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## Child Abuse Evidence: New Perspectives from Law, Medicine, Psychology & Statistics: Question and Answer Session

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## QUESTION & ANSWER SESSION

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Moderated by Professor Kimberly Thomas

- KT<sup>1</sup>: This is the portion where we're going to have all of our panelists from this morning, Patrick Barnes, Richard Leo, Keith Maddox, and Sam Sommers, available for questions. We've heard a number of thoughtful and provocative ideas and received a lot of information and so we're really inviting you to ask questions.
- AM<sup>2</sup>: My question is for Professors Maddox and Sommers. Do you have all your studies controlled for laterality [meaning dominance of one side of the brain in controlling the person's response]?
- KM<sup>3</sup>: In the studies that we do in the laboratory, using this particular task, then, yes. We control for whether the response for the black or the white or the positive or negative is on the left or right side, if that's what you're getting at. That's counterbalance, meaning that it's varied across conditions. So that what you'll do is you average. So if there is an effect of laterality, it's possible it's there. But when you average across everyone who does it, you can mitigate that effect and see what the remaining effect is based on the stimulative and manipulative.
- SS<sup>4</sup>: What you notice is that when we do this with groups, no one ever has trouble the first time white and black switch sides. What's troubling for people, what's difficult for people, is the precise combination of black-pleasant/white-unpleasant. It feels like it's order and it feels like it's the background colors, and it feels like it's the side that it's on. But if you go online, I think Keith showed the website, I think 80 million people have taken the test that we just did in this room today. They vary the sides, they counterbalance that; it turns out it's a negligible effect, if anything. Even though when I take the test, I still feel like it's the order.

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1. KT: Kimberly Thomas, Moderator and Clinical Professor of Law, University of Michigan Law School
  2. AM: Audience Member
  3. KM: Keith Maddox, Associate Professor, Tufts University
  4. SS: Sam Sommers, Associate Professor, Tufts University

AM: Very often the police will attend an autopsy. My question has to do with introducing bias in a person who's just about to do a scientific investigation. Should that be prevented? How much an effect might that have?

KM: In terms of the policemen being there during the autopsy, the assumption is that that person is going to have conversation or make comments or remarks that might imply their ideas about what may have happened to the forensic pathologist and then that might bias the person doing the autopsy to kind of look through it with a confirmatory lens as opposed to a more objective lens.

I would agree that, yeah, that would clearly be a source of bias. The idea would be to try to mitigate that. So if the police officer needs to observe, maybe observing from another room without the opportunity to have contact with the person doing the autopsy. Anything to mitigate the kinds of assumptions that that person is making in transferring them to another person would be extremely helpful.

SS: I'll defer to Professor Leo who can speak more specifically to questions of interrogation and so forth. But police investigations are not scientific endeavors. They're not experiments, they're not research based. They're not always purely hypothesis-testing either. Once an idea is in mind, then, often the mentality is "Let's find evidence that will corroborate that." We teach our students early on in research methods that you're supposed to be falsifying hypotheses as well as validating them. And the best investigators would do that.

But there are aspects of the legal investigative process that clearly would benefit from greater attention to preventing these kinds of confirmatory biases. In the eyewitness world, for example, it's very clear that the person who's administering that lineup should be blind as to who they suspect may or may not be, and that prevents any untoward contamination of what a witness might do and so forth. But I think the way police investigation is typically done, it's not a blind endeavor. It is a get-as-much-information-here-as-we-can and then the ball starts to roll from there.

KT: Either of you want to address that?

RL<sup>5</sup>: Well, I have mixed feelings. I want, on the one hand, the police to know the facts. I want them to do a good investigation. I'd want them to know what the autopsy shows. One of the problems in one of the cases that I mentioned—the Adrian Thomas case—is that they didn't pay attention to a lack of a fractured skull but assumed that there must have been one. So because of the misclassification error, I want law enforcement to do better investigation. On the other hand, as Kimberly mentioned, there's the problem of contamination and the feeding effects. And police realize this, because they talk in their manuals—they don't agree with researchers on coercion, promises, or threats. The trailer I would have shown on the Adrian Thomas case, one of the cops says, "Ten hour interrogation to get somebody to tell the truth—there's no problem with that." They don't agree about coercion but they do agree about contamination. They talk about holding back, not feeding. I want them to do a better job not contaminating.

And then finally, there's this issue mentioned by Sam of confirmation bias. Sometimes we talk about it in criminology as tunnel vision, and there have been suggestions that might be internal units of people who aren't part of the investigation but are tasked with challenging the investigators, so that they break that mindset of "we know what happened."

The idea of blinding, which is talked a lot about, I think works better in eyewitness. Sam mentioned that. I'm not sure it works as well in interrogation and confessions.

AM: I'm not particularly worried about the biasing of the detective. I'm more worried about the biasing of the pathologist doing the autopsy.

KM: If you can't mitigate the potential contamination that happens in that context, then you might want to think about the practice of those individuals conducting the autopsy to try to make them aware of the possibility that they've been biased and to make sure that they go through a process of not just confirmation but also potential dis-confirmation of the hypothesis.

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5. RL: Richard Leo, Professor of Law and Social Psychology, University of San Francisco

AM: This question is for Dr. Barnes. Before signing out a case as child abuse, do you negate the ten or twelve other possibilities that you listed?

PB<sup>6</sup>: It's really not that simple. I see the emerging standard is, the debate between differential diagnosis and differential etiology. What we run into is often we don't do enough proper testing to rule out the other potential causes. We get an opinion from whoever in a position of authority: "I really don't think it's a bleeding or clotting disorder, so I'm not going to test for it," or "I'll do the screening studies," which we know will miss them.

That's part of the problem with bias—how do we get a complete medical workup? So what I find out in the cases that we do that come through the hospital, we'll talk about all of that as part of our child abuse team and hopefully get that done. A lot of cases I review from different jurisdictions, like the one I spent ten hours in court on Wednesday before I came out here, the workup was absolutely inadequate. They didn't work up or evaluate any of the potential mimics, number one. Number two, there were findings present like a couple of cases I showed you where these collections were clearly old and went back to birth. No one goes back and does a thorough evaluation of the medical records from the birth, which they should go back and do.

Or a child, like the one that I testified about on Wednesday, who was brought to the doctor three times during the first four months of its life, who was sick, and no one did any imaging when the head circumference was huge. That means there's increased pressure above brain growth to show these collections. In a third presentation, the baby crashed.

This is the kind of problem that I see out in other jurisdictions and how they happened. If they come to a major children's hospital right off the bat, they have a better chance of getting a complete work-up. So that's part of the disparity.

So, yeah, we have a differential diagnosis; we try to deal with it, make sure we do the right things as part of that parallel workup. That doesn't go on everywhere. It's not uniform standard practice in smaller community hospitals. You

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6. PB: Dr. Patrick Barnes, Professor of Pediatric Neuroradiology, Stanford University Medical Center

may find it at the major medical centers, or at the particular the children's hospitals.

AM: When the medical staff in a smaller community with no multidisciplinary team is alleging child abuse, is there any mechanism earlier on in the process before there's a prosecution that a multidisciplinary team can be brought in that you're aware of?

PB: Well, we haven't been very successful with that in the state of California, unless the child is referred to our hospital. What we wanted was to become a center, to be able to review these cases early on, and help the local physicians with it. That's not happening as often as we like.

AM: Hi. I'm a criminal defense attorney. I've only been doing this about fifteen years. There's a lot more of experienced people in the room than I am. But I think the bias that I see more often is a mom charged with child abuse or killing a child, versus a dad or a boyfriend charged with this kind of thing. I know with the mom, she's less likely to go to trial, more likely to get a better plea agreement, and less likely for the police to land on her hard. I know with the man or the boyfriend, he's more likely to go to trial, and not going to get a very good plea offer. The police are going to go at him hard because they already think that he did it. And if I try to combat these prejudices that you're talking about in the courtroom, sometimes what we end up doing is highlighting that for three days. And so can anybody suggest to me some sort of strategy to deal with that?

SS: Certainly being aware of in front of a jury, I would share—and I'm not a litigator—I would share though your concerns that highlighting that in front of a jury could, if anything, hurt. But in dealing with the D.A., and dealing with the police, is that a place to go? I don't know. I think certainly being aware of it gives you, as an attorney, the wherewithal to at least be strategizing about the way to handle this.

PB: I have an answer to that. I don't like the cops ever being involved. For the cases that come to the emergency room that we think there may be abuse, I don't like the cops being in there, investigating whoever or what. I'd rather report it to the CPS system, maybe to the justice system, but get our social workers in there and start working on it in a

reasonable fashion. The minute you get the cops involved or I have a cop come in and want to talk to me, I have a bias. I have a problem with that. I'd like to see it decriminalized, at least from the beginning. And let's sort this out with social services, the doctors, the team, and keep the cops and the justice system or the law enforcement system out of it, period.

Now, I know that's difficult to do when you've got a dead baby. But to start every case with the cops is a problem. And that may be a bias of mine, but it biases the whole case when the doctors found out, "Well, the cops think this, and the cops think that," or, "The cops are here." That even biases the doctors.

BH7: I'm Ben Hansen. I'm one of the co-organizers here. Anna Kirkland is another member of the organizing team, and this event has to do with some of our personal experiences. We agreed in advance that we were going to try to keep the focus on a scholarship by not talking about our personal experiences. So I'm going to honor that agreement by not saying anything more about the claim that these are problems that are specific to small town hospitals, and not big hospitals with multidisciplinary teams. I'm not saying anything more than that—other than that I could not disagree more.

I will ask a question and direct a question to the speakers here. And my question stems from the fact that one part of our experience was the interview we had with the police in the children's hospital. And in the same rooms where I was comforting my daughter—she had a broken leg—I was found to be somewhat suspicious in this process. . . . One of the things that was going on for me was, after it had been revealed just a few hours before that my daughter had a broken leg and we hadn't known that, one of the things that I was thinking about was all the times I had been changing her over the past several days, and lifting up her legs unaware that she had a broken femur, and how she had called out at that moment. So in my case, I think that was probably something that contributed to this impression that he was hiding something or there was something wrong with him.

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7. Ben Hansen, Associate Professor of Statistics and Conference Organizing Committee

My question is: how could an interview like that, if it's occurring, be structured, so as to improve the record for purposes of finding out what actually happened? One of the suggestions that we forwarded on to the hospital in our case was that they start a policy of recording these interviews. To our knowledge, that policy has not been put into place. But that would be one specific suggestion that I'd be interested to hear your thoughts on.

PB: So your concern is that the police were there and that they were given access to the family to question them, maybe even before a doctor does? Or a social worker? Because I certainly object to that.

BH: In our case, the interview with the police came after conversations with doctors and more or less simultaneously with speaking to the social worker, who deferred to the police. So that's one aspect of it. How should the interview be structured, in your views?

PB: I like the idea of a family that comes in with a situation like this that we don't turn the family over to police without a social worker with him that represents the hospital. And that they are to support the family. I don't like the idea of the social worker walks out, the doctor walks out, the nurse walks out, and in come the cops. I just don't think that should happen. Period. So I think that's part of the structure.

I work with our social workers, I know they're looking for clues about where a case or something else is going. They don't seem to have an agenda, like what we hear today about what cops do.

And I think every patient that goes into a hospital—like the Mayo Clinic, for instance—you should get a person who is going to stick with you and be your advocate as you go through that system. They will never leave your side. I think it ought to be same way in that situation. They're your advocate in the hospital.

RL: I think, Ben, you're right that the recording of these interviews is very important. What you're asking reminds me of a study by Saul Kassin where he was showing how behavioral



confirmation biases were triggered by certain presumptions that the interrogators made.<sup>8</sup>

It also reminds me of stereotype threat, so my second thought after the recording of the interview or interrogation is about better training of police on behavioral confirmation biases and processes, which gets back to the misclassification point and trying to have more thorough, evenhanded investigations so that those presumptions don't set in.

I really appreciate Dr. Barnes's perspective, and I think it's a more informed one than mine, but I've seen a lot of cases where the Child Protective Services—I don't know if they were biased by the police—they were definitely part of the problem. They made rushes to judgment. So I sometimes see them as agents of the police in these investigations that go wrong.

And I also think it's vacuous to suggest, you know, "more training." That's what everyone suggests. Like at the end of academic conferences—more research. But there's something pernicious and invisible about those behavioral confirmation biases and the effects of stereotype threat that's just got to get out to the investigators, whether it's Child Protective Services or the police, to withhold judgment a little bit better.

**PB:** Yeah, and that's why I like our social workers, even the CPS people. There are parents, when these reports get out, that are reluctant to come to the hospital. When your children's hospital starts getting labeled as "don't go there because you might be accused of abuse," that becomes a bit of a problem for the hospital. That's why I think every hospital, the patient that comes in, whatever condition, you need an advocate that escorts you through the way. And that's going to cost money.

**AM:** Hi, my name is Jason Crain. I'm very happy to be here and thankful to all you guys in your work that you do. I'm a filmmaker doing a documentary about a case out of San Francisco, where a father was falsely accused of Shaken Baby Syndrome. It's interesting to hear everyone's, what to me

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8. See Saul M. Kassin, Christine C. Goldstein & Kenneth Savitsky, *Behavioral Confirmation in the Interrogation Room: On the Dangers of Presuming Guilt*, 27 L. & HUMAN BEHAVIOR 187 (2003).

feels like an assumption that larger hospitals had a multidisciplinary team at play, because that was not the experience in our case.

This happened at University of California San Francisco. There was one pediatrician who made the diagnosis of SBS and that was the trigger, that's all that was needed. So he called CPS. CPS then went to the hospitals. And after the father was interrogated by the pediatrician, he was interrogated by CPS. And what was interesting in the audio call that was recorded, the first call for the pediatrician, he said lots of very frightening things in that call. But one of the things the doctor said was, "I don't know if you want to tell the father if you've spoken to me or not." And the social worker's response was—she was in the car driving to the hospital to meet the father for the first time—she said, "Yeah, I'm not sure how I want to shake him down yet."

So I love, Dr. Barnes, that you had a positive experience with CPS. That wasn't the case here. The pediatrician was God, calling CPS, then called the police, and that's all that was required, a very minimal investigation. My question with all this longwinded buildup is, I don't understand what the incentive is in any of these domains, medical or law to prove guilt, particularly in these cases, rather than really a thorough, thoughtful investigation?

PB: Well, it's a huge inconvenience to doctors. Most doctors who run from this, they don't want anything to do with it. So they turn it over to the child abuse people. And the child abuse people, through their own intrinsic certification, have declared themselves experts in neurosurgery, neurology, endocrinology, orthopedics, and they don't need any of the rest of us. Or, instead of this multidisciplinary approach and everything, some of the specialists don't want to really be involved. And many of them don't study the literature—which, by the way, we're required to keep up with the current literature, continuing medical education. We're supposed to show it and document it so we can keep our state licenses, our practice privileges in clinics and hospital, and to maintain certification. So these people aren't reading the literature.

Some of this CME [Continuing Medical Education] would not be allowed in many medical schools or hospitals. For instance, I'm probably the only one that teaches at Stanford about the mimics of abuse because no one else really

cares. They don't want anything to do with it. That's part of the problem. It's a bias that it's going to take another generation, the next generation, the younger generation, that's more open, less biased.

AM: I'll just comment real quick. I'm a pediatrician and a physician. I think some of the bias comes from fear, I think as physicians, some of these cases are the most difficult that we see. We see children injured or in the worst case, a child who's died. Many of us have children. This is something that we don't want to believe could ever happen to us or to our own children. So I think the bias can come from a need to protect, a need to say this happens to other types of people. And so this happened to this family because this person is a bad person. That person's not like me. And so we create these biases to protect, as a society, to protect ourselves from having to face the reality that actually sometimes horrific things happen to good people.

PB: And what this stems from is the major criticism of our so-called healthcare system. It is not a healthcare system. It is chasing disease. We chase disease. We're not into preventive medicine, we're not into health, we're not into the environment, we're not educating our 18- and 19-year-old mixed cultural families to take a preemie home and how to take care of it. We would rather react to a problem than try to prevent it. And we need to spend more money instead of on big pharmaceutical companies and devices where all the money is in medicine and shift it to health and prevention. Until we do that, we're going to continue to be reactive in medicine, just like we are, in the law enforcement and in the justice system. It's all reactive.

AM: Dr. Barnes, I just want to say, it's been a pleasure working with you on cases. But I have to disagree with your comment about CPS workers. CPS workers are there, allegedly, for the child. Police are there, in my experience, is to prosecute. Truly the only advocate, a parent, who brings in a sick or injured child's going to have is if they have an attorney. And the only way they know that is if information is given out to them and the public becomes more aware of what happens. Part of the problem is, you know, my neighbor across the street was just going through medical school. He's still taught today subdural hematomas, retinal hemorrhages are Shaken Baby Syndrome, and we know that's not the science.

So when they're being taught that today, that's what they're showing the CPS workers, that's what they're telling the police. They don't look at differential diagnosis and they jump to conclusions.

PB: That's correct. When I started presenting this in 2006–07, some of this research I did at national meetings, particularly for the Society for Pediatric Radiology, which works closely with the American Academy of Pediatrics, pushing child protection advocacy, which is good. So I presented at a meeting one year . . . that there are some other causes. Well, some very conscientious people in that society came forward and said, "You know, this is important. We would like for you to be the national chair of our child abuse task force for the next year. And let's start working on this." These were the pediatric radiologists.

Within a few weeks, advocates from all other sources started putting the pressure on the Society for Pediatric Radiology, much of it from child abuse pediatricians, from the American Academy of Pediatrics. And I was asked to only serve a year after that. After submitting paper after paper, suddenly, not even reviewing papers and commentaries anymore, to being destroyed in public at a national meeting, my wife and I sitting there with all of our colleagues in the Society for Pediatric Radiology, a meeting primarily run by the American Academy of Pediatrics and their child abuse pediatricians, who in front of us, destroyed my wife and myself, over the rickets issue [a softening and weakening of bones as a result of a Vitamin D deficiency, which can simulate child abuse fractures], when we thought we were doing a service as child protection people.

You know, in these cases, there's some neglect, there's some abuse, and they have medical conditions. We're responsible for the entire patient, for the entire child. That's what's expected out of medicine, just like it is the airline industry—we expect a hundred percent safety record in the airline industry. We should have the same thing in the so-called healthcare industry. But we don't. So these are the ideological factions that we deal with. And some people have a different view of child protection and others of us have another view of child protection, spread across all these disciplines that are involved.

So what attracts people? What attracts people to be child abuse pediatricians, to be CPS people? Or in law enforcement, that want to go after caretakers, families, break up families? And within a system where you have plea bargaining, a system where you have intimidation in law enforcement and the justice system. Every time I get involved, I feel intimidated, although I respect the system.

KT: Thank you very much. We want to thank our presenters from this morning. Thank you.