

PROSECUTING BATTERED CHILD SYNDROME

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Introduction. In 1962 Henry Kempe and his colleagues first coined the phrase “Battered-Child Syndrome,” and identified it as a clinical condition in children who have suffered serious physical abuse.² This article reviews the hallmark indicators, suggested avenues for investigation, and discusses ways to meet three common untrue defenses.

Indicators. Battered-Child Syndrome (BCS) occurs where there are multiple injuries to multiple systems on multiple planes of the child’s body, resulting in serious injury or death. These injuries may be inflicted over time and in different stages of healing, or may reflect a single incident. Clinical manifestations of BCS include head injuries, which are the most common cause of death in child abuse cases. Subdural hematoma, while not a cause of death, is a marker of such abuse, as are eye injuries, such as retinal hemorrhaging, retinal detachment and optic eye injury. Abdominal injuries, bruising, scrapes and cuts may also be present in BCS. Pattered skin injuries, such as those resulting from bites or punches, or injuries caused by a manufactured item, such as a hanger, a cord or a belt may also denote BCS. The fracture of any bone or bones (without an adequate explanation or medical diagnosis), poor skin hygiene, or failure to thrive may also be physical signs of BCS.

Investigation. Another hallmark indicator of BCS is a marked discrepancy between the clinical findings and the historical data as supplied by the caretaker(s). This discrepancy may manifest itself in any of several ways. Caretakers may fail to explain the child’s injury or offer implausible explanations that are inconsistent with either common sense or medical judgment. Caretakers may tell different stories about how the child sustained the injury or claim that another child inflicted the injury. Caretakers may have delayed seeking medical care without adequate explanation.³

When investigating these cases, it’s important initially to interview the parent(s) or caretaker(s) in a non-confrontational way. At the conclusion of the investigation, when BCS is clearly indicated, investigators will have an opportunity to confront the abuser(s) with the inconsistencies and implausibility of their story.

Medical personnel, including the attending physician, pediatrician, any other specialists, and all those who had previously attended the child must be interviewed. A review of all medical records generated by those individuals is

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² C. Henry Kempe, et al., *The Battered-Child Syndrome*, 181 JAMA 17 (1962).

³ John E.B. Myers, *Evidence in Child Abuse and Neglect Cases*, 3rd Ed. (1997).

also mandated. Social service professionals should be contacted, and all their records for all the children in the house should be reviewed. Finally, other caretakers (school teachers, babysitters, etc.) and those who surround the child should be interviewed to get a complete picture of the child's life and circumstances.

Meeting Untrue Defenses. There are three classic defenses to battered child syndrome: (1) It was an accident, (2) Somebody other than the defendant is responsible for the injuries, and (3) An underlying medical condition exists that is responsible for the child's state.

Accident. When accident is raised as the defense, the circumstances surrounding the child's injuries must be assessed. What are the nature, number, age(s) and location(s) of the injuries?

Are the injuries consistent with the explanations offered by the caretaker(s)? If they aren't, the possibility of using an expert to explain how the defendant's story is inconsistent should be evaluated.⁴ Experts may be called to explain the mechanism of injury, the force necessary for such an injury to occur, or to explain patterned injuries on the child and the object that inflicted them.

What did the defendant say at the time the injuries were inflicted? What was said at the time may reflect a triggering event or motive of the defendant to harm the child. Classic triggering events include soiling, vomiting, feeding difficulties, and inconsolable crying. It must be noted, however, that there is not always a particular triggering event. Sometimes the injuries are inflicted simply because the defendant enjoys hurting the child.

Failure or delay in seeking treatment for the child's injuries should also contraindicate accident, as should failing to mention the incident and the child's condition to anyone.

Prior acts of aggression by the defendant toward the child may also help to overcome an untrue accident defense. In *Estelle v. McGuire*,⁵ the Supreme Court held that with an accident defense, prior injuries were relevant to prove intent. The evidence of injuries is admitted to show that the child was harmed at the hands of another, and that the other person acted intentionally.

⁴ For a synopsis of jurisdictions that allow expert testimony on Battered-Child Syndrome, see 98 A.L.R. 3d 306, Annotation: Admissibility of Expert Medical Testimony on Battered Child Syndrome (2001).

⁵ 502 U.S. 62 (1991). For a concise treatment of this case and its relevance to prosecutors, see *Estelle v. McGuire: An Underutilized Resource*, available on-line at http://www.ndaa-apri.org/publications/newsletters/update_volume_10_number_4_5_1997.html

Defendants often assert that the child accidentally fell from a couch, swing or countertop, or incurred some other sort of short distance fall. These shortfall explanations are used to account for both skeletal and soft tissue pummeling injuries, such as fractures, dislocations, head trauma, bruising, abrasions and lacerations. It is, however, extremely rare for short distance falls – defined as falls of less than four feet – to result in serious injury or death. For a fall to be fatal, the vertical distance generally needs to be 20 feet or more.⁶ Studies to the contrary rely for their data on uncorroborated caretaker histories.⁷ The caretaker's story of the fall – i.e., how far it was, the surface onto which the child fell, and what body part(s) the child landed on – will be of crucial importance in determining if the fall was truly accidental.

Alternatively, the defendant may also claim that the child must have sustained the injuries from mild play, such as being bounced on a knee or tossed in the air. The amount of force necessary to result in head injuries such as retinal hemorrhage or subdural hematoma, can equate to that of a 50-60 miles per hour unrestrained motor vehicle accident,⁸ or a fall from at least the equivalent of two stories.⁹ A recent study found that slightly over 80% of infants presenting at hospitals with broken ribs were actually victims of abuse.¹⁰ Posterior rib fractures are almost always caused by abuse, with the mechanism of injury being squeezing the back of ribs while compressing the front of the rib cage, which occurs during violent shaking.

Burn injuries may also indicate BCS. Whether burns are intentional or accidental can be determined by a number of factors. The length of time the child would have had to be exposed to the fluid or item for the injury to be inflicted should be assessed. If it is a hot water burn, it is critical to test the temperature of the water coming from the water heater, the setting of the water heater and the temperature at each tap. Caretakers often state that the burn resulted from fleeting contact with the harmful object or substance. However, the burn pattern on the child's body, as well as the degree of the burn, may contradict this. For

⁶ See Falls from heights Among Children: A Retrospective Review, Lallier, et al., *Journal of Pediatric Surgery*, Vol 34, No. 7 (July), 1999: pp 1060-1063; Falls and Childhood Deaths: Sorting Real Falls from Inflicted Injuries, David Chadwick, *The APSAC Advisor*, V.7,n.4, 1994: p. 24.

⁷ Williams, Injuries in Infants and Small Children Resulting from Witnessed and Corroborated Free Falls, 31 *Journal of Trauma* 1350 (1991), cited in Myers, *supra* note 3, at fnnt 203, p.325.

⁸ Brian K. Homlgren, *Prosecuting the Shaken Infant Case*, (citing studies and case law on p.307), in *THE SHAKEN BABY SYNDROME: A MULTIDISCIPLINARY APPROACH*, Stepen Lazoritz, MD & Vincent J. Palusci, MD, eds. Hawthorn Press (2001); Rob Parrish, *Battered Child Syndrome: Investigating Physical Abuse and Homicide*, USDOJ, OJP, OJJDP (1996) (citing similar serious force necessary to inflict such injuries).

⁹ Robert M. Reece, *Controversies in Shaken Baby/Shaken Impact Syndrome*, in *THE SHAKEN BABY SYNDROME: A MULTIDISCIPLINARY APPROACH*, Stepen Lazoritz, MD & Vincent J. Palusci, MD, eds. Hawthorn Press (2001).

¹⁰ Blake Bulloch, et al., *Causes and Clinical Characteristics of Rib Fractures in Infants*, *PEDIATRICS* Vol. 105 No. 4 (2000), where 32 of 39 (82%) rib fractures in infants were caused by child abuse.

example, symmetrical burns with evidence of sparing¹¹ and no splash marks are difficult to reconcile with a claim that the child accidentally fell into the tub. Similarly, second and third degree burns would appear inconsistent with a statement that the child momentarily touched a radiator, curling iron or similar object. The pain from the heat would cause a child to recoil from the object and result in less serious burns.

Third Party Blame (SODDI). In an attempt to shift the blame for the child's injuries to another, the defendant may invoke the SODDI (Some Other Dude Did It) defense. Other caretakers, such as the other parent or babysitter, the child's sibling(s) and even the child him/herself have all been known to be blamed. To assess this defense when it involves other adults, the timing of the injuries is of paramount importance. Against that background, it must be determined who had access to the child when the injuries were inflicted. It must be determined who was with the child the last time s/he was engaging in normal behavior, such as feeding, playing or talking, and when the child was noted as being injured. This "window of opportunity" will assist in eliminating others from possible culpability.

When children are targeted for blame, it is necessary first to determine if the child is physically capable of having inflicted the harm suffered. Attempts to place the blame on siblings, or on the child him/herself, should be carefully analyzed against both the physical injury involved and the sibling or child's developmental level and strength. If, for example, an infant has been shaken to the point of serious head trauma, such as retinal hemorrhage, it may be possible to defeat this defense by having an expert explain how the strength disparity between the two children is not sufficient for such violent shaking to have occurred. Alternatively, some jurisdictions have asked the alleged child perpetrator to reenact the event with a doll of the same size and weight as the victim. The physical inability of the child to actually do the harm alleged is dramatically demonstrated in these cases.

When defendants claim that the harm was self-inflicted, experts may be called to testify that the pain threshold would render a child incapable of willingly enduring the pain that would accompany such an injury. The child's developmental level may also indicate that s/he was incapable of inflicting such an injury. For example, an infant who doesn't "cruise" will rarely bruise.¹² When a child is ambulatory, there are regions of the body that would normally be expected to bruise, such as the bony prominences over the knees and shins, and the

¹¹ Sparing occurs where the child's skin is not burned due to either the body part being in direct contact with a cooler object (such as the buttocks being in contact with the tub in a forced immersion scenario) or where the child reflexively pulls into the fetal position to avoid contact (such as the stomach and the front of the thighs or the back of the calves and the back of the thighs).

¹² See Bruises in Infants and Toddlers: Those Who Don't Cruise Rarely Bruise. Sugar et al., Arch. Pediatr. Adolesc. Med. 1999;153:399.

forehead. Conversely, there are also places where it would be unusual to find bruising, such as the buttocks, abdomen or the hands.¹³

Underlying Medical Condition. Differential diagnosis, or other medical explanations for the child's condition, will vary depending on the particular type(s) of injury the child sustained. Some of the most common medical conditions claims include metabolic disorders, osteogenesis imperfecta (brittle bone disease), infectious process, hemopoietic diseases (leukemia or hemophilia) and scurvy. If this defense is anticipated, the first step is to have any tests deemed medically necessary to exclude any organic cause. Once those test results have been evaluated and organic causes excluded, one further step must follow. Does the child have injuries that are not explained by the defendant's proffered justification for the child's condition? For example, if the defendant claims that the child has osteogenesis imperfecta to explain fractures even though only trivial trauma was allegedly inflicted, this condition would not explain burn marks. Have the expert summarize his or her opinion using the totality of the facts. An expert can explain that it's not brittle bone disease, leukemia or any other organic explanation proffered by the defendant, because none of these is consistent with the injuries taken as a whole. Only Battered-Child Syndrome explains the entire constellation of injuries.

Conclusion. Battered-Child Syndrome is a form of abuse that results in life-threatening, and sometimes life-extinguishing, injury to a child. It is, therefore, imperative that prosecutors be prepared to meet untrue defenses in these cases.

¹³ Id.