Child Abuse Fatalities

"It is relatively simple to destroy the life of a child in almost absolute secrecy without the necessity of taking any elaborate precautions to ensure that secrecy." [p. 1348, Adlai, 1961].

The total U.S. death rates of children under 15 years of age have decreased systematically during the past 30 years. However, child death rates from homicide over the past 30 years have dramatically increased, and homicide is the only cause of child death to show an increase. Homicide ranks among the five leading causes of childhood death, accounting for at least 20 percent of deaths of children under 18 (Chesnoff, 1984; Lenkle-Oberstein, 1966; Paulson & Rushforth, 1986).

Child abuse fatalities nationwide have increased more than 38 percent since 1985 (Beveridge, 1989; Dvor & Mitchell, 1990). The estimated number of reported child abuse fatalities is 2.4 percent between 1988 and 1989 and numbered 1,237. Thus, more than three children a day in the United States are child abuse fatality victims (Dvor & Mitchell, 1989). Many child homicides are perpetuated by parents.

With respect to age of the child victim, the incidence is bimodal. The peaks are in early childhood and late adolescence (Chesnoff, 1984). The majority of child victims are under 1 year of age. In the first six months, the age at death is the most dangerous. For infants six months and under, child abuse is second only to Sudden Infant Death Syndrome (SIDS) as a cause of death. In some localities, child abuse is the leading cause of death. For instance, from 1974 to 1984 in Ohio, child battering was the leading cause of death for children under age 5 (Muskat, 1988).

The second largest group of fatalities are 1-5 years old. For children between 1 and 5 years old, child abuse is second only to accidents (Chesnoff, 1984; Creighton, 1986; Kaplan & Reich, 1976; Jacque, et al., 1986; Rennick, 1989). Sex of the victim does not appear significant. In most studies, boys and girls are at equal risk for fatality (Anderson, 1983; Goetting, 1988). Race does appear as a significant variable with Anglos underrepresented and blacks over-represented (Anderson, 1983; Beveridge, 1989; Hustin & Daniel, 1984; Paulson & Rushforth, 1986). When looking at total homicide statistics, most murderers are men (82 percent of homicides). Child murderers, however, are predominantly female (53 to 69 percent) (Anderson, et al., 1983; Goetting, 1988; Scott, 1973). In two-parent families, two-thirds of the fatalities involve both parents as assailants (Anderson, et al., 1983).

Children's vulnerability renders them susceptible to a great variety of methods of destruction. Many methods that are fatal to children would be ineffective for adults. Indeed, some common means of death in children are virtually unheard of in adult homicide. For example, an infant under 1 year of age is at six times greater risk of receiving a skull fracture from blows to the head compared to an older child. For those that do not die, permanent damage can result.

Methods of killing are varied. Children are drowned, suffocated, gassed, drowned, strangled, shot, bit by hands or instruments, and left exposed to elements. They are given sulfuric acid in nursing bottles, opium is given by rubbing it on nipples, and various poisons, medications, or lethal substances are disguised in foods or force fed. Children have been thrown to pigs, thrown out of windows or other high places, buried alive and run through machinery such as a drill press.

History of Infanticide

Reading historical accounts of child murder is a grim undertaking. Anthropologists have estimated that patrilineal parent may have eliminated as many as 50 percent of newborn females in some cultures (Hale, 1981). Early Romans formalized the concept that those who create may destroy by the concept of "patria potestas," a father's right to murder his children (Renick, 1970). As late as 1600 Massachusetts adopted the "Stabborn Child Act" which permitted parents to put a child to death if the child was rebellious and disobedient (Breneman, 1970, cited in Walker, et al., 1988). The idea that every child born has a right to live is a new concept (Perers, 1970).

It is difficult to learn much about infanticide prior to the 1800s as record keeping on the topic was sporadic. "When-ever infanticide was an economic necessity for an entire community, it remained an unquestioned practice and, one must assume, was not considered worth recording." [p. 44, Pier, 1978]. "That infantilicide occurs frequently in medieval England is beyond dispute." [p. 2, Dunne, 1978].

The recorded figures from the 1800s are appalling. For example, in 1860, there were more than 100,000 deaths of infants under age 1 in England and Wales. In the late 1870s, the 0-1 age group were less than 1 percent of the population but represented 50 percent of murders. By 1900, this age group had dropped to 55 percent of all murders and this percentage stayed relatively constant until the 1920s (Rose, 1986). "The death of 'surplus' or unwanted babies was a biological necessity at a time when birth control was scarcely understood and it is only in the last century that this rate fell at the very end of the last century.
SCAN Celebrates Its 10th Anniversary!

We thank each and every Virginia who has helped us in our prevention efforts. We are making a difference!

In 1985, the National Committee for Prevention of Child Abuse launched a comprehensive plan to reduce child abuse by 20 percent by 1990. As 1990 draws to a close, NCPA has published its preliminary assessment. Quoting Dr. Deborah Daro, director of the National Center on Child Abuse Research, "reducing the nation's child abuse problem is a formidable task, particularly in light of seemingly relentless social problems. When the NCPA Board of Directors established its Long Range Plan, they had no way of foreseeing the rapid explosion of the nation's drug crisis, the continued poverty and isolation in the nation's inner cities, and the failure of general social service and child welfare budgets to keep pace with the growing demand for services. Despite these problems, the data collected suggest major accomplishments."

Do we really have reason to be optimistic? Let us look at some statistics from a nationwide public opinion survey:

-100 percent awareness of child abuse being a problem

- 1 in 4 Americans annually do something to prevent child abuse

- 13 percent fewer parents are yelling at their children

- 13 percent fewer parents are spanking their children

In the advocacy arena, 20 states have abolished corporal punishment and 49 states have children's trust funds. These funds raised more than $25 million and funded close to 1,400 projects. The percentage of community-based agencies offering in-home parent aid services.

These statistics are hopeful but there remain a number of concerns.

While our group-based education prevention services have been successful in reaching consumer families (those families who recognize they need help and ask for help), we have not been as effective with dependent families. These are the families who may not recognize their limitations or cannot access help. They require more intensive intervention and need an attractive, non-stigmatizing continuum of services. There is a critical gap in these types of services which are needed to reach the more isolated, less educated or more poorly functioning parent. Only one-fourth of the hospitals with maternity wards surveyed provide any type of home visitor services following birth, and only 3 percent of hospitals provide any type of crisis hotline or drop-in service. Only 9 percent of the nation's high schools provide on-site day care for teen parents. Since 1984 there are fewer community-based resources for crisis intervention and therapeutic services for abused children, particularly young children.

The child abuse fatalities and child abuse reports continue to rise yearly. The nation is also seeing an increase in the number of broken families. Prevention efforts have met with very limited success with these families that Dr. Daro feels are a fairly untreatable 10 percent of the population. This percentage seems to be growing with the increases in drug and alcohol abuse, homelessness and poverty. We need to expand our research efforts to determine what attracts a family who does go to a program for treatment.

What Are the Implications for Future Planning?

For the consumer families the program challenge is to provide services (parenting classes, support groups, warm lines, etc.) in accessible locations and with sufficient frequency to meet the growing demand for support and information.

Dependent parents pose a more complex task as they require more intensive prevention efforts than information and parenting classes. Follow-up, home-based services will be needed to more carefully assess these families' needs and environment and to observe parent-child interactions.

Broken families, where parents exhibit serious functional problems such as extreme disinhibition, substance abuse and violent behavior, may require new ways of viewing the prevention task and include more aggressive efforts to work directly with the children in hopes of breaking the cycle of violence in these families even if the parents refuse assistance. Intensive supervision of these families with possible removal of the child and termination of parental rights may be necessary.

Many of our prevention efforts have been successful, but some have not. With increasing dedication and fervor we must continue to form partnerships within the public, civic, private, church and business communities to educate and offer support to families and children in Virginia. We must and can nurture our future.

How Do Virginians' Feel About Child Abuse?

In 1989, the Virginia Department of Social Services contracted with the VCU Survey Research Laboratory to survey by telephone a cross section of Virginians with respect to their knowledge and attitude about child abuse and neglect.

Over all adults in the commonwealth expressed awareness of the dangers and long-term effects of child abuse and neglect. Fifty-five percent felt they could do something personally that would contribute to prevention, and 16 percent had actually reported a case of suspected child abuse or neglect.

Virginians believe that prevention efforts are warranted and can be effective. In every area of the state, increased government spending for child protection and child abuse prevention programs was favored. About 60 percent of the respondents indicated a willingness to pay increased taxes to support these programs.

To receive more information about these studies contact:


- Surplus donation $3

- Virginia Department of Social Services—Ann Childress, Prevention Program Specialist, (804) 462-0861.
that the value of infant life correspondingly rose" (p. 187, Rose, 1966).

A case in point is the "wet nurse" system. "Wet nurses" were women who nursed other women's babies. Up until the 20th century, there was no way to keep an infant alive unless the mother fed it. A few women were unable to nurse because of medical problems. Many women chose not to nurse babies due to preference or pressure from husbands or friends. Some women needed work and nursing was impossible or inconvenient. Thus, a popular alternative to nursing one's baby was to hire a "wet nurse." In 1875, an ad wanting to hire a wet nurse appeared on the average every six days in London. Hospitals also kept registers of "wet nurses" even though "wet nursing" was considered a "quick but effective means of infanticide" (p. 52, Rose, 1966).

Wet nurses took on many babies (sometimes six or more) in order to earn a sufficient wage. Obviously, not all of the babies survived. In some cases, the child's death was deliberate. It is estimated that 80 percent of illegitimate children placed in the care of wet nurses died. The wet nurses accepted the infants, collected the fee, then killed the babies (Kemp & Kempa, 1978, cited in Walker, et al., 1988; Radbill, 1974). In January 1881, the British Medical Journal published an editorial entitled "Child Murder: Its Relation to Wet Nursing." The editorial expressed concern about the fate of the wet nurse's baby. Obstetricians, like Dr. William Acton, argued to preserve the wet nurse system. Wet nurses were generally mothers of illegitimate babies. If the wet nurse could not earn a living, argued Dr. Acton, her baby would die anyway. The debate culminated in 1871 with the Infant Life Protection Committee opening a home for infants of wet nurses (Rose, 1966).

It is ironic that the development leading to the fall of the wet nurse system was not medical concern or legal sanction. It was, instead, von Liebig's Malted Milk Extract in 1867 that gradually ousted the wet nurse system by the turn of the century.

Neonaticide versus Filicide

Literature suggests that there is reason to separate infanticide killed at or shortly after birth from murder of older children. The causes of murder of newborns and the dynamics of the killing appear to be a separate phenomena and are for the most part different than causes and dynamics of murder of older children. Indeed, these differences are recognized by several European countries (but not in the United States) which provide for lesser penalties for murdering a newborn if the mother is the killer (Resnik, 1970). Thus, neonaticide (murder at or shortly after birth) and filicide (murder of older children) will be discussed separately.

Neonaticide

Historically, neonaticide was extensively practiced as a population-control mechanism, as a way to eliminate weak, undesirable or deformed babies, as a ritualistic sacrifice, as a response to poverty or lack of means to sustain the child, or as a response to the inconvenience of child rearing. Some of these "reasons" persist today. Babies are still killed because they are the wrong sex. China and some Eskimo tribes in particular have been cited as cultures where this occurs (Chapman, 1980). Severe poverty is cited as a factor in neonaticide in a number of studies (Anderson et al., 1983; Gooch, 1988; Hsuan & Daniel, 1994; Kaplan & Reich, 1976).

In general, neonaticide seems due to social and economic conditions rather than psychopathology (Christoffel et al., 1983; Resnick, 1970). The profile of a parent who kills a newborn is as follows: The mother rather than the father is likely to be the murderer. She is young, not married, and unable to support herself. She may have denied the pregnancy. It is likely that the baby is a first child with no siblings. The mother is unlikely to be psychotic, depressed or suicidal. The child is killed for social reasons such as to avoid the stigma of illegitimate childbirth. The means of murder will be drowning, suffocation or death by exposure rather than robbery, arson or gun shot (Adolton, 1961; Jaquett et al., 1988; Resnick, 1969; Weisstein, 1966). Bone fractures, skull fractures, brain damage and burns are also frequent causes of death for newborn infants (Jason & Anderlech, 1983).

For example, Resnick (1970) found that only 19 percent of mothers who murdered newborns were married compared to 88 percent of those who murdered older children. Whereas 66 percent of those who murdered older children were psychotic, 71 percent were depressed and 33 percent also attempted suicide, among mothers who committed neonaticide only 17 percent were psychotic, 3 percent were depressed, and none had attempted suicide. Risk of neonaticide appears to be increasing. In 1968, the birth rate for young teenagers 15-17 years increased six times and the 1998 rate of 33.8 births per 1,000 population was higher than in any year since 1977. Increased birth rate of young, unassem- bled teens coupled with an increase in serious drug abuse heightens neonaticide risk.

Filicide

Motivations and factors for killing older children are more varied. Three psychoanalytic, (D'Orban, 1970; Resnik, 1969, 1970, Scott, 1971) have offered classifications of parental Filicide. Categories below are taken from these three but incorporate other ideas as well. Various types of mental illness have been cited as a causative or mitigating factor in some child murders. These include psychoses, acute reactive depression associated with a suicide attempt after the murder, personality disorder accompanied with ongoing depressive symptoms and post-partum depression. This type of case constituted approximately 27 percent of d'Orban's sample of 87 (Bender, d'Orban, 1979; Gilson & Klein, 1961; Rosenburg, 1971).

CASE EXAMPLE

Mrs. K., a 35-year-old wife of an engineer, killed her youngest child, age 4, by strangulation. Mrs. K., had been depressed over her seriously-ill 63-year-old mother. She began having thoughts of harming her child and of suicide. After a suicide attempt that did not work, she and her husband considered hospitalization but did not pursue it because Mrs. K. seemed improved. The next day, after her hus- band left for work and her son for school she choked her child while combing the girl's hair. When it was clear the child was dead, she phoned her husband to call the police. These years prior during a depressive episode Mrs. K. had also tried to choke her daughter, then 18 months old.

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Child Abuse Fatalities
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Retaliation against a spouse ("the Medea Complex") is another motivation noted by several (d’Orban, 1979; Gibson & Klein, 1961; Scott, 1973). The main motivation in these cases is revenge against a spouse or other parent. In line with this type of killing, Kaplan and Reich (1976) note that pare-
mours rarely murder their own children. Instead, they kill the children of predomin-
sors. Such cases amount to 10 percent in d’Orban’s sample of women.

CASE EXAMPLE

A young man, age 26, with average IQ and normal neurological testing was unable to accept his recent separation from his wife and four children. He invited them on a picnic, bought one-way tickets and took a hammer and rope with him. He killed all four children, then waited to be arrested, listening to his radio. There was no evidence of psychosis or depression, nor did he attempt suicide (Scott, 1973).

"Altruism" or "mercy killing" has been cited (d’Orban, 1979; Gibson & Klein, 1961; Scott, 1973). In these cases, there is a real degree of suffering in the victim and an absence of secondary gain for the parent. Such cases are thought to be rare. In fact, judging such motivation is a highly subject-
ive enterprise. Scott cites a case of supposed altruistic killing where a neighbor overheard the screams and came to help. The father fed the neighbor, too. Scott’s comments were:

"hardly altruistic."

Many of these cases of altruism appear questionable, others seem valid. For exam-
ple, several cases where parents have circumvented court action and discontinued life support challenge medical, legal and spiritual leaders to define murder.

Unwanted children can be killed by neglect. This is seen in large scale in poor and developing countries through uneven distribution of medical care and food. Neglect of this type is rare in developed nations, accounting for perhaps 5 percent of cases (d’Orban, 1979). Neglect can also be non-
discriminatory in a family, but lethal towards the youngest members. Younger children are the most vulnerable to failure through neglect (Anderson et al., 1983; Fein, 1979; James, 1976; Anderson & Reich, 1976; Korbin, 1986).

Neglect may be as important as abuse in fatalities. In Virginia, in about half of the 90 cases examined, the study, the child fatality was due to neglect. Neglect is a refractory problem to other problems. Those cited in child abuse fatality literature include depression (Husain & Daniel, 1984; Remick, 1969), low intelli-
gence (d’Orban, 1979; Parson, 1966) and substance abuse (Kaplan & Reich, 1979; Resnick, 1969). Substance abuse is alarming not only in terms of the high percentages Read in neglect fatalities 75 percent in Resnick; 81 percent in Kaplan & Reich, but also because of the increase in use of potent drugs such as crack cocaine in young parents (see VCPN, next issue).

The largest category of child murder, however, is battering (Christoffel, 1994; d’Orban, 1979). Cases here are varied, including children who are killed by one inpatient abuse of rage, children subject to bizarre discipline, children who have experienced repeated and escalating abuse, and children who are sadistically and systematically tortured and killed.

In many of these cases, the murderer had a history of physical or emotional abuse as a child (Anderson et al., 1983; d’Orban, 1979; Korbin, 1986, 1987; Tutera & Glorzer, 1966; Anderson & Reich, 1976; Anderson et al., 1963; Goelzig, 1986; Husain & Daniel, 1984; Jacobs & Andrecree, 1983; Kaplan & Reich, 1979; Korbin, 1986). A recent legislative (1966) although some argue that poverty is no more prevalent in any other inpatient abuse cases (Fein, 1979).

While some studies have failed to docu-
mint a pattern of abuse (Costaghin, 1984; Virginia Department for Children, 1990), it is clear that domestic violence is the cause of many of the cases. series of physical attacks on the child (Fein, 1979; Greenland in Parsons, 1988; Kaplan & Reich, 1979). In some cases, either the victim or a sibling had been placed at one point in foster or other caretaker (Fein, 1979; Kaplan & Reich, 1976; Korbin, 1986). Some, but not all, of the families (25 percent to 61 percent in Anderson et al., 1983; Kaplan & Reich, 1978) had prior contact with mental health or social service agencies. However, some isolated families with extreme dis-
function formed an unexplored and uncharted community support and are not known to agencies prior to the child’s death.

Although those who commit filicide are older than those who commit neonicide, parents kill all of their children as child abusers who do not kill their children (Anderson, 1963; Jacquet et al., 1988; James, 1976; Kaplan & Reich, 1976). Severe maternal discard, chaotic living circumstances and spouse abuse are frequent findings (Fein, 1979; Kaplan & Reich, 1976; Korbin, 1986).

Impulsive rage that is not premeditated

Methods of killing for cases of filicide are varied. Younger children are likely to die from head trauma, starvation, internal injuries and multiple injuries (Jacques, 1963; Musac, 1988). Bruises, wounds and abrasions are common in all age groups. The older the child, the more likely that the death will be from a gunshot (Musac, 1988; Paulson & Rushforth, 1986). Hand gun accounts for 50 percent or more of deaths in children over age 10 or older (Musac, 1988; Paulson & Rushforth, 1986).

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homicide is common (d’Orban, 1979; Kaplan & Reich, 1979). This was the largest group in d’Orban’s sample of 89 families, comprising 44 percent of rape total. Scott (1971) has speculated that a parent who kills in an impulsive rage is actually over-
controlled in general and lacks confidence in assertion. In other words, the parent is not trying to control great frustration but is rather a weak person who has tried to control moderate frustration over a long time period, then exploded.

Ignorance, low education or low intelli-
gence may be a factor in other cases. Restraining a child in ways that prevent self-
protection or placing a child in an inappro-
nimate environment as punishment can be fatal. A 6-year-old boy died from hypothermia (low body temperature) after being tied to his bed in an unheated room. Other children have developed pneumonia after being locked outdoors in cold weather or placed in ice baths for punishment. A 2-year-old girl who wet her pants was bound and locked in her room at 7 p.m. By 2 a.m. her crying finally stopped and at 10 a.m. when her step-father went to get her, she was dead. Debilitation was the immediate cause of death, but her condition of Sickie Cell Anemia was the reason that her inability to obtain fluid was fatal (Taylor & Mauer, 1985).

Shaken Baby Syndrome (see separate article, this issue) may be another instance where lack of knowledge contributed to the death of children, without medical advice in order to soothe or quiet crying babies, and deaths by ingestion of fatal doses of medicines (Tutera & Glorzer, 1966) feeding may be in part due to ignorance.

CASE EXAMPLE

A 42-month-old girl was brought to the corne’s office by the mother, who reported having died shortly after her mother put some pepper into her mouth. Among the most well-
developed child with a small hole/being abrasion on the left cheek, a healing fracture of the left humerus, and the entire trachea and stomach completely filled with over six grams of black pepper. Death was due to asphyxiation from blocking of the air passages. The mother poured black pepper into the child’s mouth as discipline for taking a nursing bottle from a 13-month-old sibling.
Risk Factors for Child Fatality
- Financial stress and/or poverty
- Prior instances of abuse/neglect
- Lack of support and/or lack of compensating factors
- Young parent(s)
- Abuse of drugs or alcohol
- Underutilization of social services
- Child under 1 year of age
- Spouse abuse
- Parental history of abuse/neglect
- One parent not biological

Risk Factors for Neonatalide
- Denial of pregnancy
- Lack of prenatal care
- Very young mother
- Illegitimate child
- Unwanted child

Bonny Finney has a mission — making the general public aware of child abuse. "I was so tormented from the shock of how my grandson died. He had so many bruises on his head. If this is not happening at your home, you can't know the pain and how it tortures the children." Finney is a grandmother who wants something positive to come from her grandson's death. She explains, "I had to do something to take away the anger. I chose the blue ribbon because blue reminds me of the bruises. I know that ribbons don't stop child abuse, but they do cause people to ask."

"We had suspected something," relates Finney, "but everything happened so fast. My daughter entered into a stormy marriage with a drug abuse and was barred by her husband. She finally left him in June. By July she was living with a boyfriend who was worse. Then Bobba was hospitalized."

His eyes were black, his nose, his ears, his whole head was a mass of bruises. His testicles were crushed," Finney paused, then continued. "My daughter said Bobba had fallen in soapy bath water."

"When my 16-month-old granddaughter was hospitalized, she had four broken places in her leg and severe burns. A year later she has had to have surgery on her leg," Finney continued. "No one knew where Bobba was. We learned later that he had been killed, stuffed in a tool box and dumped into the Disposal Swamp three months earlier."

"My daughter is in jail. She is working on the 12-step program. She has lost her children," says Finney. "My 6-year-old granddaughter is getting psychological help for the emotional abuse of witnessing her sister's injuries and her brother's death. Both children will need long-term psychological treatment."

"I am concerned about some solutions to child fatalities. "We need to look at the laws," she says. "We need to look at how the system responds."

Prevention, and the Blue Ribbon Awareness Campaign, remain Finney's focus. "I am very concerned about prevention," Finney states. "I want to get the message across to the general public. I have dreamed about how many children were abused."

The Blue Ribbon Campaign, according to Finney, is an opportunity to get involved. "It helps to have a symbol," she asserts. The campaign will run again next April during prevention month.

"It serves you," states Finney, "to know he was beaten so badly and stuffed in a tool box and left in the canal for so many months. I had to take something so bad and make it positive."

The blue ribbon serves as a reminder to fight for protection of children, our most precious gift. Please wear a blue ribbon during April or anytime, put one on your car, give one to a friend and share what it means. You may save a child's life! The Blue Ribbon Campaign was picked up by the Hampton Roads Pride in Parenting Child Abuse Prevention Office. In 1990 the Virginia Coalition for Child Abuse Prevention adopted the Blue Ribbon Campaign as a two-year theme and expanded the campaign across Virginia and to other states. The coalition consists of 18 agencies and organizations which have worked together since 1982 to promote statewide awareness of the need to prevent child abuse and neglect.

To obtain materials published by the Coalition for Prevention Month, including a workbook on how to successfully conduct a Blue Ribbon Community Action Campaign, contact: Stop Child Abuse Now (SCAN), 2222 West Main Street, Richmond, VA 23220, (804) 359-0014.
Handling of Cases

Many child murderers escape detection. Dr. Milton Halpern was the chief medical examiner of the City of New York and had been a professor at both New York University School of Medicine and Cornell University Medical College. In a 1976 article, he noted that until public attitude changes, child killings will continue to go undetected or mislabeled. Public pressure is needed to ensure that all suspicions or violent child deaths are reported to the medical examiner or coroner, that a mandatory investigation is undertaken to determine the cause of death, and an adequate postmortem examination is performed (Halpern, 1976). While a gradual shift towards more systematic handling of child fatalities is evident since the mid-1970s, many states still do not provide for comprehensive review of suspicious child deaths.

The Role of the Medical Examiner

The medical examiner is a forensic pathologist with the responsibility of investigating the circumstances at the scene of death and examining the body. He or she is also responsible for informing police and social services of every case in which there is an indication or suspicion that physical abuse or neglect contributed to the death (Halpern, 1976).

The medical examiner plays a key role in cases of fatal child abuse. Since the assault is not usually witnessed, the state's case is often based solely upon the testimony of the pathologist and circumstantial evidence (Zumwalt & Hirsch, 1980). To be effective, a medical examiner must be thoroughly familiar with the facts. He must approach cases with suspicion and must do a complete autopsy and investigation to establish the cause and mechanism of death. Many factors may limit the effectiveness of the medical examiner. First, cases may not be reported to the medical examiner. Halpern (1976) states, "In view of the fact that the statutes call for the reporting of all violent or suspicious deaths and unnatural deaths, it is surprising that infant deaths are lost track of, and their reporting is sporadic, in so many jurisdictions in which adult deaths are fairly consistently reported for investigation" (p. 43).

Factors causing low reporting include lack of funds for the pathologist's fees; coroners who are elected lay officials who certify the cause of death themselves, lack of external signs of trauma, and private physicians who certify the cause of death erroneously.

Dr. Ronald Reeves, a nationally known forensic pathologist from Tallahassee, Fla., frequently consults in cases of fatal child abuse which were originally misdiagnosed. He comments, "Too many doctors are ignorant about child abuse. They feel compelled to offer opinions where they are unqualified." He cites cases where a child has been rushed into the emergency room, died on arrival, and the physicians sign the death certificate despite a Florida law that a medical examiner must be called whenever there is an unusual or violent death. The category of Sudden Infant Death Syndrome (SIDS) is particularly troublesome. The literature contains many examples of misdiagnosed cases. For example, half of Johnson's 17 cases of fatal child abuse were originally thought to be cases of "cot death" (Cleghorn, 1980). "It would seem that cases with an anterior non-accidental misdiagnosis of the cause of death are not as uncommon as one might expect" (p. 147).

Noting that "there are no shortcuts to the correct diagnosis of a true crib death" (p. 43), Halpern (1976) recommends that all SIDS cases be systematically reviewed and studied. This, however, is not the rule. Dr. Reeves remarks that "a very significant proportion" of fatal child abuse cases he has consulted on were originally diagnosed as SIDS.

Researchers investigating death scene investigation of 25 SIDS cases (Bao, et al., 1986) strongly support Reeves and Halpern. Stating that SIDS should not be diagnosed on the basis of clinical evidence alone, the authors question the validity of any SIDS death not confirmed by autopsy. Dr. Reeves goes further and states that diagnosis of SIDS cannot be made without a complete autopsy and thorough investigation.

In Virginia, according to Dr. Marcella Pierro, deputy chief medical examiner with the Virginia Department of Health, not all SIDS cases are referred to her office. She states that these cases are not usually witnessed, the state's case is often based solely upon the testimony of the pathologist and circumstantial evidence (Zumwalt & Hirsch, 1980). To be effective, a medical examiner must be thoroughly familiar with the facts. He must approach cases with suspicion and must do a complete autopsy and investigation to establish the cause and mechanism of death. Many factors may limit the effectiveness of the medical examiner. First, cases may not be reported to the medical examiner. Halpern (1976) states, "In view of the fact that the statutes call for the reporting of all violent or suspicious deaths and unnatural deaths, it is surprising that infant deaths are lost track of, and their reporting is sporadic, in so many jurisdictions in which adult deaths are fairly consistently reported for investigation" (p. 43).

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In Virginia, according to Dr. Marcella Pierro, deputy chief medical examiner with the Virginia Department of Health, not all SIDS cases are referred to her office. The statewide budget cuts will affect the number of SIDS cases accepted. Says Pierro, "We will see an increase in the number of cases, especially sudden infant deaths." Does that mean that more child homicides will be missed? "I hope not," says Pierro. "We will do more telephone screening and gather more information up front."
Child Deaths Due to Lack of Safety Seats — Is this a Case of Neglect?

Child safety statistics of abuse/neglect related deaths do not include child deaths due to lack of using child safety seats. According to Martha Gilbert, director of the Virginia Department for Children, 13 children under age 4 died in traffic accidents in Virginia from January to July of 1990. Nine of these children were not in safety seats as required by law. In 1989, 1,267 children under age 4 were injured in car accidents. Of these, 379 did not have any type of restraint.

Gilbert states, "The Department of Motor Vehicles says people are becoming lax about the use of child safety seats. They have launched a new public education campaign."

Bill Dennis of the Public Information Office of the Department of Transportation explains the public education campaign.

New literature is being distributed at hospital maternity units and through voluntary groups. Public service announcements are being aired on television. Also, the Department of Transportation is conducting child safety seat checks at malls and schools across the commonwealth. Officials from DMV check to make certain that child safety seats are installed correctly and are being used properly. Questions about the campaign can be addressed to Bill Dennis, Public Information Office, P.O. Box 27412, Richmond, VA 23229, (804) 367-6400.

Any indigent family needing a safety seat can obtain an application for a free car seat by calling the DMV Toll-Free Child Safety Seat/Safety Belt Hotline 1-800-553-1992. More than 21,000 safety seats have been distributed since the program began in 1982.

Another resource is Judy A. Hammond, instructor for Virginia Commonwealth University's Transportation Safety Training Center. She regularly conducts training on the proper use of car seats and safety belts. Hammond has co-authored a picture book, Baby Seats, Safety Belts and You. A limited number of single copies are available free of charge. Organizations wishing to mass distribute this resource can obtain negatives free of charge. For further information, contact Hammond at Transportation Training Center, Virginia Commonwealth University, 816 West Franklin Street, Box 2017, Richmond, VA 23284-2017, 804-337-6257.

Role of the Prosecutor

When the police begin their investigation, they generally notify the prosecutor. (In some areas, the prosecutor is called a county attorney, a city attorney or a district attorney.) The prosecutor, the coroner and the police will jointly determine whether or not criminal charges are placed.

The district attorney's office in San Diego is a large operation with 230 lawyers. Eight are assigned to child abuse. Harry Elias, deputy district attorney meets monthly with other members of the county's child fatality review committee. The committee reviews all suspicious child deaths, generally 20 to 30 per meeting.

As a committee member, Elias offers insight as to whether criminal prosecution is possible or likely for a particular case. He answers legal questions and provides pertinent records. The prosecutor assembles and organizes the evidence in charge of filing legal documents, preparing witnesses for testimony and presenting the case.

Role of Police

It is the responsibility of the police to find the police and present evidence. Any indigent family needing a safety seat can obtain an application for a free car seat by calling the DMV Toll-Free Child Safety Seat/Safety Belt Hotline 1-800-553-1992.

More than 21,000 safety seats have been distributed since the program began in 1982. Another resource is Judy A. Hammond, instructor for Virginia Commonwealth University's Transportation Safety Training Center. She regularly conducts training on the proper use of car seats and safety belts. Hammond has co-authored a picture book, Baby Seats, Safety Belts and You. A limited number of single copies are available free of charge. Organizations wishing to mass distribute this resource can obtain negatives free of charge. For further information, contact Hammond at Transportation Training Center, Virginia Commonwealth University, 816 West Franklin Street, Box 2017, Richmond, VA 23284-2017, 804-337-6257.

This guide explains the reasons for discipline and covers techniques that are alternative to physical punishment. It reviews why children misbehave. Key concepts are highlighted and the booklet identifies when a parent should seek professional help.


This book presents the major role that social and economic factors play in physical abuse and neglect of children. It grew from a concern that professionals are relying too heavily on psychological and medical models in approaching treatment and prevention programs. An impressive group of contributors, including David Gil, Elizabeth Elmer and James Garbarino, offer analyses, data and examples to support the role of social factors, neighborhood environment and poverty as causative or mediating variables to abusive and neglectful behavior. Practitioners and policy makers will benefit from reading this work.


This book summarizes the reports of inquiries into cases of child abuse fatalities over a 10-year period. Eighteen cases were considered. The report offers insights and recommendations to improve casework practice. The areas examined include a broad range of protective service activities as well as inter-agency coordination.


This book presents broad strategies for clinicians dealing with physical and sexual abuse. Both assessment and treatment are covered. The introduction contains a brief historical overview, information about physical abuse brought with a review of models of causation. Assessment of child and family is discussed. The treatment chapter discusses how it works with abusing parents to change their management techniques, impulse control and perception of their child. Treatment for the child victim includes exploration of relaxation skills, learning new problem-solving techniques, improving social skills and reestablishing developmental delays. Anger management and self-esteem issues are reviewed briefly. Finally, intervention with social and situational factors are discussed.

The section covering sexual abuse has an identical format. The book ends with a chapter on prevention.

This book provides a good survey of myths and ideas in the field. It is limited by space and scope, thus, none of the treatments are described in great detail. Those seeking an introduction to clinical work on child abuse or those searching for an overview will find this to be a solid and rewarding resource.

Virginia Studies


This report was undertaken to learn "what improvements are needed in our communities to identify and treat other families at risk more effectively and where to focus prevention efforts" (p.1). The report studied 27 documented cases of child fatality from maltreatment from July 1966 to June 1987. Data from these cases are summarized and recommendations are offered.


During the 1985 (wealthy) assembly session, members of the Junior League of Virginia requested an amendment to the first-degree murder statute to include child abuse related fatalities. The legislature, in turn, requested a study of the commonwealth's cases of fatal abuse or neglect and a review of the outcomes of prosecution.

The study committee reviewed 90 cases of child deaths from abuse or neglect from 1966 to 1989. The committee concluded that changes to the criminal statutes were not necessary. They did, however, urge the commonwealth to develop Child Fatality Review Teams at the state and local levels to foster cooperation in investigation and prosecution of cases.
Key, "no officer does not find child homicide unit. Also, police may be more skeptical
than those in other professions and more will question and consider the possi-
bility that a child death is not accidental.
Key views thorough investigation as a
prevention tool. "Most child abuse deaths result from ongoing, protracted abuse. If we
do not train the next generation, then we may prevent fatalities," states Key.

Cooperation between CPS and law
enforcement is not found in all localities. Key explains, "It's simply turf battles. Back in
1975 when the child abuse reporting legislation was enacted, some police
responded strongly. The reaction was: If social services wants this responsibility, then
we'll let them have it! In order to overcome this attitude, I think the head of social
services and the chief of police or sheriff must communicate and model good relationships.
Both agency heads must make a commitment that child fatalities are a serious issue and
that they expect their staffs to cooperate."

Key fully supports the concept of multi-
discipline child fatality review teams. "One of the greatest benefits," he notes, "will be
the contact between agencies and the enhanced communication."

Law enforcement has much to offer other
disciplines. Key notes that officers are accustomed to data gathering in crisis and
highly emotional environments. "Most homicides involve family or friends," says

Robert Key, Chief of Police

The Role of Child
Protective Services

Child Protective Services should be involved in the investigation of any fatality
where child abuse or neglect is suspected. Legally, police medical examiners and
doctors are all required to report to CPS any case where abuse or neglect is suspected.

According to Suzanne Fountain, child protective service specialist with Virginia's
Tidewater Regional Office, CPS is not always informed in a timely manner, pre-
venting effective intervention. "Some cases only get reported after the police investiga-
tion is completed. It is less frequent, but
there are cases where the police have not
reported at all. The CPS worker learns of the
case through the media."

When CPS is informed, the worker tries
to do a joint investigation with law enforce-
ment. Working together means better infor-
mation and less stress on the family which
has suffered a major loss because of the death of a child. Fountain explains, "The worker
is dealing with an extremely family crisis. It is
a very emotional time. The investigation
requires gathering a large amount of infor-
mation in a most difficult situation."

Patricia Wrightsmith, the child protective
service principal social worker from Virginia
Beach, explains the sequence that CPS follows. "There is a need for an immediate
response because the most accurate infor-
mation is obtained at the time of crisis.
Normally I go first to the hospital. We rely
a great deal on medical information."

Next Wrightsmith interviews the family.
She comments, "Regardless of the manner of
death, the family has lost a child. It's a
powerfully emotional time. Crying, anger
and grieving are all present and these
emotions may be directed at the worker."

The CPS worker tries to pinpoint when
the injury occurred and who had access to
the child. Extended family may be inter-
viewed. Wrightsmith notes, "One must con-
front inconsistencies between the medical findings and the story offered."

The focus of CPS differs from that of law
enforcement, even when they are able to coordinate their investigations. Law enforce-
ment seeks data about criminal activity. CPS must determine whether or not abuse or
neglect has occurred and focus on doing a risk assessment to determine the safety of
siblings. CPS also attempts to assess family

Removal of siblings is notroutine but
decided on a case-specific basis. The alvawes
may not be in the home. A child may be
low risk because of age or specific charac-
teristics. If several of the children from the
parents is necessary, we ask the family
to make a plan for placement of their children first," states Wrightsmith. "We only use
foster care if they cannot give us an acceptable plan. Wrightsmith notes that
siblings are always interviewed both for information and for risk assessment.

According to Diane Maloney, child protective service specialist at Virginia's
central office, there is complete data for 34 cases of child fatalities in 1989-88. Siblings
were removed in 11 cases. Six cases had no siblings. In 17 cases, siblings remained
in the home.

Research data supports a focus on risk
assessment. For example, a study by Kaplan
and Reich (1976) found that 79 percent of
the fatality cases showed evidence of jeopardy to other children.

Wrightsmith offers some suggestions to
workers who are investigating a child abuse
fatality. "Usually I am called when the child
is not only dead but still alive. I always see
the child. Having a picture of the injuries clearly
is my mind helps me to stay focused on the
protection issues."

"You are always a potential witness," states Wrightsmith, "therefore I try to take

Investigation and
Prosecution of Child Fatalities
January 26 - 28, 1991
Holiday Inn on the Bay
San Diego, California

Program Highlights:
- Investigation of child deaths
- Trial of child homicide
- Death review committees

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Criminal Justice System Response

A number of authors have described differences in legal response to child homicide, especially child murder by a parent, versus murder of adults (Adelson, 1961; Damme, 1978; d'Orban, 1978; Goetting, 1988; Remnick, 1969). Damme, in her analysis, states that how a society values its members is reflected in the extent that it protects citizens through law. The lesser status of children was institutionalized in English laws on infanticide which prescribed lesser penalties for such homicides as well as establishing a very liberal insanity defense. Damme feels that the American jurisprudential system reflects similar attitudes.

Data on dispositional support claims of Damme and others that legal sanctions are less severe for child murderers. Many cases are never prosecuted. For instance, Adelson (1961) shows only 15 percent of his sample were tried for first-degree murder while 41 percent were tried for lesser charges and 44 percent were not tried due to successful suicide attempts, commitment to a mental hospital or failure to indict. Goetting (1988) shows 67 percent were tried and convicted of either manslaughter or murder, 16 percent acquitted and 7 percent not guilty by reason of insanity. A report of an Oregon Multidisciplinary Study Group (1986) found that only half the cases of child abuse homicide in Oregon were prosecuted in 1985.

Remnick (1969) notes differences in legal response according to sex. Fathers who murder are more likely to be sent to prison while mothers who kill are more often hospitalized. Scott (1973) in his sample of 29 battering fathers who killed their children found that 60 percent received a prison sentence. Damme (1978) documents this trend in England for women. The percentage imprisoned for child murder in the time period 1923-27 was 49 percent. That number slowly dropped to 22 percent by 1946-56, to 16 percent by 1951-55 and to 1.3 percent by 1965-65. Similar findings were obtained by d'Orban (1979).

Even when prosecutors make efforts to obtain first-degree murder convictions, laws make it difficult, if not impossible, to either obtain a first-degree murder conviction or support it on appeal. For example, in Arkansas in 1987, the state obtained a first-degree murder conviction in the case of Ronnie Midgley Jr., who died after prolonged and brutal physical abuse by his father. On appeal, the father argued that...

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Child Abuse Fatalities
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abuse related fatalities. Virginia's concerned professionals and legislators have made several responses in order to learn more and improve helping systems. In 1987, the Department of Social Services convened a study committee to review child fatalities due to abuse or neglect and to generate recommendations. Chairied by Fountain, the committee released a report in March 8, 1988.

The study profiled characteristics of abuse/neglect fatalities. Most (67 percent) were under 1 year of age, compared to 5 percent in non-fatal cases of abuse or neglect. A total of 85 percent of the child fatalities were under 5 years of age. The racial distribution was 7 percent white, 50 percent black and 7 percent biracial, compared to non-fatal cases where 63 percent were white, 34 percent black and 3 percent other races. These findings (very young victims and a higher percentage of minority victims) are similar to national trends discussed earlier.

The perpetrators were 54 percent male and 46 percent female. In 74 percent of the households, two parents lived at home (compared to 40 percent in nonfatal cases). Annual income was estimated to be less that $10,000 for 51 percent of households, from $10,000 to $25,000 in 21 percent and more than $25,000 in 15 percent.

Death resulted from abuse in 74 percent of cases and from neglect in 22 percent. Thirty percent of abuse deaths involved the child being violently shaken (see Spotlight on Prince William County for a prevention program). Of the deaths due to neglect, 81 percent were from malnutrition and 5 percent from illness.

A third of families were receiving services from a local department of social services at the time of the fatalities. At least 22 percent had received CPS services prior to the death, although none of the children at risk for abuse were removed from the home.

In 15 percent of the deaths, no legal action was taken and another 15 percent were found not guilty at trial. In about half the cases, the perpetrator was found guilty, but 20 percent of these individuals received no jail time.

The committee recommended that the central office facilitate uniform, complete data gathering by developing a standardized data collection instrument. A secured record management system to develop a case review procedure to evaluate the system's response. In response to the recommendations, the central office developed a fidelity protocol that we implemented on July 1, 1988. The protocol emphasizes an interdisciplinary response to staff the caseworker with consultation of the regional specialist. Data is compiled by the central office.

Diane Maloney, child protective service specialist with Virginia's central office, explains the purpose of the protocol. "We are trying to see if there are things to be learned that can be applied to high-risk cases. The instrument was written into policy and will and should generate some baseline information about fatalities."
Shaken Baby Syndrome: A Public Awareness Campaign: Spotlight: Prince William County

Linda Cerri, M.Ed., R.N., is a maternal retardation prevention specialist. She is also a person with a mission: preventing shaken baby syndrome. "Shaking a baby can cause blindness, brain damage or death," states Cerri. "Children under 2 are the ones affected. Their brains are not yet 'firmed up' and have a consistency similar to jelly. The motion caused by shaking can tear the brain and cause bleeding into the brain's internal cavities."

Shaken Infant Syndrome is a newly recognized injury to children. Parents, not realizing the danger, may shake a child instead of hugging or use shaking to try to soothe the baby instead of crying. An infant's head is large and heavy in proportion to its body and usually is one-third to one-fourth of the body's weight. Also, the infant's neck is weak, so jerking causes the head to flip like a hinge. The brain, which floats inside the skull on a cushion of fluid, strikes the skull with a force of about 13 times gravity, causing a whiplash injury. If a child impacts a blunt surface, such as being thrown in a crib, the force can be 428 times gravity. In either case, the brain tissue is stretched, blood vessels are torn and the vessels at the back of the eye may rupture and bleed. There may be no external signs of injury.

The usual ways that injury occurs are (1) from playing, such as when a child is thrown into the air, (2) rough brushing, (3) punishment where the child has been shaken rather than spanked, (4) shaking a child in response to crying, (5) shaking a child to try to terminate an episode of stopped breathing, (6) swinging a child by the ankles or jerking while upside down, or (7) "ciding" a child on a vigorously bouncing adult knee. While infants and very young babies are the most vulnerable, these injuries can occur in 3- and 4-year-olds as well. Also, cumulative effects are important. The usual pattern is that the infant or child is shaken frequently or every once in awhile and the damage occurs from a summation of more minor injuries.

In a video by the Prince William County Community Services Board, Dr. Joseph Pugliesi, M.D., of Woodbridge, Va., tells of a study of shaken infants. He relates that 15 percent died, 50 percent had some combination of blindness due to retinal hemorrhage, developmental delay, visual impairments, motor defects, and seizures, while 35 percent showed no effects upon short-term follow-up.

Taylor and Maurer (1985, see review, this issue) note that damage can occur. The bones of the neck and lower spine can be injured during shaking, leading to spinal deformity, paralysis or back pain. In very young infants, bones of arms or legs can be broken if they are jerked or squeezed during a violent shaking.

Early detection is important. A CAT scan or angiogram of children suspected of shaken baby syndrome is suspected. An infant who has suffered injury from shaking will be irritable, show lethargy, fussiness, poor appetite and vomiting. Bulging of the soft spot on the top of the baby's head can indicate bleeding in the brain and swelling. The common presentation of complaints are one of three problems:

(1) respiratory difficulty without infection; (2) seizures; CNS abnormalities, irritability and decreased muscle tone; (3) gastrointestinal problems such as poor feeding, poor appetite and vomiting.

Cerri's public awareness campaign began in 1988. She thinks it is working. "Over the past two years since the campaign began," she notes, "there have not been any cases of Shaken Baby Syndrome in our area."

A number of materials are available. The 10-minute video (half inch) is $30. Flyers are 15 cents each, postcards 50 cents each, bookmarks 25 cents each and a citizen's information kit is $1.25. Add $2 for postage to all orders. All funds go directly to the printing of additional materials.

For further information contact: Prince William County CSB. Prevention Services Division, 8033 Ashburn Avenue, Manassas, VA 22110, (703) 335-7770.

These materials should be of interest to persons working in hospitals, teaching family life education in schools, operating health clinics or day care centers, teaching preschool classes or managing parenting centers.

A second study, completed in 1990, focused on criminal sanctions for child abuse fatalities (see review, this issue). This study was ordered by the General Assembly and coordinated by the Virginia Department for Children. The impetus for the study came from an amendment to the state's general murder statute proposed by the Junior League of Virginia. The league's concern was prompted, in part, by a fatality case involving torture and brutal beatings by the parents of a 21-month-old child. Although prosecutors sought first-degree murder convictions, convictions for lesser offenses were obtained.

The study committee reviewed 90 cases of abuse/neglect fatalities from 1986 to 1989. After their study, the committee concluded that legal changes were not necessary. Rather, the findings of the committee suggested that lack of cooperation and coordination between agencies was a primary concern.

The committee recommended that the commonwealth establish a formal process for reviewing and investigating cases of child death where malfeasance is suspected. The committee urged the development of both local and state child fatality review teams. Legislation to establish state fatality teams was carried over from the last legislative session and will be introduced in 1991.

The state team would develop procedures for local teams, monitor and review the work of local teams, promote interdisciplinary education and training, and identify trends in time policy needs. Local teams would promote timely sharing of information and encourage consistency in investigations. These practices, in turn, would increase the probability of charges and convictions.

Martha Gilbert, director of the Virginia Department for Children, chaired the study committee. "The biggest concern is that there be more communication at the local level among entities that are relating to families either prior to or after the deaths," explains Gilbert. "There were some determinations that could have been different had there been more discussion. For example, some instances of SIDS might have been questioned had all information been 'out on the table.'"

Gilbert's opinion is echoed by national experts. Dr. Durfee, coordinator of Los Angeles County's Child Abuse Prevention Program, also supports the concept of fatality review. "Nationally these cases are horribly mismanaged," asserts Durfee, "both in terms of criminal action and in terms of CPS response. If one has the mechanisms to look at deaths logically, more homicides are discovered."

Gilbert stressed that the reviews would not become "a public forum." "Nothing now prevents the agencies from doing the review. The review teams would simply encourage and facilitate this process," explains Gilbert.

Multi-agency Teams

Dr. Durfee notes that 23 counties in California now have child death review

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Prevention Strategies
Child deaths can be prevented. Prevention relies upon two sets of strategies. One approach is reducing abuse through education and training that result in more competent parents. Persons who arrive at adulthood with self-confidence, self-respect, solid skills, knowledge about child development and satisfying relationships are unlikely to kill a child. Thus, family life education programs in schools, parent resource centers, and support services for parents of newborns can all reduce risk of fatalities if they are utilized. Since parents at risk of killing children generally isolate themselves from the community, early identification of high-risk families is essential. Once identified, high-risk families must be offered support to try intervention services and outreach services. The parenting centers featured in VCPN, Volume 30, are the kind of programs that can be effective.

A second set of strategies depends upon improving the response of the system. Identification of cases at risk for fatalities needs to improve. Once identified, better and more knowledgeable provision of services is necessary. Mental health professionals need to be alert to warning signs. While it is rare for neocritical women to seek any kind of care or help, a high percentage of those who commit infanticide see a mental health worker or family doctor shortly before the murder (D'Cebran, 1979; Kessick, 1969). Those in mental health also need to pay particular attention to talk of suicide, especially if concern is expressed for the future of the children.

Teachers, clinic workers, ministers and others who have contact with teas need to be alert to denied pregnancy or pregnant teens who avoid medical care. These mothers are at special risk for committing serious abuse or infanticide. Any pregnancy that is denied by a mother should also be a suspect.

Children at risk are identified, social workers and those in mental health need to be watchful and take the time to monitor the child carefully. Therapists and workers must avoid the "tag towards the parent" and the "rule of optimism" where it is assumed that the family is improving (Blume-Cooper, 1986; Parton, 1986; Stevenson, 1986). Fein (1979) has documented this problem in her analysis of 45 child abuse fatalities in New York. Workers appear to empathize with parents of spit's clear evidence of profound neglect and abuse.

The system must be willing to remove children from high-risk situations when needed. This may require a change in the thinking, since the case is not the goal of social services. Dr. Fierro notes, "The statutes aren't designed to take preventive action. The whole point is to preserve the family unit." Fein (1979) states that workers in her study failed to remove children from homes even when there was clear evidence of violence towards the child.

Removal must include blocking access of the parent to the child. Dr. Joseph Zanga, professor of pediatrics at MCV/VCU Children's Medical Center in Richmond relates several cases where the child was placed with the grandmother. "Invariably, grandmother lives either with the mother or down the street. The grandmother allows the mother access to the child. The child comes back with further injuries while in the mother's care," states Zanga. "Consistent follow up is needed in these cases."

Dr. Zanga feels the social service and legal systems "have gone outboard in defining perpetrators." He releases an example, "We referred an older child and CPS decided to discharge the child in the home. That child came back dead, two days later. The legal system was disinterested in prosecute. Near the mother has another child, suffering from the same symptoms as the first child. He stops breathing, but only when the mother is present along with him. They still

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Smyth County Youth Volunteer

This group of 25 teenagers adopted Child Abuse Prevention Month, April 1990, as their project. Highlights of their many activities included a one-hour radio show about emotional abuse from a teen’s perspective. Another radio appearance explained the Blue Ribbon Campaign and gave ideas for positive discipline. The group painted blue ribbons in businesses and homes. They arranged for a production of ‘‘Hugs and Kisses’’ to be presented to all school children K-6. The youth council has accomplished a great deal for child abuse prevention by involving youth directly in the campaign and offering a youth perspective on the issue.

Volunteer

Bruce Hansen

Bruce Hansen and Thomas Gerdy

As a member of the Parents Anonymous Board of Directors, Bruce Hansen conceived the idea of a national awareness campaign, ‘‘Coast-To-Coast: A Celebration For Children.’’ He drove across the country with scheduled stops between March 30 and April 14, 1990. The tour began in Richmond at the Children’s Museum with a celebration party. Stops were made in Georgia, Alabama, Texas, Arizona, California and Missouri before returning to Virginia Beach where 6,500 people attended the final celebration. Each stop had special events including a party with ‘‘Spiderman’’ and an on-stage show with Bill Cosby. Parents Anonymous received national recognition and thousands of people across the country learned more about the problem of child abuse.

Private Practitioner

John Michael E. Quiquet, M.D.
Chesapeake

Dr. de Triquet is a pediatrician who specializes in the field of child abuse. He sees over 200 abused or neglected children each year in his capacity as staff physician at Children’s Hospital of the King’s Daughters. He is president of the Tidewater Pediatric Society and a member of the Safe Kids Coalition of Hampton Roads as well as a professor at Eastern Virginia Medical School. He is a frequent lecturer at workshops both in the lay community and at professional meetings. Despite these commitments, colleagues describe him as accessible and note that he is readily available to testify in court when needed. Dr. de Triquet’s dedication to children truly sets him apart.

Volunteer

Thomas J. Gerdy

Lynchburg

Thomas Gerdy was instrumental in raising funds to start Genesis House, a temporary shelter for abused and neglected children. Located on the campus of Lynchburg Presbyterian Home, the program has served 73 children during its first year of operation. Gerdy also served on the Amherst County Multi-discipline Team from 1983-87 and helped the team sponsor the sexual abuse prevention program ‘‘Hugs and Kisses’’ in seven elementary schools. Gerdy is active in public education about child abuse and assists in prevention month awareness activities.

Volunteer

Maryjorie (Marge) Blaiswies

Great Falls

With insight, dedication and commitment, Maryjorie Blaiswies helped establish Parents Anonymous of Virginia as a vital, active statewide organization. From 1980 to 1990 she served the organization in many capacities as a member of the board of directors, chair of the Public Awareness Committee, program chair, member of the Consolidation Committee, and president of the board. She has participated in fund raisers, TV shows, public education talks and local child abuse prevention committees. In her current position as an elementary guidance counselor, Maryjorie Blaiswies has started a school mediation program for conflict resolution and chairs the school’s Human Relations Committee, both excellent prevention efforts.
The number of abuse cases we report to CPS goes up, yet the number of founded cases is static. The deaths go up. We are joining something.

Dr. Zanga stresses the importance of prevention. "We need to start telling our elected officials that this is a serious problem. It's teach more serious than AIDS, for instance. I have two abused-children on the unit right now, at a cost of over $500 per day per child. If a child is seriously brain damaged from abuse and is institutionalized, what will that child cost the state? If you want to balance the budget, prevention is the best way."

References Available Upon Request