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Rusty Duncan
Advanced Criminal Law Course

BACK TO THE FUTURE

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210.222.1234

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HOW TO BEAT THE CHILD SEXUAL ASSAULT CASE

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How to Beat the Child Sexual Assault Case
Key Successful Defense Components

• Complainant(s)
  – Motive
  – Reality
• Process
  – Interview
  – Medical examination
• Admissibility
  – Statements made for determining medical diagnosis
• Forensics
  – Experts
Motive

• Three daughters will testify that he sexually assaulted them
• Eve of trial, plead
• Reality
  – Girls angry about divorce, new girl friend
  – Interviews were driven by mother
  – First interview was on her birthday
  – Mom took girls out of town each time trial was set
• Plea found involuntary
Other motives

• Was spanked
• Accused would not play with, wanted to work
• Other kid(s) were in new complaining
• Cooperation with law enforcement
• State compensation
• Law suits
Local Scouts knew the danger

by Brian New / KENS 5

Posted on February 24, 2011 at 1:58 PM
Updated Thursday, Feb 24 at 6:30 PM

A local teenager has filed a lawsuit against the Boy Scouts of America
Reality

Cody Miller - Boy Scout
Being deployed to Afghanistan
Other victims - Not a single other boy scout was
All had become excellent military
men or productive members of
communities
Q. So your opinion is based upon the history that was given to you because you had nothing else to rely on?

A. My -- my medical diagnosis was based on the child's history to me, that's correct, in this case.

Q. That's it?

A. That's it.

Q. If the child is lying then your -- your opinion is incorrect, correct?

A. That's right.
a six-year-old child. Yet Dr. Coffman was allowed to testify over Appellant’s objection that she diagnosed sexual abuse based solely upon the history provided by the complainant, and “she had an exam which was consistent with that history.” That is, Coffman diagnosed sexual abuse by digital penetration of the anus because the child told her that digital penetration had occurred and because there was no physical evidence of any sexual abuse.

HN1 It is well settled that a witness may not give an opinion as to the truth or falsity of other evidence. ¹ In Schutz, the Texas Court of Criminal Appeals held that the State’s expert’s statements that (1) the complainant did not exhibit any evidence of fantasizing in her testimony, (2) manipulation was a less likely explanation for the complainant’s allegations, and (3) the complainant’s allegations were not the result of fantasy constituted direct comments upon the truth of the complainant’s allegations. ²
Wish it had Stopped Sooner

A  No, he didn't tell me to never tell anybody.
Q  Okay. And what did you mean by that answer, I just felt like I wish I could have told someone before they found out about it? It says here, Why? Because it would have stopped sooner. What are you talking about there?
A  Well, because the policeman writing it made me feel like him talking about that stuff was wrong to me, so I felt bad about it. I just felt like I was doing something wrong.
Notes of Exam

• Not accurate
Q  So you're saying these notes are not accurate, don't accurately reflect what you said?
A  No.
Q  That they do or do not?
A  They do not.
Q  Okay. Can you turn to page seven? Seven is typewritten on the report. Do you see that page?
A  Yes.
Q  And does this report indicate that your penis is circumcised or uncircumcised?
A  It says uncircumcised.
Q  And are you in fact circumcised?
A  No.
Q  So that's not accurate either, is it?
A  No.
Q  As far as this report goes, what's your opinion of its accuracy and the accuracy of what's written in this report?
A  I would say it's not very accurate.
GUIDELINES FOR THE EXAMINATION OF A SEXUALLY ABUSED CHILD ARE NEEDED FOR A CONSISTENT EVIDENCE BASED APPROACH THAT THE MEDICAL EXPERTS CAN BE IN AGREEMENT
Guidelines for Medical Care of Children Who May Have Been Sexually Abused

North American Society for Pediatric and Adolescent Gynecology
Results

• “Groups of 10 to 40 physician experts met at child abuse conferences between January 2002 and January 2005 to revise the table summarizing the interpretation of physical and laboratory findings in suspected child sexual abuse and to develop guidelines for medical care for sexually abused children.”
Authors

• Joyce A Adams MD
• Rich A Kaplan MD
• Suzanne P Starling MD
• Neha H Mehta MD
• Martin A Kinkel DO
• Ann S Botash MD
• Nancy D Kellogg MD
• Robert A Shapiro MD
The Introduction to the Study
GROUPS CONSISTING OF 10 TO 40 PHYSICIAN EXPERTS MET AT CONFERENCES CONCERNING CHILD ABUSE FROM JANUARY 2002 TO JANUARY 2005

• THE RESULTS ARE THE GUIDELINES THAT ARE IN YOUR MATERIALS
The materials reflect

• CURRENT KNOWLEDGE
• RECOMMENDED CLINICAL APPROACHES
• REQUIRED COMPETENCIES FOR CHILD SEXUAL ABUSE MEDICAL EVALUATIONS
Medical evaluation of a child that has been sexually abused

• REQUIRES SPECIFIC SKILLS AND KNOWLEDGE
Note

- The Presumption is that the examiners do not know if the child has been abused
- The approach is objective medical and team exam
- The only child **advocacy** is competent care taking
As the only Child Advocacy Center in Bexar County, we restore hope and healing through expert treatment to children and their families who have been traumatized by abuse.
As the only Child Advocacy Center in Bexar County, we restore hope and healing through expert treatment to children and their families who have been traumatized by abuse.
The Committee on Child Abuse and Neglect of the American Academy of Pediatrics

• SUGGESTS TAKING A HISTORY FROM THE CHILD AND THEIR CARETAKERS
• PERFORMING THE PHYSICAL EXAM
• OBTAINING LAB SPECIMENS
The Committee

• LISTS GUIDELINES TO HELP YOU MAKE THE DECISION ON REPORTING SUSPECTED CASES OF SEXUAL ABUSE OF A CHILD TO THE APPROPRIATE CHILD PROTECTIVE AGENCIES
“The timing and detail of the examination should be based on specific screening criteria developed by qualified medical providers or by local multidisciplinary teams, which include qualified medical representation.”

• For more detailed information go to the section entitled “The Child Sexual Abuse Medical Provider or Nurse Examiner) at p. 169 in your materials.
The goals of the medical evaluation are:

• TO OBTAIN THE HISTORY FROM THE CHILD AND/OR GUARDIAN
The goals of the medical evaluation are:

• TO CONSIDER ALTERNATIVE EXPLANATIONS FOR A CONCERNING SIGN OR SYMPTOM
The goals of the medical evaluation are:

• TO IDENTIFY AND DOCUMENT EVIDENCE OF INJURY OR INFECTION
The goals of the medical evaluation are:

• TO DIAGNOSE AND TREAT MEDICAL CONDITIONS RESULTING FROM ABUSE
The goals of the medical evaluation are:

• TO IDENTIFY AND TREAT MEDICAL CONDITIONS UNRELATED TO ABUSE
The goals of the medical evaluation are:

• TO ASSESS THE CHILD FOR ANY DEVELOPMENTAL, EMOTIONAL, OR BEHAVIORAL PROBLEMS NEEDING FURTHER EVALUATION AND TREATMENT AND MAKE REFERRALS AS NECESSARY
The goals of the medical evaluation are:

• TO ASSES THE CHILD’S SAFETY AND MAKE A REPORT TO CHILD PROTECTIVE SERVICES, IF NEEDED
The goals of the medical evaluation are:

• TO REASSURE THE CHILD AND FAMILY, AS APPROPRIATE
The goals of the medical evaluation are:

- TO DOCUMENT FINDINGS IN SUCH A WAY THAT INFORMATION CAN BE EFFECTIVELY AND ACCURATELY PRESENTED, IF REQUESTED BY A SOCIAL SERVICE OR LAW ENFORCEMENT AGENCY
The goals of the medical evaluation are:

• TO HELP TO ENSURE THE WELL BEING OF THE CHILD
The Medical History

• “The history taken from possible sexual abuse victims is often the most important part of the overall evaluation. While there is no clearly superior model for obtaining the history, there are certain principles and competencies that must be acknowledged.”
Specific questions should include...

• PAST HISTORY OF INJURY OR SURGERY INVOLVING THE GENITAL OR ANAL TISSUES
• PAST EPISODES OF PHYSICAL OR SEXUAL ABUSE
• RECENT OR CURRENT SYMPTOMS OF ANOGENITAL PAIN
• BLEEDING, ITCHING OR OTHER DISCHARGE
• SYMPTOMS OF PAINFUL URINATION OR BOWEL MOVEMENTS, CONSTIPATION
• ANY RECENT TREATMENT OF ANOGENITAL CONDITIONS
Adolescents

• Need to be asked about past consensual and/or forced sexual intercourse as well as the timing of the last event
Review the Information

- Information from investigative agencies
- Previous medical records may be necessary
General Rule:

• Minimize the number of times the child must recall the details or their experience
Studies show Causes for False Statements
(Dr Ferrara)

- Family members present during the room while undergoing a forensic interview
- Interview by high status officials
- Use of pressure or items as lie detector
- Use of props during interviews
- False confessions
- Child of low intellectual functioning
- Repetitive interviews
- Telling child of other abuse
Best Prosecution Practices
(Expert witness)

• Open ended questions
• Do not lead unless received other objective evidence of abuse and child is very young
  – Following with questions that test credibility and suggestibility
  – This is because leading questions are coercive
  – They also **distort and contaminate subsequent accounts made by the child**
Best Prosecution Practices continued....

• Encourage child not to guess and to correct interviewer
• Interviewer must use age appropriate language
• Have child make drawings to make sure child is not going along with interviewer terms and make sure child is not talking about something other than genitals, sexual intercourse, touching or penetration
Best Prosecution Practices continued

• Place of interview must be neutral and interviewer must also be neutral

• Not
  – Police station
  – Police interviewer
  – Repetitive interviews
  – Disapproval of responses or statements
  – Presence of parent or third party
  – Interrogation style
Medical History

• Health professional obtains the medical history from the child using:
  1. Non-leading questions; and
  2. Techniques specific for child’s cultural development and level of language development
Documentation

• Any statements by the child to the healthcare provider must be recorded in detail

• Medical charts should contain:
  1. Specific wording of **key questions** asked of the child
  2. His/her **verbatim responses** to those questions, usually in quotation marks

• Documentation of **who was in the room** at the time of the questioning is also important
Timing of the Examination

- The timing location and provider of the medical examination should be selected to ensure:
  1. A skilled evaluation is conducted
  2. Acute injuries and/or other physical findings are documented, and
  3. Biological trace materials are preserved
Reasons for Emergency Examinations

- The child complains of pain in the genital or anal area
- There is evidence or complaint of anogenital bleeding or injury
- The alleged assault may have occurred within the previous 72 hours and the transfer of biological material may have occurred which will be collected for later forensic analysis
- Medical intervention is needed emergently to assure the health and safety of the child
- Child is experiencing significant behavioral or emotional problems and needs evaluation for possible suicidal ideation/plan
Crime Scene Forensic Evidence

• Timely crime scene investigations are also encouraged when children are evaluated within a short time of the alleged assault

• Forensic evidence is more likely to be recovered from clothing, towels, and bedding than from the victim’s body
Note

• If they do not do it, you should
  – Kleenex child said was used to wipe face
  – Bedding where alleged abuse took place
  – Computer forensics (preserve)
  – Cameras and other digital media
  – Photos of locations (cave)
Cave
Documentation

• Like the medical history, physical examination findings must also be carefully and thoroughly documented in the medical record

• Photos and video are encouraged, particularly when findings are thought to be abnormal
Note

- Photos should be of abnormality and in perspective
- “Tear” may be self inflicted tiny scratch
Examination Techniques

• Conscious sedation - rarely indicated and should be used only when medical benefits clearly outweigh potential risks
• Knee-chest position
• Cotton swab or Foley catheter
• Water or saline may be dropped within the vestibule to cause the edge of the hymen to unfold or float
• General anesthesia
Sexually Transmitted Infections

• Options recommended by organizations
  • American Academy of Pediatrics
  • Centers for Disease Control and Prevention
• Provide appropriate and sensitive screening
• Minimize the risk of false positive test results
Note

• The bias here is to avoid stigmatizing the child
• Your client needs this testing
• Seek it
Interpretation of Physical and Laboratory Findings

• Medical provider should be familiar with the results of research studies of abused and non-abused children.
  • See Table 1 starting at page 165 of your materials
The Child Sexual Abuse Medical Provider or Nurse Examiner

• Baseline standards and activities for the medical practitioner performing these examinations
Medical Providers

- Relevant Training and Clinical Experience Listed:
  1. Physician, nurse practitioner, or physician assistant in pediatric medicine, emergency medicine, gynecology or family medicine
  2. Formal medical training in medical evaluation of suspected child abuse (scientific education, experience, and mentoring by an expert)
  3. Familiar with published research studies on abused and non-abused children
  4. Substantial experience and proficiency in child sex abuse evaluation with clear understanding of differential diagnosis mistaken for abuse
  5. System in place to consult with established experts when a second opinion needed with regard to physical or lab findings that are abnormal
Do not accept the SANE at face value

• **ATTACK** THE OBJECTIVITY AND COMPETENCY OF THE EXAMINER
Do not accept the complainant as being truthful

• EVEN AN INNOCENT CHILD CAN TELL A FALSE STORY

• THE CAVE
MOTIVATIONS

• CHILDREN CAN BE MADE TO TELL A FIB FOR EVEN THE SMALLEST OF REASONS

• CHILDREN DO NOT UNDERSTAND THE CONSEQUENCES OF THEIR FIB

• THE STATE COULD BE MISCHARACTERIZING THE STORY
Is there a medical or physical explanation other than abuse

- SUBPOENA THE CHILD’S MEDICAL RECORDS
- SUBPOENA THE CHILD’S SCHOOL RECORDS
- RESEARCH FAMILY HISTORIES
Exclude Statements

• IF THEY ARE NOT MADE FOR MEDICAL DIAGNOSIS
Table 1. at PP 165-166 of the Materials

• APPROACH TO INTERPRETING PHYSICAL AND LABORATORY FINDINGS IN SUSPECTED CHILD SEXUAL ABUSE: DECEMBER 2006
Findings documented in newborns or commonly seen in non-abused children:  
(The presence of these findings generally neither confirms nor discounts a child’s clear disclosure of sexual abuse)

Normal variants

1. Periurethral or vestibular bands
2. Intravaginal ridges or columns
3. Hymenal bumps or mounds
4. Hymenal tags or septal remnants
5. Linea vestibularis (midline avascular area)
6. Hymenal notch/cleft in the anterior (superior) half of the hymenal rim (prepubertal girls), on or above the 3 o’clock e 9 o’clock line, patient supine
7. Shallow/superficial notch or cleft in inferior rim of hymen (below 3 o’clock e 9 o’clock line)
8. External hymenal ridge
9. Congenital variants in appearance of hymen, including: crescentic, annular, redundant, septate, cribiform, microperforate, imperforate
10. Diastasis ani (smooth area)
11. Perianal skin tag
12. Hyperpigmentation of the skin of labia minora or perianal tissues in children of color, such as Mexican-American and African-American children
13. Dilation of the urethral opening with application of labial traction
14. “Thickened” hymen (May be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma. The latter is difficult to assess unless follow-up examination is done)
Findings Documented in newborns or commonly seen in non-abused children:

• Normal variants
  – Periurethral or vestibular bands
  – Intravaginal ridges or columns
  – Hymenal bumps or mounds
  – Hymenal tags or septal remnants
  – Linea vestibularis (midline avascular area)
  – Hymenal notch/cleft in the anterior (superior) half of the hymenal rim (prepubertal girls), on or above the 3 o’clock-9 o’clock line, patient supine
Findings commonly caused by other medical conditions:

15. Erythema (redness) of the vestibule, penis, scrotum or perianal tissues. (May be due to irritants, infection or trauma*)

16. Increased vascularity (“Dilatation of existing blood vessels”) of vestibule and hymen. (May be due to local irritants, or normal pattern in the non-estrogenized state)

17. Labial adhesions. (May be due to irritation or rubbing)

18. Vaginal discharge. (Many infectious and non-infectious causes, cultures must be taken to confirm if it is caused by sexually transmitted organisms or other infections.)

19. Friability of the posterior fourchette or commissure (May be due to irritation, infection, or may be caused by examiner’s traction on the labia majora)

20. Excoriations/bleeding/vascular lesions. These findings can be due to conditions such as lichen sclerosus, eczema or seborrhea, vaginal/perianal
   Group A Streptococcus, urethral prolapse, hemangiomas)

21. Perineal groove (failure of midline fusion), partial or complete

22. Anal fissures (Usually due to constipation, perianal irritation)

23. Venous congestion, or venous pooling in the perianal area. (Usually due to positioning of child, also seen with constipation)

24. Flattened anal folds (May be due to relaxation of the external sphincter or to swelling of the perianal tissues due to infection or trauma*)

25. Partial or complete anal dilatation to less than 2 cm (anterior-posterior dimension), with or without stool visible. (May be a normal reflex, or may have other causes, such as severe constipation or encopresis, sedation, anesthesia, neuromuscular conditions,)
Findings commonly caused by other medical conditions

- Erythema (redness) of the vestibule, penis, scrotum or perianal tissues. (May be due to irritants, infection or trauma)
- Increased vascularity (“Dilation of existing blood vessels”) of vestibule and hymen. (May be due to local irritants, or normal pattern in the non estrogenized state)
- Labial adhesions. (May be due to irritation or rubbing)
INDETERMINATE Findings: Insufficient or conflicting data from research studies: (May require additional studies/evaluation to determine significance. These physical/laboratory findings may support a child’s clear disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure. In some cases, a report to child protective services may be indicated to further evaluate possible sexual abuse.)
Indeterminate Findings

• Insufficient or conflicting data from research studies
  – May require additional studies/evaluation to determine significance.
  – These physical/laboratory findings may support a child’s clear disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives not disclosure. In some cases, a report to child protective services may be indicated to further evaluate possible sexual abuse.
Physical Examination Findings

26. Deep notches or clefts in the posterior/inferior rim of hymen in pre-pubertal girls, located between 4 and 8 o’clock, in contrast to transections (see 41).

27. Deep notches or complete clefts in the hymen at 3 or 9 o’clock in adolescent girls.

28. Smooth, non-interrupted rim of hymen between 4 and 8 o’clock, which appears to be less than 1 millimeter wide, when examined in the prone knee-chest position, or using water to “float” the edge of the hymen when the child is in the supine position.

29. Wart-like lesions in the genital or anal area. (Biopsy and viral typing may be indicated in some cases if appearance is not typical of Condyloma accuminata)

30. Vesicular lesions or ulcers in the genital or anal area (viral and/or bacterial cultures, or nucleic acid amplification tests may be needed for diagnosis)

31. Marked, immediate anal dilation to an anterior-posterior diameter of 2 cm or more, in the absence of other predisposing factors.

Lesions with etiology confirmed: Indeterminate specificity for sexual transmission (Report to protective services recommended by AAP Guidelines unless perinatal or horizontal transmission is considered likely)

31. Genital or anal Condyloma accuminata in child, in the absence of other indicators of abuse.2,4,35,36

32. Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse.2,4,35 Findings Diagnostic of Trauma and/or Sexual contact (The following findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless the child and/or caretaker provide a clear, timely, plausible description of accidental injury. (It is recommended that diagnostic quality photo-documentation of the examination findings be obtained and reviewed by an experienced medical provider, before concluding that they represent acute or healed trauma. Follow-up examinations are also recommended.)

Findings Diagnostic of Trauma and/or Sexual contact (The following findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless the child and/or caretaker provide a clear, timely, plausible description of accidental injury. (It is recommended that diagnostic quality photo-documentation of the examination findings be obtained and reviewed by an experienced medical provider, before concluding that they represent acute or healed trauma. Follow-up examinations are also recommended.)
Physical Examination Findings

- Deep notches or clefts in the posterior/inferior rim of hymen in pre-pubertal girls, located between 4 and 8 o’clock, in contrast to transections (see 41)
- Deep notches or complete clefts in the hymen at 3 or 9 o’clock in adolescent girls
- Smooth, non-interrupted rim of hymen between 4 and 8 o’clock, which appears to be less than 1 millimeter wide, when examined....
Acute trauma to external genital/anal tissues
33. Acute lacerations or extensive bruising of labia, penis, scrotum, perianal tissues, or perineum (May be from unwitnessed accidental trauma, or from physical or sexual abuse)

34. Fresh laceration of the posterior fourchette, not involving the hymen. (Must be differentiated from dehisced labial adhesion or failure of midline fusion. May also be caused by accidental injury or consensual sexual intercourse in adolescents)

Residual (healing) injuries (These findings are difficult to assess unless an acute injury was previously documented at the same location)

36. Perianal scar (Rare, may be due to other medical conditions such as Crohn’s Disease, accidental injuries, or previous medical Procedures)

37. Scar of posterior fourchette or fossa. (Pale areas in the midline may also be due to linea vestibularis or labial adhesions)
Injuries indicative of blunt force penetrating trauma (or from abdominal/pelvic compression injury if such history is given)

38. Laceration (tear, partial or complete) of the hymen, acute.
39. Ecchymosis (bruising) on the hymen (in the absence of a known infectious process or coagulopathy).
40. Perianal lacerations extending deep to the external anal sphincter (not to be confused with partial failure of midline fusion)
41. Hymenal transection (healed). An area between 4 and 8 o’clock on the rim of the hymen where it appears to have been torn through, to or nearly to the base, so there appears to be virtually no hymenal tissue remaining at that location.

This must be confirmed using additional examination techniques such as a swab, prone knee-chest position or Foley catheter balloon (in adolescents), or prone-knee chest position or water to float the edge of the hymen (in prepubertal girls). This finding has also been referred to as a “complete cleft” in sexually active adolescents and young adult women.

42. Missing segment of hymenal tissue. Area in the posterior (inferior) half of the hymen, wider than a transection, with an absence of hymenal tissue extending to the base of the hymen, which is confirmed using additional positions/methods as described above.
Presence of infection confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature:

43. Positive confirmed culture for gonorrhea, from genital area, anus, throat, in a child outside the neonatal period.
44. Confirmed diagnosis of syphilis, if perinatal transmission is ruled out.
45. Trichomonas vaginalis infection in a child older than 1 year of age, with organisms identified by culture or in vaginal secretions by wet mounts examination by an experienced technician or clinician)
46. Positive culture from genital or anal tissues for Chlamydia, if child is older than 3 years at time of diagnosis, and specimen was tested using cell culture or comparable method approved by the Centers for Disease Control.
47. Positive serology for HIV, if perinatal transmission, transmission from blood products, and needle contamination has been ruled out.

Diagnostic of sexual contact

48. Pregnancy
49. Sperm identified in specimens taken directly from a child’s body.
Medical Testimony

• “It is the obligation of the health care provider to formulate an opinion that is supported by science with an understanding of the limitations of what can and cannot be said with certainty.

• In the courtroom, the health care provider’s role is to clearly explain and articulate the clinical and scientific issues involved in a given case, and provide medical testimony that is accurate and objective.” page 170