

Inflicted Head Trauma in Maine Children

Reviewed by the Child Death and Serious Injury Review Panel 1992-1998

[Lawrence R. Ricci, MD](#)

Since its inception in 1991, the Maine Child Death and Serious Injury Review Panel has reviewed over 75 cases. In a retrospective analysis of the first 52 cases reviewed up to the publication of the panel's second report, 18 cases involved children sustaining inflicted head trauma. Data on these cases was presented this past fall at the Third National Shaken Baby Conference in Salt Lake City, Utah, and the Third Annual New England Child Maltreatment Conference in Providence, Rhode Island.

Detailed analysis of these 18 cases reveals a number of important and disturbing characteristics which were highlighted in the two reports that the panel has disseminated. These included problems in attachment, parental personality disorders, substance abuse, domestic violence, multiple caretakers, poor supervision, caretaker volatility often triggered by crying, toileting, feeding, and prior Child Protective involvement.

Case Example #1: Inadequate Medical Response.

A 4 week old infant presented to the hospital with an unexplained skull fracture. On detailed review, the initial hospital response was limited. For example, a bone survey was not done and Child Protective Services was notified after the child was discharged.

Case Example #2: Inadequate violence and parenting assessment.

A 5 week old infant died from sequelae of shaken baby syndrome. Findings included subdural hematomas, retinal hemorrhages, skull fracture, rib fractures, and bruising. Review of the male caretaker's early history revealed prior Child Protective involvement as a child and significant risk for violence that had not been addressed. Child Protective Services became involved with surviving siblings. However, issues of maternal function and protective ability appeared to be inadequately addressed.

Case Example #3: Prominent risk factors and delay in notifying law enforcement.

A 10 week old infant presented to the hospital with a skull fracture on the first visit and then on a second visit with inflicted bruising. Family history included childhood abuse, substance abuse, personality disorders, and domestic violence. There was a delayed notification of law enforcement.

Case Example #4: Lack of obvious risk factors.

An 8 month old infant died from inflicted head injuries to which the father later confessed. The family was middle class, Caucasian, and without apparent risk factors although there was evidence of the father's being easily frustrated with the child and having unrealistic expectations.

Case Example #5: Failure of family to identify risk of abuse

A 1 year old infant suffered abdominal and head trauma. Family members had noted bruising in this child after the father returned to the home. Among the important concerns identified in this case was the

role of nonprofessionals, including family members, in identifying children at risk for abuse.

Case Example #6: Failure to protect

A 6 year old boy was sadistically tortured by mother's boyfriend, sustaining multiple skeletal and head injuries along with starvation. The perpetrator had previously been convicted of child abuse involving another child. Mother stood by while her son was tortured.

Case Example #7: Multiple risk factors and early permanency planning.

A 6 week old infant suffered multiple fractures. Father admitted inflicting the injuries out of frustration. Mother had a juvenile justice history, substance abuse history, and a history of childhood victimization. Father was a child witness to domestic violence and suffered from substance abuse. The parents subsequently consented to termination of parental rights. This case was investigated and moved on quickly to permanency planning.

Among the important points of these and the other head injury case reviews were:

1. There was a clear need for the development of a child abuse and neglect safety and risk assessment tool for Child Protective Services, a task which now complete.
2. There has been and continues to be the need for the development of a cadre of psychologists skilled in parenting assessment and working with appropriate standards and peer review.
3. There needs to be improved analysis of shaken baby syndrome cases in Maine, as well as a more aggressive campaign, particularly targeting male caretakers in the home.
4. There needs to be better training of mandated reporters, particularly medical.
5. Surviving siblings need to be assessed aggressively.
6. Criminal sentencing is problematic in Maine.

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Tips for Medical Professionals Called as Witnesses

By Victor I. Vieth

Given the nature of the crime, medical professionals are often called as witnesses in cases of child abuse. Although the stress of testifying cannot be eliminated completely, medical professionals can make the process less painful by adhering to the following tips.

Before the subpoena

Medical professionals can lessen the chance of testifying by building a sound case that is more difficult for defense counsel to challenge. **First, physicians should provide "accurate, detailed, and legible documentation of their findings..."**² A detailed report signals your thoroughness to the defense attorney and will make it more difficult for her to cross-examine you. On the contrary, a report with holes will make you an easy target. In one case, a physician testified that the sexual assault victim was crying and otherwise visibly upset as she described being attacked. On cross-examination, the defense attorney pointed out that the physician did not mention these facts in her report. The defense attorney then solicited from the doctor the number of sexual assault examinations she conducts in a given month and the fact that nearly a year had passed since the examination in this case. The insinuation, of course, was that this careless doctor could have been mistaken in her description of the victim's emotions. The defense attorney would not have been able to score these points if the physician had prepared a more detailed report.

Second, physicians should make liberal use of consultants. Using a consultant notifies the jury of the extreme care taken in reaching a diagnosis of child abuse. If you are in a small, rural community you may want to take advantage of software that will enable you to link to other medical professionals and to forward colposcope photos or other documents to a consulting physician.

Third, physicians who work regularly with child abuse victims should function as part of a multi-disciplinary team. This will enable you to get acquainted with your community's law enforcement officers, social workers, and prosecutors and to make sure that efforts are not duplicative. Even in small, rural communities, effective MDT's can be developed.³

After the subpoena

In preparing to testify, the medical professional may wish to consider the following six tips. **First, know what type of witness you are.** A medical professional may testify as a lay witness, an expert witness, or both. A lay witness testifies as to facts he or she observed. When a doctor describes the victim's demeanor, for example, the medical professional is testifying as a lay witness. An expert is someone who as a result of training or experience can render opinions or otherwise educate the jury. When a medical professional testifies that a child's injuries are consistent or inconsistent with the history provided, expert testimony is being provided.

Second, know what court you will be testifying in. If you are testifying in a civil child protection action, for example, the purpose of the proceeding is to protect the child. The prosecutor may only have

to establish that a child was abused and not identify a particular perpetrator. A civil action is likely to be tried only to a judge and the courtroom may be closed to outsiders. If the judge is knowledgeable about medical issues, you may have to explain less than would be the case in a jury trial. The proceeding may also be more relaxed. As one commentator notes, the medical professional's "first step is to define the reason for going (to court)"⁴

Third, know your case file. Understand going into the proceeding that a good defense attorney may have spent hours reviewing the medical records in a given case and is prepared to ask you hard questions. To meet the challenge, the witness must be equally well-versed with these records. As noted by other commentators, "nothing will relieve the anxiety of the expert witness more than a thorough review of all existing documents, medical records, radiographs, and pertinent medical literature. The witness who is ill prepared will be easily foiled by an opposing counsel who is prepared."⁵

Fourth, know the prosecutor. There is nothing unethical about meeting with the prosecutor and discussing your testimony in advance of trial. As noted by another commentator, "face to face conferences between attorneys and expert witnesses are always desirable, and rarely impossible."⁶ If new to the process of testifying in court, you may want to ask the prosecutor if there is another trial coming up in which medical testimony will be offered and if you can sit in on the trial to get a feel of what the process will be like.

Fifth, know opposing counsel. If an opposing counsel or investigator contacts you, it may be wise to speak with these representatives of the defendant. If not, opposing counsel will attack you as an advocate for the prosecution as opposed to an advocate for justice. If you speak with one of these representatives, promptly follow up the conversation with a letter documenting what was said in the conversation. Close the letter by writing "if you feel I have inaccurately summarized our conversation or have left out anything of importance to this case, please let me know immediately."

If the other attorney has never contacted you, it may be wise to call or write the defense counsel and ask if he has any questions for you. This may give you a sense of the attorney's demeanor and may give the defense attorney first hand knowledge of your expertise and, to this end, may make a plea more likely. Many defense attorneys will be put on edge by your decision to contact them and will feel you must have a great deal of confidence in your diagnosis. More importantly, this initiative, if communicated to the jury, makes you look like less of an advocate and more like a professional interested in finding the truth.

Sixth, know the defense expert. Don't be afraid to call the defense expert who has been hired to debunk your diagnosis. Again, this shows you are not a hired gun but are interested in finding out the truth. If there is a chance you have erred, you sincerely want to know this. If the defense expert refuses to talk to you, write him or her a letter expressing your desire to consult and your reasons for doing so. The prosecutor may be able to use this information to show your reasonableness as well as the unreasonableness of the opposing expert. If the other expert does speak with you, promptly write the expert a letter summarizing your conversation and asking him or her to clarify or correct any

misunderstanding you may have of the expert's position. If the defense expert testifies contrary to the information provided to you in the conversation, you and your letter may be used to impeach the expert's testimony.

When testifying

When the battle is engaged, the testifying medical professional may benefit from the following tips.

First, know what your credentials are so that you can sell yourself to the jury. It is true that, "generally, physicians and other licensed or certified health care professionals have sufficient training and experience to express a medical opinion to help the judge or jury understand the medical aspects of the case. Therefore, in most situations, an individual with a medical degree will qualify as an expert witness."⁷ However, the weight given a physician's testimony may be determined by factors such as experience.⁸ Some defense experts may have an impressive list of publications and other academic credentials but no longer practice medicine. If the victim is a child and you have ongoing experience in diagnosing and treating children, this fact alone may distinguish you from the opposing expert. When the prosecutor asks you about your experience in treating injured children, be ready to give an answer. Does your clinic keep records of how many patients you see in a given year and, or these, how many are children? If not, you may wish to develop this sort of record keeping. You may also wish to keep track of the child abuse-related conferences you attend and journals you subscribe to in an effort to keep current in the field.

Second, use language a lay person can understand. The average educational level of jurors is eighth grade. You must testify accordingly. Think of how you explain to patients, including children, the condition of their bodies. Employ these same tactics when explaining your diagnosis of child abuse to the jury. As one commentator notes, "the very tools used by physicians in the office and classroom to simplify understanding are of value in the courtroom."⁹

Third, paint a "word picture" for the jury. Think of methods to describe medical conditions or phenomena in a manner the jury can understand. One pediatrician likens a child's brain to a bowl of covered Jello. As the bowl is shaken, the Jello cracks and, if it continues to be shaken, turns into liquid. This is what happens to a baby's brain when it is shaken. I had a case where a doctor was explaining about the injuries he found on a child's buttocks. The defendant claimed the bruises occurred because the child was constipated and sat for a long time on the toilet. I asked the doctor to explain why the defendant's explanation could not account for the child's injuries. Turning to the jury, the doctor said, "if you have sat on a toilet, you know that when you leave the bathroom you do not have bruises, much less the pattern of bruises this child has. The buttocks are natural shock absorbers, they can receive some impact and not leave a bruise. That's why we sit on our butts for a long time and not get injuries." This was an explanation the jury could understand because the witness likened it to the juror's own everyday experiences.

Fourth, don't go out on a limb. It is difficult, for example, to diagnose child sexual abuse simply by looking at the child's injuries. History is the critical component.¹⁰ Examiners "usually cannot 'tell by looking' whether sexual molestation has or has not occurred. The history from the child remains the most important factor in making that determination..."¹¹

Fifth, make liberal use of exhibits and demonstrations to illustrate your testimony. We live in a media age in which jurors are used to ten-second sound bites complete with color and moving pictures. When presenting complex testimony, it is important to use exhibits or other tools to make the point clear for the jury. A simple diagram of female genitalia can be invaluable in explaining the location, size and pattern of vaginal injuries. Charts and models may also be more effective than simply showing the jury graphic photos of vaginal tearing. Many companies sell slides or other materials that can be used by medical professionals when testifying.

When using exhibits or demonstrations, make sure the prosecutor is aware of what you will be doing at the trial. The prosecutor will likely want to alert the judge as to the material or models you will be using. The prosecutor can also alert you as to case law in your jurisdiction that may inhibit the use of some models. Before developing any exhibits, visit the courtroom you will be testifying in. Find out how close you will be sitting from the jury. This will help in determining the size of the charts or models you will be using. In addition, find out the technological capabilities of the courtroom. If there is no screen or other convenient mechanism to display imagery, it may not be wise to bring slides or computer graphics to the courtroom.

Conclusion

The stress of testifying can never be eliminated. However, this stress can be greatly reduced when a medical professional properly documents the case and devotes time before and while on the witness stand to maximize the opportunity to achieve justice.

1 Director, APRI's National Center for Prosecution of Child Abuse

2 Charles Felzen Johnson, The Use of Charts and Models to Facilitate a Physician's Testimony in Court, 4 CHILD MALTREATMENT 228 (1999).

3 See Victor I. Vieth, In My Neighbor's House: A Proposal to Address Child Abuse in Rural American, 22 HAMLINE LAW REVIEW 143 (1998).

4 Ludwig & Barton, The Physician's Role in Court in CHILD ABUSE: A MEDICAL REFERENCE: SECOND EDITION 441 (EDS. LUDWIG AND KORNBERG 1992).

5 Id. at 443.

6 John E.B. Myers, Medicolegal Aspects of Child Abuse, in MEDICAL DIAGNOSIS AND MANAGEMENT 440 (REECE ED 1994) (citations omitted).

7 MONTELEONE & BRODEUR, CHILD MALTREATMENT SECOND EDITION 597 (1998).

8 Id.

9 Johnson, *supra* note 2 at 229.

10 See generally, Adams & Wells, Normal Versus Abnormal Genital Findings in Children: How Well Do Examiners Agree?, 17 CHILD ABUSE AND NEGLECT 663 (1993).

11 Id. at 673.

“No Safe Haven” Conference

Jim Jacobs, Ph.D.

“A devastating tornado of substance abuse and addiction is tearing through the nation’s child welfare and family court systems....There is no safe haven for these abused and neglected children of drug- and alcohol-abusing parents. They are the most vulnerable and endangered individuals in America...”

-The National Center on Addiction and Substance Abuse at Columbia University findings after a two-year nationwide exhaustive analysis.

Out of the study, which included Child Welfare and Substance Abuse Treatment professionals, comes four guiding Principles which underscore the need for comprehensive, timely and appropriate interventions:

“1) Every child has a right to have his or her substance-abusing parents get a fair shot at recovery with timely and comprehensive treatment.

2) Every child has a right to be free of drug- and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment, or despite treatment, are unable to conquer their abuse and addiction.

3) Every child has the right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

4) The goal of the child welfare systems is to form and support safe, nurturing families for children—where possible within the biological family and where not possible with an adoptive family.”

A March conference, sponsored by the Child Abuse Action Network brought experts on this issue to the Augusta Civic Center in March, 2000. This conference included presentations by the Vice President and Director of Policy Research Analysis at the National Center on Addiction and Substance Abuse at Columbia University, Susan Foster, and the Directors of two innovative interdisciplinary stated programs combining expertise from Child Welfare and Substance Abuse Treatment Services who are trying to address these issues in Connecticut (Joseph Sheehan) and New Jersey (Brian Rafferty).

Child Welfare workers nationwide cite substance abuse as one of three top causes for a dramatic rise in child maltreatment. A national survey of professionals who work in child welfare agencies or family courts reported that substance abuse caused or contributed to at least half of all of child maltreatment cases and that parents who abuse or neglect their children commonly abuse a combination of drugs and alcohol. They felt that children of substance abusing parents are likelier to enter foster care and stay longer than other children. In line with the stages-of-change? research, respondents “overwhelmingly” noted “...lack of motivation as the number one barrier to getting parents into substance abuse treatment...” In spite of this, “more than 40 percent of all child welfare caseworkers either aren’t looking for the problem or aren’t aware of any policies instructing them to do so...” and although most

professionals in the child welfare system report they have received some training in substance abuse and addiction, the training was brief, sometimes a two hour seminar, and felt by the researchers to be “grossly inadequate” given the extent of the problem.

Two of the innovative programs studied by C.A.S.A. were invited to present their experiences. The “Project Safe” program in the Connecticut Department of Child and Families connects the Child Welfare and Adult substance abuse treatment systems. This is done through a centralized intake that immediately links substance abuse evaluations and child welfare assessments. A focus on substance abusing primary caregivers puts them into treatment programs with appointments within 24 hours. A centralized lab is contracted for toxicology screens for initial and ongoing needs. Almost five years of data indicates there were over 25,000 unduplicated referrals for substance abuse evaluations. Over 65% kept initial evaluation appointments and 37% entered treatment. The program also includes subsidized housing and intensive case management for recovering families.

The New Jersey program has Substance Abuse Counselors working in Child and Family Services offices for immediate consultation and assessment, and assessments are performed in the client’s own home. This enables their programs to refer clients to appropriate levels of care and monitor this area for progress and consultation with child welfare staff. They also use paraprofessional recovering “home visitors” who have been sober for at least two years and have parenting experience. They provide role models and encouraging support as parents who have successfully managed these issues.

Other areas of discussion at the conference noted some promising initial results with more intensively “motivational” models, such as “family drug courts,” in New York, Florida and Nevada. These allow the courts to closely follow treatment compliance with immediate consequences, felt to be a necessary tool for some parents struggling with substance abuse.

A panel followed and noted that here in Maine, increased communication, cooperation and new ties are being forged between Child Welfare staff and Substance Abuse Treatment staff, this conference being a good example of that evolving partnership. Much work remains to be done in this area and far too little has been provided for resources for such an effort.

1 See the Summer 2000 Issue of this Newsletter, Vol. 12, No. 1, and “Multidisciplinary Decision-Making Model for

Child Abuse in Maine,” the latter also published by the Child Abuse Action Network and available on the World Wide

Web at www.maineaan.usm.maine.edu.

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The Family Visitation Center
At the Kennebec Valley Mental Health Center

Robert Ellis

Neil B. Colan, Ed.D.

On February 22, 2000, the Kennebec Valley Mental Health Center opened a first of its kind regional Family Visitation Center. The Center is designed to meet the needs of children who are currently in the custody of the Department of Human Services and are participating in a reunification process. The Center operates on the assumption that the potential for achieving timely permanency is maximized when well-trained staff facilitates purposeful, positive visits between children and their parents. By definition, supervised visitation provides opportunities for safe contact between a maltreated child and a non-custodial adult under the guidance of a third party. At its core level, supervised visitation is founded upon the empirical evidence that children's contact with their biological parents, while they are placed in out of home care, is beneficial with respect to emotional adjustment of the children. In addition, supervised visitation is seen as an effective evaluation tool designed to identify those families where reunification is likely or unlikely to be successful. Essentially, supervised visitation is a critical time in the lives of children and their parents in that it can be the basis upon which the attachment bond is maintained, strengthened, repaired, or even terminated.

Over the last decade there has been a significant rise in the number of well- developed visitation services and centers throughout the country. This growth has been driven by a number of factors, including the substantial increase in the numbers of children in foster care placement, recognition of the psychological impact upon children of maltreatment and loss of attachment with biological parents, and changes in public policy on reunification and permanency planning. Unfortunately, until recently, visitation has not been very well developed in Maine. Historically, visitation in Maine has been predominately viewed as a functional service required by the courts. As a result, supervised visits have most often been conducted in sterile, unwelcoming environments with minimally trained staff that at best, simply record unstructured observations of family interactions.

Recent advances have enabled those in Maine who are concerned about child maltreatment and reunification to identify more specific goals to be achieved through supervised visitation. For the Department of Human Services these goals essentially include the ability to assess and document initial and subsequent changes in such things as the nature and quality of the parent-child relationship, the level of parents' understanding of, and ability to meet, their child's needs, and parents' commitment and capacity to change. For parents, the goals of supervised visitation include an opportunity to learn and demonstrate their commitment and capacity to change the way they provide care for their children. It is also an opportunity to safely interact with their child during the sometimes long family rehabilitation effort. Finally, for children, supervised visitation works to reduce the trauma of separation and to establish or maintain the bond with their parents.

The Family Visitation Center at the Kennebec Valley Mental Center is founded upon several guiding principals. First and foremost is that safety and security of children must always be of paramount concern. The Family Visitation Center has to be a place where children, who've experienced substantial neglect and abuse at the hands of their parents, can safely meet and interact with their parents. Established security measures and procedures assure that this takes place. Secondly, at the Family Visitation Center, healthy daily living skills and emotional well-being are promoted. Families are viewed as more likely to achieve functional status when normalized family living environments are available and opportunities to practice healthy daily living are provided. The Center is located in a warm and inviting two-story family home, complete with a full kitchen and individual family rooms overflowing with toys, games, books, and crafts. Healthy daily living skills are practiced and obtained by engaging in specific nurturing, play and learning activities. Finally, the Family Visitation Center conducts evaluations of functioning and interactions in order to promote change as well as document status. Through direct observation, assessment and feedback, children and parents can learn to make positive changes in their capacities and reduce overall risk of harm. In addition, evaluation can be a valuable source of information used in determining disposition during judicial reviews.

The Family Visitation Center provides several types of visits as well as specialized family education. Initially, observed visits are used to establish a baseline on family functioning. Once this occurs, they are then conducted throughout the reunification process as a means of documenting parent's progress. The second type of visit, the interactive visit, distinguishes the family Visitation Center from other programs. In this type of visit, the visit supervisor takes an active role in facilitating meaningful and purposeful interactions between the parent and child. This can take the form of direct teaching and modeling effective parenting practices. During both of these types of visits, a "check-in" and "check-out" procedure is employed. Here, the visit supervisor meets with the parent to discuss the progress and issues that have been observed during past visits with the child as well as goals for up-coming visits. During every visit, standard observations are made in several key areas including the appropriateness of communication, developmental fit, handling of resistance, parental role, and nurturance. Sealing this all together in a more comprehensive approach to visitation is a specialized parent education component. After several visits, parents who are identified as needing significant help in improving their effectiveness receive an individualized assessment and plan for remediation. Then, one on one parent training sessions takes place with a supervisor utilizing the Center and its activities as a basis for training.

The Family Visitation Center faces many challenges as it moves forward. The value of visitation is currently under-recognized, not well understood or practiced. Program standards and policies and procedures are limited, and efficacy research is sorely lacking. Nevertheless, because of the pressing need to develop innovative programs, which address the critical needs of children who have been maltreated and their families, the Family Visitation Center will continue to work with its partners to develop new program components and to improve its effectiveness.

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