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Peace Officer Standards and Training Academy

Michael N. Becar, Director

Bad Luck Subdurals and Killer Couches

By Clifford C. Nelson, M.D

The recent trial in Cambridge, Massachusetts of *au pair* Louise Woodward illustrated several points concerning the state of trying child abuse cases. The forensic literature is clear as to what causes certain injuries. For many abusive injuries seen at autopsy, the way in which they are inflicted is as certain as a gunshot wound, stab, cut or bludgeoning and often more diagnostic than what we are able to find in strangulations. If the medical evidence is certain in these cases, then why is the mechanism, cause and manner of death in child abuse the usual point of contention? In this case-of-the month, we will examine some common "excuses and explanations" for infant and child injuries, what the consensus of forensic opinion is concerning these points and where to look in the literature to find "reputable" information.

Shaken baby syndrome and shaken impact syndrome are the most common mechanisms leading to death by blunt head trauma in infants (under one year of age). A leading defense contention in these cases seems inevitably to center around a fall from a short height, or what has euphemistically been described as the "killer couch excuse." Shaking and shaking with impact of a baby's head results in rapid acceleration and deceleration of an immature gelatinous brain within an infant's skull. The telltale injuries from shaking are subdural hemorrhage (bleeding under the dural membrane, over the brain), retinal hemorrhages (pinpoint bleeding on the inner lining of the eye) and cerebral edema (brain swelling caused by tearing of nerve cells).

In at least three trials in the State of Oregon during 1997, and the Woodward trial in Massachusetts, a new claim was made about the mechanism of retinal hemorrhages. Two East Coast forensic pathologists and one now Midwest neurosurgeon attributed the retinal hemorrhages in their respective cases (all shaken baby cases) to brain swelling. The exact mechanism for why retinal hemorrhages are seen in accelerated and angular head trauma is not known; it is, however, accepted that there is a causal relationship. There is no literature which reports on the mechanism by which brain swelling leads to retinal hemorrhage. No papers describe this

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Shaken Baby Syndrome: Overcoming Untrue Defenses

by Erin O'Keefe

The recent Shaken Baby Case in Middlesex County, Massachusetts has demonstrated clearly what child abuse prosecutors have known for years: it is difficult for people to believe that caretakers harm children, particularly when the child victim bears no external signs of trauma. This phenomenon is particularly true in cases involving Shaken Baby Syndrome.

Shaken Baby Syndrome.

Shaken Baby Syndrome (SBS) is a term used to describe a constellation of injuries and the mechanism of abuse that causes these injuries. The hallmarks subdural and/or subarachnoid hematomas, retinal hemorrhages and little or no sign of external injury. These injuries may be accompanied by fractures of the long bones, ribs or skull.

Because abusive shaking is rarely witnessed, the exact mechanism in a particular case is difficult to establish. Thus, the mechanism of abuse must be gathered from comparisons to comparable accidental injuries and descriptions that have been provided by perpetrators. The child is generally held by the chest, arms or shoulders and violently shaken, with the head whipping back and forth. During the shaking the child's head experiences acceleration/deceleration forces, which cause the brain to rotate relative to the more stationary skull. This type of motion causes subdural hematomas (bleeding in the brain caused by the tearing of the tiny bridging veins that cover

the brain), diffuse axonal injury (tearing of the white matter of the brain) and cerebral edema (brain swelling). In addition to these injuries, another common characteristic of SBS is retinal hemorrhages (bleeding in the back of the inner surface of the eyes). During the shaking the child's head may be thrown or slammed onto a hard or soft surface. Some victims bear evidence of impact trauma, indicating that they may have of been slammed as well as shaken. Evidence of Shaken-Impact Syndrome can be seen when the scalp and/or subgaleal (under the scalp) hemorrhages. The lack of injury to the skull or scalp, however, does not rule out the possibility that the child's head was slammed into an object. If the skull impacts against a soft surface, injury is explained by disbursement of the contact force (rapid deceleration of the head as it strikes the object) over the wide surface of the skull. However, shaking alone is sufficient to cause severe injury and death in an infant. Despite the devastating intracranial injuries that are found in SBS cases, there is often little or no external sign of trauma.

Generally the victims of SBS are under two years of age, but the syndrome has been diagnosed in children as old as five. Infants are particularly vulnerable to SBS because of their relatively large heads and weak neck muscles, the softness of their skull, and the high water content of their brains.

Untrue Accidental injury Defense In Shaken Baby Cases

A common defense offered by perpetrators is that the child suffered from some accidental injury. When confronting an accidental injury defense particular attention should be paid to the perpetrator's account of how injury occurred. It is also vital that the prosecutor be knowledgeable on the pertinent medical literature concerning the type of accidental injury that is alleged. In addition, the prosecutor should be aware of the developmental abilities of children. Many perpetrators allege the child engaged in activity that would be impossible for a child that age. In the face of complex medical testimony, Prosecutors should encourage the trier of fact to rely on their own experience with children to sift through the accidental trauma defenses offered by perpetrators. Remind juries that children they have known were not killed or seriously injured by a short fall or a bump on the head. The key in SBS cases is to emphasize to the jury that for a child to suffer severe injuries, there must be severe and violent force inflicted on the child.

Shake to Revive

A common accidental injury defense offered by perpetrators is that the baby was in distress, choking or not breathing, and the perpetrator mildly shook the baby in a vain effort to revive the baby. This is probably partially true, except the sequence of events is reversed. A more likely scenario is that the perpetrator in attempt to quiet a crying baby, violently shook the baby and then the baby stopped breathing. To convince the jury that injuries seen in a SBS case are not the result of a desperate attempt to help a baby in distress, it must be made clear that "violent shaking, whether or not it is accompanied by

an impact, is not a casual act but rather one that would indicate to a rational observer that severe injury was being inflicted to the infant." The severity of the injury caused by violent shaking must be emphasized to discredit these false histories.

SODDI Defense- Some other Dude Did It

To date the intracranial injuries associated with SBS, experts rely on the history provided by

To date the intracranial injuries associated with SBS, experts rely on the history provided by the caretakers, the child's presenting symptoms and the images created by CT and MP scans.

the caretakers, the child's presenting symptoms and the images created by CT and MP scans. Many medical experts agree that a child with a fatal head injury will rapidly become symptomatic (altered consciousness, convulsions, difficulty breathing) soon after the incident. Thus, in the case of fatal head injury, the trauma most likely occurred after the last confirmed period of normal consciousness of the child. Investigators should ask caretakers when the child last made eye contact, grasped, smiled, played or ate normally. In an effort to remove suspicion from themselves and to confuse the jurors, a perpetrator may allege that the victim was injured by another child that was present in the home. The force that is required to shake a baby to death almost certainly

requires the strength of an adult. Therefore, it is not plausible to explain massive intracranial injury as being inflicted on the child by another young child who lives in the home.

Short Falls

A brief overview of the type of injuries children receive from falls demonstrates how these defenses can be challenged in court. Studies show the injuries children suffer in accidental falls are different from the injuries caused by SBS. Short distance falls rarely, if ever, cause skull fractures and when they do the fractures are small (less than 1mm) and linear (consisting of an unbranched fracture line) and are not associated with brain trauma. In addition, the skull fractures found in children that have been shaken and then slammed or thrown down, are complex (consisting of multiple fracture lines, eggshell), diastic (widening) and are accompanied by severe intracranial trauma. The injuries seen in SBS are comparable to the injuries seen in motor vehicle accidents or in falls from several stories.

Despite general unwillingness to believe that adults hurt children, a prepared prosecutor can demonstrate to a jury that overwhelming medical literature indicates the SBS injuries are not caused by the ordinary scrapes and tumbles of childhood, but caused by severe, violent child abuse. For more information on Shaken Baby Syndrome and assistance in prosecuting SBS cases, please contact the American Prosecutors Research Institute's National Center for Prosecution of Child Abuse.

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Upcoming Training

The Fourteenth National Symposium on Child Sexual Abuse

Presented by the National Children's Advocacy Center **When:** March 17-20, 1998 **Where:** Huntsville, Alabama **Cost:** \$395.00 or \$195 Student Rate **For Information:** NCAC Symposium Office, 200 Westside Square, Suite 700, Huntsville, Alabama 35801 Phone: 205-534-1328 Fax: 205-534-6883

Twelfth International Congress on Child Abuse and Neglect, Protecting Children: Innovation and Inspiration.

Presented by the International Society for Prevention of Child Abuse and Neglect **When:** September 6-9, 1988 **Where:** Auckland, New Zealand **Cost:** Prior to July 1, 1998 ISPCAN Members NZ\$590 New Members NZ\$725 (including 1998 membership if ISPCAN) Non Members NZ\$650 **For Information:** The Conference Company POSTAL ADDRESS: PO Box 90-040, Auckland New Zealand STREET ADDRESS: 44 College Hill, Ponsonby, Auckland, New Zealand Phone: +64 9 360 1240 Fax: +64 9 360 1242 Email: info@tcc.co.nz Internet: <http://www.nzhealth.co.nz/ispcan98>

The Second National Conference on Shaken Baby Syndrome.

Presented by Primary Children's Medical Center, Child Abuse Prevention Center, and SBS Prevention Plus **When:** September 13-15, 1998 **Where:** Salt Lake City, Utah **Cost:** n/a **For Information:** contact The Child Abuse Prevention Center of Utah 2955 Harrison Blvd., #102, Ogden, UT 84406 801-393-3366 or by email at capcente@ix.netcom.com

Northeast Regional Child Maltreatment Conference, "Challenging Our Response to Child Maltreatment: Intervention, Prevention or Both?"

Presented by the Massachusetts Society for the Prevention of Cruelty to Children and the Massachusetts Chapter, American Professional Society on the Abuse of Children and The Northeast Regional Children's Advocacy Center. **When:** November 12-14, 1998 **Where:** Providence, Rhode Island **Cost:** n/a **For Information:** Send name, address, telephone number and fax number to - NE Regional Child Maltreatment Conference, Planning Committee Tufts University School of Medicine, Office of Continuing Education, 136 Harrison Ave, Boston, Ma 02111

The Twelfth National Conference on Child Abuse and Neglect, Engaging America's Communities

Presented by The National Center on Child Abuse and Neglect (NCCAN) **When:** November 16-21, 1988 **Where:** Cincinnati, Ohio **Cost:** n/a **For Information:** 8484 Georgia Ave., Suite 1000, Silver Spring, Maryland 20910-5604 Phone: 301-589-8242 Fax: 301-589-8246



The Child Abuse Prevention Center

Shaken Baby Syndrome Information, Support and Referral Service

■ The Child Abuse Prevention Center is pleased to announce our **National Information, Support and Referral Service on Shaken Baby Syndrome**. The goal of this service is to provide valuable information and resources to professionals and parents throughout the nation.

■ Information on Shaken Baby Syndrome will be disseminated through a variety of methods including a toll-free number, newsletter, Internet home page and memos.

■ The Child Abuse Prevention Center kicked off their Shaken Baby Syndrome Prevention Program in 1990 and has numerous program models for a variety of audiences in need of this information:

✓ **Young Males** - In 1994 the Center conducted a research project on the *Incidence and Risk Factors of Shaken Baby Syndrome in the State of Utah*, and learned that 79 percent of the perpetrators of Shaken Baby Syndrome are male. We now provide educational programs designed specifically to educate young males about parenting skills, stress management and the dangers of shaking babies.

✓ **Child care providers** - It is crucial this audience learned about Shaken Baby Syndrome and how to cope with crying because they spend thousands of hours each year caring for babies and young children. The Center has developed a program to educate care givers as well as a training curriculum and information that they can pass on to the parents they serve.

✓ **Law enforcement officers and child protective services workers** - These professionals are often the first responders when a baby has been shaken. The Center's training program for law enforcement and CPS workers teaches them what to look for, questions to ask and appropriate steps to take when investigating a Shaken Baby Syndrome case.

✓ **Parents** - Parents of newborn babies are generally eager to learn all they can about caring for their child. This program model involves educating new parents in prenatal classes, discharge classes and home visitor programs about the dangers of shaking as well as coping strategies for dealing with inconsolable crying.

For more information about Shaken Baby Syndrome or our Shaken Baby Syndrome Prevention Programs, contact:

Child Abuse  Prevention Center

2955 Harrison Blvd, Suite #102

Ogden, UT 84403

Phone: (801) 393-3366 Fax: (801) 393-7019

Toll Free: 1-888-273-0071

E-Mail: capcente@ix.netcom.com

Defining the Interview Process

By Wendy Deaton, M.A. and
Lt. Mike Hertica



Over a decade has passed since a rash of child sexual abuse allegations occurred in day care centers across the nation. One result of these events was a new focus on the child interview process. A decade later, however, the plethora of articles and books that continues to emerge from therapeutic, social service and child abuse fields reveals a continued lack of consensus on a protocol that can be used with young children to produce effective, credible fact-finding interviews.

Questions still under debate include which professional discipline should be responsible for child interviews in cases where child abuse is suspected? Should direct questions be asked or must the child produce a totally spontaneous recounting of events? How susceptible are children to leading questions, direct suggestion, or subtle innuendo? Can the memories of children be trusted? Can anyone's memory be trusted?

This article proposes to add another to this profusion of questions, "What is the purpose of the interview?" It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process. The purpose of an interview determines what questions can appropriately be asked of the child, clarifies the guidelines for interviewer interaction, and defines how the interviewer can respond to the child's disclosures. It defines which type of professionals, from which

disciplines, should most appropriately conduct the interview.

This article draws on the authors' combined experience in law enforcement, social work and mental health to provide an outline of three types of interviews that may be conducted during a child abuse investigation: the investigative interview, the therapeutic assessment (also known as a forensic evaluation), and the treatment interview. Although there are tremendous overlaps, establishing credible and reliable protocols for interviewing children depends upon clearly differentiating the specific types of interviews that may be conducted. While all interviews with both children and adults use the three phases of rapport, information gathering, and closure, these three types of interviews have different purposes, requirements, goals, tasks and limitations. These differences are described below.

The Treatment Interview Purpose

The purpose of the treatment interview is to determine what should be done about what has happened. While the outcome of treatment may enable a child to provide a more credible accounting of traumatic events of interest to the criminal justice system, the purpose of treatment is not healthy disclosure, but a healthy child. In fact, the outcome of treatment may result in

a recommendation that the child stop participation in the criminal process, as such participation may be seen as too detrimental to the child's prognosis for recovery and health.

Interview Content

The treatment interview identifies goals and objectives that will help the child recover from the current traumatic events. In addition to exploring the allegations of abuse, the interview includes a review of other significant life experiences which may be affecting the child's development and adjustment. The treatment interview explores the child's current level of functioning; his or her internal perceptions, beliefs and attitudes; the defense mechanisms commonly utilized; the weaknesses and strengths demonstrated.

Interviewer

The treatment interview is conducted as a prelude to the treatment process. As such, it is conducted by the treatment therapist, with the goal of establishing a plan of action. The specific areas the therapist explores and the historical information sought are determined, in large part, by the therapist's treatment approach and style. For some therapists, the debriefing of traumatic details may be primary, while others may look to the restructuring of cognitive beliefs, the cathartic release of emotional reaction, or the redoing of wounded developmental tasks and reestablishment of the normal developmental process.

In the process of conducting the interview, the therapist may model, facilitate, support, or teach his or her client. The child may learn new names and functions for body parts, new rules regarding personal boundaries, and new methods of communicating in more assertive or aggressive way. The provision prevention education in the course of therapy, which has the capacity to alter the child's beliefs and perceptions about past abuse events, may also be utilized in the therapeutic evaluation or assessment.

During the process of treatment, therapeutic and supportive statements can be utilized to promote growth and change in the client. The therapist may express judgments about the events, such as stating that the perpetrator was "wrong to do that to you", or promote a value system such as "children are never to blame." In treatment, issues such as other current events and significant events of the past, other concerns of the child, and concerns of the parents and teachers regarding behaviors of the child may appropriately be addressed.

Referral Process & Confidentiality

The treatment process with a child is usually conducted at the request of the parents. Referrals may also be made by social services, law enforcement, attorneys, school or medical personnel. Ordinarily, the issue of confidentiality is established early on with the child, the parents, and the referring parties. All information, except that specifically required by law and determined appropriate for release by the participating parties, is considered confidential. The therapist will go to great lengths, appropriately, to keep confidential the child's revelations, except where disclosure is in the best interest of the child. James (1989) and Donovan and McIntyre (1990) provide examples of treatment

assessment interviews.

The Therapeutic Assessment Purpose

The purpose of the therapeutic assessment is to determine how the child is functioning and how the child has been affected by the events in his or her life, including those that are the focus of investigation. The therapeutic assessment examines the child's internal mental processes and emotional state related to the current events (Barker, 1990).

It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process.

Interview Content

A therapeutic assessment differs from an investigative interview in that there is less emphasis on the production of "evidentiary statements" and more emphasis on the child's view, perception, and overall reaction to the alleged events. The assessment differs from a treatment interview in that it does not detail treatment needs. The therapeutic assessment is concerned with what happened but not with how to resolve what happened. The goals of the assessment may include determining if the child can safely remain in the home during the investigative process and whether the child can participate in a meaningful way in the investigation without serious further harm.

Interviewer

A therapeutic assessment may be conducted by medical professional, forensic psychologist or mental health therapist whose skills include the ability to constructively deal with the child's emotional reactions to the process. A therapeutic assessment should always be conducted by a neutral party who has had no prior and will have no further dealings with the child, a significant departure from the treatment assessor, who will have an ongoing relationship with the child. This limitation of role ensures that the interviewer will not be biased by prior contact with the child and will not be influenced by personal interests (further business, etc.).

The therapeutic assessment is not a true fact-finding process, in that there is a bias towards the child's perceptions of the events. The investigator may offer an opinion on the accuracy of the child's perceptions, but detailed corroboration examination is left to law enforcement personnel. Information that emerges during a therapeutic evaluation very often has significance to the criminal-justice process as well as the treatment process. It is at this point, in particular, that confusion between the investigative, evaluative and treatment purposes may occur.

While the evaluator may offer the child reassurance, the evaluator will refrain from providing prevention education or working with the child to resolve emotional reactions or cognitive perspectives. The therapeutic assessment does not provide opportunity to significantly intervene or to promote change. The evaluator limits him/herself to modeling and supportive interactions. In the therapeutic assessment, both therapeutic and supportive statements may be utilized. Although the evaluator will show concern for unrelated events and issues the child introduces to

the interview, the assessment remains focused on the events which initiated referral. As with the treatment assessment, props may be used to assist the child in communicating about what happened and how they have been affected.

Referral Process & Confidentiality

The therapeutic assessment is ordinarily conducted at the request of parents, attorney, police department or the court. As such, much of the information produced will not be held confidential. A written summary or report is usually prepared and made available to a number of individuals. As with the investigative interview, the therapeutic assessment has time constraints imposed upon the process by the succession of events unfolding during an evidentiary search.

Examples of therapeutic assessments are available on the San Diego Children's Hospital Tape on Child Interviewing, in MacFarlane, et al (1986) and Barker (1990).

Investigative Interviews Purpose

The purpose of an investigative, or forensic, interview is to obtain information to be used in the criminal justice system. An investigative interview seeks to determine what happened. It is a fact finding process intended to provide information that can be corroborated and used in the prosecution phase of the case.

Interview Content

The investigative interview must focus on data that can be corroborated. The best methods of corroboration, in descending order of importance, are: confessions, physical evidence, other victims, and witness statements. The type, level and strength of the corroboration needed depends on the case, but it is always necessary. As a general rule, as the age of the child decreases, the necessary level of corroboration increases, as judges and juries tend to give less

credibility to disclosures by younger children (Goodman and Bottoms, page 177).

Interviewer

The focus of attention in a trial involving testimony by children is quite often upon the professionals involved in the investigative process, rather than on the victim. The specificity and intensity of this focus requires that those involved in the process of investigating suspected child abuse be as thoroughly trained, competent and familiar with the

The Therapeutic assessment is concerned with what happened but not with how to resolve what happened

criminal justice mandates, requirements and restrictions as possible. A criminal justice investigative interview is therefore best conducted by professionals from the criminal justice system or by someone specifically trained in the complexities of the system's process.

To ensure that an interview meets the requirements of the criminal justice process, the primary training of the interviewer should be as an investigator, however additional training in the area of child development is critical and necessary for professionals who work with child victim-witnesses.

In the investigative interview, the interviewer scrupulously maintains a position of neutrality, refraining from giving much, if any feedback, and focusing instead almost entirely on gaining information. Positive feedback is appropriately limited to supportive, rather than therapeutic statements, as therapeutic statements have the potential to alter the child's perception

and recall regarding the events. For example, a therapeutic response to a child's disclosure may be: "You are brave to talk about what happened", while a supportive response may be the more neutral "Some things are hard to talk about."

There are three phases of an investigative interview: rapport building, disclosure and closure. Much has been written about the first two stages, but equally important, and often overlooked, is closure. Child abuse victims have been exploited, used, and often feel they have been thrown away or discarded. Regardless of the fact that the interviewer has good intentions, to the child the interview may feel similar to the abusive events. The closure portion of the interview can soften this feeling of being "used". From a practical perspective, the first interview will seldom provide all the information necessary for investigative purposes. If there is not good closure in the first interview, it will make subsequent interviews more difficult for everyone involved.

In closure, the child will usually ask questions such as "Is my daddy going to go to jail?"; "Am I in trouble?"; "Am I going to a foster home?". These questions should be answered as honestly as possible, taking care to put the answer in the least frightening terms for the child. The investigator may need to explain details of the medical or social work portion of the investigative process.

Examples of investigative interviews are generally located in the law enforcement literature, however, in the therapeutic field, Hoorwitz (1992) provides a comprehensive example useful to all professionals.

We recognize that individuals in the roles of investigator, evaluator, and treatment therapist often find themselves crossing the

boundaries into other disciplines' expertise in questioning. Although some crossover cannot be avoided, interviewers with a clear understanding of their purpose will find it is possible to contain their interview to their own discipline's focus.

In this article, we utilize the concept of purpose as a focal point for establishing practical guidelines for the three types of interviews that are likely to be conducted with a child victim-witness to a crime of violence. While cross-training can provide professionals with sufficient technique to conduct an interview from another discipline's purpose and perspective, the depth and completeness of such an interview are likely to be greatly reduced. Each discipline has subtleties, intricacies, and complexities that are difficult to learn without sufficient "in the trenches" experience. Thus, didactic cross-training alone is unlikely to provide the skill needed for a successful interview process.

This discussion has attempted to clarify some of the critical differences between the investigative or forensic interview, a therapeutic assessment or evaluation, and the treatment interview. The purpose of this differentiation is to redirect professional energy from an unproductive debate regarding interview guidelines and protocols, to a productive action-oriented multi-disciplinary approach to the problems involved in interviewing child victim-witnesses.


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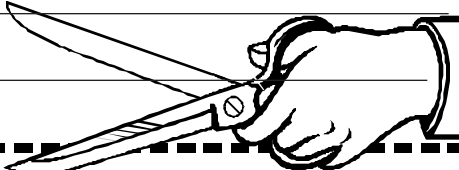
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phenomenon and in cases of diffuse brain swelling for reasons not related to accelerated or angular head trauma, retinal hemorrhages are not seen. When asked about support for their claims, these “expert” witnesses could not cite references; they could only say they thought they had seen or been told of such cases.

The idea that severe head trauma can result from short falls has been refuted. Although very rare linear non-displaced skull fractures have been described in short falls, these were not associated with intracranial (brain) trauma. In general, intracranial injuries were not seen until falls were of greater than ten feet. Even with these repeated reports, the most common claim by a perpetrator of shaken baby syndrome is that the injured child rolled off a table, chair, couch, or bed, or that the child was dropped. It just doesn’t happen this way.

A variation on the minimal injury claim has appeared recently, and has gained the designation of “the bad luck subdural.” Children who develop a subdural hematoma (from previous injury; i.e., battered child syndrome) are more likely to re-bleed into the previous subdural due to minor trauma. This was a major area of contention in the Woodward case, where it was postulated that re-bleeding due to a fall of less than two feet, a light shaking to arouse the baby or a sneeze caused re-bleeding into the previous subdural. The argument may work as a smoke screen to confuse a jury, but holds no weight as an explanation for other usual findings. First, what trauma, and by whom, caused the first subdural (and skull fracture in the Woodward case)? Second, retinal hemorrhages require severe acceleration forces to appear and

may fade out with time if the child lives. Therefore, if present, as in the Woodward case, there is much more than a minor incident causing re-bleeding into the subdurals that are associated with retinal hemorrhage. Third, acute rapid brain swelling due to shearing of neurons (brain cells) does not occur in a minor trauma re-bleeding into a subdural. An infant who receives the violent acceleration/deceleration trauma which causes shearing forces between the differently dense layers of the brain and tearing of nerve cells will not appear “normal” afterwards. If the child

It is unfortunate ... that often in the defense of these cases testimony is allowed which has no scientific or medical support and can best be characterized as quasi- or neuvo-medicine.

remains conscious, movement, level of attention, eating and general responsiveness will all be drastically effected. Brain swelling can occur as the result of an expanding subdural hematoma due to the hematoma pressing on vessels and interrupting blood supplies, but the pattern of swelling as seen on CT, MRI or autopsy is different than with shaking.

In addition to the intracranial injuries, victims of shaken baby/shaken impact syndrome may have many other injuries not explained by the story given by the perpetrator (classic for all child abuse). Bruises in a pattern unexplained by the history are common. Often bruises, abrasions, lacerations and fractures will be present on multiple striking

surfaces, and impossible to have been incurred by one fall. Neck injuries occur in a large number of shaking cases. Fractures away from the head are common and may involve wrist, arms, legs and the ribs.

In general, the injuries seen in abuse cases of infants and young children have sound medical and scientific explanations. Evidence given explaining the mechanisms of these injuries carries a high degree of medical probability or certainty. It is unfortunate (in the opinion of this writer) that often in the defense of these cases testimony is allowed which has no scientific or medical support and can best be characterized as quasi- or neuvo-medicine. Even the “experts” testifying to theories like the “killer couch” have referred to their testimony as “within the realm of medical possibilities.” This is not the degree of certainty required in the Fry test; therefore, why is it allowed into the record? It has been said that everyone is entitled to an opinion; most people will not argue that point. The question is, when “expert testimony” falls outside the accepted facts and standards of a field, should it qualify as “expert testimony?”

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CHILD ABUSE PROSECUTION AND INVESTIGATION

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Boise, Boise Center on the Grove

CHILD DEATH INVESTIGATION

Speakers include Dr. Roger Byard, Pediatric Forensic Pathologist of the University of Adelaide, Australia, foremost expert in the field of child death investigation, author of *Sudden Death in Infancy, Childhood and Adolescence*, and Dr. Randy Hanzlick Associate Professor of Forensic Pathology, Emory University School of Medicine; Forensic Pathologist, Center for Disease Control and Prevention, Atlanta Georgia. This two day workshop will cover 'Death scene investigation in sudden infant death - What to look for', 'What the pathologist needs', 'Causes of sudden and unexpected death in childhood', 'What is SIDS?' and 'How reliable is the autopsy?', 'Features of abuse in childhood', 'Munchausen Syndrome by Proxy', 'Accidental death in childhood', 'Preventative Pathology' 'Guidelines for Death Scene Investigation and CDC Protocol', 'Sudden Unexplained Infant Death Questionnaire' (SUIDQUEST)

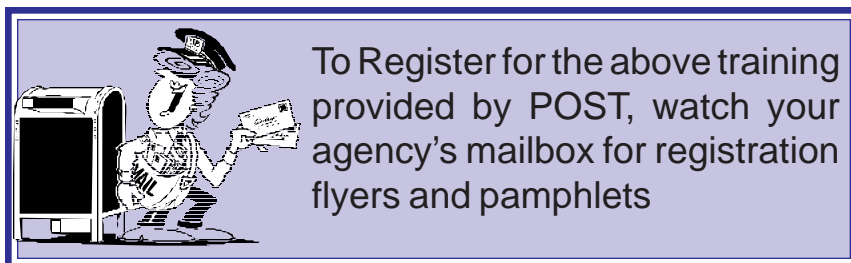
POST training hours, CLE and CEU's will be available for these workshops.

LOOK FOR REGIONAL TRAINING IN JUNE 1998

"Adoption and Safe Families Act of 1997"

With the passages of this bill sponsored by Idaho Senator Larry Craig and the probable passage of similar state legislation amending I.C. 16-1601 provides for a series of changes that will expedite the permanency of children in the Departments's care. This bill will make significant changes to the child welfare system to ensure the health, safety and permanency of a child. This training will address the changes in the law and how these changes will effect the investigation, prosecution and management of child maltreatment cases.

One day training sessions will be announced with multiple venue's statewide.



To Register for the above training provided by POST, watch your agency's mailbox for registration flyers and pamphlets



Peace Officers Standards and Training
P.O. Box 700
Meridian, ID 83680-0700

PROTOCOL
