

The Prosecution of Fatal Child Abuse

Emily M. Douglas

The National Center on Child Abuse and Neglect recently estimated that approximately 2,000 children, or five children every day, die as a result of child abuse or neglect.¹ Many of the offenders who cause these deaths do not serve time in a correctional facility and some do not even go to trial. This piece will briefly discuss the impediments to the prosecution of child abuse fatalities, child homicide legislative actions, the failure nationwide to document the effectiveness of such legislation and how these issues are playing out in the state of Maine.

Several factors can impede the prosecution of cases of fatal child abuse. First, there are often no witnesses to maltreatment fatalities, making it difficult to link the crime to a specific individual. Moreover, when there are witnesses, they are frequently family members who are reluctant to incriminate a relative. Second, for children who live in a pervasive environment of abuse, it can be impossible to identify the one individual who gave the fatal blow to the child. Third, unsuspecting law enforcement officials often fail to gather sufficient evidence of the crime. Fourth, prosecutors often have little experience with cases of child abuse. Fifth, medical examiners rarely have pediatric expertise. Sixth, it is often difficult to convince jurors that a parents or a caretaker would purposely hurt a child.² Finally, even when such complications are resolved, homicide laws often make murder convictions impossible, because prosecutors cannot prove the presence of necessary mental states such as, “purposely,” “knowingly,” and “premeditated.”³

To aid in the prosecution of child abuse and neglect fatalities, many states have adopted special child homicide statutes which permit a conviction of murder without proving the presence of mental states such as “knowingly,” etc. As of December 31, 1997, 24 states had passed a child homicide statute. (See the list at the end of this piece.) Such laws generally fall

into one of two categories. The first kind of law simply lists the physical abuse of a child as an enumerated felony in a felony murder statute; the second creates as an offense the killing of a child in the course of being physically maltreated.⁴

In the state of Maine, a child homicide statute was proposed for the 1999 legislative session. The bill remains unresolved and is being carried over to the following session in January, 2000. The bill takes the form of the first kind of statute, listing maltreatment to a child age four or under as an enumerated felony. A conviction under this law requires a sentence of imprisonment for no less than 25 years.

While many states have adopted statutes that make it easier to convict individuals who have killed children, there are few states that are monitoring the effectiveness of their statutes. I recently contacted 18 of the 24 states that have child homicide statutes and found that only three states (or region within a state) are officially collecting data on the criminal justice outcomes of cases of fatal child abuse. (Moreover, I contacted an additional 14 states that do not have child homicide statutes and found that only one is officially compiling criminal justice outcomes for child abuse homicides.) It appears that policy makers are not passing child homicide laws based on comprehensive knowledge of how child maltreatment homicides are handled in their states. Instead, the drive to pass child homicide statutes is likely fueled by high publicity cases where an offender received little or no time for taking the life of a child. Furthermore, once statutes are implemented there is no effort to track the effectiveness of the new law. In short, most states do not know, nor have they ever known, how fatal child abuse is handled in their courts.

On the positive side, Maine will shortly be among the leaders of the crusade to inform the public and those who work with children and families by compiling and publishing the criminal justice outcomes of child abuse fatalities in their upcoming child death report. If Maine adopts the proposed legislation, this tracking system will allow child welfare and criminal justice

professionals along with policy makers to assess the effectiveness of the new law. If the bill fails, we will at least be armed with data to show why such a bill might be needed in our state.

States with Child Homicide Statutes

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|------------|-------------|----------------|---------------|
| Alaska | Idaho | North Dakota | Utah |
| Arizona | Iowa | Oklahoma | Washington |
| Arkansas | Kansas | Oregon | West Virginia |
| California | Louisiana | Pennsylvania | Wyoming |
| Colorado | Minnesota | South Carolina | |
| Delaware | Mississippi | Tennessee | |
| Florida | New York | Texas | |

¹ Department of Health Human Services (1998). *A nation's shame: Fatal Child Abuse and Neglect in the United states*. [WWW document] URL <http://indy.radiology.uiowa.edu/Providers/Textbooks/ChildAbuseAndNeglect.htm>

² Mills, S. and Kiernan, L. (1998, November 15 - 20). Killing Our Children: The search for justice. Chicago Tribune; ² Department of Health Human Services (1998). *A nation's shame: Fatal Child Abuse and Neglect in the United states*. [WWW document] URL <http://indy.radiology.uiowa.edu/Providers/Textbooks/ChildAbuseAndNeglect.htm>

³ Rainey, R.H. and Greer, D.C. (1994). Prosecuting child fatality cases. The APSAC Advisor, 7, 28-30.

⁴ National Center for the Prosecution of Child Abuse (1997). Child abuse and neglect state statutes series. (Volume V Crimes, No. 29, Child homicide).

Medical Evaluation of the Physically Abused Child

Hannah Pressler

The primary care provider for the purposes of this discussion is the medical care provider who has initial contact with a child who may have been abused. All medical care providers are defined as mandated reporters by Maine statute. In any circumstance where a child presents with symptoms or injuries that might indicate child abuse, health care providers should actively seek out information that would assist them in either ruling in or ruling out the diagnosis of child abuse. In many cases of obvious accidental injury, it is possible to easily and quickly rule out possible child abuse. In some cases, it is easy to rule in the suspicion of child abuse. In other cases, after a careful examination, it is difficult to determine whether abuse has occurred. When child abuse is suspected or cannot be ruled out, further evaluation and reporting are indicated.

Any health care provider who suspects that a child has been or is a risk for being abused must make a report to CPS. If there is evidence of a crime, law enforcement should be notified. This referral might be to the local police department, the county sheriff, the state police, or the local District Attorney's office. An expeditious referral to law enforcement can help with the criminal investigation while a delayed referral can impede a criminal investigation. The child's caretaker should be notified about these referrals in a non-threatening manner. If the health care provider feels that notifying the family of the referral would put the child at further risk, then it is appropriate to make the referral prior to notifying the family. It is not the health care provider's role to determine who abused a child or if the injuries are inflicted, CPS and law enforcement have the responsibility for investigating and assessing abuse.

Health care providers may choose to not report because of their relationship with the parent(s) or because the parents are grieving and the provider feels that their privacy should not be intruded upon by an investigating agency. The provider may also be concerned that the family will leave the practice or that CPS will not take action and the provider-family trust will be broken for "no reason." These are not valid reasons to not report. It is the role of the health care provider to report suspicious injuries or concerning statements. It is the role of CPS to determine if abuse has occurred and if the child is in jeopardy. Law enforcement determines if a crime has been committed and who is responsible for the commission of that crime.

If the provider has concerns about the child's safety in the home, the child should be admitted to the hospital. Hospitalization of a possibly abused child is a reimbursable diagnosis. Hospitalization also provides for the protection of the child in a non-threatening safe environment during the medical evaluation and psychosocial evaluation of the child and the evaluation of the family by the child protective worker.

Following is a copy of the Child Physical Abuse Worksheet that can help guide your history and physical examination.

It is the responsibility of the provider to carefully describe all injuries. If the child is admitted to the hospital and there is the capability to take photographs, do so liberally. If no camera is available, the local law enforcement agency may have access to a camera. A 35mm SLR camera is preferable to a Polaroid. However, if a Polaroid is the only camera available, use it for photographs and supplement those with diagrams. An initial photograph of each injury should contain an anatomic landmark to assist the viewer to identify the location of an injury. There should also be several close-up photographs that include the entire of the area of injury. For example, if there are multiple bruises on a child's back, the initial photograph should be of the child's entire back with all of the injuries visible. This photograph should be taken as close to the child as possible. It is not helpful to include extraneous equipment and background in the photo. The follow-up photographs would be of each individual area of injury. It is helpful to include a measuring device along the edge of one photograph of an injury site to help document the size of an injury and a color bar along the edge of another photograph for comparison of color of the injury. Do not rely solely on photographs for documentation. Include adequate diagrams and measurements in notes. If there is no camera available, measure and draw the injuries and describe location, color, shape and all areas of deformity and/or swelling.

Child Physical Abuse Worksheet

Date:

Child's name:

Child's age:

Accompanying caretaker's name and relationship:

Names and relationships of other relevant individuals such as household members, parents, siblings:

Family physician:

Detailed history of injury:

Informant, who is in room during history taking, date, time, place, accidental or inflicted, in inflicted name of perpetrator, sequence of events, history of past abuse, time since injury to evaluation

Past history:

Previous trauma, hospitalizations, behavioral problems, development, birth history, toilet training

Family history:

Siblings and health, domestic violence, child abuse in the parent's childhood, substance abuse, mental illness, previous accusations of abuse

Physical examination:

Note the exact location of injuries or findings. Describe in detail including size, shape, color and estimated age. Pay particular attention to eyes including fundoscopic examination, tympanic membranes and pinna, oral cavity, genitalia. Record growth measurements and plot on a growth chart. Use drawings and photographs liberally.

Laboratory evaluation:

Bone survey on all children under the age of two with suspicion of physical abuse. Bleeding profile if indicated.

Diagnosis:

Describe the findings and assess likelihood of findings being due to inflicted vs. accidental trauma.

Disposition:

Admission
Outpatient
Consultations including specialty child abuse
Hospital or clinic social worker
Child protective services
Law enforcement

Final report typed:

The Causes and Consequences of Maltreatment

On April 9, 1999 the Child Abuse Action Network sponsored a lecture and training session called The Causes and Consequences of Child Maltreatment. The presenter was developmental psychologist Dr. Bryon Egeland from the University of Minnesota. Dr. Egeland discussed his 25 year longitudinal study of at-risk mothers and their first born children. In his presentation, he discussed the findings of this study, the ecological interpretation of his findings and a program designed to prevent maltreatment.

Dr. Egeland discussed the consequences of maltreatment that were displayed by the children in their adolescent years. Those who were maltreated as young children had lower levels of academic success and more behavioral problems than the children in the control group. They were more likely to drop out of school, to be expelled from school, to externalize their problems, to experience depression, anxiety, and to be diagnosed with conduct disorder and oppositional defiant disorder. However, some of the children who suffered from abuse and neglect had much higher levels of functioning than others. These children tended to have extended family members who helped to raise them, stable family situations and predictable home environments. Dr. Egeland stated that the hallmark of these children is that they had a good foundation in their earliest years.

Dr. Egeland devoted much of his presentation to the discussion of how we form relationships and how we learn what to expect from others during infancy. Specifically, he lectured on the work of John Bowlby – the father of attachment theory. Bowlby theorized that the relationship held between caregiver and infant serves as a model for the infant's relationships with others. This cognitive model, termed "inner-working model," is essentially a set of rules that organizes how a person sees him or herself and how that person sees others. This model serves as a guide to behavior and understanding in all future relationships. Thus, a child who is neglected by her caregiver, will come to see herself as being worthy of neglect and expect like behavior from others in her life. Although over-simplified here, this is the basis of the model.

This theory suggests that those with "insecure inner-working models" – learned from their own childhood – do not go on to become successful parents. Such persons are at have a higher risk of abusing their children than those with more secure inner-working models. However, Dr. Egeland suggests that the models that guide our understanding of

relationships can be altered. He attempted to do this very thing in a program for at-risk pregnant women called Steps Toward Effective Enjoyable Parenting, or STEEP. In this program case managers made home visits, conducted group sessions focusing on feelings about the up-coming births, made hospital visits at the time of the birth, and provided similar support for the mothers during the first year of their children's lives. Most of these women had come from at-risk homes and unstable environments, where they could not depend on the people in their lives. The goals of STEEP were to provide the mothers with empowerment, support, an understanding of their children's behavior and to alter the mothers' inner-working models of relationships. The program was intended to help develop a healthy attachment between mother and child and to help develop a secure inner-working model for the children.

Although there were not drastic differences between STEEP mothers and the mothers in the control group, the former were more likely to have a stable home environment, more social support and a deeper understanding of their children's behavior – all things which lead to less maltreatment. Dr. Egeland suggests that programs such as STEEP cannot be short-term, should continue as children move through major phases of development (i.e. the first few years of life) and should have case managers available for “booster shots” as needed by parents upon their termination of the program.

Adoption and Safe Families Act of 1997¹

The implementation of the 1997 federal Adoption and Safe Families Act (ASFA) brought changes to child welfare practices nationwide. While some of the specifications may vary from state to state, the major provisions – as outlined here – are the same.

Reasonable Efforts

The most important focus of ASFA concerns the well-being of children. The Act states that the health and safety of children shall be of paramount concern in every child welfare case. Also, reasonable efforts must be made to preserve and reunify children with their families, however, never at the expense of a child's well-being. Reasonable efforts may be waived in the following circumstances:

1. The parent has subjected the child to aggravated circumstances, such as abandonment, torture, chronic abuse, sexual abuse.
2. The parent has committed or aided in the manslaughter or murder of a child or has committed a felony assault that results in serious bodily injury to the child or to another child.
3. The parent has lost his or her parental rights of the child's sibling(s).

Reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts to prevent removal or make it possible for a child to return safely home.

Permanency Hearing

The purpose of a permanency hearing is to formulate a concrete plan for a child's future. Such plans include whether or not a child will return to his or her family, if parental rights will be terminated, if the child will be referred for legal guardianship, etc.

Often, children have lingered in the child welfare system for years without a permanent plan for their future. One of the central goals of ASFA is to shorten the length of time children spend in the system. The Act stipulates that permanency hearings for children must be held within 12 months after the date of the first judicial finding that the child has been subjected to child abuse or neglected but not later than 60 days after the date on which the child is removed from the home. Furthermore, if it has been determined that a child will not be reunited with his or her family, then a permanency hearing must be held within 30 days after this decision.

What About Children Already in the System?

In essence, ASFA expedites the processes of the child welfare system. While this will help children in the future, the child welfare system – nationwide – is full of children who have already been in limbo for many years. ASFA suggests that states include provisions that act retroactively for children who were already in foster care as of November 19, 1997. Maine has adopted a clause which states that in general,

“The Department [of Human Services] shall file a termination petition or seek to be joined as a party to any pending petition...[if] a child has been in foster care for 15 of the most recent 22 months. [However,] the Department is not required

¹ This piece is adapted from *A Worksheet: What's Required of States by the Adoption and Safe Families Act* administered by the Child Welfare League of America.

to file a termination petition if the Department has chosen to have the child cared for by a relative or the Department has documented to the court a compelling reason for determining that filing such a petition would not be in the best interest of the child.”²

New Obligation to Provide Notice and Opportunity to Be Heard

Foster parents often express frustration because they feel that their opinions are not welcomed in systematic reviews pertaining to their foster children. ASFA provides a place and an opportunity for such participation. The Act outlines that foster parents, pre-adoptive parents and relatives providing care for a foster child must be provided with notice of, and an opportunity to be heard in any periodic review or permanency plan hearing that is required under law.

State Incentives for Increasing Number of Adoptions

Close adherence to ASFA’s permanency plan timeline promises that a state will make children available for adoption (or reunify them with their families) more quickly, however, it does not ensure that children will actually be adopted. In other words, a state could follow the new laws set forth by the Act and still have children flooding the foster care system if that state has chosen to scrimp on funding for their adoption program. As a means of preventing such a scenario, the federal government has established an incentive system for states to increase their adoptions. The payment is \$4,000 for each foster child adoption above a baseline year and an additional \$2,000 for each special needs child. Moreover, ASFA stipulates that states must provide Medicaid (or another health insurance coverage) for any special needs child for whom there is an adoption assistance agreement between the state and the adoptive parent and who the state has determined cannot be placed with an adoptive parent without medical assistance because of the child’s medical or psychological condition.

² Title 22 MRSA Chapter 1071: Child and Family Services and Child Protection Act, pp. 34-35.

1999 Maine Judicial Symposium

Martha Proulx

The 1999 Maine Judicial Symposium was held from May 5-7, 1999 in Bethel. This year's topic was "Child Protection and Permanency in the Age of ASFA". ASFA is the Adoption and Safe Families Act passed by Congress and signed into law by President Clinton on November 19, 1997. This law reforms and balances the safety, permanency and well-being of children in foster care. Its intent is to stop children from lingering in the foster care system and achieve permanency in a shorter time frame. Family rehabilitation/reunification remains the first goal however it allows concurrent planning so children do not have to wait for one goal to be ruled out before another goal can be looked at.

The first day of the conference was attended by the District Court Judges, court clerks, Department of Human Services personnel, Assistant Attorneys General and lawyers from the private bar, including defense attorneys and Guardians ad litem. The welcome was given by Commissioner Kevin Concannon; Chief Judge of the Maine District Court, Michael Wescott; Director of the Bureau of Child and Family Services, Margaret Semple and First Lady Mary Herman. The topics covered the first day were:

1. An overview of the new laws and case management system.

This section covered an outline of ASFA and how this is translated into the court room. A discussion was held on front loading services for families so children do not wait too long for permanency, whether it is through a return home or being freed for adoption as the two most common outcomes. The importance of involving all parties in the case management conference was also discussed. This is a more informal forum for parties to discuss the issues and less adversarial than a contested hearing. The importance of the conference is to have all parties working toward the best interest of the child.

2. A demonstration of the Case Management Conference.

This was a helpful role play on the positive use of the case management conference.

3. The potential challenges: scheduling, continuances, one Judge-one family, and attorneys scheduled in multiple courts.

The focus of this discussion was in streamlining the system to benefit both the families and the court. The importance of the court clerks in scheduling and being aware of possible conflicts was noted as well as the priorities in schedules.

4. The Indian Child Welfare Act.

This was an overview of this law and how tribal jurisdiction takes precedence. Also discussed were the cultural differences of viewing a family unit and a child's need to be part of a larger community.

The second day of the conference began by dividing into subgroups to discuss issues pertinent to each discipline. Each group then reported back to the larger group. The morning session ended with an overview, by Linda Mitchell from the Administration For Children and Families, of the Federal requirements under Titles IV-B and IV-E.

In the afternoon of the second day the participants were expanded to include members of the Mental Health and Foster Care Communities. The afternoon began with a presentation of a Youth in Care Panel. Several teenage foster children explained their experiences in custody and with the court system to the group and then they answered questions. This was an informative session that successfully reminded the participants how our decisions directly impact children.

The afternoon closed with a presentation on Permanency Planning. The presenters were Sarah Greenblatt, Director of the National Resource Center for Permanency Planning at the Hunter College School of Social Work and Mimi Laver, Assistant Director of Child Welfare at the American Bar Association's Center on Children and the Law. They explained the concept of permanency, concurrent planning and how this impacts both the child welfare and court systems. They also discussed child focused time frames for permanency.

The final day consisted of a presentation on protection, permanency and the Judicial role. A discussion was held on holding parents accountable and the types of services that can best

benefit families. The conference ended with participants breaking up into groups based on geographical areas. These discussions are extremely important to allow the flow of ideas between judges, DHS, attorneys, therapists and foster parents. Ways to make the system work better for children and their families is the goal of these regional groups.

Overall the participants felt the conference was a success and left with a fresh outlook on the new laws.