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Emergency Department Investigation of Child Abuse

Ananya Datta

In cases of suspected child abuse, an LNC is especially challenged to maintain objectivity and focus on the facts. Ananya Datta, an emergency medicine pediatric nurse practitioner, brings her experience in this area to provide critical guidelines for evaluating such cases. You will learn how to take apart the documentation, put it together through a thorough timeline, and understanding how we can better piece together the medical interpretation for child abuse cases.

Highlights of this Legal Nurse Podcast include:

- Why detailed documentation is essential
- The importance of nonverbal information from the child, who is often unable or reluctant to speak about the cause of injuries
- The need to determine how consistent the caregiver's accounts are
- The necessity to supplement the data an ER visit provides with the patient history provided by pediatricians' records
- Applying the acronym of TEN-4: Torso, Ears, Neck, which refers to bruising in these areas in children under four years of age.

Patricia: Hi. This is Pat Iyer with Legal Nurse Podcast. And I have with me today Ananya Datta, who is an emergency medicine pediatric nurse practitioner. She has also founded Impact Clinical Strategy Consultants, which is a healthcare consulting firm that helps emergency departments and UC. Tell me what UC is, Ananya.

Ananya: Urgent Care.

Patricia: Urgent Care.

Ananya: Urgent Care.

Patricia: Okay, thank you. I was drawing a complete blank on that, thinking, "No, it's not utilization review. No." Okay, thank you.

Ananya: No problem.

Patricia: She helps emergency departments and urgent care centers improve their operations. Ananya, welcome to the show.

Ananya: Thank you so much for having me, Ms. Iyer, I really appreciate it. And thank you for allowing me to speak to you and your audience today.

Patricia: And one thing we didn't cover as we were getting ready is that I respond better to Pat rather than Mrs. Iyer, which makes me feel about a hundred years old.

Ananya: Okay. Noted, thank you.

Patricia: That's right, you can call me Pat.

Ananya: Perfect.

Patricia: I met Ananya through a mutual friend and acquaintance who suggested that we have a talk about her background, and I realized in speaking with her that she has great experience to bring to you as a legal nurse consultant listening to this podcast. Tell us a little bit about your background, your training. You're an emergency medicine pediatric nurse practitioner, which puts you in a narrow niche of people with expertise. How did you get to that point?

Ananya: Absolutely. I grew up in Memphis, Tennessee where I did my Bachelor of Science in Nursing there, and I quickly started my nursing journey as a critical care nurse. And I started to notice that I really wanted to, and I longed to be a part of a team in a more autonomous way in the child's care. So that led me to seek my Masters in Nursing and become a pediatric nurse practitioner.

I also wanted to look at the social determinants of health, which I felt was missing in my education. So, I also sought my Masters in Public Health. And I combine those two while I practice as an ER nurse practitioner in Philadelphia. And that has been my journey for the last 10 years in nursing up until now. And recently, I founded a healthcare consulting firm helping emergency departments and urgent cares, as you said.

Patricia: Excellent. It sounds like you've gotten a lot of education that has helped you in looking at the people that you serve, both from an administrative or an overview perspective as well as a clinical level.

Ananya: Absolutely. I think that clinicians, honestly, are an untapped resource in the healthcare industry in terms of how much they know and are fielding and troubleshooting and investigating challenges as we've faced, in the last six months especially, all the time in their work in addition to providing care for patients. I've been able to be both on different sides of the fence and I really appreciate all of the lessons that I've learned.

Patricia: And one of the things that we talked about in terms of being in this arena is that legal nurse consultants sometimes are consulted by attorneys on child abuse cases, and I'm thinking that with your background in emergency department and pediatric nurse practitioner that you have encountered patients where there's been a suspicion or the story doesn't match what the parents or the caretaker says happened to the child. Can you tell us, is that something that has been part of your clinical background?

Ananya: Yes. Unfortunately, this was a very prevalent type of complaint and diagnosis that we saw in the pediatric ER. We saw and we would do pretty much one patient a shift. That's how commonly, as a nurse practitioner, that I would see these types of cases. Now, not all of them were brought in unstable. Most of them were stable patients. And the way in which the complaint would be manifested could be a foster parent, it could be court-ordered examination, it could be suspected child abuse, like you said. There are different ways that the child would present, but something related to a non-accidental trauma we would see about once a shift. So, it was very common, unfortunately, in my practice.

Patricia: Take us through some of the common presentations, the symptoms that would cause the parents or I'll just say the parents, even though we know that could be any of the entities that you're talking about, such as caregivers. What would bring that child into the emergency department?

Ananya: That's a great question. So, it varies. So, we would see things such as direct disclosures from a child of someone hitting them or inflicting pain. It could be complaints from teachers writing a note for further investigation that they saw bruising that was inappropriate, or the child looked malnourished and neglected.

And then it could go to the other side of the spectrum, where we would see a child in acute abdominal pain. Abdominal trauma is one of the top child abuse experiences that we see. Or it could be unexplained bruising, it could be a lot of orthopedic injuries where the mechanism just does not align with the reported history. So, it could be anywhere along that spectrum.

Patricia: And then in the process of working up the child, did it happen that you would encounter things like fractures that would appear on x-ray, and yet there wouldn't be any history of trauma?

Ananya: Oftentimes, that would happen. It could be an old fracture that was healing, it could be just unexplained things that were not brought into the history by the parent or the caregiver that we would note. And of course, there are also obvious fractures that the patient would be experiencing, displacements, bruising, things of that nature, too.

Patricia: I got involved in a case, several years ago, involving American parents who adopted two brothers from a Russian orphanage. When they went over to pick up the one brother, they found out he had another brother, so they decided to bring both kids back. And the one who became the center of this suit was probably a fetal alcohol syndrome child. The attorney who hired me was defending the parents who were brought into a criminal action because the boy was brought into the ER, he was extremely cold. They found undigested beans in his stomach and some fractures of his fingers that didn't connect with the trauma.

And the parents' story was that he would be acting out, so they would put him into a play pen, and he was breaking his hand by hitting hard objects. The grandmother said that the playpen was down by the furnace, and that's why the child was so cold, and they used that to punish him.

And ultimately, the court system decided that the parents were indeed the ones inflicting the trauma. It was a fascinating case because it brought me into whole areas that I had never knew anything about, including the conditions in Russian orphanages, the lack of medical records about this child, what is plausible in terms of injuries, whether the hypothermia could have been related to an electrolyte imbalance.

They were all things that we were grasping at to try to defend these parents, but the grandmother's testimony did it. She was the person in the family who provided the most credible explanation. There were brothers and sisters who were talking about what was going on, and that was kind of discounted. But when the grandmother came in and said, "This is what was really happening," that was the end of the ability to defend the parents.

And in the process of working on this case, which took several months, I got all kinds of medical records, including the child protective services records. And I wondered if you could talk a little bit with us about the team of people who become involved, starting from the responsibilities of the nurses to report, and then who gets brought in to do an investigation.

Ananya: Absolutely. Thank you for sharing that story. Unfortunately, there are so many stories similar to that, but I think that in child abuse cases, we as clinicians are learning and doing better in terms of taking a more multidisciplinary approach. And something I didn't mention earlier is that I am not an expert in child abuse. There are child abuse pediatricians who are trained and have fellowship summits and they are the ultimate experts. So, I wanted to say that.

But in terms of a team, when a child is brought in, whether there is a suspicion of child abuse or there's an unclear history, we first determine in the emergency department if the patient is stable or not. If it's an acute trauma, then you address it that way. However, if it's a stable patient, we take a really good history, beginning from triage from the caregiver, and then initially the nurse practitioner or physician in charge will be taking the first primary exam of the patient.

And if the patient's stable, then we move along to determining the best course of action based on that assessment as well as the history and the patient's developmental age and stages. If there is something that is concerning, then we involve immediately a child abuse pediatrician, we consult them. If there's not one available, then we must look at the protocols in place for the hospital. But oftentimes, we also involve trauma, which is also interchangeable with surgery teams, as well. If there are any orthopedic injuries, we would involve that team, if there are any ophthalmology consults that are necessary,

those are typically the core medical consults that we see. And then of course we're involving social work, so social workers in-house, they are a great resource for a dynamic team. Then we involve the local Child Protection Services. And of course, if we need to get a police report involved, at this time it would take place.

Patricia: I'm thinking about this from the standpoint of what happens when the child comes into the emergency department and has injuries where there's a suspicion of abuse. Under what circumstances does the child leave the ER with the parents versus under what circumstances does the child get placed in a foster family?

Ananya: That's a great question. I think it really requires a very thorough history from the caregiver and then an examination and whatever the workup entails. The first thing is medically clearing that child. Whatever the indications are, if it's an infant, then you do an entire workup including a CAT scan, lots of bloodwork, making sure there's head to toe assessment. You do a skeletal survey. So, it would be very thorough.

And then if it was a toddler or school age child and if it was one focused issue, then it'd be dependent on the history there. And then also we would get CPS involved (Child Protection Services) and make a joint decision. Oftentimes, the biggest thing is making sure that the patient or the client is not returned to an unsafe environment. So that is a survey that Child Protection often does with the information that we're able to give them.

Once a patient is medically cleared, then Child Protection really works very closely with the medical team to make that decision. And if there's a safety place involved, there are a lot of factors that go into how long that's going to be and who is going to be in charge as the guardian, now, of the patient. So, it really it depends on the situation and the severity of the medical complaints.

Patricia: I'm thinking about what it's like from the child's perspective of being taken away from the only family the child knows.

Ananya: Absolutely.

Patricia: That must be traumatic, too.

Ananya: Absolutely. The entire visit and scenario are absolutely traumatic. However, I think it's really important to keep in mind that, despite how old the child is, a lot of times disclosures from a child do not happen in terms of fear and retaliation. And like you said, they don't want to be separated from their family.

However, it's important that we take a look at not only verbal disclosures from the child but nonverbal. So their affect, their engagement with our staff, if they are malnourished or neglected, things that they don't necessarily tell us that we need to really keep a vigilant eye on, those are important so we refocus our entire interests back into the child and how we can help them.

Patricia: I would think it would be challenging, and I know this is something that legal nurse consultants get involved in, trying to differentiate between what is an accidental injury and what is a deliberate injury. I was just thinking about my two sons, seven years apart in age, who were roughhousing one day, and my younger son brought his leg up at the same time that his brother was bringing his hand down, and we thought that my younger son's leg was hit hard enough to break the bone, because there was so much force.

It wasn't a deliberate strike, but it was just that, if you're watching the YouTube video, I'm raising my hand and striking the side of my fingers. It was just that accident of timing. And of course, being the concerned nurse, I took my son to the emergency department. By the time we got to the parking lot, he was perfectly fine, and I was wondering whether I was even wasting everyone's time. The obligatory x-ray was done, and there was nothing fractured.

And I think as you are talking about toddlers, the accidents that occur at that age, how do you differentiate, particularly with infants and toddlers who can't explain what happened? You know, maybe they were running, and they fell and broke an arm as opposed to somebody deliberately breaking their arm. Tell us a little bit more about that, because that's really what we get involved in as legal nurse consultants, in helping attorneys understand the mechanism of injury, how much force it takes to break a bone, for example. Am I asking that question coherently enough that you can follow what I'm saying?

Ananya: Absolutely, yes. And I think that it's often a dilemma in health care that we are in. To kind of clarify our role in being a healthcare professional as a provider is to understand and get a really good history as well as physical exam. So, the things that we're really looking for are any disclosures. We're looking for a very airtight history from the caregiver that is not evolving, that's not changing. We're looking for an excellent physical examination on our behalf. And then we're looking for developmental appropriateness and the mechanism that's being explained to us, if that all fits.

Now, with any infant, especially under four to six months, bruising is not appropriate, and we always have to keep in mind if the child is non-mobile and they're an infant, then they shouldn't be having any type of bruising which we can go into in detail. Keeping that in mind as an LNC is extremely important, that developmental stage, because that's going to drive a lot of piecing together the whole puzzle. So, in the actual clinical setting, our main goal is to really get that understanding of does this mechanism make sense with what we're seeing, and how much of a workup do we need to do? Is this patient stable? Have we investigated everything to keep this child safe and healthy?

And once that patient is medically cleared, then we hand out the decision for the disposition of that child to Child Protection. The determination of how it will be investigated and the appropriateness, we can give recommendations based on our understanding as clinicians of is this appropriate or not, does this make sense with the mechanism, we can provide those recommendations. But our role is really not to necessarily determine that, if this is inappropriate or not in that moment. We must really work closely with Child Protection to make that determination.

Patricia: I would think that that would be challenging. That's what keeps people awake at night and gives them nightmares of, "Did I do the right thing?" The obvious extremes are easy to spot, the cigarette burns on the skin of an infant that shrieks abuse, but it's these subtler areas that are the problem. The mother's boyfriend who claims that the child fell off the changing table, when the child might have been thrown off, for example. Some caretakers lie very convincingly, and I would imagine that that has happened to you. Have you sat there in an ER one time

and has it ever happened that you looked at the person and said, “I know you are lying, but you are such a good liar.”?

Ananya: Unfortunately, a lot of clinicians, including myself, have been in that situation, and the onus is on us as clinicians to protect that child and make sure that they’re safe and healthy and that we are making the most sound decision with all the information that we’re gathering. So, we almost have to put on an investigator hat at that point and really get all the information that we can.

So, the four things that I really focus on in these situations is, like we talked about, likeness of injury, physical findings, getting an excellent history that's not evolving. So, when the patient is coming in, they’re giving multiple histories, one to the nurse, one to the provider, if there’s a multidisciplinary team, they will be asking again. So really making sure that evolution does not change drastically, that's important to know. And then of course keying in the developmental stages.

You're gathering this information constantly when seeking this interviewing stage with the caregiver. So, there have been incidences where this has come up, but it is really important to discern that and be able to pinpoint any discrepancies in the storytelling.

Patricia: A challenging role.

Ananya: Absolutely.

Patricia: Now, in this role, you're in the heat of the situation, in the moment. Legal nurse consultants are looking at this after the fact. They might be working with a criminal defense attorney or with a prosecutor trying to evaluate the case retrospectively, trying to determine where is the credibility associated with this type of role or this type of situation.

Do you have any tips that you can share with LNCs who are looking at these cases from that perspective of maybe the initial providers have made their determination, but the criminal defense attorney is asserting, “No, it's not the way that it happened, there’s another plausible explanation.”? What can you share with us that would help make that role easier for the legal nurse consultant, coming up with a defense, for example?

Ananya: Absolutely. I think that it's a very challenging case for LNCs, but I think there are a few things to keep in mind. Beginning just at the top, really fine tooth-comb your documentation of the visits, of the medical chart, and create an airtight medical chronology. These are going to be very, very important. In addition to that, do a deeper dive into the specifics of the case, whether it's an abdominal trauma, for example, taking a look at the medical standards for that care. So, what are the protocols in place that were followed? What are the best practices for taking care of abdominal trauma? Was that done? And was the non-accidental trauma workup, the general workup done?

So, documentation, disposition, disclosures, all of these things are going to come into play. And then really take a deep dive into the institution's protocols and then access to the specialists. Was a child abuse pediatrician consulted? Do they have access to one? And what was their testimony? What were their recommendations? Was that followed? And then slowly piece together the views of all the consultants and specialists that were in play with the patient.

If there was trauma involved, if there was a child abuse pediatrician involved in the general team, does everyone's opinion align in terms of recommendations, and was that followed? Are there any discrepancies in the timeline or any discrepancies in recommendation and second opinions? That's really important to have a look at, and I think that will give a lot of information about whether there's credibility in what you're saying.

And then of course, lastly, like I was mentioning, our job is really not to make the determination of any criminal activity, however, it's our job is to make sure the patient is safe and healthy. What were the interpretations of the findings that were put in the medical decision-making part of the chart? What was gleaned from the diagnostics and the examination and the history? What was the documentation leaning towards? That's really important to pull out.

I think that it's really important to know that in the emergency department, this is just one snapshot of the patient's life and one presentation. So, if possible, look at the pediatrician's records and working with their local pediatrician to see if you can look at a longer timeline, and that will help you to determine are there pattern injuries occurring? Are there injuries in different stages of healing occurring?

Are there multiple injuries constantly occurring? And then of course having, in the back of your mind, the developmental stages and having a very low threshold for injuries for infants. A lot of time, we focus on infants. So, it's extremely important to have a low threshold of suspicion for any type of injury for an infant and keep that in mind.

Patricia: As you're talking, I'm thinking about what a blessing it is to work in a metropolitan area where you have a child abuse pediatrician. And the reality is that for, like the small rural parts of this country, or for people listening from other countries, there's a family practice doctor who's probably delivering the care who has a very big responsibility for being suspicious when there's reason to be suspicious, who doesn't have the resources that are available in a university emergency setting. We have two extremes, from very limited resources to all the resources available, and yet it's so challenging for both ends of the spectrum.

Ananya: Absolutely. And that can definitely happen. And I think in those circumstances, it's really important for the family practice doctor or pediatrician or anyone who doesn't have access to a specialist and consultants in the same way is to really be abreast on local guidelines for being a mandatory reporter and what are considered guidelines or areas that you would need to report as a provider. And then of course remember physical examination in developmental stages.

So, a few things that in child abuse are really important, acronyms that we talk about like TEN-4. T-E-N-4 stands for Torso, Ears, and Neck. If you see any of these areas with bruising in a child under four years old, that is a red flag and concern for a possible non-accidental trauma. Of course, you need to investigate that. And in infants, like we mentioned before, if they're non-mobile and they have any type of bruising, especially in the frenulum, angle of the jaw, cheek, eyes, or any type of sub-conjunctival hemorrhage, that definitely raises a lot of red flags.

So, those are must cannot-miss things that a pediatrician or a provider would really need to remember. And then in terms of resources, when you have a lack of resources, I think creating a collaboration with local providers is going to be really important on what is the appropriate protocol and what is everyone doing in terms of referring,

and how do you handle non-accidental traumas prior to going to the emergency room.

So, tapping into excellent resources would be American Academy of Pediatrics, which has excellent conferences and lots of literature on child abuse, both for the professional as well as for the parent. The American Professional Society on Child Abuse of Children, apsac.org has have excellent resources, their own conferences, and they are a great expertise in this field. And then of course if you're able to reach out to local children's hospitals, no matter how far away it is. It's really important to gain that trust and relationship with child abuse pediatricians if you have access, or even the local ER pediatricians, to know and have an understanding of when is appropriate to send a child, what are some protocols in place you can put in your own office. And creating that relationship, I think, would be really important.

Patricia: You've given us a lot to think about today. How can our listeners find out more about you and the services that you offer?

Ananya: Absolutely. I really appreciate this opportunity. Anyone who's interested in learning more about how I help emergency departments and urgent cares can contact me on my website on www.impactclinicalstrategy.com, which is soon to launch, and also directly via email. So, my name, A-N-A-N-Y-A@impactclinicalstrategy.com.

Patricia: All right. Thank you so much, Ananya.

Ananya: Thank you for having me.

Patricia: This has been Ananya Datta and Pat Iyer talking about child abuse. Ananya is available for emergency department pediatric nurse practitioner cases as an expert witness, and would be a great resource for you if you're analyzing a case and you need some assistance from an individual who has spent years looking at these non-accidental trauma cases as well as other types of taking care of pediatric patients in emergency departments. Thank you so much.

Ananya: Thank you.