



PROTOCOL

A QUARTERLY PUBLICATION

[HTTP://WWW.STATE.ID.US/DLE/POST.HTM](http://www.state.id.us/dle/post.htm)

Department of Law Enforcement POST Academy



every non-medical professional should know about medical exams in child sexual abuse cases

*by John Stirling, M. D.
Clark County Child Abuse
Intervention Center
Vancouver, Washington*

The medical investigation of suspected child sexual abuse is a relatively recent phenomenon. Sexual abuse itself has only been recognized as widespread during the past decade, and physicians have scrambled to keep up with a rapidly developing body of specialized knowledge. Not surprisingly, professionals outside of the medical field often find themselves confused by medical developments related to these cases. To help alleviate some of the confusion, following are the ten basic facts non-medical professionals need to know about child sexual abuse exams:

1. Physical findings are uncommon in child sexual abuse exams.

While patients and parents (and occasionally their advocates) frequently present at our clinics "to find out if something really happened," the truth is that physical

findings are the exception, not the rule. Even in referral centers, where it can be assumed that many of the patients are in fact victims, the rate of abnormal exams is between 15-25%, and not all abnormalities are diagnostic.

This lack of physical evidence doesn't mean that the exam is worthless; the medical history itself is often of forensic value, all the more so because of the hearsay exception in court testimony. Moreover, the patient and the caretakers are often greatly relieved to hear that no tissues were permanently damaged by the assault or no diseases contracted.

In fact, there are numerous documented cases in which a perpetrator has confessed to vaginal penetration as described by the victim, and yet examination by experts has shown no damage to the vaginal structures. This is due to the rapid healing and elasticity of these tissues and probably depends on a somewhat liberal interpretation of "penetration" (one can, after all, enter

LOOK FOR

2

Investigating Domestic Violence: A Call to Protect and Serve Our Families

5

Resources for Information, Training and Technical Assistance

8

400 Years of the Shaken Infant: From Henry II to John Caffey

Continued on page 10



Investigating Domestic Violence: A Call to Protect and Serve Our Families

PROTOCOL is published quarterly by Peace Officers Standards and Training Academy. This publication is made possible through a grant from the Department of Health and Welfare. The opinions expressed herein are solely those of the author and do not necessarily represent the views of Peace Officers Standards and Training Academy

If you would like to contribute an article or have any questions or comments regarding PROTOCOL, please write to P.O. Box 700, Meridian, ID. 83680 Attn. Vicki Pence

By Victor I. Vieth

It is well-established that exposing a child to acts of domestic violence between parents is a form of maltreatment. There are two compelling reasons why this is so. First, children exposed to violence between caretakers are at greater risk to be abused themselves. Studies indicate that between 30% and 60% of spousal abusers are also child abusers.

Second, domestic violence has a devastating impact on every aspect of childhood. This is true even if the child manages to escape the administration of direct blows. Violent homes breed kids with higher rates of school absences, health problems, criminal behavior, drug and alcohol dependency, and who are more likely to try to kill themselves.

The emotional scars of domestic violence often impact a child beyond the age of majority. For instance, 90% of the men in the Minnesota prison system grew up in homes where fathers assaulted mothers.

Any campaign to end child abuse in America will have muted success unless it addresses the violent dynamics existing throughout many of these families. One starting point is for prosecutors and police officers

to work together to develop strong cases against domestic abusers.

The iron hand of the criminal law is often necessary to convince recalcitrant abusers to reform and to educate both victim and perpetrator that violence is unacceptable.

In investigating a case of domestic violence, police are well-advised to keep in mind the following basic rules.

1. Separate the victim from the perpetrator prior to conducting interviews.

A recently beaten woman is acutely aware of her powerlessness in the relationship with her attacker. Asking a victim to recount the abuse in the presence of her abuser is to invite minimization or denial. Ideally, two officers should respond to a call of domestic abuse. The victim and perpetrator should be separated and interviewed outside the hearing range of the other.

2. At some point in the investigation, tape record a statement from the victim.

Fresh from an attack, a victim in need of help may fully cooperate with law enforcement. As

weeks pass, though, many victims are reluctant to continue a prosecution. It is even probable the victim may recant an original statement or claim an officer misunderstood her report. If the original statement is tape recorded, or at least in the handwriting of the victim, it becomes more difficult for the victim to accuse the officer of misrepresenting her original claim of an assault.

A police officer may not wish to tape record the statement immediately if doing so will impede the flow of the victim's statement. If the assault is recent and the victim is emotionally distraught, the officer should listen to the victim and pay careful attention to her mannerisms, behavior, and emotions. Once calmness prevails, a tape recorder can then be produced and a more detailed statement taken. The reason for this is that the victim may be in the midst of making an excited utterance which should not be interrupted. This issue is considered more fully below.

3. Make a detailed report of the emotions and behaviors of the victim.

It is essential to make note of any manifestation by the victim of excitement or fear. Examples include crying or tears, indicators of pain such as wincing, shaking, excited or hurried speech, and body posture such as curling up in a ball. I once prosecuted a case in which an officer was interviewing at the police station a victim of domestic violence. On three occasions during the interview, another officer entered the interview room and each time the victim jumped. The officer detailed this information in his police report as a clear indication the victim was in fear of being followed and harmed further by her assailant.

The importance of this information is twofold. First, this information adds credibility to the

victim's statement by confirming she was indeed fearful shortly after the attack.

Second, this evidence enables the prosecutor to argue the victim's statement is an excited utterance which should be admissible as substantive evidence at trial. An excited utterance is defined as:

"A statement relating to a startling event or condition made while the declarant was under the stress of excitement caused by the event or condition."

An excited utterance can often be found as well in the victim's original call to the police. The frightened plea of Nicole Brown Simpson to a law enforcement dispatcher is a famous and classic example of this type of excited utterance.

It goes without saying that a beating is a startling event and if an officer can document evidence showing the original statement to the police was made while the victim was still enduring the stress of the event, the statement as well as the behaviors, may be admissible evidence.

If this is true, the prosecutor's case may survive even if the victim recants or otherwise becomes uncooperative with the government.

An excited utterance can often be found as well in the victim's original call to the police. The frightened plea of Nicole Brown Simpson to a law enforcement dispatcher is a famous and classic example of this type of excited utterance. Unfortunately, many 911 tapes are destroyed within a limited time period following the call. In cases of domestic violence, officers

and prosecutors need to include in their protocols a mechanism to preserve 911 calls when the call constitutes relevant evidence.

4. Photograph bruises and collect all evidence confirming the existence of an assault.

Injuries to a victim must not only be photographed, the officer must use a camera which can record in minute detail bruising, scratches and other trauma to the body. Photographs that are blurry or do not depict light bruising are of no value. Ideally, the camera should be a high-tech instamatic which produces an immediate photograph. An instamatic camera allows the officer to be sure the photograph turned out and gives the prosecutor immediate evidence he can show a judge at a bail hearing. Instant photographs can also be used by an officer in interrogating a suspect. A suspect can be shown the photographs and asked to acknowledge the existence of the injuries and offer his explanation as to their origin.

Bruises should not only be photographed immediately after the assault but also a day or two after the attack when the bruises may be more visible. With respect to the visibility of the bruises, an officer should take note of the complexion and weight of a victim. A dark skinned individual will not show bruises as easily as a lighter skinned individuals. A heavier set victim will not display swelling to the same extent as a thinner victim.

Property damage should also be photographed. The scene of the assault may contain broken glass, turned over tables and other evidence documenting the fury surrounding the attack on the victim. Physical evidence such as blood stained clothes should be seized as well as photographed.

To ensure her safety, an

Continued on page 4

Continued from page 3

officer may wish not only to inform the victim of available services, but to periodically check on her to ensure she is not being threatened. The victim should be advised to retain and turn over to the police any threatening letters or answering machine messages the perpetrator may subsequently disseminate.

5. Have a victim sign a release for all pertinent medical records.

A victim's cooperation immediately after an assault may fade. Accordingly, it is imperative to obtain a release and recover all pertinent records promptly.

6. Interview a victim as soon as possible following the assault and make note of the time of the interview in relation to the time of the assault.

This procedure may make the victim's statement admissible into evidence as a present sense impression. A present sense impression is defined as:

"A statement describing or explaining an event or condition made while the declarant was perceiving the event or condition, or immediately thereafter."

In jurisdictions adopting this rule, the prosecutor receives an important tool. The trustworthiness of the statement is based not on the aura of excitement but on the closeness in time between the statement and the event. In some jurisdictions, however, the victim must be present at trial and available for cross-examination. If children are present in the home investigators should always cross-screen for child abuse.

7. Obtain from the victim and other witnesses not only the details of the assault under investigation but all previous

assaults, even if they occurred in other jurisdictions or the statute of limitations has expired.

It is unlikely that this is the first time the victim has been assaulted by her partner. The history of violence may reveal other acts which can be charged out or may be admissible in the instant case as a prior bad act. In states such as Minnesota, a history of domestic violence is automatically admissible evidence unless the probative value is substantially outweighed by the danger of unfair prejudice.

The history of violence may reveal other acts which can be charged out or may be admissible in the instant case as a prior bad act.

8. Obtain information at the outset which will help locate a victim as trial nears.

The address of a crime victim on the night of an assault often changes prior to trial. In some cases, a restraining order excluding an abuser from the home has the unintended consequence of inflicting a financial hardship on the victim which necessitates a move. In other cases, a victim may need the solace of a friend or relative and will take refuge with them. In still other cases, a victim makes a conscious decision to avoid contact with the government and the inevitable service of process.

Given the number of victims who cease cooperation with the State, an investigator should assume the victim will not keep the State notified of any change in address. To assist in locating the victim later

on, an officer should at the outset seek information of use in finding the victim. Where does she work? Where does she go to church? Who are her parents and where do they live? Who is her best friend? Inquiries of this nature can avoid a subsequent headache and possible dismissal of the case.

In one of her songs, folk singer Nanci Griffith suggests "if wishes were changes, we'd all live in roses, and there wouldn't be children who cry in their sleep." Most Americans wish that family violence did not exist. It is police and prosecutors however, that providence has blessed with the opportunity to address this social ill. Let us discharge this obligation with diligence and compassion.

Reprinted from UPDATE, Vol 10, Numbers 6/7, 1997- National Center for Prosecution of Child Abuse.



Resources for Information, Training, and Technical Assistance

American Professional Society on the Abuse of Children

407 South Dearborn, Suite 1300
Chicago, IL 60605
312-554-0166
312-554-0919 (fax)
<http://www.apsac.org>

The American Professional Society on the Abuse of Children (APSAC) is the Nation's only interdisciplinary society for professionals working in the field of child abuse and neglect. It supports research, education, and advocacy that enhance efforts to respond to abused children, those who abuse them, and the conditions associated with their abuse. APSAC's major goal is to promote effective interdisciplinary coordination and practice among the social workers, physicians, psychologists, researchers, attorneys, law enforcement officers, nurses, judges, educators, and allied professionals who respond to child maltreatment. APSAC is dedicated to:

- ◆ Improving coordination among professionals in the field of child abuse prevention, identification, assessment, intervention, treatment, and research.
- ◆ Developing national interdisciplinary practice guidelines for professionals who work with abused children, their families, offenders, and adult survivors of abuse.
- ◆ Encouraging research in all fields of child maltreatment and disseminating research findings in usable form to all professionals in the field.
- ◆ Furthering interdisciplinary professional education.
- ◆ Providing guidance, support, and encouragement for professionals in this difficult field.



APSAC's annual colloquium offers advanced interdisciplinary professional education with seminars addressing all aspects of child maltreatment: prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. These seminars are designed specifically for advanced professionals in mental health, law, medicine, law enforcement, child protective services, and allied fields.

Child Abduction and Serial Killer Unit

Federal Bureau of Investigation
FBI Academy
Quantico, VA 22135
800-634-4097
540-720-4700
540-720-4790 (fax)

The Child Abduction and Serial Killer Unit (CASKU) is a specialized rapid-response unit that works closely with FBI field offices and State and local law enforcement authorities. CASKU provides investigative support through violent crime analysis, forensic resource coordination, interview and interrogation strategies, behavioral science profiling of unknown offenders, trial preparation and prosecutorial strategies, and expert testimony. CASKU also provides on site assistance to law enforcement agencies upon request and can facilitate access to other FBI services such as Rapid-Start (major case management support system), Evidence Response Teams, and laboratory services.

Missing and Exploited Children's Training Programs

Fox Valley Technical College
Criminal Justice Department
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54913-2277
800-648-4966
414-735-4757 (fax)
<http://www.foxvalley.tec.wi.us/ojjdp>

Continued on page 6

The Missing and Exploited Children's Training Programs, sponsored by OJJDP and Fox Valley Technical College, serve law enforcement, social workers, prosecutors, judges, probation officers, elected officials, State Advisory Groups, and nonprofit service providers. Courses are offered on the following topics:

◆ **Child Abuse and Exploitation Investigative Techniques.** This course addresses recognition of signs of abuse, collection and preservation of evidence, preparation of cases for prosecution, techniques for interviewing victims and offenders, liability issues, child prostitution, and the perspective of child protective services.

◆ **Child Abuse and Exploitation Team Investigative Process.** This course provides hands-on training for investigative teams that focuses on the development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases. Teams are assisted in the development of their own interagency implementation plan for improved investigation of child abuse.

◆ **Child Sexual Exploitation Investigations.** This course presents information on the behavior of the child predator, missing children, child prostitution, use of computers in child exploitation, obtaining and executing search warrants, interviewing the victim, interrogating the suspect, prosecution, Federal agencies' roles and resources, Federal statutes, case enhancement victim services, and managing the child exploitation problem.

◆ **Missing and Exploited Children.** This course for experienced investigators covers interagency development/ process, advanced interviewing techniques, and advanced investigative techniques.

◆ **Responding to Missing and Abducted Children.** This course deals with the investigation of non-family abductions, family abductions, and runaway/ thrown away children; victim impact; reunification/ recovery; media; case management; and case enhancement resources.

National Center for Missing and Exploited Children

2101 Wilson Boulevard, Suite 550
Arlington, VA 22201-3052
800-THE-LOST (800-843-5678) (hot line and child pornography tip line)
703-235-3900 (business number)
703-235-4067 (fax)
800-826-7653 (TTD)
<http://www.missingkids.org>
E-mail: 77431.177@compuserve.com

The National Center for Missing and Exploited Children (NCMEC) is a private, nonprofit organization that operates under a congressional mandate through a cooperative agreement with OJJDP.

NCMEC's mission is to assist in the location and recovery of missing children and to prevent the abduction, molestation, sexual exploitation, and victimization of children. One of NCMEC's primary activities is its 24 hour multilingual hot line and child pornography tip line. NCMEC also provides a wide range of free services to law enforcement, including technical case assistance; leads/ sightings and information dissemination; photograph and poster preparation and rapid distribution; age-enhancement, facial reconstruction, and imaging/ identification services; informational analysis; data base searches; educational material and publications; and training.

The **Jimmy Ryce Law Enforcement Training Center** at NCMEC is a national training program that promotes awareness of FBI and other Federal resources that assist law enforcement agencies investigating missing children cases. The following courses are offered: Chief Executive Officer Seminars, which focus on broad coordination and policy concerns, comprehensive response protocols, liability issues, Federal resources, and the new National Crime Information Center (NCIC) flagging system; Responding to Missing and Exploited Children Cases, which provides detailed information on lead and case management, child homicide solvability factors, the impact on victims, and Federal resources; and the NCIC Control Terminal Officer (CTO) Course, which trains State CTO's with regard to the NCIC flagging system and available Federal technical assistance.

NCMEC also coordinates child protection efforts with the private sector and provides information on effective State legislation to ensure the protection of children.

National Center for the Prosecution of Child Abuse

American Prosecutors Research Institute
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703-739-0321
703-549-6259 (fax)

The National Center for the Prosecution of Child Abuse provides a central resource for improving responses to the physical, sexual, and fatal abuse of children and to criminal child neglect. Its services include expert training and technical assistance by experienced attorneys through indepth training conferences, site visits, State-specific professional development programs, and telephone consultations; the Nation's only clearinghouse on criminal child abuse case law, statutory initiatives, court reforms, and trial strategies; and publications such as the two-volume manual *Investigation and Prosecution of Child Abuse*, the monthly newsletter *Update*, monographs, annual statutory summaries, and special reports,

National Clearinghouse on Child Abuse and Neglect Information

P.O. Box 1182
Washington, DC 20013-1182
800-FYI-3366
703-385-7565 (Washington, DC, metropolitan area)
703-385-3206 (fax)
<http://www.calib.com/nccanch>
E-mail: statutes@calib.com

The National Clearinghouse on Child Abuse and Neglect Information is a service of the National Center on Child Abuse and Neglect (NCCAN), an agency within the Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The Clearinghouse provides access to the most extensive collection of information on child maltreatment in the world. Professionals and members of the general public can obtain up-to-date information on all aspects of child abuse and neglect from the Clearinghouse, which will provide annotated bibliographies on specific topics or a copy of the data base on CD-ROM on request.

NCCAN publishes the User Manual Series, manuals designed to provide guidance to professionals in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Two manuals in this series of particular interest to law enforcement officials are *A Coordinated Response to Child Abuse and Neglect - A Basic Manual* (1992) and *The Role of Law Enforcement in the Response to Child Abuse and Neglect* (1992). A related publication is *Joint Investigations of Child Abuse: Report of a Symposium* (1993). These publications are available from the Clearinghouse.

The Clearinghouse also coordinates the Child Abuse and Neglect State Statute Series. A joint project of NCCAN and the National Center for the Prosecution of Child Abuse, this five-volume series summarizes State statutes on child abuse and neglect in nontechnical language: Volume 1, Reporting Laws; Volume 11, Central Registries; Volume III, Investigations; Volume IV, Child Witnesses; Volume V, Crimes. The series is updated annually and can be purchased in whole or in part from the Clearinghouse.

National Network of Children's Advocacy Centers

1319 F Street NW., Suite 1001
Washington, DC 20004 800-239-9950
202-639-0597
202-639-0511 (fax)
<http://www.nncac.org/index.htm>

Children's Advocacy Centers (CAC's) are community-based programs that bring together representatives from law enforcement, child protective

services, prosecution, mental health, and the medical community in multidisciplinary teams to address the investigation, treatment, and prosecution of child abuse cases. The National Network of Children's Advocacy Centers (NNCAC) is a not-for-profit membership organization of CAC'S, child advocacy programs, and individuals. NNCAC sets national standards for CAC'S and provides leadership and advocacy for these programs on a national level, including national training events and training and technical assistance grants. Primary funding for NNCAC comes from OJJDP, which has also established four Regional Children's Advocacy Centers (RCAC's) to assist communities in improving their response to child abuse:

- ◆ **Midwest Regional Children's Advocacy Center**, La Rabida Children's Hospital and Research Center, Chicago, Illinois, 312-3636700 (ext. 421).
- ◆ **Southern Regional Children's Advocacy Center**, National Children's Advocacy Center, Huntsville, Alabama, 800-239-9939.
- ◆ **Northeast Regional Children's Advocacy Center**, Philadelphia Children's Advocacy Center, Philadelphia, Pennsylvania, 800-662-4124.
- ◆ **Western Regional Children's Advocacy Center**, Pueblo Child Advocacy Center, Pueblo, Colorado, 800-582-2203.

The RCAC's provide information, consultation, and training and technical assistance to help establish child-focused programs that facilitate and support coordination among agencies responding to child abuse.

Reprinted from OJJDP, *Juvenile Justice Bulletin*, June 1997



400 Years of the Shaken Infant: From Henry II to John Caffey

By Stephen Lazoritz, MD

Recently, Shaken Infant Syndrome has become a “hot topic” among child abuse professionals. It seems that we are recognizing this type of child abuse more frequently, and the first ever “Shaken Baby” conference held last October drew nearly 800 participants. History has taught us, however, that “timely” topics are frequently “timeless” as well. The Shaken Infant Syndrome is an excellent example of how a current medical syndrome possesses deep historic roots which can be traced from the mid-1500’s to the pages of today’s medical journals.

In 1559, times were good for Henry II of France. He had just signed a peace treaty with Spain at Chateau Cambresis, and many events were planned for the celebration, including a jousting match which pitted the King against the Comte de Montgomery. During that jousting match, unfortunately, the king received a blow from a lance. Here we read the description of the injury suffered by the King: “The muscular skin of the forehead, over the bone, was torn across to the inner angle of the left eye, and there were many little fragments or splinters of the broken shaft lodged in the eye, but no fracture of the bone. Yet because of such commotion or shaking of the brain, he died on the eleventh day.” (Packard, 1926, p. 58).

This description was written

by King Henry’s personal surgeon, Ambroise Pare, who described his autopsy findings: “After his death, they found on the side opposite to the blow, towards the middle of the commissure of the occipital bone, a quantity of blood effused between the dura and the pia mata.” (Packard, 1926, p. 58, 61). This is the first recorded description of the subdural hematoma, which was clearly caused by impact trauma in this case.

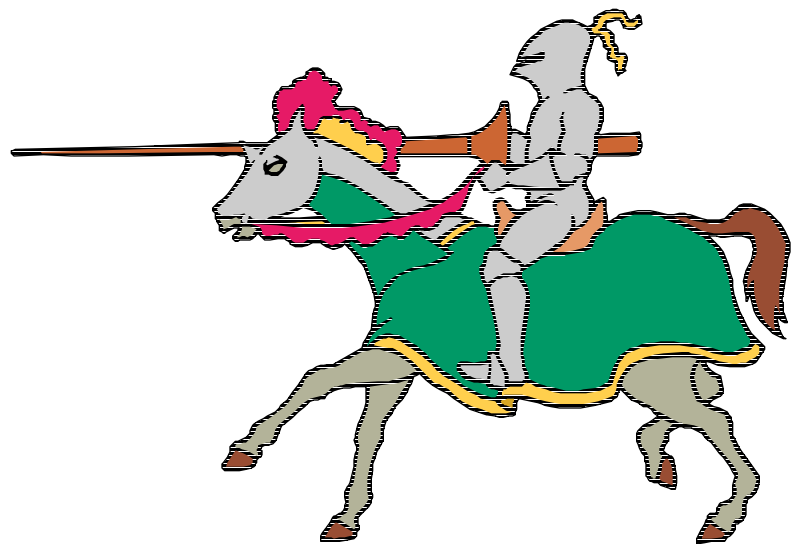
While Pare’s description clearly laid the foundation, for the subdural hematoma to be considered a traumatic injury, the work of a famous pathologist 300 years later cast doubt on the traumatic etiology. In 1856, a German pathologist named Rudolf Carl Virchow described the subdural hematoma and maintained that its cause was infection. He referred to this disorder as “pachymeningitis interna” a term which remained in use for almost 100 years.

Four years later, a French physician named Ambroise Tardieu published a report detailing the abuse and maltreatment of children. In it he described 32 children, 24 of whom were abused by their parents, and 18 of whom died. His report included descriptions of injuries associated with physical abuse that we see today. Of particular interest was his description of “thickening of blood on the surface on the brain” that he

related to trauma in these children. Thus, we had the first description of a subdural hematoma caused by traumatic head injury to a child as a result of abusive treatment.

As time passed, contributions to the medical literature, which in retrospect are quite significant, went largely unnoticed. In 1891 the great German pathologist Dohle published a study of autopsies in children and found subdural hematoma to be a common finding. In 395 autopsies of children less than one year of age, 14% were found to have subdural hemorrhage. In children greater than one year of age, the incidence was 8%. In 1914, also in Germany, Kovitz expanded Dohle’s work and performed perhaps the largest autopsy study of children to date. He examined nearly 6,000 children under two years of age and found subdural hemorrhage in 14% of infants one to three months old, 10% of infants three to twelve months old and 9% of children one to two years old. Clearly, subdural hemorrhage was not a rare occurrence in young infants and children. These studies, however, did not address causality.

One early suggestion that violent motion may injure infants can be found in the 1907 text by William Preyer, *Mental Development of the Child*. He described potentially harmful practices, including the



rocking of the cradle. He wrote, "the violent rocking in the cradle which puts the baby into a dazed condition in order that he may not trouble those that have care of him is extremely injurious" (Preyer, 1907, p. 41, He did not describe what the injury might be.

A landmark in the investigation of subdural hematoma came in 1930, with David Sherwood's publication of a classic review of nine children with cases of subdural hematoma. Of those nine cases, many had retinal hemorrhages and five of the nine had what he called "dubious home conditions." He concluded that the fact that these infants came from "dubious" environments made the histories provided by the parents to be less valuable, and raised the question of possible head trauma. Sherwood proposed that the children who presented with subdural hematoma had been injured, even though no admission of any traumatic event was made in any of these cases.

In 1939, Ingraham and Heyl presented 11 cases of children with subdural hematoma, with one particularly interesting case of an eight-month old boy who presented with seizures. The child had multiple bruises on his extremities, bruises on his face, bilateral retinal hemorrhages, and fractures of both of his forearms - a classic case of child abuse. The authors made two major points in this study: (1) the harder one looks for subdural hematoma, the more cases will be identified and (2) the etiology of subdural hematoma was traumatic in most, if not all, of the cases. Holt's well-known textbook of pediatrics, published in the 1930's and 1940's, stated that the etiology of this "hemorrhagic pachymeningitis" was unknown, and that "in patients under two years, the story of a proceeding head injury is either wanting or is a rule quite inconspicuous" (Holt, 1940, p. 1054). The author made certain observations regarding this disorder, however, which were astute: (1) "The

frequency with which the condition is encountered in foundlings, illegitimate children and those in institutions has often been commented on," (2) "Breast-fed infants are notoriously immune from this disorder." (Holt, 1940, p. 1054). These statements speak to the fact that the infant's home environment is related to this syndrome.

The greatest advances in the identification of the Shaken Infant came with the emergence of radiology as a medical specialty. Indeed, many monumental studies were done in the 1940's and 1950's. Foremost was the work done by the pediatric radiologist John Caffey in 1946 published in the article entitled "Multiple fractures in the long bones of infants suffering from chronic subdural hematoma" (Caffey, 1946). In this report, Caffey described cases of six children with subdural hematoma in which there were 23 fractures and no history of trauma. Fourteen of the fractures were metaphyseal and nine were diaphyseal. This article clearly stated the case that children with subdural hematomas had been traumatized, and a search for other evidence of trauma, specifically long bone fractures, should be made.

In 1968, the neurosurgeon Omayya showed that subdural hemorrhage could be caused by rotational displacement alone, without impact. By producing whiplash injury in rhesus monkeys, he set the stage for John Caffey's 1972 landmark article "On the theory and practice of shaking infants." In this report, Caffey describes examples of 27 children with subdural hemorrhage who had received "whiplash shaking." There was no history of trauma in any of these children. Dr. Caffey wrote, "The whiplash shaking of infants and younger children are precarious, pervasive, prevalent, and pernicious practices which can be observed whenever parents, parent substitutes, infants, and small children congregate" (Caffey, 1972, p. 165).

Interestingly enough, of his 27 cases, 15 were found to be attributed to a nurse named Virginia Jaspers, who was employed to care for these infants and whose story was told in a 1956 *Newsweek* magazine article. "The brutal and tragic career of nurse Virginia Jaspers is tied to her massive physical traits. She is an ungainly six feet, weighs 220 pounds, and has a 52 inch waist. Police conclude that she probably had no idea of the strength in her cruelly big arms and hands" How did she injure these children? "That evening Abby Kaspinov, 11 days old, didn't want to take her formula. Exasperated, the nurse picked her up and gave her a good shaking. (It was all uncontrollable... I don't know why I did it.)" (*Newsweek*, 1956, p.90).

Today, John Caffey's "Whiplash Shaken Infant Syndrome" is called "The Shaken Infant Syndrome" or the "Shaken Baby Syndrome," and many investigators have added greatly to our knowledge of this disorder; a disorder with a heritage of over 400 years.

Reprinted from APSAC Advisor, Volume 10 Number 2 Summer 1997

References

- Caffey, J. (1946). Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentgenology*, 56,163173.
- Caffey, J. (1972). On the theory and practice of shaking infants. *American Journal of diseases of children*. 124, 161-169.
- Holt, L. (1933). *Holt's Diseases of Infancy and Childhood*, 10th edition. New York: Appleton-Century-Crofts.
- Ingraham, F., and Heyl, H. (1939). Subdural hematoma in infancy and childhood. *Journal of the American Medical Association*. 113, 198-204.
- Newsweek* (1956). 48 (pt. 1):90
- Packard, F. (1926) *Life and Times of Ambrose Pare*. 2nd. Edition, p.58-61. New York: Paul N. Hoeber.
- Preyer, W. (1907) *Mental Development in the Child*. p. 41. New York: Appleton and Company.
- Silverman, F. (1972). Unrecognized Trauma in Infants, the battered child syndrome, and the syndrome of Ambrose Tardieu. *Radiology*, 104, 37-353.
- Sherwood, D. (1930). Chronic subdural hematoma in infants. *American Journal of Diseases of Children*, 39, 980.

Continued from page 1

the vagina to a significant depth before even touching the hymen, which is the elastic membrane that partially covers the vaginal opening). The conclusion, therefore, is that a normal vaginal examination cannot preclude the possibility of abuse, even with some degree of penetration.

2. Most findings disappear quickly.

This is one reason they are so rare. After all, the anal and vaginal regions are made to absorb pretty rough treatment. They are constructed of very elastic tissues and lined with mucous membranes. These membranes are well nourished with blood vessels, allowing wounds to heal almost overnight. (Think of the last time you bit your cheek, and how fast the wound disappeared. The tissues are almost identical.) Researchers have identified various patterns of healing after documented injuries, some more obvious than others.

3. Not all examinations are emergencies.

When it is suspected that a child has been abused, it is imperative that our social service agencies respond immediately to investigate and ensure the child's safety. Disclosure in child sexual abuse cases is rarely timely, as most victims wait to tell until they perceive themselves safe or until circumstances facilitate a disclosure. If this takes more than 72 hours, minor wounds (contusions and abrasions) of the anus and genitalia have disappeared, and even hymenal tears will have healed to such a point as to be impossible to date accurately. In addition, semen and motile sperm will be gone, and fibers and hairs will have been shed.

This is not all bad, however.

If the exam is non-emergent, it can be scheduled at the family's convenience and often at a location less threatening and chaotic than the usual emergency room. There is time to contact experienced medical personnel and to share information. Trained personnel, in a conducive environment, are of great value, as these are difficult exams that require special expertise.

In recent years, examiners, working systematically and using colposcopes to photograph findings, have helped to categorize normal variations in anatomy

4. Normal exams can vary widely.

The genitalia of normal children differ from child to child and from age to age. In recent years, examiners, working systematically and using colposcopes to photograph findings, have helped to categorize normal variations in anatomy. Pigmentation, hair patterns, and even the shape of the hymen can vary among children of the same developmental stage. The appearance and dimensions of vaginal structures can change dramatically depending on the exam position and the child's degree of relaxation. When we consider age as well, the picture grows even more complex. A child's genitalia grow and change along with the rest of the child. An infant's hymen, for example, is distinctively thick and grey with a convoluted edge due to the effect of maternal hormones on this sensitive tissue. As the child approaches school age, the membrane becomes more thin and pink. The onset of puberty brings yet other changes in anatomy,

of which the examiner must be aware if he or she is to distinguish normal from abnormal.

5. Abnormal exams don't always mean abuse.

Statisticians define "normal" as the area between the 2nd and the 98th percentile of the normal bell curve. Naturally, a certain number of characteristics that occur infrequently won't be related to abusive damage. For example, septa, or bands across the hymen, are only seen in 2 percent of the population, but are certainly not signs of abuse. Similarly, child abuse textbooks list a number of dermatologic conditions, infections, and congenital abnormalities which can resemble traumatic tissue damage, at least to the inexperienced eye.

Other conditions, while fairly common, are often mistaken for signs of abuse. Diaper rashes and vaginal inflammations caused by poor hygiene are often mistaken for evidence of child abuse, especially if they are seen after the child has spent time in another's care. In fact, research has shown that such inflammations are rarely diagnostic of maltreatment.

So how can we tell what's significant?

6. Colposcopes help, but not that much.

In the Star Trek shows, the medical officer waves his hand and always comes up with the proper diagnosis. For a few years, the colposcope was envisioned to have about the same properties. First introduced into child sexual abuse investigations in the early 1980s, this device, which combines a strong light source with short-focus binoculars (and often a camera), has dramatically increased our knowledge of genital anatomy and physiology. It has done so, however, not so much by showing us new

things as by allowing us to photograph, study and share our findings, and thus develop a body of knowledge. We are still developing a systematic approach to describing normal and abnormal genital anatomy, and colposcopes are invaluable to that effort. In addition, several pictorial atlases are now available to assist in making a diagnosis.

7. Exams are rarely diagnostic.

It must have been a physician who said, "Give me ambiguity, or give me something else. . .," as so many of our exams seem to conclude by stating that "the findings are consistent with, though not diagnostic of" abuse (or words to that effect). Given all the considerations, though, it's not really surprising that we seldom find the "smoking gun" that wins the case. Only a few things are unequivocally recognized as diagnostic of sexual abuse: pregnancy, sperm or clear evidence of semen, some (but not all) sexually transmitted diseases in prepubertal kids, and complete transactions of the hymen.

Medicine is a science of probabilities. Any natural phenomenon can have a number of possible causes. Doctors usually listen to the history, perform a physical exam, run lab tests, and then compile a list of the most likely explanations for what we've seen. This list is called the "differential diagnosis," and the longer your list, the smarter you appear. While admirable in the office, this approach can be intolerably frustrating to those awaiting a single clear answer. We can give you an answer, but it will always be couched in probabilities.

Naturally, there's bound to be disagreement about the probabilities. Such debate is more the rule than the exception among physicians in normal practice.

8. Not all docs are created equal.

Physicians, even within a specialty, differ widely in training and experience. Nowhere is this variation more significant than in the investigation of child sexual abuse. As the name implies, the ideal professional must be an expert in *children* and their unique developmental considerations, in *sexual* anatomy and physiology, and

Medicine is a science of probabilities. Any natural phenomenon can have a number of possible causes.

in the peculiar dynamics of *abuse*. An expert in any one of these fields, without the benefit of the others, will have significant blind spots. The most distinguished expert can be made to play the fool when reaching beyond his or her field (and the attorneys know it!), so look for expertise related specifically to abuse when shopping for medical advice.

9. Doctors can speak English.

Really. We tend to use jargon like any other professional, to efficiently describe concepts and situations unique to our field (e.g. risk matrices, countertransference, persons of interest, voir dire, etc.). Besides, Latin *sounds* smart.

Getting physicians to write legibly, however, is a different problem altogether (one that has stumped pharmacists and nurses for years). For now, chasing the doc down and asking for an interpretation is the best solution. Trends in medical record keeping, increasing oversight by insurance companies, and peer review should do a lot to increase completeness and readability in the

near future.

When the exam is finally recorded, what use is it?

10. The medical exam is not primarily forensic.

It is important to realize that the purpose of the medical examination of the sexually abused child is the same as that of any other child: to assess the physical and mental well-being of the patient and to ensure the safety of the child's environment. The medical examination is rarely a substitute for a forensic interview. The medical provider is only one member of a multidisciplinary team dedicated to the child's welfare. If each of us does a good job, the team will succeed. When we overreach ourselves, we endanger the whole investigation. By learning to work well together, we enrich our own lives and careers while providing better care to those we serve.

Reprinted from The National Child Advocated, Vol. 1, No 1, Summer 1997

Published by the National Children's Advocacy Center, Huntsville, Alabama



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

PROTOCOL
