INVESTIGATING ***CHILD*** ABUSE, EXPLOITATION & DEATH CASES

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CHILD PROTECTION UNIT

- Based on ***date of offense***, reviews:
  - Serious physical abuse cases: V <16yo
  - Sexual abuse cases: V <16yo
  - Exploitation cases: V <18yo
    - Trafficking
    - Child Pornography

    * Child witness to violent crimes (e.g., homicides)

ABUSE & EXPLOITATION

A CHILD DISCLOSES SEXUAL ABUSE … WHAT TO DO???

- Do you need to speak with child?
  - ONLY IF :
    - First Complaint = VERY FIRST person ever told
    - Safety – public, child, other children
    - Evidence Collection
- If so …
  - Open-ended v. Direct Questions

    "Can you tell me what happened? … Tell me more."
  - Don't be judgmental of abuser, child or non-offending parent
  - Ask if safe going home
  - Let know believe what telling you
  - Let know available if want to talk more later

A CHILD DISCLOSES ABUSE … WHAT TO DO???

- Speaking to child cont'd
  - Don't ask child to give written statement
  - Don't record child (video/audio)
  - Don't ask about MH history/counselors
  - Don't ask about sexual history
    - Leave for medical providers
    - Only relevant for med exam & SA evidence collection kit

A CHILD DISCLOSES ABUSE … WHAT TO DO???

- When was last incident of abuse?
  - Sexual Assault Evidence Collection Kit
  - Safety of victim – ongoing contact with P?
  - Search Warrant

A CHILD DISCLOSES ABUSE … WHAT TO DO???

- **In most cases, you only need to:**
  - Take information from caretaker about:
    - V's identifying info
    - P's identifying info
    - Allegations
    - Timeframe
    - Location of abuse (city/town)
  - Call Child Protection Unit to set up SAIN (forensic interview)
  - File 51A – oral & written
    - Document that filed in your report

MULTIDISCIPLINARY TEAM APPROACH

BEFORE SAIN

- Children making allegations of abuse were routinely questioned in numerous, separate interviews over the course of several weeks or months by the wide range of professionals necessarily involved in such investigations:
  - School
  - Family
  - DCF
  - Medical Personnel
  - Mental Health Providers
  - Police
  - DA

THE SAIN APPROACH

- Best interest of child standard
- Utilizes most neutral, non-leading, effective, child-sensitive interviewing techniques for highest quality result
- Reduces trauma of **multiple interviews**
- Permits all disciplines to obtain needed information at one time
- Fosters cooperative approach among disciplines

MULTIDISCIPLINARY TEAM MEMBERS

- DCF Response Worker (Investigator) - assesses child's safety past and present
  - Ongoing Worker should not be part of MDT if he/she is:
    - worker for the alleged perp, or
    - relationship with the family is such that it could compromise invest
- ADA - assesses viability of case and spots legal issues
- VWA - initiates relationship with family, provides referrals for services, assists getting RO (if needed)
- Forensic Interviewer - conducts legally sound interview to gather protective & investigative information
- Police Officer – conducts criminal investigation
- Pedi SANE – medical exam/consult, evidence collection

BENEFITS OF SAIN APPROACH

- Minimizes secondary trauma for child
- More quickly and effectively coordinates services for non-offending family members
- Defeats standard defense attacks on child interviews
  - Suggestibility
  - Interviewer bias
  - Leading questions
  - Forced-choice questions
  - Repeating questions within interviews
  - Use of props (e.g., anatomical dolls and drawings)
  - Peer pressure (e.g., “your friend said”)
  - Repeated interviews
  - Interview not recorded

FI CONSIDERATIONS

- Age
- Developmental level
- Disabilities
- Mental health
- Trauma/what witnessed
- Current stressors in child's life
- Child made an actual disclosure

CONSIDERATIONS CONT.

- Perpetrator still have access to child
- Safety concerns
- Who is primary caretaker of child – supportive of invest?
- Location (city or town) of offense
- DCF cases – just because screened-in for neglect doesn't mean SAIN not implicated
  - Screen in for neglect by parents, but screen out SA bet. children
  - Screen in for neglect during ongoing custody dispute between parents, but part of basis is mention of disclosure of molestation

THE PLAYROOM HELPS CHILD BECOME ACCLIMATED BEFORE INTERVIEW

PRE-INTERVIEW TEAM MEETING

- Arrive early for meeting
- Length of interview (3-5min/year old)
- Spot legal & investigative issues for CIS
  - Penetration
  - Jurisdiction
  - Dates of Offense / Age of V (14^{th} or 16^{th} Bday)
  - Delayed Disclosure
  - Identity of FC
  - Basis for possible SW
  - Does victim have a 5^{th} for any reason (always be alert to this if alleged perpetrator was < 16 or 14 for any portion of crime)
  - Potential defenses

FORENSIC INTERVIEW

- Child interviewed by CIS in private, age-appropriate room
- Team members observe behind one-way mirror
- Interview is recorded

ASSESSMENTS DURING INTERVIEW

- Competency
- Degree of specificity and context given by child
- Consistency with any prior statements
- Credibility: coaching, bias
- If child has history of prior abuse, is child able to differentiate this abuse/abuser?
- Consider potential problems re: working with child in court (e.g., language, voice, eye-contact, attention span).

DATES AND TIME FRAMES

- No requirement that a victim, particularly a child, remember exact date of abuse particularly where abuse was long term and ongoing.
- In fact, children <11 are UNABLE to accurately understand and report time
- Ask about other events that adults can then date
  - Diverse dates
  - On or about a specific date
  - On a date between…

POST-INTERVIEW TEAM MEETING

- Assess case objectively
- Has a crime been committed?
  - List of crimes and elements
- Can this child testify in court?
  - Competency, behavior, emotional state
- Will family cooperate?
  - Supporting perpetrator
  - Willing to put child through system

POST-INTERVIEW MDT MEETING

- When DCF present
  - DCF deadlines
  - Overlapping interviews – COORDINATE
    - Don't make them state agent
    - Remind them of voluntariness issues
  - What you say may end up in their 51B

POST-INTERVIEW FAMILY MEETING

- Let know child did a good job even if unable to disclose.
- Give realistic expectations of time frames, charging, bails and outcomes.
- Do not make promises you can't keep.
- If we are unlikely to charge unless there is a confession or physical evidence, explain that to them and why
- If we are closing the case, tell them that and explain why
- Explain Dwyer in the context of the particular case.
- Explain to them that we always have to assume these cases will be trials and that they need to be prepared for the possibility that their child will have to testify.
- Make sure they understand that the videotape cannot be used at trial.
- If parent is FC or witness, make them aware that they may not be able to be in the courtroom with the child.
- Alert them to the possibility of press coverage even if it is just the local paper.

POLICE INVESTIGATION

CORROBORATING THE DISCLOSURE

#WHYIDIDN'TREPORT

- STATISTICS:
  - 1 in 10 children will be sexually abused before they turn 18
  - Est. ONLY 38% of child victims disclose sexual abuse
    - 40% of those only tell a close friend rather than an adult/authority
- DELAYED DISCLOSURE OF CSA:
  - Threats, fear, embarrassment, guilt, shame … accommodation, too young
    - Fear – removed from home; not believed; getting in trouble; losing attention/gifts
  - For boys often added factors of being perceived as less of a man, being judged as a threat or predator (vampire myth – males who are abused grow up to be abusers)
- EVIDENCE:
  - "The evidence consists of the testimony of the witnesses …"
- CORROBORATION:
  - REQUIRED if SA occurred >27 years ago – must relate to element of crime and do more than bolster victim's credibility (ex: recording, DNA, witness, medical findings)

INVESTIGATIVE AVENUES

- COLLECTION OF EVIDENCE –
  - Photos of any injuries to V
  - Photos & diagrams of location of abuse
  - Clothing worn by V or P
  - Sheets, blankets – call out CSS?
  - Gifts given to V by P

- ACCESS & TIMING –
  - Parent's work records
  - Medical records – V exam, family member in hospital
  - School records – V home sick
  - Lease records

- RELATIONSHIP BETWEEN V & P –
  - Never any problems?
  - D the disciplinarian?
  - Photo of V from time of abuse – size, age disparity?

SA EVIDENCE COLLECTION KITS

- SANE available by beeper to respond w/in 60 min to designated sites:
  - BIDMC, BMC, B-W, Cambridge City, Children's, MGH, Lawrence General, N-W, U-Mass Worcester, Lowell
- Pedi-SANE for kids <12
  - Lawrence General – 24hrs/7d/wk
  - CACs of Essex, Norfolk, Suffolk, and ***Middlesex***
- Exam – can take up to 4 hours:
  - Vaginal, external genital, bite/body swabs
    - Adolescents/Adults – w/in 5 days
    - Peds – w/in 3 days
  - Oral and anorectal w/in 24 hrs
  - Perianal w/in 24 hrs unless vaginal/anorectal assault then 3-5 days

DIGITAL EVIDENCE

- Cell Phone records
- Text messages
- Images – sent to or by the V or P
- Emails
- Social Media postings

FIRST COMPLAINT

- FC admissible if relevant to V's credibility – either fact of SA or consent must be at issue
- Critical in all cases is WHY, WHEN, TO WHOM child first disclosed
  - Timing of disclosure v. Dse claimed motive to lie
    - P left home
    - P moving back into home
    - Accidental disclosure
- Substitute FC – permissible if FC unavailable, incompetent, too young, or biased

INTERVIEWING ALLEGED PERPETRATOR

- Record interview
- If P at scene when show up: lock into story!
  - Same when serve with RO (even if before SAIN)
- Ask why V would make up if not true
- Note *everything* P says and who heard it
  - Includes during transportation, booking & in custody
- Note observations of P's demeanor
- Note changes in story over time
  - Include any information provided in between

ARRESTS

- Specific considerations in CA cases:
  - When did abuse occur?
  - Ongoing risk of abuse?
  - Other children at risk?
  - Child interviewed per SAIN protocol?
  - Suspect interviewed/confessed?
  - Suspect aware of report & fleeing?
  - Discussed with CPU?

CHILD DEATH CASES

CRIMINAL CONDUCT V. MEDICAL CALL

- Criminal Conduct – Homicide
  - Abusive Head Trauma/Shaken Baby Syndrome
  - Blunt Force Trauma (e.g., abdominal)

- Child Fatality Review Team – M.G.L. c. 38, s. 2A
  - Review all deaths of children <18YO
  - Purpose: make recommendations to prevent similar deaths in the future
  - Examples: SIDS, SUID, Accident, Natural
    - SIDS (natural after rule out external risk factors and clinical history)
    - SUID (generally undetermined after rule out traumatic cause, rule out or uncertain medical cause and when suggest an associated external risk factor such as unsafe sleep)

*** YOU MAY NOT KNOW WHAT YOU ARE DEALING WITH UNTIL AUTOPSY ***

CHALLENGES IN CRIMINAL CONDUCT CASES

- Delayed recognition of crime
  - Treated as “medical call”
- Timing of injury/injuries
- Multiple potential perpetrators
- Conceptualizing caregiver as abuser
  - My client is … Mary Poppins, has no record, mild-mannered …

COMMON DEFENSES

- **IT WASN'T ME**
  - Attacks timing of injury
    - Lucid Interval
    - Access by others w/in timeframe
- **IT WASN'T ABUSE**
  - Rare medical disease/explanation – CPR, vaccines, bleeding disorder, OI
  - Accident – short fall, rough play
- **IT WASN'T THAT BAD**
  - Fragile/sick/already injured – rebleed (often combined with 3P or accident)
  - Shook but not violently (often clarifies admission later as "did to revive")

For jury - all have an element of "there but for the grace of God"

"THERE BUT FOR THE GRACE OF GOD GO I"

- Generalized belief that loving caregivers would never intentionally harm a child

- Many jurors:
  - Have been stressed by the demands of caring for an infant
  - So feel a connection to the defendant
  - Understand how "just lost it" so view incident as not intentional

= Makes jurors willing to accept a completely implausible theory of causation as it is preferable to thinking a "normal person" could inflict such violence upon a baby


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GUIDELINES

- Multidisciplinary approach
  - Each team member has a complimentary role that can be effective in learning not only HOW the child was injured but WHO inflicted the injury
  - Medical, social work, law enforcement, child protection, prosecution

- Focus on:
  - Possible & reported mechanisms of injuries (“wasn’t abuse”)
  - Timing of Injuries & access to child during timeframe (“wasn’t me”)
  - When baby last appeal normal (“wasn’t that bad”)

BIOGRAPHICAL INFORMATION

- Child's name, DOB, gender
- Parents' names, DOBs, marital status
- Where does child live
- Number of siblings, ages, gender, addresses
- Names of recent & current caretakers
- Other children in caretakers' care – names, DOB, gender, parents
- Family involved with DCF or other social services

MEDICAL TEAM INTERVIEWS

- Prognosis
- Extent of injuries – presence of old injuries
- Any medical conditions/treatment account for any of the injuries
- Mechanism of injury
- Timing
- Who brought child to hospital
- Chief complaint
- History provided – did it change? Does it account or injuries?
- Any delay in seeking care
- Diagnostic tests & studies?
- Laboratory results?
- Genetic testing?
- “Normal” developmental level for child this age

*** ATTEND CPT MEETINGS ***

Differential Diagnosis

The differential diagnosis (potential causes) can be extensive …

- Trauma
  - Accident
  - Inflicted
  - Birth-related
- Metabolic Disease (Glutaric Aciduria I)
- Genetic Syndromes (OI, EDS)
- Coagulopathies
- Infection
- Hypoxia
- ICP

Arriving at the AHT diagnosis is no different than arriving at any other clinical, medical diagnosis – it starts with a "chief complaint" …

It is important to understand what is supported by the medical literature & what has been debunked.

FIRST RESPONDERS

- 911 call – listen & preserve
- Child's condition on arrival
- Where was child found
- Who was present at scene
- Who provided history
- Any statements by caretakers
- Demeanor of caretakers
- Was child moved – by whom & where
- Scene altered by first responders
- File a 51A report?

INTERVIEWING CARETAKERS 101

- First interview should be non-confrontational & you should express condolences
- Let them talk – narrative form at beginning then ask follow up
- Ascertain what think caused the injury – don't dispute their story
- Ask to clarify details (e.g., which couch? Surface landed on? Part of body hit first? Child's reaction? Changes in appearance?)

INTERVIEW ALL CARETAKERS

- Who was present when child became symptomatic
- When was last time child appeared “normal”
- Who was in contact with child during timeframe
- Who called 911/sought medical help
- Explanation for any delay in seeking care
- Access – babysitters, family, anyone drop by
- Anyone left alone with child
- SBS education or parenting classes
- ANY explanation for injuries (known or may find) – car accident, fall, drop, shake

ASK ABOUT …

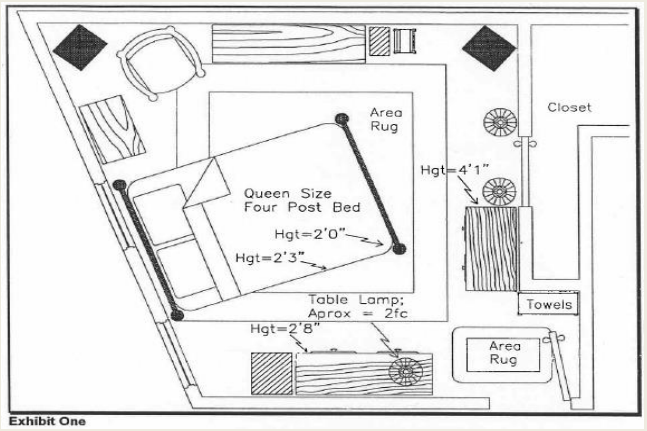
- Unexpected or unwanted birth
- Post-partum depression
- Frustration with child care responsibilities
- Attitude toward/relationship with child
- Marital problems
- Lack of experience with children
- Financial stresses
- Drug/alcohol use
- Physical abuse of caretaker when he/she was a child
- Household dynamics & attitudes toward children
- Cultural beliefs/practices concerning discipline

GET TO KNOW THE VICTIM …

- Pregnancy complications?
- Premature?
- Developmental level
  - Roll, sit up, crawl, stand, climb, follow with eyes, feed self
- Daily schedule
- Eating patterns
  - Nurse, bottle, solids, how often, last time ate & what
- Sleeping patterns
  - How long, how get to sleep, where sleep
- Diapering patterns
  - Last time changed, how often, before or after eats
- “Good baby”?

EVIDENCE COLLECTION
CONSENT OR SEARCH WARRANT

- Photograph & video entire scene
  - Pay particular attention to stairs, baby equipment, floor surfaces, wall surfaces, countertops, toys, bathroom fixtures
  - Look for “triggers” (dirty diaper, vomit, soiled clothes, cereal on wall, drugs/alcohol, layoff notice)
- Measurements
  - Height & number of stairs
  - Distance from crib/bed/couch/changing table to floor, including thickness of carpet & carpet pad
- Floor plans
- Digital devices (look up SBS?)



COLLECTION CONT'D

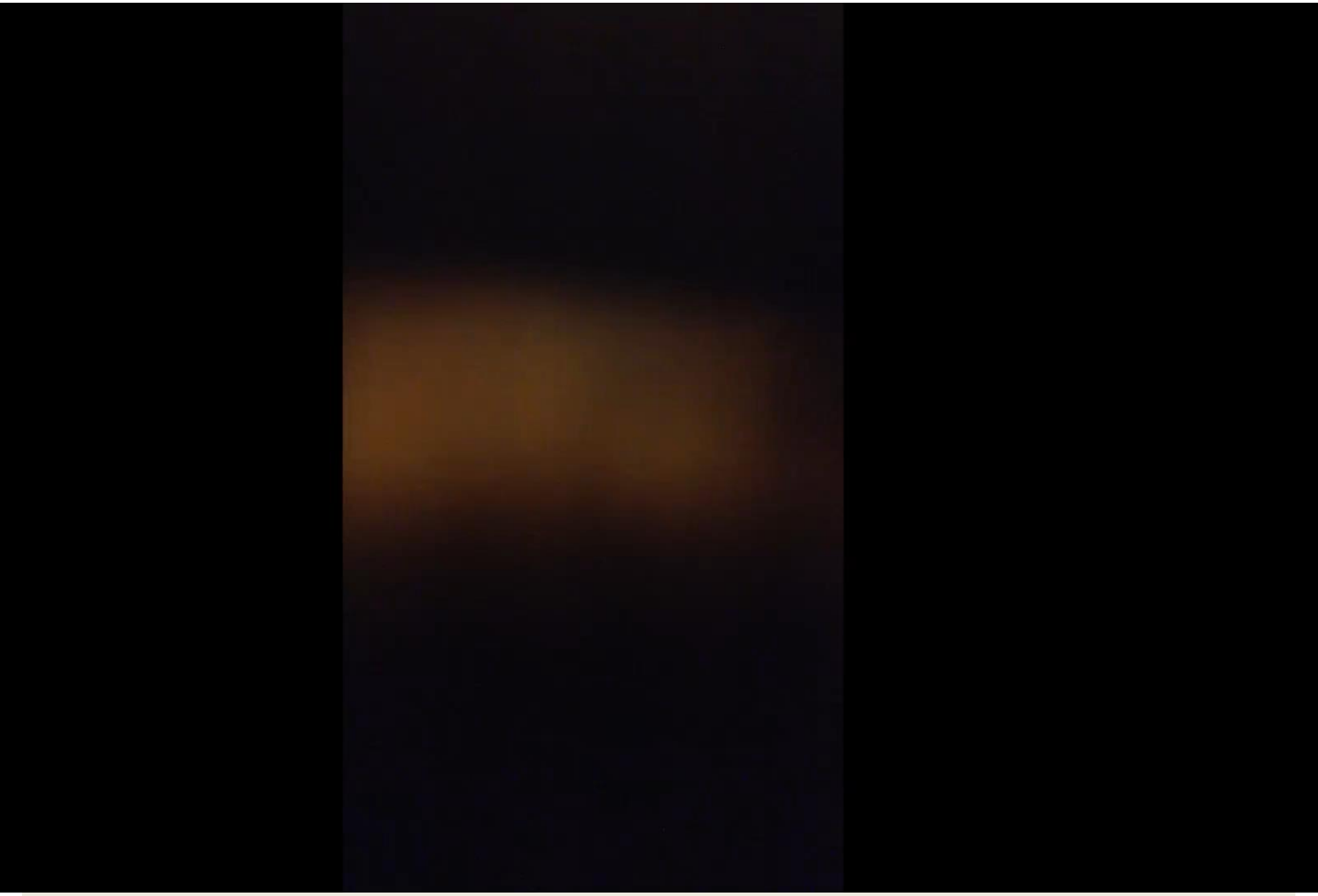
- Anything that corroborates/contradicts story or timeline
  - Car seat, toys, bed frame, crib slats, computer
- Child care & SBS Prevention lit. (hospital, pediatrician, DCF)
- Medical and health care documentation
  - Doctors names, visiting nurses, public health agencies
- Child care logs
  - Records, journals, notes of feeding times, schedules
- Bedding, bottles, food containers, trash and diaper pail, burp rags, towels
- Check refrigerator and cabinets for food and medicine (baby or caretaker)
- Any recent photos and videos of child (show developmental level, lack of injury)

RECORDS

- Talk to ADA about getting releases/subpoenas for records & to talk to providers:
  - EMT
  - Hospital medical team – outside hospital + trauma hospital
  - OB/GYN
  - Birth hospital – baby + mom's labor/delivery
  - Pediatrician
  - Specialty consultations (early intervention)
  - Drug treatment & habit management
  - School/daycare
  - Medical records for siblings
  - Phone records

INTERVIEWING THE SUSPECT

- Always record when possible – video is preferable
- Listen – let them talk & lock into a story
- Develop timeline – have describe events *in detail*
  - For day – hold bottle, follow with eyes, react to voice/face, play with toys, feedings, naps
  - For days/week prior – any changes in behavior, concerns
- Don't just account for known injuries; instead, ask, "Any reason doctors will find fractures?" "Any reason doctors will find evidence you've hurt the baby before?"
- If makes admission:
  - Have demonstrate – ideally with something
  - Ask to describe what the baby did as assaulted them (they won't want to)
  - Ask how quickly the baby became symptomatic
  - Ask how long were they with baby before inflicted injuries
  - Delay in calling for help
- Ask what know about handling of baby and education re: SBS/warnings about being "rough"
- Confirm nobody else present – Anyone stop in even briefly? Ever leave baby alone?



OTHER CONSIDERATIONS

- Notifying & get information from DCF, EEC
- Interviewing child witnesses – forensic interview?
- Medical check for other children present

KEEP IN MIND …

- These cases are NOT “there but for the grace of God”
- These are the defendants juries LEAST want to convict
- These children were real people who will never grow up to show the world who they could be
- We need EVERY TOOL POSSIBLE to help the jury understand and hold caretakers responsible for the violent homicides of these children

MIDDLESEX CPU

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