FATAL NEGLECT

—by Donna Rosenberg

Parents have a duty to their children. When a parent omits to carry out that duty and the child dies as a result, the child is said to have died in circumstances of fatal neglect. Obviously, parents cannot prevent all fatal events that might befall their children and they are not legally held to a standard of perfect care. Rather, most laws hold parents to the standard of a "reasonable" or "prudent" parent. The law does not explicitly define what constitutes a reasonable or prudent parent; that definition, presumably, is the consensus opinion of the community, as variously represented by the schools, doctors, social services, a civil court judge, or a jury of the parents' peers.

Obviously, parents cannot prevent all fatal events that might befall their children and they are not legally held to a standard of perfect care. Rather, most laws hold parents to the standard of a "reasonable" or "prudent" parent.

What precisely are parental duties? (Throughout, I refer to "parental duty," but the duty applies equally to any person or agency that is *in loco parentis*.) The duties are to provide, supervise, and to intervene; the failure to fulfill any of these duties may result in a child's death. Each of these forms of fatal neglect is definable and will be discussed below. Space does not permit a discussion here of investigative strategies, but the reader should be aware that such strategies exist for each category of fatal neglect. If logically undertaken, these investigative strategies will maximize the amount and quality of evidence gathered, whether for civil or criminal court purposes.

Failure to Provide

Children might die because their parents fail to provide one or more essentials for survival: food, fluid, and medical care.

Failure to provide food

Failure to provide food results in acute starvation and/or failure to thrive. Acute starvation is the result of lack of food on a short-term basis. The child might not appear malnourished. Failure to thrive is the condition in which the child fails to gain weight as expected for normal growth. When failure to thrive is the result of inadequate nutrition combined with emotional deprivation, it is called non-organic failure to thrive. The child appears profoundly malnourished and emaciated. Because non-organic failure to thrive is a serious form of neglect, often accompanied by other neglect or abuse, a child so afflicted is at heightened risk of death. He or she might die of failure to thrive itself, with failure to thrive but of some other cause to which the malnourishment has made him peculiarly susceptible, or having at one time had failure to thrive.

The diagnostic criteria for non-organic failure to thrive in a deceased child are:

(1) Low weight for age.

(2) Height and head circumference usually normal, though occasionally also decreased.

(3) Low total body protein and fat stores (as measured by mid-arm circumference and triceps skin fold thickness).

(4) Thinness and emaciation evident on visualization and palpation.

(5) Absence of an organic disease that would fully account for the failure to thrive.

Apart from the medical records review that must obviously be done, it is especially important that several medical findings be sought at postmortem examination. • Is there evidence of abuse—bruises, broken bones, head injury, burns, sexual abuse, etc ? A skeletal survey must be done. A rape kit may be indicated. How much food is there in the gastrointestinal tract? What is its location? What is the child's weight at death? How does this weight compare with the expected weight for age? Are there other findings at autopsy that suggest longstanding nutritional neglect, such as edema, effusions, atrophy of muscles or organs, or swelling or ulcerations of the intestinal wall? What are the results of the toxicology tests performed on blood, urine, or vitreous to detect any drugs, toxins or poisons? What are the child's electrolytes, specifically the sodium, chloride, and urea nitrogen, which may give an indication of the child's hydration status?

The pathologist should be asked the following questions: Can you approximate how long the child had been without food? Can you tell the approximate time of death? Based upon what criteria? Finally, some children with severe failure to thrive are so malnourished that they succumb to minor infections because they have little immune resistance. If this is the case, ask the pathologist if the child would have died of the immediate cause of death (e.g., viral pneumonitis) if the underlying condition (failure to thrive) did not exist.

Failure to provide fluids

Failure to provide fluids results in dehydration. Dehydration occurs when there is insufficient quantity of fluid in the body to maintain normal physiologic functioning. There are many disease-driven causes of dehydration. However, in cases of child neglect, the most common ways a child becomes dehydrated are as punishment for a toileting accident or some other perceived offense, or from traveling or staying for long periods in arid country with insufficient fluids.

The diagnostic criteria for failure to provide fluids include: dry eyes, dry mouth, tenting of the skin, vascular collapse, and thromboses (blood vessel clots). Other disorders must be excluded as the cause of these findings. Postmortem sodium, chloride, and urea nitrogen drawn from the vitreous may help characterize the dehydrating events prior to death.

Failure to provide medical care

Medical care neglect occurs when parents do

continued on next page

Fatal Neglect

continued from page 38

not make certain that their child is receiving the medical care he or she needs. Obviously, there is a spectrum of seriousness as to the consequences of failing to seek medical care for the child. Some parents fail to seek medical care for their children because of their own religious beliefs. The American Academy of Pediatrics has strongly eschewed this practice. Other parents have abused their children and fear being apprehended. Still others fail to seek medical care because of the costs, because they underestimate the severity of the problem, or because they lack judgment or motivation.

In searching the medical and autopsy records of a child who has died of a treatable medical illness that has gone insufficiently attended, four general areas should be addressed:

(1) Were the signs and symptoms of the child severe and related to the underlying illness?

(2) Were any prescribed drug levels decreased in the child?

(3) Were there increased toxic metabolites in the child as a result of the disease going unchecked over an acute period of time, usually hours to days?

(4) Is there physical evidence of chronic failure to give medical care over weeks to months?

Failure to intervene exists when one parent watches another adult abuse or neglect a child and could, but does not, intercede to protect the child at the time.

Few fatal illnesses will yield data in all four categories, but all illnesses should yield data in at least one. In assessing whether medical neglect existed, the following questions should be asked of the pediatrician and the forensic pathologist:

(1) What were the potential benefits of medical care?

(2) What were the potential risks of medical care?

(3) What was the expected outcome in the child without the medical treatment? Did the parent know, or should the parent have known, about the probable outcome?

(4) What was the likely tempo of the illness? How obvious would the symptoms of the illness have been?

(5) What was the parent's track record, over time, in getting needed medical care for the child?

(6) Was the child's death causally and specifically related to the parental omission, or were there other factors that contributed to the child's death?

Failure To Supervise

Supervision neglect is the failure to provide attendance, guidance and protection to children who, lacking experience and knowledge, cannot comprehend or anticipate dangerous situations. The parent may be in the home but impaired, as a result of drugs, alcohol, mental illness, physical illness, immaturity, or low intelligence. On the other hand, the parent may be out of the home and the chosen baby sitter may be obviously inadequate for any of the above reasons or because the baby sitter is known to be physically or sexually abusive. The oldest child might be left to care for the younger siblings, but not capable of adequately supervising them. The types of fatal incidents most likely to be associated with supervision neglect are fire (resulting in smoke inhalation and/or burns), falls, drownings, poisonings, and ingestions. When children are left unattended in cars and other places, hypothermia, hyperthermia, dehydration, kidnap, or assault may result.

Since none of the above examples in and of itself constitutes supervision neglect, one must make a careful inventory of the context in which the child's death occurred. Both for civil court (protection of surviving children) and criminal court purposes, the following questions are useful:

(1) What was the age and developmental stage of the child? (These might not be the same. A seven-year-old might only have the developmental capability of a three-year-old.)

(2) Over what period of time was the child unsupervised?

(3) What were the circumstances in which the child was unsupervised? What was the potential hazard? How obvious was it?

(4) What was the physical and mental condition of the parent?

(5) Was there a history of chronic supervision neglect?

(6) What is the acceptability of the parental behavior within his or her own ethnic group? Does this group promote or condone a duty that is less stringent than that of the general community?

(7) If the parents are poor, was the supervision neglect causally or coincidentally related to the coexisting poverty?

Failure To Intervene

Failure to intervene exists when one parent watches another adult abuse or neglect a child and could, but does not, intercede to protect the child at the time. Failure to intervene is also seen when one parent could, but does not, seek medical care for a child who has been abused or neglected by another adult.

Sometimes, a battered woman realistically fears her own torture or murder if she intercedes on the child's behalf. In other instances, the history of being battered is manufactured or grossly exaggerated and is devised to minimize her duty and, therefore, her culpability. Parents might also fail to intervene because they fear arrest, or they might claim that the child did not appear ill or injured. Every illness or injury has its usual tempo, or rate

continued on next page

Fatal Neglect

continued from page 39

of progression. Furthermore, most children with a given illness or injury demonstrate particular symptoms and signs. Therefore, the physician should be asked: What is the usual tempo of this injury? Would the child have had visible or audible signs of illness? What would they have been? When would they have occurred?

The distinction must be made between neglect unavoidably caused by financial poverty, and the neglect which coexists with poverty but which is not caused by it.

Neglect and Poverty

Poverty may be causal or coincidental in a neglectful family. The distinction must be made between neglect unavoidably caused by financial poverty, and the neglect which coexists with poverty but which is not caused by it. Certain forms of fatal neglect commonly exist with poverty but are not caused by it:

(1) Failure to feed or hydrate the child adequately, though food and fluids are provided or available.

(2) Chronic and/or egregious failure to supervise the child.

(3) Failure to ensure that the child is receiving appropriate medical care, though that care is affordable or free, and accessible.

Intervention

When a child has died in circumstances of fatal neglect, the most important consideration is the future protection of surviving children in the family. Almost always, whether or not there is a formal record of it, the other children in the family are seriously neglected, sometimes abused. When parents chronically and severely neglect their children, the outlook for their becoming even minimally adequate parents in a timely enough way to benefit the children is dim. Mere compliance with a "treatment program" does not reliably measure parental improvement. The fact that we have inflicted a good treatment program upon a family does not mean they have benefited. Child safety should be realistically, not idealistically, evaluated and must not be sacrificed to wholesale efforts to preserve families.

References

Cantwell, H. (1988). Neglect. In D.C. Bross, R.D. Krugman, M.R. Lenherr, D.A. Rosenberg, and B.D. Schmitt (Eds.), *The new child protection team handbook* (pp. 102-112). New York: Garland Press.

DiMaio, D.J., and DiMaio, V.J.M. (1989). *Forensic pathology*. New York: Elsevier.

Dubowitz, H., and Black, M. (1994). Child neglect. In R.M. Reece (Ed.), *Child abuse: Medical diagnosis and management* (pp. 279-297). Philadelphia: Lea & Febiger.

Helfer, R.E. (1987). The litany of the smoldering neglect of children. In R.E. Helfer and R.S. Kempe (Eds.), *The battered child* (pp. 301-311). Chicago: University of Chicago Press.

Peterson, L., Ewigman, B., and Kivlahan, C. (1993). Judgements regarding appropriate child supervision to prevent injury: The role of environmental risk and child age. *Child Development, 64*, 934-950.

Rosenberg, D., and Cantwell, H. (1993). The consequences of neglect: Individual and societal. In C.J. Hobbs and J.M. Wynne (Eds.), *Balliere's clinical paediatrics: international practice and research, 1* (pp. 185-210). London: W.B. Saunders.

Donna Rosenberg, MD, is a pediatrician at the C. Henry Kempe National Center on Child Abuse in Denver, Colorado.

SEXUAL HOMICIDE OF CHILDREN

—by Kenneth V. Lanning

To discuss and analyze a topic as emotional and complex as sexual homicide of children is not an easy task. Good, reliable research and data are hard to find. Americans tend to have stereotypical concepts about the innocence of children and the malevolence of those who victimize them. Americans also seem to find it difficult to openly and explicitly discuss even normal sexual behavior, much less deviant sexual behavior or homicide. This discussion will focus on defining terminology and evaluating the limited available data. Adding what I have learned in 14 years of professional study and investigation of the sexual victimization of children, analysis and recommendations will be set forth in what I hope will be an objective, clear, and useful manner.

Definitions

One impediment to any productive and intelligent discussion of sexual homicide of children is the lack of a uniform and consistent definition of the term. The definition problem is most acute when professionals from different disciplines come together to work or communicate. To avoid confusion, certain basic but key terms will be discussed and defined for the purposes of this discussion.

Homicide. For purposes of this discussion, homicide will be defined simply as the unlawful killing of another person. Unlawful homicide or murder can include causing the death of a person while committing another crime, and manslaughter.

Sexual. Defining "sexual" is not easy. Is "sexual" a function of motivation or of specific acts performed? Some would argue that a sexual homicide is one motivated by sexual gratification. But how does an investigator determine motivation? Can a crime or homicide have more than one motivation? If there are multiple offenders, whose motivation defines the crime? Can we even determine motivation from the offender?

Looking solely at the nature of the acts performed does not make matters much easier, however. A sexual act for one person (e.g., certain paraphilias) might not be a sexual act for others, and might not even be illegal. For some individuals, the act of killing itself brings sexual arousal and/or gratification. Seemingly nonsexual behavior (e.g., stabbing, shooting, killing, etc.) can be in the service of sexual needs. Seemingly sexual behavior can be in the service of nonsexual needs (e.g., power, anger, etc.). Unfortunately, in homicide cases, the primary criteria most often used by investigators and prosecutors in determining sexual assault are body orifice penetration and presence of

continued on next page