U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Recognizing When a Child's Injury or Illness Is Caused by Abuse

Portable Guides to Investigating Child Abuse

Foreword

Investigation of potential incidents of child abuse is a critical and sensitive matter. Protection of children and fairness to parents are complementary, not mutually exclusive ends. Balancing these interests is a very difficult and challenging law enforcement responsibility.

It is an important part of the investigative process that physical and sexual abuse of children not be camouflaged as accidental injury. To determine whether a child's injuries are accidental or intentional requires careful investigation, and this guide provides many practical pointers toward that end.

It is our hope that this guide will assist you in your commendable efforts to protect children.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

June 1996

Third Printing March 2000

NCJ 160938

Overview

In recent years the public's increased awareness and reports of suspected child abuse have put pressure on law enforcement to improve their investigations of such cases. This was underscored in late 1987 when a New York City toll collector observed a small girl covered with bruises in the rear of a car. The collector radioed the New York State Police, who stopped the car. The child's foster father, an attorney, explained to police that the bruises were accidental, and he was released. A week later, the child was dead from a beating.

Law enforcement personnel frequently must determine whether a child's accident or illness was caused by a parent or caretaker. However, it is often difficult even for medical personnel to discriminate between injuries and illnesses that are accidental and those that are not. The following information can help law enforcement personnel to determine if it is likely that abuse has occurred.

Could This Be Child Abuse?

Investigators must determine whether the explanation for an injury is believable. Police should begin their investigation by asking the caretaker for an explanation of the child's bruises or injuries. This is best done by asking the question: How did the accident happen?

All bruises must be investigated. If bruises are found on two or more planes of a child's body, investigators should be even more suspicious. For example, a child has bruises on his buttocks and stomach. The caretaker's explanation is that the child fell backward in the living room of the family home. This might explain the bruises on the buttocks, but not the stomach bruises. If a discrepancy exists between the reported cause of an injury and the injuries seen, law enforcement personnel should investigate further. They should also keep in mind the following points:

- All other children in the home should be examined for possible signs of child abuse.
- Victims of physical abuse often have been intimidated and will usually support the abuser's version of how their injuries occurred to avoid further injury. They also feel that the abuse was just punishment because they were bad.
- A physical examination of the child in suspected cases of maltreatment must be done and the data recorded precisely.
- Laboratory data should be obtained to support or refute the evidence of abuse.
- If the reported history of an injury or injuries changes during the course of an investigation, or if there is conflict between two adult caretakers as to the cause of injury, the likelihood of child maltreatment increases.
- The demeanor of the child's parents or caretakers is sometimes revealing. For example, the mother's assessment of her pregnancy, labor, and delivery will often provide an insight into her attitude about her child as well as give an indication of whether there is something about the child that is influencing her behavior.

- Investigators should ask questions in an unobtrusive manner; for example:
  - Was this a planned pregnancy?
  - Did you want the baby?
  - Do you like the baby?
  - How did the accident happen?
  - What were you doing just before the accident?
  - Who was at home at the time of the accident?
  - What do you feed the baby? How often? Who feeds the baby?
- Information about a child's birth and his or her neonatal and medical history are critical elements in investigations. Hospital records can confirm or eliminate the existence of birth injuries.
- Any child may be abused, and child abuse occurs in all levels of society. However, there are some factors that increase a child's risk of abuse. These include:
  - Premature birth or low birth weight.
  - Being identified as "unusual" or perceived as "different" in terms of physical appearance or temperament.
  - Having a variety of diseases or congenital abnormalities.
  - Being physically, emotionally, or developmentally disabled (e.g., mentally retarded or learning disabled).
  - Having a high level of motor activity, being fussy or irritable, or exhibiting behavior that is different from the parents' expectations.
  - Living in poverty or with families who are unemployed.
  - Living in environments with substance abuse, high crime, and familial or community violence.

The following are provided to help law enforcement personnel determine which injuries and illnesses in children are likely to be the result of abuse. However, it is also very important for law enforcement to work closely with physicians to determine the nature of all injuries.

Repetitive Accidents

Multiple bruises, wounds, abrasions, or other skin lesions in varying states of healing may indicate repetitive physical assault. Such repetitive accidents or injuries may indicate that abuse is occurring. A careful examination of the circumstances and types of injuries and an assessment of the child and family should be carried out by a professional skilled in family dynamics, usually the social worker investigating a report of suspected abuse. However, a police officer from the juvenile division may in some circumstances be responsible for this, rather than a social worker.

Cutaneous (Skin) Injuries

The most common manifestations of nonaccidentally inflicted injuries are skin injuries. Several characteristics help to distinguish nonaccidental skin injuries from accidental ones, including their location and pattern, the presence of multiple lesions of different ages, and the failure of new lesions to appear after hospitalization. Law enforcement personnel should be sure to obtain a complete history of all injuries from the caretaker.

Bruises

Bruises are due to the leakage of blood into the skin tissue that is produced by tissue damage from a direct blow or a crushing injury. Bruising is the earliest and most visible sign of child abuse. Early identification of bruises resulting from child abuse can allow for intervention and prevent further abuse.

Bruises seen in infants, especially on the face and buttocks, are more suspicious and should be considered nonaccidental until proven otherwise. Injuries to children's upper arms (caused by efforts to defend themselves), the trunk, the front of their thighs, the sides of their faces, their ears and neck, genitalia, stomach, and buttocks are also more likely to be associated with nonaccidental injuries. Injuries to their shins, hips, lower arms, forehead, hands, or the bony prominences (the spine, knees, nose, chin, or elbows) are more likely to signify accidental injury.

Age Dating of Bruises

It is important to determine the ages of bruises to see if their ages are consistent with the caretaker's explanation of the times of injury. Age dating of bruises can often be determined by looking at the color of the bruise. The ages and colors of bruises may therefore show if more than one injury is present. Table 1 shows the ages associated with the colors of bruises.

Table 1

Determining the Age of a Bruise by Its Color

Color of Bruise	Age of Bruise
Red (swollen, tender)	0–2 days
Blue, purple	2–5 days
Green	5–7 days
Yellow	7–10 days
Brown	10–14 days
No further evidence of bruising	2–4 weeks

For example, a 2-year-old boy, not toilet trained, has several yellow-to-brown bruises on his buttocks. The caretaker's explanation for the bruises is that the child tripped in the hallway the day before and fell on his buttocks. This would be suspicious because:

- Children seldom bruise their buttocks in accidental falls.
- Bruises on the buttocks are in the primary target zone for nonaccidental injury.
- The child's diaper (whether disposable or cloth), plastic pants, and clothing would have afforded some protection to his buttocks.
- If the injuries causing the bruises were sustained the previous day, the bruises should be red to purple.

Another child might have both bright red and brown bruises. The caretaker maintains that all of the bruises were the result of a fall that day. However, the bright red color indicates fresh bruises, while the brown bruises are older. The caretaker's explanation is, therefore, suspicious, and separate explanations must be obtained for each bruise.

Bruise Configurations

Bruises will sometimes have a specific configuration. This may enable law enforcement officers to determine whether bruises are accidental or nonaccidental. One of the easiest ways to identify the weapon used to inflict bruises is to ask the caretaker: How were you punished as a child?

The pattern of a skin lesion may suggest the type of instrument used. Bruise or wound configurations from objects can be divided into two main categories: those from "fixed" objects, which can only strike one of the body's planes at a time, and those from "wraparound" objects, which follow the contours of the body and strike more than one of the body's planes. Hands can make either kind of bruise, depending on the size of the offender's hands and the size of the child. Examples of fixed and wraparound objects include:

- Fixed objects: coat hangers, handles, paddles.
- Wraparound objects: belts, closed-end (looped) cords, open-end cords. (Closed-end cords leave a bruise in parallel lines; open-end cords leave a bruise in a single line.)

Natural or Normal Bruising

Injuries inflicted by human hands, feet, or teeth or those inflicted by belts, ropes, electrical cords, knives, switches, gags, or other objects will often leave telltale marks (e.g., gags may leave down-turned lesions at the corners of the mouth). These marks may also help in the investigative process. For example, the size of bite marks may help to determine the biter's approximate age; their shape may help identify whose teeth made the marks. In some cases, however, bruises are acquired innocently, through play and accidental falls, or when a child has a defect in his or her clotting mechanism.

For example, a baby is brought to the hospital with purple bruises on several body surfaces. The parents were unable to provide an explanation other than that the baby "bruised easily." Blood tests later revealed that the baby was a hemophiliac; hemophilia is associated with bruising easily, due to blood clotting problems. There is usually a history of bruising easily in families with such inherited diseases.

Other incidents of "easy bruising" in children can be explained by a low blood platelet count. Multiple bruises can occur in children with leukemia. Diseases causing easy bruising, however, are rare, and inflicted bruises are much more common. The medical diagnosis of clotting disorders requires blood tests and interpretation of those tests by qualified physicians. Therefore, law enforcement officers should try to determine if bruises are the result of an accident or due to physical abuse. Police must also remember never to jump to conclusions and to make a complete investigation of all aspects of suspected child abuse. However, their first duty is to secure the safety of the child quickly.

Mongolian spots (a kind of birthmark) also resemble bruises but can be distinguished by their clear-cut margins, the fact that they do not fade, and their steel gray-blue color. Mongolian spots may be found anywhere on the body (but are typically found on the buttocks and lower back). In addition, they are commonly found in African Americans, Asians, and Hispanics. Investigators should await medical reports when investigating such marks.

Burns

As shown in table 2, certain characteristics of the history, location, or pattern of burns may indicate whether they were nonaccidental.

Table

Distinguishing Accidental

Indications That Burns May Not Have Been Accidental

History

- The burns are attributed to siblings.
- An unrelated adult brings the child in for medical care.
- Accounts of the injury differ.
- Treatment is delayed for more than 24 hours.
- There is evidence of prior "accidents" or an absence of parental concern.
- The lesions are incompatible with the history.

Location

- The burns are more likely to be found on the buttocks, in the anogenital region (the area between the legs, encompassing the genitals and anus), and on the ankles, wrists, palms, and soles.

Pattern

- The burns have sharply defined edges. For example, in immersion burns, the line of immersion gives the appearance of a glove or stocking on the child's hand or foot.
- The burns are full thickness (all of the skin, and possibly muscle and bone as well, is destroyed).
- The burns are symmetrical.
- The burns are older than the reported history indicates.
- The burns have been neglected or are infected.
- There are numerous lesions of various ages.
- The burn patterns conform to the shape of the implement used.
- The degree of the burns is uniform (usually indicating forced contact with a hot, dry object), and they cover a large area.

2

From Nonaccidental Burns

Indications That Burns Are More Likely To Be Accidental

History

- The history of the mechanism of the burns is compatible with the observed injury.

Location

- The burns are usually found on the front of the body. They occur in locations reflecting the child's motor activity, level of development, and the exposure of the child's body to the burning agent.

Pattern

- The burns are of multiple depths interspersed with unburned areas and are usually less severe (such as splash burns).
- The burns are of partial thickness; that is, only part of the skin has been damaged or destroyed.
- The burns are asymmetrical.
- Apparently only one traumatic event has occurred, because the skin injuries are all of the same age.

Poisoning

J.A. Bay's exhaustive review of the world's literature of reported cases of nonaccidental poisoning as a form of child abuse identified certain agents that are commonly used by perpetrators ("Conditions Mistaken for Child Sexual Abuse," in Reece, R.M. (ed.): *Child Abuse: Medical Diagnosis and Management*). The most frequently used agents included barbiturates, psychoactive drugs, tranquilizers, insulin, ipecac, arsenic, laxatives, salt, water, alcohol, marijuana, and opiates. The children poisoned by such agents display a variety of presenting signs and symptoms, but nearly all have major changes in their mental status, ranging from irritability, listlessness, lethargy, stupor, and coma to convulsions. The peak age for *accidental* poisoning is 2 to 3 years, and it is rare under the age of 1 or over the age of 6. The usual history of nonaccidental poisoning is that either the ingestion was not witnessed or that it was administered by a sibling or another child. In addition, the history may change over time.

Head Injuries

Many fatalities from child abuse involve serious head injuries. Subdural hematomas due to child abuse are most common in children less than 24 months of age, with the peak incidence at about 6 months. The signs and symptoms of subdural hematomas may either be nonspecific, including irritability, lethargy, or a disinclination to eat, or there may be more classic signs of raised intracranial pressure such as vomiting, seizures, stupor, or coma. A subdural hematoma associated with a skull fracture is due to a direct impact to the head and ordinarily leaves external marks. It may be associated with shaking the baby violently or with an extreme blow to the head, such as occurs when children are thrown against a hard object.

Retinal hemorrhages strongly suggest whiplash or shaking as the origin of the injury. The presence of bilateral subdural hematomas is also positively correlated with whiplash or shaking. Therefore, law enforcement personnel need to investigate whether these were nonaccidental injuries.

Hair pulling as a means of discipline may be responsible for hair loss or baldness (alopecia).

Eye Injuries

- External eye injuries are so common in children that they are seldom clear-cut evidence of abuse.
- Two black eyes seldom occur together accidentally.
- The "raccoon eyes" associated with accidental and nonaccidental fractures at the base of the skull may look similar to each other, but raccoon eyes from nonaccidental trauma usually are associated with more swelling and skin injury. The history helps distinguish between them.
- Hyphema, the traumatic entry of blood into the front chamber of the eye, may be the result of a nonaccidental injury caused by striking the eye with a hard object, such as a belt buckle. The child will complain of pain in the eye and have visual problems.
- Retinal hemorrhages are the hallmark of shaken baby syndrome and are only rarely associated with some other mechanism of injury.
- Nonaccidental trauma must always be considered in a child under 3 years of age who has retinal hemorrhages or any traumatic disruption of the structures of the globe of the eye (e.g., the lens or retina) or the skin around the eye.

Internal Injuries

- Internal organ injuries are second only to head trauma as the most common causes of death in child abuse.
- Nonaccidental internal injuries usually involve structures below the diaphragm.
- Accidental abdominal injuries usually involve a long fall to a flat surface, a motor vehicle accident or, rarely, are the result of contact sports. Accidental abdominal injuries usually involve older children who are brought to medical attention immediately, whereas children with nonaccidental abdominal injuries will be younger, and a delay in seeking medical attention is more common. Nonaccidental abdominal injuries more commonly involve hollow organs (e.g., the gut and stomach) than accidental injuries, but the liver, spleen, and pancreas can all suffer nonaccidental injury. For some reason, the kidneys are rarely injured.

- Although there are signs and symptoms, in most cases of abdominal organ injury there are no external signs of trauma. This is due to the pliability of the abdominal wall and its ability to absorb trauma without showing bruises.
- Unusual clinical findings may indicate abuse.
- In school-age children, trauma to the pancreas is quite infrequent and usually involves an injury caused by bicycle handlebars or traffic accidents. In infants and toddlers under the age of 3, child abuse must be strongly suspected, since the pancreas is so deep in the abdomen that it is protected from all trauma except blunt force trauma.

Sudden Infant Death Syndrome

Sudden infant death syndrome (SIDS) is the "sudden death of an infant under one year which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Willinger, M., et al., "Defining the Sudden Infant Death Syndrome (SIDS): Deliberations of an Expert Panel Convened by the National Institute of Child Health and Human Development," *Pediatric Pathology* 11:677–684, 1991). SIDS is unexpected, usually occurring in apparently healthy infants ages 1 month to 1 year. Most deaths from SIDS occur by the end of the sixth month, with the greatest number taking place between ages 2 and 4 months. SIDS is the leading cause of death in the United States among infants between the ages of 1 month and 1 year, and is second only to congenital anomalies as the overall leading cause of death for all infants under 1 year of age (National Sudden Infant Death Syndrome Resource Center, 1993).

In sudden, unexplained infant deaths, investigators, including medical examiners and coroners, use the special expertise of forensic medicine (the application of medical knowledge to legal problems) to arrive at a diagnosis. A definitive SIDS diagnosis cannot be made without a thorough autopsy—including microscopic examination of tissue samples and vital organs—that fails to point to any other possible cause of death. Also, if the cause of the infant's death is ever to be uncovered, it will be from evidence gathered during a thorough pathological examination. Often, the cause of an

infant's death can only be determined by carefully collecting and evaluating information from the death scene and conducting forensic tests. Investigators should also carefully review the child's and child's family's history of previous illnesses, accidents, or behaviors. Review of these details may further corroborate what is detected in the autopsy or death scene investigation. Investigators should be sensitive, yet thorough. Criteria for distinguishing SIDS from death caused by child abuse are presented in table 3. The following is a list of key points relative to SIDS:

- SIDS is a diagnosis of exclusion following a thorough autopsy, death scene investigation, and comprehensive review of the child and his or her family's case history.
- SIDS is a definite medical entity and is the major cause of death in infants after the first month of life, with most deaths occurring between the ages of 2 and 4 months.
- SIDS victims appear to be healthy prior to death.
- SIDS currently cannot be predicted or prevented, even by a physician.
- SIDS deaths appear to cause no pain or suffering; death occurs very rapidly, usually during sleep.
- SIDS is not child abuse.
- SIDS is not caused by external suffocation.
- SIDS is not caused by vomiting and choking or by minor illnesses such as colds or infections.
- SIDS is not caused by the diphtheria/pertussis/tetanus (DPT) vaccine or other immunizations.
- SIDS is not contagious.
- SIDS is not the cause of every unexplained infant death.

Table 3

Criteria for Distinguishing SIDS From Fatal Child Abuse and Other Medical Conditions*

Consistent With SIDS	Less Consistent With SIDS	Highly Suggestive or Diagnostic of Child Abuse
Circumstances surrounding death		
An apparently healthy infant fed and put to bed. Found lifeless (silent death). EMS† resuscitation unsuccessful.	Infant found not breathing. EMS transports to hospital. Infant lives hours to days. History of substance abuse or family illness.	History is not typical of SIDS† or there is a discrepant or unclear history. Prolonged interval between bedtime and death.
Age of child		
Peak: 2–4 months (90% < 7 months). Range: 1–12 months	8–12 months	>12 months
Physical examination and laboratory studies at time of death		
Bloody, watery, frothy, or mucous nasal discharge. PM† lividity in dependent areas (portions of the body that are lower—due to gravity, the blood settles). Sometimes	Organomegaly of the viscera (enlargement of the organs). Diagnostic signs of a disease process (by PE†, laboratory tests, x-ray).	Skin injuries. Traumatic injuries to body parts: mucous membranes of the eyelids, fundi (part of the eye opposite the pupil), scalp, inside of the mouth, ears, neck,

there are marks on pressure points (places where a blood vessel runs near a bone, such as where pressure is applied to stop bleeding). No skin trauma. Apparently well-cared-for baby.

trunk, anus or genitals, and extremities. Evidence of malnutrition, neglect, or fractures may also be present.

History of pregnancy, delivery, and infancy

Prenatal care ranged from minimal to maximal. Frequently, mothers used cigarettes during pregnancy. Some victims were premature or had LBW†. Newborns showed minor defects with regard to their feeding and general temperament. Less height and weight gain after birth. Being a twin or a triplet. Possible history of spitting, GE† reflux, thrush, pneumonia, illnesses requiring hospitalization, accelerated breathing or heartbeat, (bluish) discoloration of skin due to lack of oxygen in the blood. Usually no signs of difficulty before death.

Prenatal care was minimal to maximal (therefore, it has no significance in distinguishing SIDS from non-SIDS deaths). Child has history of recurrent illnesses and/or multiple hospitalizations ("sickly" or "weak" baby). Previous specific diagnosis of organ system disease.

Pregnancy was unwanted. Little or no prenatal care. Mother arrived late at hospital for delivery, or birth occurred outside of hospital. Little or no well-baby care. No immunizations. Mother used cigarettes, drugs, and/or alcohol during and after pregnancy. Child described as hard to care for or to "discipline." Deviant feeding practices were used.

Table 3 *continued*

Criteria for Distinguishing SIDS From Fatal Child Abuse and Other Medical Conditions*

Consistent With SIDS	Less Consistent With SIDS	Highly Suggestive or Diagnostic of Child Abuse
Death scene investigation		
Crib or bed in good repair. No dangerous bedclothes, toys, plastic sheets, pacifier strings, or pillows stuffed with pellets. No cords, bands, or other possible means of entanglement. An accurate description was provided of the child's position, including whether there was head or neck entrapment. Normal room temperature. No toxins or insecticides present. Good ventilation, furnace equipment.	Defective crib or bed or inappropriate sheets, pillows, or sleeping clothes. Presence of dangerous toys, plastic sheets, pacifier cords, pellet-stuffed pillows. Evidence that child did not sleep alone. Poor ventilation and heat control. Presence of toxins or insecticides. Unsanitary conditions.	Chaotic, unsanitary, and crowded living conditions. Evidence of drug or alcohol use by caretakers. Signs of a struggle in crib or other equipment. Blood-stained bedclothes. Evidence of hostility, discord, or violence between caretakers. Admission of harm, or accusations by caretakers.
Previous infant deaths in family		
No previous unexplained or unexpected infant deaths.	One previous unexpected or unexplained infant death.	More than one previous unexplained or unexpected infant death.

Autopsy findings

No adequate cause of death at PM. Normal skeletal survey, toxicological findings, chemistry studies (blood sugar may be high, normal, or low), microscopic examination, and metabolic screen. Presence of changes in certain organs thought to be more commonly seen in SIDS than in non-SIDS deaths. Occasionally, subtle changes in liver, including fatty change and blood forming in the liver (not a normal site for blood production).	Subtle changes in liver, adrenal glands, and the heart muscle (myocardium).	Traumatic cause of death (IC† or visceral bleeding). External bruises, abrasions, burns. Evidence of malnutrition, fractures, or scalp bruises. Abnormal body chemistry values: Na†, Cl†, K†, BUN†, sugar, liver and pancreatic enzymes, and CPK†. Abnormal toxicological findings.

Previous involvement of child protective services or law enforcement

None.	One.	Two or more. One or more family members arrested for violent behavior.

*Adapted from Reece, R.M. Fatal child abuse and sudden infant death syndrome: A critical diagnostic decision. *Pediatrics* 91(2):423, 1993. Reproduced by permission of *Pediatrics*.

†Abbreviations: BUN, blood urea nitrogen; Cl, chlorine; CPK, creatinine phosphokinase; EMS, emergency medical services; GE, gastroesophageal; IC, intracranial; K, potassium; LBW, low birth weight; Na, sodium; PE, physical examination; PM, postmortem; SIDS, sudden infant death syndrome.

Investigator's Checklist for Use in Suspected Cases of Physical Child Abuse

Far too often police investigating a child's injuries will let their emotions interfere. It should be remembered that the child abuse investigation process, if performed correctly, will ultimately determine which injuries were nonaccidental. The following are some important questions and issues to be considered when investigating a suspected case of child abuse.

- ❑ Begin by asking questions about the child's family history, substance abuse or other environmental factors in the home, and the parents' marital status, employment history, or unrealistic expectations of the child.
- ❑ How could the child's behavior or the caretaker's stress have contributed to the crisis?
- ❑ Could the child do what the caretakers told you he or she did?
- ❑ Is the child a "target" child (a child perceived by the parent(s) as having negative characteristics), or are there target children present?
- ❑ Was there any delay in treatment or was hospital "shopping" involved?
- ❑ What are the locations, configurations, and distributions of the bruises, welts, lacerations, abrasions, or burns?
- ❑ Do the injuries appear to have been caused by the hands or an instrument? Can you determine what instrument might have been used?
- ❑ Are multiple injuries (in various stages of healing) present?
- ❑ Are the injuries within the primary target zone (the back, from the neck to the back of the knees and including the shoulders and arms) and on more than one leading edge (the outside of the arm or leg, etc.) of the body?
- ❑ Can you determine the positions of the offender and the child during the attack?
- ❑ Is there any evidence of attempts to hold the child in a certain position or at a certain angle during the attack? Are there such control marks on the wrists, forearms, or biceps?
- ❑ Was a careful check made for injuries on the head, mouth, ears, and nose?

Contributing Authors

Robert Hugh Farley, M.S.
Commanding Officer, Cook County
Sheriff's Police Department
Child Exploitation Unit
1401 Southmaybrook Drive
Maywood, IL 60153
708–865–4875
708–865–4818 (fax)
E-mail: rhfarley@hotmail.com

Robert M. Reece, M.D.
Clinical Professor of Pediatrics
Tufts University School of Medicine
Boston, Massachusetts
and
Director, Institute for Professional Education
Massachusetts Society for the Prevention of
Cruelty to Children (MSPCC)
399 Boylston Street
Boston, MA 02116
617–587–1512
617–587–1582 (fax)
E-mail: breece@mspcc.org

Supplemental Reading

General

Duhaime AC et al. Head injury in very young children: Mechanisms, injury types and ophthalmic findings in 100 hospitalized patients younger than 2 years of age. *Pediatrics* 90:179, 1992.

Duhaime AC et al. The shaken baby syndrome: A clinical, pathological and biomechanical study. *Journal of Neurosurgery* 66:409, 1987.

Hight DW et al. Inflicted burns in children. *Journal of the American Medical Association* 242:517, 1979.

Kessler DB, Hyden P. *Physical, Sexual, and Emotional Abuse of Children. (CIBA–GEIGY Clinical Symposia,* Vol. 43, No. 1). Summit, NJ: Pharmaceuticals Division, CIBA–GEIGY Corporation, 1991.

Kleinman PK (ed). *Diagnostic Imaging of Child Abuse*. Baltimore: Williams & Wilkins, 1987.

Ledbetter DJ et al. Diagnostic and surgical implications of child abuse. *Archives of Surgery* 123:1101, 1988.

Ludwig S, Kornberg A (eds). *Child Abuse: A Medical Reference*. 2d ed. New York: Churchill Livingstone, 1992.

McNeese MC, Hebeler JR. *The Abused Child: A Clinical Approach to Identification and Management*. (*CIBA Clinical Symposia,* Vol. 29, No. 5). Summit, NJ: CIBA Pharmaceutical Company, Division of CIBA–GEIGY Corporation, 1977.

Merten DF et al. The abused child: A radiological reappraisal. *Radiology* 146:377, 1983.

Pascoe JM et al. Patterns of skin injury in non-accidental and accidental injury. *Pediatrics* 64:245, 1979.

Reece RM (ed). *The Quarterly Child Abuse Medical Update*. Published by the Institute for Professional Education of the Massachusetts Society for the Prevention of Cruelty to Children. Abstracts of the latest information on the subject of child abuse from more than 40 medical journals.

Reece RM (ed). *Child Abuse: Medical Diagnosis and Management*. Malvern, PA: Lea and Febiger, 1994.

Reece RM, Grodin M. Recognition of non-accidental injuries. *Pediatric Clinics of North America* 32:41–60, 1985.

Saywitz KJ. Developmental considerations for forensic interviewing. *The Interviewer* 3:15, 1990.

Shepherd J, Dworn B, Farley R, Russ B, Tressler P. *Child Abuse and Exploitation: Investigative Techniques*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1992.

Whitcomb D. *When the Victim Is a Child*. 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Worlock T et al. Patterns of fractures in accidental and non-accidental injury in children. A comparative study. *British Medical Journal* 293:100, 1986.

Sudden Infant Death Syndrome

National Sudden Infant Death Syndrome Clearinghouse. *Death Investigations and Sudden Infant Death Syndrome: A Selected Annotated Bibliography*. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, September 1991.

National Sudden Infant Death Syndrome Clearinghouse. *The Professional's Role in Sudden Infant Death Syndrome: A Selected Annotated Bibliography*. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, September 1991.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome Research: A Selected Annotated Bibliography for 1993*. McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1994.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome Risk Factors: A Selected Annotated Bibliography for 1989–1993*. McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1994.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome: Trying To Understand the Mystery*. McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, February 1994.

National Sudden Infant Death Syndrome Resource Center. *What is SIDS?* (Information Sheet). McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1993.

Willinger M, James LS, Catz C. Defining the sudden infant death syndrome (SIDS): Deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatric Pathology* 11:677–684, 1991.

Organizations

General

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
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Sudden Infant Death Syndrome

American SIDS Institute
2480 Windy Hill Road, Suite 380
Marietta, GA 30067
800–232–7437
770–612–1030 (local)

Association of SIDS and Infant Mortality Programs
c/o Minnesota SIDS Center
2525 Chicago Avenue South
Minneapolis, MN 55404
800–808–7437
612–813–6285 (local)

Center for Infant and Child Loss
University of Maryland School of Medicine
630 West Fayette Street, Room 5–684
Baltimore, MD 21201
800–808–SIDS
410–706–5062 (local)

Federal SIDS Program
U.S. Department of Health and Human Services
Office of Maternal and Child Health
Bureau of Maternal and Child Health and Resource Development
Parklawn Building, Room 18A–39
5600 Fishers Lane
Rockville, MD 20857
301–443–2115

National Sudden Infant Death Syndrome Resource Center
2070 Chain Bridge Road
Suite 450
Vienna, VA 22182
703–821–8955, ext. 249
703–821–2098 (fax)

SIDS Alliance
1314 Bedford Avenue
Suite 210
Baltimore, MD 21208
800–221–7437
410–653–8226 (local)

Southwest SIDS Research Institute, Inc.
Brazosport Memorial Hospital
100 Medical Drive
Lake Jackson, TX 77566
800–245–7437
979–299–2814 (local)

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Burn Injuries in Child Abuse

Portable Guides to Investigating Child Abuse

Foreword

Our most defenseless children are the most likely to be burned intentionally. Child abuse burn victims are almost always under the age of 10 with the majority under the age of 2. Immediate identification of intentional burn victims by those individuals first responding to the call for assistance is crucial because most of the victims are unable to speak for themselves. It is also important that responsible caretakers not be unjustly accused.

In this guide you will find information that will assist you to distinguish intentional burns from accidental contact with hot objects. *Burn Injuries in Child Abuse* provides both guidance on determining the veracity of a caretaker's report by re-creating the incident and a burn evidence worksheet for use at the scene of an investigation. Information regarding the distinctions between immersion and contact burns is also included.

It is our hope that information in this guide will be of use to law enforcement as we all work to protect our children.

Original Printing May 1997

Second Printing June 2001

NCJ 162424

Overview

Although general awareness of the magnitude of child abuse is increasing, deliberate injury by burning is often unrecognized. Burn injuries make up about 10 percent of all child abuse cases, and about 10 percent of hospital admissions of children to burn units are the result of child abuse. In comparison with accidentally burned children, abused children are significantly younger and have longer hospital stays and higher mortality rates. The child burn victim is almost always under the age of 10, with the majority under the age of 2.

Children are burned for different reasons. Immersion burns may occur during toilet training, with the perpetrator immersing the child in scalding water for cleaning or punishment. Hands may be immersed in pots of water for playing near the stove. A person may place a child in an oven for punishment or with homicidal intentions.

Inflicted burns often leave characteristic patterns of injury that, fortunately, cannot be concealed. Along

with the history of the burn incident, these patterns are primary indicators of inflicted burns versus accidental ones. Findings in response to the following questions can raise or lower the index of suspicion, helping to determine whether a burn was deliberately inflicted:

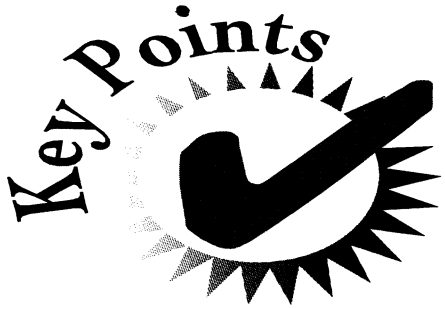
- Is the explanation of what happened consistent with the injury? Are there contradictory or varying accounts of the method or time of the "accident" or other discrepancies in the witnesses' descriptions of what happened?
- Does the injury have a clean line of demarcation, parts within or immediately around the injured area that are not burned, a burn pattern inconsistent with the injury account, or any other of the typical characteristics of an inflicted burn? Are the burns located on the buttocks, the area between the child's legs, or on the ankles, wrists, palms, or soles?
- Are other injuries present such as fractures, healed burns, or bruises?
- Are the child's age and level of development compatible with the caretaker's and witnesses' accounts of the injury?
- Was there a delay in seeking medical attention? Smaller burns may have been treated at home.
- Does the caretaker insist there were no witnesses, including the caretaker, to the injury incident?
- Do those who were present seem to be angry or resentful toward the child or each other?

A detailed history, including previous trauma, presence of recent illnesses, immunization status, and the status of routine medical care, is critical, as is careful documentation of the scene of the injury, including photographs and drawings. To investigate a burn injury:

- Stay focused on the facts in front of you and proceed slowly and methodically.
- Ask questions, be objective, and reenact the incident.
- Treat each case individually.

The incidence of further injury and death is so high in deliberate burn cases that it is critical for all concerned persons to be aware of the indicators of this form of child abuse.

The following descriptions provide information about the various types of accidental and nonaccidental burns children may incur.



- Scald burns are the most common type. They may be caused by any hot liquid—hot tap water, boiling water, water-like liquids such as tea or coffee, and thicker liquids such as soup and grease. Scald burns may be either a spill/splash type of burn or an immersion burn, the most common of the liquid burn injuries. Most deliberate burns are caused by tap water.
- Contact burns are usually of the branding type and will mirror the object used to cause the injury—curling iron, steam iron, cigarette lighter, fireplace or hibachi grill, and heated kitchen tool or other implement.

Young children have thinner skin than adults; therefore, a child's skin will be destroyed more rapidly and by less heat. Thicker skinned areas of the body include the palms, soles, back, scalp, and the back of the neck. Thinner skinned areas are the front of the trunk, inner thighs, bottom of forearms, and the inner arm area.

It is important to work with the emergency medical personnel, who were probably the first persons to see the child's injuries, hospital personnel, and social services investigators.

Classification of Burns

The preferred classification of burns used by most physicians is "partial" or "full thickness" (see table 1, page 4). Only an experienced medical practitioner can make a determination of how deep a burn is, but there are some features of partial and full thickness burns that can be observed immediately after the incident.

- Patches of reddened skin that blanch with fingertip pressure and refill are shallow partial thickness burns. Blisters usually indicate deeper partial thickness burning, especially if the blisters increase in size just after the burn occurs.
- A leathery or dry surface with a color of white, tan, brown, red, or black represents a full thickness burn. The child feels no pain because the nerve endings have been destroyed. Small blisters may be present but will not increase in size.

Table 1

Classification of Burns

Classification	Characteristics
First degree	Partial thickness burns. ✸ Characterized by erythema (localized redness). ✸ Appear sunburn-like. ✸ Are not included when calculating burn size. ✸ Usually heal by themselves.
Second degree	Partial thickness burns. ✸ Part of skin has been damaged or destroyed. ✸ Have blisters containing clear fluid. ✸ Pink underlying tissue. ✸ Often heal by themselves.
Third degree	Full thickness burns. ✸ Full skin has been destroyed. ✸ Deep red tissue underlying blister. ✸ Presence of bloody blister fluid. ✸ Muscle and bone may be destroyed. ✸ Require professional treatment.
Fourth degree	Full thickness burns. ✸ Penetrate deep tissue to fat, muscle, bone. ✸ Require immediate professional treatment.

Spill/Splash Injuries

These injuries occur when a hot liquid falls from a height onto the victim. The burn pattern is characterized by irregular margins and nonuniform depth. A key indicator to look for is where the scalding liquid first came into contact with the victim. Water travels downward and cools as it moves away from the initial contact point. When a pan of water is spilled

or thrown on a person's chest, the initial contact point shows a splash pattern. The area below this point tapers down, creating what is called an "arrow down" pattern. This pattern is more commonly seen in assaults on adults than in assaults on children.

If the child was wearing clothing at the time of the injury, the pattern may be altered. This is why it is important to determine whether clothing was worn and, if possible, to retain the actual clothing. Depending on the material, the water may have been against the skin longer, which would result in a deeper injury and pattern. A fleece sleeper, for instance, will change the course of the water and hold the temperature longer in one area as opposed to a thin, cotton T-shirt.

Questions to ask in a scalding injury investigation include the following:

- Where were the caretakers at the time of the accident?
- How many persons were home at the time?
- How tall is the child? How far can he or she reach?
- Can the child walk and are the child's coordination and development consistent with his or her age?
- How much water was in the pan and how much does it weigh?
- What is the height to the handle of the pan when it is sitting on the stove (or counter, or table)?
- Was the oven on at the time (thus unlikely that the child could have climbed onto the stove)?
- Does the child habitually play in the kitchen? near the stove? climb on the cabinets or table?
- Has the child been scolded for playing in the kitchen? for touching the stove?

It is unusual for a child to incur a scald burn on his or her back accidentally, but it has happened. As in all burn investigations, factors other than location of the burn must be considered before concluding the injury was nonaccidental. Deliberate burning by throwing a hot liquid on a child is usually done either as punishment for playing near a hot object or in anger. However, the child may have been caught in the crossfire between two fighting adults and then been accused of having spilled the liquid accidentally.

Immersion Burns

Immersion burns result from the child falling or being placed into a tub or other container of hot liquid. In a deliberate immersion burn, the depth of the burn is uniform. The wound borders are very distinct, sharply defined "waterlines" with little tapering of depth at the edges. There is little evidence that the child thrashed about during the immersion, indicating that the child was held in place, and occasionally there may be bruising of the soft tissue to indicate that this is what happened.

Only children with deliberate immersion burns sustain deep burns of the buttocks and/or the area between the anus and the genitals. Many of these injuries involve toilet training or the soiling of clothing. There may be dirty diapers or clothing in the bathroom. The water in the bathtub may be deeper than what is normal for bathing an infant or child and may be so hot that the first responding adult at the scene is unable to immerse his or her own hand in it.

Several key variables must be observed in investigating immersion burns:

- **The temperature of the water.** Variables that must be taken into account include the temperature of the water heater, the ease with which it can be reset, and recent prior usage of water.
- **The time of exposure,** an unknown that can sometimes be estimated from the burn pattern and its depth.
- **The depth of the burn.** Several days may need to pass before the true depth of the burn can be determined.
- **The occurrence of "sparing"** (areas within or immediately around the burn site that were spared).

An adult will experience a significant injury of the skin after 1 minute of exposure to water at 127 degrees, 30 seconds of exposure at 130 degrees, and 2 seconds of exposure at 150 degrees. A child, however, will suffer a significant burn in less time than an adult.

When a child's hand is forced into hot water, the child will make a fist, thus "sparing" the palm and discounting the statement that the child reached into the pan of hot water for something. A child whose body is immersed in hot water will attempt to fold up, and there will be sparing in creases in the

abdomen. Curling up the toes when the foot is forced into a hot liquid will spare part of the soles of the feet or the area between the toes. The area where the child was held by the perpetrator will also be spared. These flexing actions prevent burning within the body's creases, causing a striped configuration of burned and unburned zones, or a "zebra" pattern.

Deliberate immersion burns can often be recognized by one of the following characteristic patterns:

- **Doughnut pattern in the buttocks.** When a child falls or steps into a hot liquid, the immediate reaction is to thrash about, try to get out, and jump up and down. When a child is held in scalding hot bathwater, the buttocks are pressed against the bottom of the tub so forcibly that the water will not come into contact with the center of the buttocks, sparing this part of the buttocks and causing the burn injury to have a doughnut pattern.
- **Sparing of the soles of the feet.** Another instance of sparing occurs in a child whose buttocks and feet are burned but whose soles have been spared. If a caretaker's account is that the child was left in the bathroom and told not to get into the tub, and that the caretaker then heard screaming and returned to find the child jumping up and down in the water, the absence of burns on the soles of the child's feet is evidence that the account is not true. A child cannot jump up and down in hot water and not burn the bottoms of the feet.
- **Stocking or glove pattern burns.** Stocking and glove patterns are seen when feet or hands are held in the water. The line of demarcation is possible evidence that the injury was not accidental.
- **Waterlines.** A sharp line on the lower back would indicate the child was held still in the water. A child falling into the water would show splash and irregular line patterns. The waterline on the child's torso indicates how deep the water was.

An Evidence Worksheet for Immersion Burns and instructions for filling it out can be found at the end of this guide. This worksheet was developed to record data to help the doctor determine accidental or intentional injury. The information recorded on the worksheet is also helpful to the prosecutor in preparing the case and defeating potential defenses that may arise later in the investigation and trial. Developed with the assistance of a department of social services and several law enforcement child abuse investigative teams, the worksheet is a guideline and can be modified to suit particular investigative needs.

Contact Burns

Contact burns may be caused by flames or hot solid objects. Flame burns are a much less common cause of deliberate injury. When they do occur, they are characterized by extreme depth and are relatively well defined when compared with accidental flame burns.

When a child accidentally touches a hot object or the object falls on the child, there is a usually a lack of pattern in the burn injury, since the child quickly moves away from the object. However, even brief accidental contact can cause a second-degree burn with the pattern of the object, for example, falling against a hot radiator or grate.

Distinguishing Nonaccidental from Accidental Contact Burns

Nonaccidental burns caused by a hot solid object are the most difficult to distinguish from accidental injuries. Cigarette and iron burns are the most frequent types of these injuries. Cigarette burns on a child's back or buttocks are unlikely to have been caused by walking into a lighted cigarette, and therefore are more suspect than burns about the face and eyes, which can occur accidentally if the child walks or runs into the adult's lighted cigarette held at waist height. Accidental burns are usually more shallow, irregular, and less well defined than deliberate burns. Multiple cigarette burns are distinctively characteristic of child abuse.

Purposely inflicted "branding" injuries usually mirror the objects that caused the burn (such as cigarette lighters and curling irons), and are much deeper than the superficial and random burns caused by accidentally touching these objects. Most accidental injuries with hot steam or curling irons occur when the hot item is grasped or falls. These are usually second-degree injuries and randomly placed, as might happen when a hot iron strikes the skin in multiple places as it falls. It is important to know where the iron was—for example, on an ironing board or on a coffee table at the child's height?

Another source of accidental burns is contact with items that have been exposed for prolonged periods to hot sun. Pavement in hot sun, which can reach a temperature of 176 degrees, can burn a child's bare feet; however, these are not likely to be

deep burns. A child placed in a carseat that has been in a car in the sun can receive second- and even third-degree burns. Full thickness burns have also resulted from contact with a hot seatbelt buckle.

Key questions in this area are:

- Where is the burn injury and could the child reach the area unassisted?
- Does the child normally have access to the item (such as a cigarette lighter) that caused the injury?
- How heavy is the item and how strong is the child? For instance, is the steam iron a small travel-size one that a small child could lift or a full-size home model that might be too heavy?
- Is there any sparing that would be significant to the injury?
- How was the item heated and how long did it take to heat it to cause the injury?
- Is the injury clean and crisp, with a distinctive pattern of the object, or is it shallow or irregular, as from a glancing blow? Several cleanly defined injuries, especially on an older child, could indicate that the child was held motionless by a second perpetrator while the first perpetrator carefully branded the child.
- Are there multiple burns or other healed burns?
- Has the child been punished before for playing with or being too close to the hot object?

Skin Conditions That May Simulate Abuse

Investigators should be aware that it is sometimes difficult to distinguish between burns caused by abuse and certain diseases or medical conditions:

- **Cutaneous (skin) infections.** Some infections have patterns that may mimic deliberate injuries. Impetigo, severe diaper rash, and early scalded skin syndrome sometimes resemble a scald injury. A careful history, microbiological tests, and observation of the lesions over a 2- to 3-week period usually determine whether or not these are deliberate burn injuries or just infections.
- **Hypersensitivity reactions.** A substance in citrus fruits such as limes, when in contact with the skin and exposed to sunlight, can produce a form of photodermatitis with a pattern that resembles a splash burn. An allergic reaction causing a severe local skin irritation may be mistaken for a burn. Skin preparations such as

topical antiseptics can cause a similar burn appearance. Again, the exposure history will allow differentiation of these reactions from burns.

- **Marks left by folk remedies.** Moxibustion is an Asian folk remedy that entails placement of a hot substance, often burning yarn, on the skin of the abdomen or back, causing circular lesions that can be mistaken for other types of burn injuries. The practice of cupping, which is the placement in a cup or glass of a small amount of flammable substance that is ignited and placed on the skin, may cause a burn lesion. **Note:** Even when the cause of a burn injury is determined to be a folk remedy, investigators should exercise caution and carefully evaluate all circumstances surrounding the incident to determine whether the injury should be further investigated.

Helpful Investigative Techniques

The following investigative steps and techniques will help you and other professionals determine if burns have been purposely inflicted.

Medical Examination

The physical examination of all burned children includes careful evaluation of the entire skin surface for the presence of other signs of abuse such as:

- Healed burns.
- Multiple simultaneous burns.
- Bruises, slaps, and bite or whip marks.
- Evidence of sexual abuse.

Evaluation and documentation of the burn pattern should be precise. Multiple burns of varying ages and types that obviously could not have occurred from the same accident (for example, cigarette and scald burns or different types of scald burns) are strong indicators of child abuse. However, the absence of other injuries does not rule out child abuse, since 80 percent of deliberately inflicted burns are not associated with other trauma.

Long bone, chest, and a skull radiographic (x-ray) series (commonly called a "babygram") need to be performed on all burned children with suspected abuse. Unfortunately, there are no specific laboratory studies that will help distinguish deliberate from accidental burn injury.

Investigator's Checklist for Use in Suspected Cases of Deliberate Burn Injuries of Children

- ❑ Have you contacted the emergency response team?
- ❑ Have you contacted the child protective services team?
- ❑ Have you reviewed the medical findings with the appropriate medical staff?
- ❑ Have you carefully considered the suspicion index findings?
- ❑ Where was the primary care provider at the time of the incident?
- ❑ Where is the burn injury located on the child's body?
- ❑ How serious is the burn?
- ❑ Is the burn a wet contact burn or a dry contact burn?
- ❑ If the burn appears to have been caused by a dry source of heat, what is the shape of the burn and what object does it resemble?
- ❑ Have you completed the Evidence Worksheet for Immersion Burns?
- ❑ If the burn was produced by a hot liquid, was the child dipped or fully immersed?
- ❑ What does the line of demarcation look like?
- ❑ Are there any splash burns present?
- ❑ How symmetrical are the lines of immersion if stocking or glove patterns are present?
- ❑ Is toilet training, soiling, or wetting an issue?
- ❑ Have you recorded information concerning the child's age, height, degree of development and coordination; location of fixtures; temperature and depth of water; weight of burn object, etc.?
- ❑ Have you compared the burn injury with the area of sparing?
- ❑ Was the child in a state of flexion (tensing of the body parts in reaction to what was happening) indicating resistance? Examples of flexion on a child's body include:
  - ☐ Folds in the stomach.
  - ☐ Calf against back of thigh.
  - ☐ Arms tightened and held firmly against body or folded against body.
  - ☐ Thighs against abdomen.
  - ☐ Head against shoulder.
  - ☐ Legs crossed, held tightly together.

Reenactment of the Incident

Objectivity is without a doubt the most important quality you should possess as an investigator. Reenacting the incident as given to you by the witness is a good way to obtain objective information and to answer any questions you may have. Using yourself or another adult, but never the child, you can reenact the incident at the scene, at your home or office, and, ultimately, in court as demonstrative evidence. The following are examples of useful reenactment of the incident:

- When investigating wet contact injuries, use water with blue dye to re-create the incident and then photograph the results, which often clearly show that the child's burn injury pattern is not consistent with the pattern that would have resulted from the described incident.
- The fact that the time of exposure, temperature of the water, and degree of the burn are all related will test the accuracy of the caretaker's reenactment of the incident.
- If the suspect re-creates the incident using cooler water, thinking that if hot water is used it will look incriminating, you can point out that if the water had been at that temperature, the child would have to have been held still for a long time in order to receive the degree of injury sustained.

Another example is a burn that a witness claims happened because the child was playing with a disposable cigarette lighter. Cigarette lighters cause a specific injury pattern. Take an inkpad, re-create the top of the lighter on a piece of paper, and note the pattern. Next, using the inkpad, re-create the pattern on different parts of your body. You will see that it is difficult to make an impression without distorting the pattern and that the pattern is different on soft tissue as opposed to hard, bony parts.

Moreover, if the lighter has a safety switch, as most disposable lighters now do, could the injured child have released the safety switch, lit the lighter, kept the flame lit, and burned the area of the body that was injured without burning his or her own hand, especially the thumb closest to the flame?

Documentation

The following elements are important in diagramming and photographing the scene:

- When diagramming, be sure to include all items in the room where the incident occurred. Children often climb when they

are exploring. You may think the sink is too high for access by the child, but a determined child may have climbed from a step stool, to the toilet seat, to a hamper, and then the sink.

- Accurate measurements of the items involved in the incident—tub, basin, stove height, height to object, etc.—are essential. Photographs of these items should document the size and shape of the item and should contain a measure scale.
- Always use color 35mm film for photographs. It will give you maximum clarity and detail and is best suited for making enlargements for court evidence. Instant cameras are acceptable but do not give the same clarity and produce photographs less suitable for enlargements.

All body parts should be photographed. Photographs should include a standard front, standard back, standard left, and standard right. The significantly burned areas should be particularly well photographed. Reliable testimony, however, should not be based solely on photographs or drawings. Testimony from the treating physician or medical personnel who conducted a hands-on evaluation of the child is critical and more effective.

Working With Other Agencies

Fire and rescue teams are usually the first responders to a 911 call for a burn victim. Their observations of the scene and their communication tapes verifying the response time provide valuable information.

Another important agency is the Department of Social Services. It is advisable to work closely with the child protection services team, for their cooperation can result in evidence and information law enforcement may not be aware of. In fact, joint training sessions of social services, medical, emergency response, and prosecutorial personnel can benefit everyone—victim and investigators.

Contributing Authors

Phylip J. Peltier
Criminal Investigator
Butte County District Attorney's Office
Special Victims Unit
25 County Center Drive
Oroville, CA 95965
530–538–5224

Gary Purdue, M.D.
Professor, Department of Surgery
The University of Texas
Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, TX 75390–9158
214–648–2041

Captain Jack R. Shepherd
Commander, Executive Division
Office of the Director
Michigan State Police
714 South Harrison Road
East Lansing, MI 48823
517–336–6552

Supplemental Reading

Besharov DJ. *Combating Child Abuse: Guidelines for Cooperation Between Law Enforcement and Child Protective Agencies.* Washington, DC: AEI Press, 1990.

Butler KD, Chadwick DL. Child abuse. In Warner CG (ed): *Emergency Care: Assessment and Intervention.* 2d ed. St. Louis, MO: Mosby, 1978.

Deitch EA, Staats M. Child abuse through burning. *Journal of Burn Care and Rehabilitation* 3:89–94, 1982.

DePanfilis D, Salus MK. *A Coordinated Response to Child Abuse and Neglect: A Basic Manual* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, 1992.

Fowler J. Child maltreatment by burning. *Burns* 5:83–85, 1978.

Gary FP, Hunt JL, Prescott PR. Child abuse by burning—An index of suspicion. *Journal of Trauma* 28(2):221–224, 1988.

Gil DG. *Violence Against Children: Physical Child Abuse in the United States.* Cambridge, MA: Harvard University Press, 1970.

Helfer RE, Kempe RS (eds). *The Battered Child.* 4th ed. Chicago, IL: University of Chicago Press, 1987.

Hight DW, Bakalar HR, Lloyd JR. Inflicted burns in children: Recognition and treatment. *Journal of the American Medical Association* 242:517–520, 1979.

Lenoski EF, Hunter KA. Specific patterns of inflicted burn injuries. *Journal of Trauma* 17:842–846, 1977.

MacMillan BG, Freiberg DL. Special problems of the pediatric burn patient. In Hummel RP (ed): *Clinical Burn Therapy.* Boston (MA), Bristol, and London: John Wright/ PSG Inc., 1982.

Moritz AR, Henriques FC. Studies of thermal injury: II. The relative importance of time and surface temperature in the causation of cutaneous burns. *American Journal of Pathology* 23:695–720, 1947.

Pence D, Wilson C. *The Role of Law Enforcement in the Response to Child Abuse and Neglect* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, 1992.

Purdue GF, Hunt JL. Child abuse by burning. In Ludwig S, Kornberg A (eds): *Child Abuse: A Medical Reference.* New York, NY: Churchill Livingstone, 1992, pp. 105–116.

Schanberger JE. Inflicted burns in children. *Topics in Emergency Medicine* 3:85–92, 1981.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Stone NH, Rinaldo L, Humphrey CR, et al. Child abuse by burning. *Surgical Clinics of North America* 50:1419–1424, 1974.

Whitcomb D. *When the Victim Is a Child.* 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Organizations

American Burn Association
800–548–2876

Fox Valley Technical College
Criminal Justice Department
Law Enforcement Training Programs
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54914–2277
800–648–4966
920–735–4757 (fax)
http://www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas: recognition of signs of abuse, collection and preservation of evidence, preparation of cases for prosecution, techniques for interviewing victims and offenders, and liability issues.

Fox Valley also offers an intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Burn Victim Foundation
246A Madisonville Road
Basking Ridge, NJ 07920
800–803–5879
908–953–9091
908–953–9099 (fax)

The Phoenix Society for Burn Survivors, Inc.
2153 Wealthy Street SE., Suite 215
East Grand Rapids, MI 49506
616–458–2773
Burn survivor toll-free line: 800–888–BURN
Burn camps in the United States and abroad: 800–888–BURN
http://www.phoenix-society.org

Shriners Hospital Referral Line
2900 Rocky Point Drive
Tampa, FL 33607
800–237–5055

Shriners Burn Institutes

Boston Unit
51 Blossom Street
Boston, MA 02114
617–722–3000

Cincinnati Unit
3229 Burnet Avenue
Cincinnati, OH 45229
513–872–6000

Galveston Unit
815 Market Street
Galveston, TX 77550
409–770–6600

Sacramento Unit
2425 Stockton Boulevard
Sacramento, CA 95817
916–453–2000

Trauma Burn Center
University of Michigan Medical Center
1500 East Medical Center Drive
Ann Arbor, MI 48109–0033
734–936–9666

In addition, many communities have their own burn centers, which can be identified through local hospitals.

Record the name, location, and number of your nearest burn trauma unit here.

_____

_____

_____

(_____) _____

Instructions for Evidence Worksheet for Immersion Burns

Section A

The location should include the address and room in which the burn occurred.

Section B

Two investigators are required to gather the information on the worksheet. You will need an immersion thermometer, a 35mm camera, a measuring device, and a watch with a second hand.

Photograph the scene with a 35mm camera. Use a ruler, yardstick, or tape measure in all photographs.

Sketch the scene including all objects in the area. Be sure to include the distance from the basin or tub in relation to nearby objects and the dimensions of furniture, fixtures, etc.

Section C

One investigator holds the thermometer so that the water from the faucet is hitting at the immersion line on the thermometer. That person notes the starting temperature, which is recorded by the other investigator, who is also holding the watch. The first investigator calls out the time and the second investigator calls out the temperature in response, recording it at 5-second intervals (or when the temperature remains constant for 15 seconds). **Note:** The person holding the thermometer should not be wearing glasses since the steam will fog them up.

When recording the hot and cold water temperature together, turn the faucets on full and record when the temperature remains constant for 15 seconds.

Section D

After the tub or basin is filled, you can hold a low-key interview with the caretaker and/or witnesses while checking the temperature at 5-minute intervals.

Section E

Have the suspect show you how he or she ran the water when the burn occurred. If the suspect wants to run the water deeper than 5 inches, allow this and note it on the worksheet.

EVIDENCE WORKSHEET FOR IMMERSION BURNS

A

Case No.

Present Date:

Suspect's Name:

Victim's Name:

Incident Location (within dwelling):

Address:

City/State/Zip:

B

Bathtub Measurements (measurements should be made in inches)

Width: Inside Depth:

Top Length: Bottom Length:

Construction (porcelain, fiberglass, plastic, etc.)

C

Running Water Temperatures (in Fahrenheit)

HOT

Seconds	Degrees
0	_____
5	_____
10	_____
20	_____
_____	_____

COLD

Seconds	Degrees
_____	_____

Running Water Temperature
(Full Hot and Cold)
Seconds _____ Peak Temp. _____

D

Full Tub; Standing Hot Water, 5 Inches Deep
(temperature measured in middle of tub at water mid-depth)

FILL TIME

Inches	Minutes/Seconds
1	_____
2	_____
3	_____
4	_____
5	_____

Minutes	Degrees
0	_____
5	_____
10	_____
15	_____
20	_____
25	_____
30	_____

E

_____ ran a tub of water on my request.
Results: Depth 5 inches. One minute after water off: Temperature _____ degrees Fahrenheit.

Investigator #1 _____ ID# _____ Division _____
Investigator #2 _____ ID# _____ Division _____

Source: Phylip J. Peltier, Criminal Investigator, Oroville, California

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association
(ABA)
Center on Children and
the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association
(AMA)
Department of Mental Health
Chicago, Illinois
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society
on the Abuse of Children
(APSAC)
Oklahoma City, Oklahoma
405–271–8202
405–271–2931 (fax)

Federal Bureau of Investigation
(FBI)
National Center for the
Analysis of Violent Crime
Quantico, Virginia
703–632–4333

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse
(JJC)
Rockville, Maryland
800–638–8736
301–519–5600 (fax)

Kempe Children's Center
Denver, Colorado
303–864–5252
303–864–5302 (fax)

National Association of Medical
Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing
and Exploited Children
(NCMEC)
Alexandria, Virginia
703–274–3900
703–274–2220 (fax)

National Center for the
Prosecution of Child Abuse
Alexandria, Virginia
703–549–4253
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on
Child Abuse and Neglect
Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource
Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Battered Child Syndrome: Investigating Physical Abuse and Homicide

Portable Guides to Investigating Child Abuse

Foreword

Battered child syndrome is a tragic and disturbing phenomenon. Unfortunately, it is a crime that is often successfully hidden by its perpetrators. Law enforcement has an important role to play in uncovering cases of battered child syndrome and gathering evidence for their successful prosecution.

This guide contains practical information on the circumstances that point to the willful rather than the accidental injury or death of an infant or child and the specific evidence required to prove it. It places special emphasis on obtaining an expert medical examination, immediately documenting the injuries through photographs, and collecting and preserving physical evidence. The guide also shows investigators how their interviews with caretakers, family members, neighbors, school personnel, and others can shed light on the treatment the child has received over time and produce witnesses who can corroborate or refute suspected abuse.

Many jurisdictions are beginning to develop training programs to help police investigate this crime more effectively. I recommend this guide as an important contribution to this end and as an aid to child protection personnel and others in a position to identify, investigate, and prosecute cases of battered child syndrome.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

August 1996

Third Printing March 2000

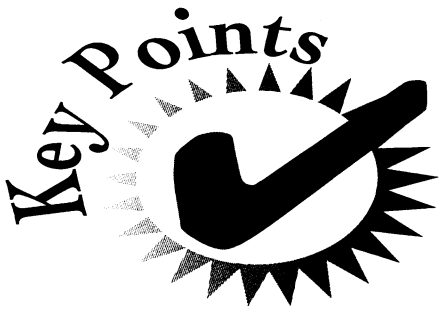
NCJ 161406

Overview

Investigators should have a working knowledge of battered child syndrome and what it means to an investigation. Battered child syndrome is defined as the collection of injuries sustained by a child as a result of repeated mistreatment or beating. If a child's injuries indicate intentional trauma or appear to be more severe than could reasonably be expected to result from an accident, battered child syndrome should be suspected. In such cases, an investigator must do more than collect information about the currently reported injury. A full investigation requires interviewing possible witnesses about other injuries that the child may have suffered, obtaining the caretakers' explanation for those injuries, and assessing the conclusions of medical personnel who may have seen the victim before.

The issue of whether information on the victim's prior injuries or medical conditions will be admissible at a trial should be left to the prosecutor. However, an investigator's failure to collect such information leaves the prosecutor without one of the most important pieces of corroborative evidence for proving an intentional act of child abuse. Evidence of past inflicted injuries also may be the only information available to help the prosecutor distinguish between two or more possible perpetrators in the current case, and may help refute claims by the child's parents or caretakers that injuries suggestive of physical abuse were caused by an accident.

Critical Steps in Investigating Battered Child Syndrome



Investigators confronted with a case of possible child abuse or child homicide must overcome the unfortunately frequent societal attitude that babies are less important than adult victims of homicide and that natural parents would never intentionally harm their own children. When battered child syndrome is suspected, investigators should always:

- Collect information about the "acute" injury that led the person or agency to make the report.
- Conduct interviews with the medical personnel who are attending the child.
- Review medical records from a doctor, clinic, or hospital.
- Interview all persons who had access to or custody of the child during the time in which the injury or injuries allegedly occurred. **Always interview the caretakers separately—joint interviews can only hurt the investigation.**
- Consider any statements the caretakers made to anyone concerning what happened to the child who required medical attention.
- Conduct a thorough investigation of the scene where the child was allegedly hurt.

Interviews With Medical Personnel

The investigator must contact all medical personnel who had contact with the family, such as doctors, nurses, admitting personnel, emergency medical technicians (EMT's), ambulance drivers, and emergency room personnel:

- Talk with those who provided treatment for the child about what diagnoses and treatments were used. The attending physician will often be able to express at least an opinion that the caretakers' explanation did not "fit" the severity of the injury. **Failure to obtain an opinion from the attending physician should *not* end the investigation.**
- Speak with any specialists who assisted the attending physician.
- Have someone knowledgeable about medical terms translate them into laypersons' terms so that the exact nature of the injuries is clear.

- Obtain available medical records concerning the injured child's treatment, including records of any prior treatment. **Note:** If only one caretaker is suspected of abuse, the nonabusive caretaker may need to sign a release of the records. If both are suspected, most States have provisions that override normal confidentiality rules in the search for evidence of child abuse. Procedures for obtaining these records must be confirmed in each State.
- Interview the child's pediatrician about the child's general health since birth and look for a pattern of suspected abusive injuries.

It is absolutely vital that photographs of the child be taken as soon as possible after the child has been brought to the treatment facility. Most clinics and hospitals have established procedures for photographing injuries in obvious cases of abuse, but when the injuries are more subtle, they may overlook the need for photographs. The investigator should make sure that the medical personnel take and preserve photographs or that the investigating team takes them.

In a child homicide investigation, an autopsy must be performed. Most States mandate that such autopsies be performed when the death of any child under a certain age is undetermined or suspicious. In States without such a statutory mandate, the medical examiner or local prosecutor often has the authority to order an autopsy. This authority should be used whenever there is an unexplained death of a child.

Other Important Sources of Information

- Interview siblings, other relatives, neighbors, family friends, teachers, church associates, and others who may know about the child's health and history. People who surround the child and are part of his or her life are sometimes overlooked as sources of background information for a child abuse or homicide prosecution.
- Review EMT records or 911 dispatch tapes. These records are frequently overlooked and can be a valuable source of information. Families with more than one emergency may in fact be abusing children and may not just be hit by a long streak of "bad luck."
- Once the family history is obtained, request any police reports that may be held by law enforcement agencies in the jurisdiction where the family lives. Also check the child welfare agency's files on the family.

- Collect additional family history concerning connections between domestic violence and child abuse, substance abuse and child abuse, and other such connections, even apparently unrelated arrests or charges. These records may be helpful in piecing together the complicated picture of what happened to the child this time and who was responsible.

Consultation With Experts

Identifying experts is as important to the child abuse investigator as identifying and cultivating street informants in other types of investigations. If the investigator does not have a basic knowledge of the causes of young children's injuries, experts may be difficult to identify. Attending training conferences can provide the investigator with a great deal of basic knowledge and help establish a network of experts.

Interviews With Caretakers

A major trait of abusive caretakers is either the complete lack of an explanation for critical injuries or explanations that do not account for the severity of injuries. The investigation must not be dictated solely by caretakers' early explanations, because once they learn those do not match the medical evidence, they will come up with new ones.

In child homicide cases, for example, investigators will learn quickly about "killer couches," "killer stairs," and "killer cribs." Abusers frequently use these items in their explanations of a child's death. However, studies show that children do not die in falls from simple household heights; they do not even suffer severe head injuries from such falls.

In nearly every case of actual abuse, the caretakers will not be consistent in their explanations of the injuries over time. Sometimes the changes are apparent from statements abusers have made to others. Additional interviews may be needed to document the changing explanations and to follow up on additional information that the investigation uncovers.

Crime Scene Investigation

Caretakers' changes in explanations often mean investigators must visit the home or the scene of the injury more than once. The ideal time to obtain such evidence is immediately after the

Investigator's Checklist for Interviewing Caretakers

Investigators should ask the following questions to ensure a thorough interview with the caretakers.

- ❑ When did the caretakers first notice the child was ill or injured, and what exactly did they observe? What do they believe caused the illness or injury?
- ❑ Who was with the child at the time of the injury or when the child first appeared ill? (Cover as much time as possible up to 3 to 5 days.)
- ❑ What was the child's apparent health and activity level for the same period up to the time of the illness? Exactly how did the symptoms develop?
- ❑ What is the child's health history since birth?
- ❑ Has the child been hospitalized or treated for prior injuries or illnesses? If so, what treatment was needed or what caused those injuries?
- ❑ Which caretaker normally disciplines the child, and what form of discipline is used?
- ❑ What is the health of other children in the family?
- ❑ Who is the family doctor or the child's pediatrician?
- ❑ Does the child attend school or day care? Who is the child's teacher (or teachers)?
- ❑ Has the child shown any recent behavioral changes that are otherwise unexplained?
- ❑ If the nature of the current injuries is known, how do the caretakers explain what caused such injuries? If no explanation is given, were there times when the child was unsupervised or in the company of others?
- ❑ What is the child's developmental level? (Children who can barely crawl around cannot injure themselves by falling from a two-story building.)

child's injury is reported, before caretakers have an opportunity to tamper with the scene.

If the caretakers do not consent to a search of the scene, a search warrant may be necessary. The strongest evidence of the need for such a warrant will be the medical evidence of what probably happened to the child and the caretakers' inconsistent or absent accounts of the events.

Whatever explanation caretakers offer for the child's injury or injuries, it is vital that the investigator secure physical evidence. Be thorough in obtaining photographic evidence of the location where the injury took place. Physical evidence and records that must be preserved include:

- The crib from which the child allegedly fell.
- The child's "environment," including bedding within the bed or crib and other beds in the home.
- Any toys or objects the child allegedly landed upon.
- In cases where the child was apparently burned, a record of any sinks, bathtubs, and pots or pans containing water. In addition to testing the temperature of the standing water, test the temperature of water from the water heater and from each tap. Check the temperature setting of the water heater. This may help disprove an allegation that the child accidentally turned on the hot water. Other sources of heat in the home should be documented, regardless of the caretakers' initial explanation of what burned the child.
- A complete photographic or videotaped record of the home or other location in which the injuries allegedly occurred. Focus on areas that the caretakers already have identified as the site of the particular trauma (i.e., stairs, beds or crib, or bathtub).

Investigators should be trained by their local crime laboratory personnel on the types of evidence that can and should be processed and preserved in these cases:

- If the child apparently suffered cigarette burns, collecting cigarette butts found in the home may facilitate analysis of the burn patterns.
- If the case involves a combination of sexual and physical abuse, collecting the child's clothing and bedding may allow identification of what happened and who was involved.
- If the child shows evidence of bite marks, saliva swabbing should be done to allow positive identification of the biter.

- If the child has suffered a depressed skull fracture, any objects the approximate size of the fracture should be seized for appropriate analysis.

Investigative Guidelines for Child Homicides

It is not always readily apparent that a child's death was the result of homicide. In some cases, homicide is evident:

- It is fairly obvious that the child's death was caused by an abusive injury.
- The person who had custody of the child at the time the abusive injury was inflicted is known. Most infant deaths occur when the baby is in the care of known individuals.
- The injuries themselves are obviously the result of a deliberate intent to do harm—that is, there is really no debate that someone abused the child and that the abuse caused the child to die. Such cases include strangulation, beating, severe inflicted burns, such as scalding, and the use of a weapon.

Unfortunately, the more careful and planned out the killing is, the less likely it is that a medical explanation for the death will be found. Most fatal injuries resulting from abuse are much more subtle than poisoning, beating, bludgeoning, shooting, or strangulation. Suffocation, for example, often leaves absolutely no medical sign of the cause of death. Most infant deaths are related to head injuries, some of which leave no external sign of trauma.

In case after case of suspicious deaths of children, the caretakers' explanation is: "She fell off the couch (chair, changing table, or bed, or down the stairs)." Investigators must be aware that **children do not die of simple falls.** When investigating whether a child's death was a homicide, investigators must ask themselves the following questions:

- How do we find out what actually did happen to the child?
- How do we make sure we are talking to the right expert about what could have caused the child's death?
- How do we know we have talked to everyone who might be able to shed light on a difficult case?

When presented with a child who has died under suspicious circumstances in which there is no obvious sign of abuse, investigators should ask an experienced pediatrician to help locate a specialist whose medical expertise can help make sense of a confusing picture. However, everyone who handles child fatalities must have a basic understanding of the following conditions:

- Shaken baby syndrome.
- Munchausen syndrome by proxy.
- Sudden infant death syndrome (SIDS).

Shaken Baby Syndrome

The classic medical symptoms associated with infant shaking are:

- Retinal hemorrhage (bleeding in the back of the eyeball), often bilaterally (in both eyes).
- Subdural or subarachnoid hematomas (intracranial bleeding, most often in the upper hemispheres of the brain, caused by the shearing of the blood vessels between the brain and the dura mater or the arachnoid membrane).
- Absence of other external signs of abuse (e.g., bruises), although not always.
- Symptoms including breathing difficulties, seizures, dilated pupils, lethargy, and unconsciousness.

According to all credible studies in the past several years, retinal hemorrhage in infants is, for all practical purposes, conclusive evidence of shaken baby syndrome in the absence of a good explanation. Good explanations for retinal hemorrhage include:

- A severe auto accident in which the baby's head either impacted something with severe force or was thrown about wildly without restraint during the crash.
- A fall from several stories onto a hard surface, in which case there are usually other signs of trauma, such as skull fractures, swelling, intracranial collection of blood, and contusions.

Simple household falls, cardiopulmonary resuscitation (CPR), and tossing a baby in the air in play are not good explanations for retinal hemorrhage. There simply is not enough force involved in minor falls and play activities to cause retinal hemorrhage or the kinds of severe, life-threatening injuries seen in infants who have been shaken.

In most cases of shaken baby syndrome, there are no skull fractures and no external signs of trauma. The typical explanation given by the caretakers is that the baby was "fine" and then suddenly went into respiratory arrest or began having seizures. Both of these conditions are common symptoms of shaken baby syndrome.

The shaking necessary to cause death or severe intracranial injury is never an unintentional or nonabusive action. These injuries are caused by a violent, sustained action in which the infant's head, which lacks muscular control, is violently whipped forward and backward, hitting the chest and shoulders. The action occurs right in front of the shaker's eyes. Experts say that an observer watching the shaking would describe it as "as hard as the shaker was humanly capable of shaking the baby" or "hard enough that it appeared the baby's head would come off." In almost every case, the baby begins to show symptoms such as seizures or unconsciousness within minutes of the injury being inflicted. The baby may have difficulty in breathing, or breathing may stop completely. Often, but not always, when shaking causes death or severe injuries, it has been followed by sudden deceleration of the action caused by throwing the child down onto a surface that may be either soft or hard.

Shaken baby syndrome occurs primarily in children 18 months of age or younger. It is most often associated with infants less than a year old, because their necks lack muscle control and their heads are heavier than the rest of their bodies. An infant cannot resist the shaking, but a toddler can, to some extent. Although the collection of injuries associated with shaken baby syndrome is sometimes seen in toddlers, it is rare and is always a sign of extremely violent and severe action against the child.

Munchausen Syndrome by Proxy

Munchausen syndrome is a psychological disorder in which the patient fabricates the symptoms of disease or injury in order to undergo medical tests, hospitalization, or even medical or surgical treatment. To command medical attention, patients with Munchausen syndrome may intentionally injure themselves or induce illness in themselves. In cases of Munchausen syndrome by proxy, a parent or caretaker suffering from Munchausen syndrome attempts to bring medical attention to themselves

by injuring or inducing illness in their children. The parent then may try to resuscitate the child or to have paramedics or hospital personnel save the child. The following scenarios are common occurrences in these cases:

- The child's caretaker repeatedly brings the child for medical care or calls paramedics for alleged problems that cannot be medically documented.
- The child only experiences "seizures" or "respiratory arrest" when the caretaker is there—never in the presence of neutral third parties or in the hospital.
- When the child is hospitalized, the caretaker turns off the life-support equipment, causing the child to stop breathing, and then turns everything back on and summons help.
- The caretaker induces illness by introducing a mild irritant or poison into the child's body.

Investigative guidelines in suspected cases of Munchausen syndrome by proxy

- Consult with all experts possible, including psychologists.
- Exhaust every possible explanation of the cause of the child's illness or death.
- Find out who had exclusive control over the child when the symptoms of the illness began or at the time of the child's death.
- Find out if there is a history of abusive conduct toward this child.
- Find out if the nature of the child's illness or injury allows medical professionals to express an opinion that the child's illness or death was neither accidental nor the result of a natural cause or disease.
- In cases of hospitalization, utilize covert video surveillance to monitor the suspect. Some cases have been solved in this way.
- Determine whether the caretaker had any medical training or a history of seeking medical treatment needlessly. Munchausen syndrome by proxy is often a multigenerational condition.

Sudden Infant Death Syndrome

Sudden infant death syndrome (SIDS) is not a positive finding; rather, it is a diagnosis made when there is no other medical explanation for the abrupt death of an apparently healthy infant. When a baby dies from shaking, intracranial injury,

peritonitis (inflammation of the peritoneum, that is, the membrane that lines the abdominal cavity), apparent suffocation, or any other identifiable cause, SIDS is not even considered a possibility. SIDS rarely occurs in infants older than 7 months and almost never is an appropriate finding for a child older than 12 months.

A SIDS death is not a homicide, and apparent SIDS cases must be approached with great sensitivity. However, before SIDS can be ruled the cause of death, the investigator must ensure that every other possible medical explanation has been explored and that there is no evidence of any other natural or accidental cause for the child's death.

An investigator's suspicions should be aroused when multiple alleged SIDS deaths have occurred under the custody of the same caretaker. Statistically, the occurrence of two or three alleged SIDS deaths in the care of the same person strongly suggests that some degree of child abuse is involved. Whenever there is evidence that the child who has died was abused, or that other children in the family have been abused, SIDS is not an appropriate finding.

Even when there is no affirmative medical finding of the cause of death, prosecution may still be possible. In some circumstances, experts can explain what occurs when a child is suffocated and can render a medical opinion that suffocation is one of the ways someone could cause the child's death without leaving obvious medical signs.

Conclusion

Both the medical and legal professions have made great strides in identifying nonaccidental trauma inflicted on children. This progress accounts for what appears to be an increase in the number of identified child abuse homicides. Sadly, however, there will always be some children who die of abuse that is never discovered. Children and society deserve investigators' best efforts to turn over every stone in cases involving any suspicion of the abuse of children.

Author

Rob Parrish
Chief Child Abuse Counsel
Office of the Attorney General
160 East 300 South, Sixth Floor
Salt Lake City, UT 84114
801–366–0510
801–366–0204 (fax)

Supplemental Reading

Child Fatalities

Anderson TL, Wells SJ. *Data Collection for Child Fatalities: Existing Efforts and Proposed Guidelines.* Chicago, IL: American Bar Association, 1991.

Combs DL, Parrish RG, Ing R. *Death Investigation in the United States and Canada, 1995.* Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Environmental Health, Division of Environmental Hazards and Health Effects, August 1995.

Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1995 Annual Fifty State Survey. Chicago, IL: National Committee for Prevention of Child Abuse, April 1996.

Granik LA, Durfee M, Wells SJ. *Child Death Review Teams: A Manual for Design and Implementation.* Chicago, IL: American Bar Association, 1991.

Kaplan SR. *Child Fatality Legislation in the United States.* Chicago, IL: American Bar Association, 1991.

Kaplan SR, Granik LA (eds). *Child Fatality Investigative Procedures Manual.* Chicago, IL: American Bar Association, 1991.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

U.S. Advisory Board on Child Abuse and Neglect. *A Nation's Shame: Fatal Child Abuse and Neglect in the United States.* Washington, DC: U.S. Advisory Board on Child Abuse and Neglect, April 1995.

Child Fatality Laws

The following statutory publications are available from the National Clearinghouse on Child Abuse and Neglect Information, 800–FYI–3366, 703–385–7565. Each contains State and territory laws on the given topic.

Child Abuse and Neglect Crimes: Child Homicide.

Child Death Review Teams/Mandatory Autopsies.

Reporting Suspicious Deaths.

Sudden Infant Death Syndrome

National Sudden Infant Death Syndrome Clearinghouse. *Death Investigations and Sudden Infant Death Syndrome: A Selected Annotated Bibliography.* U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, September 1991.

National Sudden Infant Death Syndrome Clearinghouse. *The Professional's Role in Sudden Infant Death Syndrome: A Selected Annotated Bibliography.* U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, September 1991.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome Research: A Selected Annotated Bibliography for 1993.* McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1994.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome Risk Factors: A Selected Annotated Bibliography for 1989–1993.* McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1994.

National Sudden Infant Death Syndrome Resource Center. *Sudden Infant Death Syndrome: Trying To Understand the Mystery.* McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, February 1994.

National Sudden Infant Death Syndrome Resource Center. *What is SIDS?* (Information Sheet). McLean, VA: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, May 1993.

Willinger M, James LS, Catz C. Defining the sudden infant death syndrome (SIDS): Deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatric Pathology* 11:677–684, 1991.

Death Certification and National Death Statistics

The following three references are available from the National Center for Health Statistics (NCHS), Division of Vital Statistics, Registration Methods Branch, 301–436–8815. General information on mortality statistics is available from NCHS, Division of Vital Statistics, Mortality Statistics Branch, 301–436–8884.

Funeral Directors' Handbook on Death Registration and Fetal Death Reporting. Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, September 1987. (DHHS Publication No. (PHS) 87–1109).

Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting. Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, October 1987. (DHHS Publication No. (PHS) 87–1110).

Physicians' Handbook on Medical Certification of Death. Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, September 1987. (DHHS Publication No. (PHS) 87–1108).

Organizations

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007–1098
847–228–5005
847–228–5097 (fax)
Internet: www.aap.org

The American Academy of Pediatrics publishes the following resources for professionals who come in contact with abused children: *The Visual Diagnosis of Child Physical Abuse,* a study guide and teaching slides that provide medical information about identification of physical child abuse and neglect; *A Guide to References and Resources in Child Abuse and Neglect,* a comprehensive manual on the medical diagnosis and treatment of child abuse and neglect; and the CD–ROM *Focus on Child Abuse: Resources for Prevention, Recognition, and Treatment.*

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
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Child Neglect and Munchausen Syndrome by Proxy

Portable Guides to Investigating Child Abuse

Foreword

While lurid tabloid headlines of child abuse command our attention, child neglect is a more common problem. Overlooked instances of child neglect may be devastating for young victims. Accordingly, it is imperative that allegations of child neglect be investigated thoroughly and documented in detail. *Child Neglect and Munchausen Syndrome by Proxy* provides helpful points toward those ends.

To determine instances of child neglect, we must have a clear understanding of parental duty. The guide defines and delineates this crucial concept. The interconnections between poverty and neglect are explored, while critical distinctions in the latter's causes are maintained. The ways in which children are neglected and in which cases of neglect may be detected are also described.

The final section of the guide addresses Munchausen syndrome by proxy. This syndrome is a form of child abuse in which the caregiver fabricates the child's purported illness. Its victims may be at risk for serious injury and even death. Diagnostic criteria are detailed, and investigative techniques noted.

Neglecting children may be criminal. We must not compound that crime with our own neglect of its victims. This guide is a useful tool to ensure that does not occur.

Original Printing September 1996

Second Printing August 1997

Third Printing March 2001

NCJ 161841

Overview

Child neglect is as specific a finding as child abuse, though it is more common and often more devastating. Despite this, cases of child neglect are sometimes investigated and documented poorly, simply because the definition of neglect is not clear to the investigator, who then may not be sure what precisely to look for. A definition of neglect allows investigation, collection of evidence, documentation, and court proceedings.

The cornerstone of neglect is the concept of parental duty. Parents have duties because, until many years after birth, the offspring of our species cannot look after their own basic biological needs and survival (this is quite unlike almost every other species on the planet). Our youngsters cannot gather food, protect themselves from the elements or from predators, or recognize danger. Thus, in the performance of this duty, parents do for children what the children cannot yet do for themselves. Parents thereby hugely decrease the chances of children's injury or early death.

From a practical standpoint, a parent fulfills this duty by doing certain things that promote growth, safety, and health (such as feeding the baby regularly, watching the toddler in the park, or taking the child to the doctor when sick) and protecting the child from harm (for instance, preventing a toddler from climbing a 10-foot ladder).

For various reasons, parents cannot always promote growth, health, and safety to an optimal level, either because of their own limitations, some restraint on them by their environment, or other reasons. Also, not all harm is predictable or preventable. Therefore, parents must not be held to a standard of perfect care. When the parental care falls below a *reasonable* or *prudent* level, the child may be neglected. (Throughout this guide, "parent" is meant to include any designated adult caregiver.)

The following is a working definition of the parental duty, against which neglectful parental care may be measured:

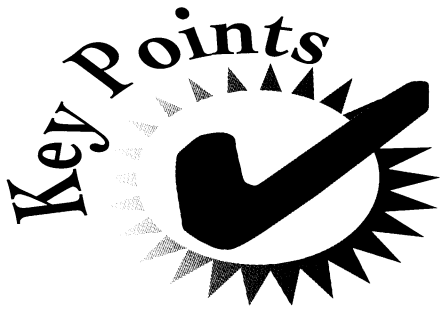
The child has the right to expect, and the parent has a duty to reasonably and prudently provide, food, clothing, shelter, supervision, medical care, nurturance, and teaching.

Specifically, these are defined as:

- **Food.** A child needs food and milk in order to fuel body growth and developmental progress. A healthy baby should double birth weight by 4 to 6 months and triple it by about 1 year. The breast milk or formula given should be supplemented at about 6 months with baby foods. Food should be of a quality, texture, and size that is appropriate for the child's age. Usual growth throughout childhood is indicated on standardized growth curves (available from any pediatrician).
- **Clothing.** Children must have clothing that is reasonably appropriate to the prevailing climate and that is cleaned and repaired at least to a minimally adequate standard.
- **Shelter.** Shelter must be provided that adequately protects the child from extreme weather, is safe, and allows a place to sleep.
- **Supervision.** The purpose of supervision is (1) the prevention of reasonably foreseeable and avoidable injuries to the child, and (2) the prompt intervention when harm is in progress or has occurred. Children need supervision because they do not have the ability to anticipate, recognize, or react to danger.

What a parent should do to prevent injuries and protect the child from harm depends upon the age and developmental stage of the child. The key question is: Would any *prudent* parent of a child at *this* age and stage also do this?

- **Medical care.** The purpose of medical care is the prevention or treatment of disease and the maintenance of health. The parent has the duty to seek and obtain needed medical care for the child.
- **Nurturance.** In this context, nurturance is attentive, responsive parental behavior that takes place throughout childhood and promotes attachment to a primary caretaker. Nurturance helps the child to develop gross motor, fine motor, language, personal, and social skills, including a good self-image. Nurturance also includes the setting of attainable, age-appropriate goals for the child's development.
- **Teaching.** The parent has a duty to ensure that the child receives teaching on language usage and comprehension, social interaction, and behavioral limits—all of these appropriate for the child's age and environment.



This guide offers important information on what parents or other primary caretakers must provide to meet the duties defined above. It suggests actions the investigator can take to gather information on individual cases of child neglect, so that children can be protected from further neglect and the case investigated for possible criminal or civil court action. Information on Munchausen syndrome by proxy—an unusual though increasingly recognized form of child abuse, to which today's investigators should be alerted—is also provided.

Neglect and Poverty

Poverty and neglect sometimes coexist. It is important to distinguish the neglect caused by poverty from the neglect not caused by poverty. The following are examples of child neglect *not* caused by poverty:

- Absence of, or poor, attachment. Some children—having no one else—are highly attached to dangerous and abusive parents.
- Failure to feed the child adequately, even though food is available.
- Chronic or flagrant failure to supervise the child.

- Lack of appropriate and consistent setting of limits.
- Lack of developmental stimulation.
- Lack of emotional nurturance and guidance for emotional growth.
- Failure to ensure that the child receives appropriate medical care, especially when the care is accessible and free or affordable. This may occur because of lack of judgment or motivation.
- Failure to send the child to school regularly.

How Children Are Neglected and How To Detect Cases of Neglect

The ways in which parents neglect their children can be classified as follows:

- Failure to provide the things children need to grow and stay healthy.
- Failure to supervise the children to keep them from harm.
- Failure to intervene when children are ill, injured, or threatened by others.

Failure To Provide Food

Failure to provide food results in one or both of two medical conditions: *acute starvation* or *failure to thrive.*

- **Acute starvation** is the result of lack of food on a short-term basis. The child may not appear malnourished, but the result may be illness or death.
- **Failure to thrive** is the failure of the child to gain weight as expected for normal growth. This may mean that the child has actually lost weight or that the child's rate of weight gain is inadequate. Failure to thrive may be either the result of a disease or the result of inadequate nutrition in an otherwise healthy child. When failure to thrive is caused by inadequate nutrition and is accompanied by emotional deprivation, it is called *nonorganic failure to thrive.* Nonorganic failure to thrive is commonly the result of neglect and may cause illness or death.

Evidence at the scene

- Look for drugs and alcohol.
- Check the home for baby bottles. Look in or under the crib, in the refrigerator, on the counter, and under the parent's bed. Look for curdled contents in the bottle. Smell the contents to see if the fluid is rancid. It may be helpful to have the fluid in the bottle analyzed for concentration, contaminants, and drugs or toxins.

- Look for cans of baby formula (formula comes as a powder, as a concentrate, and in ready-to-feed form) in the cupboards and the refrigerator. Note how much there is or if there is none. Ask parents specifics about the child's feeding habits, including the amount and frequency of usual milk intake. Ask about recent intake (past 24 to 48 hours) and behavior: Is the child alert? playing? ill? Does the child have any medical symptoms?
- It is generally not possible to assess the health of a fully clothed or sleeping child. When in doubt, the child should be immediately evaluated medically.
- Look for grocery store receipts. Check them to see if any infant formula or food was purchased, how much, and over what period of time.

Check records

- Talk to the pediatrician. Is this nonorganic failure to thrive? Have all organic explanations for the child's condition been ruled out? How? What is in the medical record? Is there information not recorded in the medical record that is known by the pediatrician from prior visits with the child?
- Check visiting nurse service records, which are often kept separately from medical records. What did the nurse see in the home? Unattended children? Propped bottles? Drugs? Alcohol? Parents passed out? Young children babysitting? Parents ignoring a hungry, crying child?
- Check the records of the child welfare agency.
- Find the medical records, death certificates, and autopsy records for other deceased children.
- Talk to the pathologist. How long had the child been without food? (Sometimes an approximation can be given.) What is the cause of death? What is the manner of death? If the cause of death is a condition that is usually not fatal in childhood (such as pneumonitis), would this child have died if there had been no malnourishment?

Failure To Provide Fluids

Failure to provide fluids results in dehydration—that is, there is not enough fluid in the body to maintain normal physiological functioning. There are many disease-driven causes of dehydration. However, in cases of child neglect, the most common ways a child becomes dehydrated are from traveling for long, uninterrupted periods in arid country or as punishment for a toileting accident or drinking. In those situations, the child is restricted from drinking. Sometimes, the child has vomiting or diarrhea that is severe, and the child

is clearly deteriorating, but the parent does not seek medical care because of lack of motivation or judgment, or for religious reasons.

Since dehydration is commonly seen in pediatrics, and since it is largely *not* consequent upon neglect, have the doctors help ascertain whether neglect is involved.

Evidence at the scene

- Look for restraints to keep the child from drinking.
- Look for a locked refrigerator or evidence of fluids rendered inaccessible.
- Look for dirty laundry with vomitus; diapers with diarrhea.

Failure To Provide Medical Care

Neglect occurs when the parent does not make certain that the child is receiving needed medical care. Obviously, the severity of such neglect can vary considerably.

Children may become ill from acute or chronic medical problems. There are several reasons why parents fail to seek medical care for their ill children:

- Religious beliefs.
- Fear of being apprehended for having abused the child or for having witnessed the abuse.
- Costs.
- Underestimation of the severity of the problem.
- Lack of judgment or motivation.

Diagnostic criteria

The parent has the duty to:

- Recognize obviously severe illness in a child.
- Bring the seriously ill child for medical care without delay.
- Comply with medical instructions which, if carried out, would reduce or eliminate the significant risk of substantial harm.

When the parent's avoidable acts of omission or commission result in harm, significant risk of substantial harm, or the death of the child, and when such acts could or should have been foreseen to be imprudent, a child is medically neglected. The risk or harm to the child may be temporary or permanent.

Who to talk to and what to ask

Talk to the general pediatrician, any subspecialists who looked after the child, and the pediatric or forensic pathologist if the child died.

- What were the potential benefits of medical care?
- What were the potential risks of medical care?
- What was the expected outcome in the child without the medical treatment? Did the parent know this?
- Did the parent have access to medical care? Access to private or public transportation, or an ambulance?
- What was the parent's track record, over time, in getting the medical care?
- Was the child's degree of illness or outcome caused slightly, somewhat, largely, or completely by the parents' failure to seek medical attention?
- What is the view of the parent's conduct from within his or her own culture? Does the cultural standard fall beneath a standard of minimally adequate care?

Evidence at the scene

- Check prescription bottles. Given the date of issue, the amount remaining in the bottle, and the prescribed dose, is there too much in the bottle? That is, was enough medicine given? Is the bottle empty, indicating the prescription had not been refilled as prescribed?
- If the child was supposed to be receiving oxygen at home, look for the oxygen tank. Is it too full? Is it empty? Check the tag for the date the tank was delivered, or contact the oxygen company for this information.
- Look for evidence of parental drug or alcohol abuse.

Other records

- Check the pharmacy records. How often were prescriptions refilled? Would the quantities have been sufficient for the length of time the child needed medication? When was the last prescription dispensed?
- Contact the visiting nurse service. Children who are chronically ill sometimes have nurses visit them at home. Check records for notes concerning the adequacy of medical supplies in the home, the amount of teaching given to parents by the visiting nurse, and the physical, intellectual, and psychological capabilities of the parents to attend to the child.

Failure To Provide Nurturance

Nurturance neglect is the failure to provide attentive, responsive care during childhood, resulting in damage to the child. There are some circumstances where the risk and outcome for the child are so severe that civil or criminal court involvement (or both) results. Nurturance neglect rarely occurs without other neglect or abuse. Examples of the results of nurturance neglect are:

- Extreme developmental and psychological abnormality in a child who has been terribly neglected emotionally.
- Psychosocial dwarfism: short stature in childhood as a result of severe parental neglect.

Evidence at the scene

- Look for one small room that appears to have been perpetually inhabited. It may be locked or sealed off.
- Check for urine, feces, food particles, and dirty dishes.

Failure To Supervise

Parents have a duty to protect the child from situations and persons they know, or should have known, to be dangerous, and the duty to intervene in behalf of the child in a timely way. Parents can only be expected to carry out this duty within the boundaries of their capabilities, assuming those capabilities have not been compromised by the parents themselves. For example, a drunk parent, but not a wheelchair-bound parent, may be accountable for failure to rescue a child in a fire.

Supervision neglect occurs when the parents fail to provide attendance, guidance, and protection to children who, lacking experience and knowledge, cannot comprehend or anticipate dangerous situations. In failure-to-supervise cases, the parent's expectations of the child exceed the child's capabilities.

Usual situations

- The parent is in the home or with the child but does not supervise. The parent may or may not be impaired as a result of drugs, alcohol, mental illness, physical illness, immaturity, or low intelligence.
- The parent is not in the home or with the child, and has entrusted the child either to no one, to an inappropriate babysitter, or to a sibling who is not capable of providing adequate supervision.

Although none of the following examples in and of itself constitutes supervision neglect, the examples show the kinds of incidents that are most commonly associated with parental failure to supervise:

- Fire, resulting in smoke inhalation, carbon monoxide poisoning, or burns.
- Falls from windows and stairwells.
- Drowning.
- Poisoning and ingestion of toxic substances or dangerous objects.
- Leaving children unattended in cars, resulting in hypothermia (low body temperature), hyperthermia (high body temperature), dehydration, kidnapping, or assault.

Evidence at the scene

- In the case of a child who has been left unattended at home, look for restraints meant to keep the child in a bed or tied to a doorknob or other fixture in the parent's absence.
- When a child has been left unattended in a car, measure the temperature both inside and outside the car; find out the humidity from the weather bureau.
- When an unattended child has taken a toxic or lethal amount of drugs, alcohol, or some other toxin, look for traces of these in the home. Where are they kept? How much of the bottle or package contents remains?

Other sources of information

- Speak to neighbors and delivery people who have recently visited the home to learn if the children were chronically left alone.
- Check the school records to see if older children in the family are often absent, and ask school authorities if they stay home to look after the younger ones.

Factors to consider when deciding to seek civil or criminal court involvement

- The child's age and stage of development. These may not be the same. For example, a 14-year-old may be developmentally delayed to the level of a 6-year-old. Supervision must be provided to children based on their *actual capabilities,* that is, their developmental stage.
- The length of time the child was left unsupervised.
- The circumstances under which the child was left unsupervised. What was the potential hazard? How obvious was it or how obvious should it have been?

- The parent's condition, such as physical and mental capabilities. Is the parental I.Q. less than 80? Is the parent physically handicapped? Psychologically handicapped? How severely? Why?
- A history of chronic supervision neglect.
- The cultural acceptability of parental care. Is the supervision standard of the culture to which the parents belong below what is reasonable or prudent? Is it even minimally adequate?
- If the parents are poor, did the poverty unavoidably cause supervision neglect, or did the poverty merely coexist with supervision neglect but not cause it?

Failure To Intervene

Failure to intervene exists when:

- One parent sees, hears, or knows of another adult abusing or neglecting a child and could intercede on the child's behalf but does not.
- One parent could secure timely medical attention for a child who has been abused or neglected by another adult but does not.

Common reasons given by parents who failed to intervene

- "I didn't know the child was injured," or "He just started looking sick."
- "I was afraid that the authorities would arrest me or take my child away."
- "I was afraid for myself." "I didn't want to be disloyal." These statements are commonly made by women who are victims of battering, or by some women who invent battering to absolve themselves.

What to look for in the medical records and at autopsy

One of the problems most often encountered in failure-to-intervene cases is that the parent who failed to seek medical care for the child says that the child did not appear ill. Every illness and injury has its usual tempo, or usual rate of progression. Furthermore, most children with a given illness or injury demonstrate particular symptoms and signs. Therefore, ask the physicians involved:

- What is the usual tempo of this injury?
- Would the child have visible or audible signs of illness? What are they? When would they have occurred?

Evidence at the scene

- Signs of a struggle between parent and child, such as dried blood on the bathroom floor, which can be DNA fingerprinted.
- Evidence of vomiting, on floor or furniture surfaces, or on clothing, cloths, towels, etc., in the laundry or garbage.
- Other abused and neglected children in the home.
- Evidence of parental drug and alcohol abuse.

Other records

- It is often useful to check with neighbors and relatives for information about the child and the parental care given.
- Check the social services central registry and canvass local hospitals with subpoenas for medical records on all the children and both parents.

Munchausen Syndrome by Proxy

Munchausen syndrome by proxy (MSBP) is a form of child abuse wherein a parent (usually the mother) intentionally fabricates illness in her child and repeatedly presents the child for medical care, disclaiming knowledge as to the cause of the problem. Child victims of MSBP are at risk for serious injury or death.

Diagnostic Criteria

MSBP occurs when there is:

- Illness in a child that is simulated (faked) or produced by a parent or other caretaker, or both.
- Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
- Denial of knowledge by the parent as to the cause of the child's illness.
- Subsiding of acute symptoms and signs when the child is separated from the parent.

Typically, but not always, the mother spends a good deal of time on the hospital ward with the child and exhibits a remarkable familiarity with medical terminology. She may be "confidentially friendly" with the hospital staff, although she may show frustration with her child's chronic illness and anger at the medical staff's inadequate vigor in pursuing her child's problems.

She may insist that she is the "only one" for whom the child will eat, drink, or swallow medicines.

If more than one child in a family dies of sudden infant death syndrome (SIDS) or of any other ill-defined disease, MSBP—that is, homicide—along with some genetic, metabolic, environmental, and toxicological causes of death, must be considered as more likely explanations.

Table 1 presents some of the medical symptoms or illnesses exhibited by children who are victims of MSBP, together with the perpetrators' strategies.

Investigation

A multidisciplinary child protection team should become involved early on. The team should include medical personnel, the primary care nurse, county social services, mental health professionals, and an epidemiologist (a person who, in part, specializes in figuring out the cause of disease). Together, they must determine if the child's medical condition can be attributed to MSBP, warranting civil proceedings to remove

Table 1

Common Presentations of Munchausen Syndrome by Proxy and the Usual Methods of Deception

Presentation	Mechanism
Apnea (breathing stops)	Suffocation, drugs, poisoning, lying
Seizures	Lying, drugs, poisons, asphyxiation
Bleeding	Adding blood to urine, vomit, etc.; opening intravenous line
Fevers, blood infection	Injection of feces, saliva, contaminated water into the child
Vomiting	Poisoning with drugs that cause vomiting; lying
Diarrhea	Poisoning with laxatives, salt, mineral oil

the child from the perpetrator's care and, possibly, criminal proceedings. Police and law enforcement personnel should become involved early in a case. Evidence collection, timely arrest, and development of a case for prosecution are some of their roles.

Records To Examine

- The hospital's medical records for the child. They may be so voluminous that a summary and analysis will have to be prepared for the use of the investigators. Medical records should always be reviewed by medical doctors, so that information is not misinterpreted.
- Medical records (preferably originals) from other institutions.
- All medical records of all siblings, including autopsy reports and death certificates.
- The parents' educational and work history.

Part of the investigation will include an interview with the primary care nurse in the hospital, for this person is often the one who has spent the most time with the child and the parent during multiple hospitalizations. This person, and others interviewed, may be nonpartisan about the possibility of MSBP or may deny it vehemently, insisting on the mother's good care of the child. Investigators should never divulge information to the person they are interviewing.

Either the pediatrician or the multidisciplinary team as a body will make the final diagnosis of MSBP, based on the facts, discrepancies between these and the mother's various accounts, and a determination of whether the discrepancies are the result of misunderstanding, incapacity, or fabrication.

Author

Donna Rosenberg, M.D.
Assistant Professor of Pediatrics
University of Colorado School of Medicine
Denver, Colorado
and
Forensic Pediatrician, Colorado Child Fatality Review Team
970–845–9058
970–845–8934 (fax)
E-mail: Donna.Rosenberg@UCHSC.edu

Supplemental Reading

Cantwell H, Kempe R, Oates K. Child neglect. In Helfer RE, Kempe RS (eds): *The Battered Child*. 5th ed. Chicago, IL: University of Chicago Press, in press.

Helfer RE. The litany of the smoldering neglect of children. In Helfer RE, Kempe RS (eds): *The Battered Child*. 4th ed. Chicago, IL: University of Chicago Press, 1987, pp. 301–311.

Levin A, Sheridan M (eds). *Munchausen Syndrome by Proxy*. New York, NY: Lexington Books, 1995.

Meadow R. Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet* 2:343–345, 1977.

Meadow R. Suffocation, recurrent apnea, and sudden infant death. *Journal of Pediatrics* 117:351–357, 1990.

Rosenberg DA. From lying to homicide: The spectrum of Munchausen syndrome by proxy. In Levin A, Sheridan M (eds): *Munchausen Syndrome by Proxy*. New York, NY: Lexington Books, 1995, pp. 13–17.

Rosenberg DA. *Investigating Child Death*. Newbury Park, CA: Sage Publications, in press.

Rosenberg DA. Munchausen syndrome by proxy. In Reece RM (ed): *Child Abuse: Medical Diagnosis and Management*. Malvern, PA: Lea and Febiger, 1994, pp. 266–278.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques*. 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Organizations

Institute of Child Development
University of Minnesota
51 East River Road
Minneapolis, MN 55455–0345
612–624–0526

Kempe Children's Center
1825 Marion Street
Denver, CO 80218
303–864–5252
303–864–5302 (fax)

Missing and Exploited Children's Training Programs
Fox Valley Technical College
Criminal Justice Department
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54914–2277
800–648–4966
920–735–4757 (fax)
http://www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for the Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–549–4253
703–549–6259 (fax)

The National Center for the Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Prevent Child Abuse America
200 South Michigan Avenue, 17th Floor
Chicago, IL 60604–2404
800–835–2671
312–663–3520
312–939–8962 (fax)

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association
(ABA)
Center on Children and
the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association
(AMA)
Department of Mental Health
Chicago, Illinois
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society
on the Abuse of Children
(APSAC)
Oklahoma City, Oklahoma
405–271–8202
405–271–2931 (fax)

Federal Bureau of Investigation
(FBI)
National Center for the
Analysis of Violent Crime
Quantico, Virginia
703–632–4333

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse
(JJC)
Rockville, Maryland
800–638–8736
301–519–5600 (fax)

Kempe Children's Center
Denver, Colorado
303–864–5252
303–864–5302 (fax)

National Association of Medical
Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing
and Exploited Children
(NCMEC)
Alexandria, Virginia
703–274–3900
703–274–2220 (fax)

National Center for the
Prosecution of Child Abuse
Alexandria, Virginia
703–549–4253
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on
Child Abuse and Neglect
Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource
Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Sexually Transmitted Diseases and Child Sexual Abuse

Portable Guides to Investigating Child Abuse

Foreword

Investigating allegations of sexual abuse of children is very difficult for law enforcement. Successful resolution of these cases is often hampered by victim reluctance or inability to communicate as well as the scarcity of corroborating evidence. While the consequences of all abuse of children are of great concern to us, sexual abuse can be particularly devastating, especially when a sexually transmitted disease is part of the tragic legacy of violation.

This guide is designed to present additional investigative techniques, utilizing the presence of a sexually transmitted disease, which will assist in identifying or eliminating suspects in sexual abuse cases. Successful investigations are crucial because they can be the gateway to treatment for victims and can help protect them from further victimization. The guide also seeks to sensitize investigators to the need for personal precautions when investigating these cases and helps them to recognize children in need of immediate medical attention.

OJJDP is proud of this offering and urges you to make use of it as we work to protect our children.

Original Printing June 1996

Second Printing July 1997

Third Printing March 2001

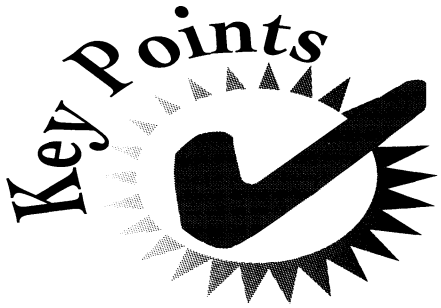
NCJ 168110

Overview

Sexually transmitted diseases (STD's) comprise a wide range of infections and conditions that are transmitted mainly by sexual activity. The classic STD's, gonorrhea and syphilis, are now being overshadowed by a new set of STD's that are not only more common, but are also more difficult to diagnose and treat. These new STD's include infections caused by *Chlamydia trachomatis* (chlamydia), human papilloma virus (HPV), bacterial vaginosis (BV), and human immunodeficiency virus (HIV). Rapid application of new technology to the diagnosis of STD's has led to a growing array of diagnostic laboratory tests that require critical evaluation by clinicians and a critical review by law enforcement (see table 1).

Accurate information about STD's in victims of sexual abuse has been hindered by a variety of factors:

- The prevalence of sexually transmitted infections may vary regionally and among different populations within the same region.
- Few studies have attempted to differentiate between infections existing prior to sexual abuse and those that result from abuse. The presence of a preexisting infection in adults is usually related to prior sexual activity. In children, however, preexisting infections may be related to prolonged colonization after perinatal acquisition (acquisition immediately before and after birth), inadvertent nonsexual spread, prior peer sexual activity, or prior sexual abuse.
- The incubation periods for STD's range from a few days for gonorrhea to several months for HPV. *The incubation periods and the timing of an examination after an episode of abuse are critically important in detecting infections* (see table 1).



When presented with a child with an STD, law enforcement officials must attempt to determine absolutely if the infection was associated with sexual contact and, for the purposes of prosecution, whether appropriate diagnostic methods were used. The following facts should be kept in mind:

- STD's may be transmitted during sexual assault.
- Multiple episodes of abuse increase the risk of STD infection, probably by increasing the number of contacts with an infected individual, and rates of infection also vary by the type of assault. For example, vaginal or rectal penetration is more likely to lead to detectable STD infection than fondling.
- Sexual assault is a violent crime that affects children of all ages, including infants.
- The majority of children who are sexually abused will have no physical complaints related either to trauma or STD infection. Most sexually abused children do not indicate that they have genital pain or problems.
- In children the isolation of a sexually transmitted organism may be the first indication that abuse has occurred.

- In most cases, the site of infection is consistent with a child's history of assault.
- Although the presence of a sexually transmissible agent in a child over the age of 1 month is suggestive of sexual abuse, exceptions do exist. Rectal and genital chlamydia infections in young children may be due to a persistent perinatally acquired infection, which may last for up to 3 years.

The incidence and prevalence of sexual abuse in children are difficult to estimate.

- Most sexual abuse in childhood escapes detection.
- Patterns of childhood sexual abuse appear to depend on the sex and age of the victim.
- Between 80 and 90 percent of sexually abused children are female (average age: 7 to 8 years).
- Between 75 and 85 percent of sexually abused children were abused by a male assailant, an adult or minor known to the child. This individual is most likely a family member such as the father, stepfather, mother's boyfriend, or an uncle or other male relative.
- Victims of unknown assailants tend to be older than children who are sexually abused by someone they know and are usually only subjected to a single episode of abuse.
- Sexual abuse by family members or acquaintances usually involves multiple episodes over periods ranging from 1 week to years.
- Most victims describe a single type of sexual activity, but over 20 percent have experienced more than one type of forced sexual act. Vaginal penetration has been reported to occur in approximately one-half and anal penetration in one-third of female victims of sexual abuse.
- Over 50 percent of male victims of sexual abuse have experienced anal penetration.
- Other types of sexual activity, including oral-genital contact and fondling, occur in 20 to 50 percent of victims of sexual abuse.
- Children who are sexually abused by known assailants usually experience less physical trauma, including genital trauma, than victims of assaults by strangers because such trauma might arouse suspicion that abuse is occurring.

Table 1

Incubation Periods, Clinical Manifestations, Transmission, and Diagnosis of Sexually Transmitted Diseases (STD's)*

STD and Organism(s)	Incubation Period	Clinical Manifestations	Transmission	Diagnosis
Gonorrhea *Neisseria gonorrhoeae*	3–5 days	1. Vaginitis, urethritis, pharyngitis, proctitis. 2. Rare: Arthritis, conjunctivitis. 3. Most pharyngeal (throat) and rectal infections and as many as 50% of vaginal infections in children may be asymptomatic.	1. Through sexual contact. 2. Exception: Neonatal conjunctivitis is acquired by the infant from his/her mother at delivery. 3. No evidence of transmission by fomites (i.e., via toilet seats, "dirty" towels, etc.).	1. Culture of *N. gonorrhoeae* using selective media with confirmation by at least two different methods using different principles, e.g., sugar fermentation, enzyme substances, serological or DNA hybridization. 2. Use of DNA probes or other nonculture methods, including Gram-stained smears or vaginal or urethral discharges, *is not recommended because*

				other bacteria may be misidentified as *N. gonorrhoeae.*
Chlamydial infections *Chlamydia trachomatis*	5–7 days	1. Most prevalent sexually transmitted infection in the United States. 2. In adults and adolescents: Urethritis and mucopurulent cervicitis, which can lead to pelvic inflammatory disease; however, most infections in adults and children are asymptomatic.	1. Sexually, in children 3 years of age or older. 2. Perinatally acquired infection (mother-to-infant) may last in the vagina and rectum for up to 3 years or longer. 3. No evidence of transmission by fomites.	1. Isolation of the organism in tissue culture only with microscopic identification of the characteristic inclusions with fluorescent antibody staining. 2. Nonculture methods, including enzyme immunoassays (EIA's), direct fluorescent antibody (DFA) tests, and DNA probes, are not approved for use in rectal or genital sites in children. Use at these sites has led to many false-positive tests.

Table 1 *continued*

Incubation Periods, Clinical Manifestations, Transmission, and Diagnosis of Sexually Transmitted Diseases (STD's)*

STD and Organism(s)	Incubation Period	Clinical Manifestations	Transmission	Diagnosis
Syphilis *Treponema pallidum*	1. Primary infection: 10–90 days, usually 3–4 weeks. 2. Secondary: 6 weeks–6 months after the primary lesion heals.	1. Primary syphilis: Chancre, i.e., a painless ulcer at the site of inoculation (penis, vulva, vagina, rectum, etc.). The chancre heals spontaneously after 1–2 weeks. 2. Secondary syphilis: Diffuse rash, fever, enlarged lymph nodes, mucous patches. 3. Latent syphilis: Asymptomatic, although positive serological findings may persist for years.	1. Through sexual contact. The chancre and mucous patches are very infectious. 2. Infants may acquire congenital syphilis from their mothers. The presentation is similar to secondary syphilis.	1. Identification of *T. pallidum* in lesions by dark-field microscopy or by staining with a fluorescein-conjugated monoclonal antibody. 2. The most common methods used are serological: Rapid plasma reagin (RPR) test; Venereal Disease Research Laboratory (VDRL)-reaginic antibody test; and fluorescent treponemal antibody-absorption

(FTA–ABS) test, a test for a specific anti-*T. pallidum* antibody.

3. Positive results on an RPR or VDRL test in a child who does not have a history of congenital syphilis.
4. RPR and VDRL test results will be negative after effective treatment; FTA–ABS remains elevated for the lifetime of the patient.

Table 1 *continued*

Incubation Periods, Clinical Manifestations, Transmission, and Diagnosis of Sexually Transmitted Diseases (STD's)*

STD and Organism(s)	Incubation Period	Clinical Manifestations	Transmission	Diagnosis
Trichomoniasis *Trichomonas vaginalis*	5–28 days	1. Vaginitis. 2. In males, infection appears to be asymptomatic, but *T. vaginalis* may cause some cases of nonspecific urethritis.	1. Through sexual contact. 2. Has not been found in children 1 year of age or older without history of sexual contact. 3. Infants can acquire infection from mother at delivery; can cause vaginitis. 4. Perinatally acquired infection may persist for 6–9 months after birth. 5. No evidence of transmission by fomites.	1. Microscopic identification of the organism in vaginal fluid. 2. Culture methods may be more sensitive, but not widely available. 3. The finding of trichomonads in urine collected for another purpose is not sufficient for accurate diagnosis, as the urine could be contaminated with *T. hominis*, a normal inhabitant of the bowel that is not sexually transmitted.

Bacterial vaginosis (BV) *Gardnerella vaginalis; Bacteroides* species and other anaerobic bacteria; and *Mycoplasma hominis.*	5–28 days	1. BV is not really an infection, but a disturbance of the normal vaginal flora, which is replaced by the organisms listed. 2. Clinically presents as gray, foul-smelling vaginal discharge, but may be asymptomatic.	1. Through sexual and nonsexual contact. 2. Probably related to poor hygiene in some young children.	1. Microscopic identification of "clue cells," which are epithelial cells studded with bacteria in vaginal secretions; a positive "whiff" or amine test, which is the release of a very characteristic fishy odor when 10% potassium hydroxide (KOH) is added to the vaginal fluid; and a vaginal fluid pH of ≥4.5. 2. The latter test should only be done in adolescents, as there are no vaginal pH standards for prepubertal children. 3. Culture of *G. vaginalis* is not indicated and is not diagnostic for BV. *G. vaginalis* can be normal vaginal flora and has been isolated in 5–15% of normal children who have not been abused.

Table 1 *continued*

Incubation Periods, Clinical Manifestations, Transmission, and Diagnosis of Sexually Transmitted Diseases (STD's)*

STD and Organism(s)	Incubation Period	Clinical Manifestations	Transmission	Diagnosis
Herpes Herpes simplex virus (HSV), types 1 and 2	2–5 days	1. Painful vesicular lesions that become ulcers on the vulva, vagina, penis, and perirectal area. 2. May be associated with inguinal lymphadenopathy (disease of the lymph nodes in the groin) and fever.	1. Through sexual contact. 2. Primarily HSV–2, although 10% of genital herpes in adults can be due to HSV–1. 3. Young children with herpetic gingivostomatitis (herpetic infection of the gum tissues), a primary, nonsexually acquired infection due to HSV–1, may	1. Isolation of the virus from the lesions. 2. There are no commercially available antibody tests that will reliably differentiate between HSV–1 and HSV–2.

			autoinoculate (infect themselves) in the genital area. There should be a history of stomatitis (sores in the mouth) in the previous 2 weeks.	
Condyloma acuminata, venereal warts Human papilloma virus (HPV)	4–12 weeks, but may be clinically inapparent for up to 18 months.	Flesh- to purple-colored papillomatous growths in the anogenital region.	1. Sexually, perinatally, and probably, but rarely, nonsexually. 2. Major confounding variable is the long period after infection before the lesions become visible to the naked eye, which could be as long as 18 months.	Clinical. HPV DNA-typing of the lesions is not generally available.

Table 1 *continued*

Incubation Periods, Clinical Manifestations, Transmission, and Diagnosis of Sexually Transmitted Diseases (STD's)*

STD and Organism(s)	Incubation Period	Clinical Manifestations	Transmission	Diagnosis
AIDS Human immunodeficiency virus (HIV)	Seroconversion: 6 weeks after exposure; more than 90% of individuals will be HIV positive by 6 months. Development of AIDS: 5–10 years.	1. Children who are HIV positive before developing AIDS are asymptomatic. 2. Some individuals develop an acute retroviral syndrome, similar to influenza, with lymphadenopathy after infection. 3. Has not been described in children with acquired HIV infection.	1. Sexually, perinatally, and via blood transfusion, intravenous drug abuse (IVDA), and sharing needles. 2. Approximately 30% of infants born to HIV-positive mothers will develop HIV infection but may not develop clinical AIDS for 5 years or longer.	Serological: Presence of HIV antibody, detection of p24 antigen. Child being evaluated for HIV after abuse needs to be tested for 6 months. Consider HIV testing if the child is from an area of high HIV prevalence, if the abuser is in a high-risk group (e.g., IVDA, crack user), or if another STD is present.

3. Acquisition by sexual abuse needs to be differentiated from perinatal infection, as risk factors for maternal infection and sexual abuse are similar.

*Source: Margaret R. Hammerschlag, M.D.

Author

Margaret R. Hammerschlag, M.D.
Professor of Pediatrics and Medicine
Division of Pediatric Infectious Diseases
State University of New York Health Science Center at Brooklyn
450 Clarkson Avenue, Box 49
Brooklyn, NY 11203–2098
718–245–4074

Supplemental Reading

Centers for Disease Control and Prevention. 1993 sexually transmitted diseases treatment guidelines. *Morbidity and Mortality Weekly Report* 42:RR–14, 1993.

Child Sexual Abuse: Report of the Twenty-Second Ross Roundtable on Critical Approaches to Common Pediatric Problems in Collaboration With the Ambulatory Pediatric Association. Ross Laboratories, 1991.

Evidence Collection Protocol. Texas Department of Health, Bureau of Emergency Management, Sexual Assault Prevention and Crisis Services Program, 1990.

Hammerschlag MR. Sexually transmitted diseases in sexually abused children. *Advances in Pediatric Infectious Diseases* 3:1–18, 1988.

Hammerschlag MR, Doraiswamy B, Alexander ER, et al. Are rectogenital chlamydial infections a marker of sexual abuse in children? *Pediatric Infectious Disease Journal* 3:100–104, 1984.

Hammerschlag MR, Retting PJ, Shields ME. False positive results with the use of chlamydial antigen detection tests in the evaluation of suspected sexual abuse in children. *Pediatric Infectious Disease Journal* 7:11–14, 1988.

Jenny C, Hooton TM, Bowers A, et al. Sexually transmitted diseases in victims of rape. *New England Journal of Medicine* 322:713–716, 1990.

Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination. U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 1985.

Understanding the Medical Diagnosis of Child Maltreatment: A Guide for Non-Medical Professionals. The American Humane Association, American Association for Protection of Children, 1989.

Whitcomb D. *When the Victim Is a Child.* 2d ed. U.S. Department of Justice, National Institute of Justice, 1992.

Whittington WL, Rice RJ, Biddle JW, et al. Incorrect identification of *Neisseria gonorrhoeae* from infants and children. *Pediatric Infectious Disease Journal* 7:3–10, 1988.

Organizations

Missing and Exploited Children's Training Programs
Fox Valley Technical College
Criminal Justice Department
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54914–2277
800–648–4966
920–735–4757 (fax)
http://www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers an intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field.

National Children's Alliance
1612 K Street NW., Suite 500
Washington, DC 20006
800–239–9950
202–639–0597
202–639–0511 (fax)
http://www.nca-online.org

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 Children's Alliance (NCA), formerly the National Network of Children's Advocacy Centers, provides leadership and advocacy for these programs on a national level, including training and publications. The following four Regional Children's Advocacy Centers work jointly with NCA, providing information, consultation, and training and technical assistance to help communities establish child-focused programs that facilitate and support coordination among agencies responding to child abuse.

- ***Midwest Regional Children's Advocacy Center,*** Midwest Children's Resource Center, St. Paul, Minnesota, 888–422–2955.
- ***Southern Regional Children's Advocacy Center,*** Rainbow City, Alabama, 800–747–8122.
- ***Northeast Regional Children's Advocacy Center,*** Philadelphia Children's Alliance, Philadelphia, Pennsylvania, 800–662–4124.
- ***Western Regional Children's Advocacy Center,*** Lakewood, Colorado, 800–582–2203.

Sexual Assault Nurse Examiners (SANE) Program
600 Civic Center
Tulsa, OK 74103
918–596–7608

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association
(ABA)
Center on Children and
the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association
(AMA)
Department of Mental Health
Chicago, Illinois
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society
on the Abuse of Children
(APSAC)
Oklahoma City, Oklahoma
405–271–8202
405–271–2931 (fax)

Federal Bureau of Investigation
(FBI)
National Center for the
Analysis of Violent Crime
Quantico, Virginia
703–632–4333

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse
(JJC)
Rockville, Maryland
800–638–8736
301–519–5600 (fax)

Kempe Children's Center
Denver, Colorado
303–864–5252
303–864–5302 (fax)

National Association of Medical
Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing
and Exploited Children
(NCMEC)
Alexandria, Virginia
703–274–3900
703–274–2220 (fax)

National Center for the
Prosecution of Child Abuse
Alexandria, Virginia
703–549–4253
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on
Child Abuse and Neglect
Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource
Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Law Enforcement Response to Child Abuse

Portable Guides to Investigating Child Abuse

Foreword

Law Enforcement Response to Child Abuse—like all the Portable Guides in this series—is designed to assist those working to help protect children from being victimized and to improve the investigation of child abuse cases.

This guide arms law enforcement professionals with the information needed to ensure consistency in their investigation of child abuse. Pertinent considerations and helpful investigatory protocols are provided. Other useful materials include suggestions on working with physicians, responding to domestic disturbance calls, and placing children in protective custody. Supplemental readings and additional resources are cited.

In protecting our children from criminal predators, law enforcement professionals are serving their communities and their Nation. We hope that this guide will aid in that worthy endeavor.

Original Printing May 1997

Second Printing March 2001

NCJ 162425

Overview

Child abuse is a *community* problem. No single agency has the training, manpower, resources, or legal mandate to intervene effectively in child abuse cases. No one agency has the sole responsibility for dealing with abused children.

When a child is physically beaten or sexually abused, the ideal set of events is that doctors treat the injuries, therapists counsel the child, social services works with the family, police arrest the offender, and attorneys prosecute the case. To promote this response, effective community intervention involves the formation of a child protection team that includes professionals from medicine, criminal justice, social work, and education who understand and appreciate the different roles, responsibilities, strengths, and weaknesses of the other team members but cooperate and coordinate their efforts. The skills of each person are viewed as different but equally important.

The role of law enforcement in child abuse cases is to investigate to determine if a violation of criminal law occurred, identify and apprehend the offender, and file appropriate criminal charges. The response of law enforcement to child abuse needs to be consistent. The intent of this guide is to provide officers who respond to this type of crime with information that will ensure this consistency. It is also to help law enforcement understand the importance of developing procedures and protocols and ways they can work with other professions to ensure that the needs of children are met.

State-mandated reporting laws require a referral when there is a suspicion of abuse. In most child abuse cases, law enforcement becomes involved in one of two ways: by a referral from a school, a physician, or an agency such as social services, or by a direct call for service from a parent, a child, or a neighbor. Because of increased reporting of child abuse, it is critical that police officers be trained to handle cases involving child maltreatment.

Child abuse cases have unique characteristics that make them different from other types of cases. For a number of reasons, children make "perfect" victims, and crimes involving child abuse, particularly sexual abuse, are among the most difficult investigated by law enforcement:

- Children are usually unable to protect themselves because of their level of physical and mental development; frequently they do not like to talk about the abuse. They may delay disclosure or tell only part of the story.
- An emotional bond often exists between the child and the offender; children may want the abuse to stop, but they may not want the offender to be punished.
- Crimes of abuse are not usually isolated incidents; instead, they take place over a period of time, often with increasing severity.
- In most sexual abuse cases, there is no conclusive medical evidence that sexual abuse occurred. Moreover, it occurs in a private place with no witnesses to the event.
- Interviews of children require special handling; legal issues governing child testimony are complicated and ever changing, and children—whether victims or witnesses—are often viewed as less credible or competent than the accused.
- Child abuse cases often involve concurrent civil, criminal, and sometimes administrative investigations; they often cross jurisdictional lines.
- The criminal justice system was not designed to handle the special needs of children.

Officers must be objective and proactive in their investigations of abuse. Questions concerning who, what, where, when, how, and why must be answered. It is important to remember that child abuse is a crime and law enforcement has a legal duty and responsibility to respond accordingly.

Multidisciplinary Team Approach

The most effective approach to cases involving child maltreatment is interagency coordination and planning. Social workers, physicians, therapists, prosecutors, judges, and police officers all have important roles to play. All must work together with a common concern—the welfare of the child—and with a common goal—to communicate with mutual respect. Differences of opinion are to be expected. Effective teamwork includes having a mechanism for discussing and, if possible, resolving these differences.

All members of the child protection team have an obligation to appreciate what the other professionals on the team are seeking to accomplish and to understand how their activities interrelate. For example, law enforcement officers need to be concerned that their investigation might traumatize a child, and physicians and therapists need to be concerned that their treatment and evaluation techniques might hinder or damage law enforcement's investigation. An ongoing discussion of problems that the team encounters during investigations will help resolve them and will also clarify the roles and responsibilities of team members.

All players on the child protection team must have clearly defined roles in order to carry out their responsibilities effectively.

- An interagency protocol helps in establishing written guidelines for those who investigate cases of child abuse and neglect.
- A properly drafted agreement also provides a blueprint for each of the principal agencies responsible for abuse cases in the community.

The team members must also invest their time in developing a long-range strategic plan that will ensure the team is ever responsive to the needs and changes within the community.

The goal should be efficient coordination of services, with the chief objectives being to determine what happened and to meet the needs of the child.

The following are essential elements of an effective interdisciplinary response team:

- Identification of the scope of the community problem.
- Identification of the resources available.
- Establishment of communication guidelines for each response team member and the victim's family.
- Establishment of clearly defined roles and responsibilities for each response team member.
- Establishment of clearly defined criteria for the types of cases with which the team will become involved.

Establishing Law Enforcement Protocols and Procedures

With their legal authority to investigate violations of the law, law enforcement officers are vital members of a community's child protection team. Failure to respond properly to child abuse cases from the outset (e.g., failure of the responding law enforcement officer to obtain certain information) can result in cases being dismissed in court or, in some cases, in innocent people being falsely accused.

Investigators should be trained and experienced in objectively investigating child maltreatment, including conducting interviews of children and interrogating suspected offenders. Training should be viewed as an ongoing process, designed to increase the competence of the interdisciplinary team.

Moreover, local law enforcement departments must establish policies and procedures to investigate child abuse cases. Personnel investigating child abuse need to consider many important factors (see figure 1, "Considerations for Child Abuse Investigations," pages 6 and 7).

Established agency protocols, guidelines, and training will guide the decisionmaking process, but officers are likely to face situations in which the officer's judgment must be the guiding light. For this reason, officers must be familiar with what is expected of them legally in their jurisdiction. As necessary, they should consult the agency's legal advisor or the prosecuting attorney to clarify this.

Speaking a Common Language

Professional terminology is used by many disciplines. Members of the child protection team must be familiar with highly specialized technical terms (such as "subdural hematoma," "dissociation," "battered child syndrome," and "pedophilia") as well as with basic or common terms (such as "child," "molestation," and "rape"). However, problems can arise because some terms do not have a universally accepted, consistent definition. It is important for clear communication and effective coordination that professional team members understand what is meant when professional terminology (or jargon) is used by other team members and that they ask for clarification when they do not.

The legal definition of a child varies from State to State and even from statute to statute in the same State. Issues such as whether the victim consented or whether the offender was a guardian or caretaker are important legal considerations in such cases. How the law determines consent is often confusing, even in the case of a 14-year-old boy who has been seduced by a 55-year-old pedophile. There is a difference between the legal definition of consent and the meaning given to it by lay people.

To determine who is a child and what is abuse, law enforcement officers must turn to the law. The penal code will legally define both, but law enforcement officers must still deal with their own perceptions and opinions as well as with those of society as a whole.

For this reason, people working as part of an interdisciplinary task force must clearly communicate how they are defining a particular term and establish common ground. Law enforcement investigators should always be aware of and communicate to others the legal definitions of terms.

Law enforcement investigators must also be able to communicate with victims, offenders, and witnesses, as well as with social workers, physicians, mental health personnel, lawyers, judges, and peers. To avoid confusion and misunderstanding, investigators must be equally familiar with various family or slang terms for body parts and sexual acts when talking to victims, witnesses, and suspects. Investigators must know not only both the slang and professional terms, but also the appropriate times for using each.

Figure 1

Considerations for Child Abuse Investigations

When You Receive the Referral

- Identify personal or professional biases with child abuse cases. Develop the ability to desensitize yourself to those issues and maintain an objective stance.
- Know department guidelines and State statutes.
- Know what resources are available in the community (therapy, victim compensation, etc.) and provide this information to the child's family.
- Introduce yourself, your role, and the focus and objective of the investigation.
- Assure that the best treatment will be provided for the protection of the child.
- Interview the child alone, focusing on corroborative evidence.
- Don't rule out the possibility of child abuse with a domestic dispute complaint; talk with the children at the scene.

Getting Information for the Preliminary Report

- Inquire about the history of the abusive situation. Dates are important to set the timeline for when abuse may have occurred.
- Cover the elements of crime necessary for the report. Inquire about the instrument of abuse or other items on the scene.
- Don't discount children's statements about who is abusing them, where and how the abuse is occurring, or what types of acts occurred.
- Save opinions for the end of the report, and provide supportive facts. Highlight the atmosphere of disclosure and the mood and demeanor of participants in the complaint.

Preserving the Crime Scene

- Treat the scene as a crime scene (even if abuse has occurred in the past) and not as the site of a social problem.

Figure 1 *continued*

- Secure the instrument of abuse or other corroborative evidence that the child identifies at the scene.
- Photograph the scene and, when appropriate, include any injuries to the child. Rephotograph injuries as needed to capture any changes in appearance.

Followup Investigation

- Be supportive and optimistic to the child and the family.
- Arrange for a medical examination and transportation to the hospital. Collect items for a change of clothes if needed.
- Make use of appropriate investigative techniques.
- Be sure the child and family have been linked to support services or therapy.
- Be sure the family know how to reach a detective to disclose further information.

During the Court Phase

- Visit the court with the child to familiarize him or her with the courtroom setting and atmosphere before the first hearing. This role may be assumed by the prosecutor or, in some jurisdictions, by victim/witness services.
- Prepare courtroom exhibits (pictures, displays, sketches) to support the child's testimony.
- File all evidence in accordance with State and court policy.
- Unless they are suspects, update the family about the status and progress of the investigation and stay in touch with them throughout the court process. Depending on the case, officers should be cautious about the type and amount of information provided to the family, since they may share the information with others.
- Provide court results and case closure information to the child and the family.
- Follow up with the probation department for preparation of the presentence report and victim impact statement(s).

Working With the Medical Profession

Physicians can be important allies in the prevention and treatment of child abuse. Doctors can serve as family counselors and educators, as influential child advocates, and as key members of the community multidisciplinary team. They can help to alleviate stress on a family by managing health problems, providing child-rearing advice, and discussing family planning alternatives.

In cases of suspected child maltreatment, doctors have five basic responsibilities:

- To identify suspicious injuries.
- To diagnose problems of abuse.
- To administer treatment to the child.
- To report suspected incidents of abuse to the appropriate authorities.
- To testify in subsequent legal proceedings.

Unfortunately, some physicians are reluctant to get involved in cases of abuse. For example, they may find few personal or professional rewards in dealing with an abusive family. They may not wish to report an incident because it may be impossible to determine who caused a child's injuries. Finally, they may not wish to testify in court because of time constraints or because of a fear of cross-examination, interrogation, challenges to their credentials, or possible litigation.

Law enforcement investigators can help counteract physicians' reluctance by fully involving members of the medical profession in the community's team approach to child abuse and by stressing the importance of medical evidence in preparing a case for court. It may also be helpful to remind physicians that all 50 States and the District of Columbia have enacted legislation regarding immunity from civil or criminal liability for persons who, in good faith, make or participate in making a report of child abuse or neglect.

Obtaining a Medical Examination

In most cases a medical assessment of the child needs to be performed as soon as possible. The primary purposes of the medical examination are to assess potential injury and identify the need for treatment. Such an examination will also protect law enforcement against accusations that a child's injuries occurred after removal from the home. Whenever possible, all children suspected of having been abused should be given a medical examination, preferably by a medical professional experienced and trained in conducting forensic examinations. This is critical in cases in which sexual abuse is alleged. The medical professional should reassure the child, who may be fearful about the procedure and concerned about the physical and emotional consequences of the abuse.

A secondary purpose of a medical examination is to determine the presence of any corroborating evidence of acute or chronic trauma. In recent years the ability and willingness of doctors to corroborate child abuse has improved greatly. Better training, the establishment of protocols, and technological advancements have improved the ability of doctors to corroborate physical and sexual abuse in children. Medical imaging technology now available includes magnetic resonance imaging (MRI), computed tomography (CT), and colposcopes (an instrument with magnification capabilities for visualizing the interior of a hollow organ, such as the vagina or rectum; pictures and video can be taken with the colposcope to document the examination results).

Law enforcement should be aware that statements made to doctors by the child during the medical examination may be admissible in court as exceptions to the hearsay rule. Many acts of child sexual abuse do not leave any physical injury that can be identified by a medical examination. In addition, children's injuries can heal rapidly. However, lack of medical corroboration does not necessarily mean that a child was not sexually abused or that an offense cannot be proved in court.

Figure 2, "Sample Child Sexual Abuse Protocol" (see pages 10 and 11), offers guidelines for the immediate law enforcement response to an allegation of child sexual abuse and provides details about obtaining the medical examination critical to investigating this offense.

Figure 2

Investigator's Sample Child Sexual Assault Protocol

Interviewing the Victim

- Assess the medical needs of the child so that emergency medical conditions can be attended to immediately.
- Determine what examinations are needed for collection of evidence.
- Determine venue.
- Establish what offenses, if any, have occurred.
- Establish date and time of the offense.
- Contact child protective services (CPS), if that has not been done.

Obtaining a Medical Examination

Note: If a sexual assault occurred within the previous 72 hours, the medical examination should be performed as soon as possible to maximize the possibility of recovering certain forensic evidence, such as blood, semen, saliva, and trace evidence. If the assault occurred more than 72 hours before, the probability of this type of evidence being recovered is reduced. However, since the investigator cannot be absolutely sure when the last encounter was, it is prudent to schedule the medical examination sooner rather than later. A physician and/or nurse examiner conducts the examination.

- Contact a physician and/or sexual assault nurse examiner.
- Coordinate with CPS to determine if you (the police investigator) or the CPS worker will accompany the child to the examination.
- Meet with the CPS representative, the physician and/or nurse examiner, the child, and the parent or guardian at the hospital treatment room.
- Assist the child and parents or guardian with the procedures for admission to the emergency room. (CPS may provide this assistance, depending on who has requested the examination.)
- Brief medical personnel concerning the facts, allegations, suspect information, the mental state of the child, past histories, and what the police department and CPS are looking for in the examination and what evidence is to be collected.

Figure 2 *continued*

Handling the Evidence

- See that the cultures are prepared and marked to maintain the chain of custody. Include the date, the initials of the person conducting the examination, and the child's name. Transport the cultures and all other materials collected for evidence to the State laboratory. Make sure that both you and the laboratory personnel have signed the chain of custody form. Local procedures may differ from this; law enforcement must know and follow all jurisdictional procedures for handling evidence.
- Make sure that photographs are marked with the date, time, victim's name, photographer's initials, and case number and turned over to you as evidence. Photographs can be taken by police officers, investigators, CPS workers, physicians, nurse examiners, or other parties.

Subpoena Procedures

- Call the physician and/or nurse examiner as soon as possible if a subpoena has been issued to compare calendars and identify any conflicts early. Such notification should include the names of the child victim, defendant, and prosecuting attorney (if known); court date; and matters to which the physician may be requested to testify. Local procedures may differ from this; law enforcement must know and follow all practices and procedures for their jurisdiction.
- As an option, law enforcement may assist in the coordination of a pretrial conference with the medical professional and the prosecutor in advance of the court hearing. At this meeting:
  - Questions that may be asked of the medical professional can be outlined.
  - Medical terminology or difficult trial issues related to the testimony can be clarified.
  - Requests for exhibits that may be helpful in clarifying testimony can be discussed and time allowed for their preparation.

  This meeting is also a courtesy to prepare the medical professional in a timely fashion and to relieve the anxiety of testifying.

Domestic Disturbance Calls

One of the most common calls for service by law enforcement is the domestic disturbance call. Most police officers understand the potential for danger associated with such calls, but many do not realize that a violent adult might also vent anger on a child. A recent study in Florida* revealed that nearly one-third of domestic disturbance calls masked an incident of some form of child victimization. For this reason, officers should ask whether there are children living at the residence and, if so, where they are.

- It is recommended that domestic disturbance calls be answered with at least two officers, not only for officer protection but also so that one officer can deal with the parties involved with the domestic disturbance while the other officer talks with any children who may be present.
- Once the involved parties are calm, most parents, if asked tactfully, will allow an officer to talk with their children and may even appreciate the officer's offer to allay a child's fear that someone has been hurt or is going to jail.
- If possible, an officer should speak directly with the children. Such conversations allow the police officer to gather information about the situation directly from the child and to assess the child's need for protection.

Officers should be observant and look for any physical signs that the child may have been abused, but they should be aware that a child in this situation is likely to be afraid and withdrawn. Nervousness or a reluctance to talk to an officer does not mean that physical abuse has taken place. The officer should be attuned to the fact that the child may not want to stay at the residence, fearing another altercation.

An officer suspecting child abuse should preserve possible crime scene evidence such as a weapon or instrument of abuse and arrange for photographing of the scene. This eliminates the need for a search warrant, since officers are already legally on the scene. The officer must also notify social services of his or her suspicions of child abuse as soon as possible.

---

* Hammond CB, Poindexter RW, Caimano JV, Kramer LH, Turman KM, Wilson JJ, Bieck W, Hillsborough County Sheriff's Office, Tampa, Florida. *Crimes Against Children Crime Analysis Project: Implications and Findings.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1993.

Placing a Child in Emergency Protective Custody

Officers who become involved in a child abuse case through social services should consider all information that has been provided to them. Based on this information, officers should ask a basic question: "If we leave and obtain a court order to remove this child, is the child likely to be injured before we return?" If the answer is yes, then the officer should remove the child. All actions should be in accordance with State guidelines and departmental policy and procedure:

- Depending on the jurisdiction, the officer may be obligated to remove the child if direct disclosure of physical or sexual abuse is made, if such abuse is alleged, or if evidence of an abusive incident is present.
- Moreover, in most jurisdictions, State law allows an officer to decide to remove a child based on observation of the facts and judgment of the information given. In some situations an officer may remove a child because he or she feels that the child may suffer further physical or emotional harm or trauma or be hidden or abducted before a court order can be obtained.

In some jurisdictions law enforcement may be called upon by child protective services to investigate allegations of child abuse, to officially place a child in emergency protective custody, or to assist with such placement. Officers in such situations need to know the laws in their State. Failure to understand their legally mandated roles and responsibilities could result in:

- A child being left in a dangerous situation.
- A child being removed illegally.
- The officer and the department being placed in a situation of civil liability.

However, if a mistake is to be made, it is better to err in the attempt to safeguard the physical well-being of the child.

In jurisdictions where law enforcement has sole responsibility for deciding to remove a child from the home, the child is usually placed in the custody of the department of social services until a final determination regarding custody of the child can be made by the courts. Social services is responsible for placing the child in a licensed foster care facility. Officers

need to be aware of the legalities regarding parental rights and their responsibilities for providing written notification of the child's removal.

In most States it is not acceptable for law enforcement to take a child from one parent and place him or her in the custody of another parent or of a relative without a court order or verification of legal authority. Also, in most States the placement of a child in the custody of another individual is the sole responsibility of the department of social services and not law enforcement. However, if social services chooses to place the child in the custody of a parent or someone other than a licensed foster care facility, law enforcement should be aware of the jurisdiction's policies and practices before participating in or agreeing to this placement.

It is highly recommended that removal or detention orders or other appropriate court paperwork accompany officers to the removal site and that this paperwork be explained to adversarial parents. In some jurisdictions there is "summary removal" authority—that is, with no paperwork in hand and based on circumstances of the case as it develops, the child may be removed from the home. Safety issues enter into the equation, especially as law enforcement is often present for the protection of social service personnel.

Law enforcement officers are responsible for ensuring that they have met all requirements of their State governing the placement of children into protective custody.

Common Mistakes To Avoid

Some law enforcement officers inadvertently cause a situation to escalate when placing a child in protective custody. Experienced officers have learned to avoid three common mistakes:

- **Making premature accusations.** Making an accusatory statement to the parent, guardian, or custodian that the child is being taken into protective custody because someone has abused the child places police officers in a situation of serious liability. A more appropriate statement is, "Because of questionable injuries, marks, or allegations about inappropriate activity, the child is being taken to a licensed foster care facility of the State until a complete and thorough investigation into the situation can be conducted."

- **Attempting to rationalize the removal of a child.** Some officers attempt to rationalize with the parent their decision to remove a child. However, the best tactic is to remove the child and vacate the situation as quickly as possible, after ensuring that everyone's rights are protected. The fact is that no amount of explaining will lessen the pain, fear, and anger (hostility) involved in having a child taken away. Officers should be aware that heightened emotions can lead to a dangerous escalation of the situation.
- **Failing to provide all of the required forms.** Police officers must be familiar with all the forms that must be completed by the parent at the time that a child is placed in protective custody. For example, many States require that a form explaining that the child has been placed in protective custody must be provided to the parents within 24 hours after the child has been so placed. The form must state that the placement was made in accordance with a particular statute, and it must describe the parents' rights in the matter. The responsibility for providing this form to the parents varies from State to State. Law enforcement officers and social service workers must know what is required in their State.

Removing the Child

If a law enforcement officer has been called to assist in the removal of a child, it is the officer's responsibility to ensure that the child is removed with as little trauma or danger to the child and the social worker as possible.

- The police officer should meet with the social worker at a neutral location before going to the residence. The social worker should explain the situation in general, describe the layout of the residence, and specify who is expected to be there. In this way the police officer and the social worker can determine a plan of action before arriving at the scene.
- Any necessary items, such as medication, should be brought with the child. The key point is that once the decision to remove a child has been made, the action should be carried out expeditiously.

Impact on the Child

Physical removal from the home is extremely traumatic for the child. Both the law enforcement officer and the social worker are relative strangers. They need to keep the following points in mind:

- Debating the situation with the parent or caretaker only raises the emotional level of the child. Such arguments may cause the child to become more nervous, upset, distraught, and emotionally unstable.

- In most situations, children are not going to leave their parents willingly, even though they have been physically or sexually abused. They may not understand what is best for them and may try to resist the law enforcement officer.
- Officers should not respond to a child's outbursts with anger or displeasure. Instead, they should behave as positively—or at least neutrally—as possible. They should do everything they can to help the child adjust to a new and scary situation.
- Once the officer has removed the child from the residence and the child has had a chance to calm down, if the child is old enough to communicate, the officer should take the time to explain that the child has not done anything wrong and was removed for his or her own protection.

Conclusion

Child abuse is a multidimensional problem that requires a multidisciplinary, multiagency team approach for successful intervention. This means that all professionals involved—in law enforcement, child protective services, mental health, medicine, and the law—communicate and coordinate with one another. A child's best interest can be served only when the various professionals that are involved understand their respective roles, possess knowledge of their State statutes and local guidelines, and have adequate training in their respective fields. Sensitive and consistent application of policies and procedures established in written protocols is essential for an effective alliance to combat child maltreatment.

Contributing Authors

Carl B. Hammond
Law Enforcement Consultant/Trainer
P.O. Box 5332
Rockville, MD 20848–5332
301–468–3416

Kenneth V. Lanning, M.S. (Retired)

Wayne Promisel, M.S.
Detective, Child Services Section
Fairfax County Police Department
10600 Page Avenue
Fairfax, VA 22030
703–246–7813

Jack R. Shepherd
Captain
Executive Division
Michigan State Police
714 South Harrison Road
East Lansing, MI 48823
517–336–6552

Bill Walsh
Lieutenant, Dallas Police Department
Youth and Family Crimes Division
106 South Harwood Street, Room 225
Dallas, TX 75201
214–670–5391

Supplemental Reading

Besharov DJ. *Combating Child Abuse: Guidelines for Cooperation Between Law Enforcement and Child Protective Agencies.* Washington, DC: AEI Press, 1990.

Briere J, Berliner L, Bulkley J, Jenny C, Reid T (eds). *APSAC Handbook on Child Maltreatment.* Newbury Park, CA: Sage Publications, 1996.

Bryan J. *Team Investigation in Child Sexual Abuse Cases: A Desk Reference for Law Enforcement Officers, Protective Service Workers, and Prosecuting Attorneys.* Little Rock, AR: Arkansas Child Sexual Abuse Commission, 1987.

Center for the Future of Children. *Sexual Abuse of Children.* Newbury Park, CA: Center for the Future of Children, the David and Lucille Packard Foundation, 1994.

Child Abuse and Neglect State Statute Series. A joint project of the National Center on Child Abuse and Neglect (NCCAN) and the National Center for Prosecution of Child Abuse (NCPCA), this five-volume series summarizes State statutes

on child abuse and neglect in nontechnical language: Volume I, Reporting Laws; Volume II, Central Registries; Volume III, Investigations; Volume IV, Child Witnesses; Volume V, Crimes. The series is updated annually and is available from the National Clearinghouse on Child Abuse and Neglect Information, 800–FYI–3366.

DePanfilis D, Salus MK. *A Coordinated Response to Child Abuse and Neglect: A Basic Manual* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, 1992.

Myers JEB. *Legal Issues in Child Abuse and Neglect.* Newbury Park, CA: Sage Publications, 1992.

Pence D, Wilson C. *The Role of Law Enforcement in the Response to Child Abuse and Neglect.* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, National Center on Child Abuse and Neglect, 1992.

Pence D, Wilson C. *Team Investigation of Child Sexual Abuse.* Newbury Park, CA: Sage Publications, 1994.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Smith JC, Benton RL, Moore JK, Runyan DK, American Association for Protecting Children. *Understanding the Medical Diagnosis of Child Maltreatment: A Guide for Non-Medical Professionals.* Englewood, CO: American Humane Association, 1989.

Whitcomb D. *When the Victim is a Child.* 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Wycoff MA, Kealoha M. *Creating the Multidisciplinary Response to Child Sex Abuse: An Implementation Guide.* Washington, DC: Police Foundation, 1987.

Organizations

National Center for the Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–549–4253
703–549–6259 (fax)

The National Center for the Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Federal Bureau of Investigation
935 Pennsylvania Avenue NW.
Washington, DC 20535–0001
202–324–3000

Forensic examination of evidence can be useful in cases of child sexual abuse. Tests that may be considered include:

- DNA profiling of body fluids or biological stains.
- Comparative examination of foreign hairs and fibers with those of a suspected source.
- Chemical analyses for petroleum jelly or lotion residues.

Questions on submission of these types of evidence can be directed to your local crime laboratory or to the FBI Laboratory at the number given above.

Fox Valley Technical College
Criminal Justice Department
Law Enforcement Training Programs
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54914–2277
800–648–4966
920–735–4757 (fax)

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.

- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers an intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Children's Advocacy Center (NCAC)
Training Department
200 Westside Square, Suite 700
Huntsville, AL 35801
256–533–0531

NCAC sponsors satellite video training conferences on a range of topics. Recent examples include interviewing children, medical aspects of child abuse, team-building for multidisciplinary teams, and the connections between domestic violence and child sexual abuse. Continuing education credits are available.

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association
(ABA)
Center on Children and
the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association
(AMA)
Department of Mental Health
Chicago, Illinois
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society
on the Abuse of Children
(APSAC)
Oklahoma City, Oklahoma
405–271–8202
405–271–2931 (fax)

Federal Bureau of Investigation
(FBI)
National Center for the
Analysis of Violent Crime
Quantico, Virginia
703–632–4333

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse
(JJC)
Rockville, Maryland
800–638–8736
301–519–5600 (fax)

Kempe Children's Center
Denver, Colorado
303–864–5252
303–864–5302 (fax)

National Association of Medical
Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing
and Exploited Children
(NCMEC)
Alexandria, Virginia
703–274–3900
703–274–2220 (fax)

National Center for the
Prosecution of Child Abuse
Alexandria, Virginia
703–549–4253
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on
Child Abuse and Neglect
Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource
Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Criminal Investigation of Child Sexual Abuse

Portable Guides to Investigating Child Abuse

Foreword

The criminal investigation of charges of child sexual abuse—a felony in every State—is one of the most difficult challenges facing law enforcement professionals.

The heinous nature of the alleged act underscores law enforcement's responsibility to conduct a thorough and objective investigation of suspected cases of child sexual abuse to determine whether they can be substantiated and to facilitate successful prosecution of perpetrators.

The information furnished in *Criminal Investigation of Child Sexual Abuse* is intended to serve as a useful tool in achieving these objectives. Barriers to successfully investigating child sexual abuse allegations are noted, and investigatory techniques designed to overcome them are suggested.

Interviews often play a key role in child sexual abuse investigations, and this guide offers helpful hints for interviewing the child and other possible victims, relatives, friends, nonoffending caregivers, and any suspects. Specific questions, including questions about the child, the suspect, and their relationship, are provided. Other techniques, including searches and medical examinations, are also covered.

As noted above, the challenges facing law enforcement in investigating purported child sexual abuse are indeed considerable. The stakes are high: The innocent—whether victims of child sexual abuse or victims of false accusations—must be protected. Your efforts to protect children and serve justice are appreciated.

Original Printing May 1997

Second Printing March 2001

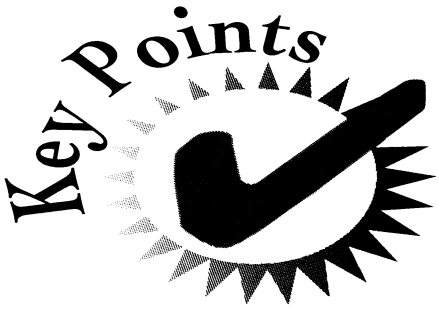
NCJ 162426

Overview

Child sexual abuse is a felony offense in all 50 States, but in many areas of the country limited resources are devoted to its response. A sexual abuse case might involve a child who has been victimized by a father, stepfather, uncle, or family friend for an extended period, sometimes involving 30, 50, 100, or even more incidents, each one a felony. Yet preliminary investigations are frequently carried out by the social service agency and only later, in the most serious cases, does law enforcement get involved.

For even the most experienced police officer, investigating child sexual abuse cases is a difficult and challenging task. The process is often long and tedious, and the toll on an officer's emotions at times can seem overwhelming. Careful investigative interviewing, comprehensive and complete documentation of facts, and painstaking collection and preservation of physical evidence are essential. Often the lack of physical or medical evidence only compounds the difficulty. Despite these obstacles, police must maintain their commitment to conduct a thorough investigation, one that will support or disprove an accusation of child sexual abuse beyond a reasonable doubt within a court of law.

In general, child sexual abuse may be defined as any sexual activity that is inappropriate for the child's age and level of maturity. Legally, however, each State defines child sexual abuse somewhat differently, so you must be familiar with the statutes governing your particular jurisdiction.



Your primary responsibility as a law enforcement agent is to protect the child and then to validate or invalidate the specific allegations the child or reporter has made. To be an effective investigator of child sexual abuse cases, you must be able to:

- Understand the developmental abilities of children at different ages and communicate with all ages effectively.
- Believe that child sexual abuse really exists and understand its dynamics.
- Distinguish among truthful, confused, or false statements by conducting a thorough investigation.
- Empathize with both the victim and the offender, putting aside feelings of anger and disgust in the interest of obtaining as much information as possible.
- Maintain your objectivity throughout emotional investigations, remaining openminded and nonjudgmental.

Barriers to the Investigation of Child Sexual Abuse Allegations

Some barriers are inherent to investigations of crimes involving child abuse. For example, child victims generally do not realize that a crime has been committed and therefore do not report the abuse to police or social services directly; instead, they confide in a parent or trusted friend.

Child victims are often sworn to keep the sexual behavior a secret and are afraid to report the abuse. They may have been warned, "If you tell, Mommy won't love us anymore," or "If you tell, Daddy will be sent to jail and you will never see me again." Occasionally, victims are threatened with bodily harm.

At the same time, many child victims genuinely care for the offender. They do not wish to see harm come to him and do

not want to testify in court against him.* The result is that as an investigator you are faced with a victim of a crime who does not wish to report or discuss the crime.

Other barriers are presented by investigators themselves. For example:

- Some investigators may not believe a child's statement when it conflicts with that given by an adult. They may be unwilling to make an arrest based on the word of a child.
- Others may suffer from overwork and burnout, or they may be unable to piece together the inconsistencies in a report or see beyond the barriers presented by the child.
- Often investigators lack knowledge about how to talk to children or interview them effectively.

Without an understanding of the expected barriers or an ability to sort and integrate the information given by all those who are interviewed, even a seasoned investigator may have difficulty organizing evidence in a case of child sexual abuse. Armed with an awareness that these barriers exist and are to be expected, however, the skilled investigator will not hesitate to pursue the allegations objectively.

The Investigation

From the moment of disclosure of a child sexual abuse complaint, your first responsibility is to protect the child. You must gather information regarding the accusation immediately, for the child's safety may be at stake and removal of the child from the home may be necessary.

It is also the responsibility of law enforcement and child protective services to conduct a thorough and objective investigation, including the gathering of physical evidence related to the alleged abuse (which may include search and seizure) and the procurement of arrest warrants.

The investigation may be divided into two broad categories:

- Interviewing of the child victim, the victim's parents or caregivers, siblings and other possible victims, other relatives and friends of the victim, and the suspect.

---

* Both men and women have sexually abused children. However, in this guide, for simplicity's sake, the male pronoun will be used and should be interpreted to include women offenders as well.

- Gathering of evidence, through the search and seizure process and through the medical examination.

The investigation, and its followup, will benefit from a multidisciplinary team approach incorporating not only law enforcement and child protective services but other community agencies as well. These can contribute information, expertise, and other resources to ensure the best interests of the child are met.

The team approach has been adopted in many jurisdictions and can include the participation of schools, community agencies, courts, and healthcare providers. Members of the team achieve consensus on common goals, mutual responsibilities, and a process for ensuring good communication and feedback.

Who Should Be Interviewed

Conduct interviews with the child, the nonoffending parent (in intrafamilial cases, i.e., when the suspect is a family member), other individuals (siblings, other relatives, the child's friends), and the suspect. If the abuse occurred within the family, it is better for you to interview the suspect after you have interviewed the victim and the nonoffending parent(s), for these interviews will provide a framework for questioning the alleged offender. In extrafamilial cases, when the suspect is not a family member, the preferred sequence is to interview the victim, other potential victims, or others having corroborative information before interviewing the suspect.

Interviewing the Child

The focal point of the investigation is the child, and the interview with the child is likely to be the single most important part of the investigation. In most sexual abuse cases, there is little or no medical or physical evidence. Consequently, validation of the allegations and proof of the child's need for protection will often rely heavily on the interview with the child. This interview should be conducted directly after the complainant's report has been received, in private, and in a neutral setting. It is important to gather as much specific

information as possible before interviewing the child, and the interview should be fully and accurately documented.

The purpose of the interview with the child is to establish the child's version of what, if anything, happened. If an allegation of abuse is made, you should determine the following:

- How and where the child was touched.
- If threats, promises, or requests were made.
- If other victims or offenders were involved.
- When the abuse occurred and how often it happened.
- Where the abuse occurred.

Begin by introducing yourself, establishing your credibility, and clarifying the purpose of the interview. A sense of trust must be established with the child in order to have an effective interview.

The child will need reassurance, support, and encouragement to tell the truth. Easy, general questions allow you to establish rapport and assess the development of the child. Associating incidents with important events, such as birthdays, holidays, or vacations, or with grade level in school can help to spur a child's memory.

Leading questions should be avoided; simple, direct, open-ended questions asked one at a time are best. The child needs to be given adequate time to respond to each question. The language and terminology used should be appropriate for the child's level of development.

Interviewing the Nonoffending Parent or Caregiver

In cases of intrafamilial abuse, and particularly when the suspected abuser is the father or any other close relative, the child's nonoffending parent or caregiver (whether or not that person is also the complainant) is an important source of information. This delicate interview with the nonoffending parent is thus very important and should take place as quickly as possible, before that person's statement can be tainted through contact with the offending parent.

Begin by informing the nonoffending parent of the allegations, as follows:

- Provide a basic account of the child's version of the incident, without giving all of the details.
- If evidence supports the allegations, let the parent know that you believe the child.
- Explain all of the steps to be taken in the investigation and discuss the possibility that the child may recant because of pressure or threats.
- Explain the importance of gathering potential physical evidence.

You should find out if the parent believes the child was sexually abused and realizes the seriousness of the allegations. For whom does this person express concern—the child? the perpetrator? himself or herself? Is the person able and willing to follow a plan that will protect the child from further access by the suspect?

If the nonoffending parent is financially or emotionally dependent on the suspect, this dependence has an influence on the information gathered and on the safety plan. Assess the situation and be prepared to take legal steps, if necessary, to ensure the protection of the child.

You can ask the nonoffending parent a number of specific questions to obtain information important to the investigation:

Questions About the Child

- What, if anything, did the child say about the abuse, and does he or she talk about it?
- Did the child exhibit any unusual behavior before or after disclosure?
- Has the child been abused before or made previous allegations of abuse?
- What else is going on in the child's life? For example, have there been changes in the child's relationships with family members or friends? In the level of involvement in hobbies or outside activities? In physical, mental, or learning abilities? Has the child had any involvement with the juvenile court system?
- How much exposure has the child had to sexual matters through contact with others, television, movies or videos, magazines, observation of adults, or sex education?

- What is the child's medical history? Has there been any drug or alcohol abuse?

Questions About the Suspect

- What was the suspect's reaction to the allegation? Did he make any other pertinent statements?
- Has the suspect possessed clothing, weapons, or other items described by the child?
- Does the suspect have a history of drug or alcohol abuse?
- Does the suspect have any scars, tatoos, or birthmarks? Unusual features on or near the genitals?
- Has the suspect ever had a venereal disease? What treatment was sought? Have you ever contracted such a disease from the suspect? Has the child ever had a sexually transmittable disease?
- Please provide any other pertinent medical information about the suspect. For instance (if the suspect is a man) has he obtained a vasectomy?
- Does the suspect use pornography, sexual aids or implements, or birth control devices? Does the suspect indulge in any strange or distinctive sexual practices?
- Have prior accusations been made against the suspect? Have there been any previous arrests or crime convictions?

Questions About the Relationship Between the Child and the Suspect

- If the suspect is outside the family (extrafamilial abuse), does he have a previous relationship with the child? What is that relationship and how would you describe it? Are there any problems between them?
- Does the child have a reason to lie about the suspect?
- How much time, if any, has the suspect spent alone with the child? When? Who else can verify this information?
- What is the suspect's responsibility for the child's care? For example, has the suspect ever bathed the child?
- What are the sleeping arrangements in the home?

Finally, ask if there have been any previous occurrences that seemed unusual or suspicious, even if nothing was done about them at the time. Explain the importance of gathering potential physical evidence and leave your name and telephone number so the parent can provide additional information or ask followup questions. You should also provide the nonoffending parent with information about available services (such as

alternative shelter and sources for food, clothing, financial aid, and support groups) and how to access them.

Interviewing Siblings and Other Possible Victims

Interview siblings and other possible victims after the victim and before or after the interview with the nonoffending parent, depending on situational circumstances and availability. Use the same techniques and sensitivity in interviewing siblings and other possible victims that you used to interview the child victim.

The purpose is to determine if other children have been victimized and to corroborate the child victim's statement. Look for information that may either verify or refute the child's statement. It is also important to assess the objectivity of the witness.

Interviewing Other Relatives and Friends of the Victim

Interview all members of the family and household for information concerning the victim, the suspect, and the abusive incident. The type of case will dictate whom you should interview. You should determine:

- Whether the child told anyone about the abuse.
- If the child or suspect asked anyone to conceal information.
- If anyone can verify details given by the child.
- If anyone was prevented from witnessing the abuse. For example, was a potential witness ever locked out of the house, locked out of a room, or asked to leave?

Interviewing the Suspect

The principal psychological factor contributing to a successful interview with the suspect is privacy. Thus, whenever possible, the interview should be conducted in private by a single interviewer. If the interview is considered an in-custody interview, the suspect should be informed of his legal rights as prescribed by the Miranda ruling of the U.S. Supreme Court.

The purpose of the interview is to gather as much detailed information as possible that either verifies or refutes the alleged abuse. When the accused cannot present credible information to refute the allegation, the ultimate goal is to obtain a confession. For many offenders, the knowledge that police are gathering material evidence can provoke overwhelming anxiety and may lead to a confession of guilt.

Timing of the Interviews

The timing of the interview must be chosen carefully and depends on whether the case is extrafamilial or intrafamilial. In *extrafamilial cases,* you should interview the suspect after you have gathered as much information as possible about the reported incident, the child, the family situation, and the suspect's background. You should perform a background check and also check the suspect's alibi, if one has been given, before the interview.

In *intrafamilial cases,* it is critical that you interview the suspect as soon as possible after your interview with the victim and the nonoffending parent. A useful approach is to ascertain from the spouse the time that the suspect will be home and attempt to approach him there for the interview (preferably when the spouse and other family members are away). This gives you the opportunity to be the first to tell the suspect of the disclosure and to note his reaction to the accusation. This approach also minimizes the opportunity for him to destroy or remove physical evidence in the home.

Another approach is to call the suspect at his place of employment, tell him there has been a problem of a sensitive nature involving his child, and ask him to come to the police station. It is not wise to give specific details over the telephone. Another option is to offer to meet the alleged offender at his place of employment. Few offenders choose this option, however, because it may create an embarrassing situation with employers. Regardless of location, it is important not to delay the interview.

Importance of Objectivity

During this type of interview, objectivity is paramount. Treat the suspect with respect, patience, and sensitivity, regardless

of the nature of the offense. Use language that is nonjudgmental and is familiar to the suspect. The atmosphere must be one in which the offender can tell you about this most difficult set of circumstances in his life. If you can create such an atmosphere, the likelihood that an intrafamilial abuser will confess to the crime is substantially increased.

During questioning, you should:

- Present the accused with the nature of the accusation.
- Establish the suspect's view of family dynamics.
- Confront the suspect with specific information revealed in the interviews of the victim, nonoffending parent, and others.
- Appeal to the suspect's love, emotional attachment, and concern for the child, spouse, and family.

Gather information from the suspect that will corroborate anything at all the child may have stated. The suspect may deny the abuse, may deny responsibility for the abuse, may offer reasons or excuses for the abuse, may ascribe a motive to the child, may minimize the seriousness of the abuse, or may downplay the number of occurrences.

If the suspect chooses to make a confession, you should take proper action according to your department's policy regarding Miranda warning, warrant application, and arrest. If the suspect denies the charges, you may offer him the opportunity to take a polygraph examination. Throughout, be aware of the policies and procedures of your jurisdiction, your State, and your department.

At the conclusion of the interview, inform the suspect that the investigation will be ongoing and that the services of police and protective services are available if he needs assistance.

Gathering Physical Evidence

A thorough child abuse investigation includes gathering any physical evidence that exists, because such evidence is extremely critical. Make every attempt to secure any evidence that corroborates statements made by the victim or by any witnesses (see table 1, pages 12 and 13).

You will be more likely to obtain the evidence if you do it early in the investigation. During interviews with the victim,

witnesses, and the suspect, pay particular attention to statements indicating the presence of physical evidence (see table 2, pages 14 and 15).

Searches of the Crime Scene

You should observe normal investigative crime scene procedures:

- Identify each piece of evidence. Indicate its position and condition, the date and time it was collected, the name of the person who found it, its relation to other evidence, and how it is marked.
- Preserve the crime scene. Using proper collection techniques, place the piece of evidence in an appropriate container and label it accurately.
- Store the evidence appropriately. List everyone who handles it.

Crime scene searches are often overlooked in child abuse cases, particularly in intrafamilial cases. But as in other types of crimes, the crime scene search can be extremely helpful in uncovering evidence of the crime and in supporting aspects of the child's statement.

Even if the child has not mentioned any specific items that might be seized, it is to your advantage to document the scene the child describes as soon after the interview as possible. The greater the delay, the greater the likelihood that the suspect or others could destroy or alter the scene to diminish the credibility of the child or to cover up indicators of abuse that the child may not have shared.

Preliminary steps in documenting the crime scene include:

- Identifying the person who first notified the authorities.
- Determining the perpetrator, either by direct inquiry or observation.
- Detaining or identifying all persons at the scene.
- Safeguarding and physically isolating the area.
- Separating the witnesses.
- Protecting the evidence from being handled or removed.

The following items should be readily available for use during any search:

- Camera (video or 35mm), tape recorder, and tape.
- Notebook, labels, paper bags, and cardboard boxes.
- Protective gloves.

Table 1

Types of Evidence

Evidence of violence: This type of evidence might include such things as broken lamps and holes in walls or furnishings.

Stain evidence: Semen will become fluorescent when subjected to black light.

Minute and latent evidence: Seminal fluid, sperm, hair, and fibers may be found in the child's bedsheets, pillowcases, and pajamas. The acid phosphatase enzyme test can locate seminal fluid many weeks, months, and sometimes years later. Like blood, sperm and seminal fluid can seldom, if ever, be washed completely from fabric.

Souvenirs: Small items, such as locks of hair, barrettes, panties, or pubic hairs may have been taken by the suspect to remember the sexual activity, or the child may have left pictures, drawings, letters, clothing, or toys with the suspect.

Lures: The suspect may have used toys, games, or stuffed animals to entice the child into the situation or to try to maintain the child's interest in the perpetrator.

Sexual aids or devices: The suspect may have used petroleum jelly and other lubricants, condoms, dildos, vibrators, or contraceptive foam or jelly with the child.

Drugs or alcohol: Evidence of the use of such substances by the suspect may be in a corroborating statement.

Child erotica: Child erotica is any material relating to children that a person may find sexually arousing; some of the more common types are child sketches, fantasy writings, diaries, and sexual aids.

Child pornography: Articles depicting sexually explicit conduct involving a child can be in any visual or print medium. Such articles are, in effect, a crime scene photograph of actual child abuse. Like souvenirs or trophies of sexual relationships, these photographs are important for establishing a relationship between the victim and suspect and for identifying other possible victims.

Obtaining Other Physical Evidence

Physical evidence is an important part of a thorough investigation. When collecting physical evidence, follow basic rules of evidence collection by carefully recording and preserving the evidence and by maintaining the chain

Table 1 *continued*

Types of Evidence

Adult pornography: Adult pornography can be used in several ways in child sexual abuse. The material may be used to sexually arouse the perpetrator or the child or may be shown to the child to lessen his or her inhibitions and to give the child an idea about sexual activities in which to engage.

Cameras (still or video) and film processing equipment: The suspect may have taken pictures of the child and then developed and printed the film using his own processing equipment. Undeveloped film and videotapes should be seized and viewed for content, no matter what the outside label says.

Home computers and software, personal letters, journals, diaries, or calendars: The suspect may have lists of other victims or offenders, or he may have correspondence from others who share a sexual interest in children.

Address book: The suspect's address book may have special notes near the victim's address or phone number, showing when the child gave the phone number or address to the suspect or when he called or visited the victim at home.

Bills, bank records, and receipts: These items may allow investigators to find items that were purchased for the victim by the suspect.

Phone bills and records: These items may allow investigators to find phone calls made to the victim.

Work records or timesheets: These items may allow investigators to demonstrate that the suspect had the time and opportunity to be with the child.

Weapons: A weapon may have been used during the abusive incident.

Other items: These can include any unique item described in the child's statement about the suspect or about the location.

of custody. The chance of finding physical evidence is greater at the beginning of an investigation, before the suspect has had an opportunity to destroy or hide evidence. Search for semen where the assault occurred. Also search the bathroom where the suspect has cleaned. (Table 1 lists other evidence that should be looked for.)

Table 2

Interview Information Provides Leads to Evidence

Child's Statement	Item Seized as Evidence
"Daddy used a green towel to wipe the yucky off."	The investigator confiscated a semen-stained green towel.
"Grandpa got my pajamas wet. It was sticky."	The female child's pajamas were seized and examined in the laboratory; semen stains were identified on the pajamas.
"Sometimes it would be wet on my legs, so I used my shirt to wipe it off."	The child's shirt was analyzed in the laboratory; semen stains were found on the shirt.
"Uncle Bill would stand next to my bed and rub his penis until white came out. It went on my rug."	The rug in the child's room was examined and found to have semen stains on it; pubic hair was found mixed with the carpet fibers.
"He tried to put a stick in my thing."	The child had a urethral injury documented by medical examination; in a search of the house, the stick used to inflict the injury was found and confiscated.
"Once he tore my underwear off."	The child's panties, which were torn by the abuser, were confiscated.

Interviews with the victim, witnesses, and the suspect will supply clues as to what physical evidence may be available. Taking pictures or videotapes can be helpful later in court to document where the items were found and under what circumstances.

Ask the child and/or the nonoffending parent to provide any items that could be physical evidence. In intrafamilial cases,

Table 2 *continued*

Interview Information Provides Leads to Evidence

Child's Statement	Item Seized as Evidence
"He showed me a magazine and said we should do this."	The magazine was confiscated.
"He took pictures of me with my clothes off."	Photographs were found and confiscated.
"He read me a book about sex."	A search of the alleged offender's room revealed the book described by the child.
"He made me dress up like Mommy and took my picture."	Photographs of the child dressed in her mother's clothes were seized as evidence.
"He made me put his thing in my mouth."	Laboratory cultures obtained from the child's throat revealed that the child had an asymptomatic gonorrhea infection of the pharynx.
"He always wears blue sweatpants."	A pair of blue sweatpants was confiscated and analyzed; semen stains were found on the clothing.
"He has a list of other boys on his computer disk; I saw it once."	A search revealed computer equipment and computer software that contained the incriminating list.

if the nonoffending parent is cooperative, you may be able to obtain additional physical evidence over which the nonoffending parent has joint control with the suspect by asking him or her to sign a consent for the search. However, be aware of your legal limitations. If you come to an area that is off limits to the spouse, such as a locked container or another area to which the spouse does not have access, it would be wise to consult with the prosecutor or obtain a search warrant.

Search Warrants

You should be thoroughly familiar with all procedures concerning search warrants. As a law enforcement official, you are required to produce a warrant to conduct a search. You may not use social service personnel, who do not have this restriction, to circumvent legal protections against unreasonable searches.

A search warrant can be issued only on probable cause, supported by an affidavit naming or describing the person, and particularly describing the property to be searched. Probable cause is a reasonable ground for suspicion, supported by circumstances sufficiently strong to permit a cautious person to believe that the accused is guilty of the offense charged. Most State laws specify what is necessary to obtain a warrant.

You should complete a detailed list of the items you are searching for, the possible location of those items, and your reasons for believing the items exist and can be found in those locations.

The affidavit, an attachment to the warrant, needs to spell out the training and experience that enables you to recognize the significance of items that might be found at the scene of the search but are not enumerated in the warrant. The warrant needs to be drafted as broadly as possible to allow you to seize everything you find that is pertinent to the case, to the motivation of the offender, to the level of interest in children, and to the identities of other victims.

When serving the warrant, you should first attempt to obtain consent from the suspect to conduct the search. Valid consent given by the suspect can prevent suppression of the seized evidence if the warrant is later invalidated.

Medical Examination

Medical evidence can provide powerful and convincing corroboration to an allegation of sexual abuse. Medical examinations should always be conducted by physicians and other healthcare workers who have received training in the area of sexual abuse and who can be sensitive to the needs of the child. You should be familiar with the normal tests

that accompany a rape case and make sure that the physician carries out these tests.

The medical examination team performs several functions critical to child abuse investigations:

- Documentation of any medical evidence that exists.
- Diagnosis and treatment of conditions, such as sexually transmitted diseases, that require medical treatment.
- Reassurance to the child that despite fears to the contrary, children are not permanently damaged as a result of sexual abuse.

The absence of medical evidence does not rule out the possibility that sexual abuse occurred. Sometimes the lack of medical evidence can be caused by a lengthy delay between an incident and the filing of a report. Moreover, some abusive acts, such as fondling, by their very nature cause no physical injuries.

Conclusion

When the investigative process is carried out carefully and conscientiously, answers to questions of guilt or innocence begin to emerge. When an abuser confesses to committing a crime, the child victim is spared the burden of testifying in court and living through a lengthy trial, and that is the very best protection law enforcement can provide.

Contributing Authors

Sergeant Richard L. Cage, M.A.
Detective, Montgomery County
Police Department
Family Services Division
2300 Randolph Road
Wheaton, MD 20902
240–773–5400

Donna M. Pence, M.A.
Special Agent
Tennessee Bureau of Investigation
901 R.S. Gass Boulevard
Nashville, TN 37216
615–744–4000

Supplemental Reading

Besharov DJ. *Combating Child Abuse: Guidelines for Cooperation Between Law Enforcement and Child Protective Agencies.* Washington, DC: AEI Press, 1990.

Bryan J. *Team Investigation in Child Sexual Abuse Cases: A Desk Reference for Law Enforcement Officers, Protective Service Workers, and Prosecuting Attorneys.* Little Rock, AR: Arkansas Child Sexual Abuse Commission, 1987.

DePanfilis D, Salus MK. *A Coordinated Response to Child Abuse and Neglect: A Basic Manual* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, 1992.

Groth N, Stevenson T. *Anatomical Drawings for Use in Investigation and Intervention in Child Sexual Abuse.* Dunedin, FL: Forensic Mental Health Associates, 1990.

Lanning K. Section I: Criminal investigation of sexual victimization of children. In Briere J, Berliner L, Bulkley J, Jenny C, Reid T (eds): *APSAC Handbook on Child Maltreatment.* Newbury Park, CA: Sage Publications, 1996, pp. 247–263.

Pence D, Wilson C. *The Role of Law Enforcement in the Response to Child Abuse and Neglect* (The User Manual Series). Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, 1992.

Pence D, Wilson C. *Team Investigation of Child Sexual Abuse: The Uneasy Alliance.* Thousand Oaks, CA: Sage Publications, 1994.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Sorenson T, Snow B. How children tell: The process of disclosure of child sexual abuse. *Child Welfare* 70:3–15, 1991.

Whitcomb D. *When the Victim Is a Child.* 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Whitcomb D, De Vos E, Cross TP, Peeler NA, Runyan DK, Hunter WM, Everson MD, Porter CQ, Toth PA, Cropper C. *The Child Victim as a Witness.* (Research Report). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1994.

Wycoff MA, Kealoha M. *Creating the Multidisciplinary Response to Child Sex Abuse: An Implementation Guide.* Washington, DC: Police Foundation, 1987.

Organizations

Many organizations sponsor annual conferences that would interest law enforcement officials. Information on upcoming conferences can be obtained from OJJDP's Juvenile Justice Clearinghouse, 800–638–8736, and the National Clearinghouse on Child Abuse and Neglect Information, 800–FYI–3366.

National Center for the Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–549–4253
703–549–6259 (fax)

The National Center for the Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

Child Welfare League of America
440 First Street NW., Third Floor
Washington, DC 20001–2085
800–407–6273
202–638–2952
202–638–4004 (fax)

Fox Valley Technical College
Criminal Justice Department
Law Enforcement Training Programs
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54914–2277
800–648–4966
920–735–4757 (fax)

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association
(ABA)
Center on Children and
the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association
(AMA)
Department of Mental Health
Chicago, Illinois
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society
on the Abuse of Children
(APSAC)
Oklahoma City, Oklahoma
405–271–8202
405–271–2931 (fax)

Federal Bureau of Investigation
(FBI)
National Center for the
Analysis of Violent Crime
Quantico, Virginia
703–632–4333

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse
(JJC)
Rockville, Maryland
800–638–8736
301–519–5600 (fax)

Kempe Children's Center
Denver, Colorado
303–864–5252
303–864–5302 (fax)

National Association of Medical
Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing
and Exploited Children
(NCMEC)
Alexandria, Virginia
703–274–3900
703–274–2220 (fax)

National Center for the
Prosecution of Child Abuse
Alexandria, Virginia
703–549–4253
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on
Child Abuse and Neglect
Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource
Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Interviewing Child Witnesses and Victims of Sexual Abuse

Portable Guides to Investigating Child Abuse

Foreword

Investigating child abuse requires talking to the children involved to seek out the truth regarding allegations. Interviewers must be objective and at the same time sensitive to the differences between children and adults and the special challenges these differences present.

This guide provides practical information for law enforcement officers, child protection workers, child abuse investigators, and others faced with the need to obtain information from children who may be victims or witnesses of child sexual abuse. The approaches and techniques provided can promote a process that is legally defensible and minimizes further trauma to the child. A particularly important aspect of the authors' work is their focus on maintaining an objective stance and avoiding the use of leading questions, especially with young children who may be susceptible to the suggestions of adults.

This guide provides basic considerations for the proper collection of information while focusing on particular techniques for interviewing children. It is my hope that the suggested approaches will prove helpful to all professionals investigating the increasing numbers of allegations of child sexual abuse.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

August 1996

Third Printing March 2000

NCJ 161623

Overview

Children are not miniature adults. They view the world from a different perspective. They relate and communicate in a forgotten language. When interviewers question children as if they were adults, misunderstandings and avoidable errors undermine children's credibility and contaminate their statements. Questions are asked in language that is too complex about concepts that are too abstract for them to understand. Children try to answer questions without the requisite skill. This happens when children who cannot count are asked how many times something occurred. Problems can also arise when few precautions are taken to minimize suggestibility or to overcome children's anxieties. As a result, children's statements may contain inconsistencies, distortions, and misinterpretations that are more a function of the interviewer's lack of knowledge than the child's lack of competence.

Interviewing children who may be victims of sexual abuse presents a special challenge to law enforcement personnel, not only because of the difficulty of talking about such private matters but also because of the child's potentially complex relationship to the perpetrator. The first part of this guide presents some basic considerations that investigators must keep in mind when interviewing children to ensure that the

interviews yield useful, factual information. The second part focuses on particular child interviewing techniques and other means of information gathering to verify or dismiss allegations of child sexual abuse. Taken as a whole, this guide is designed to help investigators get at the truth in interviews that are sensitive, objective, and fair.

General Guidelines for Interviewing Children

By Karen J. Saywitz

To maximize the accuracy and completeness of children's statements, the interviewer strives to create an accepting, unbiased environment. This is accomplished through understandable questions posed objectively, yet with empathy. The interviewer must build a bridge between the world of the child and the world of the adult to create the best opportunity for the discovery of truth.

The Interviewer's Approach

Interviewers need to exercise four important attributes: sensitivity to the child's stage of development, flexibility, objectivity, and empathy.

- **Be sensitive to the child's level of development.** This means the child's stage of development in terms of language, memory, knowledge, reasoning, and emotional maturity. The vocabulary and grammar of a question should match the child's language level, and the content of a question must be related to the child's knowledge base and experience level.
- **Be flexible.** Age alone is not a sufficient predictor of the reliability of children's statements. Be flexible in following the child's lead rather than adhering to rigid protocols or age limits. The pace, breadth, and depth of a single interview will depend on the way the child copes with anxiety, the characteristics of the event to be recalled, and a host of other factors that influence the interview process.
- **Be objective.** To elicit accurate reports from children, take extra care to maintain an objective, neutral stance. Biases can be conveyed inadvertently in tone of voice, facial expression, accusatory context, or questions that suggest a particular answer. Keep your own presuppositions in check to avoid adversely influencing young children's statements.

- **Be empathetic.** Finally, help children overcome the anxiety that is inevitable in the forensic setting. You cannot eliminate children's fears, but you can show understanding. Comments that show understanding reduce anxiety, allowing children to focus mental energy on remembering and reporting accurately.

Talking to Children

Phrase the question so the child understands

The grammar and vocabulary you use, as well as the instructions you give, must be appropriate to the child's age and stage of development (see figure 1, next page). To a young child, "court" is a place to play ball and a "hearing" is something you do with your ears. Ask children to define terms in their own words to be certain that they understand what you mean.

Talk about what children understand

The content of the questions must be geared to the child's knowledge base and experience. Forensic questions often request information in the form of feet, inches, pounds, hours, and dates. These are learned gradually over the course of elementary school. For a child who has not mastered them yet, find alternative methods. For example, instead of asking what time something happened, ask what television program was on. For dates, ask about the spring vacation during second grade.

Young children reason on the basis of what they see, not on invisible concepts or suppositions. Terms that are concrete and visual elicit more accurate reports. Don't ask, "How many times were you abused?" Rather, ask, "How many times did he hit you?" Talk in terms of pictures.

Young children also have difficulty viewing the world from other people's perspectives. A question such as "Why didn't you run away when he closed the doors and windows?" is difficult for them to answer because it requires their figuring out someone else's intentions.

Help children deal with questions they don't understand

School-age children also benefit from being warned that they might not understand all the questions. Say, "Some questions will be easy to understand and some will be hard to understand."

Figure 1

Simplifying Language

- Avoid long, compound utterances. Use shorter questions and sentences.
- Avoid three- or four-syllable words *(identify)*. Use one- or two-syllable words *(point to)*.
- Avoid embedded clauses, double negatives. Use simple grammatical constructions.
- Avoid multiword verbs *(might have been) (Might it have been the case that . . . ?)*. Use simple tenses *(-ed, was, did, has) (What happened?)*.
- Avoid hierarchical, categorical terms *(weapon, anything)*. Use concrete, visual terms *(gun)*.
- Avoid the uncommon usage found in legalese *(strike, hearing, parties)*. Use the common meaning of the term *(take out, meeting, people)*.
- Avoid pronouns *(him, her, they, he, she)*. Use proper names *(Mary, Joe)*.
- Avoid passive voice *(Was she hit by him?)*. Use active voice *(Did he hit her?)*.
- Avoid unclear references *(those things, this, it, that)*. Repeat the name of the person or thing you are talking about.
- Avoid words whose meaning varies with time or place *(here, there, yesterday, tomorrow)*. Use stable terms *(in the front of the room, in the back of the room, a lot, a little)*.
- Avoid relational terms *(more, less) (Did it happen more or less than two times?)*.
- Use several short questions to replace one overloaded question.
- Avoid questions that list several previously established facts before asking the question at hand *(When you were in the house, on Sunday the third, and Sam entered the bedroom, did Mary say . . . ?)*.

Adapted from Saywitz K, Elliott D. *Interviewing Children in the Forensic Context.* Washington, DC: American Psychological Association, in press.

Urge children to ask you to rephrase a difficult question by saying, "What do you mean?" or "I don't get it."

Be objective and avoid suggesting answers

Children produce limited information spontaneously. Open-ended questions elicit the most accurate information. Use them first. Specific questions can facilitate further recall, but if misleading, they distort young children's reports. Care must be taken especially with 3- to 4-year-olds, who are the most vulnerable to the effects of suggestion. Studies find that by 6 to 7 years of age, children significantly increase their resistance to misleading questions.

This does not mean that young children have insufficient memories or that they are always highly suggestible. Children can provide accurate information that is meaningful to an investigation if asked direct questions about central aspects of the event. Some children remain steadfastly resistant in the face of highly suggestive questioning, but others do not. The reliability of young children's reports can be highly dependent on the manner in which the children are questioned.

Provide a nonjudgmental atmosphere

You can be both kind and matter-of-fact in tone of voice and facial expression, no matter how unbelievable the response. Avoid creating an accusatory context in which suspects are labeled as "bad people" who did "bad things." Uncooperative and reluctant children should not be bullied, bribed, contradicted, coerced, or threatened. Probe inconsistencies by explaining that you are confused, not by challenging children.

Begin the interview with broad, open-ended questions

This provides an opportunity for relatively spontaneous, independent disclosure. If a child provides a brief narrative in response, you can help the child expand on the initial narrative by following up with questions focusing on information from the child first and from other sources afterwards.

Avoid leading questions whenever possible

You can limit the use of leading questions by rephrasing yes/no questions into "wh" questions (who, what, where) that

have less potential for distortion. "Did he hit you?" becomes "What did he do with his hands?" ("When" and "why" are more difficult for children 5 years and under.)

If you use yes/no questions, follow with queries that require children to elaborate, justify, or clarify their responses in their own words ("Tell me more" "What makes you think so?" "I'm confused"). This ensures that the child's yes or no means what the interviewer assumes it means.

Sometimes the more specific question is the better choice

General questions do not guarantee accurate accounts. For example, children under age 7 are likely to answer "No" to "Was there a weapon?" but "Yes" to "Was there a gun?" "No" to "Did he put something in your mouth?" but "Yes" to "Did he put a thermometer in your mouth?" In each example, the accurate response came from the specific question. The more general terms "weapon" and "something," while relatively less biasing, elicited erroneous information.

You will need to balance a variety of interests in deciding what kinds of questions to use. Particularly in cases of suspected sexual abuse (discussed in greater detail later in this guide), be certain to explore alternative possibilities. For example, if a young child confirms that she was touched on her "peepee," molestation may not be involved. Caretakers are routinely involved in toilet training and bathing. Ask about the circumstances leading to the touch.

Help children overcome their anxieties

Children's anxieties can interfere with their cooperation and recall. Try to see the interview from the children's perspective. Rather than telling children, "Don't feel nervous," which minimizes their feelings and shows you do not understand, admit that you understand how scary it is to be questioned by a stranger.

Let children know the limits on confidentiality

Children are worried about whom you will tell and why. Sometimes you can say you will tell only those who need to know to keep them and their family safe. Telling children

about the flow of information from the interview to the trial will reduce the feeling of betrayal that can compromise later testimony when they learn that what they have told you in private is now public knowledge.

Understand children's emotional reactions

Sometimes children's emotional reactions are misinterpreted as indicators of reliability. Children with posttraumatic stress disorder tend to avoid all reminders of past trauma. Interviewers can expect such children to be uncooperative. Children who are clinically depressed are withdrawn, indecisive, indifferent, or hopeless and tend to take a long time in answering questions. Their silences are due to psychomotor retardation, not invention and lying.

Phases of an Interview

Step 1: Preparation

Phrasing questions in an age-appropriate fashion can be difficult for a first-time interviewer. It can be more manageable if you plan ahead. Before the interview, list the most important points to be covered. Then turn each into an age-appropriate, nonleading question.

- Gather information on the abilities of children in the age range of the child you will be interviewing as well as relevant background information on the child with respect to age, culture, disabilities, language, emotional adjustment, and family functioning.
- Plan where it will take place, who should be present, and how it will be documented.
- Determine what information will be needed for the report and for testimony to explain the how and why of interviewer choices.
- Be prepared to conduct followup interviews if necessary. Children find it stressful to tell their experience to a series of unfamiliar adults, so limit the number of different interviewers by following through yourself.

Step 2: Setting and context

Try to interview children outside the presence of caretakers and other adults with an interest in the case. However, children ages 6 and under may be unbearably anxious about being alone with a stranger.

- To reassure children, show them where caretakers will be waiting and allow them to check on caretakers when necessary. If this fails, arrange for a familiar, trusted observer who is not involved in the case.
- Introduce yourself and your role. For school-age children, explain the steps in the investigative and judicial process. Essentially, children need to understand the purpose of questioning—that the information they provide will be given to an attorney and possibly a judge. Tell the child that the information is needed to keep children safe, to make the best plan for the family, or to decide if someone broke the rules.
- Find a child-friendly setting and remove all distracting and intriguing gadgets. Do not interrupt the session for phone calls. If you give your wholehearted attention, the child is more likely to do so as well.

Step 3: Rapport building and developmental observations

Take time to build up trust. Begin with talk about harmless topics such as favorite foods or television shows, not about family. Don't go overboard with play materials. For many children, it will suffice to offer crayons and paper.

- In the beginning, take note of the child's language, reasoning, and knowledge.
- Test the child's understanding in areas relevant for later questioning. For example, to assess the child's knowledge level, ask the colors of the crayons, your age or height, the time it is, or the name of the State and city you are in.

What you do to build rapport will depend on the facts of a given case. Figure 2 suggests ways to assess a child's understanding.

Step 4: Information exchange

It is best to begin questioning about the event under investigation by offering children an opportunity for a spontaneous statement.

- If children have been told your role in the investigative process, start by asking them if there is anything they want to tell you or want you to tell the judge or the attorney.
- If this fails to produce a description of the event, try a number of other open-ended approaches. If you know the location of the crime, you can ask children to describe the physical and personal environment of the crime scene (for instance, what it looked like or how it smelled).

Figure 2

Assessing a Child's Understanding

Conventional Systems of Measurement. Ask questions about the day, the room, the interviewer, and so forth that require answers to be formulated in terms of feet, inches, miles, pounds, years, hours, minutes, seasons, months, or days of the week. (How tall am I? How many feet is it from this side of the room to the other? What is today's date? How long have we been sitting here?) Do not overwhelm children. Ask only about the issues germane to a given case.

Basic Concepts. Find out whether children understand basic concepts that may be critical to the facts of a particular case (e.g., first, last, never, always, beside, before, after). For example, line up a row of toys and ask children to identify the first and last one.

Colors. Children may be familiar with common colors, such as red, but unfamiliar with the names of uncommon colors, such as tan, mauve, or turquoise. Use a box of crayons to find out what words they use to identify certain colors if the color of an object is critical.

Locations. Children remember locations in terms of landmarks that are meaningful to them. They may recall a place by the color of the house or by the name of the neighbor rather than the street address. Ask children to name their city, State, or street.

Kinship Terms. Many cases require children to discuss relatives before they have mastered the adult understanding of kinship relations. Elicit children's names for important people in their lives, including family members and anyone else who lives in their house.

Numbers Skills. Giving children a set of objects and asking them to hand you a certain number is one test of counting ability. However, children's ability to count objects may not extend to counting events in time. Adults typically estimate and reason out the number of instances.

Ability To Take Another's Perspective. Try to assess a child's ability to infer others' intentions, feelings, and thoughts. For example, ask what they intend to get a parent for their birthday. Is it an appropriate gift?

Adapted from Saywitz K, Elliott D. *Interviewing Children in the Forensic Context.* Washington, DC: American Psychological Association, in press.

- Then ask for a description of what happened there from beginning to end. Tell children to tell you everything, even the little things they might think are not very important.
- Over the course of the interview, move from children's spontaneous narratives in response to open-ended questions ("What happened?") to prompts that help children elaborate on the few facts they provided on their own.
- Do not interrupt children's narratives, and do not introduce information from other sources at this point. Prompt with "What else?" "What happened next?" or repeat their replies with rising intonation to help children elaborate on the facts they have raised.
- Follow the narrative with open-ended "wh" questions. Closed questions that limit answers to yes or no are reserved for the end. If you use them, employ followup prompts to elicit elaboration in the child's own words ("Tell me more") or justification ("What makes you think so?").

Step 5: Closure

Thank children for their help. Praise their effort, not the content of what they said.

- Thank children for working hard during the interview, even if no forensically relevant information was forthcoming and additional interviews are needed.
- If children are upset, give them time to recompose. Offer empathy for doing something that was hard for them to do and praise their bravery. Ask their impressions of the interview. Dispel misperceptions that arise.
- Tell children what will happen next. This reduces fears about the future. Explain when you will meet again and for what purpose. Educate children about the next steps in the investigative and judicial process.

Interviewing Children Who May Have Been Sexually Abused

By Kathleen Coulborn Faller

Investigators face many challenges when interviewing children who may have been sexually abused. The fundamental dilemma is that if the child has been abused, many factors may keep the child from disclosing information to an investigatory interviewer. At the same time, techniques that might be useful in overcoming the child's reluctance to disclose actual abuse might also result in a cajoled or coerced false allegation or the appearance of one.

- As the interviewer, your first challenge is that most children have been told by the offender not to tell. The offender may have used several strategies with the child to inhibit disclosure:
  - Manipulation ("If you tell, I won't love you any more").
  - Bribes (giving the child material goods such as food, special clothing, or a car, and allowing special privileges).
  - Threats (loss of love, removal from the home).
  - Threats of bodily harm ("I'll kill you" or "I'll kill your mom").
- Your second challenge is that many children who have been sexually abused have been told not to trust authority figures. Children may have been told, "If you tell the social worker, she will put you in foster care" or "If you tell the police, I will go to jail."
- Your third challenge is that in a large percentage of cases of suspected sexual abuse, the child has not made a decision to disclose the victimization. A concerned adult, such as a professional or a family member, has decided to involve authorities. The child may not want to see you or talk to you.
- Your fourth challenge is that you are asking the child to tell you about shameful and secret experiences. Consider how you would feel if you were asked to provide intimate details about your last sexual encounter to a stranger in a position of authority.

For all of these reasons, it will take patience and time to interview a child who may have been sexually abused. Cases in which a single interview of a half-hour yields a description of sexual abuse are uncommon.

It is also important to understand that the case you investigate may or may not be a case of sexual abuse. Approach the case with an open mind and avoid techniques that can be perceived as leading or coercive.

Level of Likelihood

- Concerns about sexual abuse may be based on strong evidence, such as conclusive medical evidence, observation of the abuse by a trustworthy third party, or the offender's confession.
- Alternatively, concerns may be based on less compelling evidence, such as behavioral changes in the child (e.g., wetting the bed, nightmares) that could be caused by a variety of factors.
- An additional situation of lesser likelihood is one in which a child has described sexual abuse that involves other potential victims. These cases may involve documented incest with additional children in a family, or they may be extrafamilial sexual abuse cases such as in a Boy Scout troop or a day care center, where other potential victims may be suspected.

- However, even in "other potential victim" cases, the level of likelihood can vary. For instance, the child being interviewed may or may not have been identified as a victim.
- Level of likelihood will guide the extent of investigation, with high-likelihood cases requiring more investigation than low-likelihood cases.

Preparing for the Interview

Sexual abuse can include a wide range of possible behavior, from sexual touching to child pornography. The sexual activity can be carried out by people with a range of relationships to the child, from parent to stranger. Sexual abuse can occur in a variety of contexts—at home, at school, or in a car, for instance. Before interviewing the child, obtain as much information as you can about sexual acts that may have occurred, the identity of the alleged offender, and the place where the abuse is alleged to have occurred. However, be aware that having this information may increase your vulnerability to leading questions. Avoid just asking the child to support the information you already have about the abuse.

You should gather information about the child's family, the child's school situation, recreational activities, and typical day. Information about the child's social situation will help you understand and place in context what the child tells you. Suppose the child's father is a bartender, for instance, and the child speaks of daddy giving people lots of drinks. Knowing the father's occupation will probably lead you to interpret the child's statement differently than not knowing.

Since assessment of possible sexual abuse involves gathering historical information, you will also want to determine the child's ability to recall past events and capacity to provide other factual information.

Questioning

Begin your questioning with a general question or statement, perhaps one that relates to your role. "I am a protective services worker. My job is to make sure kids are safe."

Try to obtain information about alleged abuse from the child rather than getting the child to confirm information you already have. Your previously acquired information about the alleged abuse can guide your questioning, but it must be used in a

nonleading way. Once the child has provided information, repeat it to make sure you have heard the child accurately and/or to cue further disclosure.

Strive to use as many open-ended questions as possible

Resort to more close-ended ones only when open-ended ones do not work. The more open-ended the questions, the greater confidence you should have in the response, and conversely, the more close-ended, the less confidence. Figure 3 (see pages 14 and 15) presents the continuum of investigative questions, beginning with the most open-ended, desirable kinds of questions for interviewing children, and concluding with the leading and coercive questions appropriate for interrogating adult suspects of crime but not child victims:

- **Focused questions.** Young children and reluctant children require focused questions. These questions should focus on "who," "what," "where," or "when," one at a time.
- **Followup questions.** Most children will not provide a narrative in response to a focused question but rather a brief answer, such as "John hurt my butt." Follow up with additional focused questions or "followup" questions.
- **Multiple-choice questions.** If open-ended questions are not adequate, you may need to resort to close-ended ones. Multiple-choice questions may be appropriate, but responses to them may be less accurate. Avoid questions when all the choices could be incorrect. The questions should be restricted to "where" and "when," unless the child's previous disclosures make it clear there is a "who" or "what."
- **Direct questions.** Even if you must resort to a direct question, ask it in an open way. "Did your dad do something to your peepee?" Follow up an affirmative response with a focused question, "What did he do?"

Avoid leading or coercive questions

Leading questions are ones in which the desired response is explicit in the question. Sometimes they are called "tag" questions because they begin or end with a tag, such as "Isn't it true that?" or "Didn't she?" Avoid using these in an investigative interview. Also avoid coercion and inducements.

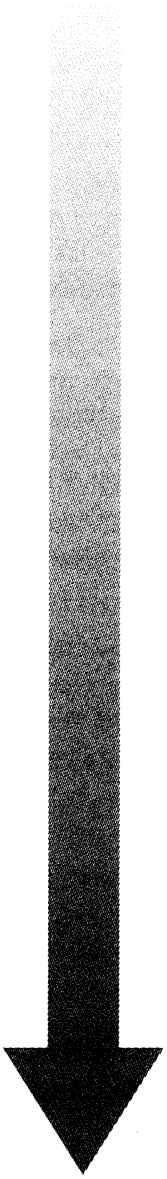
Interrogation techniques are inappropriate in interviews with children who may have been sexually abused because:

- Victims of abuse have different motivations than offenders trying to protect themselves.

Figure 3

Continuum of Questions From Open Ended to Close Ended

The following types of questions progress from the more desirable open-ended ones to less desirable multiple-choice and direct questions, and finally to undesirable leading and coercive questions. The more open-ended the question, the greater the confidence in the response elicited from the child.



General

I talk to kids when grownups don't treat them right. Has any grownup mistreated you?
Tell me everything you can remember about X.
Do you know why we are talking today?

Focused

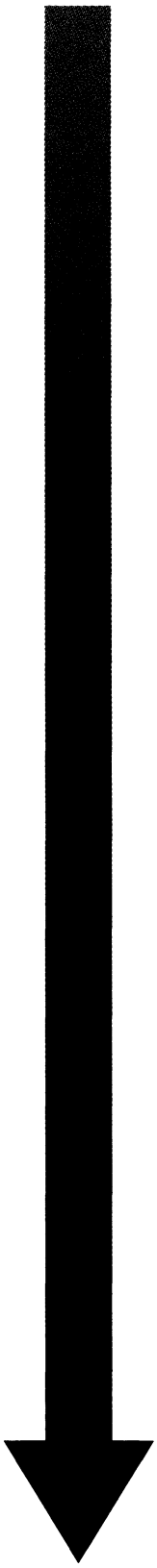
Who (person who may have abused child)
Tell me about your dad. What do you like about him?
Are there things you don't like?
Are there special things you do with Uncle Joe?

What (abuse)
Does anyone ever touch your peepee?
Did you ever see a penis? Whose?
Are there secrets at your house?
Do you ever play special games?

Where (circumstances of abuse)
Tell me what happens at day care.
What do people do at Dave's house?
What do you remember about the camping trip?

When (circumstances of abuse)
Who puts you to bed?
What happens when your dad drinks?
What happens when you get a bath?

Figure 3 *continued*



Disclosure (prior to interview)
Did you talk to your teacher about someone hurting you?
Did you have to go to the doctor?

Followup

Narrative Cue
What happened after that?
And then what?

Repeat (of child's statement)
He touched your private?

Clarify (previous statement)
You said he bit you down there?
Where exactly did his peepee go?

Multiple choice

Did it happen in the daytime or nighttime or both day and night?
Did he hurt your butt, face, arm, or somewhere else?

Direct

Was it your dad who hurt your peepee?
Did Mr. Jones put his penis in your mouth?

Leading

Isn't it true that your brother bit your peepee?
You were lying about what your mom did, weren't you?

Coercive

If you don't tell the truth, you're not leaving this room.
We can go get ice cream once you tell me what happened.

- Children are more suggestible than adults, especially children under 6 and especially if the interviewer is an adult and in a position of authority.
- Deprived and maltreated children may be especially vulnerable to giving confirmatory information. They usually have a history of compliance to adult wishes and may respond to positive attention by giving you the information they think you want.

Use of Anatomical Dolls and Other Media

Children are usually less accomplished than adults in communicating verbally. Because of this, you may need to use media or props in addition to language to gather information. This allows children to demonstrate as well as say what they have experienced. Many media can be employed, but the most useful for investigatory interviewers are anatomical dolls, anatomical drawings, and picture drawing.

However, media, especially anatomical dolls, have some drawbacks. In some jurisdictions, their use may complicate the legal case. In addition, children most in need of props, those under 4, may have difficulty reenacting events with a doll representing themselves and another the alleged offender. They may be more successful using their own bodies and a doll or pointing to relevant body parts on the doll.

Anatomical dolls and drawings

As anatomical models, dolls and drawings help the interviewer conduct a body parts inventory. The interviewer asks the child to name the body parts and perhaps describe their functions. It is advisable to use four dolls or drawings, male and female, adult and child, and to ask the child to name all body parts, not just the sexual body parts. For accurate communication when interviewing, you should use the names the child employs for the body parts. After the inventory, you may ask a focused question on body parts, such as "Did you ever see a man's wingus?"

As demonstration aids, dolls and drawings may help the child to show what happened. The interviewer helps the child choose appropriate dolls or drawings for the event to be demonstrated. An advantage of using demonstration aids is that you have to ask fewer questions. This means more information is generated by the child than by the interviewer. However, some focused and followup questions will be useful in gathering information about details of the event. For example, you could ask the child,

"Do you remember where the wiener went?" or "And then what happened?"

When the dolls or drawings are used as demonstration aids, they can:

- Facilitate a child's disclosure. If the child does not want to talk about an incident, you can ask if the child can show you with dolls or drawings.
- Clarify a child's vague communication, such as, "He hurt me," or "He humped me." You can suggest that the child show you exactly how that was done with dolls or point to the body parts involved, using the drawings.
- Corroborate the child's verbal disclosure. This provides additional support for the child's statement and may increase your level of certainty about the abuse.

Picture drawing

Sometimes called free drawing, picture drawing can also help children communicate experiences. Mental health professionals may ask the child to draw a person or the family, for instance. Research suggests that these "generic" drawing tasks usually do not yield information helpful in making a determination about sexual abuse (Friedrich, 1993). However, "abuse-specific" drawings may be useful. These include:

- A picture of the alleged offender, followed by questions about him or her.
- A picture of the place where the abuse occurred, with specific inquiry about the abusive acts.
- A picture of the abuse itself.
- A picture of an instrument, such as a knife or a vibrator, employed during the abuse.

Decisionmaking

At the end of the information-gathering phase, you must decide whether or not you think the child has been sexually abused and what to do next.

Weighing the evidence

You must consider all possible explanations for the allegation. It may be true, partly true, false, or an honest mistake. You weigh the confirming and contradicting evidence for each

explanation with the goal of arriving at the most likely one. There is general agreement that child interview data are the most important to consider. However, information from other sources should be considered in the decision process, such as:

- The child's statements about the abuse in other contexts.
- The child's symptoms (sexualized behavior, nonsexual symptoms).
- Other victims or witnesses.
- The alleged offender's functioning, statements about the abuse (confession, partial admission, explanation), and prior history.
- The nonoffending caretaker's functioning, statements about the abuse, and prior history.
- Medical evidence.
- Physical evidence gathered by law enforcement.

Level of certainty

In only rare instances will the investigative interviewer be either 100-percent certain sexual abuse did occur or 100-percent certain it did not. In fact, professionals should be skeptical about anyone who offers such a guarantee. There is no single profile of a sex offender. Rather, there is a great deal of variability among people who sexually abuse children, and research indicates many of them score within the normal range on psychological tests (Williams and Finkelhor, 1992). Similarly, children react to and describe experiences of sexual victimization in many different ways.

However, 100-percent certainty of sexual abuse is not required, even for criminal conviction.

- A criminal case must be proved "beyond a reasonable doubt"—a probability level of 95 percent.
- Child protection intervention requires much less certainty. In most States, a child protection case can be opened if there is "some credible evidence," or about 25-percent probability that the child was sexually abused.
- To take temporary juvenile or family court jurisdiction requires "preponderance of the evidence," or 51-percent probability.
- To terminate parental rights, the case must be proved at the "clear and convincing" evidence standard, 75 percent.

The polygraph

Law enforcement investigators often ask if the accused is willing to take a polygraph test, and prosecutors often make decisions about whether or not to prosecute based on polygraph results. Although these professionals put considerable weight on polygraph findings, polygraph results are not admissible in most court proceedings because they are viewed as having an unacceptable level of false positives and false negatives. They measure whether the individual experiences physiological arousal (increased heart rate, breathing rate, galvanic skin response) to abuse-focused questions, not whether the individual is lying. Their utility has been especially questioned in cases of sexual abuse (Cross and Saxe, 1992).

Null findings

The absence of findings does not necessarily mean that no sexual abuse has taken place. Many children fail to disclose. For some children there is just a small window of opportunity. For others, disclosure is an incremental process. If you are unsuccessful in making a determination but remain concerned about possible sexual abuse, it may be prudent to refer the child to a child interview specialist, a multidisciplinary team, or a therapist who can devote more time and expertise to the case.

Contributing Authors

General Guidelines for Interviewing Children

Karen J. Saywitz, Ph.D.
Professor
University of California–Los Angeles
School of Medicine
Child and Adolescent Psychiatry Division
Harbor–UCLA Medical Center
Department of Psychiatry
1000 West Carson Street
Torrance, CA 90509
310–222–4262
E-mail: ksaywitz@ucla.edu

Interviewing Children Who May Have Been Sexually Abused

Kathleen Coulborn Faller, Ph.D.
Professor of Social Work
Faculty Director, Civitis Child and Family Program
University of Michigan
School of Social Work
1080 South University
Ann Arbor, MI 48109–1106
734–763–3786
734–998–9710 (fax)

Supplemental Reading

General Guidelines for Interviewing Children

American Psychological Association Council of Representatives. *Statement on the Use of Anatomically Detailed Dolls in Forensic Evaluations.* Washington, DC, February 8, 1991.

Melton G, Goodman G, Kalichman S, Levine M, Saywitz K, Koocher G. Empirical research on child maltreatment and the law. *Journal of Clinical Child Psychology* 24(suppl.):47–77, 1995.

Saywitz K. Children in court: Principles of child development for judicial application. In Bulkley J (ed): *A Judicial Primer on Child Sexual Abuse.* Washington, DC: American Bar Association, 1994, pp. 15–48.

Saywitz K. Improving children's testimony: The question, the answer, and the environment. In Zaragoza M (ed): *Memory, Suggestibility, and Eyewitness Testimony in Children and Adults.* Newbury Park, CA: Sage Publications, 1995, pp. 113–140.

Saywitz K, Elliott D. *Interviewing Children in the Forensic Context.* Washington, DC: American Psychological Association, in press.

Saywitz K, Goodman G. Interviewing children in and out of court: Current research and practice implications. In Briere J, Berliner L, Bulkley J, Jenny C, Reid T (eds): *APSAC Handbook on Child Maltreatment.* Newbury Park, CA: Sage Publications, 1996, pp. 297–318.

Interviewing Children Who May Have Been Sexually Abused

American Professional Society on the Abuse of Children (APSAC). *Guidelines for the Use of Anatomical Dolls During Investigative Interviews of Children Who May Have Been Sexually Abused,* 1995. (Available from APSAC, 407 South Dearborn, Chicago, IL 60605.)

Cross T, Saxe L. Critique of the polygraph testing in child sexual abuse cases. *Journal of Child Sexual Abuse* 1(4):19–34, 1992.

Everson M, Boat B. Putting the anatomical doll controversy in perspective: An evaluation of the major uses and criticisms of the dolls in child sexual abuse evaluations. *Child Abuse and Neglect* 18:113–130, 1994.

Faller KC. *Evaluating Children Suspected of Having Been Sexually Abused.* APSAC Study Guide 2. Thousand Oaks, CA: Sage Publications, 1996.

Friedrich W. Sexual victimization and sexual behavior in children. *Child Abuse and Neglect 7*(1):59–66, 1993.

Groth N, Stevenson T. *Anatomical Drawings for Use in Investigation and Intervention in Child Sexual Abuse.* Dunedin, FL: Forensic Mental Health Associates, 1990.

Lanning K. Section I: Criminal investigation of sexual victimization of children. In Briere J, Berliner L, Bulkley J, Jenny C, Reid T (eds): *APSAC Handbook on Child Maltreatment.* Newbury Park, CA: Sage Publications, 1996, pp. 247–263.

Morgan M, Edwards V. *How To Interview Sexual Abuse Victims: Including the Use of Anatomical Dolls.* Thousand Oaks, CA: Sage Publications, 1995.

Sorenson T, Snow B. How children tell: The process of disclosure of child sexual abuse. *Child Welfare* 70:3–15, 1991.

Williams L, Finkelhor D. Incest and paternal absence: A test of the biosocial model of incest avoidance. Paper presented at the Center for Child Protection Conference: Responding to Child Maltreatment, San Diego, January 17, 1992.

Other

National Council of Juvenile and Family Court Judges. *Child Development — A Judge's Reference Guide.* Reno, NV: National Council of Juvenile and Family Court Judges, 1993.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Walker AG. *Handbook on Questioning Children: A Linguistic Perspective.* Washington, DC: American Bar Association Center on Children and the Law, 1994.

Organizations

American Professional Society on the Abuse of Children (APSAC)
407 South Dearborn, Suite 1300
Chicago, IL 60605
312–554–0166
312–554–0919 (fax)
Internet: www.apsac.org

Sponsors an annual colloquium and provides workshops and institutes on child interviewing at other conferences.

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
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.

- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

Provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by professionals experienced in the medical, legal, and investigative aspects of child abuse.

National Children's Alliance
1319 F Street NW., Suite 1001
Washington, DC 20004–1106
800–239–9950 or
202–639–0597
202–639–0511 (fax)
Internet: www.nca-online.org

Regional Children's Advocacy Centers (CAC's):

- Midwest Regional Children's Advocacy Center, St. Paul, MN, 888–422–2955, 651–220–6750, www.nca-online.org/mrcac.
- Northeast Regional Children's Advocacy Center, Philadelphia, PA, 215–387–9500, www.nca-online.org/nrcac.
- Southern Regional Children's Advocacy Center, Rainbow City, AL, 256–413–3158, www.nca-online.org/srcac.
- Western Regional Children's Advocacy Center, Pueblo, CO, 719–543–0380, www.nca-online.org/wrcac.

OJJDP funds the National Children's Alliance and the four regional CAC's to help communities establish and strengthen CAC and MDT programs. The Alliance does this by promoting national standards for CAC's and providing leadership and advocacy for these programs on a national level. The Alliance also conducts national training events and provides grants for CAC program development and support. The four regional CAC's provide information, onsite consultation, and intensive training and technical assistance to help establish and strengthen CAC's and facilitate and support coordination among agencies responding to child abuse. The Alliance publishes a number of manuals and handbooks of use to MDT's, including *Handbook on Intake and Forensic Interviewing in the CAC Setting, Guidelines for Hospital-Collaborative Forensic Investigations of Sexually Abused Children, Organizational Development for Children's Advocacy Centers,* and *Best Practices.*

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Understanding and Investigating Child Sexual Exploitation

Portable Guides to Investigating Child Abuse

Foreword

Awareness of the victimization of children by sex offenders is creating increased concern for parents, law enforcement officers, and other professionals working on child victimization issues. *Understanding and Investigating Child Sexual Exploitation* is designed to enhance the professional investigator's understanding of child sexual victimization, in particular that perpetrated by "preferential sex offenders"—serial offenders who prey on children.

This Portable Guide includes legal and professional definitions of key terms and explores the dynamics of child sex rings. It sets forth the characteristics of preferential sex offenders and details instructive investigative techniques. Helpful tools, including a victim interview checklist and a consent-to-search form, are provided as well.

Understanding the predilections and practices of preferential sex offenders and their impact on the child victim is critical to bringing these criminals to justice. I hope this Portable Guide—and others in the series—will assist you in your efforts to protect America's children.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

August 1997

NCJ 162427

Overview

The sexual victimization of children ranges from one-on-one intrafamilial (within the family) abuse to multioffender/multivictim extrafamilial (outside the family) sex rings and from stranger abduction of toddlers to prostitution of teenagers. As used in this guide, the sexual exploitation of children refers to forms of victimization involving pornography, sex rings, or prostitution.

Although a variety of individuals sexually victimize children, preferential sex offenders are the primary sexual exploiters of children. They are serial offenders who prey on children through the operation of child sex rings and/or the collection, creation, or distribution of child pornography. The term "preferential sex offender" is a descriptive label used only to identify, for investigative purposes, a certain type of offender. The potential significance of this identification will be discussed. The commonly used term "pedophile" has not been used here to refer to these offenders, in order to avoid confusion over whether investigators are qualified to apply what is also a mental health or diagnostic term.

Apart from legally defined child prostitution (a significant form of child exploitation that will not be discussed here), the sexual exploitation of children does not necessarily involve commercial or monetary gain. In fact, in the United States, child pornography and child sex rings most often result in a net financial loss for the offender. Cases of sexual exploitation of children may involve intrafamilial offenders and victims, although this is not typical.

Child Sex Rings

The term "child sex ring" has no legal definition. For many it conjures up images of the buying and selling of children as sexual slaves. However, this term is used simply to describe the dynamics of one or more adult offenders who are sexually involved with two or more child victims during the same general time frame. The behavior pattern of such offenders is predatory, prolific, and serial: They usually recruit, seduce, molest, and "dump" numerous child victims repeatedly over many years.

In general, a child is defined as someone who has not yet reached his or her 18th birthday. However, legal definitions of who is considered a child and to what extent consent is an issue vary from case to case, from statute to statute, and from State to State and must be considered in any criminal investigation. Unlike one-on-one intrafamilial sexual abuse, in which the victim is most often a young female, in child sex rings the victim is frequently a boy between the ages of 10 and 16.[1]

A child sex ring need not and usually does not involve any moneymaking element. When something of monetary value is exchanged, it is usually given by the offender to the victim as part of the seduction or "grooming" process. A child sex ring can involve a daycare center, a school, a scout troop, a Little League team, and neighborhood or runaway children. It can also involve intrafamilial molestation of children, including the use of marriage or a live-in relationship as a method of access to children and the use of family children to attract other victims.

---

[1] It is possible for girls to be victims in child pornography and sex rings and for women to be sex offenders. In this guide, for simplicity's sake, the male pronoun has been used to refer to both victims and offenders.

However, the dynamics of child sex ring cases are different from those of the more commonly investigated cases of one-on-one intrafamilial sexual abuse. Child sex rings are more likely to involve interaction among the multiple victims. These interactions—both before and after discovery—must be examined and evaluated. Possible child victims in sex ring cases are more often interviewed as a result of discovery (e.g., identification in recovered pornography) or suspicion (e.g., a known offender had access to them) than as a result of voluntary disclosure by the victim.

Although parents are usually not the abusers in sex ring cases, they cannot be ignored in the investigation. Their interaction with their victimized children can be crucial to the case. If the parents interrogate their children or conduct their own investigation, the results can be damaging to the case. Investigators must maintain ongoing communication with the parents of victims and attempt to channel their energy and concern in positive ways.

Child Pornography

The legal definition of the term "child pornography" varies from State to State and under Federal law. Under most legal definitions, child pornography involves a visual depiction of a child that is sexually explicit. The Federal child pornography law defines a child (minor) as someone who has not yet reached his or her 18th birthday. Under the Child Pornography Prevention Act of 1996, the Federal definition of "child pornography" has been expanded to include not only a sexually explicit visual depiction using a minor, but also any visual depiction that "has been created, adapted, or modified to *appear* [emphasis added] that an identifiable minor is engaging in sexually explicit conduct." Although this new law makes the prosecution of cases involving manipulated computer images easier, it also means that it is no longer possible in every case to argue that child pornography is the permanent record of the abuse or exploitation of an actual child.

According to Federal law, sexually explicit conduct means actual or simulated sexual intercourse (including vaginal, oral, and anal), bestiality, masturbation, sadistic or masochistic abuse, or lascivious exhibition of the genitals or pubic area. In some cases, the child may not need to be naked in order for the depiction to be covered by this definition. It is important to understand that the lasciviousness often mentioned in child pornography cases is *not* in the child's mind or even necessarily the photographer's, but in the mind of each producer, distributor, and collector of the material.

Some grossly explicit visual depictions of children clearly and obviously are always child pornography, and some visual depictions of children, no matter the context or use, do not meet the minimum legal threshold and are never child pornography. Often investigators and prosecutors want to make a decision about the nature of a visual depiction of a child based only on looking at it. The difference between simple nudity (e.g., innocent family photographs, works of art, or medical illustrations) and the lascivious exhibition of the genitals is often not in the visual depiction itself, but in the context. Many visual depictions of children may or may not be considered child pornography, depending on how they were produced (abuse, deception, trickery), saved (location, labels, packaging, modifications, computer file name), or used (to lower inhibitions of or arouse victims, to pander, to trade, to sell). Assuming it meets the minimum legal criteria, potential child pornography must always be evaluated in the total context in which it is discovered, and it must be objectively investigated.

Not all collectors of child pornography physically molest children, and not all molesters of children collect child pornography. Not all children depicted in child pornography have been sexually abused. For example, some have been photographed without their knowledge while undressing, others manipulated into posing nude. Depending on the use of the material, however, all can be considered exploited. For this reason, even those who "only" receive or collect child pornography produced by others play a role in the sexual exploitation of children, even if they have not physically molested a child.

Offenders

Preferential sex offenders tend to be predatory serial offenders.[2] Because operating a child sex ring or trafficking in child pornography usually requires above-average interpersonal skills and economic means, these offenders will generally be from a higher socioeconomic background. Preferential sex offenders may be "pillars of the community" and are often described as "nice guys." They almost always have a means of access to children (for example, through marriage, neighborhood, or occupation). Determining their means of access helps to identify potential victims. Investigators should always verify the credentials of those who attempt to justify their acts as part of some "professional" activity. Just because an individual is a doctor, priest, minister, or therapist, for example, does not mean that he cannot also be a child molester.

Characteristics of Preferential Sex Offenders

A preferential sex offender can usually be identified by the following interrelated behaviors:

- **Long-term and persistent patterns of behavior.**
  - Begins pattern in early adolescence.
  - Is willing to commit time, money, and energy.
  - Commits multiple offenses.
  - Makes ritual or need-driven mistakes.
- **Specific sexual interests.**
  - Manifests paraphiliac preferences (see next section), possibly more than one type.
  - Focuses on defined sexual interests and victim characteristics.
  - Centers life around preferences.
  - Rationalizes sexual interests.

---

[2] **Note:** The category of predatory serial sex offenders includes other types of offenders, such as those who use intimidation and force to engage in sexually motivated child abduction. A discussion of these other types of offenders is beyond the scope of this guide.

✹ **Well-developed techniques.**

- Evaluates experiences.
- Lies and manipulates, often skillfully.
- Has method of access to victims.
- Is quick to use modern technology (e.g., computer, VCR) for sexual needs and purposes.

✹ **Fantasy-driven behavior.**

- Collects pornography.
- Collects paraphernalia, souvenirs, videotapes.
- Records fantasies.
- Acts to turn fantasy into reality.

Because these sexual behavior patterns are highly predictable, it is important for investigators to recognize and utilize them, if present. If the investigation identifies enough of these characteristics, many of the remaining ones can be assumed. Most of these indicators mean little by themselves, but as they are identified and accumulated through the investigation, they can constitute reason to believe a suspect is a preferential sex offender.

Paraphilias and Sexual Ritual Behavior

Paraphilias are psychosexual disorders defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM–IV, Washington, DC: American Psychiatric Association, 1994) as recurrent, intense sexually arousing fantasies, sexual urges, or behaviors that generally involve (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons, and that occur over a period of at least 6 months. Pedophilia, sadism, voyeurism, and fetishism are examples of paraphilias.

On an investigative level, the presence of paraphilias often means highly repetitive and predictable behavior focused on specific sexual interests that goes well beyond a "method of operation" (MO). The concept of an MO—something done by an offender because it works and will help him get away with the crime—is well known to most investigators. An MO is fueled by thought and deliberation. Most offenders change and improve their MO over time and with experience.

The repetitive behavior patterns of preferential sex offenders involve some MO, but are more likely also to involve the less-known concept of sexual ritual. Sexual ritual is the repeated engaging in an act or series of acts in a certain manner because of a sexual need; that is, in order to become aroused and/or gratified, a person must engage in the act in a certain way. Other types of ritual behavior can be motivated by psychological, cultural, or spiritual needs. Unlike an MO, ritual is necessary to the offender but not to the successful commission of the crime. In fact, instead of facilitating the crime, ritual often increases the odds of identification, apprehension, and conviction because it causes the offender to make need-driven mistakes.

Ritual and its resultant behavior are fueled by erotic imagery and fantasy and can be bizarre in nature. Most important to investigators, offenders find it difficult to change and modify ritual, even when their experience tells them they should or when they suspect law enforcement scrutiny. Understanding sexual ritual is the key to investigating preferential sex offenders.

Victims

In child pornography and sex ring cases, offenders typically control their victims by seducing them with attention, affection, kindness, and gifts until they have lowered the victims' inhibitions and gained their cooperation and "consent." Because victims of child pornography and sex rings usually have been carefully seduced and often do not realize they are victims, they repeatedly and voluntarily return to the offender. Society and the criminal justice system find this difficult to understand. If victims are molested by a neighbor, teacher, or priest, why do they "allow" it to continue?

The offender may be treating these children better than anyone has ever treated them, and they may not realize they are victims until the offender pushes them out of the ring. Then they see that all the attention, affection, and gifts were just part of a master plan to use and exploit them. This may be psychologically harmful for a troubled child who has had a traumatic life.

Officers investigating child sex rings and child pornography cases must remember that children are human beings with human needs, not "innocent angels sent from heaven." Many children, especially those victimized through the seduction process, often:

- Trade sex for attention, affection, or gifts.
- Are confused about their sexuality and feelings.
- Are embarrassed and guilt ridden about their activity.
- Describe victimization in socially acceptable ways.
- Minimize their responsibility and maximize the offender's.
- Deny or exaggerate their victimization.

These things do not mean that the child is not a victim. The activity is **not** the fault of the child, even if he:

- Did not say no.
- Did not fight.
- Actively cooperated.
- Initiated the contact.
- Did not tell.
- Enjoyed the sexual activity.
- Accepted gifts or money.

Dynamics of Child Sex Rings

The operation of a child sex ring is like a pipeline. At any given moment, there are victims being recruited, victims being seduced, victims being molested, and victims being let go, or "dumped." For most preferential sex offenders, it is easy to recruit, seduce, and molest the victims. Offenders have the most difficulty in ending the relationship without causing their victims to turn against them and disclose the abuse.

Controlling the Victims

Once victims are in the pipeline, offenders control them through a combination of bonding, competition, and peer pressure. Most children, especially adolescents, want to be a part of some peer group. Any offender operating a sex ring has to find a way to bind the victims together. Some offenders use an existing

structure such as a scout troop, a sports team, or a school club. Others create their own group, such as a magic club, computer club, or religious cult. Some offenders just make up a name—for example, the "88 Club" or the "Winged Serpents"—and establish their own rules and regulations.

Offenders are most likely to use violence, threats of violence, and blackmail when pushing a victim out of the group or when attempting to hold on to a still-desirable victim who wants to leave. Sexually explicit notes, audiotapes, videotapes, and photographs effectively ensure a victim's silence. Victims worried about disclosure of illegal acts such as substance abuse, joyriding, petty theft, and vandalism are also subject to blackmail.

Many victims, however, are most concerned over (and therefore more likely to deny) disclosure of engaging in:

- Sex for money.
- Bizarre sex acts.
- Homosexual acts in which they were the active participant.
- Sex with other victims.

In child sex rings, not only does the offender have sex with the children but, in some cases, the children have sex with each other. While children may admit that they were forced by the offender to perform certain acts with him, they find it hard to explain sexual experiences with other children and frequently deny such activity. One offender stated that if you select and seduce your victims properly, getting them to keep the secret takes care of itself.

The Offender-Victim Bond

Because of their bond with the offender, victims frequently resent law enforcement intervention and may even warn the offender. Even the occasional victim who comes forward and discloses the abuse may feel guilty and then warn the offender. The offender may also continue to manipulate the victims after the investigation has begun—for example, by appealing to their sympathy or by making a feeble attempt at suicide to make them feel guilty or disloyal. Some offenders may threaten victims with physical harm or with disclosure of the blackmail material; some may bribe the victims and their families.

A particular aspect of the offender-victim bond is especially troubling for the criminal justice system. Some victims, when being pushed out or while still in the pipeline, may assist the offender in obtaining new victims. They become the bait to lure other victims. Such recruiters or "graduate" victims can and should be considered subjects of investigation. Their offenses, however, should be viewed in the context of their victimization and the dynamics of child sex rings.

Coordinating the Investigation

The investigation of sexual exploitation cases involving multiple victims molested by preferential offenders is usually complex and difficult, not only because of the amount of work involved, but also because of intense pressure from the media and the community to resolve the investigation quickly. To bring the investigation to a successful conclusion, law enforcement should work with the prosecutor, child protective services, and medical and mental health personnel in a **multidisciplinary team (MDT)**. If a protocol for MDT investigations has not been previously developed, the first step is for the team members to meet together to decide the following:

- Which agency will take the lead in the investigation, and who will be in charge?
- What office space will be utilized in order for the team to work together?
- Which agency will provide the clerical help for the team?
- Which agency will author all of the investigation reports that the team develops?
- Which agency will handle the telephone calls from the victims' parents, and who will serve as liaison with them?
- Where and when will the interviews of the victims take place, and who will conduct the interviews?
- Who will do the medical examinations of the victims and where will they be conducted?
- Will the victims be taken into protective custody and, if so, where will they be placed?
- Which agency will handle the press and the media?
- Which agency will handle the telephone calls from the community?

The agencies involved in the investigation should coordinate their needs and paperwork so that only one MDT report will be generated under the byline of one of the participating agencies—for example, the police department. If possible, all the victims should be interviewed at one centrally located, "safe" place such as a children's advocacy center. Every attempt should be made to have the same physician—ideally, a member of the MDT with experience in this type of case—conduct the medical examinations of all of the victims.

Interviewing the Victim

The interview of the "outcry" victim (the first victim to disclose abuse) or, if there is no outcry victim, of the first victim to be discovered, should be completed first. After this child has been interviewed, determine whether any children are living at the offender's residence or are in immediate danger. If a child is at risk, the MDT may need to take the child into protective custody immediately.

When attempting to identify additional victims of a child sex ring, begin with those who are about to leave or have just left the offender's pipeline. The victim most likely to disclose the abuse is one who has just left the ring and who has a sibling or close friend about to enter the ring. The desire to protect younger victims from what he has endured is a victim's strongest motivation for overcoming shame and embarrassment. Some victims are motivated by jealousy to disclose the abuse when they are pushed out of the ring after being replaced by younger victims. The next best candidates for interviewing are victims who have just entered the pipeline.

The victim may have many positive feelings for the offender and may resent law enforcement intervention. Before beginning the interview, take the time to attempt to develop a working relationship with the victim. Investigators should:

- Be able to discuss a wide variety of sexual activity without being judgmental.
- Understand the victim's terminology. Investigators must be familiar with the graphic street jargon used by victims.
- Carefully communicate to the victim that he is not at fault even though he did not say no, did not fight, did not tell, or even enjoyed it.

Investigators who have a stereotyped concept of child sexual abuse victims or who are accustomed to interviewing younger children molested within their family may have a difficult time interviewing adolescents molested in a sex ring, many of whom will be troubled, even delinquent children from broken homes. It may be more difficult to avoid being judgmental with a delinquent adolescent seduced by a "pillar of the community" than with an innocent 8-year-old girl abused by her father. A judgmental attitude can be easily and unknowingly communicated through gestures, facial expressions, and body language and can hinder the investigation. When the victim believes that the investigator understands what he experienced, he is more likely to talk.

Allow the victim to use scenarios to save face when disclosing the victimization. Adolescent boy victims are highly likely to deny certain types of sexual activity. Even if a victim discloses the abuse, the information is likely to be incomplete and may minimize his involvement and acts. Subsequent investigation may uncover evidence that contradicts the victim's sworn statement or additional victims whose stories directly conflict with the first victim's story. The most common example of this is that the victim admits that the offender performed oral-genital sex on him, but denies that he did the same to the offender. The execution of a search warrant then leads to the seizure of photographs of the victim performing oral-genital sex on the offender. Additional victims may also confirm this but vehemently deny that they did the same thing.

Investigators and prosecutors must understand and learn to deal with the incomplete and contradictory statements of victims of child sex rings. The dynamics of their victimization must be considered. They are embarrassed and ashamed of their behavior and rightfully believe that society will not understand their victimization. Many adolescent victims are most concerned about the response of their peers.

If all else fails, the investigator can try the no-nonsense approach. No matter what the investigator does, most adolescent boys will deny they were victims. Therefore, it is important to interview as

many potential victims as legally and ethically possible. It is also possible that some troubled teenagers may exaggerate their victimization or even falsely accuse individuals. Allegations must be objectively investigated and all possibilities considered.

After the interview, the child may feel the need to warn the offender that a child abuse investigation has commenced. Once warned by the victim, the preferential sex offender may attempt to hide or to destroy any evidence of the abuse. For this reason, investigators must be careful about what they disclose to the victims and must be prepared to move quickly with the search and other phases of the investigation.

Investigating the Offender

Preferential sex offenders are like human evidence machines. During their lifetime, they leave behind a string of victims and a collection of child pornography and erotica. This long-term, persistent pattern of behavior makes preferential sex offenders easy to convict if investigators understand how to recognize them and how they operate.

The investigation of the offender should establish:

- Where the offender lives and who lives with the offender.
- When the offender is usually at home.
- Where the offender works.
- Whether the offender does any volunteer work with children.
- Whether the offender has any hobbies or interests that appeal to children.
- The type of vehicle(s) the offender owns or drives and where they are located.
- Whether the offender has access to a computer and, if so, where it is located and whether the offender uses one of the online computer services.
- Whether there are any weapons in the offender's residence.
- Whether the offender has any storage places or safety deposit boxes.

Investigator's Checklist for Interviewing Victims of Preferential Sex Offenders

In interviewing victims, investigators should attempt to obtain information that would provide answers to the following questions:

The Abuse

- ❑ What are the specific circumstances of the abuse?
- ❑ Where did the abuse take place? (Obtain as specific a description as possible, including details about decorations and type of furniture.)
- ❑ When did the last incident of abuse take place?
- ❑ What were the specific dates, time of day, and frequency of the abuse?
- ❑ What was the duration of the abuse (i.e., days, weeks, months, years)?
- ❑ Did the offender use a specific name for the abuse?
- ❑ What specific items (e.g., toys, gifts, clothing) did the offender use to seduce or lure the victim, and where are these items now?
- ❑ Did the offender provide the victim with any drugs or alcohol in order to help him "relax"?

The Offender and the Victim

- ❑ Who is the offender? Were other offenders present at the time of the abuse?
- ❑ Does the offender know the exact age of the victim? If so, how?
- ❑ How can the victim identify the offender?
- ❑ Did the offender make any threats?
- ❑ When did the victim last speak with the offender?
- ❑ When did the victim last see or visit with the offender?

Other Victims

- ❑ Can the victim identify any other victims or possible victims?
- ❑ What witnesses were present at the time of the abuse? Is there anyone else who may have any knowledge of the abuse?

Pornography

- ❑ Did the offender display for the victim any pornographic images (e.g., photographs, magazines, videotapes, computer images)?

Investigator's Checklist for Interviewing Victims of Preferential Sex Offenders *(continued)*

- ❑ Did the victim independently observe any pornographic images of other children (e.g., photographs, videotapes, or computer files) in the residence of the offender? If so, does the victim know the identity of these children?

Photographing or Videotaping of the Victim

- ❑ Did the offender take any photographs or videotapes of the victim?
- ❑ Did the offender make sexually graphic photographs or videotapes of the victim?
- ❑ When were these photographs or videotapes made?
- ❑ When was the last date and time the victim saw these photographs or videotapes?
- ❑ What was the exact location where the victim last saw these photographs or videotapes?
- ❑ If photographs of the victim were taken, which processing laboratory developed them?
- ❑ How were the videotapes marked? How were the photographs packaged?

Other Forms of Physical Evidence

- ❑ Did the offender use items such as condoms, sexual devices, lingerie, lubricants, or oils with the victim?
- ❑ Did the offender keep any personal effects of the victim, such as hair, pubic hair, fingernail clippings, or soiled underwear?
- ❑ When and where were these items last seen?
- ❑ What is the specific location of any other physical evidence that may be involved in the abuse?
- ❑ Where and when did the victim last see this physical evidence?
- ❑ Does the offender hide anything anywhere and, if so, where is it hidden?

Other Instances of Abuse and Results for the Victim

- ❑ Has the victim ever been sexually abused in the past by any other offender?
- ❑ What were the circumstances of that abuse?
- ❑ Has the victim been in therapy as a result of the abuse?

Background Check

Identifying the type of offender with whom you are dealing requires the most complete, detailed, and accurate information possible. As part of the evaluation process and, if possible, before interviewing or interrogating a suspected preferential sex offender, investigate his background thoroughly. The following kinds of records should be considered as sources of information:

- Criminal records.
- Sex offender and child abuse registry records.
- Child protection records.
- Juvenile court records, unsealed or sealed.
- Civil court records, unsealed or sealed.
- Driving or automobile records.
- Military records.
- Bank records.
- School records.
- Medical records.
- Employment records.

Knowing the kind of offender with whom you are dealing can go a long way in determining investigative strategy. This knowledge can influence interview or interrogation approaches and help identify both the kind of corroborative evidence that might be found and where it might be found. It can also help determine the existence and location of other potential or past victims and of child pornography or erotica.

Interviewing the Offender

Unfortunately, many investigators put minimal effort into interviews of offenders who abuse children sexually. However, many of these offenders really want to discuss either their behavior or at least their rationalization for it. If treated with professionalism, empathy, and understanding, they will make significant admissions.

Before interviewing the alleged offender, evaluate his background information and develop an interview strategy. Simply asking an alleged perpetrator if he molested a child does not constitute a proper interview. If the offender is allowed to rationalize or project some of the blame for his

behavior onto someone or something else, he is more likely to confess. Most sex offenders will admit only what has been discovered and what they can rationalize. If you do not confront the subject with all your evidence, he might be more likely to minimize his acts rather than totally deny them. Many child molesters admit their acts but deny the intent. A tougher approach can always be tried if the soft approach does not work.

Consider noncustodial (i.e., no arrest), nonconfrontational interviews of the subject at home or work as well as interviews during the execution of a search warrant. Do not overlook admissions made by the offender to wives, girlfriends, neighbors, friends, and even the media.

Polygraphs and other lie detection devices can be valuable strategic tools in the hands of skilled interviewers. If the suspect believes that a lie detection test is available and, if administered, will reveal the truth or falsehood of his statements, he is more likely to be honest without taking the test. However, investigators must remember that, once these tests are utilized, their value is limited, because the results usually are not admissible in court. The results of polygraphs and other lie detection tests should never be the **sole** criterion for discontinuing an investigation of child sexual abuse allegations.

Recovery of Child Exploitation Evidence

The recovery of evidence in a case of multiple victim molestation can be very significant, because the evidence can be used both to corroborate the victim's statement and to identify other victims. Those who deal in child pornography and child erotica treat these materials as valuable commodities—sometimes even regarding them as collections—and retain them in secure but available places for extended periods of time. To recover this evidence from the preferential sex offender's collection, the MDT should:

- Obtain the offender's consent to search his premises and belongings. (A sample consent-to-search form is shown in figure 1 on page 18.)
- Obtain a search warrant.

Figure 2 (page 20) presents a list of items to recover from the offender. After the search, make a detailed inventory of all materials seized. Any videotapes seized should be reviewed from beginning to end, as child pornography often is found hidden

Figure 1

Sample Consent-To-Search Form

I, _____, have been informed
(name of property owner)
of my constitutional right not to have a search made of the premises and/or automobile owned by me and/or under my care, identified below, without a search warrant. However, knowing my right to refuse consent to such a search, I hereby authorize _____ and
(name of officer or agent)
_____ of _____
(name of officer or agent) *(name of law enforcement agency)*
to conduct a complete search of the premises, garage or storage shed, and any other structure at the property commonly known as _____
_____
(address and property description)
and/or the following automobile: _____
(vehicle description)
license # _____.These officers or agents are authorized by me to take from my premises and property any videotapes, photographs, letters, computer disks, or any material that is evidence in the nature of child abuse. This written permission is given by me to the above-named persons voluntarily and without any threats or promises of any kind at _____ on this _____
(time, a.m./p.m.)
day of _____, 19____.
(month)

I further understand that I will be given a receipt for any property that is taken.

Signed _____

Name _____
(please print)

WITNESSES *(both law enforcement officers named above):*

Signed _____ _____

Name _____ _____

Agency _____ _____

within commercial pornography and nonpornography videotapes. Identify any children found in photographs or videotapes taken by the offender.

Expert Search Warrants

An expert search warrant[3] is one in which an expert's opinion is used to supplement the case-specific facts learned through the investigation. The opinion usually sets forth known and documented behaviors that preferential sex offenders repeatedly engage in and then applies them to the targeted individual. Determining the type of offender in question and understanding the concept of sexual ritual (see above) are crucial to the use of expert search warrants. Note that if the expert opinion is based on the subject being a certain type of offender, the affidavit for the search warrant **must** set forth the probable cause to believe the subject is that type.

Because of legal uncertainties, expert search warrants in child sexual exploitation cases should only be used when absolutely necessary. These warrants should be considered in cases where they are needed to:

- Provide additional probable cause.
- Justify expansion of the scope of the search.
- Address problems concerning the staleness of information.

Prosecution

Most preferential sex offenders spend their entire lives attempting to convince themselves and others that they are not perverts and that they love and nurture children. Because most of them have hidden their activities for so long, when they are identified and prosecuted, they try to convince themselves that they will somehow continue to escape responsibility. This is why they often proclaim their innocence right up to the time of their trial. If, however, the investigator and prosecutor have properly developed the case, preferential sex offenders almost always change their plea to guilty. The last thing they want is to have

---

[3] For additional information on expert search warrants for child exploitation cases, see appendix I of Lanning K.V., *Child Molesters: A Behavioral Analysis. For Law-Enforcement Officers Investigating Cases of Child Sexual Exploitation.* 3d ed. Washington, DC: National Center for Missing and Exploited Children, 1992.

Figure 2

Suggested Items To Recover From Suspected Preferential Sex Offenders

- Any videotapes, 8mm movies, photographs, negatives, magazines, pictures, books, computer files, or any materials depicting a person under the age of 18 years engaged in sexual intercourse, sexually explicit conduct, or lewd exhibition of the genitals.
- Any undeveloped rolls of film or commercial and noncommercial videocassettes.
- Any video equipment, television equipment, photography equipment, darkroom equipment, computer equipment (both hardware and software), or any equipment used in the production, reproduction, display, or distribution of images of a minor being sexually exploited. Before computer equipment is seized, all connections should be noted and marked. The suspect should be prevented from touching the computer. Technical resources for avoiding accidental erasures and retrieving all available information should be identified and used in the investigation.
- Any and all documents, correspondence, calendars, telephone or address books, diaries, computer disks, or any other written or tape-recorded materials that identify or will lead to identification of persons under the age of 18 years.
- Any nonsexual photographs of a minor with whom the suspect may have had any contact.
- Any and all documents, correspondence, financial records, and other materials on paper, computer disk, or computer hard drive relating to the purchase, sale, ordering, receipt, or payment for any materials involving the exploitation of children.
- Any photographs, albums, posters, paintings, books, manuals, nudist magazines, advertisements, or any type of clothing material that could be used for training or instructing a minor in posing, modeling, or performing either clothed or unclothed.
- Any keys to safe deposit or post office boxes, bank statements, invoices, or canceled checks that would indicate the use, rental, or ownership of any storage facility, post office box, or safety deposit box.
- Any and all documents, correspondence, financial records, and other materials on paper, computer disk, or computer hard drive relating to the purchase, sale, transfer, ordering, or receipt of any materials involving the sexual exploitation of children.

the public hear the details of their sexual activity with children. After pleading guilty, they attempt to convince the sentencing authority that their lives have been ruined and that they are "sick" and need treatment. (However, they will usually tell everyone else that, although they pled guilty, they really are not guilty.)

Cases Involving Computers

The investigation of child sexual exploitation cases involving computers requires knowledge of the technical, legal, and behavioral aspects of the use of computers. However, because each of these areas is so complex, investigators must also identify experts and resources available to assist in these cases. Exploitation cases involving computers present many investigative challenges, but they also present the opportunity to obtain a great deal of corroborative evidence and investigative intelligence.

The computer—whether a system at work or, more likely, a personal computer at home—provides the preferential sex offender with an ideal means of filling his needs for validation, organization, and pornography and for finding potential new victims. It is simply a matter of modern technology catching up with long-known personality traits.

Uses of the Computer

Many preferential sex offenders are drawn to online computer services to validate their interests and behavior. The computer may enable them to communicate and obtain active validation with less risk of identification or discovery. The great appeal of this type of communication is perceived anonymity and immediate feedback.

Many preferential sex offenders are compulsive recordkeepers, and the computer offers an ideal means for organizing their collections and correspondence. Innumerable characteristics of victims and sexual acts can easily be recorded and analyzed. An extensive pornography collection can be cataloged by subject matter. Even fantasy writings and other narrative descriptions can be stored and retrieved for future use.

An offender can now use a computer to transfer, manipulate, and even create child pornography. With the typical home computer and modem, still images can easily be digitally stored, transferred from print or videotape, and transmitted, and the quality of each copy will be as good as the original. Visual images can be stored on hard drives, floppy disks, or CD–ROM's.

The offender can also use the computer to troll for and communicate with potential victims with minimal risk of being identified. The use of a vast, loose-knit network like the Internet can make identifying the actual perpetrator difficult. On the computer, the offender can assume any identity or characteristics he wants or needs. The child can be indirectly victimized through conversation ("chat") and the transfer of sexually explicit information and material or can be evaluated for future face-to-face contact and direct victimization.

Types of Offenders

Offenders who traffick in child pornography using computers usually fall into two broad categories:

- **Dabbler**— Usually either a typical adolescent searching for pornography or a curious adult with a newly found access to pornography. Dabblers can be investigated and prosecuted, but their behavior tends not to be as long term, persistent, and predictable.
- **Preferential offender**— Usually either a sexually indiscriminate adult with a wide variety of deviant sexual interests or a pedophile with a definite preference for children. The main difference between them is that the collection of the sexually indiscriminate preferential offender will be more varied, usually with a focus on the offender's particular sexual preferences or paraphilias, whereas a pedophile's collection will focus primarily on children. Also, the sexually indiscriminate offender is less likely to molest children, especially prepubescent children.

Conclusion

Investigators must recognize how child sexual exploitation cases are like and unlike other types of child sexual victimization cases. Understanding victim and offender patterns of behavior, identifying types of offenders, and applying this knowledge to the investigative process can be of significant value in the resolution of these complex and difficult cases.

Contributing Authors

Kenneth Lanning, M.S.
Supervisory Special Agent
Federal Bureau of Investigation
Missing and Exploited Children's
Task Force
FBI Academy
Quantico, VA 22135
540–720–4732
540–720–4792 (fax)

Robert Hugh Farley, M.S.
Commanding Officer
Cook County Sheriff's Police Department
Child Exploitation Unit
1401 South Maybrook Drive
Maywood, IL 60153
708–865–4875
708–865–6576 (fax)

Supplemental Reading

Burgess AW, Grant CA. *Children Traumatized in Sex Rings.* Washington, DC: National Center for Missing and Exploited Children, 1988.

Child Safety on the Information Highway (pamphlet). Washington, DC: National Center for Missing and Exploited Children, 1994.

Lanning KV. *Child Molesters: A Behavioral Analysis. For Law-Enforcement Officers Investigating Cases of Child Sexual Exploitation.* 3d ed. Washington, DC: National Center for Missing and Exploited Children, 1992.

Lanning KV. *Child Sex Rings: A Behavioral Analysis. For Criminal Justice Professionals Handling Cases of Child Sexual Exploitation.* 2d ed. Washington, DC: National Center for Missing and Exploited Children, 1992.

Shepherd JR, Dworin B, Farley RH, Russ BJ, Tressler PW, National Center for Missing and Exploited Children. *Child Abuse and Exploitation: Investigative Techniques.* 2d ed. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 1995.

Whitcomb D. *When the Victim is a Child.* 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Organizations

National Center for Missing and Exploited Children (NCMEC)
2101 Wilson Boulevard, Suite 550
Arlington, VA 22201–3052
800–THE–LOST (800–843–5678)
(hotline and child pornography tipline)
703–235–3900 (business number)
703–235–4067 (fax)
http://www.missingkids.org

A clearinghouse of information on missing and exploited children, NCMEC operates a 24-hour hotline and child pornography tipline. NCMEC also provides a wide range of free services, just a few of which are technical case assistance, link and pattern analysis on cases, forensic assistance, training programs, and educational material and publications. Single copies of the NCMEC publications listed above can be obtained free of charge by contacting NCMEC.

Other Titles in This Series

Currently there are 10 other Portable Guides to Investigating Child Abuse. Additional guides in this series may be developed at a later date. To obtain a copy of any of the guides listed below, contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at askncjrs@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, D.C.
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–321–3963
303–329–3523 (fax)

Federal Bureau of Investigation (FBI)
Child Abduction and Serial Killer Unit and Morgan P. Hardiman Task Force on Missing and Exploited Children
Quantico, Virginia
800–634–4097
540–720–4700

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
414–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Arlington, Virginia
703–235–3900
703–235–4067 (fax)

National Center for the Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, D.C.
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National Committee to Prevent Child Abuse (NCPCA)
Chicago, Illinois
800–CHILDREN
312–663–3520
312–939–8962 (fax)

National Network of Children's Advocacy Centers
Washington, D.C.
800–239–9950
202–639–0597
202–639–0511 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Use of Computers in the Sexual Exploitation of Children

Portable Guides to Investigating Child Abuse

Foreword

Like the real world, the "virtual world" of cyberspace poses serious risks to children. Unfortunately, while we advise our children not to talk to strangers at the playground, we may fail to adequately educate them about the dangers of online exchanges with strangers.

These dangers are real. As a result of the anonymity and validation it affords sex offenders, the Internet has become a cyberplayground for those who prey on children. With the evolving nature of computer technology and the legal issues surrounding its use, the investigation of child sexual exploitation involving computers poses significant challenges to law enforcement.

Use of Computers in the Sexual Exploitation of Children is designed to help investigators meet those challenges. This Portable Guide offers basic information about adapting time-tested investigative techniques to the realm of cyberspace, discusses legal issues triggered by electronic communication investigations, and describes the behavioral characteristics of sex offenders who focus on children.

Developing this knowledge about the latest technologies employed by child sexual predators can help law enforcement officials hold them responsible for their crimes and protect other children from being victimized. Anything less is unacceptable.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

June 1999

Second Printing March 2000

NCJ 170021

Overview

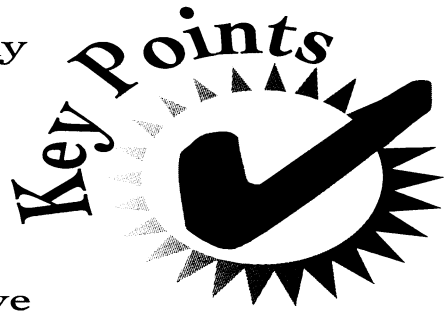
As more and more people discover the ability to communicate faster and more efficiently through computers and the Internet, the possibility that computers will be used to advance criminal activity also increases. Traditionally, online services have been oriented toward adults, but an increasing number of children are logging on to commercial services, private bulletin boards, and the Internet through schools and in their homes. This increased access to computer technology puts children at greater risk of sexual exploitation. While the vast majority of computer users rely on their computers for legitimate purposes, criminals involved in the sexual exploitation of children use the computer as a convenient tool to enter the homes of their victims, correspond with one another, and exchange depictions of illicit activities with child victims.

As used in this guide, the term "child sexual exploitation" refers to forms of sexual victimization of children involving pornography, sex rings, or prostitution. Apart from the legally defined crime of prostitution, child sexual exploitation does not necessarily involve commercial or monetary gain. In fact, in the United States, child pornography and child sex rings usually do not involve financial profit. Cases of child sexual exploitation may involve members of the child's own family (intrafamilial offenders), although this is not typical.

Given the rapid changes in computer technology and the complexity of the legal issues surrounding it, even the most basic investigation of child sexual exploitation involving computers can be a massive undertaking that requires numerous investigators with different areas of expertise. It is wise to identify experts and resources available to assist in computer-related cases. To ensure that your actions are within the law, stay in contact with the prosecutor working on your case at all times. **Mishandling of computer equipment or improper investigative techniques that result in a violation of a defendant's rights can result in the loss of valuable evidence.** Once that information is lost, it may be irretrievable.

Exploitation cases involving computers present many investigative challenges, but they also present the opportunity to obtain a great deal of corroborative evidence and investigative intelligence. The investigation of child sexual exploitation cases involving computers requires knowledge of the behavioral, technical, and legal aspects of computer use. The first section of this guide focuses primarily on the dynamics of offender behavior in the use of computers. The second section offers investigative guidelines based on this information. The final section covers the legal considerations all investigators must know when searching and seizing computer systems.

Understanding Offender Behavior in Relation to Computers



Preferential sex offenders engage in highly predictable sexual behavior patterns. The ability to recognize and use these patterns is critical to investigations of child sexual exploitation. The term "preferential sex offender" is a descriptive label used only to identify, for investigative purposes, a certain type of offender. To avoid possible confusion with a mental health diagnosis and potential challenges in court, use of the term "pedophile" should be kept to a minimum.

Although a variety of individuals sexually victimize children, preferential sex offenders are the primary sexual exploiters of

children. Using a computer to validate behavior, to facilitate interaction with child victims, or to traffic in child pornography usually requires the above-average intelligence and economic means typical of preferential sex offenders. Such offenders also tend to be predatory, serial offenders.*

Recognizing Preferential Sex Offenders

Knowing the kind of offender you are dealing with can go a long way toward determining the most effective investigative strategy. This knowledge can influence interview approaches and facilitate discovery of corroborative evidence. It can be useful in determining the existence and location of other victims or child pornography or erotica. A preferential sex offender can usually be identified by the following interrelated behaviors:

- **Long-term and persistent patterns of behavior.** The individual begins the pattern in early adolescence; is willing to commit time, money, and energy; commits multiple offenses; and makes ritual or need-driven mistakes.
- **Specific sexual interests.** The individual manifests paraphiliac preferences, possibly more than one type. (Paraphilias are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors that generally involve (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons, and that occur for a period of at least 6 months.)[1] There is a focus on defined sexual interests and victim characteristics. These individuals rationalize their sexual interests and center their lives around their preferences.
- **Well-developed techniques.** The individual evaluates experiences; lies and manipulates, often skillfully; has methods of access to victims; and is quick to use modern technology (e.g., computer, VCR) for sexual needs and purposes.
- **Fantasy-driven behavior.** The individual collects pornography, paraphernalia, souvenirs, and videotapes; records fantasies; and acts to turn fantasy into reality.

Because these sexual behavior patterns are highly predictable, investigators must recognize and use them when they are present. If the investigation identifies enough of these

---

***Note:** For a more extensive discussion of preferential sex offenders, see the 11th guide in this series, *Understanding and Investigating Child Sexual Exploitation.* The category of predatory serial sex offenders includes other types of offenders, such as those who use intimidation and force to engage in sexually motivated child abduction. A discussion of these other types of offenders is beyond the scope of this guide.

characteristics, many of the remaining ones can be assumed. However, no particular number constitutes "enough"—just a few characteristics may be "enough" if they are especially significant. Most of these indicators mean little by themselves, but as they are identified and accumulated through investigation, they can constitute reason to believe a suspect is a preferential sex offender.

How Offenders Use Computers

When you understand sex offenders, especially the preferential sex offender, the great appeal of a computer becomes obvious. The computer—whether a stand-alone system or one using online service capability, whether at work or, more likely, a personal computer at home—provides the preferential sex offender with an ideal means of filling his needs for validation, organization, finding potential new victims, and trafficking in child pornography. In this case, modern technology has caught up with long-known personality traits. Anonymous communication with people of similar criminal interests and a seemingly safe method of identifying and communicating with potential victims is a powerful attraction for the preferential sex offender.

Validation

Communicating with other people who have similar interests validates the offender's interests and behavior. This is actually the most important and compelling reason that preferential sex offenders are drawn to the online computer. Now, in addition to physical contact and putting a stamp on a letter or package, they can use their computers to exchange information and validation.

Through the Internet, national and regional online services, or specialized electronic bulletin boards, offenders can use their computers to locate individuals with similar interests. The great appeal of this type of communication is perceived anonymity and immediate feedback. The computer enables them to obtain active validation from other users with less risk of identification or discovery. Like advertisements in "swinger" magazines, computer online services are used to identify individuals of mutual interest concerning age, gender, and sexual preference. The offender may use an electronic bulletin board to which he has authorized access, or he may illegally enter a system. The

offender can also set up his own online bulletin board or participate in surreptitious or underground ones.

Organization

Offenders use computers to organize their collections and correspondence. Many preferential sexual offenders seem to be compulsive recordkeepers. A computer makes it much easier to store and retrieve names and addresses of victims and of individuals with similar interests. Innumerable characteristics of victims and sexual acts can be easily recorded and analyzed. An extensive pornography collection can be cataloged by subject matter. Even fantasy writings and other narrative descriptions can be stored and retrieved for future use.

One problem the computer creates for law enforcement is determining whether texts describing sexual assaults are fictional stories, sexual fantasies, diaries of past activity, plans for future activity, or current threats. This problem can be compounded by the fact that some individuals believe cyberspace is a new frontier where the old rules of society do not apply. There is no easy solution to this problem. Painstaking analysis and investigation are essential tools in working toward a solution.

Maintenance of Financial Records. Offenders who have turned their child pornography into a profit-making business use computers the same way any business uses them. Such things as customer lists, dollar amounts of transactions, and descriptions of inventory can all be recorded on the computer. Because trafficking in child pornography by computer lowers the risks, it may also increase profit-motivated distribution.

Finding victims

Offenders can use the computer to troll for and communicate with potential victims with minimal risk of being identified. The use of a vast, loose-knit network like the Internet can make identifying the actual perpetrator difficult. On the computer, the offender can assume any identity or characteristics he wants or needs. Adolescent boys who spend many hours "hacking" on their computers are at particularly high risk of such contacts. The child can be indirectly "victimized" through conversation ("chat") and the transfer of sexually explicit information and material, or he can be evaluated for future face-to-face contact and direct victimization. The latest technology even allows

real-time group participation in child exploitation through digital teleconferencing by computer.

Investigators must recognize that children who have been lured from their homes after online computer conversations were not simply duped while doing homework. Most are curious, rebellious, or troubled adolescents seeking sexual information or contact. Nevertheless, they have been seduced and manipulated by a clever offender who has taken advantage of their vulnerabilities, and they do not fully understand or recognize the risks involved.

Child pornography

As a result of computer online services, child pornography is now more readily available in the United States than it has been since the late 1970's. An offender can use a computer to transfer, manipulate, and even create child pornography. With a typical home computer and modem, still images can easily be digitally stored, transferred from print or videotape, and transmitted, with the quality of each copy as good as the original. Visual images can be stored on hard drives, floppy disks, CD–ROM's, or DVD's. Both information and images can be encrypted for storage or transmission to deter detection.

With newer technology, faster modems, digital cameras, and better computers, similar things can now be done with some moving images. Two other modern inventions invaluable to pornographers, the video camera and recorder, are now being paired with the computer. Multimedia images, with some motion and sound, and virtual reality programs provide an added dimension to pornography. However, it is still difficult—for now—to transmit child pornography over the Internet in the format most preferred by offenders—high-quality, lengthy moving images (e.g., videotape, films).

Some of these uses are now small problems that may eventually become big problems. Computer software and hardware are being developed so rapidly that their potential for abuse is almost unlimited. In the near future, most communication systems in a home (e.g., telephone, television, fax, videotape, music, newspapers, financial records) may be funneled through a computer. With computer graphics programs, images can be easily changed, or "morphed." The ability to manipulate digital visual images may make it difficult

to believe your own eyes. A recent television commercial makes it appear that John Wayne is talking to a drill sergeant. Halfway through the movie "Forrest Gump," Lt. Dan's legs are no longer visible. This is the same technology used to "age" photographs of long-missing children.

Computer-manipulated and, soon, computer-generated, visual images of "children" engaging in sexually explicit conduct may call into question the basis for highly restrictive child pornography laws (i.e., possession, advertising). Under the recently passed Child Pornography Prevention Act of 1996,[2] the Federal definition of child pornography has been expanded to include any visual depiction that "has been created, adapted, or modified to **appear** [emphasis added] that an identifiable minor is engaging in sexually explicit conduct." Although this new law makes the prosecution of cases involving manipulated computer images easier, it also means that it is no longer possible in every case to argue that child pornography is the permanent record of the abuse or exploitation of an actual child if no real child is involved. If the new law is found unconstitutional, only existing obscenity laws may apply to such simulated child pornography.

Types of Computer Offenders

Those who use computers to traffic in child pornography usually fall into two broad categories:

- **Dabbler.** Usually a typical adolescent searching for pornography, a curious adult with a newly found access to pornography, or a profit-motivated criminal. Dabblers can be investigated and prosecuted, but their behavior tends not to be as long-term, persistent, or predictable as that of a preferential offender.
- **Preferential offender.** Usually a sexually indiscriminate individual with a wide variety of deviant sexual interests or a pedophile with a definite preference for children. The main difference between these individuals is that the collection of the sexually indiscriminate preferential offender will be more varied, usually with a focus on the offender's particular sexual preferences or paraphilias, whereas a pedophile's collection will focus primarily on children. Also, the sexually indiscriminate offender is less likely to molest children, especially prepubescent children. With either of the preferential types, the characteristics and dynamics previously discussed concerning preferential sex offenders should be considered.

Other miscellaneous "offenders" include media reporters who erroneously believe they can traffic in child pornography as part of a news exposé, pranksters who disseminate false or incriminating information to embarrass the targets of their

"dirty tricks," and concerned citizens who, either on their own or at the suggestion of law enforcement, conduct their own investigations into this problem. Investigators must be cautious of overzealous citizens who offer their services in these cases.

When trying to determine whether an offender using a computer to traffic in child pornography is a dabbler or a preferential offender, evaluate all available background information. The following information about online computer activity can be valuable in making this assessment. This information can often be obtained from the online service provider and through undercover communication, pretext contacts (investigators posing as children online), informants, and other investigative techniques:

- Screen name.
- Screen profile.
- Accuracy of profile.
- Length of time active.
- Amount of time spent online.
- Number of files.
- Number of transmissions.
- Number of files originated, forwarded, or received.
- Number of recipients.
- Theme of messages and chat.
- Theme of pornography.

Investigators must not overreact to reported allegations, but neither should they fail to react appropriately. Remember that not all offenders are stereotypical "pedophiles" who fit some common profile. Keeping an open mind and objectively attempting to determine the type of offender involved will help you to avoid embarrassing errors in judgment and to develop appropriate interview, investigation, and prosecution strategies. For example, knowing that preferential offenders are more likely to commit multiple offenses, make need-driven mistakes, and compulsively collect pornography and other offense-related paraphernalia can be used to build a stronger case. Investigators must be alert to the fact that any offender with intelligence, economic means, or employment access may be using a computer in any or all of the above ways, but preferential sex offenders are highly likely to do so.

Investigative Guidelines

The investigation of the use of computers in child sexual exploitation is complex and may exceed the resources available to your jurisdiction. When initiating an investigation, you should take the following issues into consideration:

- **Jurisdiction.** *Will your investigation remain local or extend to Federal or State jurisdiction?* Often you will not know this until the computer system has been seized and analyzed. In most cases, computer exploitation investigations will rise to the Federal or interstate level. You must recognize this possibility at the earliest moment in order to prepare for the future involvement of all agencies as soon as possible. This will ensure the continuity of the investigation.
- **Expertise.** *Does your organization have the technical expertise to deal with this investigation?* Expertise means understanding not only the child predator but computer and software technology also. If you do not have this knowledge, look to other agencies at the Federal, State, or local level for help. The private computer industry may also be able to assist you. (See glossary for definitions of basic computer terms.)
- **Equipment.** *Does your organization have the equipment needed or the resources to obtain the necessary equipment to conduct this investigation?* If not, decisions must be made to purchase, lease, or borrow the necessary equipment from other agencies. Forensic computer examinations, depending on the sophistication of the equipment seized for evidence, may require significant resources beyond the capacity of your agency. The decision may be affected by what evidence the prosecuting attorney decides is needed and how it should be presented to the court. Early contact with the prosecuting attorney can save time and significant expense.
- **Time/Personnel.** *Does your organization have the time and personnel to devote to this type of investigation? Is it willing to do so?* Again, seeking assistance from other agencies or forming a task force must be considered. You must advise your command staff of this need and determine if they are willing to make the commitment.
- **Followup.** *Can your organization perform the necessary followup on additional suspects and victims that may arise from the investigation?* Most of these investigations will uncover more suspects and more victims—often a significant number of both. Multiple jurisdictions are often involved. Plans for dealing with such complications and for properly collecting and packaging the evidence need to be formulated before proceeding with the investigation.

Once you have answered these questions, consider the following guidelines as a basis on which to proceed with your investigation. The guidelines describe what to do and what not to do when investigating child exploitation using computer systems.

Establishing the Context

- Establish that a child sexual exploitation situation exists. To determine the type of offender you are dealing with, you must

Glossary of Computer Terms

CD–ROM: Compact disk read-only memory. A CD–ROM is a compact disk containing data that can be read by a computer. Unlike data on hard drives and diskettes, data on CD–ROM's can only be read, not altered by the user.

Computer bulletin board: See "electronic bulletin board system" (BBS).

CPU: Central processing unit; the part of a computer that controls all the other parts.

Crackers: "Hackers with malice" who want to do more than explore other computers. Crackers often attempt to plunder or pillage information.

Digital teleconferencing: Real-time, interactive conferences or meetings using sight and sound that are conducted among participants in different locations through digital means (i.e., desktop computers).

DVD: Digital video disk.

Electronic bulletin board system (BBS): Central system, accessed via modem and phone lines, where information is posted for dissemination. A BBS can have many telephone lines or one line, so the number of access points to the BBS at any given moment is dictated by the system operator, who may be an individual, a business, or an organization. A BBS may have several levels of access, often referred to as "subboards" or "conferences." Access to the various conferences is by password, which is controlled by the operator. Photographs, documents, messages, and data of various kinds may be stored at the different levels of the BBS.

A BBS functions as a meeting place in electronic cyberspace. The material presented is usually theme-oriented, offering information on specific issues or interests. Most BBS's that feature "adult"-oriented material attempt to limit minors from accessing such information, with varying success. BBS's are the destination of choice for interactive discussions with like-minded sex offenders and children.

E-Mail: Electronic mail; written correspondence between two or more online users through online servers or over the Internet.

Hacking: Activities engaged in by those who are usually quite inventive and talented in the use of computers. This may include breaking into computers.

Hard disk drive: Storage device based on a fixed, permanently mounted disk drive. It may be either internal (part of the computer itself) or external (a separate but connected component). Both applications and data may be stored on the disk.

Glossary of Computer Terms *(continued)*

Hot button: Keyboard buttons preprogrammed to open a particular file in a sequential manner that, if not executed in a predetermined sequence, destroys all electronic evidence in the file.

Input/Output (I/O) device: Equipment that sends data to or receives data from a computer. Keyboards, monitors, and printers are all common I/O devices.

Internet: Global "network of networks," not governed by any entity, with no limits or checks on the kind of information maintained by and accessible to its users. The Internet is the gateway to unmonitored communication among sex offenders of all types.

Kill command: Command automatically sent to destroy all electronic evidence within a file if an attempt is made to open the file improperly.

Modem: Device that allows one computer to communicate with another computer, normally over standard telephone lines. It converts the digital signal of the computer to the analog signal for outgoing telephone transmission and reverses the conversion for incoming messages.

Mouse: Pointing device that controls input by moving a cursor or other figure on the screen. Normally, the user points to an object on the screen and then presses a button on the mouse to indicate a selection.

Network: System of interconnected computer systems and terminals.

Online services: Commercial, self-regulated businesses that provide access to the Internet. Online services may screen or provide editorial/user controls, when possible, of the material contained in their systems.

Password: Any combination of letters and/or numbers, linked to the screen name, that provides access to online services.

Real time: Simultaneous; at the same time.

Scanner: Optical device that can recognize characters on paper and, using specialized software, convert them into digital form.

Screen name: Identification required by every online service. Each user must have at least one screen name; some services allow up to five. The names are exclusive to the user—no duplication is allowed.

Software: Programs or instructions that tell a computer what to do.

have the most complete, detailed, and accurate information possible. Your background investigation of the suspect should obtain more than the date and place of birth, credit history, and criminal background checks. School, juvenile, military, medical, driving, employment, bank, sex offender, and child abuse registry records can be valuable sources of information.

- Establish that the suspect owns or has access to a computer and uses it for child sexual exploitation. This can be done by asking specific questions related to the use of the computers of which the suspect(s), victim(s), witnesses, or others may have firsthand or circumstantial knowledge.
- Establish probable cause to show that the suspect used his computer for the crime. Again, appropriate interview questions should be used. Search warrants and searches of public information sources can also yield important information.

Obtaining a Search Warrant

- If enough probable cause exists, a warrant or subpoena can be obtained to serve on telephone companies for telephone records and online services for screen names, account information, and e-mail. Most online services require that the account be paid with a credit card and will not accept post office boxes as mailing addresses.
- If sufficient probable cause exists, obtain a search warrant for the suspect's computer system.
- In preparing the search warrant, be sure to include all the computer hardware and software, keeping in mind the independent component doctrine, discussed below. The entire system is necessary to replicate the suspect's use of it and to enable you to analyze it.
- In your search warrant, list accounting records to identify payment to online services currently in use and those used in the past. Keep in mind that these records may be located on the computer system. Remember that payment for services could be charged to credit card accounts. Such records should be seized to find these accounts.
- Once the system is transported to your agency, be aware that another warrant may be needed to search hard drives and software programs. It is a good idea to work closely with your prosecutors, as case law is forever changing in this area. Depending on the suspect, a "special master" (an attorney appointed by a judge to review privileged or confidential information in an investigation to determine its relevancy as admissible evidence) may be needed to do the searching for you. Also, if the system is used as part of the suspect's business, case law may limit your time and ability to search the system.

Handling Computer Equipment

- When executing a warrant for the suspect's computer system, make sure a computer expert is present. If your agency does not have this capability, try the private sector. Corporations are sometimes willing to assist in the actual handling of the equipment. Local offices of Federal agencies may also be able to aid with resources. **The rule to follow is, "If you don't know what to do, don't touch it."** Secure the system until you can find someone with the proper expertise to handle the equipment safely.
- While searching the suspect's residence and/or business, be sure to look for passwords for the system. Most suspects use passwords for better security. They can consist of any combination of letters and numbers. Some are as simple as the suspect's telephone number; others are more sophisticated. Some companies specialize in decoding passwords. Check with your nearest Federal Bureau of Investigation or U.S. Customs Service office for assistance in this area.
- Once the computer system is seized, try to keep it intact as much as possible. It is best to move the system as a whole, entirely connected together, if possible.
- If you need to disassemble the suspect's computer system, take pictures of the front and back to identify how the system is set up before you physically move it. Before beginning the computer analysis, you or the computer specialist can use the photographs to put the system back together exactly as it was used by the suspect.

Analyzing a Computer System

- The cleanest method of analyzing the suspect's computer system is to copy the data onto an exact duplicate of the suspect's hardware. Use the second system as the working system for your analysis. Then, if an error is made, the suspect's original system is not damaged, saving you from possible civil liability at a later time. Your agency's budget and expertise will dictate your course of action in this matter.
- With the proper software, erased files (e.g., text, graphics) can be recreated if they have not been written over with new data. Even though these files may not be visible on the system directory, they may still exist. Child sexual predators who use computers are aware of this and sometimes will erase files to keep them from being detected. An expert in this area is critical to your investigation.
- Depending on your prosecuting attorney, hard copies (i.e., paper printouts) of all the data on the system may be required. The data can be reviewed by child sexual exploitation experts to determine what is appropriate evidence.

Many of the problems that can arise during investigation of child sexual exploitation through computers can be eliminated or minimized if you follow these guidelines and act within the legal boundaries described below.

Legal Considerations in the Use of Search Warrants

This section discusses the legal principles governing the search and seizure of computer systems and provides guidance on how to avoid the pitfalls and trapdoors involved in searching and seizing computers as evidence of crimes against children. Search warrants are an invaluable investigative tool, and search warrants on computers are an integral part of a comprehensive investigative strategy. However, if you violate any of the doctrines, statutes, or principles set forth below, you and/or your employer may owe a great deal of money to the former defendant, now plaintiff, and your criminal case will disappear.

Expert Search Warrants

Behavioral characteristics may provide a basis for obtaining a warrant to search a suspect's residence, business, or computer system. An expert search warrant uses an expert's opinion to supplement case-specific, documented behaviors in which child predators repeatedly engage and applies this information to the targeted individual. Determining the type of offender in question is crucial to the use of these warrants. If the expert opinion is based on the subject's being a certain type of offender, the affidavit for the search warrant **must** set forth the probable cause for believing that the subject is that type. This technique can be used with any of the preferential sex offender types previously discussed.

As a result of legal uncertainties stemming from a lack of consistent court decisions on such warrants, expert search warrants in child sexual exploitation cases should be used only when absolutely necessary. Expert warrants should be considered, when they are needed, to provide additional probable cause, justify expanding the scope of the search, or address problems concerning the staleness of information.

Avoid the use of boilerplate or generic language in describing the behavioral traits of the target offender. Courts will suppress evidence gathered through expert search warrants if they are not factually specific and relevant to the target of the search and his behavior typology. You should develop evidence that supports a particular offender type to enable experts to assess the specific traits of the target. This evidence may be referenced in the affidavit of probable cause, which corroborates the expert opinion.

Exceptions to Search Warrant Requirements

Exigent circumstances exception

The general exceptions to the warrant requirement apply to computer systems. Exigent circumstances may justify a warrantless search under the appropriate factual circumstances. If a suspect's computer screen is displaying evidence that you reasonably believe is about to be destroyed, the doctrine of exigent circumstances permits you to download the information before obtaining a warrant. However, if you have sufficient time to procure a warrant and fail to do so, the evidence will probably be suppressed.

For the exception to apply, the specific facts of the case must cause a reasonable person to believe exigent circumstances exist. The concerns need not be correct as long as they are reasonable. Consider the following factors in determining whether exigent circumstances exist:

- The degree of urgency involved.
- The amount of time necessary to obtain a warrant.
- Whether evidence is about to be removed or destroyed.
- The possibility of danger at the site for police officers, citizens, and targets.
- Information indicating the possessors of the contraband know the police are on their trail.
- The destructibility of the contraband.[3]

While exigent circumstances may justify *seizing* a computer and/or component attachments, *searching* the computer may not be authorized without obtaining a warrant subsequent to the seizure. The authority to seize containers does not necessarily authorize a warrantless search of the containers' contents.[4] You

must be able to explain to the court why obtaining a search warrant before seizing the evidence would have jeopardized your ability to obtain the evidence at all.

The unique nature of electronic evidence and its susceptibility to humidity, temperature, magnetic fields, "hot buttons," and "kill commands" may destroy evidence instantaneously. Exigent circumstances may exist in searching computers simply because of the fragile character of such evidence.

Plain view exception

Evidence of a crime can also be seized without a warrant if the police officer is in a lawful position to observe the evidence and if its criminal character is immediately apparent. Therefore, if you observe child pornography on a suspect's computer screen, you may seize, without a warrant, not only the computer that contains the unlawful images but also access codes or notes taped to the computer that are in plain view.

Consent exception

Police officers may conduct a warrantless search, even without probable cause to search, if a person with appropriate authority consents to the search. This consent may be expressed ("Yes, you may search my computer") or implied ("Here is the password to the computer data"). The court determines the voluntary nature of the consent by looking at several factors:

- The age of the person giving consent.
- The person's educational level, intelligence, and mental and physical conditions.
- Whether the person had been advised of his right to withhold consent.[5]

In crimes involving computers, two issues related to consent emerge:

- Did law enforcement exceed the scope of consent given?
- Did the person giving consent have the proper authority to allow a search of a particular place or item?

Scope of Consent. Any person who consents to a search may expressly limit the search to a specified area. Law enforcement must respect the explicit limitations placed on the scope of the search. The scope of consent may also be limited by implication.

If a person attempts to prevent you from seeing a password to encrypted data, that act implicitly limits the scope of consent to data available without the use of the password. A person who consents to a search may withdraw that consent at any time during the search.

Multiple Users. If more than one person has access to a computer, you can usually rely on the consent of any person who has authority over the computer. In such circumstances, all persons using the computer are considered to have assumed the risk that a co-user could discover evidence of a crime or permit law enforcement to search the computer for evidence of criminal activity.[6]

The usual defense in multiple-user consent searches is that the other users had no authority to give law enforcement consent to search "my computer." Courts analyze such claims of exclusive authority by determining what, if any, special safeguards the defendant took to protect his or her data from the scrutiny of others. Creating a separate directory on the same computer may not provide the exclusivity necessary to prevent the consent search, but guarding the separate directory with a secret password may prohibit a warrantless search without the defendant's consent to search that particular directory.

The test to determine whether a person has the authority to consent is an objective one: Would the facts available to law enforcement at the time of consent cause a person of reasonable caution to believe that the consenting party had authority over the premises and, therefore, authority to grant consent to the search?

Border exception

Law enforcement may search people and property without a warrant or probable cause when the people or property cross the U.S. border or its "functional equivalent." Diskettes, tapes, computer hard drives, or other media can be searched *at the border* to determine whether they contain items prohibited from being brought into the country.

The border search exception originates in the Government's power to prohibit illegal items from entering the country. However, the rationale no longer exists once such illegal items (e.g., electronic child pornography) have entered the country.

Once the illegal contraband is in, law enforcement is bound by the constraints of the Constitution, applicable statutes, and case law in conducting a search for evidence of a crime.

Similarly, this exception to the warrant requirement probably would not apply to electronic data transmitted via the Internet, e-mail, or other nonphysical means from a foreign country to the United States. For example, if an individual living in the United States downloads child pornography from a foreign bulletin board service, a warrantless search of his computer probably would not be upheld under the border search exception.

Undercover Agents

Undercover agents may, without a warrant, infiltrate computer child pornography rings or bulletin board services that facilitate illegal activities involving the sexual exploitation of children. Varying levels of access are granted to such services: (1) open to the public, (2) open to paying members of organizations, or (3) open to trusted individuals with secret passwords.

Undercover agents must adhere scrupulously to the scope of an invitation to join the organization. They should operate only within the level the system operator has authorized and not "hack" into areas of the bulletin board service for which access has not been granted.[7]

No-Knock Warrant

Forcible entry without knocking and announcing may be permitted if people in the dwelling already know your authority and purpose or if you reasonably believe that giving notice to people in the dwelling could cause you or any other individual to be hurt, a suspect to flee, or evidence to be destroyed.

In cases involving computer crimes, destruction of evidence is of particular concern. Suspects knowledgeable in computer programming can destroy evidence of a crime in any number of ways. The nonphysical nature of such evidence often allows immediate destruction by suspects. Nevertheless, these facts in themselves are not sufficient to dispense with the knock-and-announce rule. The majority of jurisdictions require law

enforcement to articulate specifically why *these* premises and/or *these* people make it dangerous or unwise to knock and announce before a search ensues.

Special Considerations

Independent component doctrine

The assertion often heard in law enforcement circles is that "you must have probable cause to seize the computer." This statement begs the question—what is the computer? Probable cause to seize the "computer" does not necessarily mean authorization to seize the entire computer system, that is, the central processing unit (CPU) and all its peripherals.

Each component in the computer system should be considered independently from the others in analyzing probable cause to seize. It is wrong to assume that any item connected to the target device may automatically be seized. To protect the execution of the search warrant from serious challenge in court, seize only those items necessary for basic input and output functions (e.g., CPU, keyboard, monitor). (See glossary of terms for definitions of computer parts.)

When you need to search and seize devices in addition to the basic components, list only those devices for which you can articulate an independent basis. The independent component doctrine does not mean that connected items are exempt; it only requires that investigators and prosecutors articulate a reason for searching and/or seizing each targeted device. Determine what role each component might have played in the commission of the crime. That determination constitutes probable cause to seize the "computer."

Privileged and confidential communications

Search warrants to examine computer data that contain privileged communications must be written narrowly to include only data relevant to the investigation. Such data should be described as specifically as possible. Generic, boilerplate affidavits are insufficient and often result in successful suppression of the evidence by the defendant.

Doctors, lawyers, and clergy possess recognized confidential communication safeguards and are governed by special statutes regarding searches of such information. Before

executing search warrants for privileged or confidential communications, data, or documents from disinterested third parties (such as doctors, lawyers, or clergy), you should be thoroughly briefed by a knowledgeable prosecutor on the Privacy Protection Act of 1980 (PPA),[8] the accompanying regulations,[9] and all applicable State statutes. While the PPA provides safeguards for confidential relationships, it does not apply to criminal suspects. It also does not require showing anything greater than probable cause to secure a warrant for a search that may intrude on confidential relationships.[10]

Privacy Protection Act of 1980

Through the PPA, Congress has given protection to the press and others extending beyond that which is currently provided by the Fourth Amendment. It is unlawful for any government officer or employee, in connection with the investigation or prosecution of a criminal offense, to search for or seize the following:

- Work product materials (e.g., private memos, interview notes, or mental impressions).
- Documentary materials (other than work product materials) possessed by a person reasonably believed to have a purpose to disseminate to the public a newspaper, book, broadcast, or other similar form of public communication in or affecting interstate or foreign commerce.

Under the PPA, however, government officers or employees, in connection with the investigation or prosecution of a criminal offense, may search for or seize work product or documentary materials if:

- Probable cause exists to believe the person possessing such materials has committed or is committing a criminal offense, other than possession, to which the materials relate. It should be noted that possession of child pornography is not protected under the PPA.
- There is reason to believe that immediate seizure of such materials is necessary to *prevent the death of, or serious bodily injury to, a human being.*

In addition, government officials or employees may search for or seize documentary materials if service of a subpoena would result in destruction, alteration, or concealment of evidence, or a court order was not complied with and either appellate remedies are exhausted or delay would threaten the ends of justice.

For a valid claim to be made under the PPA, two conditions must exist:

- A search and seizure must have taken place.
- Intent to disseminate the information publicly must be shown.[11]

Victims of searches that violate the PPA may not move to suppress the evidence obtained. However, the statute does allow for civil remedies. The PPA also precludes the State from asserting a good faith defense (a defense based on honest belief, with the absence of malice or design to defraud or seek an unfair advantage) to civil claims. In this regard, the PPA is a strict liability statute.

Steve Jackson Games v. *United States*[12] is an important case to understand before conducting searches and seizures that may involve the PPA. (For guidelines on how to read case citations and legal opinions, see sidebar, "Using Legal Opinions.") Based on information that an employee was using company computers for illegal activities, Secret Service agents in that case executed a search warrant on the target company, Jackson Games, producer of books, magazines, and games for the public. Jackson Games immediately requested return of the seized materials, but the Secret Service retained most of the records for several months. No criminal charges were ever filed. Jackson Games filed a civil suit against the Secret Service and the United States under the PPA and the Electronic Communications Privacy Act (ECPA).[13] The court found that the Secret Service agents who seized the materials in question violated the PPA when they realized the materials were protected under the Act and failed to return them promptly. A substantial award resulted from the verdict.

Before searching computers or bulletin board services, carefully consider the restrictions of the PPA, along with its exceptions and exemptions. If your case involves the protections of the PPA or ECPA, consult legal experts about how to avoid liability for violations of these laws.[14]

Stored electronic communications

You should request direction and legal advice when seeking to obtain stored electronic communications. Under Federal and State constitutional protections against unreasonable search and seizure, Congress has provided supplemental

protections through the enactment of the ECPA. This statute encompasses, among other things, access to and search and seizure of stored electronic communications. Under the ECPA, anyone who provides an electronic communication service or remote computing services *to the public* is prohibited from voluntarily disclosing the contents of the electronic communications they store or maintain on the service.[15] For the statute to apply, the communication must be electronically stored on a system that affects interstate or foreign commerce. The ECPA protects only communications in electronic storage in the possession of the service provider. It does not protect communications downloaded by the addressee to another computer not maintained by a provider.

There are, however, exceptions to the ECPA's nondisclosure provisions:

- Persons or entities may disclose the contents of the communications with lawful consent from the originator of the communications, an addressee, or the intended recipient of such communications.
- They may disclose the contents if the communications were inadvertently discovered and appear to be related to the commission of a crime.
- If the communication has been stored longer than 180 days, prosecutors may, under rule 41 of the *Federal Rules of Criminal Procedure,* use a search warrant (which does not require notice to the subscriber) to seize communications on e-mail. Alternatively, prosecutors may use an administrative subpoena, grand jury subpoena, or court order (which all require notice to the subscriber). If the communications are in storage 180 days or less, disclosure to a governmental entity requires a warrant.[16]
- Law enforcement can compel disclosure from both types of providers by warrant or subpoena under the ECPA. The type of legal process required depends on the age of the communication as set forth above and the predisposition of law enforcement to inform the target customer about its request for electronic evidence stored in the target's computer.
- The ECPA provides law enforcement with the ability to request the service provider to preserve all records and other evidence in its possession relating to the target computer pending the issuance of a court order or other legal process. This period of retention is 90 days, with an option for an additional 90 days if law enforcement requests. Law enforcement may include in its subpoena or court order a requirement that the service provider create a backup of all contents of communications contained in the target's e-mail file. This may be done without notice to the customer/target under certain circumstances.

Drafting the Warrant

The focus of the warrant should be on the items to be seized. The warrant should be as specific as possible. You must be creative and informative in articulating to the magistrate what it is you want to seize and where you want to conduct your search.

It may be impossible to isolate the location of information. If you suspect data are at multiple sites, your magistrate must be informed that the search may require searching multiple sites. If multiple sites in different jurisdictions are involved, address this issue with the magistrate before the warrant is executed. There is some legal precedent in drug court opinions for a search conducted under a single warrant to authorize wiretaps in multiple jurisdictions.[17] It is preferable under present law to seek a search warrant from a court of competent jurisdiction in each separate site to be searched. The affidavit should explain why a specific address is not available, including the various attempts to find the address. You need to demonstrate the connection between the computer described in the warrant and an offsite storage computer.

Using Legal Opinions

In published opinions, Federal and State appellate and supreme courts interpret legal issues, decide legal disputes, and set precedent for future cases. Their findings are considered binding on lower courts when subsequent cases raise identical issues. An opinion, however, can only set a precedent with regard to the issues in dispute that were actually decided by the court. The published opinion will contain a statement of the facts, a statement of the legal issues disputed by the parties, a ruling or holding (an answer to the issues raised), and the court's reasoning or rationale for its decision. The ruling is most significant, although the court's rationale provides valuable information with which to compare or distinguish the issues in other cases.

Legal case citations such as "713 F. Supp. 1308 (D. Minn. 1989)" are read as follows: 713 (volume number), F. Supp. (reporting entity—in this example, the Federal Supplement), 1308 (page number in the particular reporter where the opinion begins), D. Minn. (name of court that decided the case—in this case, the U.S. District Court for the District of Minnesota), 1989 (year the opinion was published). When a case is unreported, pending, or available only on a database such as Westlaw or LEXIS, the citation form varies. For an opinion available only on an electronic database, for example, the citation will include the name of the database and any unique database numbers or identifiers.

The scope of the search of the target's computer should be determined by the nature of the criminal conduct. If probable cause exists to believe that the criminal conduct includes use of data, e-mail, and the computer, the warrant may be drafted in broader terms, because it is unnecessary to distinguish seizable and nonseizable items. Conversely, if probable cause exists only to seize the computer as a storage container of child pornography, your warrant must be narrow and specific to the container and the child pornography stored in it, distinguishing that evidence from other noncriminal electronic data.

Chain of Custody

Protecting the integrity of evidence seized in cases involving computers requires the same considerations as in other cases. The chain of custody (the custody of evidence from the moment it is seized until the moment it is offered in evidence) must be documented, and access to evidence must be strictly controlled to avoid challenges to the admission of evidence at trial. Essentially, the chain of custody must show that the item offered into evidence is the same item that was seized.

The preservation of evidence in electronic form as found at the scene of the crime is essential. This is true whether you process the raw data and add hearsay information (resulting in processed evidence, that is, evidence that provides a context for interpreting the raw evidence and its connection to the crime) or offer only the raw data as evidence. In either situation, the party offering the evidence must demonstrate the reliability of the procedure used in acquiring, storing, processing, and retrieving the evidence. Usually, processed evidence is offered to prove the truth of certain facts. Those facts must be developed through a demonstrated, reliable model of taking raw data and adding certain statements to draw reliable conclusions. A phone bill is an example of processed evidence.

The processing of electronic evidence—how it is collected, stored, and retrieved—is a new area of litigation for technical experts and brings new challenges to law enforcement. Therefore, a technical expert should always be available for law enforcement teams investigating computer cases. The affidavit of probable cause should request the court's permission to use private, expert personnel for the execution of the search warrant. The affidavit should be specific as to

why a private expert is required and what the expert's role will be during the execution of the warrant. The private expert should always be accompanied by an experienced police officer during the execution of a search warrant and the seizure or processing of evidence seized pursuant to the warrant. The chain of custody and integrity of the evidence should be of paramount concern during this process.

There are many more legal issues regarding searching and seizing computer evidence that cannot be addressed in the space provided by this guide. Law enforcement officers should not use their role in searching and seizing computer evidence as an introduction to this technology. Most seizures require an expert to retrieve, analyze, and preserve data. If your department does not have staff who are adequately trained in how to search and seize computer evidence, the department should hire an expert. In determining what type of expert is required, you need as much information on the target equipment and system as possible.

Summary

Armed with knowledge of the highly predictable sexual behavior patterns of preferential sex offenders and their use of computer technology, investigators can confidently devise effective investigative strategies to combat the sexual exploitation of children. Such knowledge can influence interview approaches, collection of computer evidence, and location of corroborative evidence and other victims.

The sophisticated use of computers in criminal activity complicates law enforcement efforts, but it should not deter the aggressive pursuit of those who use computer technology to victimize children. By following proper investigative procedures and keeping in mind relevant legal considerations, investigators can avoid losing valuable evidence. By keeping abreast of technological advancements, the criminal justice system can successfully hold child sexual predators responsible for their behavior.

Endnotes

1. *Diagnostic and Statistical Manual of Mental Disorders, 4th edition.* Washington, DC: American Psychiatric Association, 1994.

2. 15 U.S.C. §§ 2251 *et seq.*
3. *United States* v. *Reed,* 935 F.2d 641 (4th Cir.), *cert. denied,* 1125 S. Ct. 923 (1991).
4. *Texas* v. *Brown,* 460 U.S. 730 (1983).
5. *Schnecklath* v. *Bustamonte,* 412 U.S. 28 (1973).
6. *United States* v. *Matlock,* 415 U.S. 164 (1974).
7. *Plessent* v. *Lovell,* 876 F.2d 787 (10th Cir. 1986).
8. 42 U.S.C. §§ 2000aa *et seq.*
9. 28 C.F.R. § 59.4b.
10. *United States* v. *Mittleman,* 999 F.2d 440 (9th Cir. 1993).
11. *Esmay* v. *United States,* 1993 U.S. Dist. LEXIS 20362 (D. Ariz. 1993).
12. 816 F. Supp. 432 (W.D. Tex. 1993).
13. 18 U.S.C. §§ 2510 *et seq.* and 2701 *et seq.*
14. The issue of attorney's fees and litigation costs under the PPA is discussed in *Minneapolis Star & Tribune Co.* v. *United States,* 713 F. Supp. 1308 (D. Minn. 1989).
15. 18 U.S.C. § 2702.
16. *Davis* v. *Gracey,* 111 F.3d 1472 (10th Cir. 1997) (discusses whether incidental seizure of electronic communications, standing alone, is a violation of the ECPA and the good faith elements of defense thereto); *United States* v. *Moriarty,* 1997 U.S. Dist. LEXIS 6678 (D. Mass. 1997) (interprets term "intercept" within the ECPA); *United States* v. *Reyes,* 922 F. Supp. 818 (S.D.N.Y. 1996) (addresses whether numbers from pagers fall within the ECPA).
17. *United States* v. *Rodriguez,* 968 F.2d 130 (2d Cir.), *cert. denied,* 113 S. Ct. 140 (1992).

Contributing Authors

Daniel S. Armagh, J.D.
Director of Legal Education
National Center for Missing
and Exploited Children
699 Prince Street
Alexandria, VA 22314
703–837–6337
703–274–2112 (fax)
E-mail: darmagh@ncmec.org

Nick L. Battaglia
Sergeant, San Jose Police Department
1302 North Fourth Street
San Jose, CA 95112
408–501–0960
408–266–1406 (fax)
E-mail: nickb1706@aol.com

Kenneth V. Lanning, M.S.
Supervisory Special Agent
Federal Bureau of Investigation
National Center for the Analysis of Violent Crime
FBI Academy
Quantico, VA 22135
703–632–4337
703–632–4336 (fax)

Supplemental Reading

Armagh D. A Safety Net for the Internet: Protecting Our Children. *Juvenile Justice* 5(1):9–15, 1998.

Child Safety on the Information Highway (pamphlet). Washington, DC: National Center for Missing and Exploited Children, 1994.

Whitcomb D. *When the Victim is a Child*. 2d ed. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1992.

Organizations

Child Exploitation and Obscenity Section
Criminal Division
U.S. Department of Justice
1331 F Street NW., Sixth Floor
Washington, DC 20004
202–514–5780
202–514–1793 (fax)
202–305–4320 (fax)

The Child Exploitation and Obscenity Section (CEOS) of the Criminal Division, U.S. Department of Justice, has supervisory responsibility for Federal statutes covering obscenity, child exploitation, child sexual abuse,

activities under the Mann Act, sex tourism, missing and abducted children, and child support recovery. Created in 1987, CEOS is a specialized section composed of attorneys with broad expertise in prosecuting obscenity, child exploitation, and child abuse. CEOS's jurisdiction is limited to enforcement of Federal statutes. Section attorneys work with U.S. Attorneys on child exploitation cases across the country, providing litigation and support services. They also provide training, both domestically and internationally, for prosecutors, judges, attorneys, law enforcement, and victim service systems. CEOS attorneys advise task forces on missing and abducted children, child abuse, sex offender recidivism and registration, and youth placement. CEOS works with victim-witness offices of the U.S. Attorney's offices.

Federal Bureau of Investigation (FBI)
Innocent Images Initiative
Baltimore Division
11700 Beltsville Drive
Calverton, MD 20705
301–586–4519 (8:00 a.m. to 4:00 p.m.)
301–586–4500 (4:00 p.m. to 12:00 p.m.)
Internet: www.fbi.gov/contact/fo/balt/major.htm

Operation Innocent Images identifies and develops prosecutable cases on individuals who use Bulletin Board Systems to victimize children. FBI agents and task force officers, who pose as young children or sexual predators, go online to investigate those individuals who recruit minors into illicit sexual relationships, electronically distribute pornographic images of children, or post illegal images onto the Internet.

National Center for Missing and Exploited Children (NCMEC)
699 Prince Street
Alexandria, VA 22314
800–THE–LOST (800–843–5678)
703–274–3900
Internet: www.missingkids.org

A clearinghouse of information on missing and exploited children, NCMEC operates a 24-hour hotline and child pornography tipline and provides a wide range of free services, including technical case assistance, link and pattern analysis on cases, forensic assistance, training programs, and educational material and publications. NCMEC also offers CyberTipline (www.missingkids.com/cybertip), an online service for reporting sexual exploitation. Parents or children can file a report by completing and submitting an online form that is reviewed by an Exploited Child Unit information analyst and submitted to law enforcement to include the FBI, the U.S. Customs Service, and the U.S. Postal Inspection Service.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
Internet: www.ndaa-apri.org

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

U.S. Customs Service
Cyber Smuggling Center
11320 Random Hills Road, Suite 400
Fairfax, VA 22030
703–293–8005
Internet: www.customs.treas.gov

The Cyber Smuggling Center's main focus is to patrol the Internet for signs of the illegal importation and proliferation of child pornography or of sexual exploitation of children. The center conducts all Internet investigations from a central location.

U.S. Postal Inspection Service
475 L'Enfant Plaza West SW.
Washington, DC 20260
202–268–4286
Internet: www.usps.com/postalinspectors/

The U.S. Postal Inspection Service, often working with agencies such as the Child Exploitation and Obscenity Section of the U.S. Department of Justice and the National Center for Missing and Exploited Children, conducts undercover operations to investigate individuals who use the Internet or a Bulletin Board Service to exchange pornography or who correspond with others who do the same. In some undercover operations, postal inspectors contact suspects via computer networks and the Internet. Individuals who use the U.S. mail for the actual exchange of material or for initial contact are subject to investigation.

Internet Crimes Against Children Program

In September 1998, with 10 awards to State and local law enforcement agencies across the Nation, OJJDP began a national program to counter the emerging threat of offenders using the Internet or other online technology to sexually exploit children. Designed to encourage communities to adopt a multidisciplinary, multijurisdictional response to this threat, the Internet Crimes Against Children (ICAC) Task Force Program ensures that participating State and local law enforcement agencies can acquire the necessary knowledge, equipment, and personnel resources to prevent, interdict, or investigate ICAC offenses. Under this program, ICAC task forces serve as regional sources of prevention, education, and investigative expertise to provide assistance to parents, teachers, law enforcement, and professionals working on child victimization issues.

Policing in cyberspace presents new and unique challenges for American law enforcement. In cyberspace, traditional boundaries are ignored and the usual constraints of time, place, and distance lose their controlling influence. Because very few cases start and end within the same jurisdiction, nearly all ICAC investigations involve multiple jurisdictions and require extensive multiagency collaboration. However, multiagency collaboration is challenging. Federal, State, and local law enforcement organizations have legitimate, understandable concerns about initiating cases based on information that may have been gathered through inappropriate conduct or investigative techniques by officers of another agency.

OJJDP has established operational and investigative standards for the ICAC Task Force Program through a collaborative process with the 10 original ICAC Task Force agencies and the Federal Bureau of Investigation (FBI); U.S. Customs Service (USCS); U.S. Postal Inspection Service (USPIS); U.S. Department of Justice, Criminal Division, Child Exploitation and Obscenity Section (CEOS); and the National Center for Missing and Exploited Children (NCMEC). These standards were designed to foster information sharing, coordinate investigations, avoid duplication or disruption of ongoing investigations, ensure the probative quality of undercover

operations, and facilitate interagency case referrals through the standardization of investigative practices. Collaborative undercover operations, when properly executed and documented according to the ICAC Task Force Program standards, can collect virtually unassailable evidence and, most important, allow law enforcement to bring a case before a suspect can victimize a child.

OJJDP's ICAC Task Force Program is administered through a shared management system that combines a national perspective with the local values of participating communities to address coordination and communication concerns related to ICAC investigations. OJJDP has established a review board, composed of law enforcement managers and prosecutors from participating agencies, to assist in the administration of this program. The board, while primarily responsible for reviewing undercover operations for compliance with the ICAC Task Force Program standards, plays a critical role in assessing the needs of the field and in formulating policy for the national program. Representatives from FBI, USCS, USPIS, and CEOS serve as technical advisors to the board.

In addition, OJJDP, in consultation with Federal law enforcement and prosecutorial agencies and NCMEC, has developed a certification course for agencies participating in the program. The course prepares ICAC Task Force investigators and managers to develop policies and employ proven investigative procedures in response to computer-facilitated sexual exploitation of children.

In fiscal year 1999, $5 million is available for the ICAC Task Force Program. OJJDP will award a total of $2.6 million in grants to a minimum of eight new jurisdictions. In addition, a total of $2.4 million in continuation funds will be available to the 10 jurisdictions that received initial grants in fiscal year 1998.

For more information on the ICAC Task Force Program, visit OJJDP's Web site at www.ojjdp.ncjrs.org or contact the Juvenile Justice Clearinghouse at 800–638–8736, 301–519–5212 (fax), or askncjrs@ncjrs.org (e-mail).

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000 (AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Photo-documentation in the Investigation of Child Abuse

Portable Guides to Investigating Child Abuse

Foreword

A picture, so the saying goes, is worth a thousand words. In the case of the investigation of a charge of child abuse, a picture can determine the eventual case result.

To do the task of documentation properly, child abuse investigators require the right tools and the right techniques. Photodocumentation is one of the most important of these tools.

This guide provides valuable pointers regarding the selection and use of camera equipment, film, and photographic techniques that are most appropriate for use in cases of suspected child abuse. Proper photographing of the child's physical condition will help provide evidence integral both to the investigation and to the courtroom presentation, should formal charges ensue.

It is my hope, therefore, that this guide will help protect children from abuse through the enhancement of investigative techniques.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

June 1996

Third Printing March 2000

NCJ 160939

Overview

Photographs documenting a victim's injuries often provide key evidence in child abuse cases and convictions. To ensure effective photodocumentation, it is important to use the most appropriate camera equipment and film and to properly identify and investigate the child victim. Critical to all investigations of child abuse is the method of photographing injuries such as pressure injuries, bite marks, bruises, burns, facial injuries, amputations, neglect, and sexual abuse injuries. Accurate courtroom evidence can be hindered by the following:

- Ineffective camera equipment and film.
- Insufficient methods of photographing the victim or the victim's injuries.
- Misinformation regarding the photographs of the case.
- Mislabeling of child abuse information, including photographs.

This guide offers important information on how to document cases of suspected child abuse through photography to enhance the investigation process or provide courtroom evidence and testimony.

Camera Equipment

To be effective in documenting child abuse cases, camera equipment should have the following capabilities:

- Be easy to use and require little training.
- Offer accurate color balance.
- Provide automatic exposure and the capability for film advance and rewind.
- Have a built-in flash with quick recharge (flash recharges within 2 to 3 seconds).
- Offer comfortable operating distance from subject.
- Be able to produce life-size reproductions of trauma sites and to show much larger areas of the body or the device believed to have caused the injury.

Camera systems for photographing abused children range from expensive and sophisticated colposcopic (a specialized camera/examination unit used specifically by medical examiners for viewing or photographing subtle abnormalities or injuries to the vagina, cervix, or anus) and 35mm closeup systems to less expensive and simpler "bridge" cameras and instant or self-developing cameras. Table 1 lists the types of cameras and their advantages and disadvantages.

Film

The standard film for medical use in documenting child abuse cases is 35mm color slide film, sometimes referred to as color transparency or color reversal film. Color slides are relatively inexpensive and easy to file and can be quickly developed and converted into color prints if necessary.

Regardless of the camera equipment used, the following points concerning type and use of film are important in ensuring consistency in results and reproduction of the injury, its location, color, size, and pattern:

- Use fine-grain color slide or print film that has a film speed rating of 100 or 200 ISO (International Standards Organization). This type of daylight film allows for a greater depth of field (sharpness) with a minimum amount of grain and blurriness. Always use a flash when shooting indoors with daylight film. *Sixty-second, self-developing film is not recommended.*
- Keep film and camera equipment in a clean, empty, dry thermal container or picnic cooler. Do not store the film unprotected in a vehicle. Sunlight and extreme temperatures can adversely affect color accuracy, reduce the film's sensitivity to light, and in some cases, result in tearing or splitting.
- Store film in the refrigerator or freezer to keep it fresh, but place at room temperature for approximately 2 to 3 hours before it is to be used (24 hours if film is frozen).
- Process exposed film as soon as possible to avoid a color imbalance or shift.
- Remember when the film was loaded, the type of film, and how many exposures a roll contains. Attach an end flap from the film carton to the camera back as a reminder. Failure to do so could result in lost evidence. Always remove rewound film from the camera and attach an identification sticker or place in an evidence bag before the film is sent for processing.
- Make sure an extra camera and set of flash batteries are available at all times.

Table 1

Advantages and Disadvantages of Types of Cameras Used in Photodocumentation

Type of Camera	Advantages	Disadvantages
Instant-processing cameras	Simple operation and low cost.	Poor resolution/poor color compared with 35mm film.
Fixed-focus lens "point-and-shoot" or "compact" 35mm cameras	Inexpensive and easy to use.	Limited closeup capability and expendability. Viewfinder does not view the same image as the lens. It creates blurred images when the photographer attempts to magnify the image by moving in closer (6–7 feet) than the focusing limit of the lens.
Colposcopic cameras	Accurate, standardized equipment for examination or photography of sexual abuse injuries. Able to document findings not otherwise seen with the naked eye.	Expensive, not portable, and cumbersome to operate. Require training usually reserved for healthcare providers (i.e., physicians). Not equipped for photography of large areas of the body.
35mm-format cameras	Provide choices of cameras, lenses, and accessories that offer excellent resolution and closeup capabilities.	Generally no disadvantages.

	Offer integrated (dedicated) flash that automatically adjusts during photo sessions. Compare favorably with and are significantly less expensive than colposcopic cameras for photographing the sexually abused child. Require little training and offer comfortable operating distance from the subject. Provide accurate color balance, automatic exposure, film advance and rewind, built-in flash, and quick flash recharge.	
"Bridge" cameras	Combine the simplicity and easy use of a point-and-shoot camera with the versatility, expendability, and closeup capability of a 35mm prepackaged camera system, "bridging the gap" between these two kinds of equipment. Relatively inexpensive, fully automatic, and incorporate telephoto (35–70mm or 35–105mm) capability, built-in flash, autofocus, motor drive, and optional databack.	Cannot attach specialized lenses or flash units for optional documentation of some injuries (intraoral, intravaginal, ophthalmic).

Ultraviolet Photography

Ultraviolet (UV) photography has an established role in clinical forensic medicine and is beginning to be used in child abuse assessments. UV is a method of photography in which a standard, high-speed (ISO 800/1600) color slide film is used in conjunction with a high-powered electronic flash. The flash must be covered with a Wood's Filter (Wratten Filter 18A); another filter (Wratten Filter 2B or 2E) must be used on the camera lens. The end result of UV photography is an image that may display healed wounds, bite marks, belt imprints, and old pattern-type injuries.

There are disadvantages to UV photography. Photographing conscious subjects can be difficult and may produce little usable evidence, and the image cannot be seen until after development. In addition, the methodology is complex, the working parameters are tight, and any proof may be altered by subject movement or inaccurate focusing. If UV is to be used, the subject should also be recorded on conventional color slide film using a standard nonfiltered flash and lens combination.

Photographing Injuries

Prior to photographing the injuries, the investigator should identify the suspected child abuse victim by completing an identification sheet and/or taking a full-face picture of the child that also displays the child's name. Separate rolls of film should be used for each case to avoid losing or mixing up evidence, which could result in dismissal of the case. Although time-consuming, it is helpful to place an identifying sign, including name or initials, date of birth, date and time of photographs, case number, and the photographer's name or initials, in front of the victim's injury for each picture. In addition, many 35mm cameras contain databack attachments that imprint the time, date, and an identifying code on each film frame.

In addition, the investigator can use a medical photography form as a tool for highlighting injury sites, description of injuries, time and date of photographs, the victim's identification or case number, and the number of photographs taken and by whom. The form is then included in the finished photo envelope as relevant to the chain of evidence. A sample form is included as figure 1.

Tips for Photographing a Suspected Victim of Child Abuse

- Take two pictures of every view and angle, one for the file and one for court.
- Photograph the injury with an anatomic landmark. The inclusion of an elbow, knee, belly button, or other body part identifies the location of the wound.
- Include two pictures of each wound or other injury—one that identifies a landmark and one that provides a closeup (fills the film frame) of the wound.
- Position the camera so that the film surface or plane is parallel to or directly facing the injury.
- Vary the perspective of the picture by taking various shots from different angles and distances. This is particularly important since the flash may produce unpredictable reflections. Darker complexions can cause flash reflections and loss of definition. If unsure about correct exposures, take pictures at the camera's recommended exposure and one slightly lighter and one slightly darker (bracketing). To do this, adjust the lens aperture by one-half to one full f-stop on either side of the recommended exposure. Bracketing will ensure proper color balance and brightness when documenting victims with very light or very dark skin tones.
- Place a measuring device such as an adhesive metric scale directly above or below the injury to ensure accurate representation of the size and depth of the injury. A standardized color bar may be placed in the photographic plane for comparison with the color of the injury. This ensures that if color is distorted in the film developing process, adequate color comparisons can still be made.

Figure 1

Request For S or A No. _____

MEDICAL PHOTOGRAPHY

CHILDREN'S HOSPITAL OF BUFFALO

(please print) Form must be filled out completely

Name _____
Last First

Unit No. _____ Birth Date _____

Diagnosis _____

_____

Photograph to show _____

_____

How Patient dressed _____

☐ B&W ☐ Color

Grant or Account No. _____

Requested by _____
Physician Signature

Remarks -

Form - 44

Addressograph Plate

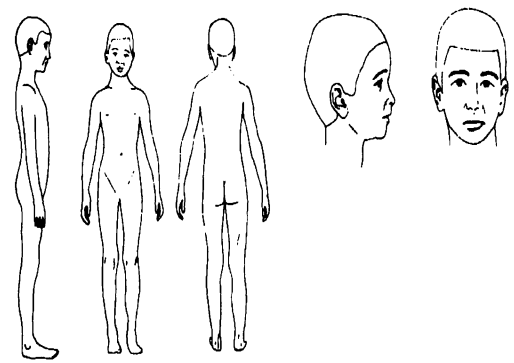
Dept use only

No. _____

Date _____

AMOUNT CHARGED:

OUTLINE AREAS TO BE PHOTOGRAPHED



Reproduced courtesy of the Children's Hospital of Buffalo, New York.

Methods for Photographing Specific Injuries

Punctures, slashes, rope burns, or pressure injuries

When documenting these types of injuries, take photographs straight on and at a slight angle. Photographing the injury straight on provides an overall view of the surface and extent of the injury, while shooting from a slight angle provides depth and texture to a picture.

Bite marks

Forensic bite mark photography is a specialized field of medical photography and is interpreted best by a forensic dentist or pathologist. Bite marks can be recorded by following the method described above for punctures, slashes, and so forth, but the size, shape, color, depth of indentations, and three-dimensional contours also need to be documented. Multiple views from various perspectives are important in delineating texture and shape. Parallel or direct views best depict shape and size, while slanted or indirect views and lighting highlight texture.

Bruises

Bruising goes through several stages of development—a bruise discovered several hours after abuse will become more pronounced as time goes on, and additional photographs will be needed to document the injury. If a second or third series of pictures is required, the investigator should reproduce the angles and positions that were used to photograph the first series. If a child shows evidence of having old and new bruises, repeated abuse may be suspected. Both old and new bruises should be photographed. Areas of swelling (edema) sometimes exhibit a strong reflection that is caused by the flash bouncing off the swollen/rounded injury site. This effect may obscure the photograph. To help minimize the reflections, take photographs from several different angles, then do a followup series when the swelling has gone down.

Burns

In cases of burns or severe scalding, take pictures from all angles *before* (especially before any creams or oils are applied) and *after* treatment. Accidental burns usually exhibit splash marks or indiscriminate patterns of injury. Intentional submersions show distinct lines or well-defined areas of damaged skin compared with healthy skin.

Facial injuries

If an injury is inside the mouth, use a plastic or wooden tongue depressor to keep the mouth open and the injury visible. If there is an eye injury, use a pocket flashlight or toy to distract the child's gaze in different directions to show the extent of the damage to the eye area.

Amputation

In cases where abuse involves the amputation of a body part, photograph the dismembered part alone and then in relation to the body as a whole. Closeups should also be taken of the skin's torn edges, which may help verify the method of amputation in court.

Neglect

When there is suspected child neglect, the child's general appearance should be photographed, including any signs such as splinters in the soles of the feet, hair loss, extreme diaper rash, wrinkled or wasted buttocks, prominent ribs, and/or a swollen belly.

Sexual abuse

If sexual abuse is suspected, the child and his or her injuries should be approached as follows:

- Photograph the child in the presence of a trusted relative or guardian.
- Inform the child of what will be involved in taking the pictures.
- Remember to consider the child's level of development when speaking to him or her.

- Do not make quick moves toward the child, as these may be frightening.
- Make eye contact with the child to make him or her feel more comfortable.
- Keep a supply of toys or coloring books as a reward for being helpful.
- Allow time for the child to become accustomed to the photographer before being photographed. Do not surprise the child. Tell him or her what parts of the body need to be photographed.
- Let the child undress himself or herself or have the parent or guardian help.
- Photograph sexual organs, including an overall view and closeups of the injury. This may require that the labia (vaginal lips) be spread apart for closer photography or that the child kneel down on all four limbs to allow the anus to be photographed.
- In general, photographing a sexual abuse injury is best done by a medical specialist in the field of child abuse, with appropriate equipment such as a colposcope.

Photodocumentation as Court Evidence

Photographic evidence should include a form with the victim's name, the case number, and the date and time the photographs were taken. The form should also contain a remarks section that includes case notes. Outline drawings of the child's body are also helpful to show the specific areas that were photographed. Photographs must be properly verified and relevant to the case so that:

- The photographer or investigator can testify in court that the pictures accurately portray the findings and can explain how the photographs were taken.
- A health professional who examined the child (other than the photographer) can verify in court that the photographs accurately represent the findings.

Photography Tips

- Establish a protocol or checklist for photodocumentation.
- Decide in advance who will be photographing the victim.
- Shoot a test roll before using a new camera system.
- Compose the picture as the injured area would normally appear.
- Magnify the picture (create a closeup to fill the film frame) as it is being taken, not during printing.
- Bracket (vary f-stop above, at, and below expected correct or recommended exposure) if correct exposures are uncertain.
- Take many pictures from different angles and distances (more is better than less).
- Review all pictures after they are developed.
- Label all the prints and slides after development.
- Keep photographs protected and techniques logged.

Contributing Authors

Lawrence R. Ricci, M.D.
Director
The Child Abuse Program
at the Spurwink Clinic
17 Bishop Street
Portland, ME 04103
207–879–6160

Brian S. Smistek
Director of Medical Media
Kaleida Health Children's Hospital of Buffalo
219 Bryant Street
Buffalo, NY 14222–2006
716–878–7302/7254
716–878–7914 (fax)
E-mail: bsmistek@kaleidahealth.org

Supplemental Reading

Barsley RE, West MH, Fair JA. Forensic photography: Ultraviolet imaging of wounds on skin. *American Journal of Forensic Medicine and Pathology* 11:300–308, 1990.

Bernstein ML. The application of photography in forensic dentistry. *Dental Clinics of North America* 27:151–170, 1983.

Cantor BJ. Is it evidence? *Industrial Photography Magazine,* August 1990.

Evidence Photographers International Council (EPIC), *Journal of Evidence Photography,* October 1975.

Ford RJ, Smistek BS. Photography of the maltreated child. In Ellerstein NS (ed): *Child Abuse and Neglect: A Medical Reference.* New York: John Wiley and Sons, Inc., 1981, pp. 315–325.

Hedgcoe J. *The Book of Photography.* New York: Alfred A. Knopf, 1987.

Hubbard SB. Ultraviolet photography. *Photo Electronic Imaging,* June:40–42, 1992.

Langford M. *Michael Langford's 35mm Handbook.* New York: Alfred A. Knopf, 1988.

Luntz LL, Luntz P. *Handbook for Dental Identification: Techniques in Forensic Dentistry.* Philadelphia: JB Lippincott, 1973.

Meadow R, Mitchels B. The ABC's of child abuse. *British Medical Journal* 229:248, 1989.

Ricci LR. Photodocumentation of the abused child. In Reece RM (ed): *Child Abuse: Medical Diagnosis and Management.* Malvern, PA: Lea and Febiger, 1994.

Ricci LR. Photographing the physically abused child: Principles and practice. *American Journal of Diseases of Children* 145:275–281, 1991.

Sansome SJ. *Police Photographs.* Cincinnati: Anderson Publishing, 1977.

Scott CC. *Photographic Evidence.* 2d ed. St. Paul, MN: West Publishing, 1967.

Smistek B. Photography of the abused and neglected child. In Ludwig S, Kornberg A (eds): *Child Abuse: A Medical Reference.* New York: Churchill Livingstone, 1992.

Vetter JP. *Biomedical Photography.* Boston: Focal Press, 1992.

Organizations

American Professional Society on the
Abuse of Children (APSAC)
407 South Dearborn, Suite 1300
Chicago, IL 60605
312–554–0166
312–554–0919 (fax)
Internet: www.apsac.org

APSAC is the Nation's only interdisciplinary society for professionals working in the field of child abuse and neglect. 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.

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
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

National Children's Alliance
1319 F Street NW., Suite 1001
Washington, DC 20004–1106
800–239–9950 or
202–639–0597
202–639–0511 (fax)
Internet: www.nca-online.org

Regional Children's Advocacy Centers (CAC's):

- Midwest Regional Children's Advocacy Center, St. Paul, MN, 888–422–2955, 651–220–6750, www.nca-online.org/mrcac.
- Northeast Regional Children's Advocacy Center, Philadelphia, PA, 215–387–9500, www.nca-online.org/nrcac.
- Southern Regional Children's Advocacy Center, Rainbow City, AL, 256–413–3158, www.nca-online.org/srcac.
- Western Regional Children's Advocacy Center, Pueblo, CO, 719–543–0380, www.nca-online.org/wrcac.

OJJDP funds the National Children's Alliance and the four regional CAC's to help communities establish and strengthen CAC and MDT programs. The Alliance does this by promoting national standards for CAC's and providing leadership and advocacy for these programs on a national level. The Alliance also conducts national training events and provides grants for CAC program development and support. The four regional CAC's provide information, onsite consultation, and intensive training and technical assistance to help establish and strengthen CAC's and facilitate and support coordination among agencies responding to child abuse. The Alliance publishes a number of manuals and handbooks of use to MDT's, including *Handbook on Intake and Forensic Interviewing in the CAC Setting, Guidelines for Hospital-Collaborative Forensic Investigations of Sexually Abused Children, Organizational Development for Children's Advocacy Centers,* and *Best Practices.*

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Diagnostic Imaging of Child Abuse

Portable Guides to Investigating Child Abuse

Foreword

Abuse of any kind is always disturbing. When the victim is a defenseless child, our moral indignation naturally intensifies. Evidence of child abuse must be investigated thoroughly and conscientiously in order that its perpetrators may be stopped and its victims protected.

Diagnostic imaging studies may provide the first clues to physical abuse. Although their scope is somewhat restricted, such studies often prove critical in determining whether abuse has occurred.

While the techniques described in this guide are noninvasive and entail minimal risk, they are important tools in examining skeletal and intracranial injuries and other trauma. The contributing authors' diagnostic recommendations regarding shaken baby syndrome are particularly timely.

The purpose of investigating potential cases of child abuse, as with all law enforcement investigations, is to determine the truth accurately and impartially. It is my hope that *Diagnostic Imaging of Child Abuse* will aid in that crucial determination.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

July 1996

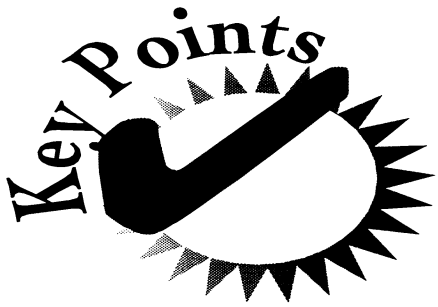
Third Printing March 2000

NCJ 161235

Overview

In cases of child abuse and neglect, the overall incidence of physical alterations documentable by diagnostic imaging is relatively small. However, imaging studies are often critical for infants and young children with evidence of physical injury, and they also may be the first indication of abuse in a child who is seen initially for an apparent natural illness. As most conventional imaging studies performed in this setting are noninvasive and entail minimal radiation risks, recommendations regarding imaging should focus on examinations that provide the highest diagnostic yield at acceptable costs and should consider their potential use as courtroom evidence of child abuse.

Skeletal Injuries



Although skeletal injuries rarely pose a threat to the life of the abused child, they are the strongest radiological indicators of abuse. In infants less than 1 year of age, certain radiological abnormalities are sufficiently characteristic to allow a firm diagnosis of inflicted injury in the absence of other clinical information. Therefore, imaging surveys performed to identify skeletal injury must be carried out with the same level of technical excellence utilized in examinations routinely performed to evaluate accidental injuries.

In general, the radiographic (x-ray) skeletal survey is the method of choice for skeletal imaging in cases of suspected abuse. A skeletal survey is critical in all cases of suspected physical abuse in children less than 2 years of age. In children older than 5 years, a skeletal survey is of little value in screening for injuries. In children between the ages of 2 and 5 years, the specific clinical indicators of abuse determine whether a skeletal survey should be performed. Skeletal scintigraphy (bone scan) is an excellent adjunct to radiographic skeletal surveys, but extreme caution is indicated in using scintigraphy as a primary screening tool in infants. Whatever the child's age, when the clinical findings point to a specific site of injury, the customary protocol for imaging that region should be followed. Application of these guidelines to cases of neglect and sexual abuse is appropriate when physical maltreatment is also suspected.

Intracranial Injuries

All infants and children suspected of having an intracranial injury must undergo cranial computed tomography (CT) and/or magnetic resonance imaging (MRI). Ultrasonography (ultrasound) also may reveal intracranial abnormalities, but it does not provide imaging that is adequate for excluding or fully evaluating intracranial injury. CT has been the accepted method for initial evaluation of intracranial injury in child abuse, and was recently described as the key diagnostic study

for identifying or confirming shaken baby syndrome. The advantages of this method of diagnostic imaging are:

- Speed — A CT scan requires from 5 to 15 minutes, in comparison to 30 minutes for an MRI scan. CT is also usually more readily available than MRI.
- Cost — A CT scan costs less than an MRI scan. The cost of CT is approximately two-thirds the cost of MRI (however, technological refinements may further reduce the time and cost of MRI).
- Better imaging of bone (although skull fractures are better detected by conventional radiographic techniques).
- Better detection of subarachnoid hemorrhage (bleeding into the ventricles—the cavities within the brain—and into the fluid that normally surrounds the brain), although MRI appears to provide a better indication of the ages of the areas of hemorrhage.

However, the extent of injuries may sometimes be underestimated by CT imaging. Preliminary studies indicate that MRI is substantially more sensitive than CT in identifying and characterizing most intracranial conditions resulting from abusive assaults. In patients with minimal external signs of injury, the increased sensitivity of MRI may provide evidence for shaking-induced injury that is not obtainable by CT scanning. MRI provides superior imaging of small subdural hematomas (blood clots), which may be the only objective imaging evidence of child abuse. Other types of intracranial injury—contusions on the cerebral cortex, cerebral edema, hypertension, injuries involving the posterior fossa (the internal base of the skull), and white-matter injuries—are also better imaged using MRI, as are conditions involving the spinal cord.

In addition to greater imaging sensitivity, MRI provides the following advantages over CT:

- Increased contrast resolution (clarity) — The visual impact of an MRI scan can lead to greater appreciation of the findings of abuse in a courtroom situation.
- Absence of ionizing radiation — This makes MRI especially attractive for repeated examinations of the brain and for use in children.
- Multiplanar imaging — Altering the magnetic field allows images to be obtained in multiple planes of view without repositioning the patient.

MRI should be performed in all cases of suspected intracranial injury when CT does not adequately explain the clinical findings. MRI examination is also indicated for children who exhibit chronic alterations in central nervous system (CNS) function and for infants who have symptoms of shaken baby syndrome but no clinical evidence of CNS injury. Because MRI may miss recent collections of blood if the examination is performed too soon after the injury, it should be delayed until several days after the suspected traumatic event.

Thoracoabdominal Trauma

Major blunt and penetrating thoracoabdominal injury (injury involving the chest and abdomen) is uncommon in the infant; thus, imaging strategies are the most critical for toddlers and older children. In a child who has suffered massive trauma, protocols similar to those used for accidental injury apply. Initial roentgenograms (x-rays) in the emergency department include a chest x-ray to evaluate for flail chest (loss of stability of the rib cage following fracture of the breast bone or ribs), pneumothorax (air or gas inside the pleural cavity), pleural effusion (fluid in the pleural cavity), and pulmonary parenchymal injury (damage to the lung tissue). Abdominal x-rays are not good indicators of injury to the viscera (solid internal organs), but they will show gross pelvic fractures. A lateral (sideways view) x-ray of the cervical spine should be obtained before further diagnostic studies are performed.

When the patient has been stabilized, examination by CT is indicated. CT is the most effective and sensitive imaging technique for identifying injuries of the lungs, pleura, and solid abdominal organs. It is particularly good for assessing pancreatic injury and duodenal hematomas (blood clots in the upper part of the small intestine), two characteristic findings in abused children.

In children less than 1 year of age, ultrasonography may be a reasonable preliminary study to perform if abdominal injury is suspected. Ultrasonography is an acceptable initial procedure in a child who shows lesser signs of injury or a constellation of nonspecific abdominal signs and symptoms that cannot be explained by the history or a unifying diagnosis. It is also a

reasonable examination to perform to diagnose occult (hidden) duodenal hematomas and injuries to the pancreas and kidneys. The diagnosis of duodenal hematoma, particularly if chronic, may be difficult with ultrasonography or CT. On occasion, x-rays of the upper gastrointestinal tract may be required to delineate the injury. Radionuclide (a radioactive material used in imaging) scintigraphy plays a relatively small role in the diagnosis of visceral injury, but it is of value in cases of renal (kidney) contusion and myoglobinuria (blood products in the urine due to muscle injury).

Investigative Guidelines

- In the acutely injured patient with significant neurological impairment, CT remains the primary screening method.
- If available, MRI is the method of choice for the detection of intracranial injuries, particularly those associated with shaking-induced trauma.
- If evidence of child abuse is being sought and the CT scan is negative (shows no evidence of injury), an MRI scan should be strongly considered if available. Even when the findings of the CT scan are positive, MRI may be advisable to portray the injury fully.
- When the patient's clinical symptoms indicate more substantial injury than that shown by CT, an MRI examination should also be performed.
- In patients who are more clinically stable, MRI is superior to CT in the screening of subacute or chronic head injury and should be the primary imaging technique whenever possible.
- When an MRI examination shows significant intracranial injuries such as subdural hematoma, cortical contusion, and shearing injury (tearing of brain tissue) that are out of proportion to the history of injury given by the caretakers, the MRI findings should be considered to indicate child abuse, and appropriate evaluation of the social situation should be undertaken.
- Obtaining the most thorough diagnostic imaging assessment possible requires advance preparation of the caretakers who accompany the child to the radiology department. The reason for the diagnostic study (e.g., to identify other injuries or underlying conditions) should be explained, and the caretakers should know what to expect.

- Achievement of adequate studies in young children may require restraint or sedation and, in cases of skeletal surveys, numerous exposures. Excessive apprehension, hostility, and resistance on the part of the child usually will result in an inadequate examination. The technician performing the study should have experience in working with young children.
- Clinical personnel should treat the caretakers in a professional and nonjudgmental manner.
- Caretakers' questions regarding either the reasons for the study or the results should be directed to the referring physician.
- Imaging examinations must be viewed in the context of other clinical findings. The implications of the examinations are best addressed by physicians and other healthcare workers familiar with the family and skilled in these sensitive interactions.
- A single view of the entire infant ("babygram") is inadequate.

Shaken Baby Syndrome

The term "shaken baby syndrome" (SBS) was developed to explain those instances in which severe intracranial trauma occurred in the absence of signs of external head trauma. SBS is the severe intentional application of violent force (shaking) in one or more episodes, resulting in intracranial injuries to the child. Physical abuse of children by shaking usually is not an isolated event. Many shaken infants show evidence of previous trauma. Frequently, the shaking has been preceded by other types of abuse.

Mechanism of Injury

The mechanism of injury in SBS is thought to result from a combination of physical factors, including the proportionately large cranial size of infants, the laxity of their neck muscles, and the vulnerability of their intracranial bridging veins, which is due to the fact that the subarachnoid space (the space between the arachnoid membrane and the pia mater, which are the inner two of the three membranes that cover the brain) are somewhat larger in infants. However, the primary factor is the proportionately large size of the adult relative to the child. Shaking by admitted assailants has produced remarkably similar injury patterns:

- The infant is held by the chest, facing the assailant, and is shaken violently back and forth.
- The shaking causes the infant's head to whip forward and backward from the chest to the back.
- The infant's chest is compressed, and the arms and legs move about with a whiplash action.
- At the completion of the assault, the infant may be limp and either not breathing or breathing shallowly.
- During the assault, the infant's head may strike a solid object.
- After the shaking, the infant may be dropped, thrown, or slammed onto a solid surface.

The last two events likely explain the many cases of blunt injury, including skull fractures, found in shaken infants. However, although blunt injury may be seen at autopsy in shaken infants, research data suggest that shaking in and of itself is often sufficient to cause serious intracranial injury or death.

Indicators and Symptoms

Crying has come under increasing scrutiny as a stimulus for abusive activity. Because shaking is generally a response to crying, a previous illness causing irritability may increase the likelihood that the infant will be shaken. The occurrence of infant abuse is a product of a delicate balance between the severity of the stimulus of crying and the threshold for violent action by potential abusers. The effects of drugs, alcohol, and environmental conditions may trigger this interaction.

The average age of infants abused by shaking is 6 months. The physical alterations characteristic of SBS are uncommon in children older than 1 year. Many symptomatic shaken infants have CNS findings of seizures, lethargy, or coma. Many are resuscitated at home or en route to the hospital and arrive there in serious condition, with a tense fontanelle (the soft spot covered by a membrane, at the top of an infant's head, where the skull bones have not yet joined). Some patients have milder changes in consciousness or a history of choking, vomiting, or poor feeding. Although gross evidence of trauma is usually absent, careful inspection may reveal sites of bruising.

Most infants in whom shaking has been documented have retinal hemorrhage (bleeding along the back inside layer of the eyeball). Other intracranial injuries ascribed to shaking trauma include extra-axial fluid collections (fluid between the skull and brain, e.g., subdural hematoma), axonal shearing injuries at the gray-matter/white-matter interfaces (tearing of brain tissue), and cerebral edema (swelling of the brain).

Diagnostic Recommendations in Cases of Suspected Shaken Baby Syndrome

Although retinal hemorrhage implies that shaking was a factor in causing an injury, physical examination, imaging studies, and pathological examination are needed to determine whether evidence of direct external trauma also exists. While medically such causative distinctions are not crucial to documenting physical abuse, legally, the mechanism of injury is useful for the physician confronted with the necessity of testifying as to the cause of a child's injuries.

- All infants suspected of being abused should undergo a radiological skeletal survey. This should be performed with high-detail systems and with painstaking attention to technique. A single view of the entire infant ("babygram") is inadequate.
- Repetition of skeletal imaging 2 to 3 weeks after the initial examination may provide evidence of a healing injury that was not apparent on initial studies, and should be performed in all infants when abuse is strongly suspected.
- High-quality, state-of-the-art skeletal scintigraphy may be an important supplement to radiological skeletal surveys and has been advocated by some physicians as a primary screening tool in cases of suspected abuse. In the toddler and young child, scintigraphy poses a practical alternative to x-rays; however, caution should be exercised in using scintigraphy as a primary screening tool in infants.
- All infants with clinical neurological findings should undergo cranial CT. This will be sufficient to define any surgically correctable condition.
- Most patients should undergo MRI eventually to define the extent of the injury fully, determine the prognosis, and provide evidence for intervention and criminal proceedings.
- Abdominal injuries are uncommon in abused infants, and imaging studies should be tailored to the specific clinical concern. CT and ultrasound are helpful in establishing whether internal abdominal trauma has occurred in infants thought to have been shaken.

Investigative Guidelines for Cases of Shaken Baby Syndrome

- The use of MRI has helped detect old and new intracranial injuries and has aided recognition of subtle instances of repetitive shaking.
- Repetitive abuse has important legal and clinical implications. If abuse is repetitive, the child is at high risk for further injury unless legal action is taken. Establishing that there has been a pattern of abuse can also help in identifying potential perpetrators and may lead to increased legal penalties.
- The fact that shaken children, and possibly their siblings, often have been previously abused should dispel the notion that shaking is an isolated and somewhat "unintentional" event.
- From the perspective of the protection of the child or the criminal prosecution of the abuser, it is not as important to distinguish the precise mechanism of injury as it is to be certain that the event was nonaccidental.
- Pediatricians should not be deterred from testifying when the cause of the nonaccidental injury is not entirely clear.
- Shaking a child creates an imminent risk for an acute injury.
- Injuries that appear to be caused by shaking create a high index of suspicion of child abuse and should be followed by intensive efforts (e.g., skeletal survey, CT, and MRI) to identify concurrent and previous abuse of the patient and any siblings.
- If an infant's injuries are fatal, an autopsy should be performed by a forensic pathologist. Autopsies of all infants who die of causes other than known natural illness should include thorough skeletal imaging.

Contributing Authors

Randell Alexander, M.D., Ph.D.
Department of Pediatrics
Morehouse School of Medicine
720 Westview Drive SW.
Atlanta, GA 30310
404–756–1347
404–756–1357 (fax)

Paul K. Kleinman, M.D.
Professor of Radiology and Pediatrics
Director, Pediatric Radiology
Director, Imaging Center for Child Abuse and Neglect
UMass Memorial Healthcare University Campus
Department of Radiology
55 Lake Avenue North
Worcester, MA 01655
508–856–3124
508–856–4669 (fax)
E-mail: kleinmap@ummhc.org

Supplemental Reading

Kleinman PK. Diagnostic imaging in infant abuse. *American Journal of Radiology* 155:703–712, 1990.

Kleinman PK. *Diagnostic Imaging of Child Abuse.* Baltimore: Williams & Wilkins, 1987.

The Pediatric Trauma and Forensic Newsletter: A centralized source of information on the medical/legal aspects of childhood trauma and disease (505–281–8109).

Reece RM (ed). *Child Abuse: Medical Diagnosis and Management.* Malvern, PA: Lea and Febiger, 1994.

Reece RM (ed). *The Quarterly Child Abuse Medical Update.* Published by the Institute for Professional Education of the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC). Abstracts of the latest information on the subject of child abuse from more than 40 medical journals (617–587–1500).

Organizations

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
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

Participants are trained in child abuse and exploitation investigative techniques, covering the following areas:

- Recognition of signs of abuse.
- Collection and preservation of evidence.
- Preparation of cases for prosecution.
- Techniques for interviewing victims and offenders.
- Liability issues.

Fox Valley also offers intensive special training for local child investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

National Children's Alliance
1319 F Street NW., Suite 1001
Washington, DC 20004–1106
800–239–9950 or
202–639–0597
202–639–0511 (fax)
Internet: www.nca-online.org

Regional Children's Advocacy Centers (CAC's):

- Midwest Regional Children's Advocacy Center, St. Paul, MN, 888–422–2955, 651–220–6750 www.nca-online.org/mrcac.
- Northeast Regional Children's Advocacy Center, Philadelphia, PA, 215–387–9500, www.nca-online.org/nrcac.

- Southern Regional Children's Advocacy Center, Rainbow City, AL, 256–413–3158, www.nca-online.org/srcac.
- Western Regional Children's Advocacy Center, Pueblo, CO, 719–543–0380, www.nca-online.org/wrcac.

OJJDP funds the National Children's Alliance and the four regional CAC's to help communities establish and strengthen CAC and multidisciplinary team programs. The Alliance conducts national training events and provides grants for CAC program development and support. The four regional CAC's provide information, onsite consultation, and intensive training and technical assistance to help establish and strengthen CAC's and facilitate and support coordination among agencies responding to child abuse. The Alliance also publishes a number of manuals and handbooks of use to MDT's.

Parents Against Child Abuse (PACA)
Cheri Robertson
P.O. Box 890095
Temecula, CA 92589
909–699–4800

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Forming a Multidisciplinary Team To Investigate Child Abuse, NCJ 170020

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Forming a Multidisciplinary Team To Investigate Child Abuse

Portable Guides to Investigating Child Abuse

Foreword

When a child is the victim of abuse or neglect, it is the responsibility of each member of the child protective service and criminal justice communities to provide a timely and appropriate response.

To promote the coordination and teamwork needed to ensure such a response—and to minimize additional trauma to children—a growing number of jurisdictions have established multidisciplinary teams (MDT's) comprising professionals from law enforcement, child protective services, prosecution, medicine, counseling, and related fields.

Forming a Multidisciplinary Team To Investigate Child Abuse delineates the benefits that an MDT offers and provides advice on forming and operating an effective team. Diverse MDT models are described and keys to making the team a success—confidentiality policies, conflict resolution practices, and periodic review—are discussed.

It is my hope that this guide will be a valuable resource to current and potential MDT members and that it will enhance coordination among these professionals and improve the timeliness and effectiveness of their investigations. Only through such improvements can we fulfill our duty to protect children and bring those who abuse and neglect them to justice.

Shay Bilchik
Administrator
Office of Juvenile Justice and Delinquency Prevention

November 1998

Second Printing March 2000

NCJ 170020

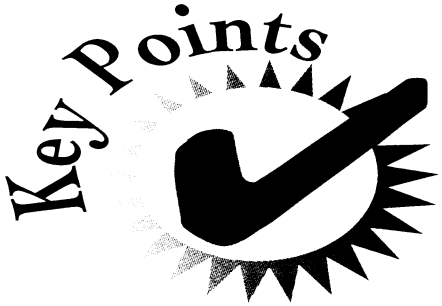
Overview

Two months before her seventh birthday in 1995, Elisa Izquierdo was killed. Over a period of months, she had been physically and emotionally abused, repeatedly violated with a toothbrush and a hairbrush, and finally beaten to death by her mother. Elisa's mother told police that before she smashed Elisa's head against a cement wall, she made Elisa eat her own feces and used her head to mop the floor. The police told reporters that there was no part of the 6-year-old's body that had not been cut or bruised. Thirty marks initially thought to be cigarette burns turned out to be the imprints of a stone in someone's ring.

An investigation after her death revealed that Elisa had been the subject of at least eight reports of abuse and that several government agencies had investigated the reports. Nonetheless, Elisa Izquierdo was left with her abuser and eventual killer.

Unfortunately, this failure to respond to reports of child abuse in a timely and appropriate manner has happened many times—and is continuing to happen—in probably every State in the country, and almost always for the same reason: As the investigation into Elisa's death revealed, there had been an appalling lack of communication and coordination among the agencies investigating reports of possible abuse. The first recommendation of the New York State commission mandated to find out how to prevent another such tragedy was to adopt legislation to authorize child protection agencies to provide complete information to all members of a county's designated multidisciplinary team (MDT) or child advocacy center.

An MDT is a group of professionals who work together in a coordinated and collaborative manner to ensure an effective response to reports of child abuse and neglect. Members of the team represent the government agencies and private practitioners responsible for investigating crimes against children and protecting and treating children in a particular community. An MDT may focus on investigations; policy issues; treatment of victims, their families, and perpetrators; or a combination of these functions. This Portable Guide deals with the investigative function of MDT's.



The MDT approach promotes well-coordinated child abuse investigations that benefit from the input and attention of many different parties—especially law enforcement, prosecution, and child protective services—to ensure a successful conclusion to the investigation and to minimize additional trauma to the child victim.

Key to the formation of successful investigative MDT's are:

- Committed members who have the support of their agencies for the multidisciplinary approach.
- An initial meeting during which each member's role and previous experience in investigating child abuse and neglect are respectfully heard.
- The development of a mission statement that clearly sets forth the purpose of the team, the scope of its activities, and its guiding principles.

- The subsequent creation of a team protocol that specifies the types of cases that will be investigated, the responsibilities of the members, and the procedures for conducting investigations.

Key to the successful operation of an MDT are:

- Confidentiality policies that accord with legislative mandates, agency policies, professional practices, and the best interests of the abused children.
- Conflict resolution practices that ensure core issues are aired and resolved satisfactorily based on mutual respect and recognition that child abuse investigations are complex, demanding, and frustrating but that they are also important, meaningful, and rewarding.
- Periodic self-analysis and outside evaluation of how the team is working so that it continues to achieve the purposes for which it was formed.

Need for a Team Approach

Over the past two decades, the number of reports of child abuse and neglect has greatly increased, straining resources to investigate allegations effectively. A number of cases have been the subject of intense media coverage. Although helping to raise public awareness of the problem, this coverage has also led to a backlash that includes charges of government witch-hunts on the one hand and accusations of government inaction on the other. Whatever the perception, there is significant outside pressure on professionals to act promptly, yet professionally and correctly, when faced with a report of child abuse or neglect.

Research related to child abuse has increased dramatically in the same period. More information than ever before—in the areas of specialized child development issues, victim and offender dynamics, diagnostic imaging, traumatic memory, linguistics, forensic pathology, and others—is available to help practitioners discover the truth of a report. Moreover, to meet the competing demands of child protection, due process, and family preservation, laws have been repeatedly changed and refined in the areas of evidence, procedure, and definitions related to abuse and neglect. The existence of such abundant yet diverse and technical data and legal requirements places significant demands upon professionals who investigate and prosecute these increasingly difficult cases.

No single profession or State agency has the ability to respond adequately to any allegation of child maltreatment. Indeed, several professions and State agencies are mandated to report or investigate suspicions of child abuse and neglect or to provide services to abused children or the perpetrators of abuse.

It is now well accepted that the best response to the challenge of child abuse and neglect investigations is the formation of an MDT. In fact, formation of such teams is authorized, and often required, in more than three-quarters of the States and at the Federal level. Hospitals have been using MDT's in a variety of ways for nearly 40 years.

The MDT approach often extends beyond joint investigations and interagency coordination into team decisionmaking. Team investigations require the full participation and collaboration of team members, who share their knowledge, skills, and abilities. Team members remain responsible for fulfilling their own professional roles while learning to take others' roles and responsibilities into consideration.

An effective response to reports of child abuse and neglect is an investigation that is timely and objective and that causes the least possible trauma to children and families. Effective teamwork can prevent further abuse to children and can bring those who harm children to justice. Some of the recognized benefits of a proficient MDT include:

- Less "system inflicted" trauma to children and families.
- Better agency decisions, including more accurate investigations and more appropriate interventions.
- More efficient use of limited agency resources.
- Better trained, more capable professionals.
- More respect in the community and less burnout among child abuse professionals.

These benefits can translate into safer communities.

Types of Multidisciplinary Teams

MDT's can take several forms and may involve different locales:

- Some are part of a children's advocacy center (CAC), which provides a child-friendly facility where forensic interviews, and

sometimes medical examinations and treatment, are conducted. The CAC may serve as the site for team meetings and trainings and may also house representatives of member agencies. CAC's also often do community outreach and public education. There are more than 400 established and developing centers nationwide.

- Other MDT's may not provide the more comprehensive services of a CAC but may establish a particular place for conducting interviews. Such teams may be based in hospitals, prosecutors' offices, or within child protective services agencies. The San Diego Children's Hospital and Health Center has specially trained interviewers who use an area designed specifically for interviewing children.
- Hundreds of effective teams are not part of a CAC and do not have special interview facilities. These teams use available resources to accomplish, in different but effective ways, many of the same purposes—reducing trauma to victims and families, improving the accuracy of information obtained during the investigation, and easing the strain on member agencies and investigators.

No single type of team is best. The model you choose will depend on the resources available and the way various agencies function in your community.

Forming a Team

Creating an MDT involves several steps: identifying and recruiting members, developing a mission statement and protocol, establishing and maintaining good working relationships among team members, and evaluating the team's performance.

Some agencies have worked together very well in an informal though systematic manner for a period of time, usually because the individuals representing them work well together. The creation of a formal MDT—by institutionalizing the team and documenting its functions and procedures on paper—ensures continuity of existing coordination and collaboration beyond the tenure of specific individuals.

Team Participants

In many States, the membership of MDT's is defined by statute. Generally, laws authorizing or requiring the formation of investigative MDT's specify that law enforcement, child protection or family services, and prosecution participate. Even if your State does not require such membership, these three

disciplines and the medical professions should be considered the core of any investigative MDT. Depending on the resources available in your community, other potential members include mental health professionals, victim services coordinators, court-appointed special advocates, and educators. In federally recognized Indian Country and government reservations, such as a military base, the Federal Bureau of Investigation has investigative jurisdiction and must be included in any MDT.

Everyone on the team must be committed to the concept that a coordinated and collaborative process is required for successful investigation of reported instances of child abuse. That commitment may not be fully developed when the team is first formed, but there must be at least an agreement to implement the team philosophy.

To be viable, an MDT must have support of the leadership of its members' organizations and agencies. To gain support for forming an MDT, seek out professionals working in other MDT's in your area or in your profession and communicate their experience to others in your organization. Share the current literature on the team approach, which overwhelmingly supports the MDT concept. For instance, one study has revealed that in a jurisdiction where an MDT created a close working relationship between law enforcement and child protective services, three out of four cases were referred for criminal prosecution, and nearly 95 percent of those cases resulted in convictions.[1] Those proportions are much higher than in jurisdictions without MDT's. Other research has suggested that MDT's, by reducing the number of investigatory interviews a child must endure, reduce "system intervention trauma" as well.[2]

Initial Meeting

An initial meeting of potential team members is critical to laying the foundation for success. Any interested person can call, convene, schedule, or coordinate the first meeting. Participants in the initial meeting should discuss their reasons for attending the meeting and the advantages

---

[1]Tjaden PG, Anhalt J, *The Impact of Joint Law Enforcement—Child Protective Services Investigations in Child Maltreatment Cases,* Denver, CO: Center for Policy Research, September 1994.

[2]Henry J, System intervention trauma to child sexual abuse victims following disclosure, *Journal of Interpersonal Violence* 12(4), August 1997.

and disadvantages of implementing the team method of investigating suspected harm to children.

The need for investigations will most likely be universally expressed, sometimes in terms reflecting the frustrations commonly felt by professionals handling these cases. It is important for all participants to hear what other people are saying and to be heard by others. Members will express opinions reflecting their professional training. Their opinions may be heated because they feel defensive about criticism of their agencies or angry about the ways their agencies have failed to protect children from abuse. Statements like the following may set a tone of angry or bitter criticism:

- "Too many cases, not enough resources."
- "Someone dropped the ball."
- "The facts are too complex."
- "The victim's behavior is unpredictable and misunderstood."
- "No one understands the restrictions I face."
- "You want to put people in jail; I need to put families back together."

It is vital that these comments be understood as the first step in acknowledging the failings of current investigative practice. These are the types of obstacles that face every new MDT.

Because participants generally concur about the importance of the work and need for a team, they should be able to maintain an overall positive attitude. The use of a seasoned facilitator, who will not be a team member, can provide the structure necessary to create a climate of mutual respect and attention. All potential team members should be consulted in the choice of a facilitator, to avoid the appearance of too much control by any one member.

At this initial meeting, participants should also discuss additional team membership—agencies or individuals vital to the proper functioning of the team. Finally, participants should begin to work on a mission statement.

Writing a Mission Statement

A mission statement is a general declaration of purpose—the scope of your team's activities, its goals, and the guiding principles for achieving those goals. It should concisely

describe the reason the team was formed and the purpose it will serve. It should be easily understood by team members and by the broader community. Your team should consider the following questions in developing its mission statement:

- Why was the team formed?
- What are the common values held by each team member?
- Who is on the team?
- What jurisdiction or community will the team serve?
- How does the team want to be perceived?
- What types of cases will the team investigate?
- What other functions will the team perform?
- What challenges does the team face?
- How will the team meet those challenges?

Do not attempt to incorporate the answers to all these questions. The mission statement is supposed to be short (five or fewer sentences) and specific enough to provide an adequate measure of success. It should be simple, direct, and inspirational. The preamble to the Constitution, for example, sets forth its mission statement in these few words: ". . . in order to form a more perfect union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity. . . ." This simple mission statement has guided a very large and complex organization for more than 200 years.

To be relevant, the mission statement must also be tied to the everyday workings of the team's member agencies. Buzzwords, jargon, and platitudes will not provide a clear vision for team members or the community. The mission statement for your team will be the reference point for its protocol, which will be the team's next project.

Writing a Protocol

A properly written protocol is essential if a team is to function well. For an MDT, it is the written understanding of how investigations and other functions will be pursued by team members and the roles and responsibilities of member agencies.

The agencies and individuals signing the document signify their mutual commitment to the team and the team's mission statement.

The team's protocol is a practical, working document. Where the mission statement is conceptual, the protocol is concrete. The protocol serves as a reference when questions or disputes arise within the team. When there is a written agreement specifying investigative roles and responsibilities, conflict is reduced because there is a shared understanding of investigatory practice. Moreover, when investigations are conducted in a relatively predictable and consistent manner, the stress associated with uncertainty is minimized, resulting in less conflict. Diminished interagency conflict means more energy and attention are spent on the investigation itself, contributing to swifter and more precise resolutions. That in turn can alleviate trauma to children and their families.

Because many State statutes now mandate team formation, it is important that you consult applicable State law when drafting your team's protocol. Many teams have also found it helpful to review protocols developed in similar communities. (Samples of protocols are available from the National Network of Children's Advocacy Centers, the four regional CAC's, and the National Center for Prosecution of Child Abuse. See pages 21–23.) However, every community should work out an agreement that suits its own resources and needs. What works in Chicago or San Diego may not work in smaller or more rural communities.

Regardless of the size or location of your community, a number of issues must be addressed in every protocol. As you address these issues, keep in mind the wide range of incidents in child abuse reports — for example, a dirty house, a 2-year-old wandering down a highway, sexual abuse, physical abuse, or suspected child homicide. Balance the need for structure and certainty with the necessity for creativity and flexibility. If you agree in writing to follow a specific procedure, there may be legal or procedural repercussions when that procedure is not followed, no matter how compelling the reason for departing from the protocol. Some teams have used a particularly complex or difficult case as a point of departure when formulating a protocol.

Figure 1 lists questions that will help in creating a protocol. Note that the questions address the "who, what, when, where, and how" of investigations and of team function. In addition to addressing these questions, some teams have found it useful to specify the criteria for arresting suspects, removing children from their homes, and filing charges.

The benefits you derive from your team's protocol will be in direct proportion to the amount of thought, discussion, and analysis of existing practice and challenges that you have invested in developing the protocol.

Dealing With Confidentiality

Confidentiality is often perceived as a barrier to team formation or effective teamwork. Often, this is due to a misunderstanding of the requirements of confidentiality imposed by law. Sometimes, legitimate confidentiality protections are used as an excuse for not sharing information when agencies mistrust each other. Misunderstanding and misuse of confidentiality protections have contributed to the continued abuse and death of too many children. As the commission that investigated the death of Elisa Izquierdo noted, "[The State's] confidentiality laws mandate silence and [its] expungement laws mandate ignorance." Confidentiality laws must continually be reviewed to ensure that their legitimate purposes are being met while, at the same time, allowing information to be appropriately shared.

The first step in determining how your team will handle the confidentiality issue is to look at the governing law. Do not assume that past practice has been or is in conformity with existing law. Federal laws mandating confidentiality have been substantially changed, and States are now permitted latitude to enact laws authorizing investigative agencies to furnish child abuse data to other agencies involved in an investigation. The Child Abuse Prevention and Treatment Act permits dissemination of confidential information to Federal, State, or local government agencies that need this information to carry out their legal responsibilities to protect children from abuse and neglect.

Many States not only permit but require the sharing of such information. Some laws make exceptions to general requirements of confidentiality when data are shared in the

Figure 1

Questions To Help You Create a Protocol

The following points should be addressed in any MDT protocol:

- What is the purpose of the team? This may be the team's mission statement, but it can be more concrete, such as "to investigate all child abuse reports in Box Butte County."
- Who are the members of the team?
- What kinds of cases will the team investigate? All child abuse? Only child sexual exploitation? Only felony physical abuse? Neglect and abandonment?
- How will investigations be conducted? Who will do what? Who will interview victims and who will interrogate suspects? Who will remove children from their home? Who will collect physical evidence? Who will refer victims for physical examinations?
- When will team members perform certain tasks? Within a specified time from receipt of report? After consultation with other team members? In a particular sequence?
- Where will particular events occur? Will interviews be conducted at a certain location? Interrogations at a different location? Will specific locations be prohibited unless there are unusual circumstances?
- How will team members carry out assignments? Jointly? Who must be present? How long will others wait? Will child interviews be recorded? On video? Audio? Other? Will nonteam personnel be present? Parents or person *in loco parentis?*
- What information can be shared under what circumstances?
- How will decisions be made? By whom and at what stage?
- When and where will the team meet?
- How will meetings be conducted?
- When (or how frequently) will the protocol and team function be evaluated? How and by whom?

context of a team investigation. Teams should remember that most laws prohibit public disclosure only of material gathered during an investigation or revealed in a report of harm. Good professional practice generally requires some disclosure of confidential reports among professionals so that proper decisions can be made.

When information is shared between agencies charged with protecting children and the privacy of individuals, there is arguably no breach of confidentiality. However, sharing information within a team and for team purposes does not justify general or public disclosure of sensitive information. Your team protocol should specify what data will be shared and how and when this can be done.

Keeping the Team Going

A team is like a car in that it consists of multiple parts joined together to accomplish a particular task. In a car, if the steering fails, there is no direction, and if the brakes fail, collisions are unavoidable. Each part or group of parts in a car must be regularly maintained, or the car will cease to operate properly. Likewise, if a team is to continue to function smoothly, the team members must pay attention to maintenance.

Dealing With Conflict

Conflict resolution is one form of preventive maintenance. Conflict that is not properly rectified will cause resentment, retribution, or retaliation. Any or all of those will eventually destroy a team. Unresolved conflict in a team is like rust in a car—it may not be immediately visible, but left unchecked it will deepen and spread, eventually ruining the team. Effective conflict resolution, on the other hand, enhances team spirit, improves team function, and protects the team against failure.

Conflict within a team is inevitable and normal, but team effectiveness is measured not by the amount of conflict but by the manner in which conflict is resolved. Not all conflict is appropriate or necessary. Conflict that thwarts the team's ability to accomplish its mission is *core* conflict and must be resolved in a constructive fashion and by consensus. This does not mean that team members must agree on every point, but they must find ways to support solutions that maintain agency

integrity and further the team's purpose. Resolving core conflicts should result in "win-win" conclusions.

Other conflicts may involve peripheral problems—issues that do not significantly hinder the team's ability to accomplish its mission. Peripheral issues can be dealt with more quickly, without necessarily building consensus. Figure 2 (page 14) lists points to remember for successfully dealing with conflict.

These points can be summarized as follows:

- Characterize the problem. Look at it from a systems perspective.
- Acknowledge relevant goals and interests by recognizing diverse agency objectives.
- Negotiate (but do not confuse negotiation with compromise).

A complete and helpful discussion of these steps can be found in the article by Fargason, Barnes, Schneider, and Galloway (cited in the supplemental reading list), in which the authors note that people involved in the helping professions often try to avoid conflict. Unfortunately, this means that the source of the conflict can undermine long-term cooperation between organizations that serve abused children. When that happens, children, families, and communities are ill served. Team members must recognize the importance of dealing with the real source of conflict in a constructive manner.

Promoting Teamwork

Many teams have found that joint training fosters good teamwork (see figure 3, page 15). Team members who train together may find opportunities to discuss issues of mutual concern, both in the training itself and during social breaks. Spending time together away from the immediate and constant demands of the office provides a break during which the team can focus on its functioning. Moreover, team members hear the same information, which improves shared understanding of the challenges and solutions common during the investigation of reported child abuse. Joint training can clarify understanding of mutual roles and responsibilities.

While not essential, social activities can strengthen team identity and function. Simply combining lunch with a team meeting can serve this social purpose. Some teams sponsor picnics, awards banquets, and other activities to reinforce

Figure 2

Points To Remember When Faced With Conflict

- Do not lose sight of the team purpose (see your mission statement).
- Look forward to opportunity, not backward to blame.
- Be respectful. Ensure each contention is considered. Listen to one another. Be sure each position is understood. Restate the other position in your own words.
- Clarify the opposing point of view until you are sure you understand. Find something positive in each view. Avoid defending your point of view until you understand the other.
- Do not withhold an opposing point of view.
- State your position clearly, firmly, but without excessive emotion.
- Once you have been heard, do not continue to restate your position.
- Avoid personalizing your position—keep the discussion focused on the issue.
- Offer suggestions rather than mere criticism of other points of view.
- Remember that conflict within a team is natural and work toward a mutually agreeable resolution.
- Base resolutions on consensus, not abdication of responsibility or integrity.
- Keep focused on the team's agreed-upon purpose and refer to your protocol for guidance.

the sense of belonging that is vital to effective teamwork. When individuals identify with the team in a positive way, commitment to the team mission is strengthened.

Preventing Burnout

People who work in child protective services, law enforcement, prosecution, medicine, mental health, and other fields associated

with children and their families are typically sensitive to the feelings of others. The difficult cases they deal with require an inordinate amount of emotional energy, and tragedy becomes almost the norm of everyday work. They must also face the often unrealistic expectations of the public, the mechanics of the system, heavy caseloads, and inadequate resources. The load can be crushing and can lead to burnout. Burnout is a syndrome of physical and emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. It is a gradual process of loss that can lead to cynicism and ineffectiveness. Recently, burnout has been recognized as a problem not of the individual worker but of the social environment in which people work.

A well-functioning team can reduce some of this emotional loss by providing a much-needed sense of community. When there is a sense of shared values and commitment, there is an accompanying sense that the crushing emotional load associated with child abuse intervention is being shared. Team members can actively encourage one another, understand the stress as others cannot, and work together to find ways of improving working conditions.

Team social activities can also help prevent burnout. While child abuse cases will always be emotionally challenging and

Figure 3

Rules for Effective Teamwork

- Identify a leader.
- Meet regularly.
- Respect others: agree to disagree.
- Listen to one another.
- Be open to constructive criticism.
- Be honest.
- Know respective abilities and limitations.
- Understand respective roles and responsibilities.

draining, they will be less so for a team than for a practitioner working alone.

Evaluation

Periodic evaluation is essential if the team is to know whether it is functioning effectively and being properly maintained. One method of evaluating team function and maintenance is to get regular feedback from team members. Members must be honestly but constructively critical of the team's performance if the team is to survive and thrive. This self-analysis can take place at regular meetings, during specially scheduled meetings, or even during a team retreat designed expressly for evaluation and renewal of purpose. A questionnaire can be prepared and submitted if team members sense a need for anonymity.

Although this self-analysis is important, there is always a danger that the team will not view itself objectively. Evaluation of the team by victims, their families, outside agencies, members of the general community, and agency managers or supervisors is critical to proper team development and as a matter of attention to constituents. The team should develop a method of regularly soliciting, collecting, and analyzing input from these sources. This process need not be elaborate or expensive. What is important is that the team see itself as others see it. If others see a need for change in a particular area, the team should give serious consideration to the suggestion without, however, subordinating its mission to public opinion or public pressure.

Conclusion

> It is beyond the power of government to prevent this from being a world in which children suffer and die, but it is the responsibility of government to protect children and bring those responsible for mistreating them to justice.
>
> *Secrets That Can Kill: Child Abuse Investigations in New York State*
> New York State Temporary Commission of Investigation, 1996

If the thousands of professionals who have had the good fortune to be part of a successful MDT could contribute to this guide, they would likely say the team approach has made an immense

difference in their communities and in their ability to do their jobs. They would relate first hand how the team improved the quality of child abuse and neglect investigations through enhanced communication and cooperation among its members. They would say that by pursuing a multidisciplinary team approach, they also reduced the number of interviews child victims faced and the length of the investigative process and intervention, thereby preventing further trauma to these children.

The MDT method of investigation significantly improves the response to child abuse. Forming and maintaining an investigative MDT will not be easy. At times during the process, people may be discouraged. It will perhaps seem easier to continue doing things "the old way" than to expend the effort to create an effective team. However, practice and experience clearly demonstrate that children and their families, communities, and the professionals serving them benefit greatly from the existence of an appropriately functioning MDT. The best mechanism to ensure that government fulfills its obligations to protect children and bring to justice those responsible for mistreating them is the cooperation, coordination, and collaboration of the responsible agencies in an investigative MDT.

Author

Mark Ells, J.D.
Research Assistant Professor
University of Nebraska–Lincoln
Center on Children, Families and the Law
121 South 13th Street, Suite 302
Lincoln, NE 68588–0227
402–472–3479
402–472–8412 (fax)
E-mail: mells@unlinfo.unl.edu

Supplemental Reading

Alexander RC. To team or not to team: Approaches to child abuse. *Journal of Child Sexual Abuse* 2:95–97, 1993.

American Prosecutors Research Institute, National Center for Prosecution of Child Abuse. *Investigation and Prosecution of Child Abuse*. 3d ed. Alexandria, VA: National Center for Prosecution of Child Abuse, 1994.

Baglow LJ. A multidimensional model for treatment of child abuse: A framework for cooperation. *Child Abuse & Neglect* 14:387–395, 1990.

Besharov DJ. *Combating Child Abuse: Guidelines for Cooperation between Law Enforcement and Child Protective Services*. Washington, DC: American Enterprise Institute for Public Policy Research, 1990.

Bross DC et al. (eds). *The New Child Protection Team Handbook*. New York, NY: Garland Publishing Co., 1988.

California State Department of Justice, Office of the Attorney General. *Child Victim Witness Investigative Pilot Project: Research and Evaluation Final Report*. Sacramento, CA: Office of the Attorney General, June 1994.

Dinsmore J. *Joint Investigations of Child Abuse: Report of a Symposium*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, July 1993.

Education Development Center, Inc., Massachusetts Child Exploitation Network. *Child Sexual Exploitation: Improving Investigations and Protecting Victims. A Blueprint for Action*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, January 1995.

Fargason CA, Barnes D, Schneider D, Galloway BW. Enhancing multi-agency collaboration in the management of child sexual abuse. *Child Abuse and Neglect* 18(10):859–869, October 1994.

Gable M. Save the children. *UCLA Magazine* 8(1):38–43, June 1996.

Helfer ME, Kempe RS, Krugman RD (eds). *The Battered Child*. 5th ed. Chicago, IL: The University of Chicago Press, 1997.

Henry J. System intervention trauma to child sexual abuse victims following disclosure. *Journal of Interpersonal Violence* 12:4, August 1997.

Jensen JM, Jacobson M, Unrau Y, Robinson RL. Intervention for victims of child sexual abuse: An evaluation of the children's advocacy model. *Child and Adolescent Social Work Journal* 13(2):139–156, April 1996.

Joint investigation: A multidisciplinary approach. *Virginia Child Protection Newsletter* 44:1, 3–7, 16, Winter 1994.

Lanning KV, Walsh B. Criminal investigation of suspected child abuse. In Briere JN et al. (eds): *The APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage Publications, Inc., 1996.

Lundy JL. *Teams: How to Develop Peak Performance Teams for World Class Results*. Chicago, IL: The Dartnell Corporation, 1992.

MacFarlane K (ed). *MDIT Handbook: A Guide to the Establishment of Multidisciplinary Interview Centers for the Investigation of Child Sexual Abuse*. San Jose, CA: Children's Institute International and Giarretto Institute, 1995.

Marx SP. Victim recantation in child sexual abuse cases: The prosecutor's role in prevention. *Child Welfare* 75(3):219–233, May–June 1996.

Maslach C, Leiter MP. *The Truth About Burnout*. San Francisco, CA: Jossey-Bass Publishers, 1997.

McIntosh-Fletcher D. *Teaming by Design: Real Teams for Real People*. Chicago, IL: Irwin Professional Publishing, 1996.

Missouri State Department of Social Services. *Child Sexual Abuse Protocols*. Jefferson City, MO: Missouri State Department of Social Services, July 8, 1993.

Neb. Rev. Stat. Sec. 28–730 (1997).

New York State Temporary Commission of Investigation. *Secrets That Can Kill: Child Abuse Investigations in New York State.* (Technical Report.) December 1995–January 1996.

Pence D, Wilson C. *Team Investigation of Child Sexual Abuse: The Uneasy Alliance*. (Interpersonal Violence: The Practice Series.) Thousand Oaks, CA: Sage Publications, Inc., 1994.

Phipps CA, Schaefer K, Ventrell MR (eds). Status and trends in child maltreatment laws: Criminal statutes. In *Children's Law,*

Policy and Practice. (Children's Law Manual Series.) Denver, CO: National Association of Counsel for Children, 1995.

Schaufeli W et al. (eds). *Professional Burnout*. Washington, DC: Taylor & Francis, 1993.

Sheppard DI, Zangrillo PA. Coordinating investigations of child abuse. *Public Welfare,* Winter 1996.

Smith BE. *Prosecuting Child Physical Abuse Cases: A Case Study in San Diego.* (NIJ Research in Brief.) Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, June 1995.

Tjaden PG, Anhalt J. *The Impact of Joint Law Enforcement — Child Protective Services Investigations in Child Maltreatment Cases*. Denver, CO: Center for Policy Research, September 1994.

U.S. Congress. Child Abuse Prevention and Treatment Act of 1974, 42 USC Sec. 5101 et seq., 1997 amendments.

Van Biema D. Abandoned to her fate. *Time Magazine* 146(24), December 11, 1995.

Walsh B. The role of law enforcement in fatal child abuse cases. *APSAC Advisor* 7(4):25–28, Winter 1994.

Organizations

American Professional Society on the Abuse of Children
407 South Dearborn Street, Suite 1300
Chicago, IL 60605
312–554–0166
312–554–0919 (fax)
Internet: 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 among professionals who respond to child maltreatment.

Missing and Exploited Children's Training and
Technical Assistance Program
Fox Valley Technical College
Criminal Justice Department
P.O. Box 2277
1825 North Bluemound Drive
Appleton, WI 54913–2277
800–648–4966
920–735–4757 (fax)
Internet: www.foxvalley.tec.wi.us/ojjdp

The Missing and Exploited Children's Training Program, sponsored by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and Fox Valley Technical College, offer a variety of courses on investigating child abuse, including an intensive special training for local investigative teams. Teams must include representatives from law enforcement, prosecution, social services, and (optionally) the medical field. Participants take part in hands-on team activity involving:

- Development of interagency processes and protocols for enhanced enforcement, prevention, and intervention in child abuse cases.
- Case preparation and prosecution.
- Development of the team's own interagency implementation plan for improved investigation of child abuse.

National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703–739–0321
703–549–6259 (fax)
Internet: www.ndaa.org

The National Center for Prosecution of Child Abuse is a nonprofit and technical assistance affiliate of APRI. In addition to research and technical assistance, the Center provides extensive training on the investigation and prosecution of child abuse and child deaths. The national trainings include timely information presented by a variety of professionals experienced in the medical, legal, and investigative aspects of child abuse.

National Clearinghouse on Child Abuse and Neglect Information (NCCAN)
330 C Street NW.
Washington, DC 20447
800–FYI–3366
703–385–7565
703–385–3206 (fax)
Internet: www.calib.com/nccanch

NCCAN provides access to the most extensive, up-to-date collection of information on child abuse and neglect in the world. The Clearinghouse will provide, on request, annotated bibliographies on specific topics or a copy of its data base on CD–ROM. NCCAN also publishes the User Manual Series, which includes several titles related to MDT's: *A Coordinated Response to Child Abuse and Neglect: A Basic Manual* (1992), *The Role of Law Enforcement in the Response to Child Abuse and Neglect* (1992), and *Joint Investigations of Child Abuse: Report of a Symposium* (1993). These publications are available from NCCAN.

National Children's Alliance
1319 F Street NW., Suite 1001
Washington, DC 20004–1106
800–239–9950 or
202–639–0597
202–639–0511 (fax)
Internet: www.nca-online.org

Regional Children's Advocacy Centers (CAC's):

- Midwest Regional Children's Advocacy Center, St. Paul, MN, 888–422–2955, 651–220–6750, www.nca-online.org/mrcac.
- Northeast Regional Children's Advocacy Center, Philadelphia, PA, 215–387–9500, www.nca-online.org/nrcac.
- Southern Regional Children's Advocacy Center, Rainbow City, AL, 256–413–3158, www.nca-online.org/srcac.
- Western Regional Children's Advocacy Center, Pueblo, CO, 719–543–0380, www.nca-online.org/wrcac.

OJJDP funds the National Children's Alliance and the four regional CAC's to help communities establish and strengthen CAC and MDT programs. The Alliance does this by promoting national standards for CAC's and providing leadership and advocacy for these programs on a national level. The Alliance also conducts national training events and provides grants for CAC program development and support. The four regional CAC's provide information, onsite consultation, and intensive training and technical assistance to help establish and strengthen CAC's and facilitate and support coordination among agencies responding to child abuse. The Alliance publishes a number of manuals and handbooks of use to MDT's, including *Handbook on Intake and Forensic Interviewing in the CAC Setting, Guidelines for Hospital-Collaborative Forensic Investigations of*

Sexually Abused Children, Organizational Development for Children's Advocacy Centers, and *Best Practices.*

National Resource Center on Child Maltreatment (NRCCM)
1349 West Peachtree Street NE., Suite 900
Atlanta, GA 30309
404–876–1934
404–876–7949 (fax)
Internet: www.gocwi.org/nrccm/

NRCCM's objectives are to identify, develop, and promote the application of child protective service models that are responsive to State, tribal, and community needs. Operated jointly by the Child Welfare Institute and ACTION for Child Protection, NRCCM offers training, technical assistance, consultation, and information in response to identified needs relating to the prevention, identification, intervention, and treatment of child abuse and neglect.

Other Titles in This Series

Currently there are 12 other Portable Guides to Investigating Child Abuse. To obtain a copy of any of the guides listed below (in order of publication), contact the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse by telephone at 800–638–8736 or e-mail at puborder@ncjrs.org.

Recognizing When a Child's Injury or Illness Is Caused by Abuse, NCJ 160938

Sexually Transmitted Diseases and Child Sexual Abuse, NCJ 160940

Photodocumentation in the Investigation of Child Abuse, NCJ 160939

Diagnostic Imaging of Child Abuse, NCJ 161235

Battered Child Syndrome: Investigating Physical Abuse and Homicide, NCJ 161406

Interviewing Child Witnesses and Victims of Sexual Abuse, NCJ 161623

Child Neglect and Munchausen Syndrome by Proxy, NCJ 161841

Criminal Investigation of Child Sexual Abuse, NCJ 162426

Burn Injuries in Child Abuse, NCJ 162424

Law Enforcement Response to Child Abuse, NCJ 162425

Understanding and Investigating Child Sexual Exploitation, NCJ 162427

Use of Computers in the Sexual Exploitation of Children, NCJ 170021

Notes

Additional Resources

American Bar Association (ABA)
Center on Children and the Law
Washington, DC
202–662–1720
202–662–1755 (fax)

American Humane Association
Englewood, Colorado
800–227–4645
303–792–9900
303–792–5333 (fax)

American Medical Association (AMA)
Department of Mental Health
Chicago, Illinois
312–464–5066
312–464–5000
(AMA main number)
312–464–4184 (fax)

American Professional Society on the Abuse of Children (APSAC)
Chicago, Illinois
312–554–0166
312–554–0919 (fax)

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Denver, Colorado
303–864–5250
303–864–5179 (fax)

Federal Bureau of Investigation (FBI)
National Center for the Analysis of Violent Crime
Quantico, Virginia
703–632–4400

Fox Valley Technical College
Criminal Justice Department
Appleton, Wisconsin
800–648–4966
920–735–4757 (fax)

Juvenile Justice Clearinghouse (JJC)
Rockville, Maryland
800–638–8736
301–519–5212 (fax)

National Association of Medical Examiners
St. Louis, Missouri
314–577–8298
314–268–5124 (fax)

National Center for Missing and Exploited Children (NCMEC)
Alexandria, Virginia
703–235–3900
703–274–2222 (fax)

National Center for Prosecution of Child Abuse
Alexandria, Virginia
703–739–0321
703–549–6259 (fax)

National Children's Alliance
Washington, DC
800–239–9950
202–639–0597
202–639–0511 (fax)

National Clearinghouse on Child Abuse and Neglect Information
Washington, DC
800–FYI–3366
703–385–7565
703–385–3206 (fax)

National SIDS Resource Center
Vienna, Virginia
703–821–8955, ext. 249
703–821–2098 (fax)

Prevent Child Abuse America
Chicago, Illinois
800–835–2671
312–663–3520
312–939–8962 (fax)