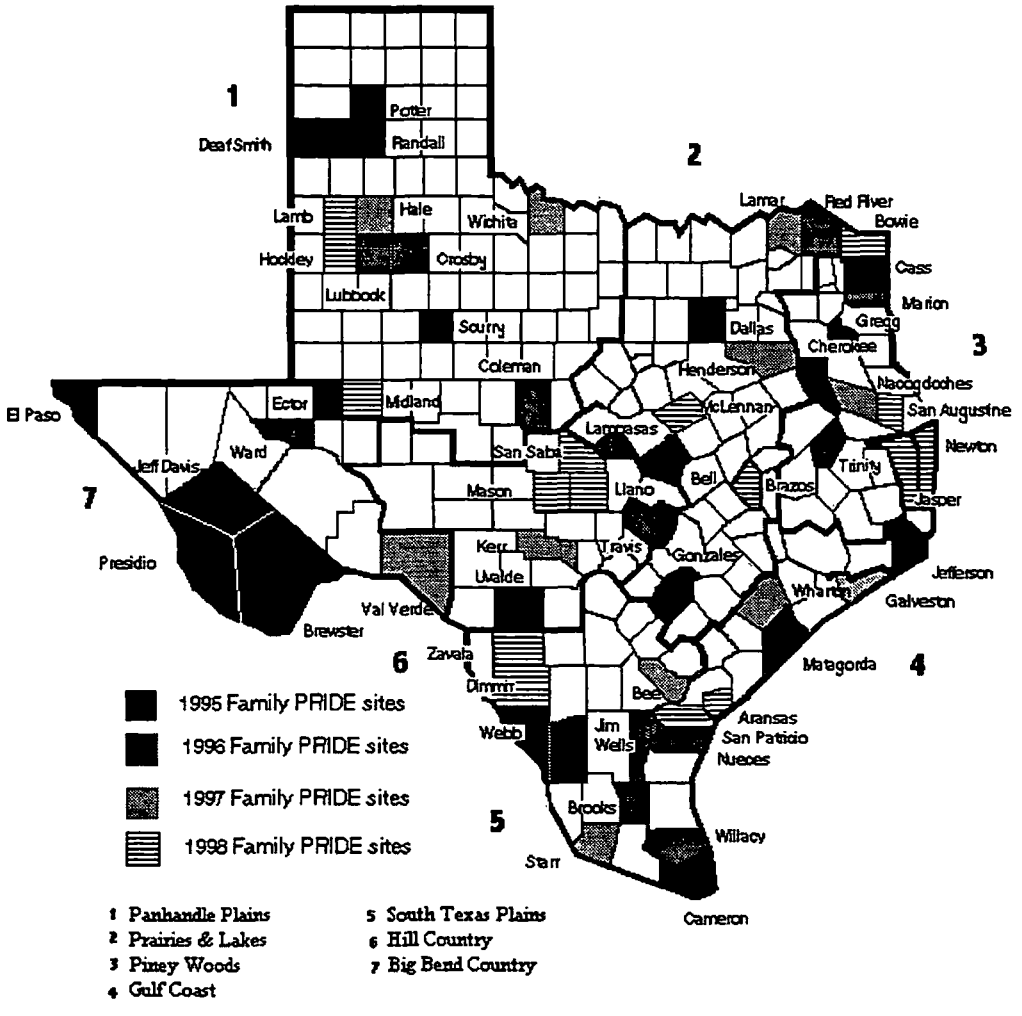
CHILDREN'S TRUST FUND PROGRAMS

Family PRIDE Initiative

Family PRIDE is a dual approach to child abuse and neglect prevention at the local level. Realizing the need to maximize the limited resources available for child abuse and neglect prevention programs, the Children's Trust Fund of Texas Council developed a strategic plan empowering entire communities to address child abuse and neglect prevention, instead of focusing on a single programs. The plan also included maximizing community volunteer involvement representing various community sectors and placing the strategic planning, program implementation, and evaluation into the hands of community families. In 1995, the initiative began with fifteen regional Family PRIDE Councils composed of volunteer representatives of business, health care, education, religion-faith, law enforcement, parents, media, and city or county government. Family PRIDE Councils advocate for services, policies and/or programs in their community to strengthen children and families and promote the awareness of child abuse and neglect prevention. Family PRIDE Councils serve as the coordinating body for activities associated with the initiative in their community. The second area of Family PRIDE includes community-based prevention programs which provide parent and children's education, professional training and public awareness campaigns.

The Children's Trust Fund of Texas is partnering with Texas Agricultural Extension Service (TAEX) to provide ongoing technical support to the existing Family PRIDE councils and assist in the development of new Family PRIDE councils. This interagency partnership will standardize the current Family PRIDE initiative in a more consistent manner and allow for the utilization of state resources as recommended by the 75th Legislature.

Children's Trust Fund
Family PRIDE Program Sites
1995-1998



Family PRIDE sites are chosen based on service needs indicators including child poverty, infant mortality, teen parents, juvenile crime, and school drop-outs, as well as incidence of child abuse and neglect. Child population, geographic location, and current availability of services are also considered. Fifty Family PRIDE Councils are currently operating and proving services in 60 counties.

The Children's Trust Fund plans to add 10 Family PRIDE sites each year in order to serve all 254 counties in Texas by the year 2010.

Children's Trust Fund of Texas
Family PRIDE Sites and Counties Served
1995-98

1995 – Sixteen Family PRIDE Programs

- Bell
- Big Bend
- Cass
- Cameron
- Cherokee
- East Dallas
- Deaf Smith
- Ector
- El Paso
- Jefferson
- Matagorda
- Potter
- Randall
- Scurry
- Uvalde
- Webb

1996 – Fifteen New Family PRIDE Programs

- Brooks
- Coleman
- Crosby
- Gonzales
- Gregg
- Jim Wells
- Lampasas
- Lubbock
- Marion
- Nueces
- Red River
- Travis
- Trinity
- Ward
- Willacy

1997 – Ten New Family PRIDE Programs

- Bee
- Hale
- Henderson
- Kerr
- Lamar
- Nacogdoches
- Starr
- Val Verde
- Wharton
- Wichita

1998 – Fifteen New Family PRIDE Programs

- Aransas & San Patricio
- Bowie
- Brazos
- Dimmit & Zavala
- Galveston
- Jasper, Newton & San Augustine
- Lamb & Hockley
- Llano, Mason & San Saba
- McLennan
- Midland

Children's Trust Fund of Texas
Family PRIDE Councils and Program Funding Available
(FY 1999 - FY 2003)

FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
50 councils 60 counties	60 councils 77 counties	70 councils 94 counties	80 councils 111 counties	90 councils 128 counties
562	682	802	922	1,042

Parent, Business and Professional Volunteers Involved in Family PRIDE Councils

The Children's Trust Fund of Texas' recognition of the importance of collaborating with other agencies to meet the needs of children and families prompted the first meeting of TEAM Texas (formerly WINGS) in November 1992. The group's purpose is to support children and families by fostering cooperation and collaboration among state agencies to avoid duplication of services and increase the positive impact of state child abuse prevention programs through joint initiatives.

New and effective linkages between state and community-based systems are imperative for a statewide network of family resource programs to be responsive to the needs of children and families. The on-going planning process emphasizes community commitment and collaboration with state support and assistance through funding, technical assistance, and resource information sharing. The state planning process is primarily the responsibility of the Interdisciplinary TEAM Texas and the local level planning process is the work of the Family PRIDE Councils.

The Children's Trust Fund of Texas Council
1997 Statewide Child Survey

BRIEFING FACT SHEET

Purpose

In order to better understand and prevent child abuse and neglect, the Children's Trust Fund of Texas Council (CTF) sponsored a biennial statewide and community telephone survey - beginning in 1995 - designed to measure the knowledge, attitudes, beliefs, and practices of Texans with respect to child rearing and public policies related to child protection. The data will be used as both baseline information and as a barometer of public opinion, as well as an important tool for understanding parenting practices and child rearing. Further, the findings will ensure better planning and use of available resources.

Sponsoring Agency

The Children's Trust Fund of Texas Council was established in 1985 by the Texas Legislature to prevent the abuse and neglect of our children by leading the way in setting policy, offering resources for community prevention programs, and providing information and education on child abuse and neglect.

Study Methods

This scientific study consisted of 2710 telephone interviews conducted with a representative sample of Texas adults, including both parents and non-parents. The target populations were parents of children under the age of six, as well as parents of children between six and eighteen. Each of these strata were further divided into race and ethnic groups. The sampling error for the entire sample was ± 2 percentage points, assuming a 95 percent confidence level. Thus, the sampling procedure yields a high degree of precision and provides confidence in the report's conclusions. Texans were asked eighty questions related to children and parenting. Specifically, respondents were asked their views on child rearing, child health and safety, child nurturing, parental stress, discipline techniques, and a variety of policy issues. The study was conducted by the Public Policy Research Institute at Texas A&M University.

Key Findings...

Incidence of abuse and neglect

About one in four Texans (25.4%) had witnessed an incident of child abuse or neglect in the past year. Slightly over six percent (6.1%) of parents reported that a child of theirs had been abused or neglected. Almost one-half (48.8%) of parents with an abused child said that the abuse or neglect had been reported.

Texans support prevention

An overwhelming majority of Texans (90.1%) felt that prevention of abuse and neglect should be a very important priority for the state, and almost three-fourths of Texans (73.4%) would even be willing to pay additional taxes for prevention programs/services. About seventy-five percent (75.4%) of respondents said that there are programs available that are effective in preventing child abuse and neglect. About half (46.7%) would attend a parenting class if available, with the optimal location for such a class being a church (34.3%) or a school (22.3%). Approximately two-thirds of the participants (65.9%) believed that they can do either a great deal or a fair amount to personally prevent child abuse and neglect.

Parents invest time in children

Nearly all survey participants (99.0%) agree that parents should daily set aside time to spend with each of their children. Texas parents were almost unanimous (95%) in reporting that their children receive regular medical check-ups. The majority of parents with children at home reported that family members regularly eat together (90.0%), and that their children typically follow a regular bedtime routine (80.5%). Parents with children at home report that someone regularly reads to their children (92.6%).

For a Full Report Contact:
The Children's Trust Fund of Texas Council
8929 Shoal Creek Blvd., Suite 200
Austin, TX 78757-6854
(512) 458-1281

Texans know more about abuse and neglect

Comparisons of the 1997 survey results with the 1995 survey results reveal some significant improvements in Texan's knowledge about child abuse and neglect. For example, there has been a dramatic improvement in Texans having heard of "Shaken Baby Syndrome" (43.6% in 1995 versus 56.8% in 1997). Respondents also know more about the number of children who die of abuse in Texas (7.4% estimated the correct number of deaths in 1995 versus 12.5% in 1997).

Parental satisfaction

The sample of Texas parents largely agreed that parenting is very rewarding (87.3%), but only approximately one-half were satisfied with their parenting (55.5%) or disciplinary actions (55.2%).

Predictors of Abuse

A series of statistical analyses were conducted to determine the predictors of child abuse. Significant predictors are described below.

(1) Life Stress: Having a life perceived as highly stressful was predictive of child abuse.

(2) Parental Stress: Finding parenting to be very difficult and child-rearing to be stressful were both predictors of child abuse.

(3) Parental Satisfaction: Respondents with an abused child were more likely to be dissatisfied with their discipline of children. Furthermore, respondents who did not find child-rearing to be very rewarding were more likely to have an abused child.

(4) Spousal support: A child was more likely to be abused if there appeared to be a lack of spousal support in child-rearing.

(5) Adult survivor of child abuse: Respondents who were abused as children were five times more likely to report that their own child had been abused relative to respondents who were not abused as children.

(6) Disciplinary style: Respondents with abused children reported more frequent use of actions that define "traditional" (e.g., yelled in anger, withdrew privilege, sent child to room, spanked child) and "non-traditional" (e.g., insulted/swore, pushed/grabbed/shoved, threatened to hit/throw object, threw something, slapped child) disciplinary styles.

Everyone can benefit from prevention programs

The major implication of the survey results is that all parents can benefit from child abuse prevention efforts in the state. All parents are potentially vulnerable to variables identified as predictive of child abuse and neglect (e.g., life stress, parental stress, lack of parental satisfaction). CTF prevention efforts can help minimize both the willful mistreatment of children and mistreatment due to ignorance.

Public Awareness Campaigns

The Children's Trust Fund of Texas public awareness and education efforts are available statewide through the Children's Trust Fund Family PRIDE Community Councils. Each year councils have an opportunity to select from a schedule of materials and events which focus on the prevention of child abuse and neglect.

Child Abuse Prevention Month Kits - A packet of community awareness ideas, sample press releases, and public service announcements are distributed for April. The kits assist council members in publicizing child abuse prevention month. Target audiences include parents, health, churches, law enforcement, media, business, schools, universities, and city or county officials. The kit is developed through a collaboration with the Texas Department of Protective and Regulatory Services and the Texas Committee to Prevent Child Abuse. A team with representatives from the three agencies and local Family PRIDE Council volunteers participate.

Shaken Baby Syndrome - Shaken Baby Syndrome is defined as the vigorous shaking of an infant or child by the arms, legs, or shoulders. This whiplash motion can result in bleeding inside the head with no outward signs of abuse. A brochure and public service announcement for television and radio are available to warn caregivers of the possible tragic and/or chronic results of shaking an infant or child, a community handbook and posters are also available. These materials have been replicated by other states' children's trust and prevention funds. The Children's Trust Fund of Texas was the state contact for the national campaign, *Don't Shake the Baby: Replication of a Successful Model*, sponsored in part by the National Center on Child Abuse and Neglect and is the only state in the country funding a variety of comprehensive local programs. There are currently twenty local community campaigns being funded.

"A Beginning" Infant Development Poster - highlights the developmental stages of a child from birth to 18 months and is available to communities throughout Texas. Helpful information provided by the poster includes nutritional needs, immunization requirements, stages of physical growth and steps in early childhood development.

Positive Parenting Just Takes TLC...TIME, Love & Communication - The TLC literature offers helpful advice to a large cross-section of the parent population in Texas. Through distribution of materials, the Children's Trust Fund of Texas hopes to reach families that may not have access to other parenting resources. Return response cards allowed parents to be added to the Children's Trust Fund resource network, receive newsletters and announcements or parent/child education in their area.

"Country Cares for Kids" Radio Production - The purpose of this radio programming is to increase public awareness of child abuse and neglect as well as to raise funds that support prevention activities. Programming is made available to selected Texas communities through the National Alliance of Children's Trust and Prevention Funds. The first event is scheduled in June, 1998 in El Paso. Funds raised are donated to the Children's Trust Fund to distribute back to the community for child abuse and neglect prevention programs. This provides ongoing funding after CTF funding ends.

Child Abuse Prevention in Youth Sports - Making sports safe and positive is the message for communities to emphasize through events and publications designed by the Children's Trust Fund. Materials are available to educate parents and coaches on "Child Centered Coaching." The Institute for Child Centered Coaching held its national kick-off at a Children's Trust Fund Youth Sports Day event at UT Memorial Stadium in Austin in April, 1993. Subsequent events and programs of the Children's Trust Fund have continued to focus on keeping child abuse out of youth sports.

START SMART – In 1997-98, a CTF child-parent program that strengthens the child-parent relationship and teaches basic sports fundamentals to 3-5 year old children in a fun, non-competitive environment through eight, 1 hour training sessions. The plan is to implement the Start Smart program in all Family PRIDE sites by 2005. The youth sports organizations participating receive a program kit that enables them to implement the program on a continuous basis.

1998 The Texas Youth Sports Child Abuse Prevention Project (TEXCAP) – In 1998, CTF initiated a comprehensive series of statewide seminars designed to provide practical guidance on how to identify and prevent abusive behavior to non-school youth sports programs. The seminars are specifically designed for professional and volunteer sports leaders. Attendees received a copy of *Child Abuse Youth Sports: A Comprehensive Risk Management Program* kit that will enable their organizations to implement the abuse prevention techniques.

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 (I%) 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.

Bibliography

Adelson L. Pedicide revisited: the slaughter continues. Am J. Forensic Med Pathol. 1991;12:16-26

Adelson L. Slaughter of the innocents: a study of forty-six homicides in which the victims were children. N Eng. J Med. 1961;264:1345-1349

Adelson L, Kinney CR. Sudden and unexpected death in infancy and childhood, Pediatrics. 1956;17:663-699

Bass M. Asphyxial crib death. N Engl J Med. 1977;296:555-556

Bauchner H, Zuckerman BS. Cocaine, sudden infant death syndrome and home monitoring. J Pediatr. 1990;117:904-906

Bauchner H, Zuckerman BS, McClain M, et al. Risk of sudden infant death syndrome among infants with in-utero exposure to cocaine. J Pediatr. 1988;113:831-834

Beal S. Sudden infant death syndrome in twins. Pediatrics. 1989;84:1038-1044

Bergman AB. Unexplained sudden infant death. N Engl J Med. 1972;287.2@255

Bergman AB. The management of sudden infant death syndrome (SIDS) in the United States. In: US Congress: Senate, Sudden Infant Death Syndrome Hearings, Committee on Labor and Public Welfare, Subcommittee on Health and on Children and Youth, 93d Congress, lst session, Sept 20, 1973. Washington, DC: US Government Printing Office; 1973:324-762

Black L, David RJ, Brouillette RT, et al. Effects of birth weight and ethnicity on incidence of sudden infant death syndrome J Pediatr. 1986;108:209-214

Brown RH. The battered child syndrome. J Forensic Sci. 1976;21:65

Caffey J. Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. Am J Roentgenol. 1946;56:163

Chasnoff IJ Burns WJ, Schnoll SH, Burns KA. Sudden infant death syndrome in infants of substance-abusing mothers. N Engl J Med. 1985;313:666-669

Christoffel KK, Zieserl EJ, Chiaramonte J. Should child abuse and neglect be considered when a child dies unexpectedly? Am J Dis Child. 1985;139:876-880

Davies DP. Cot death in Hong Kong: a rare problem? Lancet. 1985;2: 348

Emery JL, Taylor EM. Investigation of SMS. N Engl J Med. 1986;315:1676

Famularo R, Stone Y, Barnum R, Wharton R. Alcoholism and severe child maltreatment. Am J Orthopsychiatry. 1986;82:888-895

Griffith JL, Slovik LS. Munchausen syndrome by proxy and sleep disorders medicine. Sleep. 1989;12:178-183

Griffin MR, Ray WA, Livengood JR, Schaffner W. Risk of sudden infant death syndrome after immunization with the diphtheria-tetanus-pertussis vaccine. N Engl J Med. 1988;319:618-622

Groothius JR, Altemeier WA, Robarge JP, et al. Increased child abuse in families with twins. Pediatrics. 1982;70:769-773

Guntheroth WG. The pathophysiology of Petechiae. In: Tildon JT, Roeder LM, Steinschneider A, eds. Sudden Infant Death Syndrome. New York, NY. Academic Press; 1983:271-278

Hagland B, Cnattingius S. Cigarette-smoking as a risk factor for sudden infant death syndrome: a population-based study, Am J Public Health. 1990;80:29-32

Harpey JP Charpentier C, Paturneau-Jonas M. Sudden infant death syndrome and inherited disorders of fatty acid B-oxidation. Metab Prob Newborn. 1990;58(suppl):70-80-

Hoffman M, Hunter JC, Damus F, et al. Diphtheria-tetanus-pertussis-immunization and sudden infant death: Results of the National Institute of Child Health and Human Development Cooperative Epidemiological Study of sudden infant death syndrome risk factors. Pediatrics. 1987;79:598411

Huff DS. Cytomegalovirus inclusions in 401 consecutive autopsies on infants aged 2 weeks to 2 years: a high incidence in patients with sudden infant death syndrome. Presented at interim meeting of Society for Pediatric Pathology; 1986; Dallas,TX

Irgens LM, Skjaerven R, Peterson DR. Prospective assessment of recurrence risk in sudden infant death syndrome siblings. J Pediatr. 1984;104:349-351

Kempe CH, Silverman IN, Steele BF, et al. The battered child syndrome.
J. Amer Med Assoc 1962;181:17

Kirschner RH, Stein RJ The mistaken diagnosis of child abuse: a form of medical abuse? Amer J Dis Child 1985;139:873-875

Kleigman RM. Unpublished data

Kleinman PK, Blackbourne BD, Marks SC, et al. Radiologic contributions to the investigation and prosecution of cases of fatal infant abuse. N Engl J Med. 1989;320:507-511

Korbin JE. Childhood histories of women imprisoned for fatal child maltreatment. Child Abuse Negl. 1986;10:331-338

Korbin JE. Incarcerated mothers perceptions and interpretations of their fatally maltreated children. Child Abuse Negl. 1987; 11:397-407

Kraus JF, Bultreys M. The epidemiology of sudden infant death syndrome. In: Kiely M, ed. Reproductive and Perinatal Epidemiology. Boca Raton, FL: CRC Press; 1991

Lauer B, Ten Brock E, Grossman M. Battered child syndrome: review of 130 patients with controls. Pediatrics. 1974;54:67

Little RE, Peterson DR. Sudden infant death syndrome epidemiology: a review and update. Epidemiol Rev. 1990,12:241-246

Meadow R. Munchausen syndrome by proxy: the hinterland of child abuse. Lancet. 1977;2:343-345

Meadow R. Suffocation, recurrent apnea and sudden infant death. J Pediatr. 1990;117.351-357

Molz G, Hartman H. Dysmorphism, dysplasia and anomaly in sudden infant death syndrome. N Engl J Med. 1994;311-259

Nelson EAS, Williams SM, Taylor BJ, et al. Postneonatal mortality in south New Zealand: necropsy data review. Paediatr Perinat Epidemiol. 1989;3:375-385

Newman NM. Sudden infant death syndrome in Tasmania 1975-1981.Aust Paediatr I 1986;22(suppl):17-19

Peterson DR. Clinical implications of sudden infant death syndrome epidemiology. Pediatrician. 1988;15:198-203

Peterson DR, Sabotta EE, Daling JR. Infant mortality among subsequent siblings of infants who died of sudden infant death syndrome. J Pediatr. 1986;108:911-914

Scott PD. Fatal battered baby cases. Med Sci Law. 1973;13:197 134

Silverman FN. The roentgen manifestations of unrecognized skeletal trauma in infants. Am J Roentgenol. 1953;69:413

Steele BF. Psychodynamic factors in child abuse. In: Kempe CH, Helfer, eds. The Battered Child. 3rd ed. Chicago, IL: University of Chicago Press; 1980:49-85

Valdes-Dapena MA. The pathologist and sudden infant death syndrome Newborn. 1990, Amer J Pathol. 1982,106:118-131

Vawter GF, Kozakewich HPW. Aspects of morphologic variation amongst SIDS victims. In: Tildon JT, Roeder LM, Steinschneider A, eds. Sudden Infant Death Syndrome, New York, NY: Academic Press; 1983:133-134

Valdes-Dapena MA. A pathologists perspective on the sudden infant death syndrome-1991. Pathol Ann. 1992;27:133-164

Variend S, Pearse RC. Sudden infant death and cytomegalovirus inclusion disease. J Clin Pathol. 1986;39:383-390

Vawter GF, McGraw CA, Hug G, et al. An hepatic metabolic profile in sudden infant death (SIDS). Forensic Sci Int. 1986;30:93-98

Wallace BC. Crack Cocaine: A Practical Treatment Approach for the Chemically Dependent. New York, Brunner/Mazel; 1991

Wecht CH, Larkin GM. The battered child syndrome: a forensic pathologist's viewpoint. Med Trial Tech Q. 1981;28:1-24

Werne J, Garrow 1. Sudden apparently unexplained death during infancy 1: pathologic findings in infants found dead. Am I Pathol. 1953;29:633-652

Bibliography
Fatalities

Byard, RW, Carmichael, E., Beal, S. How useful is postmortem examination in Sudden Infant Death Syndrome? Pediatr. Pathol., 14:817. 1994

Cohle, SD, Hawley, DA, Berg, KK, Homjicidal cardiac lacerations in children. J. Forens. Sci., 40:212, 1995.

Hicks, RA, Gaughan, DC. Understanding fatal child abuse. Child Abuse Negl. 19:855. 1995.

Iafolla, AK, et al.: Medium chain acyl-coenzyme A dehydrogenase deficiency: Clinical course in 120 affected children. J. Pediatr. 124:409, 1994.

Kemp, A., Mott, AM., Sibert, JR, Accidents and child abuse in bathtub submersions. Arch. Dis. Child, 70:435, 1994.

Reece, RM, Fatal child abuse and Sudden Infant Death Syndrome: A critical diagnostic decision. Pediatr. 91:423, 1993.

Wetzel, RC, Slater, A, dover, GJ,: Fatal intramuscular bleeding misdiagnosed as suspected nonaccidental injury. Pediatr. 95:771, 1995.

Child Molesters: A Behavioral Analysis

For Law Enforcement Officers Investigating Cases of Child Sexual Exploitation

December 1992
Third Edition

Kenneth V. Lanning
Supervisory Special Agent

Behavioral Science Unit
Federal Bureau of Investigation
FBI Academy
Quantico, Virginia

2. A Law Enforcement Typology

Too often the terms *child molester* and *pedophile* are used interchangeably or without defining them. In fact, not all child molesters are pedophiles, and there is a clear need for a law enforcement typology to clear up the confusion. Law enforcement has frequently accepted offender categories and characteristics developed by therapists and criminologists. These typologies, however, primarily serve the needs of mental health professionals and have limited application to those of law enforcement. These typologies are usually developed from data collected *from* offenders *after* arrest or conviction and often reflect unsubstantiated information about pre-arrest behavior. It is the pre-arrest or pre-identification behavior of child molesters that is of most value to law enforcement.

In addition, law enforcement usually does not have the luxury of having a known, confessed offender in front of them. Law enforcement and prosecutors need a typology that can be applied before the perpetrator is identified or the case is proven in court.

Needs of Law Enforcement

Child sexual abuse cases can be difficult to prove. Frequently there is only the word of a child against that of an adult. Many factors combine to make it difficult and possibly traumatic for children to testify in court. In spite of some recent advances that make testimony easier for the child victim or witness, an important objective of every investigation of child sexual abuse should be to prove the case without resorting to the courtroom testimony of the child. This is best done by building such a strong case that the perpetrator pleads guilty and there is no trial. This may not always be possible, but it should be the investigative goal. Many children can testify in court if necessary.

The child victim should be carefully interviewed. The information obtained should be evaluated and assessed, and appropriate investigative action should be taken. The investigator, however, should proceed as though he or she has information about a crime from a reliable source whose identity cannot be revealed. The investigator should be an objective fact finder attempting to determine what happened.

One way to avoid child victim testimony is to avail yourself of other evidence that might help prove the case. Frequently there is more evidence available than the investigator realizes. Much of this evidence can be identified and located only if the investigator has a solid understanding of offender behavior patterns and the kinds of child molesters.

Kinds of Child Molesters

Dr. Park Elliot Dietz divides sex offenders into two broad categories: *situational* and *preferential* (*see* "Appendix II: References"). This concept can be of great practical value to law enforcement. After consulting on hundreds of cases in his work at the FBI Behavioral Science Unit and not finding a typology that fits law enforcement needs, the author decided to develop his own. Expanding on Dr. Dietz's idea, the author developed a typology of child molesters for criminal justice professionals. The author has deliberately avoided all use of di-

agnostic terminology and used instead descriptive terms. The purpose of the typology being set forth in this book is not to gain insight or understanding about *why* child molesters have sex with children in order to help or treat them, but to recognize and evaluate *how* child molesters have sex with children in order to identify, arrest, and convict them. What evidence to look for, whether there are additional victims, how to interview a suspect, and so on, depend on the type of child molester involved.

Situational Child Molesters

The Situational Child Molester does not have a true sexual preference for children, but engages in sex with children for varied and sometimes complex reasons. For such a child molester, sex with children may range from a "once-in-a-lifetime" act to a long-term pattern of behavior. The more long-term the pattern is, the harder it is to distinguish from preferential molesting. The Situational Child Molester usually has fewer numbers of different child victims. Other vulnerable individuals, such as the elderly, sick, or the disabled, may also be at a risk of sexual victimization by him or her. For example, the Situational Child Molester who sexually abuses children in a daycare center might leave that job and begin to sexually abuse elderly people in a nursing home. It is the author's undocumented opinion that the number of Situational Child Molesters is larger and increasing faster than that of Preferential Child Molesters. Members of lower socioeconomic groups tend to be overrepresented among Situational Child Molesters. Within this category at least four major patterns of behavior emerge (*see also* Table 1 on page 10).

Regressed Such an offender usually has low self-esteem and poor coping skills; he turns to children as a sexual substitute for the preferred peer sex partner. Precipitating stress may play a bigger role in his molesting behavior. His main victim criterion seems to be availability, which is why many of these offenders molest their own children. His principal method of operation is to coerce the child into having sex. This type of Situational Child Molester may or may not collect child or adult pornography. If he does have child pornography, it will usually be the best kind from an investigative point of view: homemade photographs or videos of the child he is molesting. Although this type of child molester may be very common, not many cases involving this pattern of behavior are referred to the FBI Behavioral Science Unit for case consultation.

Morally Indiscriminate In the author's experience, this is a growing category of child molesters. For this individual, the sexual abuse of children is simply part of a general pattern of abuse in his life. He is a user and abuser of people. He abuses his wife, friends, coworkers. He lies, cheats, or steals whenever he thinks he can get away with it. He molests children for a simple reason: "Why not?" His primary victim criteria are vulnerability and opportunity. He has the urge, a child is there, and so he acts. He typically uses force, lures, or manipulation to obtain his victims. He may violently or nonviolently abduct his victims. Although his victims frequently are strangers or acquaintances, it is important for the investigator to realize that his victims can also be the offender's own children. The incestuous father or mother might be this morally indiscriminate offender. He frequently collects detective magazines or adult pornography of a sadomasochistic nature. He may collect

some child pornography, especially that which depicts pubescent children. Because he is an impulsive person who lacks conscience, he is an especially high risk to molest pubescent children. Such acts may be criminal but not necessarily sexually deviant.

Sexually Indiscriminate This pattern of behavior is the most difficult to define. Although the previously described Morally Indiscriminate offender often is a sexual experimenter, this individual differs in that he appears to be discriminating in his behavior except when it comes to sex. He is the "try-sexual"—willing to try anything sexual. Much of his behavior is similar to and is most often confused with the Preferential Child Molester. While he may have clearly defined paraphilic or sexual preferences—bondage or sadomasochism, etc.—however, he has no real sexual preference for children. His basic motivation is sexual experimentation, and he appears to have sex with children out of boredom. His main criteria for such children are that they are new and different, and he involves children in previously existing sexual activity. Again, it is important to realize that these children may be his own. Although much of his sexual activity with adults may not be criminal, such an individual may also provide his children to other adults as part of group sex, spouse-swapping activity, or even as part of some bizarre ritual. Of all Situational Child Molesters, he is by far the most likely to have multiple victims, be from a higher socioeconomic background, and collect pornography and erotica. Child pornography will only be a small portion of his potentially large and varied collection, however.

Inadequate This pattern of behavior is also difficult to define and includes those suffering from psychoses, eccentric personality disorders, mental retardation, and senility. In layman's terms he is the social misfit, the withdrawn, the unusual. He might be the shy teenager who has no friends of his own age or the eccentric loner who still lives with his parents. Although most such individuals are harmless, some can be child molesters and, in a few cases, even child killers. This offender seems to become sexually involved with children out of insecurity or curiosity. He finds children to be nonthreatening objects with whom he can explore his sexual fantasies. The child victim could be someone he knows or a random stranger. In some cases the victim might be a specific "stranger" selected as a substitute for a specific adult (possibly a relative of the child) whom the offender is afraid of approaching directly. Often his sexual activity with children is the result of built-up impulses. Some of these individuals find it difficult to express anger and hostility, which then builds until it explodes—possibly against their child victim. Because of mental or emotional problems, some might take out their frustration in cruel sexual torture. His victims, however, could be among the elderly as well as children—anyone who appears helpless at first sight. He might collect pornography, but it will most likely be of adults.

Almost any child molester is capable of violence or even murder to avoid identification. In spite of a few notable exceptions, however—Theodore Frank in California and Gary Arthur Bishop in Utah—most of the sexually motivated child murderers profiled and assessed by the FBI Behavioral Science Unit have involved Situational Child Molesters, especially the morally indiscriminate and inadequate patterns of behavior. Low social competence seems to be the most significant risk factor in why a child molester might abduct their victims. (*See* "Appendix II: References.") Sadistic and morally indiscriminate Preferential Molesters (pedophiles) who kill will be discussed later in this chapter.

Preferential Child Molesters

The Preferential Child Molesters have a definite sexual preference for children. Their sexual fantasies and erotic imagery focus on children. They have sex with children not because of some situational stress or insecurity but because they are sexually attracted to and prefer children. They can possess a wide variety of character traits but engage in highly predictable sexual behavior. These highly predictable sexual behavior patterns are called sexual ritual and are frequently engaged in even when they are counterproductive to getting away with the criminal activity. Although they may be smaller in number than the Situational Child Molesters, they have the potential to molest large numbers of victims. For many of them, their problem is not only the nature of the sex drive (attraction to children) but also the quantity (need for frequent and repeated sex with children). They usually have age and gender preferences for their victims. Members of higher socioeconomic groups tend to be overrepresented among Preferential Child Molesters. More Preferential Child Molesters seem to prefer boy than prefer girl victims. Within this category at least three major patterns of behavior emerge (*see also* Table 2 on page 10).

Seduction This pattern characterizes the offender who engages children in sexual activity by "seducing" them—courting them with attention, affection, and gifts. Just as one adult courts another, the pedophile seduces children over a period of time by gradually lowering their sexual inhibitions. Frequently his victims arrive at the point where they are willing to trade sex for the attention, affection, and other benefits they receive from the offender. Many of these offenders are simultaneously involved with multiple victims, operating what has come to be called a child sex ring. (*See also Child Sex Rings: A Behavioral Analysis* listed in "Appendix III: Additional Reading.") This may include a group of children in the same class at school, in the same scout troop, or in the same neighborhood. The characteristic that seems to make this individual a master seducer of children is his ability to identify with them. He knows how to talk to children—but, more important, he knows how to listen to them. His adult status and authority is also an important part of the seduction process. In addition, he frequently selects as targets children who are victims of emotional or physical neglect. The biggest problem for this child molester is not how to obtain child victims but how to get them to leave after they are too old. This must be done without the disclosure of the "secret." Victim disclosure often occurs when the offender is attempting to terminate the relationship. This child molester is most likely to use threats and physical violence to avoid identification and disclosure or to prevent a victim from leaving before he is ready to "dump" the victim.

Introverted This pattern of behavior characterizes the offender who has a preference for children but lacks the interpersonal skills necessary to seduce them. Therefore, he typically engages in a minimal amount of verbal communication with his victims and usually molests strangers or very young children. He is like the old stereotype of the child molester in that he is more likely to hang around playgrounds and other areas where children congregate, watching them or engaging them in brief sexual encounters. He may expose himself to children or make obscene phone calls to children. He may utilize the services of a child prostitute. Unable to figure out any other way to gain access to a child, he might even marry a woman and have his own children, very

likely molesting them from the time they are infants. He is similar to the inadequate Situational Child Molester, except that he has a definite sexual preference for children and his selection of only children as victims is more predictable.

Sadistic This pattern of behavior characterizes the offender who has a sexual preference for children but who, in order to be aroused or gratified, must inflict psychological or physical pain or suffering on the child victim. He is aroused by his victim's response to the infliction of pain or suffering. They typically use lures or force to gain access to their victims. They are more likely than other Preferential Child Molesters to abduct and even murder their victims. There have been some cases where seduction molesters have become sadistic molesters. It is not known whether the sadistic needs developed late or were always there and surfaced for some reason. In any case, it is fortunate that sadistic child molesters do not appear to be large in number. (*See* "Appendix II: References.")

The Role of Law Enforcement

In our typology the term Preferential Child Molester is synonymous with the pedophile who sexually molests or exploits children. Since there are federal, state, and local laws that deal with such crimes as the possession and distribution of child pornography, law enforcement officers will sometimes be involved in the investigation of pedophiles and others who have not technically molested children but who have sexually exploited them by collecting or trading child pornography. Therefore, pedophiles who do not physically or legally sexually molest children might become of investigative interest to local or federal law enforcement. Any individual, however, who collects or distributes child pornography actually perpetuates the sexual abuse or exploitation of the child portrayed. It is no different than the circulation of sexually explicit pictures taken by a rapist of his victim during the rape. Such collectors and distributors of child pornography are, in essence, child molesters. (*See also* "Appendix V: Sexual Victimization of Children.")

Table 1

Situational Child Molester

	Regressed	*Morally Indiscriminate*	*Sexually Indiscriminate*	*Inadequate*
Basic Characteristics	Poor coping skills	User of people	Sexual experimentation	Social misfit
Motivation	Substitution	Why not?	Boredom	Insecurity and curiosity
Victim Criteria	Availability	Vulnerability and opportunity	New and different	Non-threatening
Method of Operation	Coercion	Lure, force, or manipulation	Involve in existing activity	Exploits size, advantage
Pornography Collection	Possible	Sadomasochistic; detective magazines	Highly likely; varied nature	Likely

Table 2

Preferential Child Molester

	Seduction	*Introverted*	*Sadistic*
Common Characteristics	1. Sexual preference for children 2. Collects child pornography or erotica		
Motivation	Identification	Fear of communication	Need to inflict pain
Victim Criteria	Age and gender preferences	Strangers or very young	Age and gender preferences
Method of Operation	Seduction process	Non-verbal sexual contact	Lure or force

4. Identifying Pedophiles

Sexual exploitation is a term used to describe the sexual victimization of children, involving child pornography, child sex rings, and child prostitution. While offenders utilizing the services of a child prostitute may be either Situational or Preferential Child Molesters, those involved in child pornography and child sex rings are predominately Preferential Child Molesters. And, although a variety of individuals sexually abuse children, Preferential Child Molesters, or pedophiles, are the *primary* sexual exploiters of children. (For the purpose of our law enforcement typology, *pedophile* is used interchangeably with *Preferential Child Molester.*)

An important step in investigating the difficult cases of child sexual victimization is to recognize and identify, if present, the highly predictable sexual behavior patterns of Preferential Child Molesters, or pedophiles. First, it is essential that the law enforcement investigator attempt to determine if an offender is a Situational or Preferential Child Molester.

There are most likely more Situational than Preferential Child Molesters. Each Situational Child Molester, however, is likely to abuse only a small number of children in a lifetime. A Preferential Child Molester might molest ten, fifty, hundreds, or even a thousand children in a lifetime, depending on the offender and how broadly or narrowly you define child molestation. In his study of 561 sex offenders, Dr. Gene Abel found pedophiles who targeted young boys outside the home committed the greatest number of crimes with an average of 281.7 acts with an average of 150.2 partners. Molesters who targeted girls within the family committed an average of 81.3 acts with an average of 1.8 partners. He also found that 23.3 percent of the 561 subjects offended against both family and nonfamily targets. Although pedophiles vary greatly, their sexual behavior is repetitive and highly predictable. Knowledge of these sexual behavioral patterns or characteristics is extremely valuable to the law enforcement investigator.

These highly predictable and repetitive behavior patterns make cases involving Preferential Child Molesters far easier to investigate than those involving Situational Child Molesters. If enough of these characteristics can be identified through investigation, many of the remaining ones can be assumed. Most of these indicators mean little by themselves. As they are identified and accumulated through investigation, however, they can constitute reason to believe a certain offender is a Preferential Child Molester. You do not have proof beyond a reasonable doubt, but you may have *probable cause.*

The Preferential Child Molester (Pedophile)

The four major characteristics of the Preferential Child Molester (pedophile) are 1) long-term and persistent pattern of behavior, 2) children as preferred sexual objects, 3) well-developed techniques in obtaining victims, and 4) sexual fantasies focusing on children. These characteristics, together with the listed indicators, will assist the investigator in identifying the Preferential Child Molester and collecting the evidence necessary to arrest and convict him. At the outset, it must be stated and emphasized that *the indicators alone mean*

little. Their significance and weight comes as they are accumulated and come to form a pattern of behavior. If the investigator determines the existence of enough of these indicators, there is probable cause to believe the individual is a Preferential offender. In order to identify these indicators, the investigator must be willing to go beyond the typical background check of date of birth and credit and criminal histories and learn everything legally possible. Indicators and counter-indicators must be identified and evaluated.

1. **Long-Term and Persistent Pattern of Behavior**

   Sexual abuse in background Although most victims of child sexual abuse do not become offenders, research indicates that many offenders are former victims. It is well worth the investigator's time and effort to determine if a suspect had ever been the victim of sexual abuse and what was the nature of the abuse (age it occurred, relationship with offender, acts performed, etc.).

   Limited social contact as teenagers The pedophile's sexual preference for children usually begins in early adolescence. Therefore, during his teenage years he may have exhibited little sexual interest in people his own age. But, as with several of these indicators, that fact *alone* means little.

   Premature separation from military If an individual was dishonorably discharged for molesting children, there is not much doubt about the significance. It was far more common, though, for this type of individual to be prematurely separated from the military with no specific reason given or available. The military, like most organizations, was frequently interested in only getting rid of such individuals and not necessarily in prosecuting them. Fortunately, this attitude seems to be changing.

   Frequent and unexpected moves When they are identified, pedophiles are frequently "asked" to leave town by someone in authority, by the parent of one of the victims, or by an employer. This was, and still is, a common way to deal with the problem. The result is that pedophiles frequently show a pattern of living in one place for several years with a good job and then suddenly and for no apparent reason moving and changing jobs. Chances are the investigator will find no official record of what happened. The pedophile will usually have an explanation for the move, but it probably will not reflect the true circumstances. This moving pattern can sometimes be determined from examination of drivers license records.

   Prior arrests In some cases, pedophiles have previously been arrested for child molestation or sexual abuse. Certainly, such an arrest record is a major indicator, particularly if the arrest goes back many years or is repeated. Investigators must also be alert to the fact that pedophiles may have arrest records for actions that do not appear to involve sexual abuse. These might include impersonating a police officer, writing bad checks, violating child labor laws, or

other violations that may indicate a need to check further. Any arrest of an adult in the company of a child not his own should be evaluated with suspicion. The investigator should attempt to get copies of the reports concerning the arrests in order to evaluate their significance properly.

Multiple victims If investigation reveals that an individual molested many different victims, that is a very strong indicator that the offender is a pedophile. More important, if other factors indicate that the offender is a pedophile then a concerted effort should be made to identify the multiple victims. If you know of only one victim, but have reason to believe the offender is a pedophile, then begin looking for the other victims. For instance, if a teacher who is a suspected pedophile molests one child in his class, the chances are high that he has molested or attempted to molest other children in the class as well as children in all the other classes he has taught. This is also true of incest offenders suspected of being Preferential Child Molesters.

Planned, repeated, or high-risk attempts Bold and repeated attempts to obtain children that have been carried out in a cunning and skillful manner is a strong indication that the offender is a pedophile.

2. Children as Preferred Sexual Objects

Over 25, single, never married By itself, this indicator means nothing. It has significance only when combined with several other indicators. Because they have a sexual preference for children, pedophiles usually have some degree of difficulty in performing sexually with adults. Therefore, they typically do not marry. Some pedophiles, though, do enter into marriage for specific reasons, and these will be discussed below.

Lives alone or with parents This indicator is closely related to the above. Again, by itself, it has little meaning. The fact that a man lives alone does not mean he is a pedophile. The fact that an individual who possesses many of the other traits discussed here and also lives alone might be significant.

Limited dating relationships if not married A man who lives alone, has never been married, and does not date should arouse suspicion if he possesses other characteristics discussed here.

If married, "special" relationship with spouse When they do marry, pedophiles often marry either a strong, domineering woman or a weak, passive woman-child. In any case, they will marry a woman who does not have high sexual expectations or needs. A woman married to a pedophile may not realize that her husband is a pedophile but she does know he has a "problem"—a sexual performance problem. Because she may blame herself for this problem and because of the private nature of people's sex lives, most wives will usually not reveal this information to an investigator. However, a wife, ex-wife, or girlfriend should always be considered as a possible source of information concerning the sexual preferences of an offender. Pedophiles sometimes marry

for convenience or cover. Pedophiles marrying to gain access to children is discussed below.

Excessive interest in children How much interest is excessive? This is a difficult question. The old adage "If it sounds too good to be true, maybe it is" may apply here. If someone's interest in children seems too good to be true, maybe it is. This is not proof that someone is a pedophile, but it is a reason to be suspicious. It becomes more significant when this excessive interest is combined with other indicators discussed here.

Associates and circle of friends are young In addition to sexual activity, pedophiles frequently socialize with children and get involved in youth activities. They may hang around schoolyards, arcades, shopping centers—any place that children frequent. Their "friends" may be male, female, or both sexes, very young or teenagers, all depending on the age and gender preferences of the pedophile.

Limited peer relationships Because they cannot share the most important part of their life (their sexual interest in children) with most adults, pedophiles may have a limited number of close adult friends. Only other pedophiles will validate their sexual behavior. If a suspected pedophile has a close adult friend, the possibility that the friend is also a pedophile must be considered.

Age and gender preference Most pedophiles prefer children of a certain sex in a certain age range. The older the age preference of the pedophile, the more exclusive the gender preference. Pedophiles attracted to toddlers are more likely to molest boys and girls indiscriminately. A pedophile attracted to teenagers is more likely to prefer either boys or girls exclusively. The preferred age bracket for the child can also vary. One pedophile might prefer boys 8 to 10, while another might prefer boys 6 to 12. A pedophile's age preference might not even correspond exactly with the legal definitions of a child or minor. For example, a pedophile might prefer sexual partners 13 to 19. How old a child looks and acts is more important than actual chronological age. A 13-year-old child who looks and acts like a 10-year-old child could be a victim target for a molester preferring 8 to 10 year olds. For the introverted Preferential Child Molester, how old the child looks is more important than how old the child acts. Puberty seems to be an important dividing line for many pedophiles. This is only an age and gender preference, not an exclusive limitation. Any individual expressing a strong desire to care for or adopt only a child of a very specific sex and age (other than an infant) should be viewed with some suspicion.

Refers to children as "clean," "pure," "innocent," "impish," etc., or as objects Pedophiles sometimes have an idealistic view of children that is expressed in their language and writing. Others sometimes refer to children as if they were objects, projects, or possessions. "This kid has low mileage" and "I've been working on this project for six months" are typical comments.

3. Well-Developed Techniques in Obtaining Victims

Skilled at identifying vulnerable victims Some pedophiles can watch a group of children for a brief period of time and then select a potential target. More often than not, the selected child turns out to be from a broken home or the victim of emotional or physical neglect. This skill is developed through practice and experience.

Identifies with children (better than with adults) Pedophiles usually have the ability to identify with children better than they do with adults—a trait that makes most pedophiles master seducers of children. They especially know how to *listen* to children. Many pedophiles are described as "pied pipers" who attract children.

Access to children This is one of the most important indicators of a pedophile. The pedophile will surely have a method of gaining access to children. Other than simply hanging around places children congregate, pedophiles sometimes marry or befriend women simply to gain access to their children. Pedophiles are frequently the "nice guys" in the neighborhood who like to entertain the children after school or take them on day or weekend trips. Also, a pedophile may seek employment where he will be in contact with children (teacher, camp counselor, babysitter, school bus driver) or where he can eventually specialize in dealing with children (physician, dentist, minister, photographer, social worker, police officer). The pedophile may also become a scout leader, Big Brother, foster parent, Little League coach, and so on. The pedophile may operate a business that hires adolescents. In one case known to the author, a pedophile married, had a daughter, and he molested her. He was the "nice guy" in the neighborhood who had the neighborhood girls over to his house for parties, at which he molested them. He was a coach for a girl's softball team, and he molested the players. He was a dentist who specialized in child patients, and he molested them.

Activities with children, often excluding other adults The pedophile is always trying to get children into situations where there are no other adults present. On a scout hike he might suggest the fathers go into town for a beer. He will "sacrifice" and stay behind with the boys.

Seduces with attention, affection, and gifts This is the most common technique used by pedophiles. They literally seduce the children by befriending them, talking to them, listening to them, paying attention to them, spending time with them, and buying gifts for them. If you understand the courtship process, it should not be difficult to understand why some child victims develop positive feelings for the offender. Many people can understand why an incest victim might not report his or her father, but they cannot understand why a victim not related to the offender does not immediately report molestation. There are many reasons for a victim not

immediately reporting molestation (fear, blackmail, embarrassment, confusion), but the results of the seduction process are often ignored or not understood at all.

Skilled at manipulating children In order to operate a child sex ring involving simultaneous sexual relations with multiple victims, a pedophile must know how to manipulate children. The pedophile uses seduction techniques, competition, peer pressure, child and group psychology, motivation techniques, threats, and blackmail. The pedophile must continuously recruit children into and move children out of the ring without his activity being disclosed. Part of the manipulation process is lowering the inhibitions of the children. A skilled pedophile who can get children into a situation where they must change clothing or stay with him overnight will almost always succeed in seducing them. Not all pedophiles possess these skills. The introverted Preferential Child Molester is an example of a pedophile who typically lacks these abilities.

Has hobbies and interests appealing to children This is another indicator that must be considered for evaluation only in connection with other indicators. Pedophiles might collect toys or dolls, build model planes or boats, or perform as clowns or magicians to attract children. A pedophile interested in older children might have a "hobby" involving alcohol, drugs, or pornography.

Shows sexually explicit material to children Any adult who shows sexually explicit material to children of any age should be viewed with suspicion. This is generally part of the seduction process in order to lower inhibitions. A pedophile might also encourage or allow children to call a dial-a-porn service or send them sexually explicit material via a computer as part of this process.

4. Sexual Fantasies Focusing on Children

Youth-oriented decorations in house or room Pedophiles attracted to teenage boys might have their homes decorated the way a teenage boy would. This might include toys, games, stereos, rock posters, and so on. The homes of some pedophiles have been described as shrines to children or as miniature amusement parks.

Photographing of children This includes photographing children fully dressed. One pedophile bragged that he went to rock concerts with thirty or forty rolls of film in order to photograph young boys. After developing the pictures, he fantasized about having sex with them. Such a pedophile might frequent playgrounds, youth athletic contests, child beauty pageants, or child exercise classes with his camera.

Collecting child pornography or child erotica This is one of the most significant characteristics of pedophiles, discussed in detail on pages 23-35.

If, after evaluating these indicators, the law enforcement investigator has reason to suspect that a particular subject or suspect is a Preferential Child Molester, the investigator should utilize the three most important pedophile indicators to his or her investigative advantage. These three indicators are access to children, multiple victims, and collection of child pornography or erotica.

The investigator must attempt to identify additional victims to strengthen the case against the offender. The more victims identified, the less likely that any of them will have to testify in court. But, even more important, *as soon as legally possible* the investigator must obtain a warrant to search for child pornography or erotica, which is invaluable as evidence. There is a certain urgency in this because the more interviews conducted to obtain the needed probable cause for a search warrant, the greater the chance the pedophile will learn of the investigation and move or hide his collection. Child pornography, especially that produced by the offender, is *one of the most* valuable pieces of evidence of child sexual abuse that any investigator can have. The effects on a jury of viewing seized child pornography is devastating to the defendant's case. The investigator must also attempt to develop a good interview strategy based on knowledge of the preferential offender's need to rationalize and justify his behavior.

STRATEGIES for Dealing with STRESS & BURNOUT

Theresa Kern Vo, Ph.D.
580 Denton Tap Rd. St. 270
Coppell, TX 75019
(972) 393-1596

STRATEGIES FOR DEALING WITH STRESS AND BURNOUT

Theresa Kern Vo, Ph.D.

Emotional Indicators of Stress

- Anger and irritation
- Impulse to aggression
- Depression
- Anxiety and panic attacks
- Lack of motivation
- Mood swings
- Excessive worry
- Emotional exhaustion and numbing

Physical Symptoms of Stress

- Increased alcohol, nicotine, and drug use
- Aches and pains
- High blood pressure
- Increased Risk of Coronary Disease
- Diabetes
- Stomach and intestinal irritation
- Frequent colds
- Immune system problems
- Weight loss or gain
- Inability to sleep well
- Physical exhaustion

STRESS AND WORKING WITH CHILD VICTIMS

Empathic Strain

Results from those interpersonal events in helping others that weaken, injure, or force beyond reasonable limits an empathic response to a person

Vicarious Trauma

Symptoms of trauma experienced by helpers such as rescue workers, police, CPS, and mental health providers who are helping primary victims of trauma.

Symptoms of Vicarious Trauma

- Dreams about abuse/client
- Obsessive thinking about a case
- Over-involvement in case
- Detachment and Emotional Numbing
- Overpretectiveness of self or your children

PERSONALITY FACTORS AND STRESS

Type A Personality
- Impatient
- Aggressiveness
- Sense of Time Urgency (hurry sickness)
- Free-floating hostility
- Love of competition
- Frequent anger
- Intense concentration and alertness

Harmful Components of Type A Behavior
- Cynicism
- Aggressive Responding
- Hostile Affect

Type B Personality
- Absence of time urgency
- Absence of free-floating hostility
- Greater tolerance for different people and ideas
- Less perfectionism

BURNOUT

Factors Leading to Burnout
- Emotional Exhaustion
- Depersonalization
- Lack of Personal Accomplishment
- Work Overload
- Excessive Paperwork
- Loss of Meaning in Work
- Family and Personal Problems
- High levels of responsibility with low levels of power
- Inadequate compensation for job risk

Stressful Work Environments
- Inadequate Leadership
- Role conflict
- Role ambiguity
- Lack of rewards
- Excessive red tape
- Lack of support by peers
- Lack of proper equipment to do the job properly

Personality Factors Leading to Work Burnout
- Naive Idealism
- Unrealistic Aspirations
- Lack of adequate training
- Thinking about work after hours

Overly committed to work
No one to talk to about work

Police Work Setting Factors Leading to Burnout (Cherniss, 1980)
Work Setting
Workload - lots of overtime
Stimulation - Is Job challenging and stimulating?
Scope of client contacts - Wide range of different people better, Restricted range worse
Supervision - Is Technical Help and Advice available
Social Isolation - lots of time working alone

Experienced Stress Leading to Burnout
Doubts about competence
Problems with clients
Bureaucratic interference
Lack of stimulation and fulfillment
Lack of social support

Negative Attitude Change
Reduced work goals - lowered standards
Reduced personal responsibility for outcomes
Less idealism - more cynical
Emotional Detachment
Work alienation - rather stay in bed
Dissatisfaction with pay and benefits

Burnout In The Helping Professions (Social work, mental health, nursing, etc.)
Struggle with other people
Domain fights
Role problems
Lack of support from co-workers
Lack of understanding of mate
High workload
High responsibility
Bureaucracy
Lack of fairness in system
Lack of training

Stress and Attorneys
Higher death rate in Type A

STRESS MANAGEMENT AND BURNOUT PREVENTION TECHNIQUES

Stress Management Techniques
- **Taking care of body**
- **Get Away from work**
- **Relaxation**
- **Social Activities**
- **Recreation and Fun**
- **Time with family and friends**
- **Humor is essential**
- **Cognitive techniques**
- **Relaxation techniques**

Environmental Factors to Change
- **Improve work area**
- **Build teams**
- **Flexibility**
- **Recognition of a job well done**
- **Variety in job duties**
- **Ongoing training**
- **Social activities at work**
- **Lessen time working alone**

Individual Factors to Change
- **Lower expectations about job**
- **Monitor need to rescue or detachment from clients**
- **Put job in perspective**
- **Find meaning in work**
- **Use supervision and staff support for difficult cases**
- **Become aware of stressors**
- **Limit short-term and long-term exposure to stressors**
- **Ask for assistance!**

Can Type A Behavior be Changed
- **Monitor cynical thoughts!**
- **Reason with yourself**
- **Stop negative thoughts**
- **Put yourself in other's shoes**
- **Laugh at yourself**
- **Learn to relax**
- **Pretend today is your last!**

Having Fun
- **What do you enjoy doing?**
- **How often do you do this activity?**
- **What activities in the past have you enjoyed?**
- **What would you like to try?**
- **Do I make time for fun on a weekly basis?**

Critical Incident Stress Debriefing

What is a critical Incident?

What is critical incident stress?

Post-Traumatic Stress Disorder (DSM-IV)

A. Person exposed to traumatic event in which both of the following were present:

1. Experienced, witnessed, or confronted with events involving actual or threatened death or serious injury, or threat to physical integrity of self or others
2. Person's response involved intense fear, helplessness, or horror

B. Traumatic event persistently reexperienced in one or more of the following ways:

1. Recurrent and intrusive images, thoughts, or perceptions of event
2. Recurrent distressing dreams of event
3. Acting or feeling as if the event were recurring (reliving experience, illusions, hallucinations, flashbacks)
4. Intense psychological distress at exposure to internal or external cues of event
5. Physiological reactivity on exposure to internal or external cues of event

C. Persistent avoidance of stimuli associated with trauma and numbing of responsiveness as indicated by three of the following

1. Efforts to avoid thoughts, feelings, or conversations about trauma
2. Avoidance of activities, places, or people related to trauma
3. Inability to recall important aspect of trauma
4. Markedly diminished interest in significant activities
5. Feelings of detachment from others
6. Restricted range of emotions
7. Sense of foreshortened future

D. Persistent symptoms of increased arousal indicated by two of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper vigilance
5. Exaggerated startle response

ACUTE: Symptoms less than 3 months
CHRONIC: Symptoms 3 months or more
WITH DELAYED ONSET: Onset of symptoms at least 6 months after event

TYPES OF INTERVENTIONS

Defusing
Demobilization
Debriefing

STAGES OF CRITICAL INCIDENT DEBRIEFING

1. Introduction
2. Fact
3. Thought
4. Reaction
5. Symptom
6. Teaching
7. Reentry

BIBLIOGRAPHY

STRESS MANAGEMENT AND LAW ENFORCEMENT

Mitchell, J. T. (1995). **Psychotraumatology: Key papers and core concepts in post-traumatic stress.** Plenum Press: New York.

Norvell and Belles (1993). Psychological and physical benefits of circuit weight training in law enforcement personnel. **Journal of Consulting and Clinical Psychology,** Vol 61, No. 3, 520-527.

Burke and Deszca (1988). Career orientations, satisfaction and health among police officers: Some consequences of person-job misfit. **Psychological Reports** , 65, 3-12

Burke, R. J. Career Stages, satisfaction, and well-being among police officers. **Psychological Reports,** 65, 3-12.

Follette, Polusny, and Milbeck (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. **Professional Psychology - Research & Practice,** Vol. 25 (3), 275-282.

Burke, R. (1993). Toward an understanding of psychological burnout among police officers. **Journal of Social Behavior & Personality,** Vol 8 (3), 425-438.

Burke, R. (1993). Work-family stress, conflict, coping, and burnout in police officers. **Stress Medicine,** Vol. 9 (3), 171-180.

Goodman, A. (1990). A model for police officer burnout. **Journal of Business & Psychology,** Vol 5(1), 85-99

White, Lawrence, Scott, Biggerstaff, and Grubb. (1985). Factors of stress among police officers. **Criminal Justice & Behavior,** Vol 12, 111-128.

Norvell, Hills & Murrin (1993). Understanding stress in female and male law enforcement officers. **Psychology of Women Quarterly.** Vol. 17(3), 289-301.

Norvell, Belles, and Hills. Perceived stress levels and physical symptoms in supervisory law enforcement personnel. **Journal of Police Science & Administration.** Vol 16(2), 75-79

Ostrov, E. (1986). Police/law enforcement and psychology. Special issue: Psychology in law enforcement. **Behavioral Sciences & the law,** Vol 4, 353-370.

Terry, W. (1985). Police stress as a professional self-image. **Journal of Criminal**

Justice, Vol 13, 501-512.

Bergen, G. & Bartol, C. (1983). Stress in rural law enforcement. **Perceptual & Motor Skills**, Vol 56, 957-958.

STRESS MANAGEMENT AND CHILD PROTECTIVE WORK

Powell, W. E. (1994). The relationship between feelings of alienation and burnout in social work. **Families in Society**, Vol. 3, 229-235.

Jones, M. (1993). Role Conflict: Cause of Burnout or Energizer? **Social Work**, Vol 38(2), 135-141

Kurland and Salmon (1992). When problems seem overwhelming: Emphases in teaching, supervision, and consultation. **Social Work**, 37(3), 240-244.

Reagh, R. (1994). Public child welfare professionals: Those who stay. **Journal of Sociology & Social Welfare**, Vol 21, 69-78.

Koeske, Kirk, Koeske, and Rauktis (1994). Measuring the Monday blues: Validation of a job satisfaction scales for the human services. **Social Work Research & Abstracts**. Vol 29, 5-11.

Poulin and Walter (1993). Social worker burnout: A longitudinal study. **Social Work Research & Abstracts**. Vol 29, 5-11.

Jayaratne, Himle, and Chess (1991). Job satisfaction and burnout: Is there a difference? **Journal of Applied Social Sciences**, Vol 15, 245-262.

Himle, Jayaratne, and Thyness (1991). Buffering effects of four social support types on burnout among social workers. **Social Work Research & Abstracts**, Vol 27, 22-27.

BURNOUT

Schaufeli, W., Maslach, C., and Marek, T. (1993). **Professional Burnout: Recent Development in Theory and Research**. Taylor and Francis: Berkeley, CA., 1993.

CRITICAL INCIDENT STRESS DEBRIEFING

Mitchell, J. and Everly, G. (1995). Critical incident stress debriefing (CISD) and the prevention of work-related traumatic stress among high risk occupational groups. **Psychotraumatology: Key papers and Core Concept in Post-Traumatic Stress**, Plenum Press: New York.

Detective Mike Johnson
Presentation Handouts

Overheads

Three areas of child abuse investigation. . .

Investigative Continuum

"Window of Opportunity"

Emotions may motivate. . .

Crisis Case vs. Delayed Case

Corroboration

Formula for a Confession

Definitions

Glossary of Terms - Sexual

Criminal Thinking Distortions

Defense Mechanisms

Behavioral Indicators

Alert List

Range of Sexual Behaviors - Children and Adolescents

Stages of Adjustment

Checklists/Protocols

Investigative Checklist

Articles for Reference

Reference Publications Listing

NCMEC Child Molesters: A Behavioral Analysis - Kenneth Lanning, FBI (Excerpt)

Team Child Abuse Investigation Training for Professionals

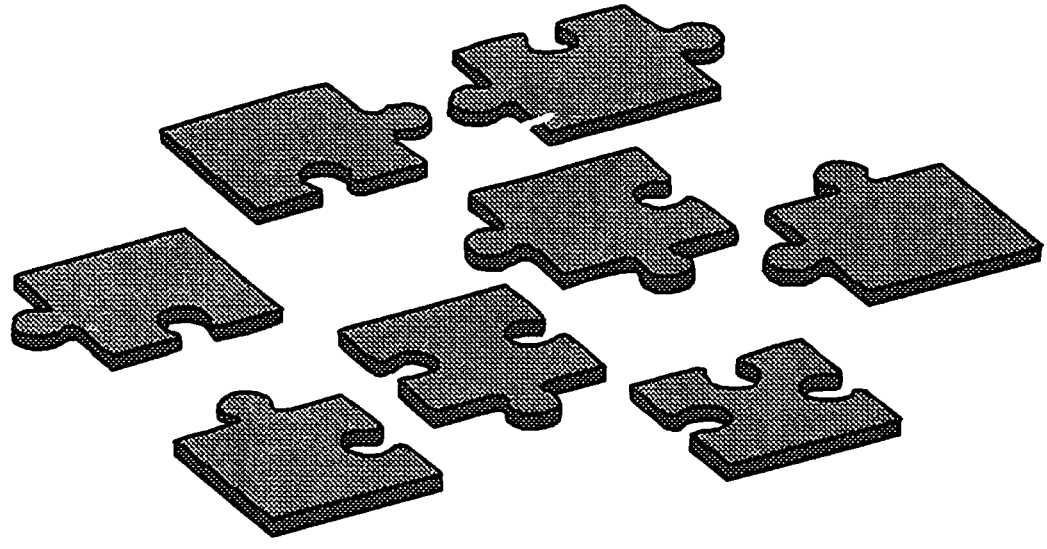
A Law Enforcement Perspective

by Detective Mike Johnson

Plano Police Department
and
Collin County Children's Advocacy Center

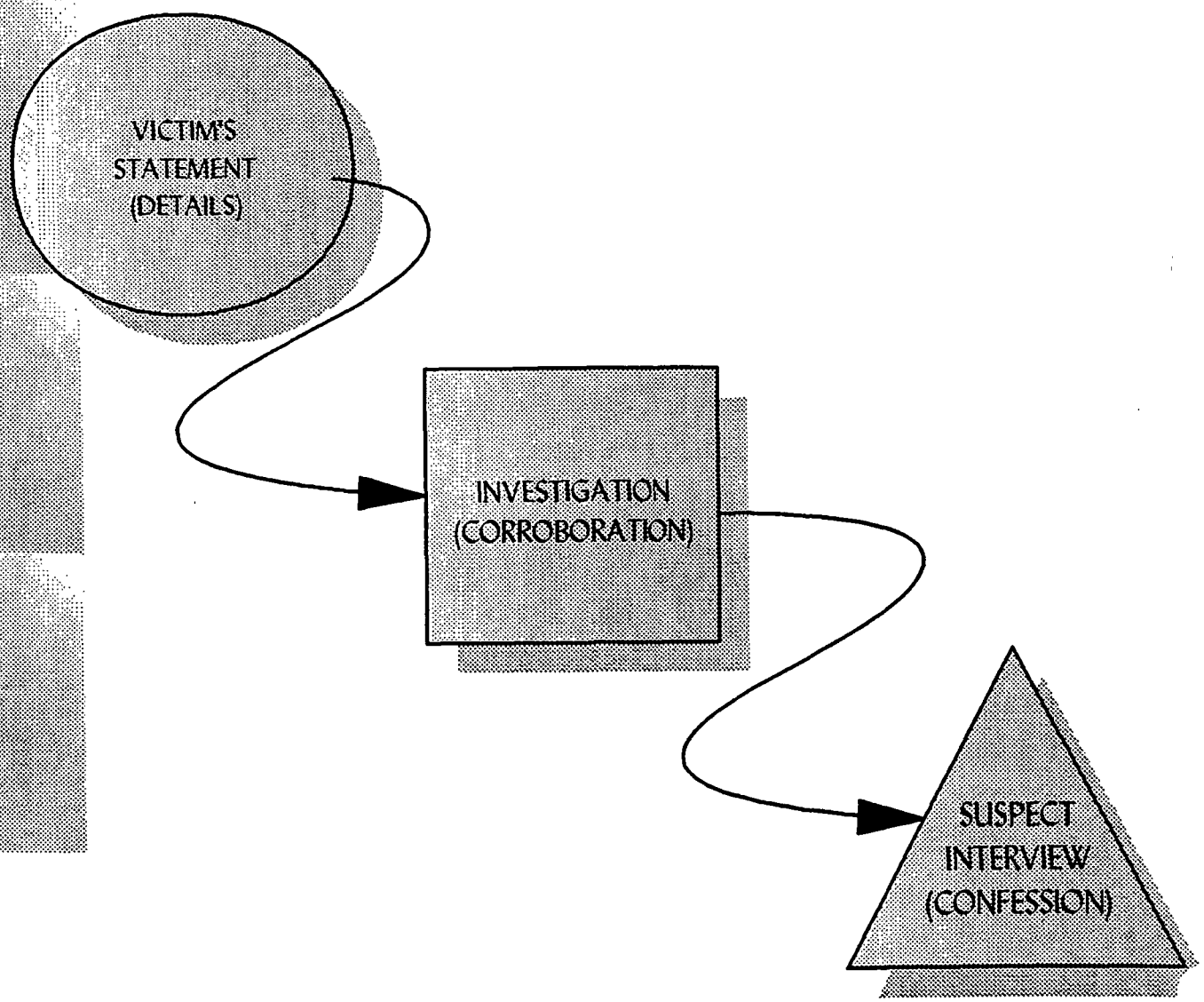
Three areas of child abuse investigation that we must strive to become experts in are:

- DETAILS, DETAILS, DETAILS
- CORROBORATION
- CONFESSION



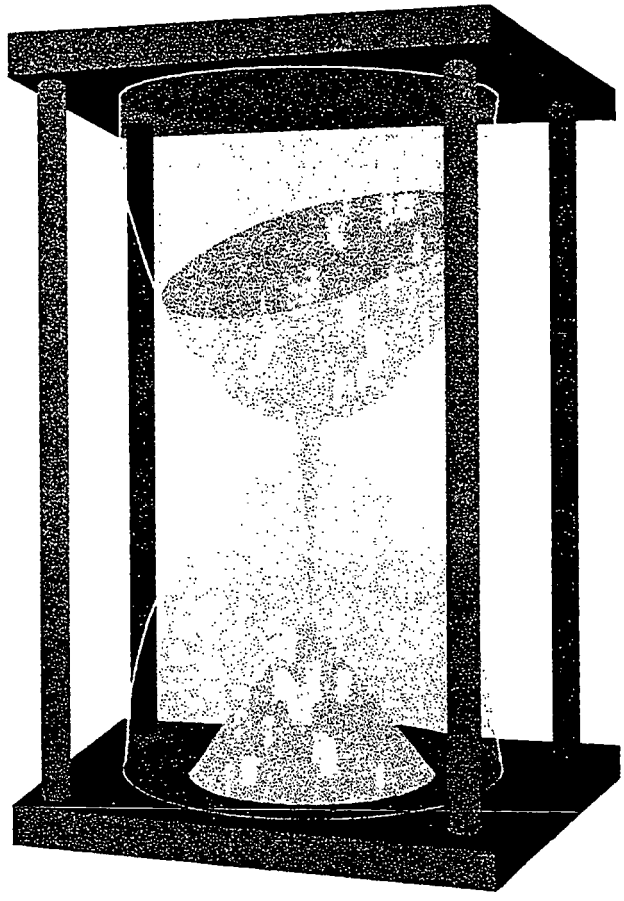
INVESTIGATIVE CONTINUUM

This is OUR investigation.



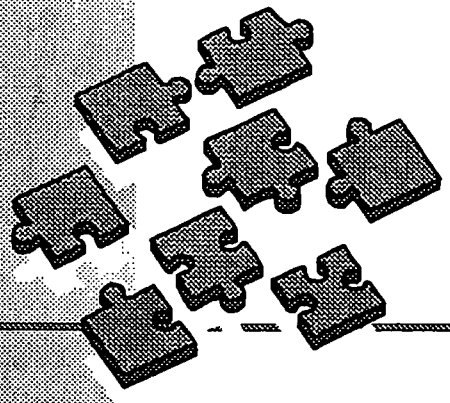
"WINDOW OF OPPORTUNITY"

- Children tell for a multitude of reasons
- We have to be ready to mobilize when the child is ready to tell
- The CAC provides an environment which is conducive for the child to tell



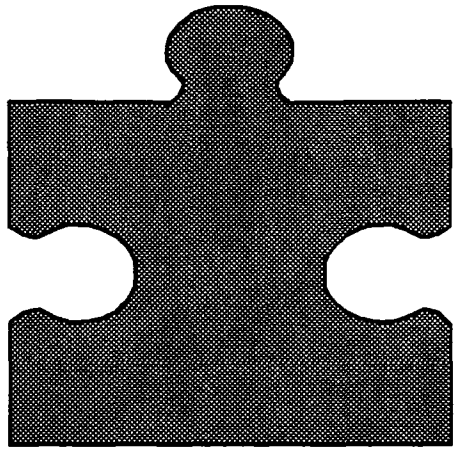
Emotions may motivate but facts must dictate.

- Detective Mike Johnson,
Plano Police Department



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).

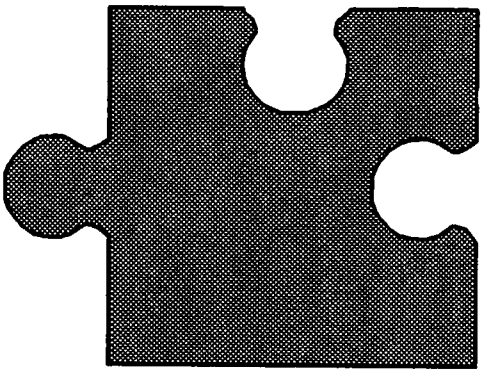


Corroboration

- ★ Confession - the ultimate corroboration
- ★ Crime Scene Evidence
- ★ Medical Evidence
- ★ Independent Other Victims
- ★ Dependent Other Victims
- ★ Criminal History

Corroboration, continued

- ★ Pre-Text (or One-Party Consent) Phone Calls
- ★ Search Warrants
- ★ Sex Offender Typology
- ★ Private Databases
- ★ Canvassing
- ★ Trash Runs/Abandoned Property
- ★ Social History



Corroboration, continued

COMPUTER CHECK:

★ State Crime Information Center

★ National Crime Information Center

★ City to State Capital, State to Washington, DC.

★ Military and Coast Guard (Grunt to Grunt, First Line to First Line)

★ Federal: FBI, Secret Service, Postal Inspector, DEA (Continuously crossing jurisdictional lines)

★ Child Protective Services (TX Canris, checks by name and SS # of mother)

IN ADDITION:

★ Apartment complex application

★ Resume and work history

★ Credit Card Information

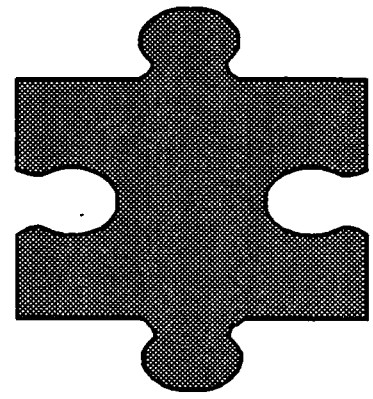
★ Schools: record of moves, counselor notes, nurses log, teachers notes

★ Emergency room records

★ Surveillance

★ Polygraph

★ Hypnosis



FORMULA FOR A CONFESSION

- Review victim interview and understand as much about the case as possible
- Identify suspect's location, contact him, and set up an immediate interview (within the hour)
- Get Miranda out of the way at beginning of interview
- Speak casually, comfortably and confidently about knowing what the suspect has done. Do not register any emotion-either through your words or your body language.
- Do not let him polarize or alibi.
- Listen for themes; manufacture an excuse if he cannot break through.
- Anticipate "big humps" and plan your parry.
- Be silent; appreciate the beauty of not giving information.
- Sweat him if he is not talking; leave the room and let him think about it.
- Reward what you want; punish what you don't want.
- Finish him - get as much information as you can.
- End friends - you may see him again.

GLOSSARY OF TERMS - SEXUAL

Note: This list of terms consists primarily of slang terms and code words used by individuals in contacting others for sexual purposes. It is not limited solely to pedophilia but the terms may be used by the pedophile in making his contacts.

AC/DC Bisexual

Annalingus Oral stimulation of the rectum

Animal Training Training of animals to participate in sexual acts

Ben-wa Balls Smooth balls placed in body orifices for sexual arousal

Bestiality Sex with animals

Bi-Sexual or Bi A person who enjoys a sexual relationship with both sexes

Body Builder (B/B) Athletic body

Bondage and Discipline (B/D) Tying sex partner up and whipping, humiliating partner

Blow Job Oral copulation

Brown Showers Fecal excrement

Butch Gay female who plays the male role

Chicken Young male

Chicken Hawk Adult male who enjoys sex with young males (chickens)

Child Molester One who abuses a child sexually and/or physically

Coprophagy Eating of fecal excrement

Cornholing Anal intercourse

Corporal Punishment (C/P) Spanking, whipping

Crisco Lubricant for fisting (see definition of F/F)

Cute Refers to young girls; may also refer to young boys

Daisy Chain Consecutive oral-genial connection

Dildo False penis

Dominance Training (D/T) Master, slave relationship

Dyke Dominant lesbian

English Whipping or spanking

Exhibitionism Sexual gratification obtained from exhibiting the genitals

F/F "Fist fucking." (Inserting the fist into a body orifice.) Also referred to as "Fisting"

FFA "Fist Fuckers of America"

Fairy Male homosexual assuming the female role

Fetishism The compulsive use of some object in attaining sexual satisfaction, e.g., high heels, panties, garters, etc.

French Oral stimulation of the genitals

French Tickler Condom with protrusions

Fruit Male homosexual

Gay Male homosexual

Golden Enema (G/E) Enema administered using urine

G/M or G/F Gay male or gay female

Greek Anal intercourse/anal worship

Golden Cocktail Drinking urine

Golden Shower Urinating on another person

G/T Genital torture

H/H High heels

Hot Sexually turned on/excited

Infibulate Piercing of nipples, genitals, etc.

Innocent Young girls; may also refer to young males

J/O Jerk off (masturbation)

K-Y Jelly Sexual lubricant

L/L Leather/Levis

Libido Sexual appetite

Lolita Young girl

Lusty Young girl; may also refer to young boy

"M" Masochist

Masochist Sexual requirement for receiving pain/humiliation

Master Dominant

M/F Male/Female

Milk Maid Activity with a woman's breast milk

Mistress Dominant female (when used in S/M content)

NAMBLA North American Man-Boy Love Association

Naturalist Nudist

Neophyte or Novice Children (male or female); may also refer to a beginner or one who is inexperienced

Nymphomania Excessive female sexual desire

Pedarest An adult who expresses an abnormal love for boys

Pedophile An adult who expresses an abnormal love for children

Pony Young boy; secondary meaning - slave

Poppers Amyl Nitrate used to enhance (generally gay) sexual activity. Product is inhaled.

P/P Photo/phone

Pros Prostitute/professional models

Ream French the anal area

Rim French the anal area

Roman Orgy/group sex

R/S Rough Stuff

Rush Amyl Nitrate used to enhance (generally gay) sexual activity. Product is inhaled.

"S" Sadist

Sadism Sexual desire to inflict pain/humiliation on others

SASE Self addressed stamped envelope

SCAT Scatology (fecal excrement)

S/F Suck and fuck, or submissive female

S/M Sadist/masochist

Slave Submissive

Sixty-Nine Simultaneous oral-genital activity

Sodomy Anal intercourse

Straight/Straight Sex Heterosexual

TS Transsexual; one who has had his/her sex surgically changed

T/T Tit torture, or toilet training

Teaser Material Material using older models dressed to look like children

Toys Sex aids

Trick A prostitute's client

Transvestite (TV) Cross-dresser

Voyeur Person who attains sexual gratification by watching others perform sex acts

Water Sports (W/S) Enemas or urine

Weapon Worship Worship deadly weapons

Youth Development Term used which denotes interest in pedophilia

CRIMINAL THINKING DISTORTIONS

Excuse Making: Avoiding accountability for one's actions by blaming situations or things for one's hurtful or irresponsible behaviors.

Externalizing Blame: Blaming other people for one's hurtful and irresponsible behavior. Finger-pointing and finding fault in another person in order to avoid accepting one's own faults.

Justifying: The process of making something right from something wrong by listing reasons that validate this and thereby avoid feeling guilty.

Minimizing: Reducing or limiting the true significance of hurtful behavior by comparing it "with worse behavior," filtering out the effects on the victim, or giving it an innocuous label or name.

Victim Stance: Picturing oneself as the victim when held accountable for hurtful and irresponsible behavior, rather than seeing the negative effects on the person who has been hurt.

Closed Channel: Secret-keeping, closed-mindedness, and self-righteousness used to selectively filter incoming information. Used to avoid facing information and opinions which would require a change in attitudes or beliefs.

Vagueness: Avoiding specifics and details of one's hurtful and irresponsible behaviors in order to avoid consequences, minimize the negative reactions of others, and avoid facing the true scope of what was done.

Redefining: Shifting the focus from oneself to someone else or changing the topic of conversation to a less threatening one. This is done to avoid taking responsibility by avoiding the issue.

Fake Anger: Manufacturing anger or pretending to be angry in order to manipulate or intimidate others into a desired response or behavior.

Power Play: Using authority, position, or unfair advantages to manipulate others into desired response or behavior.

Victim Playing: An attitude of self-pity and helplessness used to manipulate and coerce others into a desired response or behavior.

Ingratiating: Using insincere praise and fake agreement (buttering someone up) to manipulate others into a desired response or behavior.

Ownership: Viewing someone or something as a possession over which one has total control and authority when this is not the case. Abuse of power in a role relationship. Acting as if the possessions of others are one's own.

Making Fools of: Putting someone down as a means of causing embarrassment or harm to them. Sometimes involves overstating their mistakes. Used to elevate one's own position at another's expense, often to gain power over them to get one's way.

Superiortism: Establishing goals that are unrealistic and unobtainable due to the lack of a concrete plan. Wishful or "magical" thinking. Assuming one won't get caught in their irresponsible or hurtful behaviors.

Lying: Being deceptive and dishonest through the falsification or alteration of the facts. There are three forms of lying:

a. *Comission*: Saying something is true when it is not, or denying that something is true when it is.
b. *Omission*: Telling part of the truth but omitting important information in order to manipulate the outcome.
c. *Assent*: Faking agreement with someone in order to manipulate the outcome.

Uniqueness/Criminal Pride: Seeing and presenting oneself as special and different in a way that information applying to others does not apply to oneself. Seeing and presenting oneself as better than others in order to gain power over them. Exaggerating abilities and accomplishments to create a false front.

Assuming: Taking something for granted and acting on it without checking it out first. This leads to faulty outcomes based on inaccurate beliefs.

Zero State: Seeing oneself as absolutely worthless unless things are going perfectly and others are doing what one wants them to do.

Instancy/Unwillingness to Delay Gratification: Unwillingness to endure discomfort or difficulty to obtain desired results.

DEFENSE MECHANISMS

Defense mechanisms are a victim's way of psychologically coping with trauma. *All* victims of a sexual assault will experience one or more of these defense mechanisms during an investigation. The ability of an investigator to anticipate, recognize, and understand these defense mechanisms will enhance their ability to conduct a more thorough investigation. Defense mechanisms will be employed by both primary and secondary victims.

Repression The involuntary forcing of unacceptable ideas and impulses into the unconscious (amnesia, selective loss of memory, P.T.S.D.*). A sexual assault victim may not be able to remember particular parts of an assault.

Suppression A conscious effort to control and conceal unacceptable impulses, thoughts, feelings, or acts. Suppression is conscious forgetting, while repression is subconscious forgetting. An assault victim may become frightened each time she leaves the house at night. She may consciously try to control the impulse to stay home.

Denial The unconscious disclaim of unacceptable thoughts, feelings, needs, or certain external factors. An assault victim may say she won't need to take the "morning-after" contraceptive pill, even though there is a chance of pregnancy.

Reaction Formation Attitudes and behavior are adopted which are opposite to impulses. An assault victim may act overly polite, courteous, and demonstrate great concern for the offender; while subconsciously feeling intense anger, hostility, and desire for revenge.

Rationalization The unconscious effort to justify intolerable feelings, behaviors, and motives. This justification may make the feelings, behaviors, and motives tolerable at the conscious level. Hostile, punitive, sadistic questioning of an assault victim by the police officer or emergency room nurse, is rationalized by the interrogator as being necessary in order to obtain necessary information for the chart or offense report.

Projection Emotions, behavior, and motives which are consciously intolerable are denied, and then attributed to others. An assault victim experiencing great self-hate may project the hate on to the staff and assault counselor, thus feeling that the staff and counselor do not like her.

Identification An unconscious process in which a person models his attributes and behavior after another. A sexual assault counselor, who herself has been assaulted, may become as distressed as the assault victim.

Displacement The unconscious shifting of emotions from one idea or object to another. An assault victim who is subconsciously filled with rage toward the offender and anger at herself, may lash out at the nurse for causing pain during an injection.

Sublimation Channeling energy from instinctual drives to constructive, socially acceptable behavior or activity. An assault victim may consciously redirect her anger and rage regarding the assault toward a intense game of racquetball.

Isolation The separation of the emotional component from a thought. A sexual assault victim may describe the assault in horrifying detail, without apparent emotional tone.

Regression The reversion, under stress, to patterns of behavior and gratification that are more typical of a child. A 21 year old sexual assault victim, under stress in the emergency room, may become pouty, uncooperative, and childlike.

Conversion Unconscious conflicts are given expression symbolically in the form of bodily symptoms. A sexual assault victim may experience extreme pain upon intercourse for several months following the assault.

*Post Traumatic Stress Disorder or "Vietnam Syndrome". Will be discussed at length in a later paper.

ALERT LIST

Investigator should be alerted if they encounter someone who:

1. Treats a child differently from other children.
2. Wants to spend time with child alone, makes excuses to take child places, or has others leave so he can be alone with child.
3. Asks child to do things that involve physical contact, like giving back rubs or washing child's back.
4. Does things to child that involve physical contact, like giving back rubs, massaging, or helping child wash.
5. Accidentally-on-purpose touches child's private parts, brushes against breasts while wrestling, or rubs his body on child's body.
6. Looks at or touches child's body and says it is an inspection to see how child is developing.
7. Puts lotion or ointment on child when others are not around or nothing is wrong, or asks to put on suntan lotion.
8. Accidentally-on-purpose goes in child's room while he/she is undressed, or goes in the bathroom when child is there, or lets his robe fall open while walking around.
9. Does not respect child's privacy, goes into bedroom without knocking, does not allow doors to be closed to child's bedroom or bathroom.
10. Asks questions or makes accusations about sexual things between child and their boyfriend or girlfriend.
11. Teaches sex education by showing pornographic pictures, shows his body to child, or touches child's body.
12. Says things about child's body or how child dresses that make child uncomfortable.
13. Talks to child about sexual things he has done.
14. Tells child private things about his wife or mother or child's mother or father.
15. Tells child that they are different, special, the only one who understands - better than his wife.
16. Treats child like an adult and/or acts like a child himself.
17. Gives child special privileges or favors and makes child feel like they should return a favor by doing something he wants.

RANGE OF SEXUAL BEHAVIORS OF *CHILDREN*

Normal

Genital or reproduction conversations with peers or similar-age siblings
"Show me yours/I'll show you mine" with peers
Playing "doctor"
Occasional masturbation without penetration
Imitating seduction (e.g., kissing, flirting)
Dirty words or jokes within cultural or peer group norm

Yellow Flags

Preoccupation with sexual themes (especially sexually aggressive)
Attempting to expose others' genitals (e.g., pulling another's skirt up or pants down)
Sexually explicit conversation with peers
Sexual graffiti (especially chronic or impacting individuals, i.e., naming someone in threats or humiliation)
Sexual innuendo/teasing/embarrassment of others
Precocious sexual knowledge
Single occurrences of peeping/exposing/obscenities/pornographic interest/frottage
Preoccupation with masturbation
Mutual masturbation/group masturbation
Simulating foreplay with dolls or peers with clothing on

Red Flags

Sexually explicit conversations with someone of significant age difference
Touching genitals of others
Degradation/humiliation of self or others with "sexual themes"
Forced exposure of others' genitals
Inducing fear/threats of force
Sexually explicit proposals/threats, including written notes
Repeated or chronic peeping/exposing/obscenities/pornographic interests/frottage
Compulsive masturbation/task interruption to masturbate
Female masturbation, including vaginal penetration
Simulating intercourse with dolls, peers, animals (i.e., humping)

No Questions (evaluate/refer)

Oral, vaginal, anal penetration of dolls, children, animals
Forced touching of genitals
Simulating intercourse with peers with clothing off
Any genital injury or bleeding not explained by accidental cause

RANGE OF SEXUAL BEHAVIORS OF *ADOLESCENTS*

Normal

Sexually explicit conversations with peers
Obscenities and jokes within cultural norm
Sexual innuendo, flirting, courtship
Interest in erotica
Solitary masturbation
Hugging, kissing, holding hands
Foreplay (petting, making out, fondling)
Mutual masturbation
Monogamist intercourse (stable or serial)

Yellow Flags

Sexual preoccupation/anxiety
Pornographic interest
Polygamist sexual intercourse (promiscuity)
Sexually aggressive themes/obscenities
Sexual graffiti (especially chronic or impacting individuals; i.e., naming persons in threats or humiliation)
Embarrassment of others with sexual themes
Violation of others' body space
Pulling skirts up/pants down
Single occurrences of peeping, exposing, frottage with known age-mates
Mooning and obscene gestures

Red Flags

Compulsive masturbation (especially chronic or public)
Degradation/humiliation of self or others with sexual themes
Attempting to expose others' genitals
Chronic preoccupation with sexually aggressive pornography
Sexually explicit conversation with significantly younger children
Touching genitals without permission (e.g., grabbing, goosing)
Sexually explicit threats (verbal or written)

Black Flags (illegal behaviors defined by law)

Obscene phone calls, voyeurism, exhibitionism, frottage
Sexual contact with someone of significant age difference (child sexual abuse)
Forced sexual contact (sexual assault)
Forced penetration (rape)
Sexual contact with animals (bestiality)
Genital injury to others

STAGES OF ADJUSTMENT FOR PRIMARY AND SECONDARY VICTIMS OF SEXUAL ASSAULT

Each person going through a crisis of any kind progresses through stages of emotional adjustment. All people are unique; therefore, a victim may spend a great deal of time in one stage, and may spend very little time in another. A victim may also pass through a number of stages at several different times, each time experiencing them with different intensity. The individuals' life experiences may also play a major role in how the crisis is handled. It is important to remember that each person will progress at their own rate. These stages of adjustment are intended for the adult sexual assault victim; however, many may find application with the child victim (primary victim), and the non-offending parent and/or siblings (secondary victim(s)). The knowledgeable investigator should be aware and anticipate each of these stages.

FIRST STAGE: SHOCK - *"I'm numb."*

Offering information to the victim during this stage may not be helpful, as she will most likely remember very little, if anything, about what occurs during this time.

DENIAL - *"This can't have happened."*

Possibly not yet able to face the severity of the crisis, the victim may spend time during this stage gathering strength. The period of denial serves as a cushion for the more difficult stages of adjustment which follow.

ANGER - *"What did I do? Why me?"*

Much of the anger may be a result of the victim's feeling of loss of strength and loss of control over her own life. The anger may be directed toward the offender, a doctor, the police, or anyone else, including herself.

BARGAINING - *"Let's go on as if it didn't happen."*

The victim may, unconsciously, bargain: She will not talk about the assault in exchange for not having to continue to experience the pain. In so doing, she may continue to deny the emotional impact the assault has had upon her life.

DEPRESSION - *"I feel so dirty - so worthless."*

If the victim is warned of this stage ahead of time, she may not be so thrown by it. She may experience drastic changes in sleeping or eating habits, the indulging in compulsive rituals, regressive behaviors, and generalized fears completely taking over her life. Though a painful time for her, this stage shows she has begun to face the reality of the assault. If negative emotions surface, she should be reminded that these feelings are normal and will not last forever.

ACCEPTANCE - *"Life can go on."*

When enough of the anger and depression is released, the victim enters the stage of acceptance. She may still spend time thinking and talking about the assault, but she understands and is in control of her own emotions and can now accept what has happened to her.

FINAL STAGE: ASSIMILATION - *"It's part of my life."*

By the time the victim reaches this stage, she has realized her own self-worth and strength. She no longer needs to spend time dealing with the assault, as the total experience now meshes with other experiences in her life.

INVESTIGATIVE CHECKLIST

Victim:_____
Suspect:_____
Incident # 1)_____ 2)_____ 3)_____
Offense 1)_____ 2)_____ 3)_____
Date of Offense 1)_____ 2)_____ 3)_____
Description 1)_____
2)_____
3)_____
RD/Beat 1)_____/_____ 2)_____/_____ 3)_____/_____
Origin: DHS____ Parent____ School____ WHO____ Other____

CCCAC Information
Case #_____ Interviewer_____ CCCAC Records____
Interview Dates 1)_____ 2)_____ 3)_____
DHS Investigator_____ Dictation_____
On Going Worker_____ Dictation_____
Other (CASA, etc)_____
Investigative Staffing Dates 1)_____ 2)_____ 3)_____ 4)_____ 5)_____
Crime Victims Compensation _____
Victim Statement: Oral____ Written____ Video____ Audio____ No Interview____
Suspect Statement: Oral____ Written____ Video____ Audio____ No Interview____
Outcry Statement _____ Other Witness_____

Investigation
Investigative Supplements____ Case Report____ Case Report Supplements____
Arrest Report____ Affidavit____ Warrant____
Search Warrant____ Affidavit____ Return____
FD Reports____ Polygraph Exam____ School Records: Victim____ Perpetrator____
Mental Health Records: Victim____ Perpetrator____
Therapy: CCCAC____ Other____ Victim____ Perpetrator____
Other Police Agency_____ Other CPS_____

Evidence
Photos: Crime Scene #____ Victim #____ Injury #____ Suspect____ Photo Line Up____
Drawings: CCCAC Interview____ Therapy____ Other_____
Third Party Consent____ 911 tape____
Medical Report: CCCAC____ Past Medical____ REACH____ Other____ Lab Report____

Perpetrator
Aliases____ Vehicle Information____ Home Address____ Other Residence____
Previous Marriages____ Children____

Computer Check
CH____ Wanted____ CPL____ CH Other Areas____

Notes:_____
_____ _____

REFERENCE PUBLICATIONS LISTING

Single copies of most of the following publications are available free of charge. There may be a charge if more than one copy is requested.

Center for the Future of Children
The David and Lucile Packard Foundation
300 Second Street
Suite 102
Los Altos, California 94022
(415) 948-6498 fax
http://www.futureofchildren.org

The Future of Children - Journal and Executive Summary - Sexual Abuse of Children
(Summer/Fall 1994 - Volume 4, Number 2) - available free of charge

National Center for Missing and Exploited Children
2101 Wilson Boulevard, Suite 550
Arlington, Virginia 22201-3052
(800) 843-5678 or (703) 235-3900
(703) 235-4067 fax

Single copies of each book are available free of charge. Please use NCMEC document numbers when ordering.

An Analysis of Infant Abductions *(NCMEC 66)*
Child Molesters: A Behavioral Analysis *(NCMEC 70)*
Child Molesters Who Abduct: Summary of the Case in Point *Series (NCMEC 65)*
Child Sex Rings: A Behavioral Analysis *(NCMEC 72)*
Children Traumatized in Sex Rings *(NCMEC 71)*
Family Abduction *(NCMEC 75)*
Female Juvenile Prostitution: Problem and Response *(NCMEC 68)*
For Healthcare Professionals: Guidelines on Preventing Infant Abductions *(NCMEC 05)*
Interviewing Child Victims of Sexual Exploitation *(NCMEC 73)*
Missing and Abducted Children: A Law Enforcement Guide to Case Investigation and Program Management *(NCMEC 74)*
Nonprofit Service Provider's Handbook *(NCMEC 79)*

National Clearinghouse on Child Abuse and Neglect Information
P. O. Box 1182
Washington, D.C. 20013-1182
(703) 385-7565 or (800) FYI-3366
(703) 385-3206 fax
nccanch@calib.com

National Center on Child Abuse and Neglect "User Manual Series"
A Coordinated Response to Child Abuse and Neglect: A Basic Manual
The Role of Educators in the Prevention and Treatment of Child Abuse and Neglect
Child Protective Services: A Guide for Caseworkers
Working with the Courts in Child Protection
The Role of Law Enforcement in the Response to Child Abuse and Neglect
Protecting Children in Military Families: A Cooperative Response
Caregivers of Young Children: Preventing and Responding to Child Maltreatment
The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect
Child Sexual Abuse: Intervention and Treatment Issues
Child Neglect: A Guide for Intervention
Protecting Children in Substance Abusing Families
Developing Cultural Competence in the Prevention and Treatment of Child Abuse and Neglect
The Role of Health Care Professionals in the Prevention and Treatment of Child Abuse and Neglect
Treatment for Abused and Neglected Children: Infancy to Age 18
Supervising Child Protective Services Caseworkers
Organizing Communities to Prevent Child Abuse and Neglect
Using Crisis Intervention in Child Abuse and Neglect Cases
Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions
Substitute Care Providers: Helping Abused and Neglected Children

National Criminal Justice Reference Service
Office of Juvenile Justice Publications
Juvenile Justice Clearinghouse
P. O. Box 6000
Rockville, Maryland 20850
800-638-8736
askncjrs@ncjrs.org

The Portable Guides to Investigating Child Abuse are available free from the Juvenile Justice Clearinghouse in a medium to suit your needs. Please use NCJ document numbers when ordering.

Battered Child Syndrome: Investigating Physical Abuse and Homicide *(NCJ 161406)*
Child Neglect and Munchausen Syndrome by Proxy *(NCJ 161841)*
Diagnostic Imaging of Child Abuse *(NCJ 161235)*
Interviewing Child Witnesses and Victims of Sexual Abuse *(NCJ 161623)*
Photodocumentation in the Investigation of Child Abuse *(NCJ 160939)*
Recognizing When a Child's Injury or Illness is Caused by Abuse *(NCJ 160938)*
Sexually Transmitted Diseases and Child Sexual Abuse *(NCJ 160940)*
Burn Injuries in Child Abuse *(NCJ 162424)*
Criminal Investigation of Child Sexual Abuse *(NCJ 162426)*
Law Enforcement Response to Child Abuse *(NCJ 162425)*
Understanding and Investigating Child Sexual Exploitation *(NCJ 162427)*

Related publications from Office of Justice programs agencies. All are available free of charge, unless otherwise noted.

Child Abuse: Prelude to Delinquency? (*NCJ 104275* - $10.50)
Child Rape Victims, 1992 *(NCJ 147001)*
Child Sexual Exploitation: Improving Investigations and Protecting Victims - A Blueprint for Action *(NCJ 153527)*
The Child Victim as a Witness *(NCJ 149172)*
Child Victimization and Risk for Alcohol and Drug Arrests *(FS-000108)*
Child Victimizers: Violent Offenders and Their Victims *(NCJ 153258)*
Coordinated Criminal and Juvenile Court Proceedings in Child Maltreatment Cases *(FS-000157)*
The Emotional Effects of Testifying on Sexually Abused Children *(NCJ 146414)*
Federal Resources on Missing and Exploited Children: A Directory for Law Enforcement and Other Public and Private Agencies *(NCJ 161475)*
The Missing and Exploited Children's Program *(FS-9761)*
New Approach to Interviewing Children: A Test of Its Effectiveness *(NCJ 135011)*
Police and Child Abuse: New Policies for Expanded Responsibilities (*NCJ 129947* - $15.00)
Prosecuting Child Physical Abuse Cases: A Case Study in San Diego *(NCJ 152978)*
Prosecuting Child Physical Abuse Cases: Lessons Learned from the San Diego Experience *(FS-000078)*
Victims of Childhood Sexual Abuse: Later Criminal Consequences *(NCJ 151525)*
VOCA: Helping Victims of Child Abuse *(FS-9526)*

Many of the titles in the Portable Guide series, along with other related materials, are also available via OJJDPs Web site. For full-text publications, information on OJJDP or JJC, and other juvenile justice information, visit the following:

NCJRS World Wide Web page at http://www.ncjrs.org
OJJDP World Wide Web page at http://www.ncjrs.org/ojjhome.htm

A Rural Multi-Disciplinary Child Abuse Evaluation Model

Presented by

Jody Brinser, L.C.S.W.
Kerry M. Drach, Psy.D.
Marcia Goldenberg, R.N., M.S.
Diane L. Loranger, M.S.
Lawrence R. Ricci, M.D.
Joyce M. Wientzen, L.C.S.W.

The Child Abuse Program
The Spurwink Clinic
Portland, Maine

Supported in part by Project MCJ-238623 of the Maternal and Child Health Program (Title V, Social Security Act, Health Resources Administration, Department of Health and Human Services)

Purpose of the Poster Display

This poster presentation will review the structure of a state-wide multidisciplinary child abuse evaluation model as it has evolved over the past three years to serve the needs of children in rural Maine.

The problem of accessing comprehensive diagnostic services in concert with coordinated treatment planning for rural Maine children has been a pressing concern. The Child Abuse Program at the Spurwink Clinic began a program three years ago to provide these services to selected families. Such evaluations are indicated when child maltreatment concerns involve complex, long-term difficulties in multi-problem families.

Recently the Child Abuse program was awarded a five year Healthy Tomorrows Partnership for Children grant from the U.S. Department of Health and Human Services Maternal and Child Health Bureau and the American Academy of Pediatrics. This grant allows the program to deliver these multidisciplinary diagnostic services to two outlying rural sites in Maine in collaboration with local community based providers (organized by a local hospital based social worker). Over the 5 year period, multiple measures will be used to determine the efficacy of the project.

Child Abuse Program Description

The Child Abuse Program at The Spurwink Clinic is a professional child abuse diagnostic and treatment service. Children who may have been abused (physical, sexual, emotional, and neglect) or exposed to abusive environments (such as adult domestic violence, siblings of abuse victims) may receive diagnostic and/or treatment services. The Child Abuse Program attempts to assure that all children seen will have access to competent and timely evaluations. The program has two components, forensic evaluation and treatment. The function of the forensic evaluation program is to provide evaluations of children and their families which address the extent of abuse as well as the emotional, physical, and behavioral impact of the abuse. The program formulates a medical-legal opinion and recommendations for intervention.

Evaluations may include any or all of the following components: medical/nursing, evidentiary interviews, and psychological evaluations. Cases that receive two or more of these evaluation components are designated as multidisciplinary.

Cases are selected for multidisciplinary evaluation based on the complexity of the referral questions, the chronicity of the child protective issues involved, and the number of family members who are to be evaluated. Typically multidisciplinary cases involve multi-problem families with long histories of contact with child protective services. Such multidisciplinary evaluations usually involve multiple client contacts spanning a few to several months.

Physician/Nursing Evaluations

The medical evaluation involves two parallel yet coordinated processes: physician and nursing. The team works together to:

- Obtain the greatest amount of information
- Support the child and caretaker so as to minimize trauma
- Provide a medicolegal diagnosis

Nurse's Role

- Support accompanying caretaker and child.
- Orient child to the examination process.
- Assist the examination process.
- Observe and assess caretaker/child interaction.
- Perform growth measurements and developmental testing.
- Debrief the family after the evaluation.
- Provide follow-up information to family at time of discharge.

Physician's Role

- Obtain medical and psychosocial history form parent/caretaker.
- Interview alleged perpetrator if indicated.
- Perform general physical examination.
- Perform videocolposcopic anogenital examination.
- Obtain medically important history from child.
- Discuss findings with caretakers.
- Participate in and lead team discussion.

Evidentiary Interviewing

Evidentiary interviewing is completed by trained clinical social workers and/or other licensed mental health counselors in order to obtain specific forensic information concerning abuse allegations for use in the team diagnostic discussion. The interviews often require more than one session, and typically includes the following components:

- Meeting with the child's primary caretaker or legal guardian (parent, foster parent, child protective caseworker) to obtain psychosocial history and information regarding the abuse allegation(s).
- Formal, structured, standardized evidentiary interviewing of the child using a format that adheres to the guidelines for interviewing developed by APSAC.
- Consultation with child protective caseworkers, police officers, attorneys, and mental health professional about abuse concerns or allegations.
- Review of contents of all previous abuse interviews of the child completed by other individuals, such as parents and other family members, police officers, CPS caseworkers, medical professionals, etc.
- Review of additional information regarding the child's current functioning obtained from objective behavioral measures (Child Behavior Checklist and Child Sexual Behavior Inventory). Questionnaires are completed the primary caretakers and interpreted by the program psychologist.

Psychological Evaluations

Comprehensive psychological evaluations are completed on both children and adults, as determined appropriate by team discussion. Such evaluations make use of historical information, clinical impressions, psychometric testing data, and, especially in evaluations of parents, parent-child interaction observations.

<u>Evaluation Objectives</u>

The objectives of the psychological evaluation focus on assessment of the individual's <u>current</u> psychological and emotional functioning and recommendations for treatment intervention. Psychological evaluations are <u>not</u> used to reach a child abuse diagnosis.

- <u>Objectives of Child Evaluation</u>
  - Assess current psychological, behavioral, emotional, and social functioning.
  - Assess for indicators of psychological trauma.
  - Provide treatment recommendations.
- <u>Objectives of Parent Evaluation</u>
  - Assess current psychological and personality functioning.
  - Assess capacity to provide minimally adequate, safe parenting to child(ren).
  - Provide recommendations for treatment and other intervention.

Multidimensional Framework for Evaluating Parenting Capacity

When assessing capacity to provide minimally safe, adequate parenting, at least the following dimensions of functioning should be assessed:

- Attachment: The ability to function as an emotionally available, predictable, safe attachment figure able to help the child to feel safe and secure when distressed.
- Empathy: The ability to perceive accurately and respond appropriately to the child's emotional and physical needs and to place the child's needs first.
- Problem-solving: The ability to use flexible and consistent problem-solving strategies and to learn from experience.
- Perceptions and attributions: The ability to perceive the child's behavior accurately and to make correct attributions about its causes.
- Protective judgment: The ability to exercise satisfactory protective judgment while caring for the child.
- Emotional functioning: The ability to function as a parent without significant interference from personal emotional difficulties based in psychiatric disorder, substance abuse, relationship disturbances, or other life problems.
- Parenting skills: The ability to provide appropriate, routine structure and behavioral management techniques that are developmentally sensitive.
- Stress management & use of social support: The ability to use effective stress management strategies and to make use of available social supports.

Final Team Process

STEP 1

- Entire team gathers and reviews original case questions at time and modifies those questions based on the evaluation process.
- Each team member describes their findings. Diagnosis and recommendations are deferred until later in discussion.
- After all team members describe their findings the team revisits the case questions and formulates consensus answers to the diagnostic and treatment questions.

STEP 2

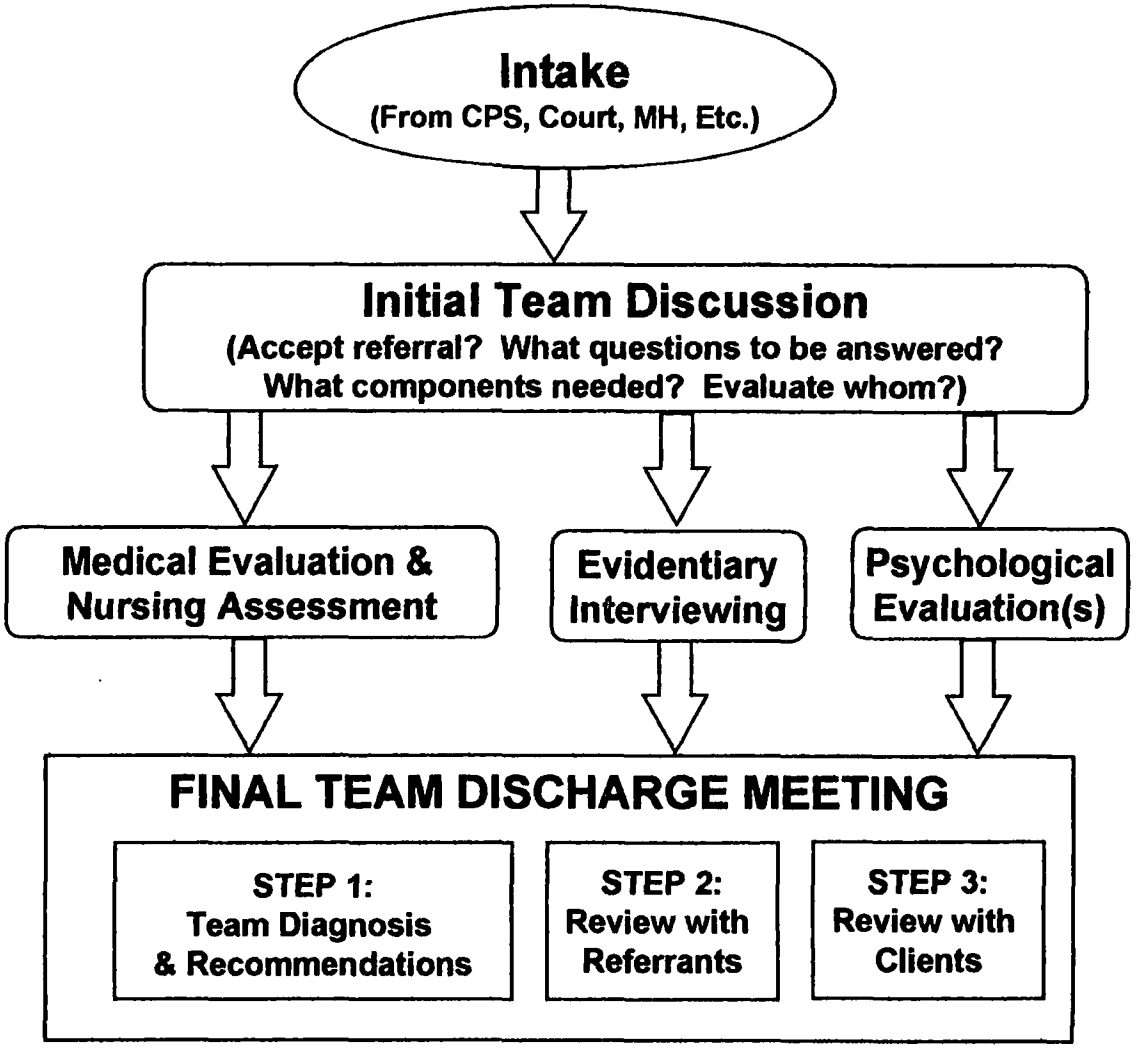
- The team next meets with the professionals referring and/or involved in the case, usually including child protective services. Other professionals who may be involved in the discussion include Guardian ad litem, Child Protective Attorney, therapists, and medical providers (particularly in failure to thrive cases).

STEP 3

- Team then meets with the adults who were either evaluated or who have a stake in the evaluation. This usually includes parent, possibly grandparents, and sometimes private attorneys. Findings are presented by a spokesperson for the team.

The final summary is dictated by a team representative who will also present the findings if needed in court. This is usually the team medical director. At times the psychological findings so predominate that the team psychologist acts as the reporter of the results.

Multidisciplinary Team Evaluation Process

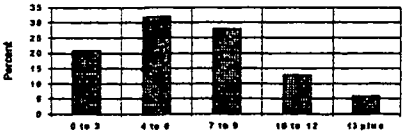


Family Demographics

Sources of Referral

Child Protective Services	85%
Mental Health	6%
Medical	4%
Attorneys	4%
Family	1%

Age of Child (N=141)



Gender of Child

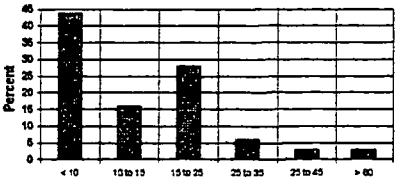
Male	50.4%
Female	49.6%

Race of Child

White	92%
Black	6%
Other	2%

Family Demographics

Annual Family Income (in $10,000's)



Child's Current Residence

Single parent family (living alone)	34%
Single parent family (living with partner)	6%
Two parent family (married or not)	27%
Child in foster care	23%
Other (relatives, etc.)	10%

Parents' Mean Education

Mother	11.9 years
Father	11.8 years

Domestic Violence in the Family	60%
Child Abuse in Parents' Childhood	72%
Custody Dispute	14%

Medical Data

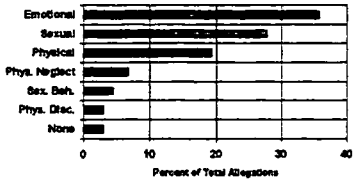
103 Children

Genital Examination	
Normal	84.5%
Nonspecific	8.7%
Suggestive	5.8%
Diagnostic	1.0%
Anal Examination	
Normal	81.6%
Nonspecific	14.6%
Suggestive	3.9%
Other Case Examples	
Inflicted bruises at time of examination	1 case
Inflicted fractures	1 case
Shaken Baby Syndrome	2 cases
Nonorganic failure to thrive	2 cases
Measure of child's stress (6 point scale 0-5)	(N=70)
Mean	1.51
Standard deviation	0.78
Median	1.00

Interview Data

114 children

Abuse Allegations (N=337, 3/child) Examined through Interview



Assessing Child's Credibility

A critical component of interviewing children around child abuse allegations is the assessment of credibility. Quantitative analysis of judgments made by our interviewers indicate the following as primary determinants of credibility:

- Resistance to Suggestibility
- Consistency of Reporting
- Detail of Reporting
- Age of child

Other variables such as gender of child, parents' marital status, family income, parents' educational level, and presence of a custody dispute do not influence rating of credibility.

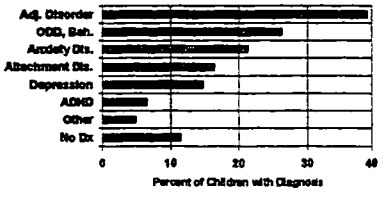
Child Psychological Findings

A total of 61 children were evaluated psychologically. The following data describe these children as a group:

Measure	Mean	SD
Intellectual Ability[1]	87.8	(15.1)
Internalizing Behaviors[2]	59.2	(12.3)
Externalizing Behaviors[2]	59.7	(11.6)
Total Behavior Problems[2]	61.0	(12.0)
Sexual Behavior Problems[3]	11.5	(13.0)

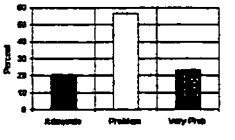
[1]Measured by K-BIT or WISC-III. Mean is considerably below the normal average of 100.
[2]Measured with the Child Behavior Checklist. All three scores are considerably higher than the normal average of 50.
[3]Measured by the Child Sexual Behavior Inventory-Revised.

Child Mental Health Diagnoses (N=61 children)



Adult Psychological Findings

Overall Parenting Competency (N=78)

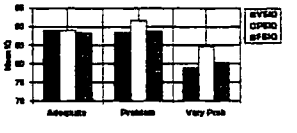


Parents are classified into three groups based on the results from multiple evaluation methods:

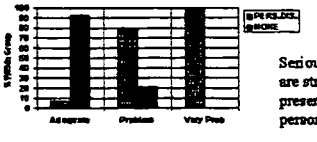
- Adequate
- Problematic
- Very Problematic

IQ Status by Parenting Competency

Individuals with the most serious parenting problems as a group score lower on the WAIS-R.



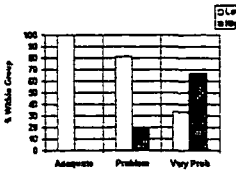
Presence of Personality Disorder by Parenting Competency



Serious parenting problems are strongly associated with presence of an Axis II personality disorder.

Adult Psychological Findings

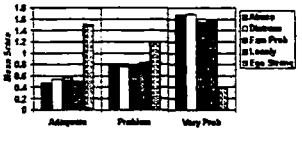
Risk for Physical Abuse by Parenting Competency



Individuals with greater parenting problems are significantly more more likely to be classified at high risk of physically abusive behavior using the Child Abuse Potential Inventory (CAP-I).

Physical Child Abuser Characteristics by Parenting Competency

Characteristics known to be associated with physical child abuse are found increasingly among parents with more severe parenting problems, as measured by the CAP-I.



Final Team Diagnoses

112 children

<u>All Allegations</u> (N=306)	
Abuse	63%
Possible Abuse	11%
No Abuse	24%
Unknown	2%
<u>Sexual Abuse</u> (N=88)	
Abuse	12%
Possible Abuse	12%
No Abuse	68%
Unknown	8%
<u>Physical Abuse</u> (N=68)	
Abuse	60%
Possible Abuse	22%
No Abuse	18%
<u>Emotional Abuse</u> (N=121)	
Abuse	94%
Possible Abuse	5%
No Abuse	1%

Recommendations

	Frequency	Percent
Child Mental Health Treatment	45	25.9%
Parent Mental Health Treatment	32	18.4%
Placement/Visitation Recommendations	22	12.6%
Parent Education Programming	16	9.2%
Developmental Evaluation	10	5.7%
Substance Abuse Evaluation/Treatment	9	5.2%
Psychological/Parenting Evaluation	8	4.6%
CPS Referral/Follow-up	7	4.0%
Domestic Violence Evaluation/Treatment	4	2.3%
Sexual Offender Evaluation/Treatment	3	1.7%
Other	18	10.3%

Case Example: Abuse and Parenting

Case Circumstances:
Family of 3 children, girl age 16, girl age 11, boy age 9 (who has been alleged to engage in serious sexual behavior with other children), and mother. Children in foster care because mother unable to protect from sexually abusing each other and allowed adult male to sleep with 16 year old. Referral came from child protective services.

Questions:
- Have these children been sexually abused?
- Is the boy demonstrating serious sexual behavior?
- Can mother protect these children?
- What treatment/placement recommendations can we make?

Components of evaluation:
- Medical evaluation of all three children.
- Medical interview of mother.
- Psychological evaluation of children and mother.
- Social worker evidentiary interviews of children.

Findings of team evaluation given to Child Protective and mom:
- Inappropriate physical discipline by mother.
- Sexual abuse of 16 year old by father and possibly by other adult male.
- Inappropriate sexual behavior for 9 year old.
- Very problematic parenting.

Recommendations:
- Continued foster placement for children.
- Developmental services for delayed children.
- Individual therapy for mom.
- Sexual behavior and abuse treatment for children.

Case Example: Failure to Thrive

Case Circumstances:
9 month old infant found to have failed to thrive (weight dropped below 3th percentile from 50th) and questions of inadequate parenting in a 16 year old mother. Child still in home with mother. Referred by medical providers

Questions:
- Does this child suffer from non-organic/environmental failure to thrive?
- What is mother's current level of psychological functioning?
- What is parent/child interaction particularly around feeding?
- What recommendations can we make around placement/treatment?

Components of evaluation:
- Medical evaluation of child and record review from prior hospitalizations.
- Psychological evaluation of mother.
- Parent child interaction observation.
- Record review of previous child protective involvement.

Findings of team evaluation given to Child Protective and mom:
- Medical findings clearly indicate no organic pathology and failure to thrive only occurs in care of mother.
- Mother demonstrates limited skills and interest in parenting.
- Mother interacts minimally with the child.
- Mother has not responded to intensive services.

Recommendations:
- Out of home placement.
- Continued work with mother around parenting and feeding.
- Prognosis for reunification poor given mother's lack of interest.

Case Example: Abuse and Custody

Case Circumstances:
Two girls, age 5 and 4, present with concerns of sexual abuse by father, grandmother, and aunt. Allegations arose in therapy based on question of sexual behavior and unclear statements, some of which are bizarre, and based on discussion of dreams. Referral came from court.

Questions:
- Have these girls been sexually abused by their paternal family?
- Has the mother fabricated the abuse allegation?
- Do either parent pose risk of abuse?
- What are treatment/placement needs for children and parents?

Components of evaluation:
- Comprehensive review of previous interviews
- Evidentiary interviews of children
- Medical evaluation of children and physician interviews of parents
- Psychological evaluations of both parents

Findings of team evaluation given to Child Protective and parents:
- No evidence of abuse based on current interviews and physical examination
- Prior evidence of abuse weak at best
- No evidence fabrication
- No evidence that either parent poses risk of abuse to children

Recommendations:
- Re-establish unrestricted contact with father
- Individual therapy for children for behavior concerns not abuse.

Interviewing Children Who Witness Homicides

Tascha Boychuk, Ph.D., RN

ASU College of Nursing
Tempe, AZ. 85287-2602
(602) 965-7561

City of Mesa Center Against Family Violence
City of Mesa Police Department
130 N. Robson
Mesa, AZ. 85201
(602) 644-4075

Interviewing Children Who Witness Homicide

Tascha D. Boychuk, Ph.D., RN

Objectives

As a result of this session, participants will have an opportunity to:

a) discuss the complexities associated with interviewing children who witness homicide,
b) describe the components of a semi-structured interview technique for child witnesses,
c) describe modifications of a semi-structured interview based upon needs of the child,
d) develop a series of non-leading questions that can be used to interview child witnesses to homicide, and
e) describe creative strategies that can be used to interview the reluctant child witness.

Abstract

Although controversies regarding interview methodologies still exist, professionals working with maltreated children have made great strides in describing interview strategies for children alleging physical or sexual abuse. Interview techniques for children who witness homicide, however, have not been addressed widely in the empirical or clinical anecdotal literature. It is estimated that as many as 20% of homicides in some urban areas are witnessed by dependent children. Children face multiple, complex issues in the aftermath of witnessing a homicide. Some of these issues include surviving post-trauma symptoms, loss, grief, anxiety and depression. The purpose of this presentation is to suggest possible interview strategies for child witnesses to homicides in light of the complexities associated with witnessing a traumatic death. The information in this session is obtained from preliminary data obtained from a pilot study in which the presenter interviewed 120 children who witnessed homicides.

Interview questions and child responses were examined in the videotapes to determine which questions yielded information that was consistent with crime scene facts. Use of non-leading questions in a semi-structured cognitive interview format will be suggested as one means of interviewing child witnesses to homicides. Other creative strategies will be discussed. Videotaped examples will be used to illustrate comparisons between questions that maximize versus those that limit information obtained from a child. In conclusion, limitations to our knowledge regarding children who witness homicides will be discussed.

Selected Reading List

Black, D. (1992). Children of imprisoned parents. *Archives of Diseases in Childhood, 67,* 967-70.

Faller, K. (1996). Interviewing children who may have been abused: a historical perspective and overview of controversies. *Child Maltreatment, 1,* 83-95.

Hendriks, J., Black, D., & Kaplan, T. (1993). *When father kills mother.* New York: Rutledge.

Pynoos, R.S., & Eth, S. (1984). The child as witness to homicide. *Journal of Social Issues, 40,* 87-108.

Investigative Interviews of Children Who Witness Homicides

Purpose of the Interview

- to collect useful and reliable information from a child using theoretically sound interview strategies during the investigation of a homicide while keeping in mind the overall well-being of the child.

Method

- investigative interview method designed to minimize leading or suggestive information
- conducted in a neutral manner
- based upon the general principles of the semi-structured cognitive interview that is often used to interview children alleging physical or sexual abuse
- interview is generally videotaped and preserved as evidence
- interview purpose and methods are different from clinical or counseling techniques

Semi-Structured Cognitive Interview

Allegations of Child Abuse	Child Witness to Homicide
a) Develop Rapport	***a) Develop Rapport***
- discussion of neutral topics - obtain a language sample	- discussion of neutral topics - obtain a language sample
suggestions:	
introductions & then obtain a narrative about a neutral topic, e.g. "Tell me about your (birthday party, pet, friends, favorite sport, etc.)	
b) Obtain a Narrative About the Alleged Abuse	***b) Obtain a Narrative About What the Child Witnessed***
"Something may have happened to you. Tell me about that so I can understand everything that happened.	"Something happened to your (deceased, e.g. Mommy). Tell about that so I can understand everything that happened. (current investigation) "I talk to boys and girls who have mother that died. I understand that your mother died. Tell me everything about that so I can understand what happened." (cold case)
suggestions:	
use, "and then what happened" as much as possible to maximize the likelihood that the narrative will contain a sequence of events	

c) *Open-ended Questions*

"You've told me about a lot of things. I need to ask you some questions to understand better...

c) *Open-ended Questions*

"You've told me a lot of things. I need to ask you some questions to understand better....

suggestions:

tell me about the last time that something happened to you...

tell me about a time that you remember the clearest

tell me about the first time that something happened to you

(structure questions in a non-leading way regarding the possibility of different locations, acts, etc.)

tell me about the last time you saw your (mother)...

tell me about the time that you remember the clearest (if chronic family violence appears to have occurred)

tell me about what happened right before the (police, firemen, ambulance) came

(If child has named the offender), "When (offender) came to the (location), tell me what happened from the beginning to the end."

If child is having difficulty with sequencing, start with... "O.K., you've told me that (name of offender) came to (location),...what happened first? What happened very next? What happened next?

d) direct questions ***d) direct questions***

Are based upon the information obtained in the narrative account provided by the child. Direct questions are necessary in all interviews to clarify information. If children are providing more information to direct questions, follow the question with "tell me about that..."

suggestions:

(develop direct questions to address possibilities of: use of pornography, threats, gifts, other perpetrators, other victims, additional acts or locations and to clarify any information that child provided earlier in the interview)

(develop questions to address any aspects of the crime scene that were not fully described by the child as well as questions that address sensory information such as what was heard, touched etc., questions that could help_ establish motive, rule out other offenders...)

Did anyone else besides (name of perpetrator) do anything to you?

*What did (mommy) say?

Did you see (name of perpetrator) do anything to anyone else?

*What did (offender) say?

Did (name of perpetrator) do something to any other part of your body? (If yes, then "tell me about that...)

What else did you hear?

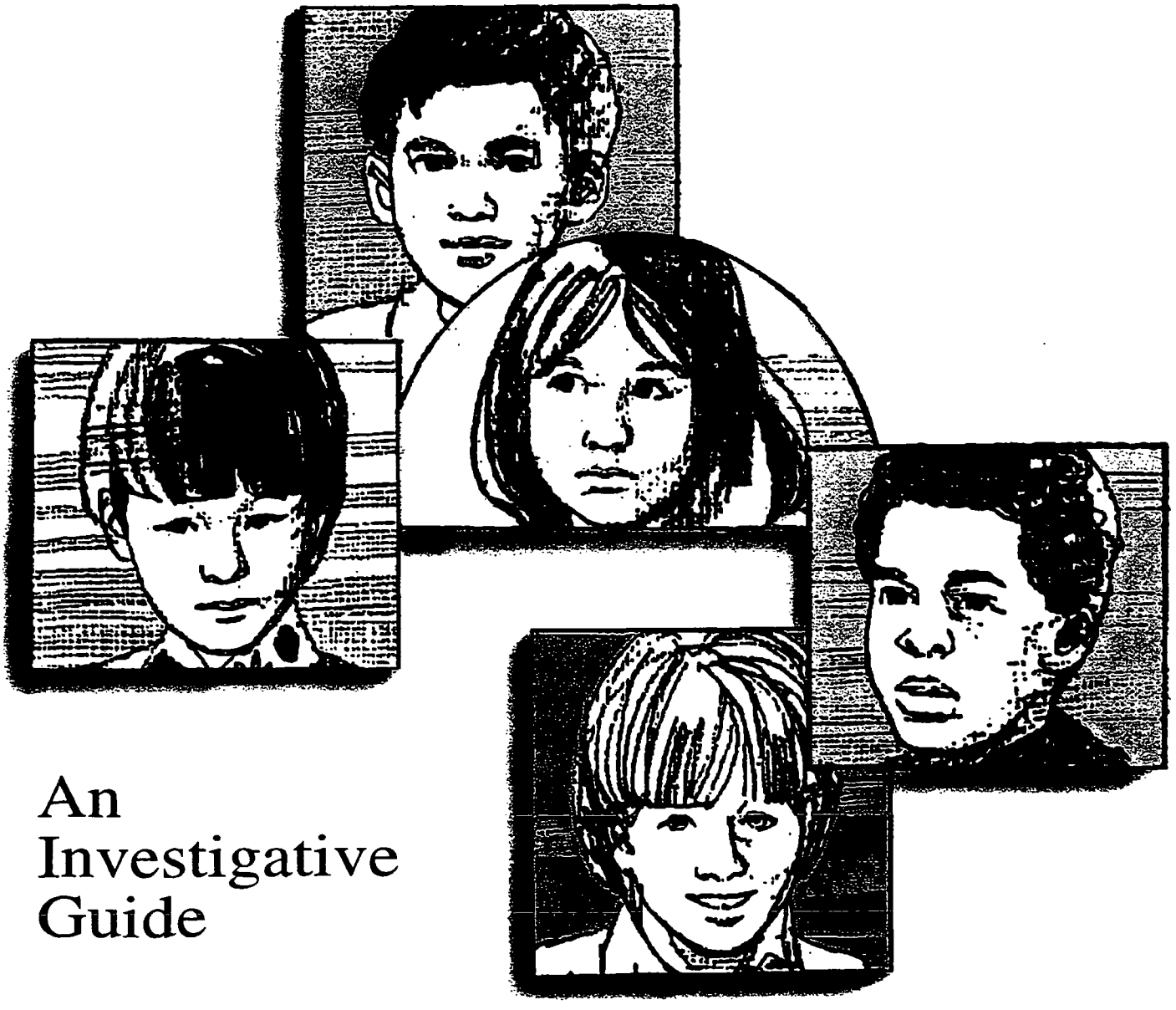
*Where did (offender) put the (weapon) when he/she finished?

Did anybody else (verb that child used such as hurt, stab, shoot, etc.) your (mommy)?

If child states they were "asleep" follow up with "and what did you See with your very own eyes...what did you hear...etc.)

e) Neutral Closure: End the interview talking about neutral topics. Do not leave the child in distress. Answer any questions that the child may have.

CHILD ABDUCTION RESPONSE PLAN



An Investigative Guide

Federal Bureau of Investigation
Critical Incident Response Group
Quantico, Virginia 22135

PAGE_____OF_____

DATE_____

ADMINISTRATIVE WORKSHEET

LOCATION		PERSONNEL INVOLVED IN SEARCH AND THEIR RESPECTIVE DUTIES	
CASE IDENTIFIER			
PREPARER/ASSISTANTS			
TIME AND DATE OF ARRIVAL			
PERSON(S) PRESENT AT SCENE AT TIME OF ARRIVAL			
PERSON IN CHARGE OF SCENE AT TIME OF ARRIVAL		PRELIMINARY SURVEY / EVIDENCE EVALUATION (NOTES / OBSERVATIONS)	
CONTROL OF SCENE OBTAINED FROM			
TIME AND DATE OF CONTROL ACQUISITION			
CONDITION OF SCENE ON ARRIVAL (SECURED / UNSECURED)			
LIGHTING CONDITIONS		SPECIAL SITUATIONS OR CONDITIONS (NOTES / OBSERVATIONS)	
WEATHER CONDITIONS			
SCENE CONSISTS OF (GENERAL DESCRIPTION)			

ADMINISTRATIVE WORKSHEET (CONTINUED)

DATE_____

CRIME SCENE CONFERENCE (NOTES / OBSERVATIONS)

CRIME SCENE INVESTIGATION COMPLETED AND RELEASE OF SCENE AUTHORIZED

NAME _____

TITLE _____

DATE _____

TIME _____

SIGNATURE _____

CRIME SCENE RELEASED TO

NAME _____

TITLE _____

DATE _____

TIME _____

FINAL SURVEY (NOTES / OBSERVATIONS)

ADDITIONAL NOTES / OBSERVATIONS

ADMINISTRATIVE LOG

TIME	PERTINENT DESCRIPTION / INFORMATION

NARRATIVE DESCRIPTION

LOCATION _____

DATE _____

CASE IDENTIFIER _____

PREPARER / ASSISTANTS _____

_____

_____

MODE OF NARRATIVE PREPARATION _____

_____

PAGE_______ OF ______

PHOTOGRAPHIC LOG

LOCATION __________________________________

DATE __________________________________

CASE IDENTIFIER __________________________________

PREPARER / ASSISTANTS __________________________________

CAMERA __________________________________

TYPE OF FILM AND RATING __________________________________

REMARKS __________________________________

PHOTO #	DESCRIPTION OF PHOTOGRAPHIC SUBJECT	USE OF SCALE	MISCELLANEOUS COMMENTS	SKETCH (IF APPLICABLE)

DIAGRAM SKETCH

LOCATION _____

DATE _____

CASE IDENTIFIER _____

PREPARER / ASSISTANTS _____

REFERENCE:
- Scale of Disclaimer
- Compass Orientation
- Evidence
- Fixed Objects
- Measurements
- Key/Legend

EVIDENCE RECOVERY LOG

LOCATION ______________________________ **PERSONNEL** ______________________________

DATE ______________________________ ______________________________

CASE IDENTIFIER ______________________________ ______________________________

PREPARER / ASSISTANTS ______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ITEM #	DESCRIPTION	WHERE FOUND	RECOVERED BY	PHOTO	MARKING DIRECT = D INDIRECT = I	PACKAGING METHOD	MISCELLANEOUS COMMENTS

LATENT LIFT LOG

LOCATION _____

DATE _____

CASE IDENTIFIER _____

PREPARER / ASSISTANTS _____

_____

_____

LIFT #	DATE LIFTED	LIFTED BY	OBSERVED BY	SOURCE	ADDITIONAL INFORMATION OR COMMENTS

VICTIMOLOGY AND LIAISON WITH VICTIM'S FAMILY

Victimology and the liaison with the victim's family are two crucial areas of the investigation that are often neglected. Victimology is directed toward collecting information about the victim. Liaison is directed toward assisting the emotional needs of the family members as they experience this devastating ordeal and keeping the channels of communication open. Complicating this process is the fact that one or more family members could become the focus of the investigation.

Victimology

A detailed account of the victim's lifestyle and personality assists in determining the nature of the disappearance, the risk level of the victim, and the type of person who could have committed the crime. Complete information regarding the victim's physical description, normal behavioral patterns, the family dynamics, and known friends and acquaintances should be obtained as soon as possible.

- **Physical Characteristics** [1]

___ Obtain complete detailed description of victim. Include birthmarks, scars, tattoos, and peculiarities (chipped teeth, broken bones, etc.).

___ Obtain a detailed description of all items of last known clothing, jewelry worn, or personal belongings (such as backpack or purse), including brand names, sizes, and date/location purchased.

___ Obtain current photograph and/or recent videotapes.

___ Document any recent physical changes.

___ Determine if the victim has any disabilities or injuries.

___ Obtain medical/dental records, to include X-rays, eyeglass prescriptions, and any medication being taken at the time of the abduction. Ensure information is entered into NCIC Missing Person's File.

___ Determine normal style of dress.

---

[1] *Collection of known hairs and fibers is addressed in Section 3. Searches.*

- **Behavior/Personality**

___ Develop and verify detailed timeline of victim's last known activities up to the time noticed and reported missing (window of opportunity).

___ Determine habits, hobbies, interests, favorite activities.

___ Note any recent changes in behavior or activity patterns, any recent unusual events, or recent stressors (failed relationships, pregnancies, school problems, etc).

___ Identify normal activity patterns, to include the "comfort zone" (area the victim frequents or in which he or she regularly plays, etc).

___ Identify and separately interview close friends, schoolmates, teachers, class counselors, church youth leaders, or other significant persons.

___ Determine verbal skills and how the victim normally interacts with others.

___ Determine any history of drug and/or alcohol abuse.

___ Determine any history of gang activity.

___ Identify and interview boyfriends/girlfriends; determine normal dating patterns, including any sexual activity.

___ Identify membership in clubs, sports teams, or other organizations; determine most recent participation/events. Identify and interview adult members or leaders.

___ Obtain and review personal writings, diaries, drawings, and schoolwork, including any entries into a personal computer or interest in or interaction with on-line computer systems or services. Search locker at school, if applicable.

___ Determine any history of running away or discontent with home life.

___ Identify and interview employment associates/coworkers.

___ Determine the victim's history of victimization (victim of other crimes).

- **Family Dynamics**

___ Identify and **separately** interview all immediate and extended family members (to include their spouses, boyfriends/girlfriends, or other close associates) who reside in the residence and immediate area.

___ Determine who has normal parental control over the victim and the relationship and location of same. This includes natural parents, stepparents, foster parents, divorced or estranged parents, or any others who exercised guardianship of the victim.

___ Determine the relationship of the victim with the immediate family members.

___ Prepare a detailed timeline of significant family members' whereabouts during the window of opportunity. **Immediately confirm this information.**

___ Determine if there are any custody/visitation disputes between parents.

___ Document the parental reaction to the disappearance.

___ Determine parents' employment and interview employers/coworkers as to recent behavior of parents.

___ Determine the level of parental supervision normally provided to victim.

___ Determine any history of drug and/or alcohol abuse by any family member.

___ Identify recent "stressors" within the family (termination of employment, separations, deaths, fights).

___ Identify any criminal history/activity and/or psychiatric history of all family members.

___ Determine family financial status, including any large or recent debts and insurance policies on victim.

___ Identify and interview any babysitters/caretakers of the victim.

___ Consider and evaluate the culture of the family and any bearing that may have on the incident.

___ Determine whether Child Protective Services (or similar agencies) have responded to the residence and, if so, the nature of the incident.

NEIGHBORHOOD CANVASS

1. Address:

2. Type of Structure

3. Vehicle descriptions and registration numbers present at location.

4. Is the victim's home visible from this location?

5. Is the abduction site visible from this location?

6. Full name of person contacted:

   DOB:

   Telephone numbers:

7. Do you know the _____ family and specifically the victim, _____ ?

8. Were you home on the day of the incident?

9. Names of all occupants and visitors at this home at the time of the incident.

10. What did you observe on that day?

11. What did you hear?

12. What activity did you see or hear at or near the victim's home?

13. Tell me everything you know about the victim and his/her family.

14. What is the usual daily activity in this area (day and night)?

15. What have you noticed in the past two months that is suspicious or unusual?

16. What delivery people come to this area?

17. Describe the normal vehicle and pedestrian traffic in the area during the time of the incident.

18. What vehicles were observed in the area around the time of the incident?

19. Are any of the vehicles not normally in the area?

20. What person(s) were observed in the neighborhood around the time of the incident?

21. Which of these people are not usually in the neighborhood?

22. Who is usually arriving in or leaving the area around the time of the incident?

23. Have any neighbors recently left the area?

24. Are you aware of anyone who may have information or evidence relating to this incident?

25. Do you have any other information about this incident that you feel is important?

26. Is there anything else you would like to tell us?

27. If appropriate, obtain consent to search the residence, vehicles, storage areas.

Date:
Time:
Interviewing Officers:

ROADBLOCK CANVASS

Location of Roadblock:

Advise drivers of nature of investigation.

1. Vehicle Registration (State & Tag Number):

2. Vehicle Description:

3. Completely identify all vehicle occupants:

4. How often do they travel this route?

5. Did they travel this route on the day of the incident?

6. What time did they travel this route and in what vehicle?

7. What did they observe?

8. Determine the time they made observations and how they established the time.

9. What other vehicles were observed in the area?

10. What people were observed in the area?

11. Obtain any other information they can provide.

12. If appropriate, obtain consent to search vehicle.

DATE:
TIME:
INTERVIEWING OFFICER:

GENERAL ASSESSMENT QUESTIONS

FOR EASE AND TO EXPEDITE ASSESSMENT, PLEASE WRITE THE ANSWERS LEGIBLY DIRECTLY ON THIS FORM (or circle the correct response). ATTACH ADDITIONAL SHEETS AS NEEDED.

Source of information_____ Age _____

Relationship with subject_____

GENERAL

1. Name of subject _____

2. Date of birth _____ Present age _____

3. Place of birth _____

4. Male Female Race _____

FAMILY

5. Socioeconomic status while growing up:

   upper middle lower

6. Moving while growing up:

   grew up in one place

   moved a few times

   moved many times

7. Type of area(s) where subject grew up:

   rural small town suburban city

   (name areas, if known):

8. Number of brothers ____
(provide names and ages):

9. Number of sisters ____
(provide names and ages):

10. Subject's place in birth order:

oldest middle youngest

11. Status of parents during subject's childhood:

married never married divorced (year _____)

mother: employment:

criminal history:

lived in household?

father: employment:

criminal history:

lived in household?

12. Current status of parents:

mother: living age ____ physical & mental health:

deceased year of death_____

residence location:

father: living age____ physical & mental health:

deceased year of death_____

13. Religion of family and degree of practice:

Did that ever change significantly?

14. Did any family member have a great deal of influence in subject's life? If so, who and why?

15. Describe the subject's relationship with parents and siblings and the frequency of contacts. Include any significant changes in the relationship in recent years.

PERSONAL APPEARANCE

16. What are your overall impressions of subject's personal appearance? (handsome, pretty, ugly, fat, skinny, etc.)

17. What is subject's dress and grooming style compared with others in the subject's group? (neater, sloppier, stylish, etc.)

18. Has the subject had this appearance as long as you have known him/her?

19. Has the subject experienced any recent changes in weight? When? Provide known or suspected reasons for this change.

20. Does subject have any distinguishing scars, marks, tattoos, or physical abnormalities? If so, do any of them seem to concern the subject?

21. Does the subject have any mannerisms or gestures that stand out? (talks loudly when scared, hand over mouth when nervous, etc.)

22. If male, does the subject wear a beard or moustache? How long has he had it? Does he say why he grew it?

PERSONAL CHARACTERISTICS

23. Does subject smoke?

    What? For how long? How much?

24. Does subject drink alcoholic beverages?

    What? How often?

    Drink to excess? How often?

25. Does the subject partake of other drugs?

    What? How often?

26. Describe the subject's usual sleep patterns.

27. Describe the subject's usual eating habits (balanced meals, junk food, cooks at home, eats out, etc.).

28. How is the subject's physical health and well-being?

29. Has the subject had any major illnesses or injuries? If so, when and what?

30. What is the subject's attitude about his/her health and level of physical fitness?

EMPLOYMENT

31. Is the subject currently employed? Where?

    Job title:

    Income:

    How long employed there?

    Describe what the job involves:

32. Is subject specially skilled in any areas? (welding, electrician, computers, machinist, carpentry, etc.)

33. How does subject relate to co-workers? (leader, loner, agitator, etc.)

34. How does subject relate to superiors? (subservient, defiant, angry, unconcerned, etc.)

35. How does subject relate to subordinates?

36. What personal/professional impact would the subject experience if he/she were to lose that job?

37. Provide information regarding subject's significant prior employments. Describe type(s) and reasons for leaving.

    Any military service? No Yes (when/where)

    Type of discharge:

    Attitude toward military service:

EDUCATION

38. What is the highest level of schooling subject completed? Include vocational/technical.

    Where?

39. Did subject ever leave school/training without completing it? Why?

40. Did the subject experience any problems in a formal academic setting?

INTERESTS

41. What are the subject's current hobbies/interests?

42. What are the subject's former hobbies/interests?

43. Has the subject ever belonged to any groups or organizations? (clubs, professional groups, volunteer police/fire, etc.)

44. What does the subject do in his/her spare time?

45. How does the subject relax?

46. What types of movies/television shows does the subject prefer? (e.g. action/adventure, mystery, drama, comedy, sci/fi, history)

    Give examples of favorite movies/shows:

47. What types of reading material does the subject prefer? (fiction, nonfiction, spy novels, pornography, etc.)

    Does the subject subscribe to or regularly purchase any publications? If so, what?

GENERAL DATA

48. Type of residence and general description of neighborhood: Own Rent

49. Does the subject live alone? Yes No

    If not alone, with whom?

50. Does the subject seem to have friends?

    none some several many

    How do they compare to him/her?
    (higher/lower/same class; more/less educated; older/younger, etc.)

51. Does the subject own any vehicles? Yes No

    If yes, describe:

    How well is it maintained?

    If no, what is the normal mode of transportation?

52. How would you describe the subject's driving habits?

53. What is subject's current financial status?

PERSONAL

54. Does the subject currently embrace a structured belief system that influences his/her behavior? If so, what?

    How strong is this influence?

    Is this a recent development?

55. Is the subject currently married or in a monogamous relationship? Yes No

If yes, to whom and for how long?

56. Describe the nature of his/her current main relationship.

57. Was the subject ever married or involved in a significant relationship in the past?

If yes, describe:

Was there anything unusual in any of the subject's prior marriages/relationships (divorce due to "extreme cruelty," relationships lasted very short time, etc.)?

58. Does the subject have any children? Yes No Unknown

If yes, names and ages:

What is the quality/quantity of subject's relationship with his/her children?

Does the subject frequently talk about his/her children?

59. Is there evidence of promiscuity?

60. Does the subject engage in intimate acts that could be regarded as unconventional?

Is the subject excessively blatant or secretive regarding this intimate activity?

PERSONALITY/ATTITUDES/BEHAVIORS

61. Does the subject hold any particular prejudices?

62. What makes the subject happy?

63. What makes the subject angry?

How is that anger displayed?

64. What events seem to shake subject's self-confidence?

65. What days/dates are especially significant to the subject (birthdays, holidays, anniversaries, etc.)?

66. What are the subject's strengths?

67. What are the subject's weaknesses?

68. What are the subject's life ambitions?

69. What are the subject's life failures?

70. What is the subject's general attitude toward law enforcement and other authority figures?

71. How does the subject react under stress?

72. Describe recent/ongoing stresses in the subject's life (emotional, criminal, financial, professional, personal, etc.).

73. Is the subject viewed by others as someone who can be trusted?

74. Describe any significant mood changes that the subject experiences and the situations that cause the subject to display positive or negative emotions.

75. Does the subject accept responsibility for his/her own acts or place blame elsewhere? Provide examples.

76. How does the subject react to the loss (by death, separation, alienation, etc.) of people important to him/her?

77. To whom does the subject turn for advice?

78. What is truly important to the subject?

HISTORY

79. What is the subject's criminal history?

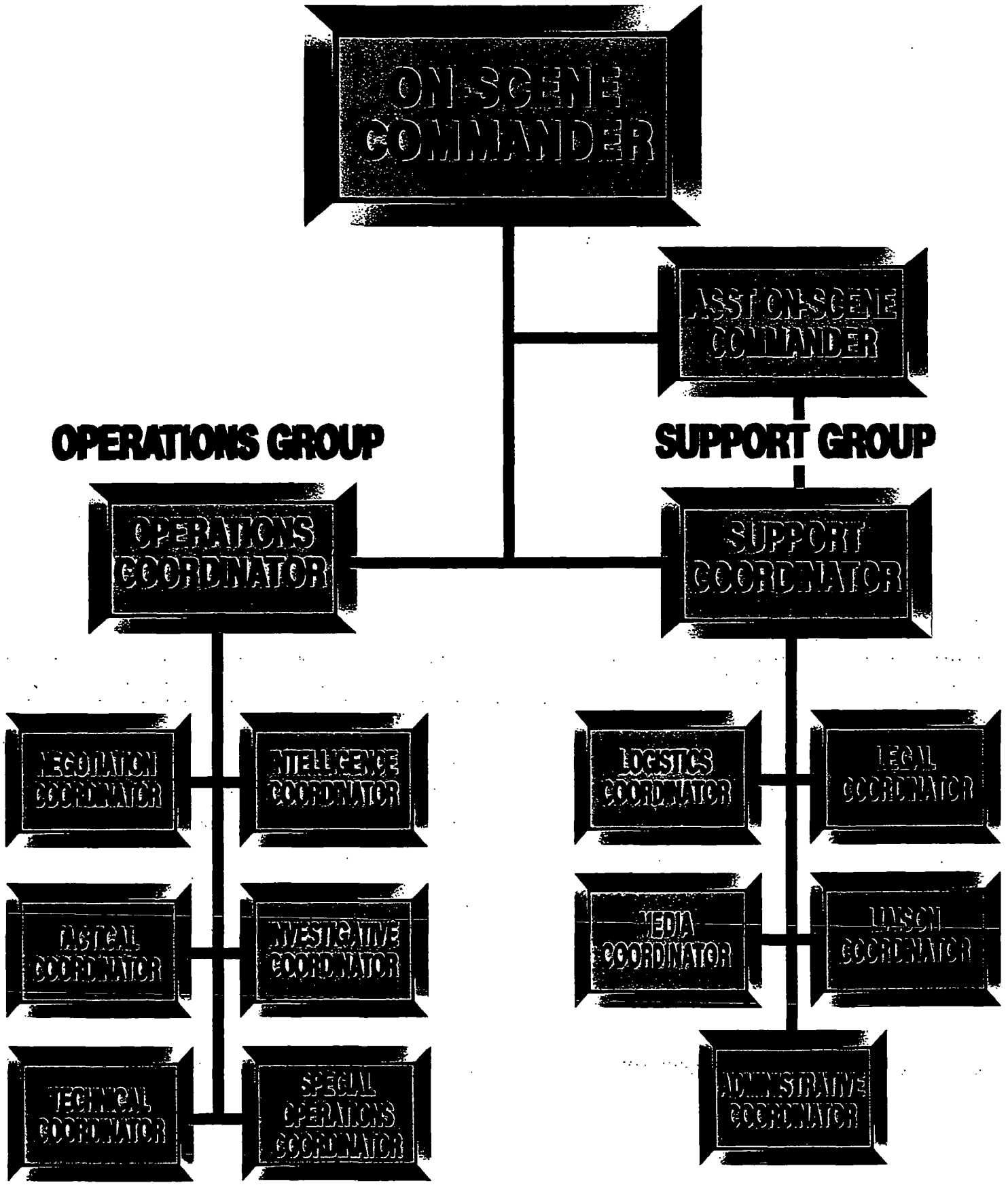
80. What is the subject's mental health history?

OTHER INFORMATION THAT WOULD HELP IN UNDERSTANDING THE SUBJECT'S PERSONALITY. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THIS INDIVIDUAL'S PERSONALITY.

PERSONALITY CHARACTERISTICS

INTROVERT (reserved)	1	2	3	4	5	EXTROVERT (outgoing)
LONER (prefers to be alone)	1	2	3	4	5	SOCIAL (enjoys others' company)
SELF-CENTERED ("me" oriented)	1	2	3	4	5	CONCERNED FOR OTHERS
AGGRESSIVE (dominant)	1	2	3	4	5	PASSIVE (submissive)
EMOTIONAL (led by the heart)	1	2	3	4	5	RATIONAL (led by the head)
MOOD SWINGS (seesaw emotions)	1	2	3	4	5	EVEN-TEMPERED (consistent emotions)
DISORDERLY (sloppy)	1	2	3	4	5	ORDERLY (neat)
IRRESPONSIBLE	1	2	3	4	5	RESPONSIBLE
REBELLIOUS (risk taker)	1	2	3	4	5	CONSERVATIVE (conformist)
VINDICTIVE (gets even)	1	2	3	4	5	FORGIVING (lets bygones be bygones)
NERVOUS (anxious)	1	2	3	4	5	CALM (laid back)
PESSIMISTIC (glass half empty)	1	2	3	4	5	OPTIMISTIC (glass half full)
RIGID (uncompromising)	1	2	3	4	5	FLEXIBLE (easygoing)
DEPENDENT	1	2	3	4	5	INDEPENDENT
IDEALISTIC	1	2	3	4	5	PRACTICAL
INSECURE	1	2	3	4	5	CONFIDENT
MANIPULATOR	1	2	3	4	5	STRAIGHTFORWARD

COMMAND POST ORGANIZATION



INFORMATION CONTROL

Assigned by
CONTROL NUMBER*: INTELL

SOURCE*: Origin of Info documented on Form
Affiliation: Organization of source or private citizen, etc.
Phone Number: POC for source

Method of Contact*

_____ In Person _____ Telephone

_____ Observation _____ Written

Prepared by*: Person completing form Date*: Date form completed Time*: Time form completed

NARRATIVE*: Synopsis of information received, continue on 2nd page if necessary. Source document may be attached if desired. However, synopsis must still be completed.

_____ continued

Narrative reviewed by: Initials - INTELL Lead Set? (Y/N): Y or N

Categories

Rapid Start Section to be completed by INTELL or INVEST Component or Rapid Start.

Assigned to: Investigative Asset(s) assigned lead Date & Time: Date and time lead assigned

LEAD: Description of leads to be covered.

_____ continued

DISPOSITION: Synopsis of investigative results, supporting documents may be attached but synopsis must be completed for Rapid Start.

_____ continued

Lead Completed: Y or N with initials

White - Original Yellow - Rapid Start Pink - Lead

Local Resources				
Type of Resource	Contact Person	Agency	Address	Telephone #

COLLIN COUNTY LAW ENFORCEMENT CHILD ABUSE TASK FORCE

NEEDS ASSESSMENT

Collin County has 13 different law enforcement agencies working in partnership with the Collin County Children's Advocacy Center (CAC) to investigate and prosecute child abuse. Five (5) of these departments have officers designated to work specifically on this type of investigation, either full-time or part-time. The remaining departments use patrol officers to investigate these offenses. These departments have difficulty performing high quality investigations on a timely basis for the following reasons:

LACK OF TRAINING IN CHILD ABUSE INVESTIGATIONS: These smaller communities have very limited budgets and cannot afford to send an officer to specialized schools that range in cost of $500 up to $5,000, nor can they spare the on-duty time to send them. They are also reluctant to dedicate this kind of training dollars because officers with this kind of training tend to move on to bigger departments.

LACK OF EQUIPMENT TO THOROUGHLY INVESTIGATE: Again the rural departments have limited budgetary funds and cannot afford to purchase the high tech equipment necessary to conduct a thorough crime scene investigation.

OFFICERS WORKING ON A PART-TIME OR VOLUNTEER BASIS: Most of these departments utilize officers on a part-time or volunteer basis. Child abuse investigations consume 40 to 60 hours of an officer's time per case. The smaller departments cannot dedicate this amount of time to just one case.

COLLIN COUNTY CASE INVESTIGATION TIME ANALYSIS BREAKDOWN

Hospital/Emergency Room Interview	4.8 hours
Report Review	0.5 hours
Contact Complainant	0.75 hours
CAC Interview/Video	4.0 hours
Medical Reports	1.5 hours
Perpetrator Interview	2.0 hours
Polygraph	2.5 hours
Affidavit/Search Warrant	3.0 hours
Crime Scene Photography	1.0 hours
Follow-up Calls	1.0 hours
Affidavit/Arrest	2.0 hours
Supplements	1.0 hours
Report	1.0 hours
Review/Grand Jury	0.5 hours
Consultation with D.A.	2.0 hours
Trial	40.0 hours

The issue is further complicated by the fact that none of these rural departments have a case load high enough to warrant the added expense of specialized training or equipment.

DEPARTMENT	# OF CASES IN 1995
*Wylie Police Department	07
*Farmersville Police Department	03
*Princeton Police Department	10
*Parker Police Department	02
*Celina Police Department	03
*Others Combined	44

For comparison, the larger county cities investigated in the same time period:

DEPARTMENT	# OF CASES IN 1995
*Plano Police Department	81
*McKinney Police Department	20
*Allen Police Department	09
*Frisco Police Department	13
*Sheriff's Office	19

Through the formation of a law enforcement child abuse task force, these smaller departments would turn over the investigation of these cases to the Sheriff's Office. The combined total cases would warrant a full-time, specialized officer, whereas separately they would not.

The Law Enforcement Child Abuse Task Force would include one supervisor and officers from Plano Police Department, 1 to 2 officers full-time; Allen Police Department, 1 officer for 10 to 20 hours per week*; McKinney Police Department, 1 officer for 10 to 20 hours per week*; Frisco Police Department, 1 officer for 10 to 20 hours per week*; Sheriff's Office, 1 to 2 officers, full-time.

* Hourly allotments of officer time will depend on the department's specific child abuse case load and will increase annually according to population and case projections.

Currently, Collin County has a strong working agreement to investigate and prosecute child abuse cases through the Collin County Children's Advocacy Center. All 13 law enforcement agencies, the District Attorney, Child Protective Services (CPS), medical and therapy providers, and community volunteer groups participate in the project. Between 250 and 300 child abuse victims and their families receive services through the Center annually.

A previous 421 Criminal Justice Division grant through the District Attorney's Office allowed Collin County to hire a designated Assistant District Attorney to prosecute cases managed through the Children's Advocacy Center. Dramatic result have been accomplished, including increased conviction rates, stiffer sentences and increased consistency in case resolutions.

Case numbers have significantly increased enough to warrant the hiring of a second prosecutor to work in the Child Abuse Unit.

It was through this specialized prosecution unit that we were able to identify the disparities between cases investigated by departments with specialized investigators and those using untrained patrol officers. It has further given us the opportunity to identify the need to standardize investigation protocols across the county.

TASK FORCE ORGANIZATION

The Law Enforcement Child Abuse Task Force works within the expansion project of the Collin County Children's Advocacy Center. The project further develops the Children's Advocacy Center model of multi-disciplinary teams and allows for individual geographic work units that include:

A Law Enforcement Officer
A Child Protective Services Investigator
Two (2) Child Protective Services On-going Workers
A Volunteer Child Advocate
A Therapy Liaison.

The personnel assigned to each unit will have specialized child abuse and team training. They will be able to develop a close partner working relationship because they will only have to develop that relationship among the six (6) team members, instead of on a random working assignment basis.

The Children's Advocacy Center is currently pursuing an opportunity to co-house all members of the disciplines in one location to further enhance the multi-disciplinary approach to child abuse investigation, prosecution and treatment. The Law Enforcement Child Abuse Task Force will be housed at the site.

Specific goals for this grant project are to:

Recruit and form the actual Law Enforcement Child Abuse Task Force
Establish the task force officers within the Children's Advocacy Center
Develop a unified child abuse investigation protocol to be used by the task force county wide
Train all task force members in effective child abuse investigation techniques
Monitor task force effectiveness.

We will be able to evaluate the effectiveness of this project by using the Children's Advocacy Center's case tracking system to analyze information pertinent to case progression for task force cases. Specific control items include:

Number of cases investigated (GOAL: Identify and investigate more cases in rural areas.)
Locations of cases within the county (GOAL: Determine if abusers are more highly concentrated in rural areas versus metropolitan settings.)
Types of offenses by locale (GOAL: Determine if the type of abuse is effected by locale.)
Time elapsed from outcry to prosecution and specific intervals in-between (GOAL: Decrease the amount of time a child is involved in investigation and prosecution and evaluate the interval time frames for future improvements.)
Actual case outcomes (GOAL: Increase prosecution rates on rural cases.)
Case sentencing (GOAL: Accomplish more consistency in rural case sentencing.)

This information will then be compared to pre-task force data to determine improvement in case time frames and outcomes, as well as any new trends. The Collin County Children's Advocacy Center developed this tracking system in conjunction with EDS and Technology Helps and the system is now being distributed nationwide through the National Network of Children's Advocacy Centers. A full copy of the tracking system can be made available on request.

Application for 421 Criminal Justice Division funds are to cover the salary and benefits of the Law Enforcement Child Abuse Task Force supervisor; salary and benefits for one additional Sheriff's Office investigator to investigate rural area cases; and rent at the Children's Advocacy Center to house the task force.

Mission Statement

The mission of the Collin County Law Enforcement Task Force on Child Abuse is two-fold. First, it will provide rural communities expertise and effective investigation of child abuse cases. Second, while not all law enforcement agencies located within Collin County have an established protocol for conducting child abuse investigations, the Task Force will allow for standardized investigations throughout the County.

CASE GENERATION

Local Law Enforcement Generated

Outcry

Local law enforcement agency generates offense report

Local law enforcement agency contacts CCSO investigator

Local agency contacts CPS by use of state wide 800 LE Only telephone line

CPS forwards case to local office investigator

CPS notified by CCSO investigator

CPS case worker assigned

CAC number assigned during staffing meeting

CCSO investigator investigates jointly with CPS

CCSO investigator prepares case for filing, if required
(If no formal case is required, CCSO investigator shall document disposition of incident report and report disposition to originating agency)

CCSO investigator reviews case with assistant district attorney assigned to CAC

CCSO investigator reviews case with local police department chief or designee

Case filed with District Attorney's Office

Task Force coordinator notifies local police department chief or designee o. outcome of case.

<u>Child Protective Services Generated</u>

Outcry, generally through 800 number

CPS forwards case to local CPS office

Local CPS investigator assigned

CPS notifies Law Enforcement Child Abuse Task Force
(Within 24 hours on P-1; within five (5) days on all others)

CCSO investigator logs case and, if necessary, has responsible law enforcement agency generate incident report
(NOTE: If CCSO case, CCSO investigator will generate incident report)

CAC number assigned during staffing meeting

CCSO investigator and CPS investigator investigate jointly

CCSO investigator prepares case for filing, if required
(If no formal case is required,CCSO investigator shall document dispositi of incident report and report dispostion to originating agency)

CCSO investigator reviews case with local police department chief or designee

Case filed with District Attorney's Office

Task Force coordinator notified local police department chief or designee of outcome of case

Collin County Sheriff's Office Generated

Outcry

CCSO patrol generates offense or turns incident report over to proper jurisdiction for them to generate

Local agency contacts CPS by use of state wide 800 LE Only telephone line

CPS forwards case to local office investigator

CPS notified by Collin County Sheriff's Office (CCSO) investigator

CPS case worker assigned

CAC number assigned during staffing meeting

CCSO investigator investigates jointly with CPS

CCSO investigator prepares case for filing, if required
(If no formal case is required, CCSO investigator shall document disposition of incident report and report disposition to originating agency)

CCSO investigator reviews case with assistant district attorney assigned to CAC

CCSO investigator reviews case with local police department chief or designee

Case filed with District Attorney's Office

Task Force coordinator notifies local police department chief or designee of outcome of case.

INVESTIGATIVE PROTOCOL

The Collin County Law Enforcement Child Abuse Task Force, investigative protocol, is designed as a general outline to be used when investigating child abuse cases. The protocol is a guide which may be followed and is not limited to the following steps.

Outcry Made By Victim

Notify Patrol (CCSO or Local Agency)

Generate Incident Report

Contact Investigator From Child Abuse Task Force
Contact Child Protective Services
Contact Crime Scene Unit
NOTE: First Responders Do Not Interview Victim Except Bare Essential Incident Report Information.

Obtain Crime Scene Documentation

Collect Evidence
Take Photographs
- Residence
- Room
- School
- Surroundings

Photograph Victim
- At Time Of Offense
- At Hospital
- Obtain School Picture

Secure Evidence In Property Room

Obtain Medical Support For Victim

Transport Victim to Hospital (If under 72 hours since offense)
Request Sexual Assault Examination (If under 72 hours since offense)
Overall Medical Examination
Sexual Trauma Examination (Colposcopic examination)
Obtain Signed Medical Release From Parent

Prepare Victim Case Documentation

Review Details With Reporting Patrol Officer
Review Details With Parents
Review Details With Appropriate Witnesses
Conduct Initial Interview With Victim
Establish Path To Outcry
Identify Witnesses And Obtain Statements
Interview Victim
- Forensic Interview At CAC
- Video Tape
- Written Or Audio Statement
- Anatomical Drawings

Obtain Statement From Parent Or Guardian If Appropriate

Obtain Victim's Ongoing Medical History

Interview Attending Physicians, Nurses, Ambulance Or Fire Department Personnel And Obtain Statements

Identify A School Teacher Who Can Vouch For The Victim And Obtain Statement About Truthfulness

Prepare Affidavits

Search
Arrest
Evidentiary, If Appropriate

Obtain Warrants

Search
Arrest
Evidentiary, If Appropriate

Prepare Perpetrator Case Documentation

Arrest Perpetrator
Interview Perpetrator
Does He Invoke His Rights
Does He Give Voluntary Statement
Video When Possible
Audio
Obtain Full Length Photograph
Obtain Jail History
Obtain Criminal History
Check Previous Residences
Obtain Polygraph, If Necessary

Obtain Child Protective Services Documentation

Statement From Investigators
Statement From Ongoing Workers
Case History

Obtain Children's Advocacy Center Documentation

Case File
Therapy Records

Prepare Case For Filing

Picture of Perpetrator
Case Report
Warrant
Arrest
Search
Case Summary
Witness List
Incident Report
Supplemental Reports
Dispatch Log Or Recordings
Evidence List
Medical Reports
Ambulance
Hospital
Medical Doctor
Sexual Assault Nurse Examination

Medical Examiner

Mental Health Reports

Related Offense Reports

Victim Information

- Statements
- Photographs
- Background Information
- Criminal History

Suspect Information

- Statements
- Photographs
- Background Information
  - Driving History Report
  - Wanted Persons Check
  - Criminal History Report

Arrest Report

Photographic Line-up

Statements

- Victim
- Suspect
- Person(s) Receiving Outcry
- Other Witnesses

Crime Scene

- Notes
- Sketches
- Photographs

Child Protective Services

- Intake Report
- Investigation Action Report
- Risk Assessment
- Log Of Contacts

Communications

- Teletypes
- Press Releases
- Crime Bulletins
- Newspaper Clippings

Investigator Notes

Case Filing

Review With Assistant District Attorney Assigned To CAC
Review With Appropriate Law Enforcement Jurisdiction

Grand Jury

Criminal Trial

Meet With Appropriate Jurisdiction On Outcome Of Case

Media Relations

The coordinator for the Collin County Law Enforcement Child Abuse Task Force will provide information to CCSO Public Information Officer (with regards to media relations). All inquiries regarding task force operations or current law enforcement investigations will be referred to the Public Information Officer of CCSO.

Reporting Procedure

INITIAL STAGE: Outcry received by CPS or CCSO, local jurisdiction notified by CCSO Dispatch to respond for initial incident report.

ONGOING: Regular updates from Task Force on status of investigation.

CONCLUSION: Entire case to be reviewed with local jurisdiction prior to case filing.

FOLLOW-UP: At conclusion of trial and sentencing phase, Task Force to review with local jurisdiction, the outcome of the trial.

A Community Response to

Child Predators

Presented by

Commander Bradley L. Russ,
Sergeant. Gary O'Connor,
Patty Wetterling and
Ronald Laney

COMMUNITY RESPONSE TO CHILD PREDATORS:

INVESTIGATION

Police Response

- Critical Hours
- Type of Response
- Intensity of Resources

Factors Influencing Response

- Perceived threat to child
- Departmental organization/resources
- Departmental policy
- Existence of pre-plan

Law Enforcement Response: Dispatch

- Intake and preserve initial report
- Obtain basic facts
- Dispatch officer
- Broadcast known details

8 Law Enforcement Tasks

- Determine validity of abduction
- Obtain the "victimology"
- Conduct the neighborhood investigation
- Set up command center

8 Law Enforcement Tasks (con't)

- Establish support services
- Establish liaison with victim's family
- Set up media procedures
- Conduct searches

Determining Validity

- Assume worst until proven otherwise
- Location
- Time of day
- Potential witnesses
- Area search
- Child's history

Victimology

- Physical description
- Photographs
- Friends/relatives/siblings
- Problems
- Interests

Victimology (con't)

- Relationship between abduction scene + child's routine
- Parental attitudes
- Family's financial status
- Child's room

Neighborhood Investigation

- Conduct as soon as possible
- Keep officers free from CFS
- ID any possible witnesses
- Obtain positive identification of all persons
- Note and recontact vacant locations
- Utilize detailed maps

Neighborhood Investigation

- Appoint single N.I. coordinator
- Photograph and videotape neighborhood
- Determine dynamics of neighborhood
- Determine history of neighborhood
- ID areas where victim could be taken
- ID areas where suspect may have been
- Check for prior attempts

Case Organization & Management

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

Command Center

- Away from victim's home
- Accommodate large number of phones/personnel
- Some degree of privacy/security
- Nearby area for media briefings
- Amenities
- Information management system
- Tip lines
- Trap and Trace

Liaison Officer at Victim's Residence

- Brief family
- Trap and Trace
- Log and record
- Contact with command center
- Screen and log visitors
- Record tags

Liaison Officer at Victim's Residence (pt. 2)

- Secure the residence
- Search thoroughly
- Photographs of victim
- Enhance victim information
- Obtain "key" information (unique to victim)
- Interview friends
- Obtain letters, diaries, etc.
- Obtain fingerprints, hair samples

Liaison Officer at Victim's Residence (pt. 3)

- Counsel victim's family
- Explain procedures
- Prepare family for emotional stages/changes
- Link family with appropriate support
- Help family meet basic needs
- Provide a sense of security and professionalism

Search Coordinator

- Organize both ground and air searches immediately
- Law enforcement present w/all search elements
- Utilize all resources
- Logistical support
- Positive ID on all searches

Media Coordinator

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

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 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

Dentistry's Role in Recognizing Orofacial Trauma in Child Abuse:

Orofacial region is dentistry's area of expertise
Patients/parents typically return to the same dentist, but avoid the same physician and ER. Public perception of dentistry's role.
Estimated 1-10% of children visiting the dental office will show signs and symptoms of abuse (ADA News, May 1995)
Orthodontists, Pediatric Dentists, and Oral and Maxillofacial Surgeons very likely to see orofacial signs and symptoms
Dentists are mandated reporters, yet less than 1% of all cases reported are reported by dentists.
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.

Categorization of Head and Facial Trauma

Landmark study by Becker, Needleman and Kotelchuck--JADA 1978.
Retrospective study found that 65% of child abuse involved trauma to head and facial structures.
Of the head and facial injuries, three categories defined:

Head trauma	33%
Facial injuries	61%
Intraoral trauma	6%

I. **Extraoral Trauma**

A. 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.

1. Black eyes - look for possible orbital, zygomatic, or nasal fractures
   a. screening film: Water's view
2. Limited movement of lower jaw (mandible) may indicate a fracture of the jaw joint (condyle) or cheek bone (zygoma)
   a. mandibular fractures often occur at two sites, usually opposite sides
   b. look for malocclusion
   c. screening film: panograph or PA Cephalograph

B. **Ears**

1. Injuries to the ears are considered by some to be pathogonomic for child abuse
   a. This area is part of a dentist's extra-oral exam
      1). Bruises, cuts, "cauliflower ear" indicates slapping, pinching, pulling or twisting.
      2). A perforated tympanic membrane (ear drum) is suspicious.

C. **Neck**

1. Also part of the dentist's purview, and may show rope burns, scratches, bruises

D. **Nose**

1. Broken, bruised, deviated septum

E. **Lips**

1. Scars on the lips are very rare, and repeated trauma should be suspected if scars are present.
   a. Burns - burning implements, force feeding hot foods
   b. Rope burns - at corners of mouth would suggest gagging
   c. Tears at corners of mouth - forced opening

F. **Bruises/Burns**

1. look for patterns of bruises/burns
2. examine for origin and evaluate stage(s) of healing
3. Ages of Bruising

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

G. **Burns**
   1. 60% of burns can be viewed while child is clothed
      a. immersion burns
      b. cigarette burns (end 500 degrees F)
      c. patterns

H. **Bite-Marks**
   1. 65% can be seen without disrobing
   2. can be inflicted by adult, self, or other child

II. **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
   e. Unattended rampant decay - neglect
3. Evaluation of dental injuries with radiographs -- can also aid to determine normal eruption patterns.

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. common in childhood play
   - B. a primitive form of assault
   - C. seen in forcible rape and hand-to-hand mortal combat
   - D. seen in some folk remedies
   - E. seasonal incidence
   - F. may be self-inflicted

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 - 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
        - b. 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. 1994 - 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

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

B. Permanence
   1. Change in dentition over time

C. 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
      b. Need at least 4-5 teeth marks present

REFERENCES: OROFACIAL TRAUMA OF CHILD ABUSE

ADA News. March 18, 1996: 30.

Ambrose, JB. Orofacial Signs of Child Abuse and Neglect: A Dental Perspective. Pediatrician 1989: 188-192.

American Dental Association Council on Dental Practice. The Dentist?s Responsibility in Identifying and Reporting Child Abuse and Neglect: 1989 Revision.

American Dental Association Council on Dental Practice. The Dentist?s Responsibility in Identifying and Reporting Child Abuse and Neglect; 1995 Revision.

Becker, DB, et al. Child Abuse and Dentistry: Orofacial Trauma and Its Recognition by Dentists; JADA 1978: 24-28.

Bernat, JE. Child Abuse and Neglect: Dentistry?s Role. NYS Dental Journal; March 1989: 34-37.

DeFonseca, MA, et al. Dental Aspects of 1248 Cases of Child Maltreatment on File at a Major County Hospital. Pediatr Dent; 1992: 152-157.

Garlick, JA and LB Taichman. Human Papilloma virus Infection of the Oral Mucosa. American Journal of Dermatopathology; 1991: 386-395.

Journal of the American Dental Association, Question of the Month. JADA; 1996: 730.

Hanna, MJ. Reporting Child Abuse and Neglect. Texas Dental Journal; May 1995: 33-35.

Kirkland, K. Assessment and Treatment of Family Violence. The Journal of Family Practice; 1982:713-718.

Larkin, S. Child Abuse on the Rise. Missouri Dental Association; Update 1994: 12-15.

Marcus, DM and DM Albert. Recognizing Child Abuse. Arch Ophthalmol; 1992: 766-767.

McDowell, JD, et al. Recognizing and Reporting Victims of Domestic Violence. JADA; 1992: 42-48.

Meadow, R. ABC of Child Abuse; Epidemiology. BMJ; 1989: 727-730.

Monteleone, JA and AE Brodeur. Child Maltreatment; A Clinical Guide and Reference. GW Medical Publishing, Inc. St. Louis, 1994.

Mouden, LD. And DC Bross. Legal Issues Affecting Dentistry?s Role in Preventing Child Abuse and Neglect for the Dental Profession. JADA; 1982: 55-56.

Mouden, LD, et al. How to Recognize Situations that Suggest Abuse/Neglect. Missouri Dental Association; Update 1994: 16-19.

Mouden, LD. The Hygienist?s Role in recognizing and Reporting Child Abuse and Neglect. Practical Hygiene; March/April 1996:25-28.

National Center on Child Abuse Prevention Research. Current Trends in Child Abuse Reporting and Fatalities. National Committee for Prevention of Child Abuse. Chicago, IL, April 1992:2.

Paterson, CR and SJ McAllion. Differentiation of Child Abuse from Osteogenesis Imperfecta. AJR; 1990: 1346-1347.

Persaud, D. Child Abuse Medical Training Program. University of Texas Southwestern Medical Center Dept of Pediatrics, 1995.

Ramos-Gomez, F, D Rothman, and S Blain. Knowledge and Attitudes Among California Dental Care Providers Regarding Child Abuse and Neglect. JADA ; 1998: 340-348.

Ross, CA, et al. Abuse Histories in 102 Cases of Multiple Personality Disorder. Can J Psychiatry; 1991: 97-101.

Sanders, RW. Resistance to Dealing with Parents of Battered Children. Pediatrics; 1972:853.

Sanger, RG and DC Bross. Implications of Child Abuse and Neglect for the Dental Profession. JADA 1982: 55-56.

Schmidt, BD. Types of Child Abuse and Neglect: An Overview for Dentists. Pediatr Dent; 1986: 67-71.

Sfikas, PM. Does the Dentist Have and Ethical Duty to Report Child Abuse? JADA; 1995: 1173-1180.

Silver, LB, et al. Child Abuse Syndrome: The ?Gray-areas in Establishing a Diagnosis. Pediatrics; 1969: 594.

Simon, Patricia A. A Summary of Facts About Child Abuse/Neglect. The Texas Dental Journal; January 1997: 37-40.

Simon, Patricia A. Dentists Are Responsible for Reporting Child Abuse. Dateline: Official Publiciation of the Dallas County Dental Society; April 1997: 4.

Simon, Patricia A. Recognizing and Reporting Child Abuse Child Abuse/ Neglect. Dateline: Official Publication of the Dallas County Dental Society, April 1998: 6.

Tate, RJ. Facial Injuries Associated with the Battered Child Syndrome. British Journal of Oral Surgery; 1971: 41-45.

US Advisory Board on Child Abuse and Neglect. A Nation?s Shame: Fatal Child Abuse and Neglect in the United States. US Dept of Health and Human Services. Administration for Children and Families, Washington, DC, 1995: 1-248.

REFERENCES: BITE MARK ANALYSIS

American Board of Forensic Odontology, Inc., Guidelines for Bite-mark Analysis, JADA (112); 1986: 383-6.

American Dental Association Council on Dental Practice. The Dentist?s Responsibility in Identifying and Reporting Child Abuse and Neglect: 1995 revision.

American Dental Association Council on Dental Practice. The Dentist?s Responsibility in Identifying and Reporting Child Abuse: 1989 revision.

Anderson, W. and Hudson, R. Self-inflicted Bite-marks in Battered Child Syndrome. Forensic Science 7; (1976): 71-74.

Becker, D.B., Needleman, H. L., Kotelchuck, M. Child abuse and Dentistry: Orofacial Trauma and Its Recognition by Dentists. JADA (97); 1978: 24-28.

Bundy vs. Florida, So. 2d Aug. 1979.

Frye vs. United States, 293 F. 1013 (D.C. Cir 1923).

Hale, A. The Admissibility of Bite-mark Evidence. South California Law Rev. 51:309-334, 1978.

Jakush, J., Forensic Dentist., JADA (119); 1989:355-368.

Karazulas, C.P. The Presentation of Bite-mark Evidence Resulting in the Acquittal of a Man After Serving Seven Years in Prison for Murder. J. Forensic Sci 1984;29 (1):355-8.

Leung, A.R.C., and Robson, W.L.M., Human Bites in Children. Pediatric Emergency Car, 8; (1992): 255-257.

People vs. Marx, 54 Cal. App. 3d 100, 126 Cal Rptr. 350 (1975).

People vs. Milone, 43 Ill. App. 3d 385, 356 N.E. 2d 1350 (1976).

People vs. Jennings, 252 Ill. 534, 96 N.E. 1077 (1911).

Pierce L. J., Strickland, D.J., Smith, E.S. The Case of Ohio vs. Robinson: an 1870 Bite-mark Case. Am J. Forensic med Pathology 1990; 11:171-7.

Rothwell, B.R. Bite-marks in Forensic Dentistry: A Review of Legal, Scientific Issues. JADA (126); (1995): 223-232.

Whittaker, D.K. Some Laboratory Studies on the Accuracy of Bite-mark Comparison. Int Dent J 1975; 25:166-71.

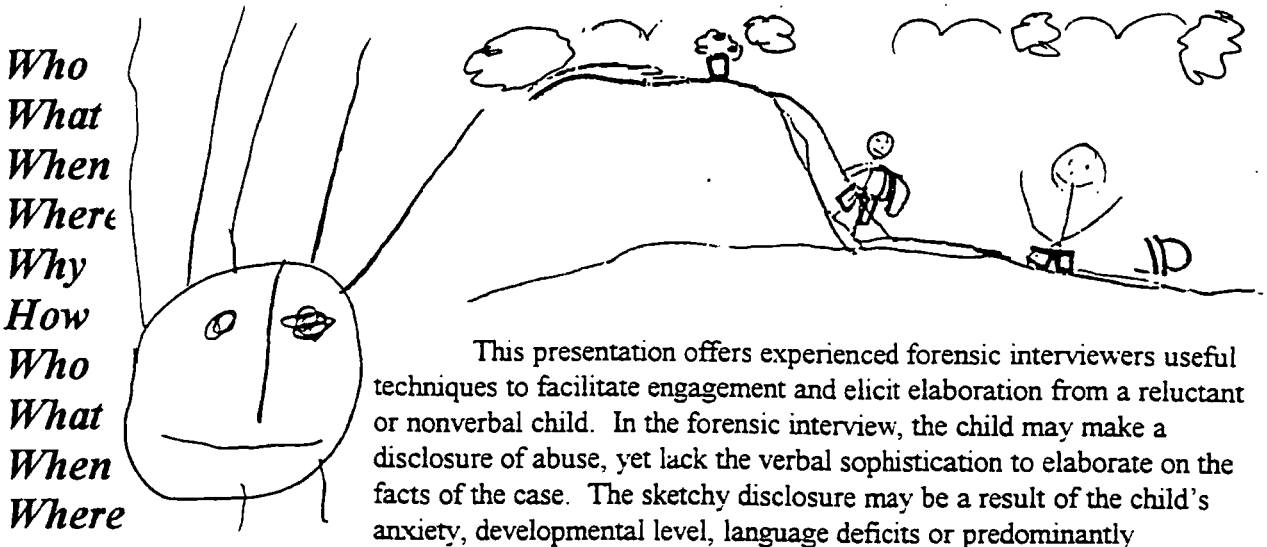
Woolridge, E.D., Legal Problems of the Forensic Odontologist. J of Forensic Sciences; 18(1); Jan 1973:133-6.

THE CHILDREN'S SAFEHOUSE • 1709 MOON STREET, NE • ALBUQUERQUE, NM 87112

"Show me what happened..."

MAXIMIZING NONVERBAL COMMUNICATION TO CLARIFY CHILDREN'S DISCLOSURES

Presented by Madaline Lindy Merry, MA, RMHC



This presentation offers experienced forensic interviewers useful techniques to facilitate engagement and elicit elaboration from a reluctant or nonverbal child. In the forensic interview, the child may make a disclosure of abuse, yet lack the verbal sophistication to elaborate on the facts of the case. The sketchy disclosure may be a result of the child's anxiety, developmental level, language deficits or predominantly nonverbal orientation.

A child typically has a single interview to communicate essential information about traumatic experience, and the investigation may hinge on explicit and sufficient details regarding the case facts. The outcome of the investigation may be affected by insufficient or confusing information, and the child may exit the interview discouraged by a sense of failure to perform the task.

Research (Van der Kolk, et al , 1997) suggests that traumatized children lack, or fail to develop, the left-brain abilities required for the verbal communication of experience. This type of communication--a cohesive narrative-- is typically the desired outcome for investigations. Elements of the trauma are stored in the right hemisphere, which governs nonverbal awareness and emotional, synthetic, concrete and analogical functions. An attempt by the interviewer to access these memory realms may open a rich storehouse of information to clarify the disclosure and receive tangible, demonstrative evidence. In addition, the child gains the opportunity to communicate more effectively and to be seen and heard in a self-directed manner that minimizes the inherently stressful situation of relating to an unknown adult.

Many of the tools that will be presented have been adapted for forensic viability from principles and techniques of expressive therapies. An overview of child artistic development will be presented and contrasted with verbal and social development. Media and props will be addressed, with an emphasis on low-cost or free resources adaptable to multiple situations. Slides and videotaped segments will illustrate effective approaches to problematic cases.

THE CHILDREN'S SAFEHOUSE • 1709 MOON STREET, NE • ALBUQUERQUE, NM 87112

"Show me what happened..."

MAXIMIZING NONVERBAL COMMUNICATION TO CLARIFY CHILDREN'S DISCLOSURES

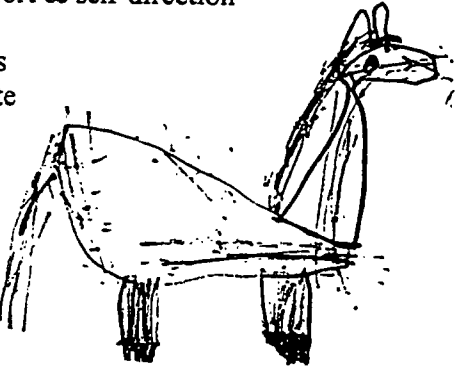
Presented by Madaline Lindy Merry, MA, RMHC

Who
What
When
Where
Why
How
Who
What
When
Where
Why
How
Who
What
When
Where
Why
How
Who
What
When
Where
Why
How
Who
What
When
Where
Why

I Who benefits by maximizing nonverbal communication in the forensic interview?
   1. The dominantly nonverbal child
   2. The preschool child
   3. The reluctant child
   4. The culturally-different child
   5. Investigators

II Incorporating expressive therapy principles & techniques
   1. Relevance to the forensic interview
   2. Relevance to increasing child's comfort & self-direction

III Engaging reluctant children and adolescents
   1. Providing motivation to communicate
   2. Techniques
   3. Case examples

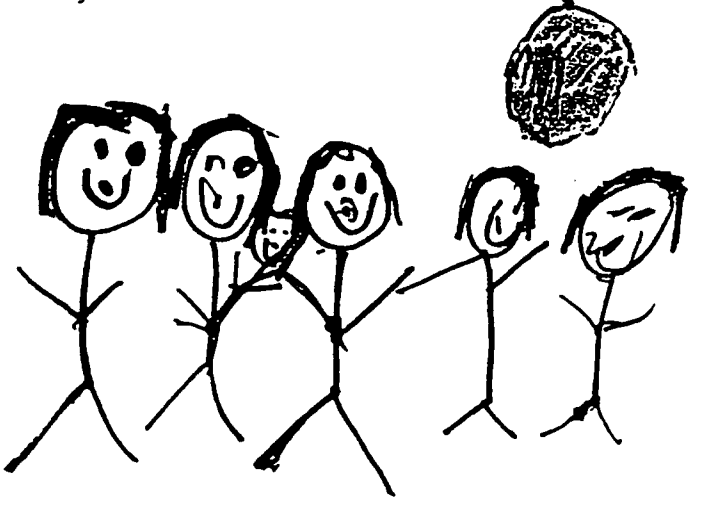


IV Clarifying and expanding disclosures
   1. Products as concrete evidence
   2. Techniques
   3. Case examples

V Children's verbal vs. nonverbal development
   1. Developmental markers in drawing & plastic media
   2. Implications for interviewing

VI Materials and props
   1. Appropriateness by age/developmental level
   2. Simplicity and economy

VII Discussion



1 *LIMITATIONS ON FORENSIC APPLICATION OF CHILDREN'S MEMORY AND SUGGESTIBILITY RESEARCH:*

A CRIMINAL JUSTICE PERSPECTIVE

Presented by Daniel Armagh,
APRI's National Center for
Prosecution of Child Abuse
(703) 739-0321

2

State v. Michaels

625 A.2d 489 (N.J. Super. 1993)
642 A.2d 1372 (N.J. 1994)

3 ## *State v. Michaels*

642 A.2d 1372 (N.J. 1994)

Interviews of children were so coercive and "suggestive" that the children's testimony was facially unreliable--state has to prove reliability before re-trying the case.

4 ## TAINT HEARINGS FOR CHILD WITNESSES? A STEP IN THE WRONG DIRECTION

John E.B. Myers

46 *Baylor Law Review* 873 (1994)

5

Multiple Interviews Or Not?

6 ## *Multiple Interviews Or Not ?*

Risks

- May traumatize some children
- Children frequently inconsistent over multiple interviews
- Increases likelihood interviewers will use improper forms of questioning
- May reinforce suggested information from prior interview

7 ☐ ***Multiple Interviews Or Not ?***

Benefits

- May assist child in preparation for court
- Research reveals children frequently recall more information during subsequent interviews
- Reinforces information recalled during prior interview

8 ☐ ***Reasons For Use Of Suggestive Questions***

- Psychological dynamics of sexual abuse
- Developmental capacities of children
- Other avenues exhausted
- Protective concerns

9 ☐ ***Reasons For Use Of Suggestive Questions***

Psychological Dynamics Of Sexual Abuse

- Piecemeal disclosure process
- Threats to silence
- Emotional attachment to abuser
- Guilt and shame
- Trauma from victimization
- Cognitive appreciation for wrongfulness of behavior

10 ☐ ***Reasons For Use Of Suggestive Questions***

Developmental Capacities Of Children

- Ability to provide information using free recall vs. recognition

- ➢ Language skills
- ➢ Memory retrieval mechanisms

11 KIDS IN COURT

What you really need to know about memory

Three *Phases*

❶ Acquisition

❷ Storage

❸ Retrieval

12 KIDS IN COURT

What you really need to know about memory

Acquisition

- ✦ Children have more difficulty than adults with complex issues
- ✦ Ability increases till age twelve
- ✦ Young children remember familiar things well

13 KIDS IN COURT

What you really need to know about memory

Storage

Ability does not increase with age

14 KIDS IN COURT

What you really need to know about memory

Retrieval

Event *reporting* affected by

- ✦ Cognitive development
- ✦ Language acquisition
- ✦ Delay between event & interview
- ✦ Secrecy inducement

15 KIDS IN COURT

What you really need to know about memory

Retrieval

Memory & Reporting affected by

- ✦ Stress
- ✦ Both a help & hindrance

16 KIDS IN COURT

What you really need to know about memory

Three *tasks*

❶ Recognition

❷ Reconstruction

❸ Free recall

17 ***Federal Rules of Evidence***

Rule 702

If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue a person qualified by knowledge, skill, experience, training or

education, may testify thereto in the form of an opinion or otherwise.

18 ☐ ***Federal Rules of Evidence***

Rule 704

Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

19 ☐ ***Federal Rules of Evidence***

Rule 803(18) LEARNED TREATISES

To the extent called to the attention of an expert witness upon *cross-examination* or relied upon by him in *direct examination*, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, *established as reliable authority* by *testimony* or *admission* of the witness or by other *expert testimony* or by *judicial notice*. If admitted, the statements may be *read* into evidence but may *not be received as exhibits*.

20 ☐ **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)

21 ☐ **CRITERIA UNDER *DAUBERT***

- ❶ **Whether the theory or technique can be or has been tested.**
- ❷ **Whether the theory or technique has been subjected to peer review or published.**
- ❸ **Whether the theory or technique has a known or potential rate of error and what it is.**
- ❹ **The existence and maintenance of standards controlling the technique's operation.**
- ❺ **Whether the theory or technique is generally accepted in the relevant scientific community.**

22 ☐ **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.

Daubert v. Merrell Dow Pharmaceuticals

23 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.

Daubert v. Merrell Dow Pharmaceuticals

24 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.

Daubert v. Merrell Dow Pharmaceuticals

25 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.

Daubert v. Merrell Dow Pharmaceuticals

26

Research Issues

Analog Studies

- ✪ General issues of memory
- ✪ No direct parallel to CSA

Example: staged event studies

27

Research Issues

Ecological Validity Studies

- Tries to recreate aspects of CSA
- Can isolate one or a few aspects

Example: medical exam study

28 KIDS IN COURT

Suggestibility

"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

29 KIDS IN COURT

Suggestibility

- Situational
- Unique to individual in context
- No simple relationship between age and suggestibility

30 Memory and Suggestibility

Suggestibility Factors

→ Interviewer's mental set

- → Stereotypes
- → Erroneous suggestions
- → Delay
- → Intimidating environment
- → Repeated questioning
- → Form of question
- → Secrecy inducements

31

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

32

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

33 JEOPARDY IN THE COURTROOM: A Scientific Analysis of Children's Testimony

by Stephen J. Ceci and Maggie Bruck

published by

American

Psychological

Association

34 JEOPARDY IN THE COURTROOM

preface at x

> *". . . [W]e focus disproportionately on [children's] weaknesses, because it is our contention that [these weaknesses] are less well understood by experts and nonexperts. . ."*

35 JEOPARDY IN THE COURTROOM

preface at x

> *"So to repeat, although the literature is skewed toward case studies that entail weaknesses, these are probably not the most common types of cases."*

36 JEOPARDY IN THE COURTROOM

page 4

> *". . . [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."*

37 **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)***

38 ☐ **What the Expert Witness on Children's Suggestibility *Should* Tell the Court**

1. **There are reliable age differences in children's suggestibility, with preschoolers being more vulnerable than older children to a variety of factors that contribute to unreliable reports.**

Ceci & Bruck, *Jeopardy in the Courtroom*

39 ☐ **What the Expert Witness on Children's Suggestibility *Should* Tell the Court**

2. **Although young children are often accurate reporters, some do make mistakes - particularly when they undergo suggestive interviews; and these errors are not limited to peripheral details, but may include salient events that involve children's own bodies.**

Ceci & Bruck, *Jeopardy in the Courtroom*

40 ☐ **What the Expert Witness on Children's Suggestibility *Should* Tell the Court**

4. **Finally it is important that the court appreciate the complexity of the interrelationships among the factors affecting children's report accuracy. As in most areas of social science, effects are rarely as straightforward as one might wish. For example, even though suggestibility effects may be robust, they are not inevitable, nor are they ineluctably large in magnitude...**

Ceci & Bruck, Jeopardy in the Courtroom

41 ☐ ***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."

42 ☐ **"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*

43

"As social scientists whose opinions can influence legal and societal decisions, we have a duty in our presntation 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.

44

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.

45

APA CODE OF ETHICS

2.04 USE OF ASSESSMENT IN GENERAL AND WITH SPECIAL POPULATIONS

Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.

46

APA CODE OF ETHICS

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...

47 ☐ **APA CODE OF ETHICS**

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.

48 ☐ **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.

49 ☐ ***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

50 ☐ ***Daubert* Criteria: Theory Tested?**

- →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

51 ☐ ***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 suggestibilityfactors
- →Inability to account for individual differences
- →Developmental age Vs chronological age

52 ☐ *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

53 ☐ *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

54 ☐ *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

55 ☐

"There is hardly anything not palpably absurd on its face that cannot now be

proved by some so-called expert."

Chaulk v. Volkswagen of Am. Inc.., 808 F.2d 639, 644 (7th Cir.. 1986)

56

"The law extends equal dignity to the opinions of charlatans and Nobel Prize winners."

Donald Elliot

Yale Law Professor

57 ***Federal Rules of Evidence***

Rule 703

The facts or data in the particular case upon which an expert bases an opinion or inference may be those ***perceived*** by or ***made known*** to him at or before the hearing. If of a type ***reasonably relied upon by experts*** in the particular field in forming opinions or inferences upon the subject, the ***facts or data need not be admissible in evidence.***

58 ***Federal Rules of Evidence***

Rule 705

PANDORA'S BOX FOR PROSECUTORS

59 ***Federal Rules of Evidence***

Rule 705

The expert may testify in terms of ***opinion*** or ***inference*** and give his

reasons therefor ***without prior disclosure*** of the ***underlying facts or data, unless the court requires otherwise***. The expert may in any event be required to ***disclose*** the underlying facts or data on ***cross-examination***.

60

Frye Test

Basis for testimony must be sufficiently established to have gained general acceptance in the relevant scientific community

61 EXPERT WITNESS TESTIMONY

DAUBERT v. MERRELL DOW PHARMACEUTICALS INC.

___ U.S. ___ , 113 S.Ct. 2786,
125 L.Ed.2d 469 (1993)

62 CRITERIA UNDER *DAUBERT*

- ❶ Whether the theory or technique can be or has been tested.
- ❷ Whether the theory or technique has been subjected to peer review or published.
- ❸ Whether the theory or technique has a known or potential rate of error and what it is.
- ❹ The existence and maintenance of standards controlling the technique's operation.
- ❺ Whether the theory or technique is generally accepted in the relevant scientific community.

63 ***Assessing Children's Credibility: Scientific and Legal Issues in 1994***

Charles Robert Honts

70 North Dakota Law Review 879

64 Honts, *Assessing Children's Credibility: Scientific and Legal Issues*

in 1994

Statement Validity Analysis Satisfies the standards for admissibility of scientific evidence under *Daubert.*

"There does not seem to be any reason to suspect that direct expert testimony on child witness credibility will have the magical powers to overwhelm juries that other scientific evidence lacks."

65 ☐ ***Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse***

David Raskin and Phillip Esplin,

13 Behavioral Assessment 265 (1991)

66 ☐ ***Statement Validity Analysis (SVA)***

Components

❶ Structured interview of child

❷ Criteria-based content analysis (CBCA) - systematic assessment of content and quality of statements under Undeutsch hypothesis

❸ Integration of CBCA with information derived from set of questions (Validity Checklist)

67 ☐

"It is important to note that the purpose of the SVA is to provide an assessment of the *validity of the recorded statement, not of the general credibility of the child witness*"

Raskin and Esplin, *Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse,*

13 Behavioral Assessment 265 (1991)

68 ☐

"(SVA is)...not a formal instrument developed by empirical research and subjected to psychometric evaluation as is typical of

psychological tests."

Raskin and Esplin, *Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse,*

13 Behavioral Assessment 265 (1991)

69

"...the criteria of logical consistency and quantity of details must be present...However, the number of additional criteria that should be present has not been determined."

Raskin and Esplin, *Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse,*

13 Behavioral Assessment 265 (1991)

70

"CBCA is not a sufficient basis to form a definite conclusion concerning the validity of the allegations...additional factors must be analyzed to select the most plausible explanation... This is done by means of the Validity Checklist."

Raskin and Esplin, *Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse,*

13 Behavioral Assessment 265 (1991)

71

"Presently, there are no specific rules for the number of criteria that must be satisfied in order to support a tentative conclusion that a statement was derived from actual memory of the events."

Raskin and Esplin, *Statement Validity Assessment: Interview Procedures and Content Analysis of Children's Statements of Sexual Abuse,*

13 Behavioral Assessment 265 (1991)

72

The Complexities of Eliciting and Assessing Children's Statements

David Marxsen, John Yuille, and Melissa Nesbit

1(2) Psychology, Public Policy, and Law (1995)

73 *The Complexities of Eliciting and Assessing Children's Statements*

Statement Analysis has proved of some use in the differentiation of truthful from false statements of primary school aged children... This technique shows real promise, but it has some clear shortcomings, foremost of which is subjectivity.

74

"The first five criteria are thought to be necessary, that is, any truthful statement should contain all five."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

75

"The presence of the remaining 14 are thought to add to the credibility of the statement, but the absence of any particular criterion from this group does not necessarily imply that the statement is not credible."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

76

"A common *rule of thumb* is that a credible statement must include the first 5 and any 2 of the remaining 14."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

77

"Many of the implicit assumptions of SA are based on little more than face validity. We do not know if all children cannot coherently prevaricate in a spontaneous manner. It certainly seems likely that most young children would find this an impossible task, but we do not know the base rates for different developmental levels."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

78

"We do not claim that SA is an adequate system or even an entirely practical one. Various studies have found very disparate results for the different criteria. SA must be applied in a context of pursuing multiple hypotheses and is not a sort of 'no tech' lie detector."

Marxsen, D., Yuille, J.C. & Nesbit, M. (1995). *The Complexities of Eliciting and Assessing Children's Statements.* 1(2) Psychology, Public Policy & Law 450.

79

"By and large, however, low CBCA scores may reflect responses to focused interview prompts, reliance or recognition memory, or the absence of reference to an experienced event. Low scores are thus inherently more difficult to interpret and cannot be used to assert a lack of credibility."

Hershkowitz, et al. (1997 in press). The Relationship Among Interviewer Utterance Type, CBCA Scores, and the Richness of Children's Responses. Legal and Criminological Psychology

80

"Overall, the results reported here are quite sobering, particularly when viewed from the perspective of forensic application... the level of precision clearly remains too poor to permit the designation of CBCA as a reliable and valid test suitable for use in the courtroom."

Lamb, et al. (1997 in press). *Criterion-Based Content Analysis: A Field Validation Study.* Child Abuse and Neglect

81

"[The results] also underscore that CBCA scores should not - and perhaps should never - be used in forensic contexts to evaluate individual statements..."

Lamb, et al. (1997 in press). *Criterion-Based Content Analysis: A Field Validation Study.* Child Abuse and Neglect

82

"However, age is not the only important factor, large-scale analyses that also take into account type of abuse, chronicity of abuse, physical force and/or verbal threats, the number of times a child has been interviewed, and cultural factors are needed before SVA can be used as a scientifically validated instrument."

Lamers-Winkelman & Buffing (1995). *Children's Testimony in the Netherlands: A Study of Statement Validity Analysis.*

83

Arguments Against Admission

❶ Singles out child victims for specialized scrutiny
- Reinforces notion that children's statements can't be trusted
- Defendant's statements not subjected to SVA

❷ Abdicates jury's historical function as determiners of credibility

❸ Likelihood jurors overwhelmed by expert testimony on credibility

84

Arguments Against Admission

❹ SVA really measures the quality of the investigative interview, not the accuracy or reliability of the child's statement

❺ Most of the criteria used to evaluate the statement are the same criteria the jurors would themselves use to evaluate the statement or testimony - therefore the expert testimony will not be helpful to the jury on a subject outside their general knowledge

85

Arguments Against Admission

❻ If SVA not designed to determine credibility of child witness but only validity of recorded statement, then SVA would only be applicable if the child's statement were introduced as a hearsay

exception.

❼ Jury not likely to draw distiction between credibility of recorded statement and credibility of child witness overall.

❽ Testimony vouching for child's credibility is almost universally excluded.

86 ☐ *Daubert* Criteria: Theory Tested?

→Little research done on actual victims

→Virtually impossible to ethically conduct ecologically valid laboratory research

→Ability to discriminate false negatives not established

→Only CBCA capable of empirical testing, validity cheklist and interview protocol not testifiable

→CBCA is not sufficient independently to make validity determination

87 ☐ *Daubert* Criteria: Error Rate?

→Base rates lacking for different age and developmental groups

→Research involving young children identifies problems with developmental appropriateness of several criteria

→Minimum number of criteria on CBCA checklist not determined

→No data on criteria present in statements from victims making false denials

88 ☐ *Daubert* Criteria: Error Rate?

→ Not all criteria differentiate in some and/or all of the research

→ Some criteria have been found unreliable

→ Some research shows some criteria more likely to be present in implausible allegations than probable statements

→ Conflicting research data on minimum criteria and validating criteria

→ No way to determine error rate on Validity Checklist or Interview Protocol

89 ☐ *Daubert* Criteria: Standards?

→ Research has not determined the appropriateness of the various CBCA criteria

→ Don't know which criteria are absolutely necessary for discriminating truthful from non-truthful accounts

→ Don't know which criteria are necessary or inappropriate based on

age or development

90 ☐ *Daubert* Criteria: Standards?

- → Don't know minimum number of criteria which must be present
- → Disagreement amongst practitioners over application of CBCA criteria to statements which are not obtained using SVA interview protocol

91 ☐ *Daubert* Criteria: Acceptance?

- → Only a small percentage of practitioners using and testing the technique
- → No published decisons admitting technique
- →No general acceptance of SVA in the scientific community
- → Substantial disclaimers in the published research on SVA regarding its use, limitations, reliability and admissibility in court proceedings

CIVIL LAW FOR LAW ENFORCEMENT OFFICERS[1]

With the increasing amount of litigation taking place in the country, several aspects of working as a police officer have changed. First, police officers have a heightened concern that persons are more willing to file a lawsuit against the officer for a variety of reasons. Yet, few officers are aware of the legal principles that may form the basis of a lawsuit against them. This paper will help explain to the officer the typical causes of action that may be asserted against an officer conducting child abuse investigations. Second, accompanying the increasing amount of litigation taking place in the country is the fact that many child abuse investigations conducted by police officers are the prelude to the filing of a civil suit between the child and the facility where the alleged abuse occurred. For instance, a child sues a child-care facility because he is molested or abused at the facility, i.e., day-care, YMCA, church, school, etc. Central to these civil suits is the investigation handled by the police department. As a result, this paper will serve as a reference for officers for some commonly asked questions for the following two areas: (1) what type of liability do I face when I investigate a child abuse case; and (2) what do I do when my investigation becomes the center of a civil dispute?

What kind of liability do I face when I investigate a child abuse case?

A plaintiff may assert a federal cause of action, a state law cause of action, or a combination of both, against an officer. The following is an explanation of both federal and state law claims that may be utilized in a lawsuit against the officer arising from a child abuse investigation.

I. Federal Liability

A. Lawsuits against police officers under federal law are usually based on an alleged violation of 42 U.S.C. section 1983.

> 42 U.S.C. section 1983 ("Section 1983") provides:
>
> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws,

[1] The purpose of this paper is to inform police officers about certain liability the officer may confront in child abuse investigations. As such, this paper should only be used as a general reference and the officer should always consult with an attorney if he or she has concerns as to his or her liability respecting a particular matter.

shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

1. Simply put, two essential elements are required to assert a cause of action for police misconduct under Section 1983:

a. the conduct complained of was committed by a person acting under color of state law; and

b. the conduct deprived a person of rights, privileges and immunities secured by the Constitution or laws of the Unites States.[2]

2. **Under color of state law:** most actions taken by a police officer who is investigating an offense are considered "under color of state law" because officers are cloaked with the authority of state law when they are acting in their official capacities.[3] Thus, the first element will always be satisfied if the suit arises from an incident that occurred while the police officer was working in his official capacity.

3. **The conduct must deprive a person of a right secured by the constitution.** If the conduct does not violate a right secured by the constitution, then Section 1983 does not create any liability.[4]

a. Many cases brought under Section 1983 involve claims that the police violated a person's Fourth, Fifth, Eighth, or Fourteenth Amendment rights.[5]

b. Moreover, there is no specific intent requirement necessary to make a case under Section 1983.[6] In order to prove a constitutional violation in certain cases, however, the person will need to show a certain type of intent. For example, in false arrest cases under Section 1983, a seizure must be intended, but there is no requirement of a specific intent to violate the Fourth Amendment.[7]

B. What are some common types of constitutional violations that can be asserted

---

[2] *Parratt v. Taylor*, 451 U.S. 527 (1981).

[3] FONTANA, MUNICIPAL LIABILITY: LAW AND PRACTICE, sec 8.1 (1990)[hereinafter MUNICIPAL LIABILITY].

[4] *Id.* at sec. 8.4; SILVER, POLICE CIVIL LIABILITY, sec. 8.03[1] (Supp. 1995)[hereinafter POLICE CIVIL LIABILITY].

[5] MUNICIPAL LIABILITY, *supra.*, sec. 8.4.

[6] *Parratt v. Taylor*, 451 U.S 527 (1981).

[7] POLICE CIVIL LIABILITY, *supra.*, sec. 8.02[2].

against a police officer under Section 1983 for child abuse investigations?

The following represent some of the potential constitutional violations that may arise in child abuse investigations. This list is not designed to be an exclusive list, but merely a list that indicates constitutional violations that could surround an officer's actions in handling child abuse investigations.

1. **Fourth Amendment Violations**: the basic principle of the Fourth Amendment is that a person has the right to be free from unreasonable searches and seizures, i.e., a person has a reasonable expectation of privacy. The fundamental inquiry in considering Fourth Amendment issues is whether or not a search or seizure was reasonable under all the circumstances.

a. False Arrest/ Imprisonment:

- defined as an arrest made without proper legal authority that restrains a person's liberty.[8]

i. Arrest made pursuant to a warrant:

A. An arrest made pursuant to a warrant should be immune from a Fourth Amendment false arrest claim because a neutral and detached magistrate makes an independent determination whether probable cause exists for arrest.[9] An action may lie under Section 1983, however, if the warrant was recklessly procured or it was grossly defective on its face (The following cases serve as examples for officers, but the examples are not exclusively limited to child abuse investigations).

e.g. A detective investigating the death of a child failed to apprise the D.A. of medical theories that conflicted with the detective's theory that the babysitter was responsible for the death of the child. The court found that the failure of the officer to apprise the D.A. of the conflicting theories led to the false arrest of the plaintiff.[10]

e.g. An officer altered the information on the warrant after the magistrate signed the warrant to reflect a different person than that named in the warrant. The court found that this constituted a classic Fourth Amendment violation.[11]

---

[8] BLACK'S LAW DICTIONARY 540 (5th ed. 1979).

[9] CLARK & BOARDMAN, POLICE MISCONDUCT, sec. 2.3(a)(3)(2d ed. 1995)[hereinafter POLICE MISCONDUCT].

[10] *Deloach v. Bevers*, 922 F. 2d 618 (10th Cir. 1990), *cert. denied*, ___U.S.___, 112 S. Ct. 65 (1991).

[11] *Brown v. Byer*, 870 F. 2d 975 (5th Cir. 1989).

e.g. Sheriff caused the issuance of a warrant even though he had concerns regarding the proper identification of the alleged offender. The name and description of the offender given to the sheriff by the undercover officer did not match the description of the person the sheriff knew and named in the warrant. There was a twenty year age difference between the description given by the undercover officer and the person named in the warrant. The sheriff did not apprise the magistrate of this information. The court found that this violated the Fourth Amendment. [12]

Compare: An officer was investigating hot checks written by a girl named Melinda Allen, who went by the name of "Mindy." The officer went to the health club where Allen worked to arrest her for outstanding warrants. In the health club, he asked for a girl named "Mindy." A girl came out and identified herself as "Mindy," and protested the claim that she wrote any hot checks. Her appearance was substantially similar to the description given to the officer by the dispatcher. She gave him her driver's license, which the officer put in his pocket. He arrested the girl and took her down to jail, where it was subsequently discovered that she was not the right person. The court found that the officer acted reasonably and was entitled to qualified immunity. (See section discussing "qualified immunity").[13]

ii. Warrantless Arrest:

A. Section 1983 claims for warrantless arrests are based most commonly on the assertion that the warrantless arrest was not based on probable cause.[14] The authority of a peace officer to arrest without a warrant in Texas is set forth in Chapter 14 of the Texas Code of Criminal Procedure; however, violations of state law under Chapter 14 will not be actionable under Section 1983 if no other constitutional violation is alleged.[15]

B. A court will probably evaluate whether an officer had probable cause to arrest without a warrant based upon the "totality of the circumstances" test set forth in *Illinois v. Gates*.[16] This will be based upon an objective standard of whether probable cause existed to arrest. In other words, even if the officer lacks the subjective belief that

---

[12] *Tillman v. Coley*, 886 F. 2d 317 (11th Cir. 1989).

[13] *Blackwell v. Barton*, 34 F. 3d 298 (5th Cir. 1994).

[14] POLICE CIVIL LIABILITY, *supra.*, sec. 8.06[2].

[15] POLICE CIVIL LIABILITY, *supra.*, sec. 8.06[2][f].

[16] MUNICIPAL LIABILITY, supra., sec. 8.23.

probable cause existed to arrest, there may be an objective finding by the court that probable cause existed.[17] It is interesting to note, however, that the Supreme Court has never quantified the degree of certainty required for a determination of probable cause.[18]

C. If, based upon the objective evidence of the information available to the police officer at the time of the arrest, there was probable cause to make the arrest, there is no liability under Section 1983.[19]

e.g. The plaintiff was walking back to his house when the officer stopped him and asked him for his name. The plaintiff gave the officer his name and at that point, the officer proceeded to arrest the plaintiff for disorderly conduct. At trial, the officer could not give any testimony to contradict the plaintiff's claim. The court found that probable cause did not exist to arrest since the actions of plaintiff did not fit into any of the definitions of disorderly conduct enumerated in the Texas Penal Code. The court awarded damages to the plaintiff.[20]

Compare. Officers developed probable cause to arrest based upon the following factors: (1) suspect visited the grave one year after the murder - this action fit the FBI psychological profile; (2) suspect was identified by two people who saw him at the apartment the same day of the crime; (3) witness admitted to seeing the suspect at the apartment complex that day; (4) suspect rinsed the sink in the police station in same manner that the killer had done at the apartment; (5) suspect matched the physical description given by the witnesses; (6) suspect had parka similar to one worn by offender; (7) suspect's alibi conflicted with other witnesses; (8) suspect came to class emotionally upset; (9) lab reports of blood and saliva did not rule out suspect; and (9) wires used to tie up the victim were available to suspect at school. The court found that the police officers had enough probable cause to make a warrantless arrest, so there was no liability present pursuant to Section 1983. (NOTE - in Texas, the officers would have needed a warrant because the circumstances permitting the warrantless arrest in this case are not provided for in Chapter 14 of the Texas Code of Criminal Procedure.)[21]

b. Excessive force:

---

17 *See Simmons v. Pryor*, 26 F. 3d 650 (7th Cir. 1994), *cert. granted*, 114 S. Ct. 1833 (1994).

18 *Greene v. Reeves*, 80 F. 3rd 1101, 1105 (6th Cir. 1996).

19 MUNICIPAL LIABILITY, *supra.*, sec. 8.23.

20 *Vela v. White*, 703 F. 2d 147 (5th Cir. 1983).

21 *Simkunas v. Tardi*, 930 F. 2d 1287 (7th Cir. 1991).

- defined as the use of force that exceeds the amount of force that is justified in that particular circumstance.

i. Excessive force claims are analyzed under the Fourth Amendment. Excessive force claims, however, are concerned with the manner in which the person is arrested, and not with the justification or reasonableness of the arrest.[22]

ii. Where Fourth Amendment violations are alleged because of the use of excessive force, violations are based on the factual circumstances in each case and no specific intent is required.[23]

iii. To establish an excessive force claim under the Fourth Amendment, the following must be shown: (1) physical injury (but not a *de minimis* claim of injury), which (2) resulted directly and only from the use of force that was clearly excessive to the need; and the excessiveness which was (3) objectively unreasonable.[24]

e.g. A police officer went into a business office looking for a suspect that was involved with in a high speed chase. He entered the office with his nightstick drawn and pushed a pregnant woman into the wall. Two other people entered the room to find out what was happening and the officer pulled his gun. The officer pushed his gun into the throat of one person and the person sustained injuries when he jumped back to avoid the officer's gun. The court found that plaintiff properly stated an excessive force cause of action under Section 1983.[25]

c. Illegal Searches:

- a search conducted without probable cause or proper legal authority.

i. Courts and juries tend to regard illegal searches as heinous violations of the Fourth Amendment (and the Fourteenth Amendment).[26] Likewise, officers conducting illegal searches are liable under Section 1983.[27]

---

22 MUNICIPAL LIABILITY, *supra.*,sec. 8.23; *citing Graham v. Connor,* 490 U.S. 386, 109 S. Ct. 1865 (1989).

23 *Id.*

24 *Hudson v. McMillian,* ___U.S. ___, 114 S. Ct. 995 (1992); *Knight v. Caldwell,* 970 F. 2d 1430 (5th Cir. 1992); *Johnson v. Morel,* 876 F. 2d 477, 480 (5th Cir. 1990).

25 *Mouille v. City of Live Oak,* 918 F. 2d 548 (5th Cir. 1990), *cert. denied,* ___U.S.___, 113 S. Ct. 2443 (1993).

26 MUNICIPAL LIABILITY, *supra.*, sec. 8.25.

27 *Monroe v. Pape,* 365 U.S. 167 (1961).

ii. Section 1983 liability will arise for searches in a variety of circumstances. The following indicates some of the common situations where Section 1983 liability may exist for child abuse investigations: (1) the search conducted by the officer exceeds the scope of the warrant; (2) the officer falsified information on the affidavit for the warrant or the want of probable cause on the warrant was so apparent that the officer should have known that the search warrant lacked probable cause; or (3) in cases of warrantless searches, the justification for the search does not fall within one of the enumerated exceptions to the warrant requirement, i.e., hot pursuit, consent, search pursuant to a lawful arrest, etc.

iii. Even though the evidence may have been suppressed in a criminal case, not all constitutional violations under the Fourth Amendment will lead to recovery under Section 1983. The officer may be entitled to qualified immunity (See "qualified immunity" discussion).[28]

e.g. Sheriff obtained a warrant to dig up a gravel-filled well in search of a body. When the sheriff did not find a corpse, he used the bulldozers to dig up a 3-acre pasture. The court found that the search violated the plaintiff's constitutional rights because the search conducted by the sheriff exceeded the scope of the search warrant and denied the sheriff the use of the qualified immunity defense.[29]

e.g. Officers received a tip that the plaintiff was selling obscene CD-ROMs from his business premise. The judge issued a search warrant to search the plaintiff's premises for pornographic CD-ROMs and "equipment, order materials, membership lists and other paraphernalia" pertaining to the distribution of pornographic material. Officers seized computer equipment from the business, including equipment that accessed a bulletin board where the plaintiff could have received the illegal CD-ROMs. The plaintiff was convicted for distributing and possessing obscene material. The plaintiff sued under Section 1983 on the basis that the search and seizure of his computer system violated the Fourth Amendment because the warrant was not sufficiently particular to seize the computer equipment. The court found that there was no Fourth Amendment violation because the warrant properly specified what the officers were to seize. Moreover, the warrant was not overbroad because the warrant was only directed to equipment related to the criminal activity. Therefore, there was no Fourth Amendment violation.[30]

---

28 POLICE MISCONDUCT, *supra.* sec. 2.3(e)(1).

29 *Husband v. Bryan*, 946 F. 2d 27 (5th Cir. 1991).

30 *Davis v. Gracey*, 111 F. 3rd 1472 (10th Cir. 1997).

3. **Failure to investigate/failure to provide police protection:**

a. Generally, litigation under Section 1983 based upon a claim that the officer failed to adequately investigate complaints of child abuse usually will not succeed. The United States Supreme Court has ruled that the state's failure to protect an individual from violence does not constitute a violation of the due process clause because the constitution imposes no duty to protect its citizens against the harm or invasion of private actors.[31]

e.g. Court awarded custody of son to father. There were many indications that the father was abusing his son, including complaints from the father's second wife and a hospital visit where the physician suspected the child was abused. The Child Welfare Department temporarily took custody of the child, but returned the child to the father on the condition that he receive counseling and that his girlfriend move out. The child was sent to the hospital again, but the Department did not do anything. Finally, the child was hospitalized with permanent brain damage and the father was arrested. The Court found that there was no Section 1983 action for violating the due process clause because the due process clause is designed to protect the people from the state, and does not require the state to protect people from other people. Therefore, the Constitution does not impose an affirmative duty upon the state to come to the aid of others.[32]

b. However, if the officer takes some type of affirmative action that places a person in danger, then liability under Section 1983 may exist.

e.g. Police arrested the driver of a vehicle and left the woman passenger to find her way home in a high crime area. Woman was raped. She sued under a Section 1983 cause of action. The court found that she had validly stated a cause of action under Section 1983.[33]

3. **Malicious prosecution:**

- defined as a prosecution instituted against a person that is begun with malice and without probable cause to believe the charges

---

31 *See DeShaney v. Winnebago County Department of Social Services,* 489 U. S. 189 (1989). Some legal texts believe that the increasing concern about child abuse and battered spouses is reflected in recent decisions against police for their failure to protect such persons where there is a restraining order or a documented history of previous assaults. *See* POLICE MISCONDUCT, *supra.*, sec. 2.3(1)(2). This appears to contradict the holding in *DeShaney*. Therefore, we will have to await further case law that clarifies the issue.

32 *Id.*

33 *Wood v. Ostrander,* 879 F. 2d 583 (9th Cir. 1989), *cert. denied,* 498 U.S. 938, 110 S. Ct. 507 (1990).

could be sustained.[34]

a. A plaintiff must show five elements to be successful on a malicious prosecution claim:

1) the defendant attempted to start a criminal action against the plaintiff;
2) without probable cause;
3) the prosecution must end in the plaintiff's favor;
4) the defendant acted maliciously; and
5) the plaintiff suffered actual damages.

b Recently, the U.S. Supreme Court found that a malicious prosecution claim will not exist for a Section 1983 action based on an alleged violation of the plaintiff's Fourteenth Amendment right. The Court left open the question of whether a malicious prosecution claim could be brought under the Fourth Amendment.[35] More than likely, however, malicious prosecution will be brought as a state claim, rather than as a Section 1983 cause of action.

4. Illegal interrogation:

- defined as a statement obtained in violation of a person's Fifth Amendment rights.

a. Illegal interrogations are actionable under Section 1983 as a violation of a person's Fifth Amendment rights. Section 1983 liability usually occurs in situations where (1) the confession was taken in violation of *Miranda v. Arizona* and the statement was used against the defendant in a criminal proceeding; or (2) the confession is coerced or involuntary.[36]

b. Police conduct of undue coercion can lead to a cause of action under Section 1983 under the assertion that such action violated the Fifth and Fourteenth Amendments' prohibitions against self-incrimination.

eg. The victim alleged that the defendant sexually assaulted him when he was staying at the defendant's house. The detectives investigating the offense went to the defendant's house to question him. Although the detectives had enough probable cause to arrest the defendant, they did not obtain a warrant. Moreover, the detectives did not read the defendant his *Miranda* rights prior to questioning him. The defendant

---

34 BLACK'S LAW DICTIONARY 864 (5th ed. 1979).

35 *See Albright v. Oliver*, ___U.S.___, 114 S. Ct. 807 (1994).

36 POLICE CIVIL LIABILITY, *supra.*, sec. 8.06[8].

alleged that the detectives intimidated him while they were questioning him at his home. The detectives did not give the defendant his *Miranda* rights until the interview was completed. One of the detectives later testified to the statements given by the defendant in a grand jury proceeding. The court found that this constituted a violation of the defendant's Fifth Amendment right.[37]

C. **Defense to Section 1983:**

1. Qualified immunity:

a. A police officer will be entitled to a defense of qualified immunity to a Section 1983 claim if it can be shown that a reasonably well-trained officer would not have known that his conduct would violate the plaintiff's constitutional rights.[38] The right the officer is alleged to have violated must have been clearly established at the time that the conduct occurred.[39]

b. This means that an officer's conduct may be judged on the basis that the conduct was objectively reasonable, even though the conduct was in fact unconstitutional.[40] Thus, even though the officer may have acted in violation of a constitutional right, he will be entitled to qualified immunity if the officer's actions were reasonable.

e.g. A student organization from a university held a party at a hotel. A woman reported to the police that she was sexually assaulted at the party several months later. An investigator from the police department was assigned to investigate the incident. While interviewing the witnesses, the investigator made comments to the witnesses that: "that the incident did not seem like rape", "the victim had the hots for the alleged offender", "there is only so much provocation a person can take", and "that the victim, offender, and third person had a love triangle." One witness commented that the investigator asked her offensive questions, such as if she would bite someone if forced to give a blow job. The victim sued under Section 1983 and for violations of state law for invasions of privacy due to the investigator's comments. The court found that the investigator was entitled to qualified immunity because the investigator did

---

[37] *Weaver v. Brenner*, 40 F. 3rd 527 (2nd Cir. 1994).

[38] *Anderson v. Creighton*, 483 U.S. 635 (1987).

[39] *Cantu v. Rocha*, 77 F. 3rd 795, 806 (5th Cir. 1996).

[40] *See Mouille v. City of Live Oak*, 918 F. 2d 548 (5th Cir. 1990), *cert. denied*, ___U.S.___, 113 S. Ct. 2443 (1993).

not tell the witnesses anything the witnesses did not know about the complainant. The court also noted that law enforcement should be allowed latitude to explore reasonable inferences raised by what witnesses offer in an investigatory context. Therefore, the investigator was entitled to qualified immunity.

e.g. Plaintiffs were drinking beer on railroad property where "no trespassing" signs were posted. Officers requested that the plaintiffs leave. One refused and was arrested for criminal trespass. Others were arrested for disorderly conduct when they became disruptive from the actions of the officers. The court applied the qualified immunity defense to plaintiffs' claims of false arrest because the court determined that the officers acted in an objectively reasonable manner.[41]

II. State law claims:

A. State law causes of action, and claims under Section 1983, are frequently joined.[42] When a deprivation of a constitutional right cannot be demonstrated under Section 1983, there may be an alternative remedy available in state court.[43] Therefore, an officer may be subject to liability for allegations of false arrest, illegal searches, excessive force, etc. under violations of state law.[44]

1. Under state law, the officer can also be subject to negligence claims, as well as other claims such as defamation and invasion of privacy.

2. Most of the causes of action asserted against the government and its employees under state law are subject to the Texas Tort Claims Act ("TTCA"). Therefore, in order to be actionable, there must be a waiver of liability under the TTCA. Moreover, even if there is a waiver of liability under the TTCA, the officer may be entitled to the defense of official immunity, as discussed in the next section.

B. **Defense:** Official or qualified immunity (these terms are used interchangeably in state law):

1. Typically, when the liability of a government officer or employee is in question, the doctrine of official or qualified immunity should be utilized.[45] To the extent that individual liability exists, government

---

41 *Pfannstiel v. City of Marion*, 918 F. 2d 1178 (5th Cir. 1990).

42 *Travis v. City of Mesquite*, 830 S.W. 2d 94, 100 ft. 2 (Tex. 1992).

43 POLICE MISCONDUCT, *supra*., sec. 2.3.

44 *See* TEX. CRIM. CODE PROC. arts. 1.04, 1.06 (West 1994).

45 *Copeland v. Boone*, 866 S.W. 2d 55, 58 (Tex. App.-San Antonio 1993, dism'd w.o.j.).

officials and employees may be entitled to official immunity.[46]

2. Official immunity is established by showing the following factors:

i. the official was performing a discretionary duty;
ii. in good faith; and
iii. acting within the scope of his or her authority.[47]

Courts have found that officers are performing a discretionary duty when an officer is investigating an offense.[48] Likewise, courts have determined that the officer's good faith will be evaluated on a standard of the whether the reasonably prudent officer would have acted in the same manner.[49] This standard is substantially the same as the test that is used for the qualified immunity defense in Section 1983 cases.

3. The granting of official immunity evolved out of the public policy that encouraged public officers to carry out their duties without fear of personal liability.

What do I do when my investigation becomes the center of a civil dispute?

The determination of what to do when a child abuse investigation becomes the center of a civil dispute between the child and the child-care facility depends on whether the investigation involving the child is on-going or completed. If the investigation is on-going, then most of the information contained in the file should be privileged from disclosure. On the other hand, if the investigation is completed, the information contained in the file becomes more difficult to protect from disclosure.

The officer will probably become aware that a civil suit has been filed when he receives either a subpoena for a copy of the entire investigative file or a request for a copy of the entire file made under the Public Information Act (formerly the Texas Open Records Act). The following will explain what information, if any, can be protected from disclosure for a request made (1) under the Public Information Act; and/or (2) from a subpoena duces tecum issued in relation to the civil dispute.

I. Request for a copy of the entire investigative file under the Public Information Act:

A. On-going investigations:

---

46 *City of Houston v. Newsom*, 858 S.W. 2d 14, 17 (Tex. App.-Houston[14th Dist.] 1993, no writ).

47 *Id.*

48 *Cantu v. Rocha*, 77 F. 3rd 795 (5th Cir. 1996).

49 *City of Lancaster v. Chambers*, 883 S.W. 2d 650, 656 (Tex. 1994).

1. Information contained in a child abuse investigation, including sexual assault cases involving children, is confidential by law pursuant to Section 261.201 of the Texas Family Code. Therefore, the Texas Attorney General's Office has held that this information may be withheld from disclosure.

2. Moreover, information contained in law enforcement files, except for front page offense and arrest report information, is currently exempt from disclosure under Section 552.108 of the Texas Public Information Act.[50] Section 552.108 was recently amended, however, by the 75th Texas Legislature. On September 1, 1997, information will be protected from public disclosure under Section 552.108 only if:

> a. release of the information would interfere with the detection, investigation, or prosecution of a crime;
> b. it is information that deals with the detection, investigation, or prosecution of crime only in relation to an investigation that did not result in conviction or deferred adjudication;
> c. it constitutes work-product of the attorney representing the state in the criminal action.[51]

A copy of the new legislation has been attached for your review. Please note, however, that under the new law, active investigations still remain exempt from disclosure.

3. The identities of complaining juvenile victims in serious sexual offenses must be withheld from the front page of an offense report on the basis of common-law privacy; and in limited circumstances, constitutional privacy may protect the identities of juvenile victims of other types of crimes (although the Texas Attorney General's Office has not specified the types of crimes that warrant the withholding of a juvenile victim's name on the basis of constitutional privacy).[52]

4. The name of a sexual assault or aggravated sexual assault victim may also be withheld pursuant to Article 57.02 of the Texas Code of Criminal Procedure; *however,* in order to be entitled to the confidentiality provisions of Section 57.02, the victim must elect to use a pseudonym. If the victim does not use a pseudonym, then the provisions of Article 57.02 do not protect the disclosure of the name. The name of the juvenile victim may still be protected from disclosure, however, as discussed above.

---

50 *Holmes v. Morales*, 924 S.W. 2d 920 (Tex. 1996).

51 Tex. H.B. 951, 75th Leg. (1997).

52 Tex. Att'y Gen. ORD-628 (1994).

B. Closed or suspended[53] cases:

1. Again, information contained in a child abuse investigation, including sexual assault cases involving children, is confidential by law pursuant to Section 261.201 of the Texas Family Code. Therefore, the Texas Attorney General's Office has held that this information may be withheld from disclosure.

2. Furthermore, as discussed above, information contain in law enforcement files is currently exempt from disclosure pursuant to Section 552.108 of the Texas Public Information Act.[54] On September 1, 1997, however, information will be protected from public disclosure under Section 552.108 only if:

a. release of the information would interfere with the detection, investigation, or prosecution of a crime;
b. it is information that deals with the detection, investigation, or prosecution of crime only in relation to an investigation that did not result in conviction or deferred adjudication;
c. it constitutes work-product of the attorney representing the state in the criminal action.[55]

Therefore, information in closed cases will be exempt from disclosure only if the release of the information will interfere with the detection, investigation, or prosecution of a crime or the investigation did not result in a conviction or deferred adjudication. Please remember, however, that child abuse investigation still remain confidential by law pursuant to Section 261.201 of the Texas Family Code.

2. The following information may also be withheld from disclosure:

a. The names of juvenile victims in sexual offense cases by either a claim of common-law privacy or the use of a pseudonym pursuant to Article 57.02 of the Texas Code of Criminal Procedure.

b. If a lawsuit or a claim has been filed against the city or the officer that relates to the child abuse investigation conducted by the officer, then portions of the file may be protected from disclosure pursuant to Section 552.103 of the Texas Government

---

53 The use of the term "suspended cases" refers to old cases that the police department has determined there is little chance that the case will be completed.

54 *Holmes*, 924 S.W. 2d 920.

55 Tex. H.B. 951, 75th Leg. (1997).

Code. Section 552.103 protects from disclosure information relating to litigation of a civil or criminal nature if the city or the officer is a party.

C. Other types of information that may be withheld from disclosure under the Public Information Act:

1. information in the file that relates to a juvenile suspect, prior to January 1, 1996.[56] After January 1, 1996, juvenile information held by law enforcement agencies is public information.[57]
2. confidential informant information.[58]
3. the names of witnesses, if such release might subject the witness to retaliation or harassment, i.e., offense is gang-related.[59]
4. medical records.[60]
5. results of a polygraph examination.[61]
6. criminal history information.[62]

NOTE: assertions that information contained in the investigative file is protected from disclosure under the Public Information Act must be submitted in writing to the Texas Attorney General's Office within 10 days of the receipt of the request by the governmental body.[63] Otherwise, any objection to the release of the information is waived and the information is presumed to be public information.[64] Therefore, an officer seeking to withhold the information from disclosure should contact the police legal advisor or the city attorney's office and inform them that a letter to the Texas Attorney General's office needs to be written prior to the 10-day deadline.

II. Request for the entire investigative file made by a subpoena duces tecum:

A. On-going investigations:

1. Generally, the information contained in a police file that is under active investigation should be protected from disclosure pursuant to Article 39.14 of the Texas Code of Criminal Procedure and Rule 166b(3)(a) of the Texas Rules of Civil Procedure. Police reports and

---

56 TEX. FAM. CODE sec. 51.14 (West 1994)(repealed now TEX. FAM. CODE sec. 58.007).

57 TEX. ATT'Y GEN. ORD-644 (1996).

58 TEX. R. CRIM. EVID. 508 (West 1994).

59 Tex. Att'y Gen. ORD-628 (1994).

60 TEX. REV. CIV. STAT. art. 4495b, sec. 5.08 (Vernon Supp. 1995).

61 TEX. REV. CIV. STAT. art. 4413(29cc), sec. 19A (Vernon Sup. 1995).

62 TEX. GOV'T CODE sec. 411.083 (Vernon Supp. 1995).

63 TEX. GOV'T CODE sec. 552.301 (Vernon 1994).

64 TEX.GOV'T CODE sec. 552.30 (Vernon 1994).

offense reports are protected from disclosure pursuant to Article 39.14 of the Texas Code of Criminal Procedure, because such reports are developed for use by the District Attorney's Office in the prosecution of criminal cases and, as such, qualify as the work product of counsel.[65] This privilege has also been recognized by the United States Supreme Court.[66]

2. Although the above case law exists to protect active investigations from disclosure, many civil judges who do not have experience with criminal cases may not recognize the above privilege and order the release of the information. Therefore, there is no guarantee that the information will not be ordered to be released by a judge, even though it is still an active investigation.

3. Information contained in a child abuse investigation, including sexual assault cases involving children, is confidential by law pursuant to Section 261.201 of the Texas Family Code. The court may release this information to the parties, however, if a motion has been filed with the court, notice of hearing has been served on all parties, and the court determines that the information is essential to the administration of justice and not likely to endanger the safety of the child, the person making the report, or any witnesses.

3. Also, as discussed above, if the juvenile victim of a sexual assault crime uses a pseudonym as set forth in Article 57.02 of the Texas Code of Criminal Procedure, then the name of the victim may be withheld from disclosure. This may be a moot point, however, if the juvenile victim is the one asserting the lawsuit against the facility. Even if the victim is a party to the civil suit, however, I would still attempt to obtain a release from the victim before I release the name to the party requesting the subpoena, unless it is the juvenile victim who is requesting the information.

B. Completed or suspended investigations:

1. Again, information contained in a child abuse investigation,

---

[65] *See Holloway v. State*, 525 S.W. 2d 165, 169 (Tex. Crim. App. 1975); *Garcia v. State*, 495 S.W. 2d 257, 259 (Tex. Crim. App. 1973); *Brem v. State*, 571 S.W. 2d 314, 322 (Tex. Crim. App. 1978); *Haywood v. State*, 507 S.W. 2d 756, 759 (Tex. Crim. App. 1974); *Bradshaw v. State*, 482 S.W. 2d 233, 235 (Tex. Crim. App. 1972).

[66] *United States v. Nobles*, 422 U. S. 225, 95 S. Ct. 2160, 2169-2170, 45 L. Ed. 2d 141 (1975), wherein the Court stated:

> Although the work-product doctrine most frequently is asserted as a bar to discovery in civil litigation, its role in assuring the proper functioning of the criminal justice system is even more vital. The interests of society and the accused in obtaining a fair and accurate resolution of guilt or innocence demand that adequate safeguards assure the thorough preparation and presentation of each side of the case. *Id*. at 2170.

including sexual assault cases involving children, is confidential by law pursuant to Section 261.201 of the Texas Family Code. The court may release this information to the parties, however, if a motion has been filed with the court, notice of hearing has been served on all parties, and the court determines that the information is essential to the administration of justice and not likely to endanger the safety of the child, the person making the report, or any witnesses.

2. If the file is released through the above procedure, the following information may still be withheld from disclosure:

1. information in the file that relates to a juvenile suspect prior to January 1, 1996.[67]
2. confidential informant information.[68]
3. medical records.[69]
4. results of a polygraph examination.[70]
5. criminal history information.[71]

D. Process once an officer receives a subpoena duces tecum:

1. Contact the police legal advisor or a city attorney and inform him/her of your receipt of the subpoena. Notify the attorney of any information you believe should be withheld from disclosure.

2. The attorney should then file a motion to quash the subpoena in court. The filing of the motion to quash must be done prior to the time the records are to be produced, or any objections to the release of the information are waived.[72]

3. The court should then set the motion for hearing and make a determination whether the information requested in the subpoena duces tecum should be released.

III. Subpoenas for depositions of the officer who conducted the investigation:

A. Generally, a subpoena issued to an officer requesting that he or she give a deposition regarding the investigation of a child abuse case will be subject to the same guidelines as that set forth for a subpoena duces tecum for the

---

67 TEX. FAM. CODE sec. 51.14 (West 1994).

68 TEX. R. CRIM. EVID. 508 (West 1994).

69 TEX. REV. CIV. STAT. art. 4495b, sec. 5.08 (Vernon Supp. 1995).

70 TEX. REV. CIV. STAT. art. 4413(29cc), sec. 19A (Vernon Supp. 1995).

71 TEX. GOV'T CODE sec. 411.083 (Vernon Supp. 1995).

72 TEX. R. CIV. P. 177a (West 1995).

investigative file. In other words, if the case is still active, then the information that the officer could testify to is privileged from disclosure, as discussed above. Therefore, the officer should contact an attorney to file a motion to quash the subpoena requesting the officer's deposition.

B. On the other hand, if the case is closed, then the information that the officer could testify may be subject to disclosure if the process set forth in Section 261.201 of the Texas Family Code is satisfied. The officer should still contact an attorney, however, to determine whether the officer should give testimony regarding the identification of a juvenile victim in a sexual offense case. Moreover, if there is information contained in the file that is confidential, as discussed in (I)(C) and (II)(C), then an attorney should be contacted to file a motion to quash the subpoena in an effort to protect the confidential information.

C. Finally, always be aware that in a civil suit arising from a police investigation for child abuse, one side to the litigation will probably attempt to discredit your investigation for the benefit of his client. Therefore, be prepared to answer some adverse questions regarding your investigation.

OTHER TYPES OF QUESTIONS THAT MIGHT BE ASKED BY OFFICERS:

Do I have to release my investigative notes under the Texas Open Records Act or if I receive a subpoena duces tecum for my investigative file?

Unless the information contained in the file can be protected from disclosure, as discussed above, the officer will have to release his investigative notes when he releases the investigative file. The investigative notes are considered part of the file and cannot be protected from disclosure, except as discussed.

Should I take a lot of notes when I am conducting an investigation, especially since my notes may become public information?

Generally, it is a good idea to document everything you have done in an investigation. As time passes, it will be more difficult to remember what you did on an investigation and the notes may help refresh your memory. This is important because the discovery process for civil disputes takes a long time and therefore, the parties may not take your deposition until two to three years after the investigation is completed. Also, careful note taking will help dispel any disputes as to whether or not you did something during an investigation because your actions will be documented; however, keep in mind that what you are writing in your notes may become public information sometime in the future.

Can I release criminal history information to persons who are not law enforcement officers?

No. Criminal history information is confidential by law.[73] Moreover, many contracts between TCIC/NCIC and law enforcement agencies limit the use of criminal history information for "law enforcement purposes" only. A person can get local criminal history information under the Texas Public Information Act.

CONCLUSION:

The purpose of this paper was to give the officer an idea of what type of liability may confront him or her while the officer is conducting a child abuse investigation. Also, the paper hopefully apprised the officer of what to do when a civil dispute between the child and a facility arises and the findings contained in the police investigation are essential to the civil suit. Should questions arise that are not covered by this paper, the officer should contact an attorney for guidance.

---

[73] TEX. GOV'T CODE sec. 411.083 (Vernon Supp. 1995).

H.B. 951
75TH TEXAS LEGISLATURE

AN ACT

relating to the Texas open records law.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section **552.108**, Government Code, is amended to read as follows:

Sec. **552.108**. EXCEPTION: CERTAIN LAW ENFORCEMENT AND PROSECUTORIAL INFORMATION. (a) Information held by a law enforcement agency or prosecutor that deals with the detection, investigation, or prosecution of crime is excepted from the requirements of Section 552.021 if:

(1) release of the information would interfere with the detection, investigation, or prosecution of crime;

(2) it is information that deals with the detection, investigation, or prosecution of crime only in relation to an investigation that did not result in conviction or deferred adjudication; or

(3) it is information that:

(A) is prepared by an attorney representing the state in anticipation of or in the course of preparing for criminal litigation; or

(B) reflects the mental impressions or legal reasoning of an attorney representing the state.

(b) An internal record or notation of a law enforcement agency or prosecutor that is maintained for internal use in matters relating to law enforcement or prosecution is excepted from the requirements of Section 552.021 if:

(1) release of the internal record or notation would interfere with law enforcement or prosecution;

(2) the internal record or notation relates to law enforcement only in relation to an investigation that did not result in conviction or deferred adjudication; or

(3) the internal record or notation:

(A) is prepared by an attorney representing the state in anticipation of or in the course of preparing for criminal litigation; or

(B) reflects the mental impressions or legal reasoning of an attorney representing the state.

(c) This section does not except from the requirements of Section 552.021 information that is basic information about an arrested person, an arrest, or a crime.

SECTION 2. Section 552.221(d), Government Code, is amended to read as follows:

(d) If an officer for public information cannot produce public information for inspection or duplication within 10 business [~~calendar~~] days after the date the information is requested under Subsection (a), the officer shall certify that fact in writing to the requestor and set a date and hour within a reasonable time when the information will be available for inspection or duplication.

SECTION 3. Section 552.230, Government Code, is amended to read as follows:

Sec. 552.230. RULES OF PROCEDURE FOR INSPECTION AND COPYING OF PUBLIC INFORMATION. (a) A governmental body may promulgate reasonable rules of procedure under which public information may be inspected and copied efficiently, safely, and without delay.

(b) A rule promulgated under Subsection (a) may not be inconsistent with any provision of this chapter.

SECTION 4. Subchapter F, Chapter 552, Government Code, is amended to read as follows:

SUBCHAPTER F. CHARGES FOR PROVIDING [~~COST OF~~] COPIES OF PUBLIC INFORMATION

Sec. 552.261. CHARGE FOR PROVIDING [~~DETERMINING COST OF~~] COPIES OF PUBLIC INFORMATION. (a) The charge for providing [~~cost of obtaining~~] a copy of public information shall be an amount that reasonably includes all costs related to reproducing the public information, including costs of materials, labor, and overhead. If a request is for 50 or fewer pages of paper records, the charge for providing the copy of the public information may not include costs of materials, labor, or overhead, but shall be limited to the photocopying costs, unless the pages to be photocopied [~~copied~~] are located in:

(1) more than one building; or

(2) a remote storage facility.

(b) If the charge for providing a copy of public information includes costs of labor, the requestor may require the governmental body's officer for public information or the officer's agent to provide the requestor with a written statement as to the amount of time that was required to produce and provide the copy. The statement must be signed by the officer for public information or the officer's agent and the officer's or the agent's name must be typed or legibly printed below the signature. A charge may not be imposed for providing the written statement to the requestor.

[~~Sec. 552.2611.~~] [~~Charges for Public Records by State Agency~~] [~~(a) The General Services Commission by rule shall specify the methods and procedures that a state agency may use in determining the amounts that the agency should charge to recover the full cost to the agency of providing copies of public records under this chapter.~~]

[~~(b) Each state agency by rule shall specify the charges the agency will make for copies of public records. A state agency may establish a charge for a copy of a public record that is equal to the full cost to the agency of providing the copy.~~]

[~~(c) A state agency shall pay to the comptroller for deposit in an unobligated account designated by the comptroller in the general revenue fund all money collected by the agency for providing copies of public records.~~]

[~~(d) Of the total amount of money deposited in the general revenue fund under Subsection (c), the comptroller may transfer 25 percent of the money collected for providing copies of mailing lists and 15 percent of the money collected for providing copies of other public records to the general revenue fund.~~]

[~~(e) The comptroller shall adopt rules to administer Subsections (c) and (d).~~]

[~~(f) In this section, "state agency" has the meaning assigned by Section 1.02, State Purchasing and General Services Act (Article 601b, Vernon's Texas Civil Statutes).~~]

Sec. 552.262. Rules of the General Services Commission. (a) The General Services Commission shall adopt rules for use by each governmental body in determining charges for providing copies of public information under this subchapter. The rules adopted by the General Services Commission shall be used by each governmental body in determining charges for providing copies of public information, except to the extent that other law provides for charges for specific kinds of public information. The charges for providing copies of public information may not be excessive and may not exceed the actual cost of producing the information. A governmental body, other than an agency of state government, may determine its own charges for providing copies of [~~producing~~] public information but shall not charge an amount that is greater [~~more~~] than [~~e~~] 25 percent more than the amount [~~variance from the rules~~] established by the General Services Commission unless the governmental body requests an exemption under Subsection (c).

(b) The rules of the General Services Commission shall prescribe the methods for computing the charges for providing copies of public information in paper, electronic, and other kinds of media. The rules shall establish costs for various components of charges for providing copies of public information that shall be used by each governmental body in providing copies of public information.

(c) A governmental body may request that it be exempt from part or all of the rules adopted by the General Services Commission for determining charges for providing copies of public information. The request must be made in writing to the General Services Commission and must state the reason for the exemption. If the General Services Commission determines that good cause exists for exempting a governmental body from a part or all of the rules, the commission shall give written notice of the determination to the governmental body within 90 days of the request. On receipt of the determination, the governmental body may amend its charges for providing copies of public information according to the determination of the General Services Commission.

(d) The General Services Commission shall publish annually in the Texas Register a list of the governmental bodies that have authorization from the General Services Commission to adopt any modified rules for determining the cost of providing copies of public information.

(e) The rules of the General Services Commission do not apply to a state governmental body that is not a state agency for purposes of Subtitle D, Title 10.

Sec. 552.263. Bond for Payment of Costs or Cash Prepayment for Preparation of COPY OF Public Information. (a) An officer for public information or the officer's agent may require a deposit or bond for payment of anticipated costs for the preparation of a copy of public information if the charge for providing the copy of the public information specifically requested by the requestor is estimated by the governmental body to exceed $100.

(b) The officer for public information or the officer's agent may not require a deposit or bond be paid under Subsection (a) as a down payment for copies of public information that the requestor may request in the future.

Sec. 552.264. Copy of Public Information Requested by Member of Legislature. One copy of public information that is requested from a state agency by a member of the legislature under Section 552.008 [~~in the performance of the member's duties~~] shall be provided without charge.

Sec. 552.265. CHARGE FOR Certified Record Provided by District or County Clerk. The charge for providing a copy made by [~~in~~] a district or county clerk's office shall [~~may not~~] be [~~more than the actual cost of copies, as provided by Sections 552.261 and 552.262, unless a certified record,~~] the charge provided [~~cost of which is set~~] by law[~~, is requested~~].

Sec. 552.266. CHARGE FOR Copy of Public Information Provided by Municipal Court Clerk. The charge for providing a copy made by a municipal court clerk shall be the charge provided by municipal ordinance.

Sec. 552.267. Waiver or Reduction of CHARGE [~~FEE~~] FOR PROVIDING Copy of Public Information. (a) A governmental body shall provide [~~furnish~~] a copy of public information without charge or at a reduced charge if the governmental body determines that waiver or reduction of the charge [~~fee~~] is in the public interest because providing the copy of [~~furnishing~~] the information primarily benefits the general public.

(b) If the cost to a governmental body of processing the

collection of a charge for providing a copy of public information will exceed the amount of the charge, the governmental body may waive the charge.

Sec. 552.268. Efficient Use of Public Resources. A governmental body shall make reasonably efficient use of supplies and other resources to avoid excessive reproduction costs.

Sec. 552.269. Overcharge or Overpayment for COPY OF Public Information. (a) A person who believes the person has been overcharged for being provided with a copy of public information may complain to the General Services Commission in writing of the alleged overcharge, setting forth the reasons why the person believes the charges are excessive. The General Services Commission shall review the complaint and make a determination in writing as to the appropriate charge for providing the copy of the requested information. The governmental body shall respond to the General Services Commission to any written questions asked of the governmental body by the commission regarding the charges [~~made~~] for providing the copy of the public information. The response must be made to the General Services Commission within 10 days after the date the questions are received by the governmental body. If the General Services Commission determines that a governmental body has overcharged for providing the copy of requested public information, the governmental body shall promptly adjust its charges in accordance with the determination of the General Services Commission.

(b) A person who overpays for a copy of public information because a governmental body refuses or fails to follow the rules for charges adopted by the General Services Commission is entitled to recover three times the amount of the overcharge if the governmental body did not act in good faith in computing the costs.

Sec. 552.270. CHARGE FOR [~~COST OF~~] Government Publication. (a) This [~~The cost provisions of this~~] subchapter does [~~do~~] not apply to a publication that is compiled and printed by or for a governmental body for public dissemination. If the cost of the publication is not determined by state law, a governmental body may determine the charge [~~to be made~~] for providing the publication.

(b) This section does not prohibit a governmental body from providing a publication free of charge if state law does not require that a certain charge be made.

Sec. 552.271. Inspection of PUBLIC INFORMATION IN Paper RECORD if Copy Not Requested. A charge may not be imposed for making available for inspection any public information that exists in a paper record, except that if a requested page contains confidential information that must be edited from the record before the information can be made available for inspection, the governmental body may charge for the cost of making a photocopy [~~copy~~] of the page from which confidential information must be edited. No charge other than the cost of the photocopy [~~copy~~] may be imposed.

Sec. 552.272. Inspection of Electronic Record if Copy Not Requested. (a) In response to a request to inspect information that exists in an electronic medium and that is not available directly on-line to the requestor, a charge may not be imposed for access to the information, unless complying with the request will require programming or manipulation of data. If programming or manipulation of data is required, the governmental body shall notify the requestor before assembling the information and provide the requestor with an estimate of charges that will be imposed to make the information available. A charge under this section must be assessed in accordance with this subchapter.

(b) If public information exists in an electronic form on a

computer owned or leased by a governmental body and if the public has direct access to that computer through a computer network or other means, the electronic form of the information may be electronically copied from that computer without charge if accessing the information does not require processing, programming, or manipulation on the government-owned or government-leased computer before the information is copied.

(c) If public information exists in an electronic form on a computer owned or leased by a governmental body and if the public has direct access to that computer through a computer network or other means and the information requires processing, programming, or manipulation before it can be electronically copied, a governmental body may impose charges in accordance with this subchapter.

(d) If information is created or kept in an electronic form, a governmental body is encouraged to explore options to separate out confidential information and to make public information available to the public through electronic access through a computer network or by other means.

Sec. 552.274 [~~552.270~~]. Report by State Agency on Cost of Copies. (a) Not later than September [~~December~~] 1 of each odd-numbered [~~even-numbered~~] year, each state agency shall provide [~~file a report with~~] the [~~Legislative Budget Board, comptroller, and~~] General Services Commission detailed information, for use by the commission in preparing the report required by Sections 2(c) and (d), Chapter 428, Acts of the 73rd Legislature, Regular Session, 1993, describing the agency's procedures for charging and collecting fees for providing copies of public information [~~records~~].

(b) In this section, "state agency" has the meaning assigned by Sections 2151.002(2)(A) and (C) [~~Sections 1.02(2)(A) and (C), State Purchasing and General Services Act (Article 601b, Vernon's Texas Civil Statutes)~~].

SECTION 5. Section 552.301, Government Code, is amended to read as follows:

Sec. 552.301. REQUEST FOR ATTORNEY GENERAL DECISION. (a) A governmental body that receives a written request for information that it wishes to withhold from public disclosure and that it considers to be within one of the exceptions under Subchapter C must ask for a decision from the attorney general about whether the information is within that exception if there has not been a previous determination about whether the information falls within one of the exceptions. The governmental body must ask for the attorney general's decision and state the exceptions that apply within a reasonable time but not later than the 10th business [~~calendar~~] day after the date of receiving the written request. For purposes of this subchapter, a written request includes a request made in writing that is sent to the officer for public information, or the person designated by that officer, by electronic mail or facsimile transmission.

(b) A governmental body that requests an attorney general decision under Subsection (a) must within a reasonable time but not later than the 15th business [~~calendar~~] day after the date of receiving the written request:

(1) submit to the attorney general written comments stating the reasons why the stated exceptions apply that would allow the information to be withheld;

(2) submit to the attorney general a copy of the written request for information;

(3) submit to the attorney general a copy of the specific information requested, or submit representative samples of

the information if a voluminous amount of information was requested; and

(4) label that copy of the specific information, or of the representative samples, to indicate which exceptions apply to which parts of the copy.

SECTION 6. Section 552.027, Government Code, as added by Chapter 302, Acts of the 74th Legislature, Regular Session, 1995, is renumbered as Section 552.028, Government Code.

SECTION 7. Section 552.124, Government Code, as added by Chapter 219, Acts of the 74th Legislature, Regular Session, 1995, is renumbered as Section 552.125, Government Code.

SECTION 8. Section 552.124, Government Code, as added by Chapter 260, Acts of the 74th Legislature, Regular Session, 1995, is renumbered as Section 552.126, Government Code.

SECTION 9. Sections 552.324 and 552.325, Government Code, as added by Chapter 578, Acts of the 74th Legislature, Regular Session, 1995, are repealed because those sections duplicate the same Government Code sections as added by Chapter 1035, Acts of the 74th Legislature, Regular Session, 1995.

SECTION 10. Section 3, Chapter 428, Acts of the 73rd Legislature, Regular Session, 1993, is repealed.

SECTION 11. (a) This Act takes effect September 1, 1997.

(b) To the extent of any conflict, this Act prevails over another Act of the 75th Legislature, Regular Session, 1997, relating to nonsubstantive additions to and corrections in enacted codes.

(c) The change in law made by this Act to Section 552.108, Government Code, applies to information, records, and notations collected, made, assembled, or maintained on, before, or after the effective date of this Act.

SECTION 12. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

_____ _____

President of the Senate Speaker of the House

I certify that H.B. No. 951 was passed by the House on May 15, 1997, by a non-record vote; that the House refused to concur in Senate amendments to H.B. No. 951 on May 28, 1997, and requested the appointment of a conference committee to consider the differences between the two houses; and that the House adopted the conference committee report on H.B. No. 951 on June 1, 1997, by a non-record vote.

_____

Chief Clerk of the House

I certify that H.B. No. 951 was passed by the Senate, with amendments, on May 23, 1997, by a viva-voce vote; at the request of the House, the Senate appointed a conference committee to consider the differences between the two houses; and that the Senate adopted the conference committee report on H.B. No. 951 on June 1, 1997, by a viva-voce vote.

_____

Secretary of the Senate

APPROVED: _____

Date

_____

Governor