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SC SUPREME COURT

THE STATE OF SOUTH CAROLINA

In The Supreme Court

CERTIORARI TO THE COURT OF APPEALS

Appeal from Spartanburg County
Court of Common Pleas

J. Derham Cole, Post-Conviction Relief Judge

Farid A. Mangal, #320609

Respondent,

v.

State of South Carolina,

Petitioner.

BRIEF AS AMICI CURIAE IN SUPPORT OF PETITIONER, STATE OF SOUTH CAROLINA SUBMITTED BY

SOUTH CAROLINA NETWORK OF CHILDREN'S ADVOCACY CENTERS AND UNIVERSITY OF SOUTH CAROLINA CHILDREN'S LAW CENTER

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INTRODUCTION

This brief Amici Curiae is filed by child advocates in support of the State's appeal of the reversal of the PCR judge's finding that counsel was not ineffective. It is Amici's firm belief that the Decision below will have a chilling effect on physicians' ability to diagnose and testify in child abuse cases and in other types of litigation; and will further discourage pediatricians from seeking the Child Abuse Pediatrician specialty board certification. Moreover, the decision is unclear and confusing, effectively silencing the few children who have finally mustered the courage to speak against their abusers. For these reasons, explained more fully below, Amici respectfully request this Court reverse the Court of Appeals' decision below.

INTEREST OF AMICI CURIAE

The legal issues presented by Mr. Mangal's conviction should not be decided without an appreciation of the disastrous unintended consequences of the underlying Decision. Amici represent child advocates and child maltreatment scholars with a keen understanding of the State's child abuse response system and realities of child victimization in South Carolina. Amici have watched as children's rights have been systematically eroded by our appellate Courts, making the most difficult cases to try nearly insurmountable for prosecutors. First, the Courts chipped away at the scope of forensic interviewer testimony to the point these experts in child abuse assessment can offer nothing to aid the trier of fact to understand the complex dynamics of child sexual abuse. Now, the Decision below extends that line of cases to physicians, unjustifiably muzzling the last voice for children on the witness stand. This dangerous precedent brings many irreparable negative consequences on the scope of medical expert testimony in all cases.

STATEMENT OF CASE

Farid Mangal ("Respondent") stood trial in March 2007, on charges of criminal sexual conduct with a minor, first degree; criminal sexual conduct with a minor, second degree; lewd act on a minor; and incest. The State offered expert testimony of Dr. Nancy Henderson, a Child Abuse Pediatrician who examined the victim. Dr. Henderson testified she observed a "narrowing [of the hymenal tissue] consistent with penetration." She went on opine that, "Based on the history the victim shared with me and based on my examination, I felt that it was consistent with a, that she had been abused." At the PCR hearing, Respondent's trial counsel testified he had fully expected this testimony from Dr. Henderson and was prepared to counter it with his own medical expert and the victim's medical records.

On cross-examination, Respondent's trial counsel probed further into Dr. Henderson's opinion, asking her to elaborate about the history she took from the victim and directly asking her if she assumed what the victim told her was true. At the PCR hearing, PCR counsel did not question trial counsel about the trial strategy he was employing with this cross-examination. Even without that critical information, the Court of Appeals seized on the comments elicited on cross-examination as combining with her opinion on direct examination to conclude Dr. Henderson believed the victim was truthful. The Court stated, "Dr. Henderson's testimony was improper bolstering, and trial counsel was deficient for failing to object to it or otherwise bring it to the trial court's attention."

ARGUMENT

I. The Decision below will have a chilling effect on physicians' ability to diagnose and testify in child abuse cases and in other types of litigation.

Physicians rely on the histories they receive from patients to inform their clinical

judgment. Here, Dr. Henderson did not share the history the victim relayed to her or indicate who the victim named as the perpetrator, if anyone; she merely mentioned the history was part of the basis for her medical diagnosis of sexual abuse. "Child sexual abuse" is the actual medical diagnosis used by a board certified child abuse pediatrician after the child is given a full forensic medical exam. The child abuse pediatrician must identify and document on the medical form the appropriate code fitting the diagnosis for that particular child after the exam. Child abuse pediatricians use the "SCCAMRS Child Abuse and Medical Neglect Encounter Form," a tool for evaluating and medically diagnosing the child. (See attached Exhibit A.) The medical providers are professionally and ethically required to follow this procedure and identify their conclusions on this form. The abuse diagnosis codes on this form include, "child sexual abuse, confirmed", "child sexual abuse, suspected", "child physical abuse, confirmed", and "child physical abuse, suspected", etc. (See attachment A.) The second page contains diagnosis codes for disease/injury/symptoms, including but not limited to the presence of a sexually transmitted disease, contusions, lacerations, bite marks, burns, etc. (See attachment A.)

The Court of Appeals stated, "[i]t was proper for her to opine that based on her examination, Victim's injuries were consistent with sexual abuse." It was Dr. Henderson's mention of having taken a history—with no mention of what that history was—made just prior to the opinion on sexual abuse the Court found problematic, when combined with her elaborating testimony elicited on cross-examination. If her report was entered into evidence or if she read from the history provided by the victim, then it would have been improper as previously ruled by this court in State v. Jennings, 394 S.C. 473, 716 S.E.2d 91, (2011). However, Dr. Henderson properly testified as to her medical diagnosis of the victim and not to the veracity or credibility of the child.

Every juror who has been to the doctor knows the doctor takes a history from the patient, often in the form of a stack of paperwork replete with HIPAA-compliant forms. To find Dr. Henderson's comment about taking a history—in and of itself—to be outcome-determinative is illogical. Thus, the Court of Appeals certainly relied on the elaborating testimony elicited on cross-examination in concluding the testimony was impermissible bolstering and sufficient to satisfy the prejudice prong of Strickland v. Washington, 466 U.S. 668 (1984).

Moreover, the dangerous consequence of the Court of Appeals' Decision is that child abuse pediatricians will be crippled in giving expert opinions about diagnoses in child sexual abuse cases. While the Court of Appeals held in one paragraph the diagnosis of sexual abuse was proper, it went on to apply precedent that would prohibit physicians from testifying about diagnoses. The Court cited State v. Chavis, 412 S.C. 101, 109, 771 S.E.2d 336, 340 (2015), for the proposition that a forensic interviewer's recommendation the child stay away from the defendant was enough to convey to the jury the interviewer believed the victim's abuse claims and, thus, improper.

Applying Chavis to the case at bar prohibits medical experts from testifying about diagnoses because all are based, at least in part, on patient histories. Furthermore, allowing medical experts to rely on history given by his/her patient is not only a key requirement within the medical profession, but it is also a legally accepted exception to the rules of hearsay. The well-established hearsay exception adopted by our state from the Federal Rules of Evidence, Rule 803(4) "Statements for Purposes of Medical Diagnosis and Treatment" is clearly rooted in the law. The justification behind this exception is that a patient will provide truthful information to his medical provider to achieve proper treatment. Credibility is a concern in every case; however, applying the rules of evidence and the ability of medical experts to opine regarding a

diagnosis *differently* because it is a child sexual abuse case is a slippery slope, and the resulting harm to these vulnerable victims is huge.

Recently the U.S. Department of Justice issued a report regarding the pediatric forensic medical exam. The purpose was to provide a national protocol which is evidence based and trauma informed. The protocol includes a piece regarding recommendations for medical providers related to the medical history. First of all, it is considered a critical component of the medical forensic care of the child. The protocol confirms that gathering this history "guides the examination, formulation of a diagnosis, treatment and other health care interventions." *See*, U.S. Dept. of Justice Office on Violence Against Women, A National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric, April 2016, page 121. The protocol report then emphasizes the need to keep the medical history gathered during the forensic medical exam and the forensic interview separate in order to avoid any "rule confusion" that would "impede the medical provider's ability to testify under the medical exception to the hearsay rule." *Id.* at 122

II. The Decision below will discourage pediatricians from seeking the Child Abuse Pediatrician subspecialty certification, perpetuating the shortage of Child Abuse Pediatricians in South Carolina.

In 2006, the American Board of Pediatrics approved Child Abuse Pediatrics as a new subspecialty. Child Abuse Pediatrics addresses the comprehensive medical assessment and diagnosis of child maltreatment. To be certified, a physician must have first completed an accredited residency program in General Pediatrics followed by a two-year or three-year subspecialty fellowship in child abuse pediatrics; or be certified by proof of practice experience.

"A number of studies indicate that more experienced medical examiners and those with child sexual abuse assessment experience provide higher quality and more consistent decision-

making than those with less experience, pediatricians or family practice residents." W.A. Walsh et al, Which Sexual Abuse Victims Receive a Forensic Medical Examination? The Impact of Children's Advocacy Centers, Child Abuse & Neglect 31, 1053, 1054-1055 (2007). "Forensic examiners need to know how to conduct a specialized exam, including using a colposcope (which provides magnification and photographic documentation); distinguish signs of child sexual abuse from normal anatomical variation or other conditions; preserve and report medical evidence; work with law enforcement and child protective services, and serve as an expert witness in court, if necessary." Id.

Unfortunately, only eight child abuse pediatricians serve South Carolina's children. The result is that many suspected child abuse victims in the state do not receive the highest level of care. Amici know anecdotally that pediatricians are hesitant to enter the subspecialty because of the widespread belief our courts are unfriendly toward medical experts testifying on behalf of children. The Decision below certainly supports that notion.

South Carolina clearly recognized the importance of implementing best practices in our state for response to child abuse/maltreatment. The legislature responded by codifying the Children's Advocacy Centers (CAC) under S.C. Code Section 63-11-310 in 2008 and S.C. Children's Advocacy Medical Response System (SCCAMRS) S.C. Code Section 63-11-400 in 2014. Both statutes were designed to timely respond to child abuse reports, provide a thorough examination of the child in one child-friendly environment, document and maintain all the information gathered, and submit it to the investigative agencies. The South Carolina Department of Social Services annual reports show that approximately 12,700 children per year would have benefited from a medical examination by a board certified child abuse pediatrician. Unfortunately, the data from SCCAMRS shows that roughly 30% of those children's medical

needs are being met. The SCCAMRS network of child abuse pediatricians and medical providers are able to see an average of 3,100 children per year for a total of 3,400 medical evaluations. This is a serious shortfall and results in the remaining 70% of children with indicated cases of abuse/maltreatment not receiving appropriate medical care. Abused children should have no further impediments to getting these critical medical examinations.

The impact of the Decision below for these particular child victims will be truly devastating. Child sexual abuse does not happen in front of witnesses; therefore, we must rely heavily on evidence and the experts who can explain the evidence, or lack thereof. If we further limit a child abuse pediatrician from giving a medically recognized diagnosis, our most vulnerable children will be left without a voice and without recourse against the perpetrator.

CONCLUSION

Accordingly, amici respectfully request this Court reverse the lower court's ruling.

Respectfully submitted,

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By: ____________________
Counsel for Amici Curiae South Carolina Network of Children's Advocacy Centers and University of South Carolina Children's Law Center

Exhibit A

Facility Logo Facility Address Facility Telephone Facility Fax Facility Tax ID

SOUTH CAROLINA Children's Advocacy Medical Response System

SCCAMRS Child Abuse and Neglect Encounter Form

Child's Name (last, first, MI)		
Address (street, city, state, zip code)		
Date of Birth ___/___/_____ MM DD YYYY	**Sex** ☐ Male ☐ Female	**Date of Evaluation** ___/___/_____ MM DD YYYY
Healthcare Provider		**NPI #**
Facility (Services Provided At)		
Referring Agency/Healthcare Provider		

Service Nature	Initial Outpatient Consult	New Patient Office Visit	Follow-up Outpatient Visit	Initial Inpatient Consult	Subsequent Hospital Care (Per day)
Focused H&P Complexity	☐ 99241 *5 min*	☐ 99201 *10 min*	☐ 99211 *5 min*	☐ 99251 *20 min*	☐ 99231 *15 min*
Expanded H&P Low Complexity	☐ 99242 *30 min*	☐ 99202 *20 min*	☐ 99212 *10 min*	☐ 99252 *40 min*	☐ 99232 *25 min*
Detailed H&P Low Complexity	☐ 99243 *45 min*	☐ 99203 *30 min*	☐ 99213 *15 min*	☐ 99253 *55 min*	☐ 99233 *35 min*
Comprehensive H&P Medium Complexity	☐ 99244 *60 min*	☐ 99204 *45 min*	☐ 99214 *25 min*	☐ 99254 *80 min*	
Comprehensive H&P High Complexity	☐ 99245 *80 min*	☐ 99205 *60 min*	☐ 99215 *40 min*	☐ 99255 *110 min*	

Additional Patient Services		
Prolonged services without direct patient contact	☐ G9008 ______ *first 30 min*	☐ G9009 ______ *15 min x*____ units **(max 8 units)**
Initial Comprehensive Assessment for Foster Care	☐ 99420 TG	**Note:** Each G-code must have attached one of the following modifiers: Physician, PA or P-SANE add AF; ARNP add TD

Case Management Services – Medical Team Conference		
Without patient/family present	☐ G9010 ______ (physician) *15 min x*____ *units*	☐ G9011 ______ (non-physician) *15 min x*____ *units*
With patient family present	☐ G9007 ______ (non-physician) *15 min x*____ *units*	**Note:** Maximum 4 units per service code

Procedures	
☐ 99170 Colposcopy to diagnose Child Sexual Abuse	☐ 99070 Supplies/Materials
☐ 99420U1 Health Risk Assessment Tool Administration	☐ 96110 Standardized Development Screening – Administration & Interpretation

Abuse Codes/V Codes			
☐ T74.22XA	Child Sexual Abuse, Confirmed	☐ T74.92XA	Child Abuse NOS, Confirmed
☐ T76.22XA	Child Sexual Abuse, Suspected	☐ T76.92XA	Child Abuse NOS, Suspected
☐ T74.12XA	Child Physical Abuse, Confirmed	☐ Z04.42	Observation and evaluation for alleged sexual abuse
☐ T76.12XA	Child Physical Abuse, Suspected	☐ Z04.72	Observation and examination for alleged physical abuse
☐ T74.02XA	Child Neglect or Abandonment, Confirmed	☐ Z13.850	Encounter for screening for traumatic brain injury
☐ T76.02XA	Child Neglect or Abandonment, Suspected	☐ ____________	Specify:
☐ T74.4XXA	Shaken Infant Syndrome	☐ ____________	Specify:

Findings: Disease/Injury/Symptoms Diagnosis Codes

Anogenital Diseases/Symptoms		☐ ________	Specify:	☐ X98.1XXA	Assault by hot tap water, initial encounter
☐ A54.02	Gonococcal vulvovaginitis, unspecified	☐ ________	Specify:	☐ X11.8XXA	Contact with other hot tap-water, initial encounter
☐ A54.03	Gonococcal cervicitis, unspecified	☐ ________	Specify:	☐ X98.0XXA	Assault by steam or hot vapors, initial encounter
☐ A54.6	Gonococcal infection of anus and rectum	**Contusions**		☐ X13.1XXA	Other contact with steam and other hot vapors, initial encounter
☐ A54.5	Gonococcal infection, pharynx	☐ S00.11XA	Contusion to eyelid and periocular area, right eye, initial	☐ ________	Specify:
☐ A56.01	Chlamydial cystitis and urethritis	☐ S00.12XA	Contusion to eyelid and periocular area, left eye, initial	☐ ________	Specify:
☐ A56.02	Chlamydial vulvovaginitis	☐ S40.021A	Contusion of right upper arm, initial encounter	☐ ________	Specify:
☐ A56.3	Chlamydial infection of anus and rectum	☐ S40.022A	Contusion of left upper arm, initial encounter	**Miscellaneous – Perpetrator of Maltreatment and Neglect**	
☐ A59.01	Trichomonal vulvovaginitis	☐ S50.11XA	Contusion of right forearm, initial encounter	☐ Y07.11	Biological father
☐ A59.03	Trichomonal cystitis and urethritis	☐ S50.12XA	Contusion of left forearm, initial encounter	☐ Y07.420	Foster father
☐ A59.09	Trichomonal cervicitis	☐ S70.11XA	Contusion of right thigh, initial encounter	☐ Y07.430	Stepfather
☐ A60.04	Herpetic vulvovaginitis	☐ S70.12XA	Contusion of left thigh, initial encounter	☐ Y07.432	Male friend of parent (co-residing in household)
☐ A60.01	Herpetic infection, penis	☐ S80.11XA	Contusion of right lower leg, initial encounter	☐ Y07.12	Biological mother
☐ A60.1	Herpesviral infection of perianal skin and rectum	☐ S80.12XA	Contusion of left lower leg, initial encounter	☐ Y07.421	Foster mother
☐ B37.3	Candidiasis of vulva and vagina	☐ ________	Specify:	☐ Y07.433	Stepmother
☐ L90.0	Lichen sclerosus et atrophicus	☐ ________	Specify:	☐ Y07.434	Female friend of parent (co-residing in household)
☐ N76.0	Acute vaginitis, unspecified - includes bacterial vaginosis	☐ ________	Specify:	☐ Y07.499	Other family member
☐ A63.0	Venereal warts – includes Condyloma Acuminatum	**Head Injuries**		☐ Y07.59	Other non-family member
☐ T19.2XXA	Foreign body in vulva and vagina, initial encounter	☐ H11.31	Conjunctival hemorrhage, right eye	☐ Y07.9	Unspecified perpetrator
☐ B08.1	Molluscum Contagiosum	☐ H11.32	Conjunctival hemorrhage, left eye	☐ ________	Specify:
☐ ________	Specify:	☐ H11.33	Conjunctival hemorrhage, bilateral	☐ ________	Specify:
☐ ________	Specify:	☐ ________	Specify:	☐ ________	Specify:
☐ ________	Specify:	☐ ________	Specify:	**Personal History of...**	
Anogenital Injuries		☐ ________	Specify:	☐ Z62.810	Physical & sexual abuse in childhood
☐ S30.812A	Abrasion to penis, initial encounter	**Secondary Codes**		☐ Z62.811	Psychological abuse in childhood
☐ S30.817A	Abrasion to anus, initial encounter	☐ Y04.1XXA	Assault by human bite, initial encounter	☐ Z62.812	Neglect in childhood
☐ S30.0A	Contusion to buttock	☐ X98.2XXA	Assault by hot fluids, initial encounter	☐ Z62.819	Unspecified abuse in childhood
☐ S30.23XA	Contusion to vulva and vagina, initial encounter	☐ X10.0XXA	Contact with hot drinks, initial encounter	☐ ________	Specify:
☐ S30.21XA	Contusion to penis, initial encounter	☐ X98.3XXA	Assault by hot household appliances, initial encounter	☐ ________	Specify:
☐ S30.22XA	Contusion to scrotum and testes, initial encounter	☐ X15.8XXA	Contact with other hot household appliances, initial encounter	☐ ________	Specify:
☐ S31.41XA	Laceration of vulva and vagina (includes hymen, posterior fourchette), initial encounter	☐ X15.0XXA	Contact with hot stove (kitchen), initial encounter	**Miscellaneous**	
☐ : 31.831A	Laceration to anus, initial encounter	☐ X97.XXXA	Assault by smoke, fire and flames, initial encounter (includes burning by cigarette)	☐ F94.8	Other disorder of social functioning in childhood, not elsewhere classified (sexualized behavior)

Healthcare Providers Signature: ______________________________ **Date of Evaluation:** ______________

MM/DD/YYYY

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the Motion for Leave to Participate as Amici Curiae and Conditional Brief has been served upon the parties by mailing two (2) copies in the United States mail, postage prepaid, addressed to Petitioner's Counsel and Respondent:

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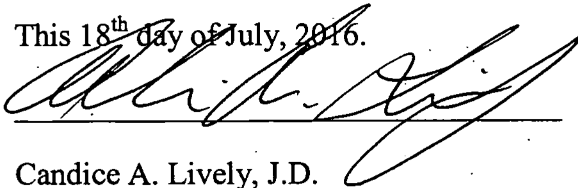
This 18th day of July, 2016.



Candice A. Lively, J.D.
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SWORN to before me this 18th day of July, 2016.

Notary Public for S.C.
My commission Expires: 9/8/2018