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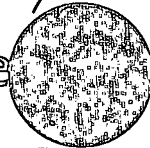
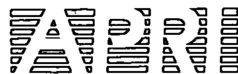
National Center for Prosecution of Child Abuse



TRAINING

Basic Training for Child Abuse Prosecutors



The American Prosecutors Research Institute

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

Program Information

BASIC TRAINING FOR CHILD ABUSE PROSECUTORS

May 29 - June 2, 1990

Criminal Justice Center

Sam Houston State University

Presented by

American Prosecutors Research Institute's

National Center for Prosecution of Child Abuse

in cooperation with

Texas County and District Attorneys Association

Program Goals

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

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

At the end of this seminar, participants will:

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

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

Training Agenda

TUESDAY, MAY 29

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

WEDNESDAY, MAY 30

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

Wednesday, May 30 continued

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

THURSDAY, MAY 31

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

Thursday, May 31 continued

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

FRIDAY, JUNE 1

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

Friday, June 1 continued

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

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

Harry Elias

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

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

Tom Krampitz

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

SATURDAY, JUNE 2

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

The American Prosecutors Research Institute

and

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applaud the support of

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Empress Travel, Falls Church, Virginia

Sam Houston State University

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Texas District and County Attorneys Association

which has made this conference possible.

Basic Training for
CHILD ABUSE PROSECUTORS

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

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Tuesday

Resource Materials

Dynamics of Victimization and Child Development

Presented by
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THE PROCESS OF VICTIMIZATION: THE VICTIMS' PERSPECTIVE

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

Key Words—Prevention, Sexual offenses, Victimization process

INTRODUCTION

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

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

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

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

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

METHOD

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

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

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

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

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

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

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

FINDINGS

The Victims

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

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

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

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

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

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

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

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

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

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

He was like my buddy instead of my stepfather.

At that time I really needed love, and he did love me and told me this. He made me feel like I was really important.

He was my mother's boss at the time. He would come over and we would have a BBQ and things like that. He was a friend of the family. I felt pretty close to him.

I got close to him because I wanted a dad.

We were very close. Everyone would say you are just like your father.

We were really good friends, best friends. After about a month I was over at her house every day from when I woke up until I went to sleep. Before she abused me, we went places, we went shopping.

I thought he was kind of funny, but he was really nice, someone I could talk to, someone who cared about me, cared enough to ask, you know, the questions nobody else did.

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

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

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

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

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

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

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

Verbal warnings included such statements:

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

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

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

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

> He would start putting his hands down my pants. The first time I didn't think it was anything bad because he told me it wasn't. The second time I knew it was bad because I felt gross inside.
> He'd keep searching his pockets, and wanted us to fish for him, my 9-year-old sister and me, and we would fish for him in his pockets. He had real long pants pockets. He used to have treats for us like that.
> When you'd go swimming you put your feet in his hands and (he'd) spring you out of the water. He would be touching me under the water, sticking his fingers.

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

> I didn't know there was anything wrong with it, because I didn't know it was abuse until later. I thought he was showing me affection.
> She had me believing it was a boyfriend/girlfriend relationship.
> I was led to believe it was a teaching process.
> Neat, he's going to teach me now. Now I'm going to be an adult.
> He was teaching me how to do all the stuff so when I got older and got married and stuff, I knew how to keep my body satisfied, and I was too young.

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

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

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

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

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

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

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

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

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

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

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

Child Vulnerability

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

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

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

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

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

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

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

In many instances the child did not initiate the report:

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

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

Current Beliefs

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

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

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

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

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

IMPLICATIONS FOR TREATMENT AND PREVENTION

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

Sexualization

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

Justification

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

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

Cooperation

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

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

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

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

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

Prevention

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

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

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

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

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

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

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

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

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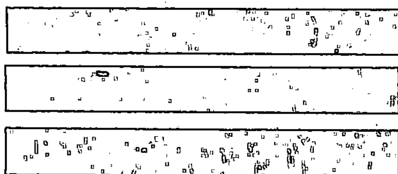
Résumé—On a interrogé 23 enfants; âges de 10 à 18 ans, ayant été victimes de sévices sexuels. Les questions ont porté sur le processus de "victimisation," la personne qui avait abusé d'eux et la manière dont le sévice sexuel aurait pu être évité. Par des questions spécifiques, on a obtenu des renseignements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

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



Resource Materials

The Interdisciplinary Approach to Investigation and Prosecution of Child Abuse

Presented by
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TEAM BUILDING: THE MULTI-DISCIPLINARY APPROACH

I. Objectives

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

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

II. Purpose of Multi-Disciplinary Teams

A. To develop a coordinated approach among important disciplines.

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

B. Types of Teams

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

C. Goals of Team

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

D. Benefits of Multidisciplinary Teams

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

III. General Principles in the Development of a Coordinated System

A. Careful Planning

B. Political Strategizing

C. Psychological Insight

D. Finesse of a Seasoned Diplomat

E. Patience and Tolerance

F. No Single Method Works In Every Community

G. Keep Objectives In Mind Throughout

IV. The Implementation Stages

A. Identify your needs

B. Develop a working group

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

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

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

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

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

C. Methods of avoiding turf battles.

1. Rotate the meeting places.

2. Select a neutral meeting place.

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

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

5. Share publicity and credit for the accomplishments.

D. Idea Formation Process.

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

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

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

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

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

E. Financial Assessment and Feasibility.

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

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

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

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

F. Adjustment.

1. Anticipate an adjustment period.
2. Treat modifications as normal rather than as setbacks.

V. Implementation Planning--A Must

A. Determine who will assign tasks and supervise.

B. Set an implementation schedule with agreed upon deadlines.

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

1. Designate a person to release information to the media.
2. Plan how and when to explain the program to employees.

D. Anticipate and manage resistance.

1. Encourage response, don't discourage objections.
2. Invite interested parties to an open forum.

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

1. A highly visible commitment of resources can thwart pointless conflict.
2. Announcement of the program should be made by the agency head, along with mid-management and on-line supervisors.

F. Develop an evaluation process, now.

1. Two important components of an evaluation are:
   a. An outcome that measures whether the goals have been met.
   b. A process that documents how the program is functioning, specifically naming persons, duties and timetables.
2. Delineate what factors represent a successful program, or a failed one.

VI. Team Orientation/Training

A. Purpose and function of team must be agreed upon

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

C. Team management protocols

D. Legal guidelines

1. CA/N definitions
2. Police holds
3. Reporting mechanism
4. Court process
5. Evidentiary standards
6. Testimony

E. Perspectives on child abuse

   1. National scope and history

   2. Community and state resources

   3. Problems

   4. Statistics

F. Referral/consultation process

   1. Who can refer cases to the team?

   2. Referral criteria

   3. Forms

   4. Reports

G. Format for case staffings

   1. Case selection

   2. Content for presentation

   3. Methods for presentation

H. Group process, decision making, conflict resolution

I. Other concerns of members related to team

VII. Action

A. "Doing the work" of the program.

   1. Frequent meetings should be helpful as members become better acquainted with each other.

   2. Reinforce team-bonding with joint travel training, case resolution.

   3. Minimize turn-over among professionals handling the cases.

      a. Discussions of team development may be needed.

      b. Attendance at training sessions for other disciplines will rapidly acquaint new personnel with another perspective.

B. Case coordination

   1. Confidentiality agreements

   2. Case selection criteria

   3. Referral assessment criteria

      a. Acute/emergency referrals

      b. Non-acute/emergency referrals

      c. CPS/law enforcement notification

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

VIII. Case data base

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

IX. Case conference questions

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

X. Data collection

A. Number of cases referred

B. Number of cases actually staffed

C. Type of services provided

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

E. Diagnosis--type of abuse/neglect

F. Severity of abuse

G. Number of deaths

H. Number of re-abuse cases

I. Age/sex of child

J. Identification of perpetrator

K. Source of referrals

L. Geographic area of referrals

M. Number of children hospitalized

N. Number of out-of-home placements

O. Number of courts involved (civil and criminal)

P. Number of cases opened for CPS service

Q. Number of cases terminated

XI. Supporting the Program

A. Identify affected groups

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

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

XII. Evaluation

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

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

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

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

XIII. Institutionalization

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

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

XIV. Why teams fail

A. Role confusion

B. Power/control issues

C. Lack of mutual respect

D. Lack of participation

E. Lack of flexibility

F. Lack of sense of humor

G. Scheduling problems

H. Absenteeism

I. No leadership

J. Lack of coordination

K. Lack of referrals

L. No feedback on what happens to cases

XV. Why teams succeed

A. Mutual respect

B. Attend to group process

C. Shared decision making

D. Equal participation

E. Communication

F. Agency and community support

G. Commitment of members and agencies

H. Task oriented meetings

I. Logistics of meetings

J. Team training

K. Personalities involved

POINTERS FOR PROSECUTORS IN THEIR ROLE ON MULTI-DISCIPLINARY TEAMS

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

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

   b) establishing and maintaining consistent reporting practices;

   c) providing better quality investigations and eliminating duplication;

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

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

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

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

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

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

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

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

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

   a) training needs and opportunities;

   b) disclosure and reporting procedures;

   c) investigation and court processes; and

   d) counseling and support services.

10. Begin with Law Enforcement Agencies. Inquire:

    a) which agencies perform which investigative functions;

    b) is there overlap; and

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

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

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

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

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

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

Reference Materials

Patterns of Injury in Child Abuse and Homicide

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

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By Appointment Only
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May 29, 1990

Forensic Pathology with special interest in Child Abuse and Neglect

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

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

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

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

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

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PEARLS TO REMEMBER

I. The injuries speak for themselves.

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

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

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

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

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

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

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

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

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

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

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

A. All skin must be incised.

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

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

D. Must examine all cavities and orifices.

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

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

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

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

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

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

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

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

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CASE: MC, 5 Year Old WM

INVESTIGATED BY: Honolulu Police Department

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

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

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

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

This case is presented to illustrate several important points:

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

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

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UPDATE ON CASE: MC, 5 Year Old WM

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

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

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CASE: SL 1 month WF

INVESTIGATED BY: US Air Force OSI

MEDICAL EXAMINER'S OPINION: Child Died of SIDS

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

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

PROBLEMS:

1. There was no rash. The red lesions on the face were very deep abrasions caused by non-accidental trauma.
2. Re-investigation proved that although penicillin had been ordered, the child had never actually taken any.
3. This is not the way an allergic reaction to penicillin occurs.
4. There is inflicted trauma that is confined just to the face.
5. Child is too young for SIDS.
6. SIDS is a diagnosis of exclusion - which includes homicide.
7. Because of the severity of the abrasions, this should be considered overkill.

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

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

Medical examiner was unwilling or unable to exclude accidental trauma.

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

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

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

PROBLEMS:

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

RESULTS:

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

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

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

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

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

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

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CASE: K.S. 15 month WF

INVESTIGATED BY: The FBI

MEDICAL EXAMINER OPINION:

COD: Sudden Infant Death Syndrome

MOD: Natural

Autopsy was incomplete and grossly inaccurate with flagrant misrepresentation.

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

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

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

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

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

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

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

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

UPDATE

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

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

Ronald L. Reeves, M.D.
Forensic Pathologist
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REPLY TO: THE DIRECTOR
ATTN: AFIP-RRR

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

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

DW/jtl
DATE: 15 October 1987

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS:

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

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

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

FRANK B. JOHNSON, M.D.
Associate Director

Review and examination by:

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

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

Reviewed by:

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

AFIP F/L61 1 Jul 84

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Fort Ritchie mother on trial

By CLYDE FORD
Staff Writer

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

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

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

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

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

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

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

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

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

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

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

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

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

THURSDAY, MARCH 10, 1988

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FBI agent says mother admitted killing infant

By Karen E. Warmkessel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The trial is to resume Monday.

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

Army wife Silvia, 19, accused of killing her daughter

By Kelly Gilbert
Evening Sun Staff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By Karen E. Warmkessel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scientific battle ends mother's murder trial

By Kelly Gilbert
Evening Sun Staff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1/1

FRIDAY, MAFCH 18, 1988

Experts disagree on Silvia girl's death

One blames ailment, the other suffocation

By Karen E. Warmkessel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

'irl died of heart failure, witness say!

Hopkins doctor disputes suffocation theory

By Kelly Gilbert
Evening Sun Staff

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

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

utchins, an anatomical patholo-
ınd specialist in pediatric and
ıovascular microscopic re-
h, said he made that conclusion
studying slides of the child's or-
The slides were made last Au-
by Dr. Ronald L. Reeves, a fo-
.c pathologist who did a
.topsy of the body for the FBI.
.eeves testified Monday for the
:cution. He said Kimberly died
ıphyxiation caused by suffoca-
and said her mother, the de-
ıt, probably did it.

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

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

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

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

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

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

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

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

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

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

The trial is scheduled to conti(nue) tomorrow afternoon with Ringl(er's) cross-examination of Hutchins. (The) case could go to the jury for delib(er)ations Friday.

THE SUN

Woman convicted in daughter's slaying

Silvia found guilty on 2nd-degree count

By Karen E. Warmkessel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROBLEMS:

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

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

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

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

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

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

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

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

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

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

9. Pattern of injury speaks for itself.

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

11. Opinions given to investigator by physician were ignored.

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

1. Child was placed in tub of water against his will and was held down against his will.

2. The position he was in in the tub.

3. The temperature of the water relative to the time of exposure.

4. Surface area of burn and angle child was in.

5. Injuries were intentional and nonaccidental.

RESULTS: Babysitter was tried and convicted in Federal Court of Second Degree Murder.

U.S. Department of Justice

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

United States Attorney
District of Guam

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

Overseas Operator
472-7332

May 11, 1983

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

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

Dear Dr. Cowan:

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

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

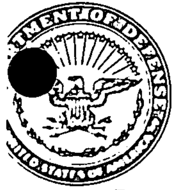
From comments of AUSA Paul Vernier, who handled the case prosecution, and comments of people who listened to Dr. Reeves' testimony, and from my own conversations with him, the above thanks is extremely appropriate.

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

Cordially,

DAVID T. WOOD
United States Attorney
District of Guam

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



DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
TRIPLER AMC, HAWAII 96859

REPLY TO
ATTENTION OF:

June 29, 1983

Department of Pediatrics

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

Dear Colonel Cowan:

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

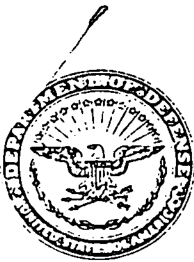
Major Reeves has been here at Tripler Army Medical Center on several occasions over the past year. He has been involved in two cases of child abuse that resulted in death. These cases were not properly referred to the county medical examiner for autopsy and prosecution of the homicide. They were reviewed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

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

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

Sincerely,

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



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

18 JAN 1983

REPLY TO ATTN OF: JA

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

TO: AFIP/CC
Washington DC 20306

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

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

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

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

John A. Arrigo

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

Peace . . . . is our Profession

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

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

<u>INVESTIGATED BY:</u> FBI, Army CID

<u>MEDICAL EXAMINER OPINION:</u> COD: Blunt Head Trauma
MOD: Undetermined

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

<u>PROBLEMS:</u> Won't prosecute without medical examiner's opinion.

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

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

U.S. Department of Justice

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

United States Attorney
District of Maryland

MHK:nbv

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

301/539-2940
FTS/922-4822

July 15, 1983

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

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

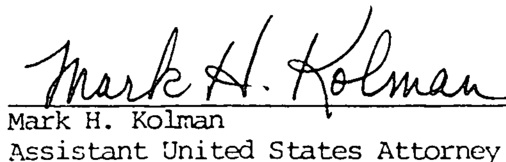
Dear Dr. Reeves:

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

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

Very truly yours,

J. Frederick Motz
United States Attorney

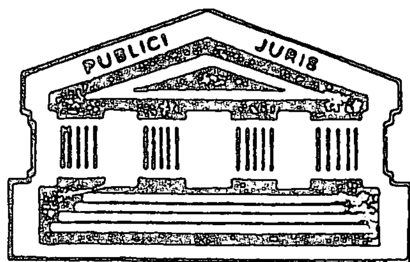


Mark H. Kolman
Assistant United States Attorney

TRIAL COUNSEL

FORUM

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



VOL II, NO. 3 DATE: MARCH 1983

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

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

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

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Issues In Child Abuse/Homicide Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

REPLY TO
ATTENTION OF:

AFZI-JA-MJ

14 March 1983

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

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

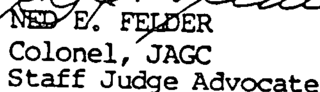
TO: Major Ronald M. Reeves, M.D.
Division of Forensic Pathology
Armed Forces Institute of Pathology
Washington, D.C. 20306

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

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

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

4. Thank you.



NED E. FELDER
Colonel, JAGC
Staff Judge Advocate

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<u>CASE:</u> SM, 2 week WM

<u>INVESTIGATED BY:</u> Naval Investigative Service

<u>MEDICAL EXAMINER'S OPINION:</u> Case NOT referred to Medical Examiner

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

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

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

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

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

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

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

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

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

In reply refer to

4 August 1983

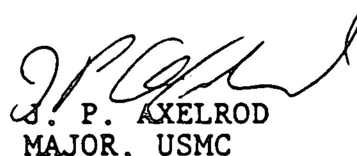
From: Senior Trial Counsel
To: Commanding Officer, Armed Forces Institute of Pathology

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

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

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

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



J. P. AXELROD
MAJOR, USMC

Copy to:
Dr. Reeves

Ronald L. Reeves, M.D.
Forensic Pathologist
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<u>CASE:</u> FW: 10 month old male

<u>INVESTIGATED BY:</u> Naval Investigative Services and the FBI (Territory of Guam)

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

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

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

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

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

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

At trial, both parents pleaded guilty.

PROBLEM:

1. Diagnosis of child abuse was missed long before the fatal event. This death was predictable and preventable.

2. Pathologist took the time to review the extensive records of FW's past history - but then did not know how to use it.

3. The two experts simply blew it. They ignored the basic principles of forensic pathology. **You must consider all facts and evidence in context to all the surrounding events and circumstances.**

4. Background of parents strongly supports case.

5. Clear established pattern of repeated abuse - "the battered child syndrome".

6. "Failure to thrive" that is non-organic must raise the question of abuse and neglect.

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CLINICAL SUMMARY:

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

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

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

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

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

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

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

GROSS DESCRIPTION

EXTERNAL EXAMINATION:

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

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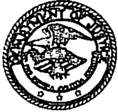

U.S. Department of Justice

United States Attorney
District of Guam

DPV(03):vsp
CR-7/WttsBrZu

Suite 502-A, PDN Building
238 O'Hara Street
Agana, Guam 96910
Telephone: 472-7332/7283

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October 14, 1984

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

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

Dear Dr. Reeves:

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

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

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

Sincerely,

DAVID T. WOOD
United States Attorney
District of Guam

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

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

CASE: AM 6 Year Old WF

INVESTIGATED BY: Ocala Police Department

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

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

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

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

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

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

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UNUSUAL CASES AND PROBLEMS

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

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

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

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

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

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

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

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

PROSECUTION OF NON-FATAL CHILD ABUSE CASES MUST BE

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

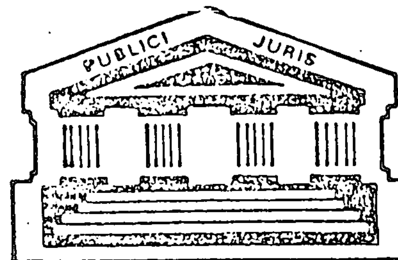
One key consideration must be given to all cases. That is the prosecutor, investigator and medical expert must consider all possible explanations for injuries and/or a death. This should be obvious but surprisingly it is commonly overlooked. This approach must start at the very beginning of any investigation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

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

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

The attached Florida Supreme Court Decision addresses this issue.

TRIAL COUNSEL
FORUM



Vol. II, No. 9 September 1983

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

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

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

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

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

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

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

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

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

CPT ANNE M. NORFOLK
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Fort Benning, Georgia

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

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

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

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

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

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

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

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

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

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

Fowler, 492 So.2d at 1347.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Emphasis added.)

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

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

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

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

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

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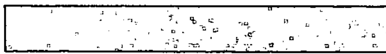
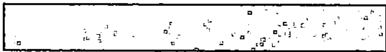
Wednesday





Case Scenarios

Child Abuse Investigations

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

Investigation of Abuse

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

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

Case Scenario 1

On Monday Bob J., age 16, asked to talk with his track coach, Jim, after practice. At that time he reported that his girlfriend, 15 year old Janie E., had told him that her father is sexually abusing her. Jim tells Bob that he should report it to his counselor or to the police. Jim does not report to his supervisor. Jim never checked to see if Bob reported to anyone else.

The next day Bob reports the situation to his counselor Mr. Grimm. On Wednesday Mr. Grimm got busy and didn't call the police, on Thursday, he forgot. Bob, tired of waiting for something to happen, called the police himself on Friday. Officer Friendly responded to the school, Janie was called to the office and officer Friendly and Social Worker Sally M. interview her.

Janie revealed that her father Chuck E., the local Chief of Police, has been molesting her since she was five years old. She said he began with fondling and gradually moved to more and more serious acts. She indicates that he ordinarily ejaculates on the bedspread and wipes it up with a towel. Two weeks ago Janie underwent an examination at a local clinic to determine if she was pregnant. Her father took her to the clinic but used false names for both of them. Janie says she was not pregnant but the possibility was a result of the abuse as she is not otherwise sexually active.

Janie say that she believes some of the sex acts may have been video taped. She has seen the video camera set up in Chuck's room and the red light on it was blinking while he was molesting her.

Janie reports that the most recent molest occurred on Wednesday night.

Case Scenario 2

Sallie S., 14, has been caring for Barbara B.'s children every weekday afternoon for about one year. The children, Jodie, age 3, and Jerry, age 4, normally stay with Sallie from 2:30 to 5:00 while Barbara attends a class. On Thursday when Barbara came to pick up the children Sallie was waiting for her in the drive-way. Sallie was clearly upset. She told Barbara that Jerry had walked in on her while she was changing her cloths and she had spanked him when he refused to leave the room.

Barbara left Sallie's with both children and went home. both children had seemed especially glad to see Barbara and were unusually quiet on the way home.

Later that evening Jerry recounted to his father that he had taken a nap with Sallie and she got mad at him. When questioned by his father, Jerry said that Sallie had been naked during the nap time and that Jodie had been in bed with them. He said Sallie tried to make him do things he didn't want to do. Jerry said he had told Bertha, Sallie's mother, what happened and Bertha said she would take care of it.

Jerry's father called Bertha and she admitted that Jerry told her what happened and she had told him she would take care of it. Bertha indicated it was just childish curiosity.

Officer Friendly was called and took a statement from Jerry in which he essentially recounted the same events he had told his father. In addition he described Sallie making him suck on her "boo-boo" and put his fingers in her "boo-boo".

Jerry's father told Officer Friendly what Jerry had told him. There was no interview with Jodie.

Case Scenario 3

Keith, age 7, was in the playground of his grammar school during recess. He and a friend named Jason saw a man standing outside the school yard fence watching them. They had no contact with the man. Three classes and two yard supervisors were on the playground at the time.

After Keith went back to his class his teacher asked him to go to the office to get some supplies for her. Keith's classroom was in a detached building so it was necessary for him to cross the school yard to get to the office.

On his way to the office the man he had seen at the fence earlier approached Keith in the school yard. The man told him that the principal had instructed him to take Keith to a special office off the school grounds. When Keith demonstrated reluctance he was told he would be in a lot of trouble with the principal if he didn't go.

Keith followed the man to an apartment house where he was pulled into a crawl space under the building and sodomized. The man released Keith immediately after the assault and Keith returned to school and told his teacher what had happened. The teacher took Keith to the office where the police were called.

Two days later the police showed Keith a book of photographs of known sex offenders and Keith identified Berry G. as the man who had sodomized him. Berry had a long history of sexual assaults of young boys, the most recent of which was under almost identical circumstances.

Case Scenario 4

Johnny J., age 10, was watching T.V. with his father when there was a public service segment on "good touch, bad touch". Johnny, who had been talking with his father about school, suddenly became very quite and withdrawn. When his father, John, asked if there was something wrong, Johnny denied there was a problem. John continued to press Johnny and finally asked if his silence was related to the segment they had seen on T.V.

Johnny told his father that his soccer coach, Bill, sometimes touches the other boys on their genitals, through their clothes. John immediately called the police and Officer Friendly responded.

In the presence of his mother, father and grandmother Johnny is questioned by Officer Friendly. The interview is tape recorded. Johnny is largely non-responsive but does indicate that he has seen Bill touch some of his teammates on their genitals through their clothes. He says he can't recall who those boys were and says that he was never touched.

John recalls that Bill has been a soccer coach for 5 years and coached John's older son, Jason, when he played. John also is aware that Bill is in the habit of taking the soccer team members, in groups of two or three, on over night campouts. There are currently approximately 20 boys on the soccer team roster.

Case Scenario 5

Karen, 15, is a resident of Rainbow House, a residential treatment program for emotionally disturbed adolescents. Karen entered the program after a near fatal suicide attempt. She has been marginally involved with drugs but is apparently not drug dependent. She remains severely depressed and suicidal and is currently taking anti-depressant prescription medication.

On Thursday night, during group counseling, Karen revealed that she had run away from home several months ago. After two weeks on the street a 50 year old man, Douglas, offered her a place to stay and food if she would help him with his photo business. Karen went home with Douglas. There were two other girls staying at the house at the time, Debbie, age 16, and Betty, age 15.

Karen, in exchange for her room and board, was required to sleep with Douglas and both orally copulate and masturbate him to ejaculation. Occasionally one of the other girls would sleep with them and the three would engage in sexual acts. After two weeks Douglas told Karen that it would be necessary for her to work to earn her keep. Douglas had the three girls engage in sexual activity with one another while he took both video and still photographs. During these activities all of the participants usually took either cocaine or hashish. The drugs were always supplied by Douglas.

After several weeks of these activities Karen couldn't stand it and she ran away. Shortly after running away, depressed and with nowhere to go, she attempted suicide.

Karen told the police that she did not know the last name of either of the girls nor of Douglas. She can, however, point out the house. Karen says that there is a photo lab in the house and Douglas develops his own still photos.

Counselors at the home suggest that Karen ran away from home because her father was sexually molesting her.

Case Scenario 6

The Happy Times Day Care Center has been in operation for 15 years. They are currently licensed by the State Social Services Department. The Center is run by Peggy S., she and her 18 year old son Ray live on the premises. Ray helps with the day care when he gets home from school at 3 p.m. each day. Twenty-three year old Mary also works at the Center.

Susie, 4 1/2, has been attending the center for 4 months. Susie was previously in a much larger pre-school where she had seen an abuse prevention play, "Good Touch - Bad Touch."

On Tuesday Susie didn't want to go outside and play. She told Mary it was because she didn't like Ray. Mary ask why and, after some coaxing, Susie told her that Ray had taken her into the playhouse outside, wanted her to play "nasty" games and took "bad" pictures of her.

Later that evening Mary told Peggy what Susie had said. Peggy told Mary that she had caught Ray 2 months before in the playhouse with Tammy, 5. Tammy's underware was off, Ray's pants were unzipped, and the book "Show Me" was laying on the floor.

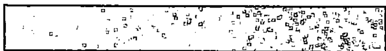
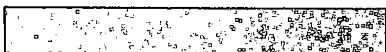
Mary called the police. Officer Friendly responded. He spoke briefly with Mary and then referred both Susie and Tammy to a local therapist for an interview.

Case Scenario 7

Dan brought his 2 year old daughter Betty into the emergency room of the local hospital. Betty had blistered burns over her buttocks and on her feet up to the level of her calves. She appeared to be in a great deal of pain and was crying.

Dan reported that he had set Betty on her infant potty chair in the bathroom and turned the water on to prepare her bath. A friend, Bill, had knocked on the door and Dan went to answer it. A few minutes later he heard Betty cry out and went to see what was wrong. Betty had moved her potty chair over to the tub, climbed on it and fell into the water. She was crying and the water was very hot. Dan indicated that he had turned on both the hot and the cold water but apparently had turned the hot water too high. Dan said that he took Betty into the bedroom and laid her on the bed, she seemed to him to be all right so he put her clothes on her and went to prepare dinner. Half an hour later Dan's mother came to visit. Betty wet her pants while Dan's mother was there and when she was changed Dan's mother discovered that she had blisters on her bottom.

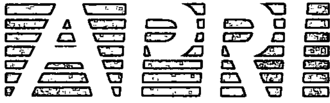
Police responded to the hospital spoke with doctors and went to Dan's house. Dan invited them in and showed them the bathroom. Betty was hospitalized with second degree burns.

Outline

Special Problems of Urban Prosecutors

Presented by
Wanda Keyes-Robinson, J.D.
and
Mimi Rose, J.D.



National Center for the Prosecution of Child Abuse
A program of APRI—the research, technical assistance and program affiliate of the National District Attorneys Association

American Prosecutors Research Institute

"THE URBAN PROSECUTOR AND CHILD ABUSE CASES"

PRESENTATION BY:

WANDA KEYES-ROBINSON
DIVISION CHIEF
STATE'S ATTORNEYS OFFICE FOR BALTIMORE CITY
BALTIMORE, MARYLAND

PREMISE - There are a variety of issues unique to the urban prosecutor who handles child sexual abuse cases. There should be a forum for the expression of ideas, problems and solutions to enable large urban jurisdictions to share and benefit from varied experience.

OUTLINE OF PRESENTATION:

I. GENERAL PURPOSE AND INTRODUCTION

Child sexual abuse cases are among the most difficult cases to investigate and prosecute. Urban centers are faced with the difficult task of locating trained law enforcement officers, investigators and prosecutors who are willing to deal with the daily emotional stresses and pressures in handling the large numbers of cases in this area. The number of reports of child sexual abuse continue to grow at an alarming rate totally out pacing the staff and manpower charged with the responsibility of investigating and prosecuting these matters.

It has recently been estimated that in Baltimore City the number of reported incidents of child sexual abuse has tripled since 1981. But dispite the increased number of reports and the statutory mandates to police, social services and prosecutors to investigate, the number of professionals in this area has not increased due to, in many cases budgetary constraints. The result? Heavy caseloads and great stress compounded on an already stressful job for many investigators and prosecutors.

Understanding the reality of this work environment and the difficulty of practicing law under very real budgetary and bureaucratic constraints, urban prosecutors must be imaginative and creative in order to work

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effectively in the criminal justice system. Although there are no cures or easy solutions, it is incumbent upon urban prosecutors to utilize a number of mechanisms to assist in minimizing the stress related to the heavy case loads and to extend the arm of the prosecutor's office into collateral agencies and organizations to gain assistance in the prosecution effort. Organizations like the Child Advocacy Network (CAN) and Court Appointed Special Advocate (CASA) and other programs are and can be set up to assist sexually abused children in the court process and be of great benefit to prosecutors as well.

A. DEFINING THE ROLE OF THE URBAN PROSECUTOR - MYTHS AND REALITIES

(Prosecutor, Investigator, Social Worker)

1. Managing Caseloads

   A. Prioritizing Cases

   B. Utilization of Investigators, Law Clerks, Detectives

   C. Use of stats to redistribute case loads (i.e., a one defendant, multiple victim case does not equal a one defendant, singular victim case)

   D. Utilization of DSS

      1. Treatment for victim
      2. Treatment for family
      3. Support CINA, Legal Aid, etc.

2. Managing Family of Victims/Child Witnesses

   A. Utilization of Child Advocacy Programs and Collateral Groups

      1. Child Advocacy Network/Court Appointed Special ADvocate

      2. Sex Assault Centers

      3. Department of Social Services

      4. Volunteers - w/i SAO victim witness groups

      5. Therapy Groups/Hospitals

3. Specialization

   A. Pedophile Cases

   B. Ritualistic Crimes

   C. Intra-Family Abuse

   D. Day Care Center Cases

   E. Physical Abuse vs. Sexual Abuse

B. INSERVICE TRAINING FOR SEX OFFENSE PROSECUTORS

A. Staff Meeting with case presentations/speakers

B. Minimizing cost

C. Utilizing speakers, programs and institutes that do not require payment

D. Grant money/foundations

C. EDUCATING THE PUBLIC

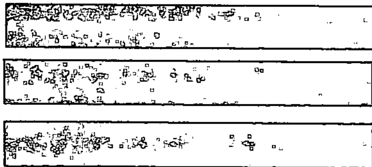
A. Community Groups

B. Social Workers

C. Police

D. Legislators

E. Private monies/grants



Resource Materials

Special Problems of Rural Prosecutors

Presented by
Seth Dawson, J.D. and
Susan Terrell, J.D.

Resource Materials

Support and Preparation of Child Witnesses

Presented by
Lucy Berliner, M.S.W.

Journal of Social Issues, Vol. 40, No. 2, 1984, pp. 125–137

The Testimony of the Child Victim of Sexual Assault

Lucy Berliner and Mary Kay Barbieri
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Sexual abuse of children, though widely condemned, is nevertheless more prevalent than has been previously realized. When the accused offender does not admit guilt, the testimony of the child victim is likely to be the only or the main evidence. Members of the criminal-justice system often share general societal beliefs that children are not as credible as adults and that children cannot participate in such legal proceedings without serious trauma. In this article, we address some of the social and legal barriers to successful prosecution of child sexual abuse cases, and to the child's effective participation in such cases. Then, we discuss some steps that can be taken to help reduce, eliminate, or overcome these barriers.

Prosecution of child sexual assault often rests largely on the child victim's testimony. Yet there are both social and legal barriers to the acceptance of the child's statements as courtroom evidence. Furthermore, court appearance under such potentially traumatic circumstances can pose some psychological hazards for the child. But, we feel, these barriers and hazards are not insurmountable. Between us, we have had direct experience with hundreds of cases of child sexual assault, as a social worker in a specialty clinic that treats child victims and as an attorney in the prosecutor's office, respectively. On the basis of that experience, we will argue in this paper that both the potential psychological hazards to the child, and the social and legal barriers to effective courtroom performance by the child can be overcome, circumvented, or eliminated if the adults involved in the criminal-justice process take certain appropriate steps to deal with them. This paper is about those hazards and barriers, and about the steps we think can be taken to deal with them.

We would like to thank Joseph McGrath for this thoughtful editing of an earlier draft of this paper.

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The Nature of the Problem

Sexual activity with children is prohibited by custom in all known societies and is illegal in every state of this country (Herman, 1981), regardless of the degree or type of coercion by the adult, or accommodation by the victim. Children under a certain age are considered legally incapable of consenting to sexual relations. Although there are a few exceptions to this generalization at certain times and in certain cultures these typically occur only under strictly defined cultural circumstances (such as during a puberty rite). The crime has been known as rape, statutory rape, indecent assault, incest, sexual battery, criminal sexual conduct, indecent liberties, and a variety of other names (Bulkley, 1981a). By whatever name, child molestation is universally considered to be deviant behavior.

Yet it has been estimated that thousands of children are sexually victimized each year (Sarafino, 1979). Child sexual abuse can be generally defined as sexual contact with the child by an adult, by a person who is more than five years older than the child, or by anyone with the use of force. In retrospective studies of nonclinical adult populations, sexual abuse during childhood is reported by substantial percentages of respondents. For example, in one well-designed study of females in randomly selected households in a large western city, 38% reported having been sexually abused before age 18 (Russell, 1982). In another survey of college students, 19% of the women and 9% of the men reported having been victims of sexual abuse (Finkelhor, 1979). In both of those studies, most respondents said they did not report the assault(s) at the time.

In studies of clinical populations of molested children, most reported having been assaulted by a known and trusted adult, who used indirect or nonviolent means of coercion to involve them in repeated sexual activity (Conte & Berliner, 1981). Strangers constitute only a small percentage of offenders. Incest, once considered rare, is now believed to be a common type of child abuse. Parents and parent surrogates account for a substantial portion of offenders in reported cases (Burgess, Groth, Holmstrom, & Sgroi, 1978).

The offender often evades being caught by threatening or pressuring the child not to tell for fear of negative consequences. The child is usually no match for the adult in size, power, or sophistication, so the offender can often control and abuse the child over long periods of time without detection. If the child does report the abuse, the offender often denies it—and often is believed.

In addition to these features of child sexual abuse, which tend to keep offenders from being detected and prosecuted, there are a number of further barriers to successful prosecution of such cases once they are reported. There are four main reasons why it is so difficult to prosecute cases of sexual assault against children. First, adults are often skeptical when children report having

been molested. Second, many lay and professional people believe that sexual abuse is caused by a mental disorder, and therefore that the mental-health system, not the criminal-justice system, is the proper forum for dealing with the matter. Third, many fear that children will be traumatized by taking part in such legal proceedings and hence be further victimized. Fourth, many prosecutors do not want to undertake cases that rest heavily on testimony of child victims because they fear that the child will not be able to perform adequately as a witness.

Can Children Be Believed as Witnesses?

The child's believability in sexual-assault cases arises first in relation to the parents or other adults in whom the child confides about the abuse, then in relation to doctors and counselors who treat the child, and later in relation to prosecutors, judges, juries, and others in the justice system. In the legal arena, the child's statements become official testimony. Therefore, a key issue is whether the child is judged to be competent to testify, and whether that testimony is credible.

While adults are often skeptical when children report sexual abuse, especially by those in or close to the family, there is little or no evidence indicating that children's reports are unreliable, and none at all to support the fear that children often make false accusations of sexual assault or misunderstand innocent behavior by adults. The general veracity of children's reports is supported by relatively high rates of admission by the offenders (Conte & Berliner, 1981). Not a single study has ever found false accusations of sexual assault a plausible interpretation of a substantial portion of cases (Burgess et al., 1978).

Recall that Freud originally contended that childhood sexual trauma formed the basis of his female patients' neuroses. He then altered that view, making his patients' *fantasies* of childhood sexual activity the cornerstone of his theoretical system. Some contend that he made the shift at least in part because it was personally and/or professionally more acceptable to disbelieve his patients than to accept the reality of widespread sexual abuse of children (Masson, 1984; Rush, 1977). It was after this shift that Freud's views became accepted by the medical/psychiatric community.

Our clinical experience indicates that many children who report being assaulted actually underreport the amount and type of abuse; exaggeration is rare. Moreover, children often fail to report, or recant their reports, because the consequences of telling seem even worse than the consequences of being victimized again (Gentry, 1978). But children can and do report such abuse if there is a climate of belief, as evidenced by the high rates of reporting in communities that have visible treatment programs for sexually abused children (Kroth, 1979).

And those high rates of reporting are *not* accompanied by any evidence that such a climate has spawned an increase in "false positives."

Should Child Sexual Abusers Be Prosecuted or Rehabilitated?

Most child sexual abusers know that they are breaking the law and can be held legally responsible (Groth & Birnbaum, 1979). But many mental-health professionals believe that such offenders have psychological disorders that, in some sense, excuse their behavior and make them candidates for mental-health intervention. The family and the victim often share this goal of getting help for the offender, especially when the offender is in or known to the family. And from this viewpoint, the criminal-justice system offers only a punitive outcome.

But sexual offenders rarely seek mental-health treatment voluntarily. Some form of external pressure is almost always necessary to make them enter and complete treatment programs. Often, the law can be used effectively as a leverage, even when the goal of all concerned is treatment rather than punishment (Bulkley, 1981b).

Will the Child as Witness Suffer More Than the Child as Victim?

One major barrier to prosecution of child sexual-assault cases is the fear that the child will be further traumatized by involvement in the legal process. In cases where the accused is a stranger, children are more likely to be believed by the adults in their families, and the behavior is more likely to be viewed as criminal. But even under these circumstances, the victims and their families may be reluctant to report the crime to authorities because of the fear that the child will be subjected to further trauma by the criminal-justice process. It can be lengthy and requires the child to repeatedly face traumatic memories: The victims and their families can have no guarantee that the child will not encounter untrained or insensitive personnel.

When the offender is known to the family, there is an additional reluctance to report the crime or to follow up its prosecution, lest the victim or the offender be further injured. The most reluctance occurs when the offender is a family member. Many people hold greater loyalty to family members, even errant ones, than to society at large. Criminal prosecution of a family member, particularly a parent, is likely to have negative consequences for all family members. Furthermore, the child victim may have mixed feelings toward the accused: The child wants the abuse to stop but does not understand the necessity of legal intervention to stop it. The nonoffending parent, as well as the child, may feel dependent on the offender. On top of all these concerns, the child is likely to suffer guilt over accusing a family member of such a taboo crime, and fear hostility from and rejection by others in the family.

Will the Child Be a Credible Witness?

Prosecutors are reluctant to try a case that hinges mainly on the uncorroborated testimony of a child victim. Sexual abuse is a crime that by its very nature contains major burden-of-proof problems. There seldom are other witnesses or corroborating physical evidence. For the case to be successfully prosecuted, the child's competence must first be established; then, the child's statements, elicited under constraints defined by the formal structure of the law, must be believed. Furthermore, the crime usually involves many separate acts occurring over a period of time which are not reported until some much later time. In such circumstances, accurate reporting of the sequence of events is a difficult task for child or adult.

While these are difficult circumstances for obtaining accurate testimony, there is no reason to dismiss such testimony out of hand simply because of the age of the witness. To be sure, age differences in perceptual, memory, and verbal capacities should be taken into consideration in assessing witness competence. But research evidence (see Johnson & Foley, 1984; Marin, Holmes, Guth, & Kovac, 1979; Perlmutter, 1980), and our own practical experience suggest that children, even very young ones, can give valuable testimony if they are properly prepared for their courtroom appearances.

Prosecuting Child Sexual Assault Cases

Some communities have developed highly successful programs for the legal handling of child sexual-assault cases. These programs invariably seem to involve several key features. First, they are staffed by professionals who have been trained in several pertinent areas: the dynamics of child sexual assault; principles of child development, including emotional reactions such as fear, self-blame, and ambivalence; and interviewing and rapport-building techniques. Second, the intervention process of the criminal-justice system is modified in various ways to accommodate child witnesses: The investigation is telescoped to reduce the number of times the child is interviewed and the number of different people involved in those interviews. Sometimes joint interviews are conducted, or videotaping used to reduce the need for repeat interviews. Third, the various steps are taken to make the child less anxious and more comfortable. Assigning the same people to handle the case all the way through the proceedings can help give the child the comfort of being with familiar adults. Special settings, such as playrooms, can help too. So can the use of interviewing aids, such as anatomically correct dolls, that permit the child to demonstrate the sexual activity rather than having to describe it verbally. These three features—professional personnel appropriately trained, a criminal-justice system that accommodates its procedures to the needs and capabilities of the child victim/witness, and a set of

procedures designed to give support and comfort to the child—seem to be highly facilitative (if not necessary and sufficient) conditions for effective use of child witnesses in sexual assault cases. They also seem conditions that victims and their families in all jurisdictions might reasonably expect to find when involved in such cases, and that the criminal-justice system in all jurisdictions might reasonably take as goals for immediate improvement of their effectiveness.

In addition to these general features of successful community programs, there are some more specific steps that can help reduce the barriers to, and hazards of, prosecution in such cases. These specific steps apply at different stages of the criminal-justice process.

Alternatives to a Court Appearance by the Child

The heart of a child sexual-assault case is the child's testimony, but this need not always be given in court. In some jurisdictions, grand jury indictments can be obtained on the basis of the child's out-of-court deposition, in some cases even using videtaped testimony. In general, grand jury settings are not so formal, nor the rules of evidence so stringent, as a courtroom trial by *petit* jury.

Given an indictment, offenders are more likely to plead guilty—thus sparing the child a courtroom appearance—when there is a range of sentencing alternatives available. Accused offenders who are judged to be amenable to treatment can be offered a recommendation for treatment—along with or instead of incarceration—in exchange for a guilty plea. A number of states operate such treatment facilities within their correctional system (Brecher, 1978). Some of them combine community-based treatment programs for offenders who have been placed on probation with secure facilities for more dangerous offenders. The latter systems seem to work best, both for the offenders and for the justice system (Conte & Berliner, 1983).

Preparing the Child for a Court Appearance

From the beginning of a case, even before it is known whether a trial will take place, the personnel responsible for carrying through the legal procedures must assume that the child may have to testify. If the child eventually does testify, it is likely that the child's word will be pitted against that of the adult defendant. The attorney who may present the child as witness should do everything possible from the outset to give the child emotional support and accurate information about what will ensue. The first step is to establish rapport with the child. This can be facilitated by having the initial interviews in surroundings that are comfortable and nonthreatening for the child. Some time should be spent in getting acquainted. Early on, when the need for a trial is still uncertain, the attorney may want to explore how well the child can talk about what happened.

When it becomes clear that a trial is likely and that the child's testimony will be needed, the attorney should try to arrange an opportunity for the child to become familiar with the physical arrangements of a courtroom, and must insure that the child is prepared for the procedural arrangements as well. For example, the child should know, in advance, that the accused will be in the courtroom during the child's testimony, that the defense attorney will cross-examine, and what that cross-examination will be like. The child should be instructed not to answer questions that he or she does not understand, but instead to ask for clarification before answering. The child should be instructed to tell the truth—no matter what—and the attorney should explain to the child how important telling the truth is in the legal process.

The Court Appearance

In most jurisdictions, young children must be qualified as witnesses by the judge before they are permitted to testify before the jury. To qualify a child as a witness, the attorney must demonstrate to the judge's satisfaction that the child (a) can receive and relate information accurately, (b) can understand the difference between telling the truth and telling a lie, and (c) can appreciate the necessity of telling the truth in court. This can be done rather easily even with children as young as 3 or 4 years of age, provided the questions are asked in a way that the child can understand and provided he or she has been prepared to undergo such questioning.

The first test can be met by questioning the child about familiar everyday events: school, playmates, a hobby. Children as young as 3 or 4 can describe familiar events and give accurate informations about them (Nelson, 1978). It is also fairly easy to demonstrate the child's knowledge of the difference between a truth and a lie, but not by asking for definitions. Most children, and for that matter most adults, cannot give good definitions of such abstractions. Instead, examples of clear facts and errors of fact should be used ("If I said 'You are wearing a red dress,' would that be a lie or the truth?"). Most children can answer such questions easily and convincingly.

The third test, that of the child's appreciation of the need for truth in the courtroom, is somewhat more abstract. It can sometimes be demonstrated by asking the child about the consequences that usually follow the telling of a lie in everyday life,and then by shifting the topic to the courtroom and getting the child to promise to tell the truth in court.

Not all children can be qualified. Very young children below the age of 3, although they have memories and can communicate in a rudimentary way (Perlmutter, 1980), may simply not be able to meet the legal criteria. Unless there are other witnesses, or physical evidence of the assault, there may be no way to provide evidence of the sexual assault of infants and preverbal children, even

though such abuse does take place. Some older children, too, cannot be qualified as witnesses because the postassault psychological effects can include problems of memory and concentration.

After the child has been qualified as a witness, the testimony itself begins. This process is difficult for the child, and can lead to unexpected results. It is important that attorneys remain alert to potential problems, and try to deal with them by using procedures that may be unusual but are not improper or illegal. For example, sometimes a child seems truly terrified at taking the witness stand alone. In such cases, the problem might be solved by having the child sit on the lap of a familiar adult while testifying. Such a procedure may seem foreign to judges and attorneys, but there is no rule in any jurisdiction that forbids it, provided the child's testimony is not prompted. As another example, children are extremely literal in their answers to questions. This can sometimes lead to situations in which adults think the child is being self-contradictory when he or she is simply being concrete. The attorney needs to be alert to such child–adult misunderstandings, and find ways to restate questions so that the meanings of the child's answers are clear to the adults.

A child's approach to answering questions can have serious consequences for the unwary attorney. In the following case example, a 5-year-old child, on direct examination, told the jury about her father putting his penis in her mouth. On cross-examination by the father's defense attorney, the following exchange took place:

Defense Attorney: And then you said you put your mouth on his penis?
Child: No.
Defense Attorney: You didn't say that?
Child: No.
Defense Attorney: Did you ever put your mouth on his penis?
Child: No.
Defense Attorney: Well, why did you tell your mother that your dad put his penis in your mouth?
Child: My brother told me to.

At this point, it looked as if the child had completely recanted her earlier testimony about the sexual abuse and had only fabricated the story because her brother told her to. However, the experienced prosecuting attorney recognized the problem and clarified the situation:

Prosecuting Attorney: Jennie, you said that you didn't put your mouth on daddy's penis. Is that right?
Child: Yes.
Prosecuting Attorney: Did daddy put his penis in your mouth?
Child: Yes.
Prosecuting Attorney: Did you tell your mom?
Child: Yes.
Prosecuting Attorney: What made you decide to tell?
Child: My brother and I talked about it, and he said I better tell or dad would just keep doing it.

As another example, children sometimes become embarrassed or reluctant to answer questions about the sexual activity. This situation can be helped by using anatomically correct dolls, with the child demonstrating the acts with the dolls while the attorney describes those actions for the written record.

Cross-examination is especially difficult for child witnesses. The defense attorney's job is to impeach the child's testimony. Usual cross-examination tactics, such as bringing up other situations that tend to cast doubt on the witness's veracity or competence or using an intimidating manner in the questioning, are less acceptable in the case of child witnesses and should not go unchallenged. Sometimes judges will intervene to shield child witnesses from such practices. When that does not occur, the prosecuting attorney must do so.

Bolstering the Child's Testimony With Supporting Evidence

However well the child testifies in court, the attorney must always try to support that testimony with as much other evidence as possible. Such corroborating evidence might come from any of several sources: the child's earlier, out-of-court statements; the offender's admissions; medical evidence; and evidence of experts on child sexual abuse.

Some of the most powerful potential evidence in cases of child sexual abuse lies in the child's prior out-of-court statements. When a child first reveals that there has been sexual abuse, the content and manner of the revelation is often striking in its clarity and ring of truth. For example, one 7-year-old girl said casually to her father: "Daddy, does milk come out of your wiener? It comes out of Uncle Bob's and it tastes yukky." There could be little doubt that the child making such a startling statement has been sexually abused. But by the time the child gives testimony in a court, the description of sexual abuse will probably be flat and cursory, and may even appear rehearsed.

There are certain exceptions to the hearsay rule that sometimes permit the child's out-of-court statements to be entered as evidence. One of them is for "excited utterances" (*res gestae*), statements made soon after a traumatic event while the person is still emotionally upset. Unfortunately, this exception is of limited use in child sexual-abuse cases, because children rarely tell of the abuse soon after the event. In some jurisdictions, prosecutors have successfully argued for an expansion of the rule to cover a longer period of time, based on the particular nature of child sexual abuse. Another potential exception to the hearsay rule is for statements made to a medical doctor. Although children are rarely injured when they are molested, medical care may be necessary to rule out infection. If the child tells or shows the doctor where the sexual contact took place, this may be introduced as evidence as part of the medical record.

Another potential source of evidence supporting the child's testimony is from the offender's own admissions. In a surprising proportion of child sexual-

abuse cases, the defendant will voluntarily make damaging statements. It is common for accused molesters to tell how the children were the aggressors and they the victims; or to admit touching the child but assert that it was for nonsexual reasons. These statements can sometimes be very useful in supporting the child's testimony. Sometimes they are made to police after Miranda rights have been read; sometimes such admissions are made to friends, relatives, or spouse. While testimony of spouses is not permitted in most kinds of cases, many jurisdictions allow the spouse's testimony if the child of the accused is the victim of the alleged crime. Even statements about the sexual abuse made to psychiatrists or psychologists may be admissible. Normally, information which is disclosed to a therapist cannot be revealed without the consent of the client. Nevertheless, most jurisdictions have laws requiring the reporting of child sexual abuse, thus abrogating the client/therapist privilege in this situation.

Medical evidence can corroborate a child's testimony of sexual abuse, but molestation, though coercive, is seldom so violent as to cause medically specifiable trauma. Medical experts are more likely to contribute to the prosecution by explaining why it is not reasonable to expect identifiable trauma rather than by documenting its presence.

Other experts on child abuse can sometimes contribute by testifying about the dynamics of child sexual abuse. Such expert testimony has been used in some jurisdictions, and has been upheld on appeal in the state of Oregon (*The United States Law Week*, 1983). Such expert testimony most often is used to rebut defense contentions, such as "If this really happened, the child would have told someone right away." Child sexual-abuse experts can provide information about typical child reactions to sexual abuse, including certain symptoms characteristic of posttraumatic stress in such cases: disturbances in physical and cognitive functioning, re-experiencing the traumatic event, withdrawal from usual and familiar activities, and numbing of affective responses (American Psychiatric Association, 1980). While such experts cannot testify to the truthfulness of the child's statements, they can provide the judge and jury a richer context within which to interpret the child's testimony.

When the Child Should Not Testify

From a prosecutor's standpoint, the child victim should testify only when that testimony will substantially increase the chance of a conviction and will not do serious harm to the child. Some cases do not meet those conditions. If the child is unable or unwilling to give a coherent statement and there is no other evidence, the case cannot proceed. Sometimes, even if the child can give a statement, there may be so little chance of conviction that it is not worth putting the child through the stress of the proceedings.

Another issue is the child's own "record." If the child has adjustment

problems or a history of trouble, that record will undoubtedly be used to try to impeach him or her in court. It may seem so likely that a jury will be influenced by these background facts that there is little hope for a conviction—hence no purpose in having the child testify. Furthermore, the trauma of being publicly discredited, either by cross-examination or by an acquittal, might be so overwhelming as to exacerbate the child's previous problems.

Yet, it is a mistake for prosecutors to assume, in general, that juries cannot untangle these issues. The probability of winning cannot be the only criterion for filing a charge. And if the more difficult cases are never filed, the opportunity to change the climate within the legal system, and within the society as a whole, will be lost.

Even if charges are filed, the child's behavior on the stand may lead the prosecution, or the parents, to end the proceedings. If the child freezes in the courtroom setting, or is very upset, and if efforts to comfort and support the child fail, it is better to dismiss the case than to proceed. Under these circumstances, no outcome would justify the child's ordeal.

On the other hand, the experience of testifying in court can have a therapeutic effect for the child victim. The child can learn that social institutions take children seriously. Some children report feeling empowered by their participation in the process. Some have complained, when the offender pled guilty, that they did not have an opportunity to be heard in court.

Still, an acquittal can have a devastating effect on the child victim/witness. It is very difficult to explain to children that telling the truth does not always result in an outcome they consider just. The responsible adults must mitigate these effects both by pretrial preparation and by posttrial follow-up. It is essential that the child understand beforehand that court is not a forum for finding out what happened, but rather a very special system by which society tries to identify and control offenders, and that it has a special set of rules for arriving at a result. If there is an acquittal, and even if there is a conviction, children are likely to need follow-up counseling to help resolve their emotional conflicts about the experience—both the abuse and the legal process.

Concluding Comments

We have noted the prevalence of child sexual abuse and described certain barriers to its successful prosecution. The barriers are not insurmountable. We have noted three general features of successful community programs for dealing with child sexual abuse, and a number of specific steps that the responsible adults in such cases (judges, prosecutors, legal-system personnel, medical personnel, parents) can take, both to further the successful prosecution of such cases and to minimize further trauma to the child.

The operation of any criminal-justice system requires a careful balancing of

the interests of all parties: the child victim/witness, the accused offender, the family, the legal system, and the community. We argue that the current system is out of balance in ways that do not always do full justice to the interests of the child victim/witness. That imbalance needs to be redressed, and we believe it can be done in ways that do not seriously threaten the legitimate interests of the other parties. We have suggested some of those ways throughout this paper, and will recapitulate the most important of them below.

Community programs dealing with child sexual abuse must have appropriately trained professional staff, must have a criminal justice system that can respond flexibly to the special needs of children as victims and as witnesses, and must make use of settings and procedures that offer maximum comfort and support for the child who is enmeshed in such legal proceedings. The responsible adults must establish a climate of belief within which the child's competence and credibility is regarded as neither more nor less problematic than that of adults under comparable circumstances. The legal system must adapt its rules of evidence to fit the nature of the crime. For example, there need to be changes in the statutes of limitation for child sexual abuse, since most children do not report the crime immediately after it occurs, and since the first adults to whom they report it often do not believe them and therefore do not act at once on the information. Some states have recently extended their statutes of limitation for such offenses. As another example, there needs to be a broader interpretation of *res gestae* and other exceptions to the hearsay rule to take into account the special circumstances of child sexual abuse (e.g., the likely delay in reporting, the low probability that there were direct witnesses other than the victim, the likelihood that the criminal activities were more clearly described on the first, out-of-court telling than on later, in-court retelling). Such changes have recently been enacted in Washington (State of Washington Law, 1982), permitting statements made outside the court by child victims of sexual abuse to be admitted at the judge's discretion.

Child sexual abuse occurs in part because of the inequalities between child and adult in size, knowledge, and power. The legal system should not perpetuate these same inequalities by failing to take such differences into account. A criminal-justice system fails if it does not protect its most vulnerable and innocent members at least as well as the more powerful.

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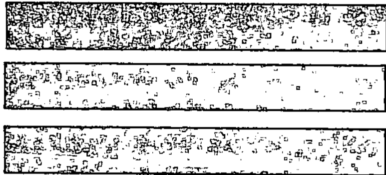


Outline

Interviewing Child Witnesses: An Investigative and Prosecutorial Perspective

Presented by
Patricia A. Toth

I. Recognize Purpose and Importance of Interview

A. Shared/common goals of all professionals

1. To elicit accurate information about the nature and extent of abuse

2. To minimize trauma experienced by child during interview process

3. To get necessary information in a timely manner so appropriate decisions about future action and intervention can occur

4. To protect child from further abuse and assist child in recovery process

B. Interview is often critical source of information for different agencies/professionals to carry out their responsibilities

1. Child protective/social services agencies

a. Decisions about child's placement and protection

b. Decisions about service provision to children and families and civil case disposition

2. Medical professionals

a. Decisions about extent of medical exam and tests necessary

b. Decisions about medical diagnosis, treatment and follow-up care

3. Therapists

a. Decisions about child's treatment needs

b. Determination of impact of abuse on child and child's reaction to entire range of experiences which follow

4. Law enforcement and prosecutors

a. Responsibility to protect child from additional abuse but also to protect other potential victims from abuse by the offender

b. Decisions about other aspects of complete and thorough investigation

1. Identifying other potential victims

2. Identifying other potential offenders

3. Obtain physical and/or medical evidence which corroborates and verifies or refutes allegation

4. Locate other witnesses with relevant information before influenced by someone else

5. Obtain suspect's statement before time to reflect/embellish/create misleading account, and before he/she can hide, alter, influence or destroy other evidence and witnesses

c. Overlap is obvious. The challenge: How can we work cooperatively to achieve most efficient and effective interviewing process?

II. Preparation for the Investigatory/Forensic Interview

A. Most common issue and criticism-contention that interviewer will be biased by any information reviewed prior to talking to child

B. Despite this issue, "blind" interviews aren't preferable or realistic

1. Review of reports and other available information crucial to provide background

2. Background info. may alert you to need for special interviewing arrangements or techniques

3. Background info. can also alert you to areas of concern and allow you to check out and evaluate validity of potential defenses

C. Approach to interview must be open-minded, objective, "ready for anything"

III. Who Should Conduct Interview?

A. Possibilities are many

1. Possibilities are many

2. Police officer

3. Therapist

4. Physician

5. Victim advocate or social worker

6. Prosecutor

B. May perceive different and conflicting goals-can lead to disagreements about whose purposes are most important

C. Why law enforcement/prosecutors want to be involved and have input in process

1. Accurate and complete info. needed about the abuse allegation (who, where, when, who else was there, exactly what occurred) to make correct filing and arrest decisions

2. Conduct of interviews, no matter by whom or for what purpose, will be subject of scrutiny and attack by defense in any subsequent criminal action

D. Attributes of a good interviewer-training, skill, sensitivity, intuition, comfort, experience, objectivity

IV. How Many Interviews Should Occur?

A. Belief that process can be reduced to a single interview is unrealistic

1. Progressive disclosure is usual pattern with children--their trust level must increase
2. Most serious and involved situations (e.g. ritualistic abuse) will not be fully revealed by child at initial interview

B. Joint efforts, however, can and should be pursued so unnecessary duplication is avoided; also allows more efficient use of limited agency resources

C. More realistic is agreement to minimize number of different interviewers of individual child

V. Who is Present at Interview?

A. Advantages of early prosecutor involvement

1. Prosecutor can assess child's demeanor early on
2. Less chance of overlooking information needed for filing charges--correct crime, number of counts, time frame, etc.
3. Development of earlier and better rapport with victim

B. Should more than one interviewer question or be with the child?

1. Probably not--confusing for child and perhaps difficult for interviewers to work together
2. One-way mirror allowing others to view an consult with interviewer is a solution
3. Videotaping may help also
4. A witness to the interview is normally a good idea to combat later attacks on interviewer and methods used

C. Should child's (non-offending) parent or caretaker be present?

1. Bolsters defense argument that parent coached or brainwashed child
2. Child will often be negatively affected by parent's natural anxiety
3. Child may be more embarrassed in front or parent
4. Preliminary introductions and setting at ease can be done with parent or caretaker

VI. Documentation of Interview

A. Videotaping--not a panacea

1. Potential advantages:

a. May reduce need for additional interviews
b. May capture emotion and details early on (which are likely to be lost as time passes)

c. Provides verbatim account should there be later dispute about suggestibility, use of leading questions, etc.

d. Child may be more comfortable because less formal setting

e. Might be useful in inducing guilty pleas or generating family support for child

f. Could be used to refresh child's recollection or combat later recantation or as prior consistent statement or as basis for expert testimony

g. Could possibly be used at grand jury or other pre-trial hearings in lieu of child testifying

2. Pitfalls and drawbacks

a. May make child or interviewer nervous or uncomfortable or distracted-child may want to play with equipment

b. Single interview will give incomplete or fragmented description because of progressive disclosure, especially if initial interview is the one taped; if a later interview is taped, more complete account may be told, but early untaped interviews will be deemed by defense to be leading, suggestive, "coaching"

c. Early interviews may contain denials or highlight a victim's usual reluctance and hesitancy to disclose--obviously can be exploited by defense; danger with later interviews that child may recant or show less convincing emotion; having any of these on tape increases their harmful effects on cases

d. Cannot accurately capture and present entire context of child's statements/disclosures about abuse on video-tape; for instance, almost never will first disclosure be on tape, but whatever is on tape takes on increased importance and that which is not on tape becomes easier to discount or attack. Impractical to tape every contact with children where they may discuss abuse (e.g. courthouse steps, bathtime)

f. If there are no solid agreements or good control you could have multiple agencies or professionals interviewing and taping or at least acting inconsistently: this increases vulnerability to attack by defense of "selective taping" and increases chances of seemingly inconsistent statements by child, especially if different interviewers involved and if skill level or style differ

g. Ineffective video becomes defense ammunition: -used to impeach child's trial testimony, or -used as prior inconsistent statement, or -used to support claims of coaching

h. Issue may become whether interviewer's conduct, expertise and technique were appropriate rather than whether abuse occurred; and since there is not agreement among the various so-called experts about what the ideal interviewing style/techniques are or about extent of children's suggestibility, this

is always an area defense can capitalize on - e.g. support and sensitivity to child's difficulty ("I know it's not easy, you're doing good") will be criticized as reinforcement/leading; challenging child's denial or encouraging reluctant child will be seen as coercive;

i. Can't always assure quality: soft voices won't be picked up, children move around, interviewer repeating answers will be criticized also as reinforcement; may sometimes lose sound altogether and then be left with no record of interview

j. Practical issues of expense, storage space and how long to preserve, must have good cataloging and storage system, assure tapes won't be erased or destroyed or lost, and preserve for future appeal periods

k. Privacy and confidentiality issues may arise, especially when taping is done by someone other than law enforcement; potential conflicts over who owns tapes, who can see them, victims' rights to control access, etc.

3. Prerequisites to successful use of video

a. Control over who, when, where, how many

b. Skillful and trained personnel

c. Awareness of and experience the criminal trials

B. Alternatives to taping

VII. Use of Anatomical Dolls

A. As a tool to help child demonstrate what happened, generally okay

B. Do not use as a diagnostic tool; reliance on child's actions with the dolls as a basis for concluding abuse occurred can lead to reversal--IN RE AMBER B., 236 Cal. Rptr. 623, 1987.

C. Must be used with care--See Freeman and Estrada-Mullaney, "Using Dolls to Interview Child Victims", NIJ Reports, No. 207, Jan./Feb. 1988.

D. See "Interaction of Normal Children With Anatomical Dolls," Sivan et al, child Abuse and Neglect, Vol. 12, pp. 295-304, 1988.

E. A favorite area of defense criticism; see "Behavior of Abused and Non-Abused children in Interviews With Anatomically Correct Dolls," by William McIver, Hollida Wakefield and Ralph Underwager is ISSUES IN CHILD ABUSE ACCUSATIONS, Vol. 1, No. 1, Winter 1989.

F. See also JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 3, No. 4, Dec. 1988 for several commentaries regarding use of dolls.

VIII. Other Issues Related to Interviewing Techniques and Children's Testimony

A. The push toward interviewing protocols

1. Impracticability of restrictive interview guidelines

2. Different interview styles and philosophies make agreement on optimum and universal interviewing method highly unlikely and undesirable

3. Hidden dangers with detailed protocols--giving the defense extra ammunition to attack case

4. Proposals to expand scope of competency hearings--Christiansen, "The Testimony of child Witnesses: Fact, Fantasy, and the Influence of Pretrial Interviews," WASHINGTON LAW REVIEW, Vol. 62, p. 705, 1987 (also suggested by Lee Coleman) - a step backward

B. Children's memory and suggestibility

1. Young children are often able to accurately recall and describe experiences, contrary to popular opinion

a. Recall of the very young must almost always be cued

b. Like adults, memories most accurate during free recall

c. Children spontaneously recall less than adults but what they recall is generally NOT less accurate

d. Children tend to remember actions best; are most inaccurate about locating events in time or distinguishing separate recurrent events; (Therefore, beware of the "detail trap.")

2. Children are much more resistant to suggestion than commonly believed

a. At least down to age five, children aren't anymore suggestible than adults

b. Preschoolers are more vulnerable to suggestion, but even the youngest resist suggestion involving central information; form of questions and authority of interviewer are important factors

3. See PROSECUTORS PERSPECTIVE, Vol. II, No. 1, Jan. 1988 for reviews of recent research in this area; additional information appears in CHILDREN'S EYEWITNESS MEMORY, edited by Ceci, Toglia and Ross (Springer-Verlag, 1987)

IX. Assessing Validity: No Simple Answers

A. Difficulty and complexity of these cases makes "checklists" attractive

B. Tempting to let others decide if believe child is truthful or not

C. "Sexual Abuse Legitimacy Scale" developed by Richard Gardner and promoted by VOCAL--Beware!

D. "Statement Validity Analysis" or "Statement Reality Analysis"

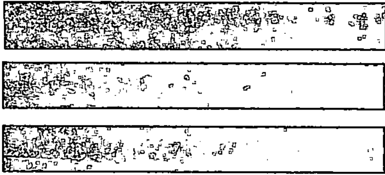
1. See "Assessing Credibility," Farr and Yuille, PREVENTING SEXUAL ABUSE, 1988.
2. See also "The Development of Statement Reality Analysis" by Udo Undeutsch, to appear in J.C. Yuille (Ed.) CREDIBILITY ASSESSMENT, Dordrecht, The Netherlands, Kluwer; Spring 1989.
3. In U.S., David Raskin has presented workshops and testified based on this method.

E. Be careful before abdicating your responsibility and that of the jury to someone else

F. These "scales" and "systems" are not empirically based or validated

G. Evaluators must consider alternative explanations for child's statements, for information given by others, and for behavior observed

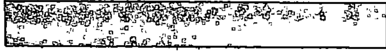
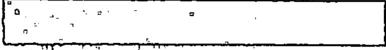
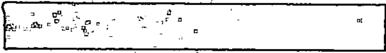
1. To determine if abuse, in fact, occurred
2. To anticipate and meet defenses so we can successfully prosecute those cases we concluded abuse did occur



Resource Materials

Anticipating and Meeting Untrue Defenses

Presented by
James M. Peters

Outline

Aftermath of McMartin: Current Issues in Child Abuse Prosecution

Presented by
Patricia A. Toth, J.D.

OVERVIEW

I. The "Backlash:" What Is It and Why Should We Care?

   A. Causes

   B. Actual Extent of Child Abuse

   C. Its Impact and Implications

II. Facts and Fallacies about False Allegations Generally

III. False Allegations in Divorce/Custody Disputes: Epidemic or Illusion?

IV. Issues Related to Interviewing Techniques and Children's Testimony

   A. The Push Toward Interviewing Protocols

   B. Children's Memory and Suggestibility

   C. Video-taping of Interviews

   D. Use of Anatomical Dolls

   E. Closed Circuit TV and Shields After COY v. IOWA

V. Assessing Validity: No Simple Answers

VI. Expert Witnesses

VII. Medical Evidence

VIII. Child Abuse Reporting and Investigation Policies

   A. "Consensus" Document

   B. NAPCWA Guidelines

   C. Police and Prosecutor Decision Making

   D. Public Opinion

IX. Drug-Affected Infants and Children

DETAILED OUTLINE

I. The "Backlash"-What Is It and Why Should We Care? Describes turnabout in media focus and public opinion regarding child abuse reports, questioning legitimacy and actual extent; generally applies to child sexual abuse while attention currently given to child physical abuse and death often goes opposite direction.

An excellent article discussing the backlash and its implications is "Protecting Children from Sexual Abuse: What Does the Future Hold?" by John E. B. Myers, Journal of Contemporary Law, Vol. 15, No. 1, 1989

A. Causes

1. Soaring reports and limited resources

a. Over 2.2 million reports of suspected child abuse and neglect in '88 (Source: American Humane Association and National Committee for the Prevention of Child Abuse)

b. An increase of over 200% in reports of possible child maltreatment in last 10 years

c. Between '80 and '86 reports increased an average of 11.4% annually but since then there has been a slowdown in reporting rates, thought to be due in part to policies limiting situations considered to be reportable offenses requiring investigation; see "consensus" document and NAPCWA Guidelines in Section VI.

d. Washington state showed a significant "decline" in number of reports between 1987 & 1988 (down 23%); officials indicate this may be due to failure of child welfare workers to file formal reports with state central registry due to time involved.

e. In Kansas, reports decreased by 12% between 1987 and 1988 (compared to a 25% increase between 1986 and 1987.)

f. 36% increase in child abuse deaths since 1985; 1171 child deaths resulting from abuse and neglect in 86, 1163 in '87; 1225 in '88.

g. As reports have gone up, so have caseloads everywhere

h. Resources have not kept pace - despite 55% increase in reports between '85 and '86, House Select Committee on Children, Youth and Families reported only a 2% increase in total resources to deal with them in same period

2. Reluctance to believe abuse actually so widespread - a historical phenomenon evident in Freud's dismissal of female patients' accounts of child sexual abuse

3. Media attention to sensational cases (e.g. Jordan, Minn., McMartin, etc.) and descriptions such as "hysteria", "witch-hunt", etc.; compare and contrast with reactions to child death cases such as the Creekmore case in Washington and Steinberg in New York

4. Philosophy that treatment INSTEAD OF punishment is the only appropriate response; proponents object to focus on criminal nature of child abuse

5. See: THE BATTLE AND THE BACKLASH-THE CHILD SEXUAL ABUSE WAR by David Hechler (D.C. Heath & Co., 1988); BY SILENCE BETRAYED-SEXUAL ABUSE OF CHILDREN IN AMERICA by John Crewdson (Little, Brown and Co., 1988); and ON TRIAL-AMERICA'S COURTS AND THEIR TREATMENT OF SEXUALLY ABUSED CHILDREN by Dziech and Schudson (Beacon Press, 1989)

B. What do we know about actual extent of child abuse?

1. Second National Incidence Study; December, 1987; National Center on Child Abuse and Neglect

   a. Follow-up to First National Incidence Study of 1980 (NIS-1)

   b. Purpose: to estimate national prevalence of child abuse and neglect; looked at figures for 1986

   c. Findings:

   1) In 1986, an estimated 1.5 million children were known victims of abuse and neglect - 63% were victims of neglect - 43% were victims of abuse (a rate of 10.7 per 1,000 for a total of approximately 675,000 children)

   2) Since 1980, a 74% increase in known incidence of abuse - 58% increase in physical abuse - rate of sexual abuse tripled (about 150 to 160,000 known cases)

   3) Report indicates increase probably reflects better recognition of child maltreatment rather than increase in incidence per se

   4) Report found, despite increased likelihood for recognition of abuse and neglect, cases were not reliably more likely to appear among screened-in reports to CPS Either:

   a) Potential reporters do not report or

   b) CPS is screening out cases which previously would have received services as "unfounded"

2. Sexual Abuse in Day Care: A National Study; March, 1988; David Finkelhor, Family Research Laboratory, University of New Hampshire

   a. This research prompted by rising alarm over growing numbers and attention to sexual abuse in day care; attempted to identify all such cases in United States reported between 1/83 and 12/85

   b. Cases within scope of study

   1) Facility with at least 6 children

   2) Alleged abuse involved at least one child under 7

   3) A daycare or preschool but not a residential facility

   4) Abuse substantiated by at least one investigating agency

c. Based on identification of 270 cases involving 1,639 children, estimated 500-550 cases and 2,500 victims in this three-year period (a total of 7 million children are in 229,000 day care facilities nationwide)

d. Risk of sexual abuse in day care lower than risk of abuse in child's own household

1) Rate of 5.5 children per 10,000 enrolled in day care vrs.

2) Rate of 8.9 children per 10,000 in own households (under age 6)

e. Abusers did not fit conventional pedophilic molester stereotypes

1) 40% were women

2) In 38% of cases, abuser was not a child care worker; instead, was a family member of provider or peripheral person, e.g., janitor, bus driver, outsider

3) Only 17% of cases involved multiple perpetrators, remaining 83% involved single perpetrator

4) Only 8% had previous sex offense arrests

f. Victims

1) 62% were girls and 38% boys

2) Most common ages = 3 and 4 (the most common ages for kids in day care)

g. Dynamics

1) Two-thirds of the abuse occurred around toileting, in bathrooms

2) Touching and fondling of genitals was most common form of abuse; however, penetration of some form occurred to at least one child in 93% of all cases

3) Frequencies of other forms of abuse

a) 21% - children forced to abuse other children

b) 14% - allegations of pornography production

c) 13% - allegations of drug use

d) 13% - allegations of ritualistic abuse

h. Investigations by multidisciplinary teams were much more successful than solo child welfare investigations or parallel and overlapping investigations by 2 or more agencies

i. Once cases reach criminal justice system, do not fare badly--of cases in which charges are filed and pursued 85% conviction rate (35% are guilty pleas and 65% go to trial)

C. Impact on and implications for prosecutors and other professionals

1. Prosecutor often the target of intense scrutiny and criticism, along with other professionals

a. Popular image of prosecutor has shifted from true "public defender" to portrayal as ambitious (often unscrupulous) politician

b. Prosecutors often accused of being tough on child abuse, without regard for the truth of allegations, in order to make a name and advance their careers Reality: Careless handling of child abuse cases can much more easily ruin than "make" careers

c. Prosecutors and others accused of manipulation, coercion, bias, etc. resulting in children falsely alleging abuse

d. Involvement in multidisciplinary teams and advocacy centers may be criticized

e. Prosecutors and others characterized as destroying families, unconcerned about child's well-being, and "abusing" the child by pursuing criminal investigation or prosecution; Be aware of current research re: system's impact - "Children's Reactions to Sex Abuse Investigation and Litigation," Tedesco and Schnell, Child Abuse and Neglect, Vol. 11, 1987; and "Impact of Legal Intervention on Sexually Abused Children," Runyan et al, Journal of Pediatrics, Vol. 113, No. 4, pp. 647-653, Oct. 1988; and "Going to Court: The Experience of Child Victims of Intrafamilial Sexual Abuse," King, Hunter and Runyan, Journal of Health Politics, Policy and Law, Vol.13, No. 4, Winter 1988.

f. Prosecutors seen as interested only in punishment and opposed to therapy

g. Prosecutors' responsibility goes beyond duty to individual victims but includes duty to entire community and other potential victims; prosecutor also held to a higher ethical standard and is often placed in the middle, a difficult position

2. Results-some good and some bad

a. Efforts to improve investigations, coordination, skills and knowledge. Example: National Center for the Prosecution of Child Abuse

b. Increased attention generally to this area; see, for example, CHILD WITNESS LAW AND PRACTICE by John E. B. Myers (Wiley Law Publications, 1987) and "The Child Witness: Techniques for Direct Examination, Cross Examination & Impeachment," by John E.B. Myers, Pacific Law Journal, Vol. 18, No. 3, April 1987

c. VOCAL, National Pro-VOCAL Council and NASVO: Victims of Child Abuse Laws, founded in 1984, National Pro-VOCAL Council-a spin-off of VOCAL, included professionals and others (Ralph Underwager chaired its Board of Directors), and National Association of State VOCAL Organizations; NASVO now promoting "A NEW MODEL"-

1) Solid definition of abuse, what to report and what NOT to report together with screening of calls for validity and appropriateness for investigation; they claim over 600,000 reports could thus be eliminated, saving children and families "from harmful unnecessary investigations/interventions"

2) Investigations handled by specially trained police and community professionals with ONE initial STANDARDIZED interview that is video-taped

3) Interview format "developed by university research and non-harmful to the child"

4) Total removal of social services from investigations

5) "Hotlines" staffed by most experienced personnel

6) Face to face interview with reporter before family is involved

7) Interview of other witnesses (family, teacher, M.D., etc.) before child

8) Ending anonymous reporting

9) Tape recording ALL interviews

10) Certification and special training of judges

11) Short time frames for cases involving children

12) "One family, one judge"

d. Increasing aggressiveness on the part of defense attorneys

1) Example: "The A-Team" or "Annihilation Team" - a group of attorneys, mental health professionals, pediatricians and others who aim "to destroy false allegations"; first advertised in VOCAL newsletter and apparently now the reason for a split in VOCAL

2) Development of specialized defense expert witnesses (See Section. VI.B.)

e. Emergence of self-proclaimed experts and critics of the system:

1) THE CHILD ABUSE INDUSTRY by Mary Pride (Crossway Books, 1986)

2) THE PARENTAL ALIENATION SYNDROME AND THE DIFFERENTIATION BETWEEN FABRICATED AND GENUINE CHILD SEX ABUSE by Richard Gardner (Creative Therapeutics, 1987)

3) THE POLITICS OF CHILD ABUSE by Paul and Shirley Eberle (Lyle Stuart, 1986)

4) ACCUSATIONS OF CHILD SEXUAL ABUSE by Hollida Wakefield and Ralph Underwager (Charles C. Thomas, 1988); Note that the introduction by Besharov states that "the overzealous prosecution of sexual abuse charges...imperils the future credibility of all child protective efforts."

f. Evaluate above references very carefully and do not accept at face value. There may be serious reason to question their motives and objectivity.

g. Efforts to discourage or decrease reporting and investigations of suspected child abuse Examples:

1) For a time, legislation in Maryland (repealed this session) allowed therapists providing psychiatric treatment to pedophiles to be exempt from mandatory reporting of child sexual abuse revealed by clients in treatment where abuse occurred prior to commencement of therapy

2) Policies and procedures calling for fewer reports, investigations or prosecutions; see Section VI

II. False Allegations - Facts and Fallacies

A. Where do claims about false allegations come from?

1. Controversy over substantiation rates

a. Douglas Besharov claims 65% of all reports made to CPS are "unfounded" now compared to much less in past (see: Special Report: Solomon's Choice," MS. MAGAZINE, June 1989 and "An Overdose of Concern: Child Abuse and the Overreporting Problem," in Regulation: AEI Journal on Government & Society, Nov./Dec. 1985.)

1) Based on his own interpretation and analysis

2) Source of data and others do not reach same conclusion

3) "Recognizing how statistics are badly misused would go a long way toward reducing the current hysteria about child abuse," Douglas J. Besharov, Wall Street Journal August 4, 1988.

b. STUDY OF NATIONAL INCIDENCE AND PREVALENCE OF CHILD ABUSE AND NEGLECT prepared for the National Center on Child Abuse and Neglect, reported that 53% of investigated reports were substantiated in 1986, a significant INCREASE from 43% in 1980

c. Child Welfare League found substantiation rates remained stable despite increased reports

2. "Unfounded" gets translated to inappropriately made or "false" - a blatant misrepresentation

B. Meaning of "unfounded"--"dismissed or not substantiated after investigation"

1. Includes ALL reports of suspected abuse and neglect made to child protection agencies; majority of these (55%) are neglect reports, 27% are physical abuse and 16% are sexual abuse

2. "Investigation" may not really occur if caseload high or may be superficial and incomplete

3. Cases may be screened out without investigation or labelled "unfounded" for reasons having nothing to do with validity of allegation

a. Perpetrator not a family member or caretaker and therefore not within CPS responsibility

b. Reporter involved in a custody dispute

c. Unable to identify perpetrator

d. Unable to locate victim or family

e. Victim or family moved to different jurisdiction

f. Caseload control

g. Lack of resources or skill to adequately investigate

h. CPS determines no services available to help family

i. Child recants for reasons other than falsity of original allegation

4. May mean different things in different states

5. INCIDENCE STUDY noted that 9% of cases classified as unfounded in fact involved mistreatment resulting in physical harm to the child.

6. Very few reports are deliberately false

a. Jones and McGraw, "Reliable and Fictitious Accounts of Sexual Abuse to Children," JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 2., No. 1, March 1987

1) Reviewed 576 child sexual abuse cases reported to Denver CPS in '83

2) In 137 cases (24%), there was insufficient information

3) Of the remaining cases, 70% were deemed reliable

4) 22% were appropriate suspicions/good faith reports which turned out to be in error

5) Only 8% were deliberately false or fictitious-of these only 2% were made by a child and 6% originated with an adult

6) Characteristics of the 45 fictitious reports in study

a) 4 of the 5 children making fictitious reports were girls ages 12-17 who had been sexually abused before and had post-traumatic stress symptoms

b) Some of the adults had been sexually abused as children and displayed significant psychological distress as a result; two of the adult reporters suffered from major psychosis

c) Some of the allegations made by adults evolved from custody or visitation disputes

b. These figures consistent with other studies; see Berliner, "Deciding Whether a Child Has Been Sexually Abused", in SEXUAL ABUSE ALLEGATIONS IN CUSTODY AND VISITATION CASES: A Resource Book for Judges and Court Personnel, American Bar Association, Feb. 1988, and "False Allegations of Sexual Abuse by Children and Adolescents," by Mark Everson and Barbara Boat, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 28, No.2, March 1989.

1) Peters, 1976-study of 64 cases determined 6% false

2) Goodwin, 1979 - 3 out of 46 cases false - 7%; only one of these (2%) from a child

3) Horowitz, 1984 - out of 181 cases referred to a medical center 8% of those from children deemed false

4) Faller, 1988 - 142 cases, 3% from children untrue

5) Everson and Boat, 1989-1249 cases, 5% from children deemed false.

III. False Allegations in Divorce/Custody Disputes-Epidemic or Illusion?

A. Increasingly, it is claimed that allegations of sexual abuse are mushrooming in contested divorce/custody cases, e.g., "Fathers On Trial," NEW YORK MAGAZINE, 1/11/88

B. Frequent assertions (by VOCAL, Underwager, etc.) that 60-80% of cases involve false allegations instigated by vindictive spouses

1. "False Allegation Syndrome" coined by Lawrence D. Speigel in A QUESTION OF INNOCENCE (Unicorn Publishing House, 1986)

2. "Parental Alienation Syndrome" coined by Gardner

3. "SAID Syndrome-Sexual Allegations in Divorce," coined by Gordon Blush

C. Many articles and studies purporting to show large percentage of false allegations in these situations based on few cases and individual, subjective interpretations, rather than empirical assessment of probability samples, e.g. Benedek and Schetky (1984), Green (1986), Coleman (1985), McIver (1986), Gordon (1986), etc.

1. Benedek and Schetky, 1984 - 10 of 18 reports judged false: all these made by adults

2. Green, 1986 - 4 of 11 reports considered invalid: unclear which originated from children, if any

D. A contrasting point of view is represented in "Mothers on Trial," Washington Woman magazine, July/August 1987, indicating that divorcing mothers who raise concern are often branded as liars and may be penalized as a result;

E. Recent phenomenon of new "underground railroad"

F. Actual numbers are instructive--The Sexual Abuse Allegations Project, federally funded study conducted by the Research Unit of the Association of Family and Conciliation Courts, "Allegations of Sexual Abuse in Custody & Visitation Cases: An Empirical Study of 169 cases from 12 States," March 1988.

1. Looked at ALL contested divorce cases in 8 courts nationwide

2. Child sexual abuse allegations were raised in less than 2% of all contested cases

3. Of the 169 cases identified, only 3 resulted in criminal charges

4. Only 1/2 involved a wife accusing child's father

5. In 11%, the allegation originated with someone other than a parent

6. In 16%, the father was the accuser

7. Findings about validity indicate a rate of false allegations which is not terribly higher than for all reports of child sexual abuse

a. 50% were believed to involve abuse

b. In 17%, no determination could be made

c. 33% were believed to have not involved abuse; doubt about the good faith nature of the report was a factor, however, in only 14%

G. Need for careful investigation and assessment

1. Approach at outset should be no different than any other child abuse allegation

2. Investigation should be objective, prompt, thorough and sensitive

3. Circumstance of divorce/custody dispute is a factor to consider together with all other evidence gathered in the investigation; See MacFarlane, "Child Sexual Abuse Allegations in Divorce Proceedings," Chapter 7 of SEXUAL ABUSE OF YOUNG CHILDREN, Guilford Press, 1987

a. "Coached Child"

b. "Avenging Parent"

c. "Overanxious Parent"

4. See Corwin et al, "Child Sexual Abuse and Custody Disputes, No Easy Answers" in JOURNAL OF INTERPERSONAL VIOLENCE, Vol.2, No. 1, March, 1987, critiquing Green, "True and False Allegations of Sexual Abuse in Child Custody Disputes", JOURNAL OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY, Vol. 25, No. 4, 1986.

IV. Issues Related to Interviewing Techniques and Children's Testimony

A. The push toward interviewing protocols

1. Impracticability of restrictive interview guidelines

2. Different interview styles and philosophies make agreement on optimum and universal interviewing method highly unlikely and undesirable

3. Hidden dangers with detailed protocols--giving the defense extra ammunition to attack case

4. Proposals to expand scope of competency hearings--Christiansen, "The Testimony of Child Witnesses: Fact, Fantasy, and the Influence of Pretrial Interviews," WASHINGTON LAW REVIEW, Vol. 62, p. 705, 1987 (also suggested by Lee Coleman) - a step backward

B. Children's memory and suggestibility

1. Young children are often able to accurately recall and describe experiences, contrary to popular opinion

a. Recall of the very young must almost always be cued

b. Like adults, memories most accurate during free recall

c. Children spontaneously recall less than adults but what they recall is generally NOT less accurate

d. Children tend to remember actions best; are most inaccurate about locating events in time or distinguishing separate recurrent events; (Therefore, beware of the "detail trap.")

2. Children are much more resistant to suggestion than commonly believed

   a. At least down to age 5, children aren't any more suggestible than adults

   b. Preschoolers are more vulnerable to suggestion, but even the youngest resist suggestion involving central information; form of questions and authority of interviewer are important factors

3. See PROSECUTORS PERSPECTIVE, Vol. II, No. 1, Jan. 1988 for reviews of recent research in this area; additional information appears in CHILDREN'S EYEWITNESS MEMORY, edited by Ceci, Toglia and Ross (Springer-Verlay, 1987)

C. Video-taping of interviews--not a panacea

1. Potential advantages:

   a. May reduce need for additional interviews

   b. May capture emotion and details early on (which are likely to be lost as time passes)

   c. Provides verbatim account should there be later dispute about suggestibility, use of leading questions, etc.

   d. Child may be more comfortable because less formal setting

   e. Might be useful in inducing guilty pleas or generating family support for child

   f. Could be used to refresh child's recollection or combat later recantation or as prior consistent statement or as basis for expert testimony

   g. Could possibly be used at grand jury or other pre-trial hearings in lieu of child testifying

2. Pitfalls and drawbacks

   a. May make child or interviewer nervous or uncomfortable or distracted-child may want to play with equipment

   b. Single interview will give incomplete or fragmented description because of progressive disclosure, especially if initial interview is the one taped; if a later interview is taped, more complete account may be told, but early untaped interviews will be deemed by defense to be leading, suggestive, "coaching"

   c. Early interviews may contain denials or highlight a victim's usual reluctance and hesitancy to disclose--obviously can be exploited by defense; danger with later interviews that child may recant or show less convincing emotion; having any of these on tape increases their harmful effects on cases

   d. Cannot accurately capture and present entire context of child'statements/disclosures about abuse on video-tape; for instance, almost never will first disclosure be on tape, but whatever is on tape takes on increased importance and that which is not on tape becomes easier to discount or attack

e. Impractical to tape every contact with children where they may discuss abuse (e.g. courthouse steps, bathtime)

f. If there are no solid agreements or good control you could have multiple agencies or professionals interviewing and taping or at least acting inconsistently: this increases vulnerability to attack by defense of "selective taping" and increases chances of seemingly inconsistent statements by child, especially if different interviewers involved and if skill level or style differ

g. Ineffective video becomes defense ammunition: - used to impeach child's trial testimony, or -used as prior inconsistent statement, or - used to support claims of coaching

h. Issue may become whether interviewer's conduct, expertise and technique were appropriate rather than whether abuse occurred; and since there is not agreement among the various so-called experts about what the ideal interviewing style/techniques are or about extent of children's suggestibility, this is always an area defense can capitalize on - e.g. support and sensitivity to child's difficulty ("I know it's not easy, you're doing good") will be criticized as reinforcement/leading; challenging child's denial or encouraging reluctant child will be seen as coercive;

i. Can't always assure quality: soft voices won't be picked up, children move around, interviewer repeating answers will be criticized also as reinforcement; may sometimes lose sound altogether and then be left with no record of interview

j. Practical issues of expense, storage space and how long to preserve, must have good cataloging and storage system, assure tapes won't be erased or destroyed or lost, and preserve for future appeal periods

k. Privacy and confidentiality issues may arise, especially when taping is done by someone other than law enforcement; potential conflicts over who owns tapes, who can see them, victims' rights to control access, etc.

3. Prerequisites to successful use of video

   a. Control over who, when, where, how many

   b. Skillful and trained personnel

   c. Awareness of and experience with criminal trials

D. Use of anatomical dolls

1. As a tool to help child demonstrate what happened, generally okay

2. Do not use as a diagnostic tool; reliance on child's actions with the dolls as a basis for concluding abuse occurred can lead to reversal--IN RE AMBER B., 236 Cal. Rptr. 623, 1987.

3. Must be used with care--See Freeman and Estrada-Mullaney, "Using Dolls to Interview Child Victims", NIJ Reports, No. 207, Jan./Feb. 1988.

4. See "Interaction of Normal Children With Anatomical Dolls," Sivan et al, Child Abuse and Neglect, Vol. 12, pp. 295-304, 1988

5. A favorite area of defense criticism; see "Behavior of Abused and Non-Abused children in Interviews With Anatomically Correct Dolls," by William McIver, Hollida Wakefield and Ralph Underwager in ISSUES IN CHILD ABUSE ACCUSATIONS, Vol. 1, No.1, Winter 1989.

6. See also JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 3, No. 4, Dec. 1988 for several commentaries regarding use of dolls.

E. Closed Circuit TV and shields after COY vs. IOWA, 108 S. Ct. 2798, 101 L.Ed. 2d 857, 56 U.S.L.W. 4931 (1988)

1. Facts: defendant charged with sexual assault of 2 13 year old girls; at trial, screen between him and victims blocked him from their sight but allowed him to hear and see them dimly; placement of screen was pursuant to 1985 Iowa state statute; defendant argued violation of 6th Amendment confrontation rights

2. Holding: conviction reversed and remanded because screen violated defendant's right to face-to-face confrontation; based in part on lack of individualized findings that these witnesses needed special protection

3. Majority Opinion (5 justices) leaves open possibility that exceptions to confrontation might be able to be made when necessary to further an important public policy but gives virtually no guidance on what those might be

4. Justice O'Connor's concurring opinion more reasonable and helpful - suggests that specific finding of necessity by trial judge could allow use of procedure such as closed circuit TV

5. Two way closed circuit (6 states) where defendant and child see and hear each other probably still okay

6. One way closed circuit schemes (17 states) where defendant can see and hear child but child can't see or hear defendant are most likely in trouble

7. Since majority of child abuse cases are handled without use of such procedures, this ruling won't affect large numbers of cases; prosecutors will have to be cautious using special procedures that might affect confrontation rights and do so only when absolutely necessary to present case

V. Assessing Validity: No Simple Answers

A. Difficulty and complexity of these cases makes "checklists" attractive

B. Tempting to let others decide if believe child is truthful or not

C. "Sexual Abuse Legitimacy Scale" developed by Richard Gardner and promoted by VOCAL--Beware!

D. "Statement Validity Analysis" or "Statement Reality Analysis"

1. See "Assessing Credibility," Farr and Yuille, PREVENTING SEXUAL ABUSE, 1988.

2. See also "The Development of Statement Realilty Analysis" by Udo Undeutsch, to appear in J.C. Yuille (Ed.) CREDIBILITY ASSESSMENT, Dordrecht, The Netherlands, Kluwer; Spring 1989.

3. In U.S., David Raskin has presented workshops and testified based on this method.

E. Be careful before abdicating your responsibility and that of the jury to someone else

F. These "scales" and "systems" are not empirically based or validated

G. Evaluators must consider alternative explanations for child's statements, for information given by others, and for behavior observed

1. To determine if abuse, in fact, occurred

2. To anticipate and meet defenses so we can successfully prosecute those cases we concluded abuse did occur

VI. Expert Witnesses

A. Prosecutors must use experts in case in chief with caution

1. Risk of reversal; see, for example, ST. v. MILBRADT, No. SC 534731, Oregon, May, 1988

2. Encourages and creates opening for defense "experts"

3. See McCord, "Expert Psychological Testimony About Child Complainants in Sexual Abuse Prosecutions: A Foray Into the Admissibility of Novel Psychological Evidence," 77 Journal of Criminal Law & Criminology 1, 1986; and Lorenzen, "Admissibility of Expert Psychological Testimony in Cases Involving the Sexual Misuse of a Child," 42 U. Miami L.REV., in press

B. Defense experts--a growing business

1. Ralph Underwager (See State of Minnesota v. Cain, 427 N.W. 2d 5, July, 1988.

2. William McIver

3. Kenneth Von Cleve

4. Lee Coleman

5. Lawrence Spiegel (see "Child Abuse Hysteria and the Elementary School Counselor," by Spiegel in Elementary School Guidance and Counseling, Vol. 22, April 1988)

6. Elizabeth Loftus

7. David Raskin

8. Lawrence Daly

VII. Medical Evidence

A. Local protocols should address issues of medical evidence collection

B. Prosecutor should be involved together with police, medical personnel and criminalists in formulating any procedures or agreements relating to evidence collection, analysis and preservation

C. See "Surgeon General's Letter on Child Sexual Abuse" issued Nov. 15, 1988--available from National Maternal & Child Health Clearinghouse, (202) 625-8410.

D. Be aware of recent issues related to medical evidence

   1. "Child Abuse Evidence Debated," in MS Magazine, March, 1989

   2. Lee Coleman in "Medical Examination for Sexual Abuse: Are We Being Told the Truth?" says "It should be obvious that second [medical] examinations are a must in cases of alleged child sexual abuse."

   3. "Child Abuse and Neglect, the International Journal," vol. 13, No. 2, 1989 - majority is devoted to medical issues and contains articles on anal findings, genital findings, vaginal introital diameter and anogenital warts.

E. New techniques/technology--educate yourself

   1. Colposcope

   2. Toulidine blue dye

   3. DNA fingerprinting

F. Pediatricians have limited knowledge about social and medical aspects of sexual abuse; See "Do Physicians Recognize Sexual Abuse?" Ladson et al, AJDC Vol. 141, April 1987

G. COLOR ATLAS OF CHILD SEXUAL ABUSE by Chadwick, Berkowitz et al., Year Book Medical Publishers, 1989--a good reference; to order, call 1-800-622-5410

VIII. Child Abuse Reporting and Investigation Policies

A. "Consensus" document - CHILD ABUSE AND NEGLECT REPORTING AND INVESTIGATION, POLICY GUIDELINES FOR DECISION MAKING, 1988, Douglas J. Besharov, "Rapporteur"

B. "Guidelines for a Model System of Protective Services for Abused and Neglected Children and Their Families" 1988, National Association of Public Child Welfare Administrators - Increasingly, states are screening out cases based on specific family situations or parental behaviors; examples:

   1. Children born drug-addicted

   2. Homelessness

   3. Parental substance abuse

   4. Attempted suicide or drug use by a teenager

C. "Child Abuse - A Police Guide," 1987, Douglas J. Besharov, Police Foundation and The American Bar Association; note definition of "Sexual abuse" in chart on p.6 - vaginal, anal or oral intercourse; vaginal or anal penetrations; or other serious forms of inappropriate sexual contacts."

D. "Child Abuse: Arrest and Prosecution Decision Making," Douglas J. Besharov, American Criminal Law Review, Vol. 24, No. 2, Fall 1986

E. Besharov advocates for more restrictive definitions of abuse (requiring serious injury or the potential for serious injury) and more screening of referrals; he has said, "Unfortunately, the determination that a report is unfounded can be made only after an unavoidably traumatic investigation that is inherently a breach of parental and family privacy...Each year, over 500,000 families are put through investigations of unfounded reports. This amounts to a massive and unjustified violation of parental rights."

F. Public opinion poll, "Public Attitudes and Actions Regarding Child Abuse and Its Prevention," February, 1988 conducted by Schulman, Ronca and Bucuvalas, Inc. for National Committee for the Prevention of Child Abuse

   1. Telephone interviews of representative random sample of adults across U.S.

   2. Over 2/3 of American public feel public child welfare agencies should investigate all child abuse reports regardless of seriousness of charge rather than only those with clear evidence of serious injury or harm to the child

   3. Public supports strong and aggressive application of reporting standards and majority would rather see investigation of potentially unfounded reports rather than wait until clear evidence of abuse occurs

IX. Drug-Affected Infants and Children - An Emerging Issue of Great Importance

A. Scope of the problem: estimates range from 50,000 or 60,000 up to 375,000 children born each year to women who have used illegal drugs during pregnancy; "crack-babies" seen as a recent and unprecedented phenomenon attributed to widespread use of crack=cocaine by women.

B. Role of criminal justice system

   1. Hotly debated issue: ACLU and many women's rights advocates are against "punitive" measures--including prosecution and often even threat of removal of children using civil dependency/neglect system.

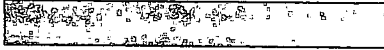
   2. Relatively few criminal prosecutions to date

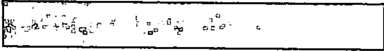
      a. Some using existing drug laws, such as delivery of controlled substance

      b. Some using existing criminal child abuse and neglect statutes

      c. All involve women who have already delivered

   3. Careful consideration of all options is needed; prosecutors need to be included in the discussions about how to tackle this problem.





Presentation Materials

Jury Selection

Presented by
Jill Hiatt, J.D.

Jury Selection

Please review the following juror profiles. Consider whether or not they would be appropriate jurors for a child abuse case and the reasons why or why not. During the workshop there will be discussion of each of these possible jurors, whether they may be appropriate for some abuse cases and not for others, and what other information may be needed to make a decision.

Possible Jurors

1. Mary Muggins
Appears to be in her late fifties to early sixties
Married - Never worked
Husband is retired, was a bricklayer
Has three grown children - one a teacher, one a secretary, one a salesman
Four grandchildren - sees them fairly regularly
Doesn't watch T.V. programs about child abuse and can't recall ever having read anything about the subject.

2. Jane Jones
Appears to be in her late twenties - attractive outgoing
Unmarried - lives with boyfriend who is a salesman
Has no children
Has two married sisters who have four children that she sees about once every other week
Works as an executive assistant to an advertising executive
College degree
Says she has seen some media pieces on subject of abuse
Doesn't believe children are less honest than adults

3. Bill Bennett
Late thirties to early forties
Married - Wife is bank teller
Three children - ages 7 to 12
Manager of a large drug store - part of chain
Is a little league coach
Older brother accused by ex-wife of sexual abuse of child - no prosecution

4. Sister Martha Maguire
Late sixties
Catholic nun
Worked as both a teacher and a social worker for the church
Has had incidents of abuse among both students and social work clients

5. John Johnson
Late thirties
Architect - large local firm 12 years
Unmarried - lives with a man who is a florist
No children
Has one brother who lives in another city - little contact
Active with church youth groups

6. Carl Conrad
Late fifties
Married - wife is housewife
Executive of large oil company
Two children - private practice attorney and housewife
Daughter rape victim when 19 years old - perpetrator never caught

7. Jennifer Jacobs
Early twenties
Waitress in restaurant bar
Unmarried - lives with two other women both waitresses
Has four married siblings - seven nieces and nephews
Often baby sits for siblings
Part time college student

8. Mildred Matthews
Late fifties
Divorced
Works for department of motor vehicles - supervisor
Has five grown children
One son in prison - auto theft
Other children teacher, social worker, secretary, mechanic
Six grandchildren - two living with her full time - 7 and 8

9. Jerome Jettson
Late forties
Married - wife runs two day care centers
Attorney - general practice
Two children - 14 and 16
Works with son's swimming team

10. Larry Lathrop
Middle twenties
Carpenter
Unmarried - lives alone
Is a "Big Brother"
Father a retired police officer - one married sister no children

11. Sarah Simonsen
Early thirties
Teacher
Married - husband a salesman
One child 4 years
Has had two physical abuse victims in her classes that she reported

12. Peter Peterson
Late forties
Librarian
Unmarried - lives with his mother
Very interested in computers - hobby
Has neighborhood children over often to play computer games

13. Patricia Paulson
Middle thirties
Telephone company supervisor
Married - husband a salesman
Two children age 2 and 5
Child abuse victim of her father - never reported - father now dead

14. James Jefferson
Late fifties
Salesman and part time pastor of Church of Forgiveness and Peace
Married - wife is housewife ("women shouldn't work")
Nine children ages 4 to 25
Church's basic teaching is all things can be forgiven

15. Allen Adams
Late thirties
Divorced - Ex-wife is nurse
Two children - 12 and 10
Associate Professor of Psychology - U.C. Berkley
Never practiced as treating psychologist

16. Matilda Mason
Early forties
Single
Registered nurse - Emergency room care
Little or no contact with children outside of work
Has seen some abuse cases

JURY QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions as completely as possible. If there is any question which you do not wish to answer in writing, feel free to so indicate and the court will arrange a private conference.

1. Name____

Age_____Sex_____Birthplace________________________________

Do you have any type of physical disability, handicap or other problem? Yes_____No_____

If yes, please describe_________________________________

Languages spoken or understood other than English_________

____

Please describe your educational background:

Highest grade completed?_____________

Name, location of high school and college and major areas of study:

____

____

2. Marital status:

Married_____Separated_____Divorced_____Widowed_____Single

If married or separated, does spouse work? Yes_____No____

What type?____________________Where_________________

If widowed or divorced, what was former spouse's occupation?____

3. Area of Residence____

Do you own or rent your home? Own_____Rent_____

Number of persons living with you________________________

How long have you lived at your present home?____________

How long at your previous home?__________________________

4. Work outside the home? Yes_____No_____Retired________________

If yes, where?____

How long with present employer?__________________________

How long did you work at your previous job?______________

What were your previous jobs or occupations?_____________

____

Have you ever worked or volunteered at any job or activity which involved regularly coming in contact with children?

Yes_____No_____

If yes, please give details:

____

____

5. Do children live in your household? Yes_____No_____

If yes:

How many?__________Age and sex of each:__________________

____

If not your own children, what relationship:

____

If no, do you have children living elsewhere? If so, complete below:

Age and sex of each ______________________

If minors, who has custody? ______________________

If adults, employment of each ______________________

____

Have you ever lived in a household with children?

Yes_____ No_____

If yes, please give details:

____

____

6. Do any adults, other than yourself, reside in your home?

Yes_____ No_____

If yes, how many?________ What are their jobs or occupations?______________________

____

____

7. What are your leisure-time activities?

____

____

How do you find out about the news?

T.V.______ Radio___________

Newspapers_____________ Other?______________________

What newspapers or magazines do you read on a regular basis?

____

What kinds of books do you read?____________________________

Are you currently reading a book? Yes_____No_____

If yes, describe book and give title:____________________

____

What television or radio programs do you watch or listen to on a regular basis?_______________________________________

____

____

What radio station do you normally listen to?_____________

8. What organizations, clubs, sports teams, etc., do you belong to now or in the past (for example, bowling leagues or gun clubs)?

____

____

9. What volunteer activities or committees do you belong to now or in the past (for example, neighborhood associations or political groups)?____

____

10. Have you ever been on jury duty before? Yes_____No_____

If yes, list all cases, indicating whether civil or criminal, where you served, when, what type of case (e.g. drunk driving) and whether the jury was able to reach a verdict (do not indicate what the verdict was):

____

____

____

Have you ever been a witness in court? Yes_____ No_____

If yes describe: ____

____

Aside from the above have you ever been in a courtroom other than as a juror? Yes_____ No_____

If yes, please explain:

____

____

11. Do you know anyone who is a police officer, lawyer or anyone who works within the court system (example: prosecutors, defense attorneys, judges, court reporters, clerks, bailiffs, etc.)?

Yes_____ No_____

If yes, list (include relationship or job)

____

____

12. Have you, any member of your family, any acquaintances ever:

Been a victim of a crime? Yes_____ No_____

Been accused of a crime? Yes_____ No_____

Been arrested? Yes_____ No_____

Please explain your yes answers to any of the above:

____

____

13. Has anyone ever:

* Told you about having been sexually molested?

Yes_____ No_____

* Told you about having been sexually touched in a manner they felt was wrong? Yes_____No_____

* Told you about having been spoken to in a sexually improper manner they felt was wrong? Yes_____No_____

* Lied to you or to anyone you know about having been sexually molested or touched? Yes_____No_____

How did you know it was not true?

____

Please explain any of your yes answers to the above questions.____

____

____

____

14. When you were a child:

Were you sexually touched or molested? Yes_____No_____

Talked to in a sexual manner you considered wrong at the time? Yes_____No_____

Talked to in a sexual manner you consider wrong now? Yes_____No_____

Were present when someone else was sexually touched or molested? Yes_____No_____

15. Do you know anyone who was accused of sexually molesting, touching, annoying or raping a child or adult? Yes_____No_____

16. Do you know anyone, either a child or adult, who was actually or came close to being sexually molested, touched or raped?

Yes_____ No_____

17. Do you know anyone who has had a sexual relationship as an adult with someone under the age of 16? Yes_____ No_____

If yes, what was the age of the person under 16?_____

What was the age of the adult?_____

What was your opinion about that relationship? __________

____

____

18. Have you, any member of your family, any acquaintance ever been involved in any way with an investigation by police or social service workers regarding allegations of child abuse:

as a witness? Yes ___ No ___

as a victim? Yes ___ No ___

as a suspect? Yes ___ No ___

Please discuss the circumstances of any yes answer: ________

____

____

____

19. Have you seen or read any T.V. shows or articles about child abuse? Yes ___ No ___ If yes, what was your reaction? ___

____

____

20. Do you favor or oppose having sex education courses in the public schools? Favor ___ Oppose ___ Why do you feel that way?

____

____

21. In very general terms what effect do you feel sexual molestation has on a child? ____

____

____

22. In very general terms what do you believe causes sexual molestation of children? ____

____

____

____

23. Do you have an image of the type of man who would sexually molest a young girl or boy? If so, please describe: _____

____

____

____

____

24. Do you have an image of the type of woman who would sexually molest a young girl or boy? If so, please describe: _____

____

____

____

____

25. What measures should be taken to prevent or cut down on sex offenses against children? ______________________________

____

____

____

____

____

26. If a child has been sexually molested, what should be done to help the child get over the incident? (Circle one)

(1) make sure the child gets psychological counseling;

(2) leave the child to get over the incident on his or her own;

(3) restrict the child from leaving home without permission;

(4) other (please describe): ___________________________

____

____

27. Do you approve or disapprove of parents with children having magazines, such as Playboy or Penthouse, around the house?

(1) approve (2) disapprove

Please state why you feel this way: ____________________

____

____

____

____

28. Do you have any knowledge of this case, other than what you have heard here in court, from any other source, such as television, radio, newspaper or friends? Yes_____No_____

If yes, please describe:

____

____

____

____

____

29. Do you know any of the following people who are involved in this case? If so, please indicate how well:

[witness list]

30. Is there anything that you would like to bring to the court's attention that might affect your ability to be a fair and impartial juror in this case?_______________________________

____

____

____

I declare that the forgoing answers are true and correct to the best of my knowledge.

Signature:_______________________________

Dated:__________

Articles

Understanding When and How to Use Expert Witnesses

Presented by
John E.B. Myers, J.D.
and
Harry Elias, J.D.

CHILD WITNESS LAW AND PRACTICE

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§ 4.8 Demonstrative Evidence as an Aid to Testimony

Demonstrative evidence is "evidence addressed directly to the senses without the intervention of testimony."[56] McCormick gives depth to this definition when he writes:

> There is a type of evidence which consists of things, e.g., weapons, whiskey bottles, writings, and wearing apparel, as distinguished from the assertions of witnesses (or hearsay declarants) about things. Most broadly viewed, this type of evidence includes all phenomena which can convey a relevant first-hand sense impression to the trier of fact, as opposed to those which serve merely to report the secondhand sense impressions of others.[57]

Within the generic class called demonstrative evidence, it is useful to distinguish between things which played an actual part in the matter being litigated (e.g., a gun) and things which "played no such part but [are] offered for illustrative or other purposes."[58] The former category is often called *real* or *original* evidence. The instant discussion is limited to the latter class of demonstrative evidence, which is designed to illustrate or aid testimony.

There are many uses for demonstrative evidence in litigation involving children. Professor Imwinkelried reminds us that "[t]he only limits on the use of demonstrative evidence are the trial judge's discretion and the trial attorney's imagination."[59]

As mentioned above, use of demonstrative evidence lies within the discretion of the trial judge.[60] Courts generally permit use of such evidence if it will aid the child in testifying or if it will assist the jury in understanding the child's testimony.[61] McCormick writes that "the theory justifying admission of these exhibits requires only that the item be sufficiently ex-

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[56] Black's Law Dictionary 519 (4th ed. 1968). For discussion of demonstrative evidence, *see* McCormick § 212, at 663–69.

[57] McCormick § 212, at 663 (footnotes omitted).

[58] McCormick § 212, at 667.

[59] Imwinkelried at 78.

[60] *See* State v. Eggert, 358 N.W.2d 156, 161 (Minn. Ct. App. 1984) ("In general, the use of models and other types of illustrative evidence is within the discretion of the trial court"; it was not an abuse of discretion to permit a young sex abuse victim to illustrate her testimony with dolls); McCormick § 212, at 669 ("Whether the admission of a particular exhibit will in fact be helpful, or will instead tend to confuse or mislead the trier, is a matter commonly viewed to be within the sound discretion of the trial court").

[61] State v. Eggert, 358 N.W.2d 156, 161 (Minn. Ct. App. 1984) ("The test is whether or not the testimonial aid will likely assist the jury in understanding the witness's testimony"). *See also* Newton v. State, 456 N.E.2d 736, 741 (Ind. Ct. App. 1983) ("Demonstrative evidence is admissible if the item is sufficiently explanatory or illustrative of relevant testimony to be of potential help to the trier of fact").

planatory or illustrative of relevant testimony in the case to be of potential help to the trier of fact."[62] The party desiring to use demonstrative evidence is not required to show that the witness will be completely unable to testify without the assistance of the demonstrative aid. Rather, the test is whether the demonstrative evidence will assist the child in describing what happened so that the jury can understand. For example, in *State v. Eggert,*[63] a young sex abuse victim was permitted to illustrate her testimony with dolls. The defendant objected that the demonstrative evidence was unnecessary because the child was able to tell her story without the aid of dolls. The appellate court disagreed, stating that:

> Appellant's argument does not correctly state the true test of the use of testimonial aids. For instance, a doctor or engineer may be allowed to use artificial mockups of the human anatomy, cutaways, maps and diagrams, etc., even if the witness acknowledges that he does not *have* to have those things to testify. The test is whether or not the testimonial aid will likely assist the jury in understanding the witness's testimony.[64]

In sexual abuse litigation in criminal and juvenile court, young children often use anatomically correct dolls to illustrate their testimony.[65] The trial judge has broad discretion to authorize the use of dolls, and appellate decisions discussing the matter uphold trial-level decisions to permit children to illustrate their testimony with the aid of dolls.[66] Some states have enacted legislation expressly authorizing use of dolls during testimony. A recent Alabama statute provides that:

> In any criminal proceeding and juvenile cases wherein the defendant is alleged to have had unlawful sexual contact or penetration with or on a child, the court shall permit the use of anatomically correct dolls or mannequins to assist an alleged victim or witness who is under the age of 10 in testifying on direct or cross-examination at trial, or in a videotaped deposition as provided in this chapter.[67]

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[62] McCormick § 212, at 668.

[63] 358 N.W.2d 156 (Minn. Ct. App. 1984).

[64] *Id.* at 161 (emphasis in original).

[65] The need for dolls to aid testimony is especially acute with the youngest children. *See* Vera v. State, 709 S.W.2d 681, 686 (Tex. Ct. App. 1986) ("The use of dolls is often critical when the complainant witness is very young").

[66] *See* Cleaveland v. State, 490 N.E.2d 1140, 1141 (Ind. Ct. App. 1986); Commonwealth v. Trenholm, 14 Mass. App. 1038, 442 N.E.2d 745, 746 (1982); State v. Eggert, 358 N.W.2d 156, 161 (Minn. Ct. App. 1984); State v. DeLeonardo, 315 N.C. 762, 340 S.E.2d 350 (1986); State v. Madden, 15 Ohio App. 3d 130, 472 N.E.2d 1126, 1130 (1984); Bryant v. State, 685 S.W.2d 472 (Tex. Ct. App. 1985); Vera v. State, 709 S.W.2d 681, 686 (Tex. Ct. App. 1986); Kehinde v. Commonwealth, 1 Va. App. 342, 338 S.E.2d 356 (1986).

[67] Ala. Code § 15-25-5 (1986 Supp.).

The dolls employed to aid testimony in sex offense cases are usually anatomically correct, although the fact that a doll is not completely anatomically correct does not mean that it cannot be used. In *Cleaveland v. State,*[68] the court wrote:

> One of the victims, D.C., was eight years old at the time of the trial, and testified with the aid of two dolls, one representing a male and the other a female. Using the dolls, D.C. demonstrated that Cleaveland had pulled down her pants and underwear and put his hand between her legs, touching an area indicated in pink on the doll. Cleaveland argues that because the pink area between the doll's legs did not accurately represent the human vagina, D.C. should not have been allowed to use the doll during her testimony.
>
> The trial court has discretion in allowing or prohibiting the use of demonstrative evidence. . . . Such evidence may be admitted if it is sufficiently explanatory or illustrative of relevant testimony in explaining what occurred. . . . The doll D.C. used had sufficient anatomical detail to help the jury. Cleaveland has not established that the doll's lack of an accurately depicted vagina in any way misrepresented D.C.'s testimony or misled the jury, or prejudiced him in any other way.[69]

The test is whether the doll will help the jury to understand the child's testimony.

Before handing anatomical dolls to a child witness, counsel should state for the record that the dolls are anatomically correct.[70] This statement permits an appellate court to comprehend the child's testimony, and is important because the dolls, which are expensive, are not made a part of the record. In addition to describing the dolls for the record, it is appropriate for counsel to ask the child to identify the dolls. The child might say, "This is a girl doll and this is a boy doll." As a follow-up, counsel may ask the child to tell how he knows which is which. Counsel should also ask whether the dolls will help the child describe what happened. As the child illustrates the story with the dolls, counsel should clarify the record with such statements as, "May the record reflect that the witness has placed the penis of the male doll inside the vagina of the female doll while the male doll is lying on top of the female." Absent such clarification, an appellate court cannot recreate the child's testimony.

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[68] 490 N.E.2d 1140 (Ind. Ct. App. 1986).

[69] *Id.* at 1141.

[70] *See* Kehinde v. Commonwealth, 1 Va. App. 342, 338 S.E.2d 356, 358 (1986), where the court expressed concern "that the record does not disclose whether the doll was anatomically correct."

Dolls are particularly helpful with youngsters who are linguistically immature. Such children may not have the vocabulary to effectively describe the details of an occurrence. In particular, they may not know the proper terms for parts of the human body.[71] By using anatomically correct dolls, such children can show what they cannot tell. Such demonstrative evidence may be very helpful, indeed indispensable, to the jury.

If sexual penetration is an issue, anatomically correct dolls may be used to help a child illustrate how penetration occurred. Dolls are particularly helpful on this issue because many children are less than effective in describing penetration. They say such things as, "He put it in me," "He put it between my legs," "He touched my bottom," or "His popsicle hurt my peepee."[72] It is hardly reasonable to expect the average seven-year-old calmly to recite, "The accused penetrated my vagina with his penis," and if the child did use such words, most adults would suspect coaching. Accepting the fact that children use childlike language to describe events, including penetration, it is important to assist the jury to understand precisely what the child means. Anatomically correct dolls are well suited to this end. The child can testify orally using his own descriptive terms, and can illustrate what those terms mean by showing the factfinder what happened.[73]

It is also appropriate to use dolls in preparing children to testify.[74] In *State v. Eggert,*[75] the Minnesota Court of Appeals addressed the issue of preparation with dolls in a sex abuse case. The court wrote:

> Appellant additionally argued that allowing the victim pre-trial practice with the dolls was prejudicial. We find that contention without merit. The

---

[71] *See* State v. Madden, 15 Ohio App. 3d 130, 472 N.E.2d 1126, 1130 (1984):

> A review of the transcript reveals that [witness] testified that appellant placed "his thing" on her and that he put it in between her legs. The girl did not know the correct name for appellant's "thing" nor could she give a description of it. A doll with anatomical details was then used to illustrate and clarify the girl's testimony. Based on the victim's obvious lack of knowledge of the correct terms for human reproductive organs, there was no abuse of discretion in allowing the use of dolls to clarify the girl's testimony.

See also State v. Lee, 9 Ohio App. 3d 282, 459 N.E.2d 910, 912 (1983) ("The record indicates that the witness was unable to relate to the jury the events using the appropriate sexual or physiological terminology. The dolls were used to clarify the witness's explanation and to insure a common understanding between the witness and jury as to the events which took place.").

[72] *See* State v. Madden, 15 Ohio App. 3d 130, 472 N.E.2d 1126, 1130 (1984).

[73] *See* State v. DeLeonardo, 315 N.C. 762, 340 S.E.2d 350, 352–53 (1986) (male sex abuse victim permitted to illustrate anal penetration with dolls); Bryant v. State, 685 S.W.2d 472, 474 (Tex. Ct. App. 1985) (five-year-old sex abuse victim permitted to illustrate how defendant touched her vagina by using dolls).

[74] *See* Newton v. State, 456 N.E.2d 736, 741 (Ind. Ct. App. 1983): Defendant

> further argues the pretrial use of the dolls impinged upon his right to counsel and his right to cross-examination. He analogizes the witness's out of court experience with the dolls to hypnotically enhanced testimony. . . . His argument is based on his assumption the witness was able to remember details at trial she was previously unable to remember at her deposition as a result of her practice with the dolls.

Although the court found defendant's argument "creative," it was rejected.

[75] 358 N.W.2d 156 (Minn. Ct. App. 1984).

child had described the incidents to adults several times before there was any use of the dolls, not only to her parents but to the child psychologist and the pediatrician. There is no indication that the child's testimony was improperly reinforced by the use of the dolls at trial. It is accepted and ethical trial procedure for either side in a civil or criminal case to display to a potential witness a testimonial aid that he or she may be asked to use during the testimony.[76]

Needless to say, caution must be exercised to ensure that pretrial preparation with dolls does not degenerate into a coaching session in which the adult uses the dolls to show the child what happened. The cross-examiner may delve into this possibility, and if improper coaching is disclosed, the effect on the child's testimony can be devastating.[77]

Dolls are not the only type of demonstrative evidence used with child witnesses. Much the same explanatory effect can be achieved through use of diagrams of the human body. *Pittman v. State*[78] provides an example. In this sex offense case, the prosecutor presented the 13-year-old victim with an anatomically correct diagram representing her body. The child circled the mouth and hand on the diagram, and testified that these were the parts of her body which the defendant wanted her to use to touch him. Following this, the child was given an anatomically correct diagram representing an adult male. She was asked to circle the part of the diagram that defendant forced her to touch. In response, she circled the male sex organ. It is not difficult to imagine the impact of such illustrated testimony on the jury. The defendant objected to use of the diagrams, but the Georgia Court of Appeals rejected the objection, and held that the trial court acted within its discretion in permitting such demonstrative evidence.

In addition to dolls and diagrams, it may be proper in some cases to permit a child witness to draw a picture of an event.[79] Obviously, such a picture may be out of scale or otherwise inaccurate. Inaccuracy should not render such evidence inadmissible, however, unless the opponent can demonstrate that the picture is prejudicial or of no help to the jury. Counsel has the right to cross-examine the child about the picture in an effort to undercut its accuracy. In the final analysis, the use of in-court drawings by a child witness should be left to the sound discretion of the judge.

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[76] *Id.* at 161.

[77] *See* Newton v. State, 456 N.E.2d 736, 742 (Ind. Ct. App. 1983) (court held that it was proper to use dolls in pretrial preparation; it noted, however, that "the fact the witness did practice is a factor properly considered in determining her credibility"). See also § 4.43 for discussion of cross-examinations of a witness who used a doll on direct.

[78] 178 Ga. App. 693, 344 S.E.2d 511, 512 (1986).

[79] *See* State v. Eggert, 358 N.W.2d 156, 161 (Minn. Ct. App. 1984) (child was "allowed to draw a picture of the alleged actions which were shown to the jury").

CHILD WITNESS LAW AND PRACTICE

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§ 4.8 Demonstrative Evidence as an Aid to Testimony

* *Page 142, add to footnote 65:*

See State v. Fletcher, 322 N.C. 415, 368 S.E.2d 633 (1988), in which the four-year-old victim used anatomically detailed dolls to illustrate her testimony. The court held that the practice of allowing children to illustrate sexual abuse with dolls "is wholly consistent with existing rules governing the use of photographs, and other items to illustrate testimony. It conveys the information sought to be elicited, while it permits the child to use a familiar item, thereby making him more comfortable." *Id.* at 637.

Page 142, add to footnote 66:

Phillips v. State, 505 So. 2d 1075, 1077 (Ala. Ct. Crim. App. 1986) (seven-year-old victim; proper to permit child to illustrate touching of "intimate parts" with dolls); State v. Jarzbek, 204 Conn. 683, 529 A.2d 1245, 1247 (1987); People v. Hutson, 153 Ill. App. 3d 1073, 506 N.E.2d 779, 780 (1987) (11-year-old victim; proper to illustrate penetration with doll); State v. Watson, 484 So. 2d 870, 875 (La. Ct. App. 1986) (15-year-old victim; dolls used to illustrate that victim knew names of female and male genitalia); People v. Foreman, 161 Mich. App. 14, 410 N.W.2d 289 (1987).

In People v. Garvie, 148 Mich. App. 444, 384 N.W.2d 796, 799 (1986) (seven-year-old victim), the court wrote:

> Defendant argues that he was denied a fair trial when Troy was shown, over objection, two suggestive and prejudicial "anatomically correct" dolls to demonstrate the sexual offense. Defendant asserts that the dolls were prejudicial as depicted because the "man" doll when compared to the "cute little boy" doll was designed particularly to appear "cynical" looking (defendant possibly intends to say "sinister" looking). Our review at oral argument of photographs of these dolls does not suggest that untoward prejudice would have resulted to defendant at trial from the mere appearance of the dolls.
>
> Defendant further asserts that the dolls were admitted at trial without a proper foundation establishing that their use was necessary to assist Troy while testifying. Defendant acknowledges that Troy was timid but suggests that timidity is not unnatural in such a sensitive case. We think the situation presented to the trial court was one for the sound exercise of its discretion. . . . The court did not find the dolls' looks to be prejudicial and believed they would assist Troy in testifying. We find no abuse of discretion.

(Footnote omitted.)

See also People v. Herring, 135 Misc. 2d 487, 515 N.Y.S.2d 954 (1987) (70-year-old aphasic sodomy victim permitted to illustrate sodomy with anatomically detailed dolls); State v. Watkins, 318 N.C. 498, 349 S.E.2d 564, 565 (1986) (six-year-old victim illustrated penetration with dolls); Pryor v. State, 719 S.W.2d 628, 631 (Tex. Ct. App. 1986) (six-year-old victim illustrated penetration with dolls); Murriel v. State, 515 So. 2d 952 (Miss. 1987).

In addition to their use as demonstrative evidence, anatomically detailed dolls are used to assist clinicians and other professionals in determining whether children have been sexually abused. For discussion of anatomically detailed dolls as an aid to diagnosis of sexual abuse, see § 4.17I in this supplement.

§ 4.17L —Use of Dolls to Diagnose Sexual Abuse or as Evidence of Sexual Abuse (New)

Anatomically detailed dolls are often used as an aid when interviewing children who are suspected of being sexually abused. For example, dolls are widely used by law enforcement professionals, child protective service workers, and clinicians. In the hands of a trained professional, the dolls are helpful in the interview and diagnostic process.

* A number of empirical studies have investigated children's interaction with anatomically detailed dolls. These studies indicate that although the dolls are not a litmus test for sexual abuse, they are a useful adjunct of interviewing children who may be sexually abused.

See White, Strom, Santilli, & Halpin, *Interviewing Young Sexual Abuse Victims with Anatomically Correct Dolls,* 10 Child Abuse & Neglect 519 (1987)(Sample: 25 children referred for suspected sexual abuse, and 25 children with no evidence of sexual abuse. Age range, two to five years. The children in the referred group displayed more sexualized behaviors with the dolls than the nonreferred children. The differences were statistically significant. Children not suspected of being abused showed no unusual sexualized behaviors with the dolls. Merely exposing nonabused children to anatomically detailed dolls does not itself produce indicators of sexual abuse); Jampole & Weber, *An Assessment of the Behavior of Sexually Abused and Nonsexually Abused Children with Anatomically Correct Dolls,* 11 Child Abuse & Neglect 187 (1987)(Sample: 10 sexually abused children and 10 nonabused children. Age range, three to eight years. There was a statistically significant difference between the two groups, as evidenced by the presence or absence of sexual behavior in play with the dolls. Ninety percent of the sexually abused children demonstrated sexual behaviors with the dolls. Eighty percent of the nonabused children did not demonstrate sexual behaviors with the dolls); Sivan, Schor, Koepple, and Nobel, *Interaction of Normal Children with Anatomical Dolls,* 12 Child Abuse & Neglect 295 (1988)(study of 144 children with no history of sexual abuse. Age range, three to eight years. The children interacted with anatomically detailed dolls. "Little aggression and no explicit sexual activity was observed. In contrast to clinical observation of abused children, the doll play of nonreferred children is unlikely to be characterized by agression or sexual concerns; thus these behaviors when observed in interaction with these dolls should be taken seriously").

See also Boat & Everson, *Interviewing Young Children with Anatomical Dolls,* 67 Child Welfare 337 (1988); Boat & Everson, *Use of Anatomical Dolls among Professionals in Sexual Abuse Evaluations,* 12 Child Abuse & Neglect 171 (1988); White & Santilli, *A Review of Clinical Practices and Research Data on Anatomical Dolls,* 3 J. Interpersonal Violence 430 (1988).

A number of cases discuss use of anatomically detailed dolls as an adjunct to interviewing and/or diagnosis.

See United States v. Gillespie, 852 F.2d 475, 480-81 (9th Cir. 1988)(expert testimony that child was molested by male rather than female was based in part on child's play with anatomically detailed dolls. Court holds that such use of dolls must meet the requirement established in *Frye v. United States,* 293 F. 1013 (D.C. Cir. 1923)).

In re Amber B., 191 Cal. App. 3d 682, 236 Cal. Rptr. 623 (1987)(when expert bases opinion of sexual abuse partially on child's use of dolls, such use of dolls constitutes a novel scientific test. Before evidence based on such a novel scientific test is admissible, proponent must prove that the test is generally accepted in the relevant scientific community). *See also Seering v. Department of Social Services,* 194 Cal. App. 3d 298, 239 Cal. Rptr. 422 (1987); *In re Sara M.,* 194 Cal. App. 3d 585, 239 Cal. Rptr. 605 (1987); *In re Christine C.,* 191 Cal. App. 3d 676, 236 Cal. Rptr. 630 (1987); *In re Cheryl H.,* 153 Cal. App. 3d 1098, 200 Cal. Rptr. 789 (1984).

In re M.E., 715 S.W.2d 572 (Mo. Ct. App. 1986)(dolls were used by social workers to determine whether sexual abuse occurred; children played with dolls in a way that suggested they had sexual knowledge far in advance of their ages. Defendant objected that children's assertive play with the dolls was hearsay. Court stated that the assertive doll play was not admitted to prove that abuse occurred, but to prove the children's sexual knowledge, thus it was not hearsay); *State v. Mayfield*, 302 Or. 631, 733 P.2d 438 (1987)(assertive conduct with dolls is hearsay); *In re C.L.*, 397 N.W.2d 81 (S.D. 1986)(child's use of the dolls was evidence of sexual abuse; child's use of dolls was nonassertive, thus not hearsay); *In re Penelope B.*, 104 Wash. 2d 643, 709 P.2d 1185 (1985); *State v. Hunt*, 48 Wash. App. 840, 741 P.2d 566, 568 (1987).

People v. Garrison, 166 Mich. App. 557, 420 N.W.2d 851, 852 (1988)(expert "testified that the victim's use of the anatomically correct dolls corroborated the victim's allegations of sexual abuse. Defendant argued that the trial court erred in allowing this testimony because the opinion was given as though supported by scientific certainty. "Testimony as to a child's reaction to an anatomically correct doll may be admissible as a foundation for an expert witness's opinion that the child has been sexually abused even though their use does not rise to the level of a scientific test"); *In re Rinesmith*, 144 Mich. App. 475, 376 N.W.2d 139, 141-42 (1985)(anatomically detailed dolls were not a scientific test implicating admissibility rule of *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923); "The dolls are not calculated to elicit a particular result but as a tool to permit children to communicate ideas which they are unable to express verbally because they are too young or anxiety-ridden or because they lack the vocabulary").

§ 4.8 Demonstrative Evidence as an Aid to Testimony

Page 141, add to footnote 60:

Brady v. State, 540 N.E.2d 59 (Ind. Ct. App. 1989).

Page 142, add to footnote 65:

Brady v. State, 540 N.E.2d 59 (Ind. Ct. App. 1989); State v. Chandler, 376 S.E.2d 728 (N.C. 1989)(not error to permit testifying social worker to use dolls to illustrate what victims did with dolls during interviews); Williams v. State, 539 So.2d 1049, 1050 (Miss. 1989)("The use of anatomically-correct dolls during a trial is a matter of discretion with the trial judge, although . . . great caution should be exercised when making this determination"); State v. Hewett, 376, S.E.2d 467, 476 (N.C. Ct. App. 1989).

Page 145, add to footnote 79:

State v. Hewett, 376 S.E.2d 467, 476 (N.C. Ct. App. 1989).

Are Anatomical Dolls Too Suggestive?

Mark D. Everson and Barbara W. Boat

In Press in The Advisor,

Newsletter of the American Professional

Society on the Abuse of Chidlren

The use of anatomical dolls in the assessment of sexual victimization of young children has become standard practice in many settings (Boat and Everson, 1988: Conte et al 1988). The use of anatomical dolls in such evaluations, however, has become increasingly controversial, culminating in recent court decisions in California severely limiting the admission of evidence from anatomical doll interviews (e.g. In re Amber B. [1987] and In re Christine C. [1987]).

At the heart of the controversy is the belief that anatomical dolls may be overly suggestive to young children (e.g., Terr in Yates and Terr, 1988a and b; Yuille, 1988). According to this position, the anatomical novelty and sexual explicitness of the dolls are likely to induce even normal, non-abused children to have sexual fantasies and to act out in sexually explicit ways which might then be misinterpreted as evidence of sexual abuse. This problem can be exacerbated by certain interviewer errors such as asking highly leading questions, posing the dolls in sexual positions, or verbally reinforcing sexualized play (Underwager et al, 1986; White, 1986).

The possible suggestibility of anatomical dolls is a concern that doll users must take seriously. Fortunately, there is a growing body of research that bears directly on this critical issue. This research can be categorized under the following three questions about the suggestibility of the dolls:

1. Does the use of anatomical dolls as interview aids or props lead young children to make false allegations of sexual abuse?

Goodman and Aman have addressed this question directly in their often-cited study of the impact of anatomical dolls on children's recall (Goodman and Aman, in press). Eighty 3 and 5 year-old children experienced a brief individual play session with a man. During the session they played a series of games including a version of "Simon Says" in which the man asked the child to touch parts of the child's own body (e.g., ear, toes) and also to touch the man's knee while the man touched the child's knees. A week later the child was questioned by a woman about the play session, under one of three experimental conditions: with anatomical dolls as props, with regular (non-anatomical) dolls as props, and with no dolls as props. In the two doll conditions, the dolls were available during the questioning and the child was encouraged to use the dolls to show what had happened in the play session.

The children were asked a series of specific questions about possible "abuse" during the play session, modeled after questions

that might be asked in a sexual abuse investigation. The questions were: "Show me where he touched you," "Did he keep his clothes on?" "Did he touch your private parts?" "Did he ask you to keep a secret about your private parts?" and "Did he put anything in your mouth?" In addition, the children were asked three misleading questions about possible abuse: "He took your clothes off, didn't he?" "He kissed you, didn't he?" and "How many times did he spank you?"

The use of anatomical dolls as interview props was not found to decrease the accuracy of the children's responses to the abuse questions. Regardless of their age, the children interviewed with anatomical dolls did not make any more errors on the specific or misleading abuse questions that the children interviewed either with regular dolls or with no dolls. The three-year-olds, on average, did prove to be less accurate in all three interview conditions than the 5 year olds. However, the vast majority of errors they made on the abuse questions occurred in response to the two "private parts" questions, a term many 3 year olds did not understand. When asked the more understandable question, "Show me where he touched you," none of the children indicated their genitals. Nor did any of the children in the study provide spontaneous comments or elaborations that would suggest that sexual abuse had occurred.

Goodman and Aman's results suggest that the use of anatomical dolls as interview props does not lead young children to make false

reports of abuse -- even under conditions of suggestive questioning.

2. When exposed to anatomical dolls, are normal, sexually-naive young children prone to engage in explicit sexual play with the dolls?

The answer to this question depends upon one's definition of "explicit sexual play." We recently completed a study of over 200 children drawn from a general pediatric clinic population (Everson and Boat, 1989). The children ranged in age from 2 to 5 years and represented a wide socioeconomic distribution. The children were seen in a structured anatomical doll session which included a review of body parts and functions and free play with the dolls both in the presence and in the absence of the adult interviewer.

Touching and exploration of the doll genitalia was a common behavior, occurring in over 50% of the children at each age. However, explicit sexual play in the form of apparent demonstrations of vaginal, oral or anal intercourse (i.e., penile insertion, sexual placement with "humping" motions, mounting a doll's genitals) occurred in only 6% of the total sample (12 out of 209 children).

This low incidence rate of explicit sexual play is consistent with the findings of seven prior studies in which non-referred, presumably non-abused children were observed with anatomical dolls.

The studies include: August and Forman (1986), Cohn (1988), Gabriel (1985), Glaser and Collins (1989), Jampole and Weber (1987), Sivan et. al (1988), and White et al (1986). The studies varied in session format from free play sessions in a preschool setting to highly structured interviews with an adult, and the children ranged in age from 2 years to 8 years. Summarizing across all seven studies, exploration of doll genitalia was fairly commonly observed, but less than 2% of the non-referred children in these studies enacted apparent sexual intercourse between dolls or between a doll and themselves (5 of 332 children). Such play was rare even though four of the studies included conditions in which the child was left alone with the dolls, minimizing the likelihood of the presence of an adult inhibiting such fantasy play. (Refer to Everson and Boat, 1989 for a more complete review of these studies.)

Although only 6% of our total sample demonstrated explicit sexual play, the frequency of such play was significantly related to the child's age, socioeconomic status (SES), and race and somewhat to the child's gender. In fact, over 20% of the 4 to 5 year old, low SES, black males in our sample demonstrated apparent sexual intercourse of some type during our sessions.

We believe, that our research, together with the seven prior studies in this area, offers substantial evidence that anatomical dolls do not induce young, non-abused, sexually naive children to engage in explicit sexual play. But our research suggests that the

dolls may provide sexually knowledgeable children with at least implicit permission as well as an easy vehicle for revealing their sexual knowledge.

3. <u>Following exposure to anatomical dolls, do young children engage in more sexualized behavior or play?</u>

We addressed the question of whether anatomical dolls might have delayed impact on the behavior of children by conducting follow-up interviews of 30 mothers whose children had been exposed to anatomical dolls (Boat, Everson, and Holland, in press). The children ranged in age from 3 to 5 years and had been subjects in our normative study of 209 children described above. The interview occurred about 2 weeks after the doll session. Mothers were asked in general terms abut any changes in their child's behavior that they attributed to their child having participated in the doll session as well as specific questions about changes in sexual curiosity and sexual play since the session.

Twenty-three percent of the children were reported as displaying a heightened awareness of sexual body parts (e.g., a 4-year-old boy asked how boys and girls differ; a 4-year-old girl asked when she would get pubic hair). None of the children were reported to have begun playing with toys or regular dolls in a sexual way or to add genitals to their drawings of people. Only one child was described in any way as "acting out sexually" -- a 3-year-old boy who took his clothes off while playing with a little

girl his age. As his mother explained, "He thought since he took the dolls' clothes off, it was okay to take his own clothes off."

Neither this child's mother nor any of the other mothers had any concerns about the behavior of their children after exposure to the dolls, nor did they report any behavior that might be misconstrued as an indication that sexual abuse had occurred.

Are anatomical dolls too suggestive? The research evidence thus far offers a strong and reassuring "no." The one study (McIver and Wakefield, 1987) that is sometimes cited as proof of the suggestibility of the dolls is methodologically flawed and difficult to interpret. Nonetheless, more research is needed on this controversial issue, especially in replicating the Goodman and Aman study using a larger, demographically more diverse sample as a test of the generalizability of their important findings. Perhaps a target event to be recalled could also be devised that is a closer analogue to sexual abuse than a play session (e.g., a normal genital examination).

At this point, we can be confident in our continued use of anatomical dolls in sexual abuse evaluations, especially if we adhere to the excellent recommendations of Myers and White (1989). First, doll users should be prepared to describe how and why the dolls were used in a particular case. Second, we should be familiar with the research on the dolls and be sure that our use of them falls within acceptable practice in the field. Third, we

should be aware of the limits in the use of anatomical dolls and acknowledge that they are interview aids rather than a litmus test for sexual abuse.

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No. 89-260

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THE STATE OF IDAHO,
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vs.

LAURA LEE WRIGHT,
Respondent.

On Writ of Certiorari to the
Supreme Court of Idaho

BRIEF OF *AMICI CURIAE* AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN MEDICAL ASSOCIATION, NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ASSOCIATION OF COUNSEL FOR CHILDREN, STATE OF RHODE ISLAND OFFICE OF THE CHILD ADVOCATE, AND SUPPORT CENTER FOR CHILD ADVOCATES

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THE STATE OF IDAHO,
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BRIEF OF *AMICI CURIAE*
AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN MEDICAL ASSOCIATION, NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ASSOCIATION OF COUNSEL FOR CHILDREN, STATE OF RHODE ISLAND OFFICE OF THE CHILD ADVOCATE, AND SUPPORT CENTER FOR CHILD ADVOCATES

INTERESTS OF THE *AMICI CURIAE*

The American Professional Society on the Abuse of Children (APSAC) is a multidisciplinary society of professionals working in the fields of child abuse research, prevention, treatment, investigation, litigation, and policy.[1] The purposes of APSAC are to promote effective identification, intervention, and treatment of abused children, their families, and offending individuals, to increase knowledge about abuse, and to improve the competence of professionals work-

1. Section II of this brief was prepared by Gail S. Goodman, Ph.D., Department of Psychology, State University of New York at Buffalo and Karen J. Saywitz, Ph.D., Department of Psychiatry, UCLA. Josephine Bulkley, J.D. and others also assisted.

ing with abused children and their families. APSAC was founded in 1987, and now has more than 1100 members.

The American Academy of Pediatrics (AAP) was founded in 1930 to create an independent forum for the special health and development needs of children. AAP is a nonprofit association of approximately 38,000 physicians specializing in the care of infants, children, and adolescents. The AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health. To these ends, AAP's members frequently are called upon to testify regarding the condition of such children. The AAP is concerned that the physician's ability to provide proper treatment and counseling not be burdened by legal requirements surrounding the interview process unless mandated by the Constitution and laws, and that any such requirements be sensitive to the particular difficulties attendant upon detecting child sexual abuse.

The American Medical Association (AMA) is a private voluntary, nonprofit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and the improvement of public health. Today, its membership exceeds 280,000 physicians and medical students.

The National Association of Counsel for Children (NACC) is a voluntary national membership organization concerned with the rights and interests of children who are the subject of child protective, matrimonial, and custody litigation. Established in 1977, the Association has 1200 members in fifty states.

The National Organization for Women (NOW), founded in 1966, is the largest organization in the United States devoted to protecting and securing women's rights. NOW has over 250,000 members and 792 chapters nationwide, and actively supports legal and legislative action to protect victims of child abuse.

The State of Rhode Island Office of the Child Advocate is a state agency designated by the Rhode Island General Assembly to protect the civil, legal, and special interests of abused and neglected children in state care and day care settings.

The Support Center for Child Advocates is a Pennsylvania nonprofit corporation that provides free legal and social services to abused and neglected children in criminal and juvenile court proceedings in the city of Philadelphia. Legal services are provided by staff attorneys and more than four hundred volunteer members of the Philadelphia bar. Social work services are provided through a staff of six social workers.

Amici, with the written consent of the parties, submit this brief as *amici curiae* to call the Court's attention to the widespread and potentially harmful impact which several conclusions of the Idaho Supreme Court could have on the way children are interviewed in child sexual abuse cases. This brief supports neither party, and *Amici* take no position on whether the hearsay statements at issue in this case should have been admitted or excluded from evidence.

INTRODUCTION AND SUMMARY OF ARGUMENT

Sexual abuse of children is a tragic phenomenon affecting thousands of children. Although the precise prevalence of sexual abuse is unknown, research discloses that abuse is widespread. The first national survey investigating personal histories of child sexual abuse was conducted by the *Los Angeles Times Poll* in 1985. "A history of sexual abuse was disclosed by 27% of the women and 16% of the men" surveyed.[2] The American Humane Association estimates that 132,000 children were sexually abused in 1986.[3] The Association also reports that "estimates of the number of children sexually maltreated . . . have increased significantly between 1976 and 1986."[4] Most child sexual abuse is never reported to authorities, and the actual prevalence rate is probably higher than the estimates of the American Humane Association.[5] Age offers no protection from sexual abuse. Victims range from infants to adolescents.[6]

2. Finkelhor, Hotaling, Lewis & Smith, *Sexual Abuse and Its Relationship to Later Sexual Satisfaction, Marital Status, Religion, and Attitudes*, 4 J. Interpersonal Violence 379, 381 (1989).

3. American Humane Association, *Highlights of Official Child Neglect and Abuse Reporting 1986* 23 (1988)[hereafter cited as *Highlights*].

4. *Id.*

5. Russell, *The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children*, 7 Child Abuse & Neglect 133 (1983).

6. See *Highlights*, *supra* note 3 at 21.

Although most victims of child sexual abuse go on to productive and satisfying adult lives, the clinical and scientific literature establishes that sexual abuse has serious short and long-term consequences for many victims. In particular, sexual abuse is associated with a wide variety of medical, mental health, and social problems of adolescence and adulthood.[7]

The scope and consequences of child sexual abuse require a decisive response from society and, in particular, from the legal system. As the Court has observed, however, "[c]hild abuse is one of the most difficult crimes to detect and prosecute, in large part because there often are no witnesses except the victim." *Pennsylvania v. Ritchie*, 480 U.S. 39, 60 (1987). Furthermore, corroborating medical evidence exists in only a minority of cases.[8] In many cases, the ability to prove abuse turns on children's trial testimony and the admissibility of their out-of-court statements. Because of the paucity of evidence that plagues child abuse litigation, children's hearsay statements play a vital evidentiary role.

Although there are many hearsay exceptions, only a handful are important in the day-to-day run of child abuse cases. The exception employed most frequently authorizes admission of excited utterances. Fed. R. Evid. 803(2). Also of great importance is the exception for statements for purposes of medical diagnosis or treatment. *Id.* 803(4). Of particular importance in the present litigation, courts frequently employ the so-called residual exceptions to admit reliable hearsay statements of children. *Id.* 803(24), 804(b)(5). Finally, and of equal relevance in the present case, a majority of states have enacted special hearsay exceptions for reliable out-of-court statements of children in child abuse litigation.[9] These statutes are essentially residual exceptions for child abuse cases.

The Confrontation Clause of the Sixth Amendment works in tandem with the hearsay rule to exclude unreliable evidence. *California v. Green*, 399 U.S. 149, 155 (1970); *Dutton v. Evans*, 400 U.S. 74, 86-87 (1970). Like the hearsay rule, the Confrontation Clause seeks to "advance 'the accuracy of the truth-determining process in criminal trials.'" *Tennessee v. Street*, 471 U.S. 409, 415 (1985). To this end, "[t]he focus of the Court's concern has been to insure that there are 'indicia of reliability which have been widely viewed as determinative of whether a statement may be placed before the jury though there is no confrontation of the declarant,' . . . and to 'afford the trier of fact a satisfactory basis for evaluating the truth of the prior statement . . . .'" *Mancusi v. Stubbs*, 408 U.S. 204, 213 (1972).

7. See *Lasting Effects of Child Sexual Abuse* (G. Wyatt & G. Powell eds. 1988).

8. Myers, Bays, Becker, Berliner, Corwin & Saywitz, *Expert Testimony in Child Sexual Abuse Litigation*, 68 Neb. L. Rev. 1, 34 (1989).

9. American Bar Association, National Legal Resource Center for Child Advocacy and Protection, *Protecting Child Victim/Witnesses—Sample Laws and Materials* 51 (2d ed. R. Eatman & J. Bulkley eds. 1987).

The Court has long held that a defendant's right to confront accusatory witnesses, although vitally important, is not absolute, and can be balanced against competing interests. *Ohio v. Roberts*, 448 U.S. 56, 64 (1980); *Mattox v. United States*, 156 U.S. 237, 243 (1895). The confrontation right is balanced against the state interests in "effective law enforcement, and in the development and precise formulation of the rules of evidence applicable in criminal proceedings." *Ohio v. Roberts*, 448 U.S. 56, 64 (1980). In the context of child abuse litigation, an additional interest is at work. The state has a strong *parens patriae* interest in protecting children. *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). In some cases, a child's out-of-court statements are the most powerful evidence of abuse, and the need for the statements is compelling. As stated in *Bourjaily v. United States*, 483 U.S. 171 (1987), the Court has "attempted to harmonize the goal of the Clause—placing limits on the kind of evidence that may be received against a defendant—with a societal interest in accurate fact finding, which may require consideration of out-of-court statements." *Id.* at 182. Nowhere is the need for out-of-court statements greater than in child abuse litigation.

The trustworthiness of a particular hearsay statement is evaluated in light of the circumstances of the case. With the residual and child hearsay exceptions in particular, courts consider a wide array of factors to determine whether hearsay passes muster under the Confrontation Clause and the rules of evidence. (Reliability factors considered by the courts are discussed in section IV., *infra*). Unfortunately, in the present case, the decision of the Idaho Supreme Court appears to elevate three reliability factors above all others, and to establish them as virtual litmus tests of reliability. The Idaho court

ruled that a child's statements to a pediatrician during an interview were untrustworthy because: (1) the interview was not videotaped, (2) the doctor employed leading questions, and (3) the doctor was aware that the child may have been sexually abused. *Amici* acknowledge that these factors are relevant in the assessment of reliability. *Amici* respectfully submit, however, that the Idaho court overestimated the value of these factors as indicators of reliability. Exaggerating the importance of videotaping, leading questions, and interviewer knowledge of a child's circumstances will cause courts to place unwarranted reliance on these factors to the exclusion of other, equally important, indicia of reliability, and will lead to exclusion of reliable hearsay.

Most interviews of children cannot, as a practical matter, be videotaped or otherwise recorded. Research and clinical experience establish that it is often necessary and proper during interviews of young children to employ directed questions, some of which may be leading. Finally, contrary to the conclusion of the Idaho Supreme Court, possession by an interviewer of background information on a child need not undermine the reliability of what the child states during an interview. *Amici* respectfully urge the Court not to adopt the Idaho Supreme Court's narrow focus on three reliability factors, and to adhere instead to the well-established judicial practice of considering all factors that bear on reliability of hearsay offered under residual and child hearsay exceptions.

ARGUMENT

I. CHILDREN DISCLOSE SEXUAL ABUSE IN A VARIETY OF WAYS, FEW OF WHICH LEND THEMSELVES TO AUDIO OR VIDEOTAPING

Disclosing sexual abuse is difficult for most children, and research demonstrates that in many cases abuse is not disclosed during childhood.[10] Abuse that does come to light is disclosed in several ways. Some children reveal abuse to their parents. Others confide in a trusted adult outside the family, such as a teacher. Children sometimes disclose their "secret" to a friend, who, in turn, reports the abuse to their parent. For many children, however, the fear and embarrassment that accompany sexual abuse prevent disclosure. When the child cannot tell, adult suspicion about abuse may be kindled by changes in the child's behavior such as nightmares, fear of specific persons or places, unusual knowledge of sexual matters, sexualized play, or medical evidence of abuse.

10. Finkelhor, Hotaling & Smith, *Risk Factors for Sexual Abuse in a National Survey of Adult Men and Women*, 14 Child Abuse & Neglect 19 (1990)(42% of males and 33% of females did not disclose abuse during childhood until questioned as adults).

The realization that their child has been sexually abused comes as a terrible shock to parents, and the first thought of many is to rush to the pediatrician, family doctor, or hospital emergency room. Thus, in many cases physicians are the first professionals to interview children. Such interviews often occur on an emergency basis in the doctor's office or hospital. In other cases, the first professionals to interview children are police officers or social workers employed by child protective services agencies. These professionals may talk to children at home, in the police car on the way to the hospital, at school, or at a children's shelter. In some cases, children first disclose abuse to mental health professionals providing therapy. In such cases, the therapist may have no advance notice of when the child will unlock the secret of abuse. Thus, children disclose sexual abuse in a wide variety of settings and at unpredictable times. Seldom is a tape recorder or video camera available at the critical moment. Yet, children's statements during interviews may bear all the hallmarks of trustworthiness. Given the myriad circumstances in which children are interviewed, interposition of audio or video recording as a litmus test for reliability leads to exclusion of reliable evidence.

The marked reluctance of many children to discuss sexual abuse during interviews illustrates the danger of equating audio or video recording with reliability. In intrafamilial abuse cases, most victims are intimidated into silence. Summit writes that "[h]owever gentle or menacing the intimidation may be, the secrecy makes it clear to the child that this is something bad and dangerous. The secrecy is both the source of fear and the promise of safety: 'Everything will be all right if you just don't tell.'"[11] Threats and coercion are common in extrafamilial abuse as well. In Finkelhor and Williams' national study of sexual abuse in day care, approximately 50% of victims were

11. Summit, *The Child Sexual Abuse Accommodation Syndrome*, 7 Child Abuse & Neglect 177, 181 (1983).

threatened with harm to themselves or their families if they disclosed sexual abuse.[12] In addition to fear of reprisal, many youngsters keep the secret of sexual abuse because they believe the abuse is somehow their fault, and that if they tell, they will be disbelieved, punished, or disliked.

Thus, many sexually abused children are slow to disclose during the interview process. A recent study by Sorensen and Snow illustrates children's resistance to disclosure. The researchers evaluated 116 cases in which sexual abuse was confirmed by criminal conviction, confession, or strong medical evidence of abuse. During early interviews, most children denied having been abused.[13] For many children, disclosure is a gradual process that can take weeks or months. Furthermore, many children disclose a little at a time, to test the reactions of adults. If the interviewer does not respond with shock or disgust, the child feels confident to reveal a little more. Portions of what a child reveals during interviews may be sufficiently reliable to gain admission in evidence, but in most cases it is impossible to videotape hours of interviews extending over days, weeks, or months; revealing again the harm that flows from equating reliability with audio or video recording.

In addition to the serious practical problems raised by audio and videotaping, it is important to note the current divergence of professional opinion on the wisdom of recording interviews. In 1986 the California State Legislature established the Child Victim Witness Judicial Advisory Committee to study investigative and judicial practices pertaining to child witnesses, and to make recommendations to the Legislature for reform. In its Final Report, the Committee wrote that "[t]he value of videotaping interviews with children is a highly controversial issue."[14] The Committee found the issues surrounding videotaping so unsettled that it could offer no recommendation to the California Legislature on whether interviews should

12. D. Finkelhor & L. Williams, *Nursery Crimes: Sexual Abuse in Day Care* 104 (1988).

13. Sorensen & Snow, *How Children Tell: The Process of Disclosure* (Paper presented at The Eighth National Conference on Child Abuse and Neglect, October 23, 1989).

14. *California Child Victim Witness Judicial Advisory Committee: Final Report* 28 (1988).

be recorded.[15]

An issue not mentioned by the Committee, but of great concern to parents of sexually abused children, concerns the confidentiality of videotapes. In some cases, highly sensitive tapes of children have found their way onto television news programs, to the embarrassment of children and their families. Systems for protecting confidential videotapes have not been perfected.

There is no doubt that the difficult task of evaluating the reliability of children's out-of-court statements can be facilitated by audio or videotaping, and taping should be encouraged in some circumstances. It is a mistake, however, to exaggerate the importance of videotaping. Although the presence or absence of a videotape is relevant in the assessment of reliability, videotaping is not the *sine qua non* of trustworthiness. Courts consider a host of factors to determine whether hearsay bears the circumstantial guarantees of trustworthiness required by the Sixth Amendment and the rules of evidence. (See Section IV., *infra*) Videotaping is an important factor, but only one among many. With due respect for the Idaho Supreme Court, *Amici* suggest that the lower court accorded exaggerated importance to videotaping interviews.

Bearing in mind the tremendous practical problems engendered by videotaping, the considerable professional uncertainty and disagreement that surrounds the subject, and the availability of other means to assess reliability, it is respectfully submitted that it would be premature and potentially very damaging to engraft audio or videotaping onto the Sixth Amendment as a litmus test for the reliability of children's hearsay statements.

II. DURING INTERVIEWS, DIRECTIVE AND LEADING QUESTIONS SHOULD BE USED SPARINGLY, HOWEVER, SUCH QUESTIONS ARE SOMETIMES NECESSARY WITH YOUNG CHILDREN, AND DO NOT NECESSARILY UNDERMINE THE RELIABILITY OF CHILDREN'S HEARSAY STATEMENTS

Interviewing young children is a delicate task requiring considerable skill and patience. There is no single "right" or "wrong" way

15. *Id.* at 29.

to interview children, and professionals continue to develop and improve interview techniques. Various professional organizations have promulgated guidelines for interviewing, which are updated as new knowledge develops.[16]

The consensus of professional opinion is that the interviewer should begin by establishing an atmosphere in which the child feels comfortable and free to talk. Initial questioning should be as non-directive and open-ended as possible to encourage spontaneous statements. When young children fail to respond to generic, open-ended questions, more directive questioning may be necessary. At some point during the interview, it is usually necessary to question the child directly about possible sexual abuse. When directive questioning is employed, the interviewer proceeds along a continuum, usually beginning with questions that simply direct the child's attention to a particular topic, and, when necessary, moving gradually to more specific questions. Highly specific questions, which may be leading, are generally to be avoided unless other methods of questioning fail, and the interviewer possesses reliable information indicating that abuse has occurred. In many cases, however, especially with young children, highly specific questions are necessary to elicit reliable information. No two interviews are the same, and professional judgment and discretion remain key components of the interview process.

The psychological dynamics of sexual abuse, which cause many children to resist disclosure, combine with the developmental immaturity of young children to justify greater use of directive questioning than is ordinarily necessary with older children and adolescents.[17]

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16. *See, e.g.*, American Medical Association, *Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect*, 254 J.A.M.A. 796 (1985); American Academy of Child and Adolescent Psychiatry, *Guidelines for the Clinical Evaluation of Child and Adolescent Sexual Abuse*, 27 J. Am. Acad. Child & Adolescent Psychiatry 655 (1988); American Professional Society on the Abuse of Children, *Proposed Guidelines for Evaluation of Suspected Sexual Abuse in Young Children*, 3 The APSAC Advisor (in press).

17. An analogy can be drawn between the need for leading questions during interviews of young children, and the need for such questions during direct examination of some child witnesses at trial. Normally, leading questions are not permitted on direct examination. Fed. R. Evid. 611(c). However, the Advisory Committee on

Unfortunately, however, the very children who need the most directive questioning are the ones about whom there is the most concern about suggestibility, memory, and ability to distinguish fact from fantasy. Thus, it is important to review current scientific knowledge of children's memory, suggestibility, and ability to differentiate fact from fantasy. An understanding of children's developmental capabilities and limitations makes it possible to gauge the influence of leading questions on the reliability of children's descriptions of sexual abuse. A review of current psychological literature is also needed to update, and, in some respects, take issue with the discussion of child development contained in the Idaho Supreme Court's decision in this case. The Idaho court's conclusions about children's memory, suggestibility, and ability to distinguish fact and fantasy are based in large part on controversial assumptions about child development and proper interviewing technique. Many of the Idaho court's assumptions concerning the reliability of children's statements are not supported by current scientific and clinical literature.

In discussing children's ability to provide accurate reports of events they have experienced or witnessed, it is important to keep in mind that across ages, children vary widely in their abilities. A two-and-a-half-year-old has different abilities than a five-year-old, and a five-year-old has different abilities than a ten-year-old. It is equally important to note that children of the same age differ markedly. One three-year-old will be an excellent reporter of events, while another will say nothing. Thus, in considering children's ability to describe events, one should not treat children as a single, uniform group.

Taken as a whole, research and theory in the field of child development suggest that children, like adults, bring both strengths and weaknesses to the interview room and the witness stand. Children can demonstrate adult-like reliability when providing certain kinds of information, under certain conditions. In other situations,

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the Federal Rules of Evidence expressly noted the propriety of leading questions with "the child witness or the adult with communication problems." Fed. R. Evid. 611 [illegible] advisory committee's note. The decisions are legion approving leading questioning during direct examination of children who are reluctant to testify. *See, e.g., United States v. Rossbach*, 701 F.2d 713, 718 (8th Cir. 1983); *United States v. Iron Shell*, 633 F.2d 77, 92 (8th Cir. 1980), *cert. denied*, 450 U.S. 1001 (1981). See J. Myers, *Child Witness Law and Practice* Section 4.6, at 130 n. 16 (1987) (collecting cases).

children perform less well than adults. To further complicate matters, there are some conditions under which children may actually outperform adults. For example, children sometimes observe and remember details that adults overlook. Thus, it is a mistake to conclude that children are uniformly less reliable reporters of events than adults.

A. Memory

Memory is not always accurate. This is a truism for adults as well as for children. However, memory for the gist of events and for personally significant events tends to be more accurate than memory for details or for events of little consequence to one's life or interests. Only recently have psychologists focused their study on children's descriptions of real-life events of personal significance to them.

Research suggests that even young children possess the memory skills needed to recall events and testify, at least when they are asked simple questions in a supportive atmosphere.[18] Research shows that even infants have long-term memories for familiar events as well as some novel events.[19] Although infants cannot communicate their memories in words, they can remember events for weeks at a time.

Once toddlerhood is achieved, at about age one, children can retain information for longer durations and can verbalize at least parts of their memories. Familiar, repeated events, as well as novel, one-time events, can be retained in the memories of young children.[20] Traumatic and other negative events, such as sexual assault, that children witness or experience in early childhood, can also be retained, even by two-year-olds, who can use words to describe parts

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18. G. Melton, J. Petrila, N. Poythress & C. Slobogin, *Psychological Evaluations for the Courts* 102 (1987).

19. Fagen, *Infants' Delayed Recognition Memory and Forgetting*, 16 J. Experimental Child Psychology 424 (1973); Myers, Clifton & Clarkson, *When They Were Very Young: Almost-Threes Remember Two Years Ago*, 10 Infant Behavior and Development 123 (1987)(behaviors of children approaching their third birthday demonstrated memories retained from infancy).

20. K. Nelson, *Event Knowledge: Structure and Function in Development* (1986).

of their memories.[21] In several studies, some including children as young as three years of age, researchers found that memory for stressful events is even more enduring than memory for nonstressful events in children.[22] In a more limited set of studies, researchers found that stress can inhibit children's memory.[23]

One of the most stable findings in memory research is that when young children are asked open-ended questions, they spontaneously recall less information than older children and adults. This is not to say that young children necessarily remember less, but that their developing memories are not as proficient at the task of "free recall" (that is, recounting an event in response to a very general, open-ended question such as "What happened?").

Although young children typically recall less than older children and adults, research reveals that, absent motivation to lie, children tend to recall real-life events they have experienced quite accurately. Children's recall appears to contain no more error than the recall of older children or adults. When psychologists say that "most of the development of accurate recall skills occurs between the ages of five and ten," as the Idaho court reported in this case, 775 P.2d at 1227, they are referring to the ability to report *greater amounts* of accurate information. The quoted statement should not be taken to imply that

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21. Miller & Sperry, *Early Talk About the Past: The Origins of Conversational Stories of Personal Experience*, J. Child Language (in press); Terr, *What Happens to Early Memories of Trauma? A Study of 20 Children Under Age 5 at the Time of Documented Traumatic Events*, 27 J. Am. Acad. Child & Adolescent Psychiatry 96 (1988).

22. Goodman, Rudy, Bottoms & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds. in press); J. Ochsner & M. Zaragoza, *The Accuracy and Suggestibility of Children's Memory for Neutral and Criminal Eyewitness Events* (Paper presented at the American Psychology and Law Association, March, 1988); A. Warren-Leubecker, C. Bradley & I. Hinton, *Scripts and the Development of Flashbulb Memories* (Paper presented at the Conference on Human Development, March, 1988).

23. Peters, *The Impact of Naturally Occurring Stress on Children's Memory*, in *Children's Eyewitness Memory* 122 (S. Ceci, M. Toglia & D. Ross eds. 1987).

younger children tend to be less accurate in their recall than older children and adults. The standard developmental finding is that with age, free recall becomes more complete, not necessarily more accurate. In psychological studies, children tend more often to omit information than to report events that did not occur.[24]

The difficulty young children experience with free recall means that young children often require "cuing" of their memories. Whereas an adult, teenager, or older child might be able to provide a detailed account of an event in response to an open-ended question about "what happened," young children are more likely to need specific questions or reminders of an event to activate their memories.[25] For example, in a study of children's memory for daily routines, two-year-olds generally required more specific prompts than four-year-olds.[26] Price and Goodman found that two-and-a-half-year-olds, on their own, could recall little about a repeated event, but were able to

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24. Children of different ages may make different types of memory errors. One study found that in reporting an event, adults made more errors of "intrusion," that is, of information that did not occur but that would be expected to have occurred (e.g., stating that upon meeting someone, they shook the person's hand when in fact they had not), whereas errors made by young children tended to be fantasy errors, although most young children made no such errors. Goodman & Reed, *Age Differences in Eyewitness Testimony*, 10 Law & Human Behavior 317 (1986).

Memory researchers used to think that the use of conscious memory strategies such as "rehearsal" (repeating information over and over in one's mind as one might do in trying to remember a new phone number) was necessary for the formation of long-term memories, and that young children did not possess or use memory strategies. These ideas are no longer generally accepted. Craik & Lockhart, *Levels of Processing: A Framework for Memory Research*, 11 J. Verbal Learning & Verbal Behavior 671 (1972). Although considerable development occurs in the use of memory strategies between the ages of five and ten years, even young children possess and use simple memory strategies. DeLoache & Todd, *Young Children's Use of Spatial Categorization as a Mnemonic Strategy*, 46 J. Experimental Child Psychology 1 (1988); DeLoache, Cassidy & Brown, *Precursors of Mnemonic Strategies in Very Young Children's Memory*, 56 Child Development 125 (1985). Children do not, however, use memory strategies as well or as pervasively as do adults. In any case, it is now realized that the use of explicit memory strategies is not necessary for the formation or retrieval of memories. Many real-life events are retained well by children and adults without the use of conscious memory strategies such as "rehearsal" or "elaboration" (relating a new event to previously experienced events).

communicate their memories in more detail when given toy props to act out the event, or when placed back in the room where the event occurred.[27] Thus, unlike adults or even older children, young children often have a special deficit in providing accounts of events on their own. Moreover, young children may lack the words needed to articulate their memories. At times, questioning, as a form of memory cuing, may be required to elicit information from young children.

In sum, young children generally can accurately recall and relate what they have experienced. They may need help to do so, however, which raises the issues of suggestibility and leading questions.

B. Suggestibility and Leading Questions

Are young children so suggestible that their reports of sexual abuse during interviews should be rejected unless the interviews are videotaped? There is legitimate concern that young children's reports of sexual abuse become a blend of their initial memories plus information suggested by interviewers, parents, and others. But adults are suggestible too, and children are not always more suggestible than adults.

The argument is sometimes made in child abuse litigation that persons who interviewed a child employed leading questions that may have misled the child into inaccurate or false allegations of sexual abuse. In some cases this argument has merit. It is important to reiterate, however, that the developmental limitations of young children sometimes necessitate careful use of specific and, at times,

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25. *New Directions for Child Development* (Vol. 10, M. Perlmutter ed. 1980); Price & Goodman, *Visiting the Wizard: Children's Memory for a Recurring Event*, Child Development (in press).

26. Wellman & Somerville, *Quasi-Naturalistic Tasks in the Study of Cognition: The Memory-Related Skills of Toddlers*, in *New Directions for Child Development* (Vol. 10, M. Perlmutter ed. 1980).

27. Price & Goodman, *Visiting the Wizard: Children's Memory for a Recurring Event*, Child Development (in press).

leading questions. Furthermore, modern research discloses that young children are more resistent to suggestive questioning than many adults believe.

Studies on children's suggestibility differ greatly in their relevance to child abuse litigation. Most studies involve brief presentations of pictures, films, or stories that children may not remember well and that do not involve their own bodies.[28] Such studies do not involve personally significant events such as sexual abuse. Goodman and Helgeson caution against generalizing from such studies to children's suggestibility regarding real-life events.[29] Other studies do concern children's suggestibility about personally experienced events, and ask questions like those asked by the physician in the instant case. 775 P.2d at 1225. In its discussion of psychological literature on suggestibility, the Idaho Supreme Court did not differentiate between studies that are relevant to real-life events experienced by children, and studies that are less germane to child abuse investigations and interviews.

Overall, studies have not converged on a simple relation between age and suggestibility.[30] It is clear, however, that children are not always more suggestible than adults. When and if a person (child or adult) is suggestible depends on cognitive, social, emotional, and situational factors such as level of interest or salience of an event. Other factors, some of which were mentioned by the lower court in this case, may also be important, and are discussed below.

Researchers consistently find that children ten to eleven-years-old are no more suggestible than adults. Four to nine-year-olds are sometimes more suggestible than older children and adults. Even

28. Cohen & Harnick, *The Susceptibility of Child Witnesses to Suggestion: An Empirical Study*, 4 Law & Human Behavior 201 (1989); Loftus & Davies, *Distortions in the Memory of Children*, 40 J. Social Issues 51 (1984).

29. Goodman & Helgeson, *Child Sexual Assault: Children's Memory and the Law*, 40 U. Miami L. Rev. 181 (1985).

30. Zaragoza, *Memory, Suggestibility, and Eyewitness Testimony in Children and Adults*, in *Children's Eyewitness Memory* 53 (S. Ceci, M. Toglia & D. Ross eds. 1987).

three-year-olds are not always more suggestible, although there appears to be a greater risk of suggestibility in very young children.[31] Young children may be particularly subject to the influence of suggestion regarding peripheral details and ambiguous events. When an event is ambiguous, there is some evidence that young children's labels for the event can be manipulated through strongly worded interrogation, but children's answers to specific questions about the event remain accurate.[32] Resistance to suggestion appears to be highest concerning the core aspects of events. Moreover, participation in an event, as opposed to mere observation, appears to lower children's suggestibility.[33]

In recent years, studies have been conducted which have concerned children's suggestibility when leading questions about abuse are asked. These studies were not cited by the Idaho Supreme Court. For example, researchers have studied children's suggestibility about personally significant and sometimes stressful events such as receiving a genital examination or inoculations by a doctor. Researchers have also studied children's suggestibility regarding crime-like events, as well as nonstressful, noncrime-like events, following which children were interviewed with leading questions such as "He took your clothes off, didn't he?" to determine if false reports of abuse could be elicited. These studies indicate that children as young as four years of age do not make significantly more false reports (for example, by

31. Ceci, Ross & Toglia, *Suggestibility of Children's Memory: Psycholegal Implications*, 116 J. Experimental Psychology: General 38 (1987); Goodman & Reed, *Age Differences in Eyewitness Testimony*, 10 Law & Human Behavior 317 (1986); Zaragoza, *Memory, Suggestibility, and Eyewitness Testimony in Children and Adults*, in *Children's Eyewitness Memory* 53 (S. Ceci, M. Toglia & D. Ross eds. 1987), M. Zaragoza & D. Wilson, *Suggestibility of the Child Witness* (Paper presented at the Society for Research on Child Development, April, 1989).

32. Clark-Stewart, Thompson, & Lepone, *Manipulating Children's Testimony Through Interrogation*, in *Can Children Provide Accurate Eyewitness Testimony?* (G. Goodman, Chair, Society for Research in Child Development, 1989).

33. Goodman, Rudy, Bottoms & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds. in press); Rudy & Goodman, *Effects of Participation on Children's Testimony* (Submitted for publication 1989)

responding "yes" to the question, "He took your clothes off, didn't he?") than do older children.[34]

Relatively few studies of three-year-old's suggestibility exist, and research discloses no published studies on suggestibility of two-and-a-half-year-old children. When a brief story is read to children, or children view a brief slide sequence, some studies have shown three-year-olds to be more suggestible than older children.[35] Other studies have been unable to replicate these effects, however, calling them into question.[36] When children are exposed to real-life events and then questioned, three- and four-year-olds vary considerably in their abilities, with some three- and four-year-olds being resistant to leading questions concerning abuse and some being suggestible.[37] When three- and four-year-olds are suggestible with regard to acts related to abuse (e.g., having their clothes removed, having their "private parts" touched), their suggestibility is typically limited to a nod of the head or saying "yes." In the studies, spontaneous and detailed comments, such as those made by the child in the present case (i.e., that her daddy "does do this with me, but he does it a lot more with my sister than with me." 775 P.2d at 1225), are typically (although not always) accurate, even when elicited in the context of leading questions.[38]

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34. Goodman, Rudy, Bottoms & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds. in press); Rudy & Goodman, *Effects of Participation on Children's Testimony* (Submitted for publication 1989).

35. Ceci, Ross & Toglia, *Suggestibility of Children's Memory: Psycholegal Implications*, 116 J. Experimental Psychology: General 38 (1987).

36. Zaragoza, *Memory, Suggestibility, and Eyewitness Testimony in Children and Adults*, in *Children's Eyewitness Memory* 53 (S. Ceci, M. Toglia & D. Ross eds. 1987).

37. Goodman & Aman, *Children's Use of Anatomically Detailed Dolls to Recount an Event*, Child Development (in press); Goodman, Rudy, Bottoms & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds. in press).

38. Rudy & Goodman, *Effects of Participation on Children's Testimony* (Submitted for publication, 1989).

Young children's suggestibility is influenced by their understanding of the words used in a question. When children do not know what the term "private parts" means, for example, some may nod their head "yes" when asked if their private parts were touched.[39] The physician in the present case established that the child knew what was meant by the term "pee-pee." 775 P.2d at 1225.

Although it is appropriate to be concerned about use of directive and leading questions during interviews, it is important to reiterate once again the developmental and psychological need in selected cases to use such questions with young children. Although studies to date indicate there is a risk of obtaining some false information as a result of using leading questions with young children, studies also indicate that there is a danger in not using leading questions. For example, when information of a sensitive or embarrassing nature is at issue, leading questions may be necessary to elicit information from children. A study by Saywitz and her colleagues makes this point clearly.[40] Seventy-two five- and seven-year-old girls experienced a medical examination by a pediatrician. As part of the examination, half the girls at each age received a visual inspection of the vaginal and anal areas, and half were checked for scoliosis by touching the spine. When the children were later questioned about the examination, they were first asked an open-ended question ("What happened?"), then asked to demonstrate what occurred using anatomically detailed dolls, and finally asked a set of leading questions, including whether their vaginal and anal areas had been touched. The majority of the children who had received the vaginal and anal examination revealed this part of the examination only when asked specific leading questions about it ("Did the doctor touch you there?"). The genital examination was usually not mentioned when open-ended questions or anatomical dolls were used. In contrast, when the children who had the scoliosis examination were asked leading questions about vaginal and anal touching, the vast majority

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39. Goodman & Aman, *Children's Use of Anatomically Detailed Dolls to Recount an Event*, Child Development (in press).

40. K. Saywitz, G. Goodman, E. Nicholas & S. Moan, *Children's Memories of Genital Examinations: Implications for Cases of Sexual Assault* (Paper presented at the Society for Research on Child Development, April, 1989).

(92%) resisted the suggestion. However, three children (8%) provided a false "yes." In this study, the researchers found that the risk of obtaining a false report about genital touching when open-ended, doll-aided, and leading questions were used was one percent. However, the risk of children not disclosing the genital inspection was much greater (64%). For most children, the genital examination was revealed only when leading questions were used. Thus, although there was a small danger of obtaining false information from children when leading questions were used, there was a much greater danger that potentially embarrassing information would not be revealed unless leading questions were used.

In the present case, the Idaho Supreme Court was concerned that the child might be especially subject to suggestive questions from the pediatrician because of the child's deference to his status as a doctor. 775 P.2d at 1228. Although there is some evidence in the scientific literature to suggest that children are more suggestible when interviewed by an authority figure,[41] there is also evidence to the contrary.[42]

It should also be noted that to the extent an authority figure might make a young child more suggestible, such results can be reversed by having the authority figure build rapport with the child. In one study, young children who experienced a stressful event as part of their regular health care (i.e., inoculations at a medical clinic) were later questioned by adults. Half of the children were interviewed by an adult who acted warm and friendly toward the child (e.g., smiled, complimented the child, gave the child cookies and juice), whereas the other half were interviewed by an adult who was more distant and cold (e.g., smiled infrequently, did not compliment the child, did not give the child cookies and juice). Three- to four-year-olds were substantially less suggestible when they were interviewed by the friendly adult. Of particular note, the children who were interviewed by the friendly adult were less suggestible on leading questions

41. Ceci, Ross & Toglia, *Suggestibility of Children's Memory: Psycholegal Implications*, 116 J. Experimental Psychology: General 38 (1987).

42. Brigham, VanVerst & Bothwell, *Accuracy of Children's Eyewitness Identifications in a Field Setting*, 7 Basic & Applied Social Psychology 295 (1986).

relevant to charges of child abuse (e.g., "How many times did she kiss you?" "You took your clothes off, didn't you?").[43] Thus, a doctor who establishes rapport with a child (as a doctor would be expected to do before performing a genital examination on a young child) might well have the effect of reducing the child's suggestibility, despite the fact that the doctor was an authority figure.

In summary, research findings are mixed on whether children are more suggestible when interviewed by an authority figure. To the extent that being interviewed by an authority figure increases children's suggestibility in regard to answers to leading questions about abuse, these effects can be reversed by being supportive of children.

The Idaho Supreme Court expressed concern that leading questions might so taint a child's memory that the child's description of sexual abuse would be unreliable. The lower court wrote that "[t]he problem of tainted memory is much more severe in young children. . . . Once this tainting of memory has occurred, the problem is irremediable." 775 P.2d at 1228. Contrary to the Idaho court's statement, research has not definitively demonstrated that memory can be so tainted by misleading information that accurate memory can never again be reinstated. Some studies have suggested that once a person accepts misleading information, the person's memory is forever tainted, although such studies do not examine memory for real-life events actually experienced by subjects.[44] Evidence concerning irreparable tainting is quite mixed, with some studies showing no permanent effects on memory of misleading information,[45]

43. B. Bottoms, G. Goodman, L. Rudy, L. Port, P. England, C. Aman & M. Wilson, *Children's Testimony for a Stressful Event: Improving Children's Reports* (Paper presented at the 97th Conference of the American Psychological Association, August, 1989); Goodman, Rudy, Bottoms, & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds., in press).

44. E. Loftus, *Eyewitness Testimony* (1979).

45. Bekerian & Bowers, *Eyewitness Testimony: Were We Misled?*, 9 J. Experimental Psychology: Learning, Memory, and Cognition 139 (1983); Lindsay & Johnson, *The Eyewitness Suggestibility Effect and Memory for Source*, Memory & Cognition (in press); McCloskey & Zaragoza, *Misleading Postevent Information and Memory for Events: Arguments and Evidence Against Memory Impairment*

and other studies indicating the possibility of more permanent tainting.[46] Research is inconsistent on whether children who initially accept misleading information about an event are likely to recall the inaccurate information later, when they describe the event.[47] Although it is possible that leading questions can permanently taint memory, the Idaho court exaggerated the certainty of this conclusion.

In the present case, the Idaho court quotes at length from the testimony of a child psychologist who testified for the defendant at trial. At one point, the psychologist contended that children's responses can be easily "shaped." The psychologist went on to state that "one of my colleagues in the Portland area, Bill McGeiver has found that simply by nodding the head and saying "um-hum" he can shape, so to speak, gradually shape behaviors in young children that border on the sexually bizarre." 775 P.2d at 1229. *Amici* would point out that it is unclear from the Idaho court's decision what the defense psychologist meant by behaviors that "border on the sexually bizarre." *Id.* Furthermore, the defense psychologist does not state whether Mr. McGeiver's findings were based on research, or were merely his clinical observations of a few children. Finally, the defense expert provides no clue regarding Mr. McGeiver's credentials. It is clear that the McGeiver findings are not to be found in the scientific literature. *Amici* know of no scientific studies indicating that children or adults can be "shaped" by nodding of the head and saying "um-hum" to make false claims of sexual abuse.

Hypotheses, 114 J. Experimental Psychology: General 3 (1985); Zaragoza, McClosky & Jamis, *Misleading Postevent Information and Recall of the Original Event: Further Evidence Against the Memory Impairment Hypothesis*, 13 J. Experimental Psychology: Learning, Memory, and Cognition 36 (1987).

46. Ceci, Ross & Toglia, *Suggestibility of Children's Memory: Psycholegal Implications*, 116 J. Experimental Psychology: General 38 (1987); E. Loftus, *Eyewitness Testimony* (1979); Tversky & Tuchin, *A Reconciliation of the Evidence on Eyewitness Testimony: Comments on McCloskey and Zaragoza*, 118 J. Experimental Psychology: General 86 (1989).

47. Clark-Stewart, Thompson & Lepone, *Manipulating Children's Testimony Through Interrogation*, in *Can Children Provide Accurate Eyewitness Testimony?* (G. Goodman, Chair, Society for Research in Child Development 1989); Goodman & Reed, *Age Differences in Eyewitness Testimony*, 10 Law & Human Behavior 317 (1986).

C. Differentiating Fact and Fantasy

Are children so prone to confuse fantasy and reality that their descriptions of events are unreliable? In the instant case, the psychologist testifying for the defense stated that "children who have a mental age of five years and chronological age of five years would have difficulty distinguishing fantasy from reality." 775 P.2d at 1128. The psychologist's statement is not born out by the scientific literature. Some developmental theorists, including Freud and Piaget, have suggested that children routinely confuse reality with fantasy, but researchers have not found evidence to support these claims. Experimental work does not bear out Freud's notion of infantile hallucination or Piaget's belief that children are so egocentric that they routinely fail to distinguish reality from fantasy. Moreover, although children like to use pretend in their play, they seem to know when they are pretending. Thus, the defense psychologist erred when he opined that children cannot distinguish what is real from what is imagined. Modern research suggests that children are less likely than adults to differentiate fact from fantasy in some situations, but not others.

Researchers have examined children's and adults' ability to discriminate between fresh memories of an event itself, memories of one's later thoughts about the event, and memories of what other people have said about the event. Johnson and her colleagues report that children (six-year-olds) show a deficit in some of these areas, but not in others.[48] In Johnson's studies, children were no more confused than adults when asked to discriminate what they saw someone else do or say from what they themselves did or said. Children were not more likely than adults to confuse memories of what two other people did or said. In other words, children accurately remembered who said and did what. When considering the aspects of Johnson's studies that are most relevant to children's ability to distinguish fact from fantasy

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48. Johnson & Foley, *Differentiating Fact from Fantasy: The Reliability of Children's Memory*, 40 J. Social Issues 33 (1984); Lindsay & Johnson, *Reality Monitoring and Suggestibility: Children's Ability to Discriminate Among Memories From Different Sources*, in *Children's Eyewitness Memory* 92 (S. Ceci, M. Toglia & D. Ross eds. 1987).

during child abuse interviews, the children did not have difficulty making the distinction. However, six-year-olds did have more difficulty than adults in discriminating memories of what they themselves had said or done from what they had only imagined themselves saying or doing. Although adults also showed confusion on this task, children did so to a greater extent.

Johnson notes that the relevance of any of these findings for children's testimony may be limited by the fact that the stimuli used in the experiments were artificial (i.e., imagining a picture of an object), and were not embedded in a context that was meaningful to children's lives. Children's understanding and memory of events is considerably improved when the events are meaningfully embedded in their lives.[49] In contrast to the artificial stimuli used by Johnson, crimes that children experience, such as sexual assault, are likely to be compelling, vivid, important, and embedded within the children's lives.

Johnson's research on children's ability to differentiate imagined from experienced events did not include children as young as two-and-a-half years of age. It is possible that such children may have a greater deficit in the ability to distinguish fantasy from reality. The relevant studies remain to be done.

In discussing children's ability to distinguish fantasy from reality, it is not accurate to suggest, as the defense expert did in this case, that children have special difficulty in remembering actions correctly. 775 P.2d at 1228. A number of studies indicate that children's memory is particularly strong for actions.[50]

A final aspect of children's ability to distinguish fact from fantasy relates to the possibility that a young child could fabricate a report of

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49. M. Donaldson, *Children's Minds* (1978); K. Nelson, *Event Knowledge: Structure and Function in Development* (1986).

50. Fivush, Gray & Fromhoff, *Two-Year-Olds Talk About the Past*, 2 Cognitive Development 393 (1987); Goodman, Aman & Hirschman, *Child Sexual and Physical Abuse: Children's Testimony*, in *Children's Eyewitness Memory* 1 (S. Ceci, M. Toglia & D. Ross eds. 1987); Jones, Swift & Johnson, *Nondeliberate Memory for a Novel Event Among Preschoolers*, 24 Developmental Psychology 641 (1988).

sexual abuse. It should be noted that young children have little accurate knowledge of adult sexual activities and reproduction.[51] Moreover, several studies have demonstrated that even under conditions of leading questioning, young children are not prone to sexual fantasy.[52] Although young children (e.g., three-year-olds) may at times indicate an affirmative answer to a leading question (e.g., shake their heads or say "yes"), most children have not been found to elaborate on their simple "yes" answers, or to fabricate detailed accounts of sexual abuse in response to such questions.

Even young children are capable of intentionally lying and misstating reality. However, intentional lying generally occurs in young children in order to avoid punishment. Moreover, unlike older children, young children tend to be unconvincing liars, and adults can often detect young children's falsehoods.[53] Unless young children have been personally or vicariously exposed to adult sexual activity, they do not possess the knowledge to fabricate descriptions of such activity.

The child development literature indicates that young children possess the capacity to remember and relate events. Furthermore, although young children are more suggestible than adults in some circumstances, children are not as suggestible as many adults believe, and in some studies young children are quite resistent to suggestive and misleading questioning. Finally, children can usually differentiate the real from the imaginary.

Children, like adults, can be mislead by leading and suggestive questions, and professionals who interview young children should

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51. R. Goldman & J. Goldman, *Show Me Yours: Understanding Children's Sexuality* (1988); R. Goldman & J. Goldman, *Children's Sexual Thinking* (1982).

52. Goodman & Aman, *Children's Use of Anatomically Detailed Dolls to Recount an Event*, Child Development (in press); Goodman, Rudy, Bottoms, & Aman, *Children's Concerns and Memory: Issues of Ecological Validity in Children's Testimony*, in *What Young Children Remember and Know* (R. Fivush & J. Hudson eds., in press).

53. DePaulo, Stone & Lassiter, *Deceiving and Detecting Deceit*, in *The Self and Social Life* (B. Selenker ed. 1985).

use such questions sparingly and with caution. In some cases, however, highly directive questioning is required to enable traumatized and frightened children to describe events. As the number of directive and leading questions rises, so does concern about the reliability of a child's out-of-court statements. Thus, when assessing the reliability of a child's statements, it is appropriate to examine the types of questions asked during the interview. This is not to say, however, that the use of leading questions indicates unreliability. Many statements in response to leading questions are trustworthy. Thus, as was the case with videotaping, presence or absence of leading questions is but one of many factors considered in analyzing the reliability of children's out-of-court statements.

III. MOST PROFESSIONALS BELIEVE THAT INTERVIEWERS SHOULD POSSESS BACKGROUND INFORMATION ABOUT A CASE BEFORE INTERVIEWING A CHILD

The prevailing practice among professionals who interview sexually abused children is to obtain information about the child and the possibility of sexual abuse before conducting the interview. This practice is consistent with the long tradition in medicine, psychiatry, psychology, and social work of obtaining a medical, developmental, or family history before examining or treating a patient.

In the instant case, the Idaho Supreme Court concluded that the child's statements to the interviewing pediatrician lacked trustworthiness because the doctor had a "preconceived idea of what the child should be disclosing." 775 P.2d at 1227. That is, because the doctor knew the child may have been sexually abused, the interview necessarily produced unreliable information. With all due respect for the lower court, *Amici* urge this Court to reject the conclusion that prior knowledge of a child's circumstances undermines a professional's ability to elicit trustworthy information from the child. It is true that interviewers should not entertain general preconceptions such as "children never lie about sexual abuse." There is an important distinction, however, between preconceptions that can cloud judgment, and background information that is needed for a thorough evaluation of possible abuse.

Given that at least mildly leading questions are often necessary with young children, interviewers must know something about the alleged abuse in order to frame meaningful questions. Young children cannot be expected to understand the purpose of an interview. Unlike an adult rape victim, who understands the context and meaning of a question such as "What happened?", young children often have no idea of the purpose of the interview or the topic of interest until it is introduced by the interviewer through specific questions.

The substantial majority of professionals who work with sexually abused children believe that, in the discretion of the professional, it is proper to obtain relevant background information before interviewing children. Interviewers perform more effectively when they are armed with relevant information.

IV. THE COURT SHOULD REAFFIRM THE TOTALITY OF THE CIRCUMSTANCES APPROACH TO RELIABILITY USED BY FEDERAL AND STATE COURTS TO ASSESS THE RELIABILITY OF CHILDREN'S HEARSAY STATEMENTS OFFERED UNDER THE RESIDUAL AND CHILD HEARSAY EXCEPTIONS

During the 1980s, Federal and State courts grappled with the difficult task of assessing the reliability of children's hearsay statements offered under the residual and child hearsay exceptions. The uniform approach of the courts is to consider all circumstances that bear on trustworthiness. The following factors, among others, are discussed in the cases, and provide an adequate basis for assessing the reliability of children's hearsay statements.[54]

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54. Professor Graham provides a thorough analysis of factors relating to reliability. See Graham, *The Confrontation Clause, the Hearsay Rule, and Child Sexual Abuse Prosecutions: The State of the Relationship*, 72 Minn. L. Rev. 523 (1988), where the author writes:

> Courts consider several criteria in evaluating the trustworthiness of a hearsay statement, including the credibility of the statement and the declarant at the time of the statement in light of the declarant's personal knowledge, the availability of time

If the content of a child's hearsay statement is supported by other evidence, the reliability of the statement may be bolstered. *State v. Allen*, 157 Ariz. 165, 755 P.2d 1153, 1164 (1988). In some cases, an eyewitness corroborates the child's statement. *State v. Robinson*, 153 Ariz. 191, 735 P.2d 801, 812 (1987). In others, medical evidence supports the statement. *People v. District Court*, 776 P.2d 1083, 1090 (Colo. 1989). The fact that a child's statement is overheard by more than one person may enhance the reliability of the statement. *State v. Cooley*, 48 Wash. App. 286, 738 P.2d 705 (1987).

Courts view the spontaneity of a child's statement as an important indicator of reliability. The more spontaneous the statement, the less likely it is to be fabricated. *State v. Robinson*, 153 Ariz. 191, 735 P.2d 801, 811 (1987). Reliability is also enhanced when a child repeats an out-of-court statement more than once, and when each version is consistent. *United States v. Cree*, 778 F.2d 474, 477 n.5 (8th Cir. 1985); *State v. Robinson*, 153 Ariz. 191, 735 P.2d 801, 811 (1987); *State v. Kuone*, 243 Kan. 218, 757 P.2d 289, 292 (1988). When a child is inconsistent, doubts arise about trustworthiness. This is not to say, however, that complete consistency is required. Young children are often inconsistent regarding peripheral details of events they have experienced. What is more important is consistency regarding core aspects of events.

The reliability of a hearsay statement can be influenced by questioning during interviews and in other situations. When a

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to fabricate, the declarant's bias, and the suggestiveness created by leading questions. Courts further consider other, corroborating factors arising after the statement was made, including the credibility of the person testifying to the statement, the availability of the declarant at trial for cross-examination . . . , whether the declarant has recanted or reaffirmed the statement, and the existence of corroborating physical evidence. In child sexual abuse cases, courts should also consider whether the child's statement discloses an embarrassing event that a child would not normally relate unless true, is a cry for help, employs appropriate childlike language, or describes a sexual act beyond a child's normal experience. Also relevant are the child's age and maturity, the nature and duration of the sexual contact, the child's physical and mental condition when the statement was made, and the relationship of the child and the accused.

Id. at 532-33 (footnotes omitted).

statement is made in response to questioning, especially leading questioning, the possibility arises that the questioner influenced the statement. However, directed and even leading questions do not *ipso facto* destroy trustworthiness. The fact that a child's statement was made in response to questioning is a relevant consideration, but should not be considered a litmus test for reliability.

Numerous courts and commentators observe that young children lack the experience to fabricate detailed and anatomically accurate accounts of sexual acts. When a child's out-of-court statement describes an event which a child of similar age and experience could not reasonably be expected to fabricate, the statement gains in reliability. *Morgan v. Foretich*, 846 F.2d 941, 948 (4th Cir. 1988)(discussing excited utterance exception); *State v. D.R.*, 109 N.J. 348, 537 A.2d 667, 673 (1988); *State v. Sorenson*, 143 Wis.2d 266, 421 N.W.2d 77, 85, 87 (1988). Reliability is enhanced when a child describes sexual abuse in terminology one would expect from a child of similar age. *State v. Sorenson*, 143 Wis.2d 226, 421 N.W.2d 77, 85 (1988).

Evidence that a child had no motive to fabricate at the time an out-of-court statement was made supports reliability. *State v. Kuone*, 243 Kan. 218, 757 P.2d 289, 292-93 (1988); *State v. J.C.E.*, 767 P.2d 309, 315 (Mont. 1988). An adult with custody or control of a child may bear a grudge against another adult, and may attempt to coach a child into making false charges of abuse. Thus, evidence of adult incentive to fabricate, or the lack thereof, is relevant. *State v. Conklin*, 444 N.W.2d 268, 276 (Minn. 1988).

The fact that the defendant had the opportunity to commit the act described in a child's statement may increase the trustworthiness of the statement. *State v. Sorenson*, 143 Wis.2d 226, 421 N.W.2d 77, 85 (1988).

The foregoing factors are among the many indicia of reliability discussed in Federal and State court decisions discussing the trustworthiness of children's hearsay statements offered under the residual and child hearsay exceptions. *Amici* respectfully urge the Court to endorse the totality of the circumstances approach now in general use, and to eschew an approach that establishes a small

number of factors as litmus tests for reliability. The totality of the circumstances approach works well in practice, and protects defendants against unreliable hearsay evidence.

CONCLUSION

When considering the trustworthiness of children's hearsay statements offered under residual and child hearsay exceptions, courts should consider all factors that bear on reliability, and should eschew reliance on a small number of factors that may lead to exclusion of reliable and important evidence.

Respectfully submitted,

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Resource Materials

Stress Management: Avoiding Burnout

Presented by
Cabell Cropper, M.B.A.

TYPE "A" PERSONALITY?

As you can see, each scale below is composed of a pair of adjectives or phrases separated by a series of horizontal lines. Each pair has been chosen to represent two kinds of contrasting behavior. Each of us belongs somewhere along the line between the two extremes. Since most of us are neither the most competitive nor the least competitive person we know, put a check mark where you think you belong between the two extremes.

		1 2 3 4 5 6 7	
1.	Doesn't mind leaving things temporarily unfinished.	_ _ _ _ _ _ _	Must get things finished once started.
2.	Calm and unhurried about appointments.	_ _ _ _ _ _ _	Never late for appointments
3.	Not competitive	_ _ _ _ _ _ _	Highly competitive.
4.	Listens well, lets others finish speaking	_ _ _ _ _ _ _	Anticipates others in conversation (nods, interrupts, finish sentences for the other.)
5.	Never in a hurry	_ _ _ _ _ _ _	Always in a hurry.
6.	Able to wait calmly	_ _ _ _ _ _ _	Uneasy when waiting.
7.	Easygoing	_ _ _ _ _ _ _	Always going full speed ahead.
8.	Takes one thing at a time.	_ _ _ _ _ _ _	Tries to do more than one thing at a time thinks about what to do next.
9.	Slow and deliberate in speech	_ _ _ _ _ _ _	Vigorous and forceful in speech (uses a of gestures).
10.	Concerned with satisfying himself, not others.	_ _ _ _ _ _ _	Wants recognition from others for a job Well done.
11.	Slow doing things	_ _ _ _ _ _ _	Fast doing things (eating, walking, etc.)
12.	Easygoing	_ _ _ _ _ _ _	Hard driving
13.	Expresses feelings openly	_ _ _ _ _ _ _	Holds feeling in
14.	Has a large number of interests	_ _ _ _ _ _ _	Few interests outside work.
15.	Satisfied with job	_ _ _ _ _ _ _	Ambitious, wants quick advancement on the job.
16.	Never sets own deadlines	_ _ _ _ _ _ _	Often sets own deadlines.
17.	Feels limited responsibility	_ _ _ _ _ _ _	Always feels responsible.
18.	Never judges things in terms of numbers	_ _ _ _ _ _ _	Often judges performance in terms of numbers (how many, how much).
19.	Casual about work	_ _ _ _ _ _ _	Takes work very seriously (works weekends brings work home).
20.	Not very precise	_ _ _ _ _ _ _	Very precise (careful about detail).

Type A Test:

120-140	True "A"
76-119	"A"
56-75	Balanced!
30-55	"B"
0-29	Laid Back

STRESS: SIGNS OF TROUBLE

CHECK ALL THAT APPLY TO YOU:

__ Inability to slow down, relax, or to occasionally do absolutely nothing

__ Anxiety because things seem to be going wrong too often

__ Unexplained loss of appetite, general lack of interest in food

__ Racing or pounding heart

__ Fear of being in open spaces, tendency to avoid such situations

__ Inability to concentrate on one thing for any length of time

__ Loss of sexual drive or pleasure

__ Feeling of being trapped

__ Frequent headaches

__ Nervousness when left alone for even brief periods of time

__ Fatigue, difficulty sleeping

__ Cold hands or feet, aching neck and shoulders or back

__ Sudden, groundless fears, trembling, sudden tears

__ Anxiety or tension lasting more than a few days

__ Heart palpitations, shortness of breath

__ Increased tendency to drop or break things, frequent minor accidents

__ A sense of hopelessness about life, despair about the future

__ Diarrhea, nausea, vomiting

__ Explosive anger in response to a minor irritation

__ Tendency to blame oneself whenever anything goes wrong

__ Overeating, increased consumption of drugs or alcohol

__ Frequent low-grade infections

__ Menstrual distress/change

ARE YOU UNDER DISTRESS?

Answer the following questions: 2 = often 1 = few times per week 0 = rarely

__ 1. I feel tense, anxious or have nervous indigestion.

__ 2. People at home or at work arouse my tension.

__ 3. I eat, drink, or smoke when I'm tense.

__ 4. I have tension or migraine headaches, pain in my neck/shoulders or insomnia.

__ 5. I can't turn off my thoughts on weekends long enough to feel relaxed.

__ 6. I find it difficult to concentrate on what I'm doing due to worrying about other things.

__ 7. I take tranquilizers or other drugs to relax.

__ 8. It is difficult to find enough time to relax.

__ 9. If I find time it is hard for me to relax.

__ 10. I have too many deadlines.

A total score of 12 or more indicates HIGH TENSION / DISTRESS!

In the past 12 months, which of these have happened to you . . . ?

Add up the total points for all the items you have experienced in the last year. A score below 150 is about average. If your score is between 150 and 300, you have a better than average chance of showing some symptoms of stress. If your score is above 300, you are likely to experience a serious change in health and/or behavior.

ADULT'S TEST

event	points	score
Death of a spouse	100	
Divorce	73	
Marital separation	65	
Jail term	63	
Death of a close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired from work	47	
Marital reconciliation	45	
Retirement	45	
Change in family member's health	44	
Pregnancy	40	
Sex difficulties	39	
Addition to family	39	
Business readjustment	39	
Change in financial status	38	
Death of a close friend	37	
Change in number of marital arguments	35	
Mortgage or loan over $10,000	31	
Foreclosure of mortgage or loan	30	
Change in work responsibilities	29	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or starts work	26	
Starting or finishing school	26	
Change in living conditions	25	
Revision of personal habits	24	
Trouble with boss	23	
Change in work hours, conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreational habits	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan under $10,000	18	
Change in sleeping habits	16	
Change in number of family gatherings	15	
Change in eating habits	15	
Vacation	13	
Christmas season	12	
Minor violation of the law	11	
TOTAL		

CHILDREN'S TEST

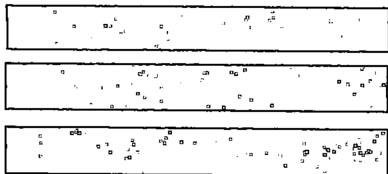
event	points	score
Parent dies	100	
Parents divorce	73	
Parents separate	65	
Parent travels as part of job	63	
Close family member dies	63	
Personal illness or injury	53	
Parent remarries	50	
Parent fired from job	47	
Parents reconcile	45	
Mother goes to work	45	
Change in health of a family member	44	
Mother becomes pregnant	40	
School difficulties	39	
Birth of a sibling	39	
School readjustment (new teach or class)	39	
Change in family's financial condition	38	
Injury or illness of a close friend	37	
Starts new (or changes) extracurricular activity	36	
Change in number of fights with siblings	35	
Threatened by violence at school	31	
Theft of personal possessions	30	
Changes responsibilities at home	29	
Older brother or sister leaves home	29	
Trouble with grandparents	29	
Outstanding personal achievement	28	
Move to another city	26	
Receives or loses a pet	25	
Changes personal habits	24	
Trouble with teacher	24	
Change in hours with babysitter or at daycare center	20	
Move to a new house	20	
Changes to a new school	20	
Changes play habits	19	
Vacations with family	19	
Changes friends	18	
Attends summer camp	17	
Changes sleeping habits	16	
Change in number of family get-togethers	15	
Changes eating habits	15	
Changes amount of TV viewing	13	
Birthday party	12	
Punished for not "telling the truth"	11	
TOTAL		

OVERCOMING YOUR JOB STRESS

There are ways you can cope better with your job stress. It's best to begin with the simpler ones first to build your confidence. Here are some possibilities you can try.

TEN TIPS FOR HANDLING STRESS

1. SET PRIORITIES—Approach your work in a realistic way.
2. List your priorities. Don't overburden your memory.
3. Avoid trying to do several things at one time.
4. Take your breaks and ENJOY them. Walk outside, read something non-work related or rest and put your feet up.
5. Occasionally treat yourself to a different lunch. Meet a friend or visit a nearby museum or park.
6. Don't make a habit of taking work home with you. Consider occasionally coming early or staying late.
7. Avoid drinking caffeine products, like coffee and soft drinks. They can actually add to stress.
8. Avoid heavy foods for breakfast and lunch. They will zap your energy later.
9. Start your day with a nutritional breakfast.
10. Get a good night's sleep. Rest is important in maintaining a healthy lifestyle.



Resource Materials

Expert Witness Demonstrations

Presented by
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Dr. Carole Jenny
Steven Jensen, M.A.
James Peters, J.D.
Wanda Robinson, J.D.