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THE JOURNAL OF
**Legal Nurse
Consulting**



FORENSIC NURSING

IN THIS ISSUE:

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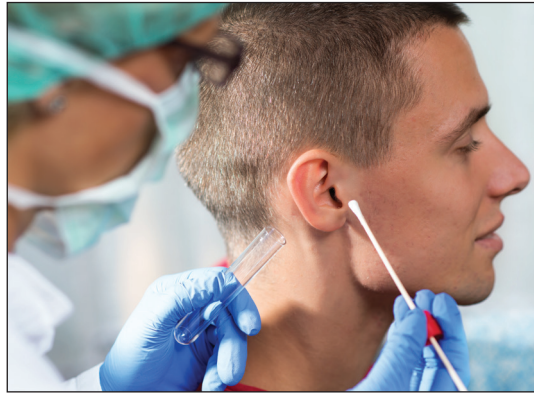
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**06
 FORENSIC NURSING**

Kirsten O. Turkington, DNP, APRN, FNP-C, AFN-BC

CE CREDITS

**15
 THE QUAGMIRE OF SOCIAL DETERMINANTS OF HEALTH FOR THE LEGAL NURSING CONSULTANT: EVALUATING FAILURE TO THRIVE**

Steadman Lee McPeters, DNP, CPNP-AC, CRNP, RNFA
Pamela Harris Bryant, DNP, CRNP, AC-PC
Patricia M. Speck, DNSc, FNP-BC, DF-IAFN, FAAFS, DF-AFN

**26
 THE ROLE OF THE FORENSIC NURSE IN CRIMINAL AND CIVIL CASES**

Barbra A. Bachmeier, JD, MSN, APRN, NP-C, DF-AFN, FAEN
Shaunette Terrell, JD

**31
 HUMAN TRAFFICKING, LITIGATION, AND LEGAL NURSE CONSULTANT**

S. Randall Hood, Esq.
Christina R. Hedges, RN, CEN

CE CREDITS

**38
 A GENERALIST VIEW OF FORENSIC NURSING PRACTICE: MORE THAN A BOX OF SWABS**

Catherine Rossi, MSN, RN, FNP-C, SANE-A, SANE-P, DF-AFN
Angelia Trujillo, DNP, MSN, WHNP-BC, DF-AFN

**44
 GUN SHOT WOUNDS: IMPLICATIONS FOR FORENSIC NURSES**

Christine Foote-Lucero, MSN, RN, CEN, SANE-A, SANE-P

**50
 CRIMINAL CASE CONSULTATION: ENTERING THE LION'S DEN**

Dr Jennifer L. Johnson, DNP, APRN, WHNP-BC, AFN-BC, SANE-A, SANE-P, DF-AFN
Teresa J. Devitt-Lynch, MSN, RN, AFN-BC, SANE-A



- 02 Manuscript Review Process
- 03 Article Submission Guidelines
- 04 From the President
- 05 From the Editor

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PURPOSE

The purpose of The Journal is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

MANUSCRIPT SUBMISSION

The Journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

MANUSCRIPT REVIEW PROCESS

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

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The Journal of Legal Nurse Consulting (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The JLNC follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: <http://publicationethics.org/resources/code-conduct>.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

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- Manuscript length: 1500 – 4000 words
- Use Word® format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 7th edition) (<https://owl.english.purdue.edu/owl/resource/560/01/>)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Include a 100-word abstract and keywords on the first page
- Write the manuscript in third person only. If you feel an exception is warranted for the topic of your manuscript, please contact the Editor to discuss.
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

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- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art should be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

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Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

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Mary Flanagan,
BSN, RN, CNOR, LNCC

President, AALNC

President's Update

Dear AALNC Members and colleagues,

Ah, fall...my absolute favorite time of year. I write to you today on the last day of our hugely successful 2021 LNC Awareness Week. I hope many of you took advantage of the great discounts offered exclusively that week on an array of products and education offerings, most important our second annual *LNC Jumpstart* virtual program coming up this month. I was privileged to participate in one of my favorite AALNC offerings, "So You Want to Be an LNC" webinar with my fellow board members Erin Gologly and Lisa Mancuso. On Friday we wrapped up a fun week with something new, "Things I Wish I Would've Known: LNC Lessons Learned." I was joined by board members Jeanine Frumentti, Laura Nissim, and Jennifer Parks in an interactive round table discussion providing great advice from seasoned LNCs. Completing the panel was our own Karen Wilkinson, Director of Programs and Nurse planner. Both events were well attended and offered 1 hour each of CNE. If you missed either session, they are both available on demand at AALNC.org.

If you haven't already, I encourage you to check out [The Briefing](#), AALNC's newly launched content hub. Many months of hard work went into creating this official content source loaded with valuable and relevant information tailored to legal nurse consulting. *The Briefing* is a great resource for our LNC community and our clients. Each month you will see industry stories tailored specifically to your needs. We are excited to offer this new resource to our legal community as we continue to set the gold standard in our field.

The second annual [LNC Jumpstart](#), our virtual workshop, is just days away on Friday, September 10th. We received much constructive feedback from last year's attendees and have integrated the best ideas into this year's event. Karen Wilkinson and her team have a unique program planned for this year including LNC clinical, practice, and business education, complete with hands-on takeaways. We have several excellent speakers lined up who will give real world, valuable guidance to new and seasoned LNCs. Not only will you walk away with over 4 hours of CNE, but also with form and report templates you can use immediately in your own practice. I hope to see you all there!

By now you all know the important difference between a *certificate* received when completing an LNC course and board *certification*, LNCC®, the only LNC certification recognized by the ANCC. But do you know the difference between the word 'autumn' and 'fall'? Well, it turns out there isn't much difference. Both words are used to describe the season between summer and winter. Both originated in Britain. Autumn is older and from the Latin *autumnus* which has no derivation and was the more popular term for a long time. Fall is more American and derived from the leaves of the trees *falling*. Whichever you prefer, I hope you enjoy all the beauty, traditions, and fun associated with the season.

Mary Flanagan, BSN, RN, CNOR, LNCC

Editor's Note

Dear Members and Colleagues,

Family bonfires, pumpkin patches, and the thoughts of fall are finally upon us, as is our fall journal. This journal theme focuses on Forensic Nursing. If your case involves victims of violence, sexual assault, potential neglect versus intentional injury, you're going to need a Legal Nurse Consultant that specializes in Forensic Nursing. These critical resources help set the stage in the courtroom by collecting evidence and preparing testimony to help prosecute perpetrators or explain the innocence of someone wrongly accused in some scenarios. LNCs can collect evidence and ensure it is preserved, help explain to juries about the facts of the case, prepare fact witnesses or victims for trial, and even differentiate various types of injuries. The role of Forensic Nursing can be as vast and varied. There is certainly no shortage of work for the LNC in this industry.

Joseph Biden, when he was Vice President of the United States, was once quoted saying, "Forensic Nurses play an integral role bridging the gap between law and medicine." I absolutely agree! Our *Journal of Legal Nurse Consulting* committee has worked hard to select articles of interest and importance to the practice of Legal Nurse Consultants with a specialty in Forensic Nursing. Please enjoy these manuscripts authored by subject matter experts from across the country. We are pleased they chose to share their expertise with our readers.

While reading this journal, please pay special attention to our CE articles. The committee chooses two or three articles for CE opportunities, and the CEs are reasonably priced. This is our second journal with CEs hosted inside the journal. We sincerely hope this assists you with staying current on your certifications and licensure, while finding valuable content to help elevate your knowledge in your chosen field of expertise. Each CE article is delineated in the Table of Contents and at the beginning of the article. Keep a lookout for them as you read through the manuscripts.

Our Winter journal is open-themed so that it will have a variety of content. We recognize our readers have a varied background and varied expertise. We are committed to our readers and LNCs to continue to provide content worthy of reading and exploring. I also invite you to consider writing an article to contribute to the journal. Your experiences and expertise are worth writing and reading about to fellow LNCs around the country. If you have never submitted a manuscript, our committee members are here to help. *The Journal of Legal Nurse Consulting* committee members work diligently to assist all authors to produce the best manuscripts available so LNCs have a platform for sharing experiences and content.

I hope you enjoy a good marshmallow roast this fall season with friends and loved ones. Roast some chestnuts and take a deep breath while the fall breeze brings the smells of autumn. A good crisp autumn night allows time to view the starry sky, while getting prepared for the winter season. Take time for yourself and for your loved ones. I look forward to hearing from you about your potential contribution to *The Journal of Legal Nurse Consulting*.

Sincerely,



Martha R. Kelso, RN, HBOT



Martha R. Kelso,
RN, HBOT

Editor, JLNC



Forensic Nursing

Kirsten O. Turkington, DNP, APRN, FNP-C, AFN-BC

Keywords: Forensic nursing, Violence, Investigation, Advocate

Availability of qualified FNs and the essential training required for forensic roles improves access to high quality care. This care relates to both victims and perpetrators, depending on the clinical expectation and specific case needs. FNE engagement improves both the foundation of case evidence and overall process transparency by following specific scientific methodology and high levels of scientific training.

Violence is pervasive in society and is a significant cause of morbidity and mortality worldwide (WHO, n.d.). All types of violence are associated with some form of trauma. It presents as physical, sexual, psychological, and deprivation or neglect. Violence presents as self-directed behaviors, interpersonal behaviors, and collectively from social, political, and economic causes.

Violence as a public health issue is not selective (Dahlberg & Mercy, 2009). It

impacts all ages, genders, and socio-economic levels. Violence continues to be a significant cause of death (Heron, 2019). These diverse presentations and the overwhelming impact violence have on individuals, families, and communities trigger far-reaching and costly side effects. These effects must be addressed using knowledge, skills, and training. These traits are shared by Forensic Nurses.

The American healthcare systems regularly use Forensic Nurses to address violence and its sequelae. Forensic

Nurses are highly qualified experts offering a vital link between awareness, prevention, intervention, and treatment guidance. They also provide evidence collection and preservation of essential details as they assess, evaluate and implement forensic care.

The Forensic Nursing role is unique relative to other nursing roles. Their training bridges gaps between traditional law enforcement agencies and the judicial system as members of the health care system. In fact, the Joint

Commission on the Accreditation of Healthcare Organizations (JCAHO) recognizes the necessary role of forensic nursing as it specifically relates to adult domestic violence victims (Barnett, 2018). JCAHO updated guidelines for identification and treatment for victims of abuse, violence, and neglect in 2004. Today, as a result, many violence victims see a Forensic Nurse before other providers in the hospital setting (Berishaj, Boyland, Reinink, & Lynch, 2020).

Developing a collaborative relationship with qualified Forensic Nurses is an essential connection for Legal Nurse Consultants (LNC). This is important for evaluating initial case needs and for possible future testimony. However, before LNCs can find and fully engage the right expert, they need additional case information. That is where Forensic Nurses should be the first on your list of experts, especially with cases involving violence.

FORENSIC NURSES AND LEGAL NURSE CONSULTANTS.

LNCs are often faced with assessing and evaluating cases for litigation purposes. The initial evaluation can involve meritorious claims. Ongoing case assessments can relate to evidence reviews, case reviews, or testimony. Forensic cases can be challenging and are frequently complex. Forensic Nurses help bridge the knowledge gap between health-related issues and the legal system because of their specialized training (IAFN, 2021b).

Many LNCs doing case reviews don't have a specific clinical background in forensic nursing. However, they are tasked with finding the right experts to review cases and possibly testify. LNCs cannot critically evaluate forensic standards without specific forensic knowledge, training, or a background in evidence collection (ANA & IAFN, 2017). The LNC, like many other nursing specialties, may not have the essential

knowledge to assess or identify specific case issues (Sakalli & Aslan, 2020).

Forensic Nurses are the essence of the LNC role in a variety of clinical scenarios (Valentine, 2018). Forensic Nurses offer the highest levels of training for specific forensic case concerns regarding violence and other forensic issues (IAFN, 2021d). Understanding the evolution of the Forensic Nurse role is helpful in applying this specific expertise to cases you are assigned to.

FORENSIC NURSING HISTORICAL PERSPECTIVE

Forensic Nurses are specifically trained to address individual and community violence (IAFN, 2021b). Violence is a public health issue and has been for decades. The United States first acknowledged violence as a public health issue in 1985 (Dahlberg & Mercy, 2009). Since that time, violence has escalated to epidemic levels. Violence is now recognized as a world health crisis (Freire-Vargas, 2018).

Virginia Lynch created a new nursing specialty when she pioneered the first Forensic Nurse role in 1984. She unexpectedly began her career as a medicolegal death investigator. At the time, there was no recognized specialty for Lynch's role. Hers was a novel concept never before defined.

Nearly seven years later, the American Academy of Forensic Science ((AAFS), 1991) recognized forensic nursing as a scientific discipline. Nursing recognition quickly followed with the establishment

of the International Association of Forensic Nurses (IAFN, 2021d). This organization unified nurses working with victims and perpetrators of violent crime. Forensic Nurses finally had a collective "voice," and their professional advancement continues through today.

Twenty years after IAFN was organized and twenty-eight years after Lynch became a death investigator, the American Nurses Credentialing Center ((ANCC), 2012) recognized forensic nursing as a professional specialty. The ANCC expanded that recognition with the development of an Advanced Forensic Nurse, Board Certification, also known as AFN-BC (2016).

The World Health Organization (2021) recognizes violence as a significant worldwide health determinant and focuses on identification and prevention as a priority. Forensic nursing as a specialty is uniquely qualified to address violence-related health needs both locally and globally. Forensic Nurses play a vital role in addressing overall violence awareness through clinical practice, as peer resources, and through ongoing translational research. The ultimate goal is to improve outcomes, whether through prevention, treatment, or prosecution.

Forensic nursing is continually evolving as a professional role. It impacts health care, legislation, government, individuals, families, and communities on a daily basis (Valentine, 2018). Before we can discuss specific role variations, we need context on what forensic nursing actually is.

LNCs are often faced with assessing and evaluating cases for litigation purposes. The initial evaluation can involve meritorious claims. Ongoing case assessments can relate to evidence reviews, case reviews, or testimony.

WHAT IS FORENSIC NURSING?

Forensics is widely recognized as the intersection of healthcare and the law (IAFN, 2021e). This specialty builds on many common nursing essentials. The Forensic Nurse role combines a foundation of RN or Advanced Practice Registered Nurse (APRN) training, investigation, and scientific methodology. Nurses are well versed in life and psychosocial sciences.

RNs are already highly educated. They are trained in biology, chemistry, and pathophysiology. RNs also have experience with anatomy and physiology, psychology, and interpersonal skills. This broad scientific foundation supports the forensic paradigm.

The Forensic Nurse definition, roles, behaviors, and processes make up the core of Forensic Nurses' practice (ANA & IAFN, 2017). They are trained to treat trauma and function as a critical community resource. Forensic Nurses are nonbiased, objective, and highly skilled. They have additional education in forensics, often with subspecialty training (IAFN, 2021c).

These subspecialties can be generalized or specific. The Forensic Nurse may focus on age-related populations by working only with adult, adolescent, or pediatric cases. They may also focus on gender-specific concerns for males or females. Forensic Nurse can choose to focus on environmental issues such as natural or manmade disasters such as terrorism, earthquakes, and explosions.

Forensic Nurse can be highly specialized with specific clinical conditions such as sexual assault, firearms, and ballistics, wound pattern identification, death investigation, and strangulation. Forensic Nurse can also choose a specific population focus within their subspecialties, such as adult or pediatric sexual assault.

FORENSIC NURSING: STANDARDS WITH A SCIENTIFIC BACKGROUND

Forensic Nurses provide direct and indirect services across a wide variety of conditions. Forensic Nurses work on both sides of injury and fatalities. They engage with victims and perpetrators of violence, criminal activity, intentional trauma, and accidents. They work with individual clients, agencies, and organizations. They offer consultation services to nursing, medical, and legal agencies.

Forensic Nurses also provide expert court testimony in forensic cases depending on their skill test, clinical background, education, and training (IAFN, 2021c). Forensic Nurses regularly perform death investigations, traumatic injury evaluations, mental health assessments, and manage vulnerable populations. Forensic Nurses also address legal investigative processes, evaluating provided services and specialized nursing diagnoses (table)

FORENSIC NURSE AS A DISCIPLINE

Forensic Nurses apply scientific aspects of healthcare to their nursing training. Forensic Nurses are recognized as a relatively new nursing discipline. Forensic nursing as an advanced discipline continuously expands into new settings and evolves into new roles (IAFN, 2021a). Forensic Nursing was once limited to death investigations, sexual assault evaluations, and evidence collection. Now the role is expansive in many ways and in a variety of clinical and non-clinical settings.

Healthcare

Forensic Nurses work directly and indirectly in a variety of clinical and non-clinical environments. The nursing process is the clinical and scientific foundation for forensic nursing. It provides an essential framework for

interdisciplinary collaboration throughout the healthcare environment. Forensic Nurses combine Nursing methodology and attention to investigative details.

Forensic Nurses are trained RNs that often continue in clinical practice as well as forensic subspecialties. Forensic Nurses work directly and indirectly within the medical environment, whether it is prehospital, hospital, or outpatient clinics.

Many Forensic Nurses come from ED, ICU, and Maternal-Child backgrounds. This preparation allows Forensic Nurses to engage directly with Nursing staff, patients, families, and students in meaningful ways. Direct services include both patient care and evidence collection.

RN and Advanced Practice RNs often collaborate within their respective disciplines and work environments. However, forensic nursing roles transcend typical healthcare opportunities. Forensic Nurses often assist with legal and investigative services.

Legal and Investigative Services

Forensic Nurses work with law enforcement offices and various investigative agencies to integrate the health-related investigative process and eliminate agency silos (Duquesne University, 2020). Approximately 20% of deaths are investigated as unusual, suspicious, or unexplained (Davis, 2020; Le, Brooks, McNulty, Gill, Herstein, Rios, Patlovich, Jelden, Schmid, Lowe & Gibbs, 2018). In the US, there are vastly differing perspectives on death investigation strategies.

The specific roles used in a jurisdiction depend primarily on resource availability, service location, and existent legislation (Davis, 2020). Some jurisdictions use coroners. Some use medical examiners. Others use combinations of the two. Problems occur when these investigators have no specific medical training.

Medical examiners are usually pathologists trained in a traditional medical model. Coroners, however, are either appointed or elected officials within their jurisdiction. Oftentimes, coroners are laypeople, though exceptions do exist (Davis, 2020). There is no national mandate that coroners have specialized medical training. Because of this glaring difference in education, training, and national guidelines, there are gaps.

Both medical examiner and coroner offices work in parallel with other investigative agencies and perform death investigations. However, this is done with inconsistent expertise and training. Ultimately, all forensic investigations require a foundation of detailed medical and social histories, physical examination of the body, and scene documentation.

The foundation of properly documented crime scene data can modify a case substantively (Lee, Palmback & Miller, 2006). These on-scene investigations must be comprehensive and complete to ensure necessary details and evidence are not overlooked. Without appropriate attention to detail, the manner and cause of death can be missed. Forensic Nurses are especially useful as adjuncts to the medical examiner and coroner offices because of their nursing background and specialized training.

Many jurisdictions use Forensic Nurses for a death investigation. This is particularly helpful with complex situations or when medical examiners are not readily available or in coroner jurisdictions (Greenwood, n.d.). They can work to uncover suspicious circumstances by assessing scene details and interviewing witnesses. Forensic Nurses are often liaisons between investigation agencies, health care agencies, and the criminal justice system because of their unique skill set.

Criminal Justice

Forensic Nurses may also specialize in criminal justice matters in varying

Many jurisdictions use Forensic Nurses for a death investigation. This is particularly helpful with complex situations or when medical examiners are not readily available or in coroner jurisdictions.

capacities. There is often alignment with either district attorney or public defender's offices. The increased availability of Sexual Assault Nurse Examiner programs (SANE) allows prosecutors direct access to high-quality witnesses that are experienced in assessments, evaluations, and evidence collection (Reed, Symonds, Stier, Peluso & Watson, 2020). Most Forensic Nurses and nearly all SANEs have specialized courtroom training as part of their clinical role.

Forensic Nurses also assist with defense cases for the same reasons. They review evidence collected, medical and legal documentation, just like their similarly training colleagues working with the prosecution. However, defense Forensic Nurses are using that same training to look for gaps in procedure, documentation, or evidence collection. They evaluate whether the required logical and systematic approach to a given scenario was followed (Lee, Palmback & Miller, 2006).

Some Forensic Nurses take this same role one step further and teach about or opine on the scope and standards of practice in a given case (ANA & IAFN, 2017). Occasionally, the Forensic Nurse in criminal justice overlaps with that of Forensic Nurses in correctional environments because they work with alleged perpetrators and staff exposed to violence in jails and prisons.

Correctional Facilities

Violence occurs within correctional systems as well. Perpetrators have specific,

constitutionally protected rights when in custody (American Civil Liberties Union, 2021). The US Constitution created and protected basic rights for all people, including prisoners. These rights include the Bill of Rights (Table 1.) and the protection of American Civil Liberties (Table 2.). The expectation is that prisoners have access to reasonable medical care and receive humane treatment while in custody. Forensic Nurses work with prisons, correctional facilities, and immigration centers to provide that care and collect evidence as needed for an appropriate situation (Chavali, 2016).

Prisoners have a right to adequate medical care (American Civil Liberties Union, 2021). This includes competent

Table 1. Summary of The Bill of Rights, Amendments I-X

First: Religion, Speech, Press, Assembly, Petition
Second: Bear Arms
Third: Quartering of Troops
Fourth: Search and Seizure
Fifth: Grand Jury, Double Jeopardy, Self-Incrimination, Due Process
Sixth: Criminal Prosecutions – Jury Trial, Right to Confront and to Counsel
Seventh: Common Lawsuits – Jury Trial
Eighth: Excess Bail or Fines, Cruel and Unusual Punishment
Ninth: Non-Enumerated Rights
Tenth: Rights Reserved to States or People

Table 2. Examples of American Civil Liberties

- Right to free speech
- Right to privacy
- Right to remain silent in a police investigation
- Right to be free from unreasonable searches of your home
- Right to a fair court trial

assessment, evaluation, and treatment for many acute and chronic conditions. Sometimes, the care is routine health management. Other times it directly relates to violence.

The correctional Forensic Nurses role requires both competence and clinical skill along with an investigative mindset. They may work in the infirmary directly administering medications and treatments. They can be called upon to collect evidence and document specific findings for future trial-related concerns. Their nursing skills and forensic mindset engage equally within this unique clinical setting. This combination is necessary to properly assess

illness and injury while simultaneously ensuring the safety of the patient, staff, and the prison community.

Injury and death in correctional settings are the results of accidents, interpersonal violence with inmates and/or staff, and self-directed. There is also a mental health consideration with incarcerated individuals. Because of this, prisoners have a right to justice and are against cruel or inhumane treatment (American Civil Liberties Union, 2021). Some jurisdictions include Forensic Nurses on the corrections clinical team. This includes treating prisoners that are victims of physical or sexual assault. A Forensic Nurse is often tasked with taking photographs, measuring injuries, collecting evidence, and documenting the events.

Forensic Nurses in some jurisdictions also engage perpetrators who are in custody but haven't yet been convicted of an alleged crime (Butler & Mallet-Boucher, 2020). One specific instance is when Forensic Nurses are needed to remove taser barbs after being subdued by law enforcement (Starr, 2019). For those awaiting trial, situations such as jailhouse altercations often result in injuries to staff and perpetrators, and nurses are frequently there to assess, evaluate, treat and document the injuries.

This role occurs both inside the correctional facilities and alongside law enforcement agencies. Forensic Nurses provide a unique collaboration with law enforcement roles to treat and consult on various types of cases. FNs work in both the public and private sector as well as with city, county, state, and federal government agencies.

Government

Forensic Nurses also work with these various government agencies in similar capacities. Forensic Nurses can be clinical or

administrative, working directly with victims, workplace readiness of agency employees, or in occupational health roles (Federal Bureau of Investigation, 2021). Clinically, the Forensic Nurse can evaluate specific needs with staff and perpetrators. They can also work as investigators for Boards of Nursing, Attorneys General, and the Federal Bureau of Investigation (Green, 2019; Haas, 2021).

Forensic Nurses can function as consultants with active military investigations having to do with domestic violence, sexual violence, and related concerns. Occasionally, the Forensic Nurse testifies as court-martial expert witnesses. Forensic Nurses are also called upon as consultants to explain pertinent clinical details at a presiding judge's request. Alternately, they may be a fact witness after collecting evidence with criminal or civil trials and case appeals.

Nontraditional Roles

Forensic Nurses offer direct services to clients, agencies, and the legal system. They also offer these services in more nontraditional environments. One such area is the prehospital setting (Silva, Santos, dos Santos, da Silva, Santos & deMelo, 2020). Forensic Nurses work in hospitalist settings where they are called to assist with evidence collection outside of Emergency Departments, such as in ICUs, skilled nursing, or assisted living facilities (Berishaj, Boyland, Reinink, & Lynch, 2020). They address mental health and workplace trauma issues through occupational health or urgent care placements (Newman, Roche, & Elliott, 2021).

Femicide and human trafficking are additional focus areas that use Forensic Nurse expertise. Women are disproportionately affected by domestic and sexual violence. This includes physical and sexual assault as well as strangulation.

However, women are also disproportionately impacted by human trafficking



and female genital mutilation. Similarly, some Forensic Nurses can be found working specifically with gender and transgender-related cases (DuMont, Saad, Kosa, Kia, & Macdonald, 2020)

Forensic Nurses are experienced with abuse of all types and in different settings. This includes physical, emotional, elder, child, sexual, and financial abuse. Their foundation, training, and attention contribute to improved health-related outcomes both clinically and administratively.

CHANGING OUTCOMES

Forensic Nurses change outcomes at the bedside and in the courtroom using a foundation of nursing practice and forensic training. Forensic Nurses apply nursing theory and other nursing concepts to diagnose and treat human conditions. Early Forensic Nurse engagement helps minimize physical and mental disability associated with violence-related injuries.

Forensic Nurses address outcomes in death investigations with appropriate evidence collection and documentation. Program expansion and increased training demonstrate prosecutor satisfaction with Forensic Nurse testimony (Reed, Symonds, Stier, Peluso, and Watson, 2020). This behavior is mirrored throughout the US because Forensic Nurses are well-trained clinical experts.

There is substantial evidence that Forensic Nurses have significant international appeal as well. Unlike traditional nursing roles and international training requirements, Forensic Nurses share the same scope and standards, further unifying their representation across borders. The Forensic Nurse role is active in the middle east (Kelishami, Manoochehri, Mohtashami & Kiani, 2020), New Zealand (Donaldson, 2019), Africa (Mageto, Omoni, Gabelus & Inyega, 2017), South America (Silva, Santos, dos Santos, da Silva, Santos & de Melo,

2020). Increased access to online education resources makes international role expansion a reality (IAFN, 2021c).

Some of the more common forensic nursing diagnoses are located in table 3 (NANDA, 2021). These diagnoses help address specific injuries and help identify actions and behaviors for both patients and perpetrators.

EDUCATION REQUIREMENTS

Undergraduate education and active, unrestricted licensure as an RN is the foundation of all Forensic Nurses. This equates to critical experience with the nursing process. It offers a link between nursing as a profession and other forensic disciplines. The educational foundation helps address limited resources for improved evidentiary evaluations and faster medical response times. Some go on to obtain masters or doctoral degrees with a forensic specialty. While a bonus, there is no expectation of attaining a graduate degree to be a Forensic Nurse.

Clinical acumen, attention to detail, and a high degree of clinical suspicion contribute to an overall successful forensic career. Forensic Nurses need strong assessment skills, planning ability and coordination for multiple simultaneous tasks. The work environment is anything but typical.

Evaluation skills are also essential. Forensic Nurses need to be able to identify what nursing and medical diagnoses are related to a case (Table 3). The Forensic Nurse needs to communicate these details effectively.

Additionally, Forensic Nurses require heightened awareness of legal responsibilities and chain of custody requirements. Forensic Nurses are the evidence collection and preservation experts. Failure to collect and maintain evidence within the chain of custody can destroy a case (Lee, Palmbach, Miller, 2006).

Table 3. Examples of Forensic Nursing Diagnoses (NANDA-I, 2021)

<p>Domain 1. Health Promotion</p> <ul style="list-style-type: none"> • Risk-prone health behavior • Ineffective family health management
<p>Domain 2. Nutrition</p> <ul style="list-style-type: none"> • Ineffective adolescent eating dynamics • Risk for impaired liver function
<p>Domain 3. Elimination</p> <ul style="list-style-type: none"> • Impaired urinary elimination • Impaired gas exchange
<p>Domain 4. Activity/rest</p> <ul style="list-style-type: none"> • Insomnia • Risk for ineffective tissue perfusion
<p>Domain 5. Perception/cognition</p> <ul style="list-style-type: none"> • Knowledge deficit • Impaired memory
<p>Domain 6. Self-perception</p> <ul style="list-style-type: none"> • Hopelessness • Risk for situational self-esteem
<p>Domain 7. Role relationship</p> <ul style="list-style-type: none"> • Interrupted family processes • Impaired social interaction
<p>Domain 8. Sexuality</p> <ul style="list-style-type: none"> • Sexual dysfunction • Risk for disturbed maternal-fetal dyad
<p>Domain 9. Coping/stress tolerance</p> <ul style="list-style-type: none"> • Risk for post-trauma syndrome • Rape-trauma syndrome
<p>Domain 10. Life principles</p> <ul style="list-style-type: none"> • Moral distress • Spiritual distress
<p>Domain 11. Safety/protection</p> <ul style="list-style-type: none"> • Risk for injury • Risk for female genital mutilation
<p>Domain 12. Comfort</p> <ul style="list-style-type: none"> • Impaired comfort • Risk for loneliness
<p>Domain 13. Growth/development</p> <ul style="list-style-type: none"> • Risk for delayed development

Forensic Nurses require heightened awareness of legal responsibilities and chain of custody requirements. Forensic Nurses are the evidence collection and preservation experts. Failure to collect and maintain evidence within the chain of custody can destroy a case.

CERTIFICATION VS. CERTIFICATES

There is a distinction between certification in a nursing specialty and a training certificate. The American Board of Nursing Specialties (2020) has an essential role in overseeing the quality of and uniformity of nurse certification. Without this management, variability and professional inconsistency occur. It is important to understand the distinctions between certified Forensic Nurses

and those that have a certificate for several reasons.

First, the pathways differ. Certification includes a specific process which reviews knowledge, skills and competency resulting in an earned credential (AALNC, 2021). Certification typically requires more rigor than a certificate.

Second, while not fully researched for forensics, nursing certification does have some impact on improved patient outcomes (Coehlo, 2020). Oversight of the nursing certification process is a hallmark of our profession.

A training certificate, on the other hand, is an educational process that does not necessarily require the same level of rigor to obtain or maintain the credential. This is a unique distinction when sourcing a forensic expert for your cases. The certified expert usually has additional knowledge, skills, training and clinical experience which requires ongoing educational requirements (IAFN, 2021b).

SUGGESTIONS FOR LEGAL NURSE CONSULTANTS

Legal nurse consultants can maximize their case impact by identifying which cases need forensic nursing input, when, and why. Several questions to ask are listed in table 4.

The first steps involve reviewing initial case documents and pertinent details. This allows the LNC an opportunity to

determine specific gaps and other case concerns. It also allows legal staff to determine when input from a Forensic Nurse is most helpful. Timely engagement is paramount.

Determining why a Forensic Nurse is necessary or justified is a bit more complex. Each case has specific nuances from a statute of limitations to causation. Once the LNC has thoroughly evaluated the initial case details, they can work on identifying the specific complexities and concerns of each case.

The specific case complexities and overarching concerns allow the LNC to determine what type of forensic nursing expert is necessary. For example, if this is a federal criminal case, you want to find a Forensic Nurse with similar experience in current clinical practice that is able to generate a qualified report. Likewise, if the case is in civil court for sexual assault, the LNC needs to locate a sexual assault expert working with a similar population.

When locating a Forensic Nurse, seek out nurses that are forensically trained either through formalized institutional or organizational programs and have certifications or certificates. Some nurses have academic forensic degrees (IAFN, 2021a). Others have graduate degrees with minors in a forensic specialty. You may need to ask specific education questions during screening.

It is preferable to identify nurses holding either current forensic nursing certification or forensic certificates. There are many different organizations where certificates are obtained, but organizations offering forensic certification are less voluminous. The Advanced Forensic Nurse Board Certification is the highest available credential but is no longer issued (ANCC, n.d.). The few Forensic Nurses who are AFN-BCs must maintain the credential by renewing it every five years.

Table 4. Questions to Ask When Evaluating A Forensic Nursing Case	
1.	What is this case about?
2.	How complicated is this case?
3.	What case needs do I have?
4.	Am I familiar with the specific conditions or circumstances?
5.	Can a Forensic Nurse help me evaluate the case or circumstances?
6.	Do I need to consult a Forensic Nurse for further assistance?
7.	What is my case timeline?
8.	What type of forensic nursing concern is there?
9.	What qualifications should my expert have?
10.	What domain of forensic nursing does this impact?

You also need to evaluate what skill set you need for a particular case. If a case relates to elder abuse or female genital mutilation, you want an expert with similar experiences and skills to both to evaluate cases and testify if necessary. Forensic Nurses should clearly explain how their education, skills, and training relate to their specific needs.

Engage a selected Forensic Nurse as early as possible. Doing so allows the nurse expert to help you evaluate specific records, documents, and other pertinent findings in advance of deadlines.

Selecting the right Forensic Nurses for the right cases at the right time is essential to case success. The forensic nursing specialty is founded on a scientific, evidence-based methodology that improves outcomes for your clients. The right approach to finding and screening a Forensic Nurse can streamline your case process in the long term.

CONCLUSION

The availability of qualified Forensic Nurses and the essential training required for forensic roles improve access to high-quality care. This care relates to both victims and perpetrators, depending on the clinical expectation and specific case needs. Forensic Nurses' engagement improves both the foundation of case evidence and overall process transparency by following specific scientific methodology and high levels of scientific training.

Clinically, the Forensic Nurse is an educator, active clinician, and client advocate. Administratively, Forensic Nurses increase LNC access to resources necessary to assess, evaluate and educate those that are involved in the medicolegal systems. The inclusion of specially trained and certified Forensic Nurses can be a secret weapon for challenging cases with both plaintiff and defense cases for LNCs that choose to use them properly.

REFERENCES

- American Association of Legal Nurse Consulting. (2021). Certification vs. certificate. <http://www.aalnc.org/page/certification-vs.-certificate>
- American Board of Nursing Specialties (ABNS). (2020). About us. <http://www.nursingcertification.org/About-ABNS>
- American Civil Liberties Union. (2021). Civil Liberties in Prison. <https://www.aclu.org/issues/prisoners-rights/civil-liberties-prison#:~:text=The%20ACLU's%20National%20Prison%20Project,in%20Turner%20v.>
- American Nurses Association (ANA) & International Association of Forensic Nursing (IAFN). (2017). *Forensic nursing: Scope and standards of practice* (2nd ed.). Nursebooks.org.
- American Nurses Credentialing Center. (n.d.). Advanced Forensic Nursing Certification (AFORENSIC NURSE-BC). <https://www.nursingworld.org/our-certifications/advanced-forensic-nursing-renewal/>
- Barkley, L.B. (2018, July 30). What are the JCAHO requirements for hospitals treatment victims of domestic violence? <https://www.medscape.com/answers/805546-157831/what-are-the-jcaho-requirements-for-hospitals-treating-victims-of-domestic-violence>
- Berishaj, K., Boyland, C. M., Reinink, K., & Lynch, V. (2020). Forensic Nurse Hospitalist: The Comprehensive Role of the Forensic Nurse in a Hospital Setting. *Journal of Emergency Nursing*, 46(3), 286–293. doi 10.1016/j.jen.2020.03.002
- Butler, L. J., & Mallet-Boucher, M. (2020). Healthcare in secure Environments: Leading a Collaborative for Forensic Nursing Education. *Nursing Leadership (1910-622X)*, 33(1), 25–34. doi 10.12927/cjnl.2020.26194
- Coelho P. (2020). Relationship between nurse certification and clinical patient outcomes: A systematic literature review. *Journal of Nursing Care Quality*, 35(1), E1–E5. <https://doi.org/10.1097/NCQ.0000000000000397>
- Dahlberg, L.L. & Mercy, J.A. (2009). *The history of violence as a public health issue*. US Department of Health and Human Services Centers for https://www.cdc.gov/violenceprevention/pdf/history_violence-a.pdf Disease Control and Prevention.
- Davis, G.J. (2020). The medical examiner and coroner systems. <https://emedicine.medscape.com/article/1785357-overview#a2>
- Donaldson, A. (2019). Forensic clinical nurses in emergency departments: An emerging need for New Zealand. *Kai Tiaki Nursing Research*, 10(1), 54–58.
- DuMont, J., Saad, M., Kosa, S.D., Kia, H. & Macdonald, S. (2020). Providing trans-affirming care for sexual assault survivors: An evaluation of a novel curriculum for Forensic Nurses. *Nurse Education Today*, 93. <https://doi.org/10.1016/j.nedt.2020.104541>
- Duquesne University. (2020). Forensic Nurses Working with Law Enforcement. <https://onlinenursing.duq.edu/blog/forensic-nurses-working-with-law-enforcement/>
- Federal Bureau of Investigation. (2021). Discover medical and counseling opportunities at the FBI. <https://www.fbijobs.gov/career-paths/medical-counseling>
- Freire-Vargas, L. (2018). Violence as a public health crisis. *American Medical Association Journal of Ethics*, 20(1), 25-28. doi: 10.1001/journalofethics.2018.20.1.fred1-1801.
- Green, D. (2019). Becoming a nurse investigator. <https://www.myamericannurse.com/becoming-a-nurse-investigator/>
- Greenwood, B. (2021). The roles & responsibilities of Forensic Nurses. <https://work.chron.com/roles-responsibilities-forensic-nurses-11667.html>
- Haas, L. (2021). What training do FBI Forensic Nurses need? <https://work.chron.com/jobs-involve-nursing-criminal-justice-20081.html>
- Heron, M. (2019, June). Deaths: Leading causes for 2017. *National Vital Statistics Reports*, 68(6). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_06-508.pdf
- International Association of Forensic Nursing. (2021a). Academic programs in forensic nursing. <https://www.forensicnurses.org/page/ForensicNursingSchools>
- International Association of Forensic Nursing. (2021b). Certification. <https://www.forensicnurses.org/page/Certification>
- International Association of Forensic Nursing. (2021c). Education. <https://www.forensicnurses.org/page/Education>
- International Association of Forensic Nursing. (2021d). History of the association. <https://www.forensicnurses.org/page/AboutUS>
- International Association of Forensic Nursing. (2021e). What is forensic nursing? <https://www.forensicnurses.org/page/WhatisFORENSICNURSE>

Le, A.B., Brooks, E.G., McNulty, L.A., Gill, J.R., Herstein, J.J., Rios, J., Patlovish, S.J., Jelden, K.C., Schmid, K.K., Lowe, J.J. & Gibbs, S.G. (2019) US Medical Examiner/Coroner capability to handle highly infectious decedents. *Forensic Science, Medicine Pathology*, 15, 31–40. <https://doi.org/10.1007/s12024-018-0043-2>

Lee, H.C., Palmback, T.M. & Miller, M.T. (2006). *Henry Lee's crime scene handbook*. Elsevier Academies Press.

Kelishami, F. G., Manoochehri, H., Mohtashami, J., & Kiani, M. (2020). Consequences of presence of Forensic Nurses in health care system: A qualitative study. *Iranian Journal of Nursing & Midwifery Research*, 25(3), 195–201. doi:10.4103/ijnmr.IJNMR_119_19

Mageto, I. G., Omoni, G., Cabelus, N. B., & Inyega, J. O. (2017). Preparedness and practice of forensic nursing in Kenya. *International Journal of Nursing Education*, 9(3), 64–68. doi:10.5958/0974-9357.2017.00072.1

NANDA International, Inc. (2021). *NANDA-I Definitions & Classifications, 2021-2023*

Now Available (English). <https://nanda.org/2021/02/nanda-i-definitions-classification-2021-2023-now-available-english/>

Newman, C., Roche, M., & Elliot, D. (2021). Exposure to workplace trauma for forensic mental health nurses: A scoping review. *International Journal of Nursing Studies*, 117. <https://doi.org/10.1016/j.ijnurstu.2021.103897>

Reed, G.D., Symonds, A., Stier, A., Peluso, S. & Watson, S.O. (2020). Prosecutor preference for Forensic Nurse testimony: Outcome of expanding a forensic program. *Journal of Emergency Nursing*, 46,(3), 310-317. <https://doi.org/10.1016/j.jen.2020.02.014>

Sakalli, D., & Aslan, M. (2020). Levels of knowledge of emergency nurses regarding forensic cases and approaches to evidence. *Signa Vitae*, 16(1), 65–72. doi:10.22514/sv.2020.16.0009

Silva, J. O. M., Santos, L. F. S., dos Santos, S. M., da Silva, D. P., Santos, V. S., & de Melo, C. M. (2020). Preservation of forensic evidence by nurses in a prehospital emergency care service in

Brazil. *Journal of Trauma Nursing*, 27(1), 58–62. 97/JTN.0000000000000483

Starr, Kristopher T. (2019). Treating a patient who has been tasered. *Nursing*, (49)12, 20 doi:10.1097/01.NURSE.0000604704.33793.00

Valentine, J. L. (2018). Forensic nursing: Overview of a growing profession. *American Nurse Today*, 13(12), 42–44.

World Health Organization. (n.d.). *Violence – A global public health problem*. https://www.who.int/violence_injury_prevention/violence/world_report/en/chap1.pdf

World Health Organization. (2021). *Violence Prevention*. <https://www.who.int/teams/social-determinants-of-health/violence-prevention>



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The Quagmire of Social Determinants of Health for the Legal Nursing Consultant:

Evaluating Failure to Thrive

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Keywords: Legal Nurse Consultant, Failure to Thrive, SDoH, Neglect, Child Maltreatment, Child Abuse

When healthcare expires all potential diagnoses for Failure to Thrive (FTT), they often enter the realm of "neglect." A reportable crime, child neglect, involves parents and guardians, families, medical personnel, child protection services, and legal professionals. The medical record documents harm, and a quagmire occurs between multiple medical diagnoses associated with the process of starvation, systemic and provider bias about obvious Social Determinants of Health (SDoH). When "neglect" is a medical diagnosis of elimination and SDoH influences provider-systemic bias, Legal Nurse Consultants employ strategies for separating the quagmire necessary to help establish the actual cause(s) of harm.

This activity is designed to augment the knowledge and skills of legal nurse consultants and assist in their understanding of the analysis of medical malpractice claims involving failure to thrive diagnosis and treatment.

Upon completion of the learning activity the learner will be able to:

- Evaluate medical malpractice claims involving failure to thrive (FTT) and identify if practice standards, guidelines, and algorithms for FTT are met.
- Understand the medical diagnosis and treatment of FTT and identify possible implicit and/or explicit bias of the providers and systems diagnosing and treating FTT.
- Assist attorneys to create timelines, identify gaps, determine harm, and identify elements contributing to harm in infants diagnosed with FTT.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until September 1, 2024.

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INTRODUCTION

Because the causes of organic and environmental weight loss in the infant are numerous, failure to thrive (FTT) is a difficult diagnosis. Social Determinants of Health (SDoH) often influence parents' capacity to care for their children (Francis et al., 2018; Storfjell et al., n.d.). Intentional causes of FTT are known as child maltreatment (CM), defined as an expectation that parents or caretakers deny "adequate food, clothing, shelter ...though financially able to do so or offered financial or other reasonable means to do so" (Rizvi et al., 2021). Often providers are trained to have a low threshold for reporting suspicions of CM (Brown et al., 2021; Child Welfare Information Gateway, 2019). However, in medical environments, the CM diagnosis differential in FTT is a diagnosis of elimination from health indicators that begin with deficits in growth parameters (Brown et al., 2021). For the ill infant, the diagnosis for FTT occurs after significant laboratory analysis and assessment, and monitoring is to avoid a predictable cascade of worsening medical findings.

For healthcare providers (HCP), the diagnosis is predicated on worsening conditions, not on a family's financial situation or living environment. Healthcare diagnoses occur without witnessing the event that causes injury, and typically, the HCP has no knowledge of a family's crisis or community experience. Therefore, determining the cause of FTT and intent, which is necessary for the diagnosis of CM, is elusive when evaluating the totality of FTT in limited healthcare systems.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines legal exceptions when healthcare professionals can breach confidentiality without permission. These exceptions often include gunshot wounds, stab wounds, injuries sustained in a crime, child and elder abuse, infectious, communicable, or reportable diseases (Edemekong et al., 2021). Judgments are made about types of injuries. FTT is a medical diagnosis, and CM is a diagnosis of intent with a suspected perpetrator, which is usually a parent. The expectation is that healthcare providers make an unbiased, accurate medical diagnosis

in a healthcare system that is not biased against individuals or their circumstances. When the medical diagnosis is FTT, and the healthcare provider suspects intentional injury, they are mandatory reporters to Child Protection Services (Child Welfare Information Gateway, 2019). When healthcare providers believe FTT to be an intentional injury related to neglect, the LNC looks for explanations. When found to be biased, an FTT diagnosis implies *overconfidence* without full exploration of the situation (Fargen et al., 2020).

The medical diagnoses are important today because many state laws have changed to allow adult victims to seek justice years later from their childhood abusers (Baker & Brassard, 2019). The analysis of cases of FTT is difficult, and the LNC needs medical information to distinguish between organic FTT and CM. The data in the medical record helps to discern provider implicit and explicit bias (e.g., ageism, racism, culture-ism, income-ism, etc.) in their judgments. These biases are noted in failure to access information for differential diagnosis as well as in testing choices that deviate from standards of practice. Alternatively, information from investigative reports related to a family's situation or environment offers additional discovery materials, including SDoH in the caregiver's environment (e.g., income, race, housing, food deserts, etc.). The SDoH, medical diagnosis and treatment of FTT, and consideration of possible implicit or explicit bias are necessary for determining the preponderance of evidence supporting CM or organic FTT demonstrated in Figure 1.

BACKGROUND

Organic FTT

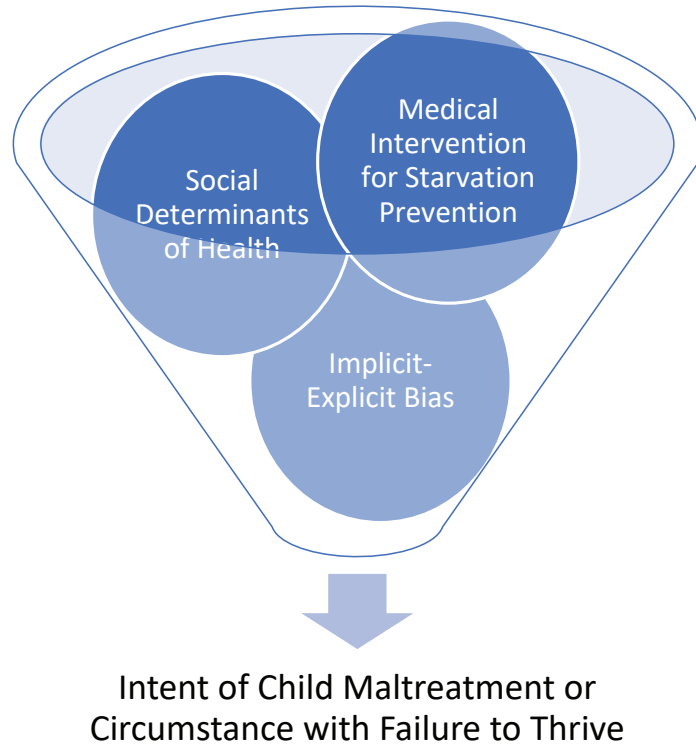
Organic causes of FTT are frequently misdiagnosed. The LNC is often called to work behind the scenes in areas of expertise to create a pattern of activities from discovered medical records for

an attorney (whether civil, criminal, or defense). The LNC works with attorneys to create timelines, identify gaps, determine harm, the elements contributing to harm. The narrative often explains the long-lasting effects of the diagnosis, assisting the attorney in determining the ‘what’ and degree of association. The summary assists the attorney in calculating financial redress for the diagnostic malfeasance.

Broadly, the definition of FTT is lack of weight gain proportional to age determined by standard growth charts (WHO Child Growth Standards, 2020). The FTT assessment is the best practice for infants for the purposes of weight loss documentation. Newborns frequent pediatric primary care practices (PCP) (WHO Child Growth Standards, 2020) where newborn evaluation is standardized to include repeated growth measures using age-appropriate percentile charts over time (Goh et al., 2016). If weight loss is detected, then additional PCP assessments include a thorough history and physical examination, observation, and documentation of the child’s feeding pattern and amount, as well as the parent-child interaction (Bryant et al., 2020). PCPs observe mothers and babies during breastfeeding to ensure bonding, breastfeeding techniques, and to check the breast milk using a Crematocrit. (Bryant et al., 2020). Close PCP observation for the infant at risk and follow-up frequency is necessary to see weight gain. Documented clinical symptoms are typical findings useful to the LNC building a timeline.

Some patients with FTT arrive in provider practices with insufficient care histories and with serious medical needs, such as dehydration. The infant may have a history of multiple episodes of vomiting, appear wasted, lethargic, and with significant weight loss. In cases of FTT, the search for the cause of underlying medical conditions is standardized (Homan, 2016). The provider considers all other differential diagnoses

Figure 1: Decision Influencers in Failure to Thrive: SDoH, Medical Intervention for Starvation Prevention and Implicit-Explicit Bias



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(Bryant et al., 2020), including phenotypic, genetic variations (Bryant et al., submitted). Detectable manifestations of organic FTT seen by PCPs are in Table 1.

When the PCP suspects a significant decline in the infant’s health and physical presentation, the symptoms may be indicative of starvation. Accordingly,

further diagnostic testing proceeds to distinguish the stage of starvation and the potential for reversal. The most common cause (>80%) is insufficient caloric intake resulting in a nutritional deficiency without an underlying medical condition (Maaks, Starr, Brady, Gaylord, Driessnack & Duderstadt, 2020). While harm is possible, medical diagnoses with charges of CM in

Table 1: Some Common Clinical Manifestations of Failure To Thrive (FFT)

Affect	Feeding	Integument
Poor weight gain	Poor intake	Dehydration
Vomiting	Food refusal	Tenting of skin
Irritability	Food fixation	Dry mucous membranes
Psychosocial problems	Abnormal feeding practices	
Chronic physical problems		

Source: Bryant et al, 2020

Table 2: Cognitive Biases that Affect Decision-Making in Failure to Thrive with Patients and Parents

Biases	Definition	Example
Aggregate Bias	Provider believes patients are exceptional without cause in comparison with patients in which guidelines were developed	Guidelines rule out organic causes, and in this case not completely applied because PCPP opinions developed about teen parents and their neglectful intent
Confirmation Bias	Provider interprets and focuses on information that confirms one's preconceptions	Asks limited questions once specific answers confirm preconception, e.g., "I didn't buy the milk" confirms intent, when SDoH prevents purchase of milk
Fundamental Attribution Error	Provider will blame patients for their respective situation than assess the factual circumstances	PCPP lens is myopic blaming parents for circumstances of unemployment, contributing to SDoH
Overconfidence Bias	Provider believes they are more knowledgeable and/or skilled than they actually are, leading to action on intuition, incomplete data, or in the absence of data	With this bias, team trusted the PCPP diagnosis of CM, not considering incomplete medical data about SDoH and the influence of loss of income
Search Satisfying	Provider will stop looking for other problems/diagnoses once one is identified	Limited testing related to medical GERD omitted, and absent critical SDoH information related to seeking help and the current living environment resulted in inadequate analysis of circumstance contributing to a CM medical diagnosis without all data

Source: Fargen et al, 2020 edited to demonstrate implicit and explicit bias in Failure to Thrive

FTT are unlikely when there is medical etiology and forgiving judgments about caretakers, which is riddled with structural bias. Often a quagmire occurs when there is an assignment of multiple diagnoses, each related to one of four medical stages of starvation (Weiss, 2020). The liver system responds first with enzyme elevations; then the brain changes with developmental delays, and then muscle degradation is detectable with elevated proteins. The kidneys respond with diuresis of the protein, ending in cardiac arrhythmia from electrolyte imbalances, ketosis, and alkalosis. Regardless, the medical aspects and clinical presentation of the causes of organic weight loss in the infant are numerous. Often healthcare providers are very forgiving when knowledge of environmental factors is introduced as

a correctable deficit. A possible contributing factor in medical diagnoses and reporting of CM is that intentional neglect cannot be ruled out, even when there are organic causes determined.

Systemic and Implicit Bias

Many LNCs specialize in healthcare for unique populations by addressing patient needs in hospitals and community agencies. Others achieve advanced practice degrees, responsible to the nursing license practice authorities in their respective states, and depending on the state; they have the capacity to create differential diagnoses. Often the LNC is an advanced practice nurse in primary care pediatric practice (PCPP) with extensive experience addressing FTT in infancy. All providers experience implicit and explicit bias in healthcare

structures that impacts diagnoses of complex situations like FTT. A third key is recognition and minimization of the LNC's personal implicit and explicit biases and working to correct structural biases often discovered in the caseload.

The LNC, who is an expert in CM, understands there are multiple manifestations of FTT, with many detected only with laboratory testing. The existence of systemic bias is harder to determine, evident in provider charting known as aggregate bias (Fargen et al., 2020). The LNC's FTT evaluation includes an understanding that implicit and explicit bias about patient populations by providers and systems reflect unique attitudes and actions toward groups of patients (FitzGerald & Hurst, 2017). To determine bias, the LNC looks at the PCP documentation in the record with new mothers and babies. The visits begin within a couple of days after delivery, and periodically every month or two months, following best practice guidelines for growth, development, and immunization schedules. Often weight loss is expected in the first week or two, with rapid increases in weight by the second week. By then, the metabolic and genetic panels return to the PCP, where results for phenylketonuria, thyroid, and cystic fibrosis are shared with the mother. Absent is karyotype testing for genetic diseases, such as Turners Syndrome (T.S.) and T.S. Mosaicism, often a cause of growth delays (Bryant et al., 2020 submitted). When weight loss is severe, alkalosis is associated with starvation. Measuring intent for harm in medical settings may include an evaluation of the parental actions related to infant sustenance, which is variable, requiring interprofessional collaboration among medical, nursing, social, nutritional, biobehavioral, and other specialties. The measurement of growth with sustenance and observation is the subsequent reason for hospitalization. The decline in

sustenance juxtaposed with increasing medical symptoms is predictive of a worsening condition. When patient populations with similar circumstances and appearance align with the providers' culture, reporting CM may reflect *fundamental attribution error* (Fargen et al., 2020). Typically, routine laboratory testing rarely identifies a cause in the early stages of organic FTT. Laboratory analysis is not generally recommended, creating an absence of data, possibly due to *overconfidence bias* (Fargen et al., 2020). In biased cases, the HCP decision for early laboratory testing may be fears of tort. *Fundamental attribution error* includes efforts to minimize care, discharge early, or blame the vulnerable persons for their circumstances. (Fargen et al., 2020). In these cases, the metabolic workup identifies the most serious threat to the infant's life, which is organ failure and metabolic alkalosis. Interventions follow with the requisite re-balancing of deficits found in the blood work. Following evidence-based standards, guidelines, and algorithms create equity in care, regardless of unconscious bias. Juxtaposed is the overconfidence bias, where providers reflect overconfidence in the diagnosis, leading to gut reactions (Fargen et al., 2020). The demonstration of *fundamental attribution* (FitzGerald & Hurst, 2017) by the healthcare provider is noted in judgment and explicit actions toward a patient that is based on patient appearance (gender, race, age) or environment (sociodemographic characteristics and behaviors).

The LNC looks to the patterns in a medical assessment and interventions to determine if practice standards, guidelines, and algorithms for FTT are met. The LNC determines associations between the lack of adherence, including provider implicit and explicit bias, as contributors to the negative outcomes and experiences with the healthcare system. Implicit bias beliefs emerge with explicit and biased actions, which

is evident in the number and types of questions asked of both teen parents about the infant. When older parents are not asked similar questions as teen parents, explicit bias reflects an implicit bias related to age. Explicit bias results in a referral to parenting classes for the teen parents, acting on the belief that the teens need parenting classes, also known as *confirmation bias* (Fargen et al., 2020). Table 2 lists examples of implicit and explicit bias characteristics (FitzGerald & Hurst, 2017).

Environmental FTT

FTT related to the environment is often neglected in the assessment of the infant. When an injury is considered intentional harm or is a missed diagnosis, the LNC has a role when a tort is brought in civil or criminal courts. For infants and children harmed with FTT, tort may also occur years later in states that allow adults to sue offenders for harm in childhood (Kearney, 2001; Neeley, 2000). When the cause of FTT reflects influence by SDoH, the medical outcomes are similar. The physiology of starvation does not change, but the lack of healthcare access, parental education, economic stability, and social or community support creates poorer outcomes (Office of Disease Prevention and

Health Promotion, 2018, 2020). The SDoH elements are listed in Table 3.

The LNC looks at bias in explicit measurements and diagnoses when SDoH is found in the medical record. Structural bias is difficult to assess in medical and health records (FitzGerald & Hurst, 2017; Weber et al., 2017) when SDoH contributes to disparities related to income, race, housing, age of parent(s) (adolescence), language, and literacy, transportation access, violence, and access to nutritious foods. SDoH contributes to an explanation, not an interpretation, of intent in the diagnosis of starvation of an infant or child. The LNC uses the neglect diagnosis and subsequent biological and physiological findings for the harm, but the assessment of consequences without SDoH is structurally flawed. For the CM diagnosis, both SDoH and organic outcomes contribute to the elimination of medical causes. Failure to use both in the consideration results in reporting CM when none exists. The consequence of reporting SDoH causes of FTT as CM, coupled with individual and systemic bias, are significant ramifications for the child, family, community, and systems. Poverty may be the situation. Complicating adequate nutrition are food insecurities seen in impoverished

Table 3: Goals of Social Determinants of Health (SDoH)

Domain	Goal
Economic Stability	Help people earn steady incomes that allow them to meet their health needs
Education Access and Quality	Increase educational opportunities and help children and adolescents do well in school
Healthcare Access and Quality	Increase access to comprehensive, high-quality healthcare services
Neighborhood and Built Environment	Create neighborhoods and environments that promote health and safety
Social and Community Context	Increase social and community support

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved {December 8, 2020}, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

Figure 2: Social Determinants of Health**Social Determinants of Health**

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Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [December 8, 2020], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

families. Situational poverty during Covid-19 creates disadvantages related to the potential for illness, rapid absence of income with job loss, and subsequent insecurity with food and housing (Patel et al., 2020; Pereira & Oliveira, 2020; Van Lancker & Parolin, 2020). When the sudden loss occurs, several changes are predictable, including economic instability, change in access to quality education, reduced healthcare access, and quality, and changes in the neighborhood and built environments in the social and community context. SDoH is insecurities that become structural deficits and opportunities for systematic bias and are characterized by five domains, as noted in Figure 2. When CM and family food insecurity is a consideration (Homan, 2016) as a differential for “reasonable suspicion” of neglect in FTT, there is a report to child protective services (Child Welfare Information Gateway, 2019).

The LNC should complete a comprehensive search for organic causes, both implicit and explicit bias, and an environmental origin associated with the SDoH and seen in Table 4 as an explanation for the lack of weight gain.

Report to CPS***Criminal Justice process following report of a crime.***

Typically, the differential diagnosis is for a medical cause. A suspicion of parental neglect is an atypical and non-medical diagnosis. The LNC looks for provider biases like *Aggregate Bias*, *Confirmation Bias*, *Fundamental Attribution Error*, *Overconfidence Bias*, or *Search Satisfying* biases. Suspicions of neglect require reporting to Child Protective Services in these cases (Child Welfare Information Gateway, 2019). Regardless, suspicions of neglect

require reporting to Child Protective Services (Child Welfare Information Gateway, 2019). Hospitalization is recommended if there is reason to believe the parental neglect is intentional. The purpose of hospitalization is to evaluate the parent-child interaction and provide increased caloric intake. Medical professionals often report to state authorities and cooperate with criminal justice professionals and child protective services. However, child abuse teams rely heavily on medical opinion for intent. When unconscious biases influence the provider opinion, child abuse teams build a case for neglect rather than look for a circumstance that creates the medical condition of FTT. Medical diagnosis does not consider circumstances or the family’s challenges when affected by SDoH. External stakeholders (such as law enforcement and child protective services) rely heavily on the medical explanation for determining intent. Providers use the diagnosis to explain the infant’s medical condition and then interpret intent based on incomplete information. The gap in the medical workup is the thorough social investigation into the situation of the family, which often reveals difficult challenges known as SDoH. Often the bias is implicit, and provider diagnostic judgment and explicit actions occur to correct the medical condition of the child. Diagnosis is typical without all the information about the family decisions and circumstances external to the medical environment. Subsequently, *confirmation*, *attribution*, and *other* biases drive decisions when there is a gap in the information necessary to determine CM, as illustrated in Table 3.

In cases of tort, the LNC has access to most records associated with the tort, including records reflecting SDoH, such as joblessness, poverty, youth naïveté, or knowledge deficits (Francis et al., 2018; Storjfell et al., n.d.). Often records reflect unintended personal judgments

about parents' intent (Francis et al., 2018). The PCP has the responsibility to query elements of SDoH and refer to services in the community to support the health of the infant in an interprofessional collaboration (Francis et al., 2018; Oldfield et al., 2020; Storfjell et al., n.d.). Once hospitalized, the record reflects other social determinants, which include financial, environmental, community, healthcare access, and education (Francis et al., 2018; Oldfield et al., 2020; Storfjell et al., n.d.). The interprofessional team analysis may be available to the LNC. If not, the risk assessment may be protected in incident reporting processes. The expectation is to have a full case analysis by the multidisciplinary professional team. These teams include healthcare providers who are physician child abuse specialists, forensic nurses, pharmacists, social workers, lactation specialists, and nutritionists (Homan, 2016).

The expectation of the LNC is that once the report of CM – FTT neglect, CPS open a file, looks for previous family member reports with outcomes in the records, and starts a thorough current medical and social investigation, talking not only to the healthcare providers, but to family, neighbors, and community contacts. Typically, the CPS file is not available to the LNC. The LNC uses conversations by or testimony by CPS to disclose important information not in the medical record. CPS builds a narrative that describes the condition and situation of the core family and the infant, birth record, and other reports if there are other children. CPS will also speak to neighbors and other family members about the parents and their care of the child(ren), gathering reports of incidents from witnesses. Often hearsay is accepted and considered in the final disposition. Their report is a judgment directly linked to the query, "Is this child safe in this situation (or with the guardian or parent)?" If the determination is no, the child is removed and

either placed with another family member or in foster care. The report is shared with the prosecutor, who collects additional evidence from law enforcement's investigation. Law enforcement, like CPS, also speaks to a variety of persons with knowledge about the family and the situation, but these summary reports are available under *freedom of information* to the attorney who hired the LNC. They include the details of the complaint, and the arrest is made. In many communities, the child protection team (CPT) meets to discuss the elements of each child abuse case, and a decision about prosecution is made with CPT input. If charged and arrested, the individual has all the rights and privileges guaranteed by the U.S. Constitution, which includes Miranda rights. Miranda guarantees the right to legal representation, and if they cannot afford representation, an attorney is appointed to defend the rights of the accused. When adjudicated, courts seal all records related to CM.

PURPOSE/AIM

The purpose of the pseudo case exemplar is: (1) to provide insight into the analysis of the records for the legal strategy that uses LNC subject matter expertise (SME) to discover explanations and weaknesses in the process that evaluated FTT, and (2) to reconstruct the event when parents face an accusation of child neglect or when children, as adults, seek redress.

Case Study

The Infant

JL is a 3-month-old cisgender male born of teen parents. J.L. began vomiting and was taken to the emergency department. The provider medically diagnosed failure to thrive without all the information about the family or the family's efforts to ameliorate their situation and provide care for their infant. The provider also diagnosed the *cause* of the vomiting as parental neglect—the provider based their judgment on the parents and the infant's presentation. The provider had no knowledge of the pre-hospital visit activities of the parents. The provider made a formal report of neglect to state child protection authorities. The decision to remove the infant and his siblings from the parents contributed to law enforcement's decision to charge the parents with child neglect. The provider's testimony in court was, "this was the worst case of failure to thrive in the 600 cases I've seen."

The Parents

The 19-year-old parents had four children ranging in age from 3 months to 3 years. The parents married when they were 16 with their parent's permission and had three pregnancies. The children were three births, two cisgender males aged three years and three months, and two 18-month-old cisgender twin females. The three-month-old is the child of interest, and the three older

Table 4: LNC Quagmire Analysis from Tables 1-3

SDoH	Biases	Organic FTT
Economic Stability	Aggregate Bias	Affect
Education Access and Quality	Confirmation Bias	Feeding
Healthcare Access and Quality	Fundamental Attribution Error	Integument
Neighborhood and Built Environment	Overconfidence Bias	Laboratory
Social and Community Context	Search Satisfying	Observation outcome

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children met all growth and developmental milestones. However, during the mother's last pregnancy, the father lost his job, and their son was born. The pre-unemployment income prevented them from qualifying for WIC benefits. Subsequently, the mother's milk dried up under stress. In order to feed the infant, the grandparents bought formula. The parents added extra water to the bottle to stretch the feedings. During this time, the parents sought food for their family from dumpsters. The older children ate the collected food provided and were documented to be normal in growth and development. The mother chewed her food and fed it to the infant for extra calories.

The Situation

Feeding a 3-month-old infant masticated food has the potential for harm. Watering the formula causes nutritional deficits, and both have the potential to cause vomiting in the infant. Once vomiting started, the records reflected that the parents sought medical attention 24 hours before hospitalization. The primary care record reflects the calls, but the primary care provider did not respond. With no response, the parents went to the pharmacy and sought advice from the pharmacist. The pharmacy tech recommended an over-the-counter medication for the vomiting infant, but when questioned in court, they did not remember the couple or their problem. When the infant continued to vomit through the night, the parents took the infant to the pediatric hospital emergency department.

The Workup

The LNC uses the data from the workup in all healthcare charts. Data includes a series of documented decisions by all providers, laboratory data available to the providers, and information about best practices. The first components of an FTT workup in primary care are to determine the height and weight of the child according to the age of the child, where weight that is less than five percentiles for age as determined by *WHO Growth Standards Recommended for Use in the U.S. for Infants and Children 0-2 Years of Age* (WHO Child Growth Standards, 2020). Serial weights are important as loss weight of greater than two percentiles fits the criteria for FTT. The ideal weight is 50 to 80 percent for age. In the hospital, similar measurements provide a slice in time, but both records facilitate comparison and add to the timeline of understanding the presentation. The LNC uses the primary care chart to validate that the PCP monitored and evaluated the pregnancy and birth experience, attachment interaction, oral-motor function, and family and social support. Once hospitalized, the urgent care provider uses laboratory studies in the clinical settings to determine medical conditions by ordering creatinocrit on the mother's breast milk. Also ordered is a complete CBC with differentials, urinalysis, electrolytes, intake and output, metabolic studies, and thyroid levels. The physical assessment completed for nutritional status by all providers includes assessment of skin turgor, mucous membrane, infant

activity, and alertness, and serial weights (Bryant et al., 2020).

The Child Abuse Team

Often in resource-rich communities, a coordinated community response to child abuse complaints occurs through child advocacy or justice centers. Multidisciplinary and interprofessional stakeholders often have co-located offices. The child abuse team consists of healthcare providers (physicians, nurses, child psychologists, and pediatric neurology), social services (licensed social worker), risk management (hospital attorneys), chaplains (faith), nutrition specialists (dietician), and child life specialist. Other members may include child advocacy center specialists (child advocates, legal child advocates, forensic interviewers, psychologists, and legal team members), child protection services (Department of Child Services/Protection), law enforcement (police and child abuse investigators), prosecutors, and defense attorneys.

Resource-rich communities have routine meetings to discuss cases with ongoing investigations and recovery of data. The items considered are associated first and foremost with the safety of the child. The next item is a determination of intent that causes hospitalization. Once the medical determination is made, when there are no or undetermined causes for the injury, healthcare providers often lean toward maltreatment (Bryant et al., 2020). Providers may not fully realize the situational influences, e.g., SDoH (poverty, job loss, access, and equity in healthcare) (Francis et al., 2018; Oldfield et al., 2020; Storfjell et al., n.d.). Often, the formal records and review process are not available to the LNC. Regardless, the team is collaborative with obvious team leaders – physicians and lawyers, and they compile available information for their respective conclusions about the medical diagnosis or prosecution, respectively. By virtue of the type of

information collected, both physician and lawyer operate with deficits because some records are protected, and elements are redacted from team members and public view. In this case, the patient's parents were adolescents who experienced sudden poverty from job loss. The LNC reviewed records from the interprofessional response, which included the legal system documents.

The Legal Nurse Consultant Analysis

The attorney provided documents that included hospital records, primary care records, labs, images, S.W. reports, income, social standing. The SME LNC analysis found gaps in the care of the patient, insufficient to meet a reasonable standard of care with FTT. The standard of care aligns the medical diagnosis with appropriate definitive testing to support the diagnosis. Instead, without a full medical evaluation, the timeline revealed that the emergency provider made a clinical diagnosis based on the presentation without fully evaluating the cause of FTT. Judgments about parental neglect were the first clinical decision resulting in a report to child protection services. Consequently, the child abuse team was notified prematurely for suspicion before determining medical causes or evaluating the social situation bringing the parents to seek help. While suspicion is all that is necessary for child abuse reports (Child Welfare Information Gateway, 2019), failure to eliminate the medical possibilities, not requiring a report to child protection, placed the family members in awkward positions of not trusting the medical establishment. The SME LNC analysis also revealed abject poverty in the records and a consistent effort by the parents to reach out to the medical community about the child's weight loss. The medical community was inconsistent with their responses, leaving the family to devise interventions without medical literacy. The LNC analysis found the complexity of a medical situation compounded with abject poverty, job loss,

and adolescent parenting. These SDoH elements created risk for the child, but there was no intent for harm. The expert opined that the SDoH and the age of the parents diminished the opportunity for intervention by the detached medical community. The failure of the medical community to respond in a timely manner with supportive interventions might have stopped the entire child abuse investigation. When discovered in primary care practices, the intervention of education about feedings (e.g., adding water to formula or adding masticated food to the infant diet) and frequent follow up aligns with best practice that provides support to young, naïve parents in a temporary social situation that creates risk for their children. Had the situation occurred during the Covid-19 pandemic, the outcome would present more complex solutions. The final SME LNC opinion would have presented that there was no "intent" to harm by the parents attempting to reach out for help for their infant, as evidenced by the continued attempts at engagement with indifferent professional health-care systems.

Legal Outcomes

The Child Abuse team assessment revealed age, SDoH, and access to care as influences in the medical outcome of hospitalization for FTT. As such, the team made recommendations to the Child Protective Services to make available community systems for support. Community support included local organizations that assist in unemployment, distribution of food and sustenance for infants, as well as housing support services. The CPS

determined that supervision with an assigned caseworker for the next year was in the best interest of the infant and other children. Caseworker contact information was provided, and a list of community services educated and empowered the parents in the event of recurrent stressors of unemployment that threaten the family's health. Inherent in these instructions were implied state actions of removal for any future event. In the authors' experiences, families intersecting with legal systems often use emergency departments as health care because they fear child removal.

SUMMARY/DISCUSSION

The LNC analysis relies on records from hospitals and community organizations, testimony, and affidavits from experts. The LNC understands that often healthcare providers, when unable to find a biological cause for FTT, assign neglect as the clinical (not definitive) diagnosis of elimination. Torts arise when the diagnosis results in poor outcomes affecting the infant's development. The organic causes of FTT are often difficult to ascertain but are not impossible. The contributions of SDoH and situational crisis must be factored into the medical diagnosis before determining the intent of parents. This type of bias ultimately leads to the *search for satisfying* diagnoses (Fargen et al., 2020). Search satisfying occurs when the provider is too busy or does not pursue alternate diagnoses. This case demonstrates the need to withhold judgment until a complete and validated assessment that includes not only the health of the child but the circumstance of the

The LNC understands that often healthcare providers, when unable to find a biological cause for FTT, assign neglect as the clinical (not definitive) diagnosis of elimination.

The diagnosis of Child Maltreatment, in the face of provider bias, offers an opportunity for tort. Parents suffer the consequences of biased accusations that are unfounded or explained using Social Determinants of Health.

family, identifying their vulnerabilities, and efforts to love and protect their child. Reporting the FTT to CPS was appropriate, but the diagnosis of CM was not based on information about the SDoH or the efforts of the parents in the community who searched for help. The diagnosis of CM, in the face of provider bias, offers an opportunity for tort. Parents suffer the consequences of biased accusations that are unfounded or explained using SDoH.

REFERENCES

- Baker, A. J. L., & Brassard, M. (2019). Predictors of variation in state reported rates of psychological maltreatment: A survey of statutes and a call for change. *Child Abuse and Neglect*, 96, 104102. <https://pubmed.ncbi.nlm.nih.gov/31386997/>
- Brown, C. L., Yilanli, M., & Rabbitt, A. L. (2021). Child Physical Abuse And Neglect. In *StatPearls*. StatPearls Publishing, Copyright © 2021, StatPearls Publishing LLC. <https://www.ncbi.nlm.nih.gov/books/NBK470337/>
- Bryant, P. H., Jacoby, D., Bunch, M., Speck, P. M. (est.2021). Turner Syndrome Mosaicism: Challenges in Identification and Management in Primary Care. *Journal of the American Association of Nurse Practitioners (JAANP)* x: xx, xx-xx. (Submitted, assigned manuscript #JAANP-D-21-00063)
- Bryant, P. H., Roche, C., Debiassi, L., McPeters, S., & Speck, P. M. (2020). A Case Report of Failure to Thrive in an Exclusively Breastfed 6-Month-Old Infant. *Pediatric Nursing*, 225.
- Child Welfare Information Gateway (2019). *Mandatory reporters of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/pubPDFs/manda.pdf>
- Edemekong, P. F., Annamaraju, P., & Haydel, M. J. (2021). Health Insurance Portability and Accountability Act. In *StatPearls*. StatPearls Publishing, Copyright © 2021, StatPearls Publishing LLC. <https://www.ncbi.nlm.nih.gov/books/NBK500019/>
- Fargen, K. M., Leslie-Mazwi, T. M., Chen, M., & Hirsch, J. A. (2020). Physician, know thyself: implicit and explicit decision-making for mechanical thrombectomy in stroke. *Journal of Neurointerventional Surgery*, 12(10), 952-956. <https://doi.org/10.1136/neurintsurg-2020-015973>
- FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BMC Medical Ethics*, 18(1), 19-19. <https://doi.org/10.1186/s12910-017-0179-8>
- Francis, L., DePriest, K., Wilson, M., & Gross, D. (2018). Child Poverty, Toxic Stress, and Social Determinants of Health: Screening and Care Coordination. *Online Journal of Issues in Nursing*, 23(3), 2. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6699621/>
- Goh, L. H., How, C. H., & Ng, K. H. (2016). Failure to thrive in babies and toddlers. *Singapore Medical Journal*, 57(6), 287-291. <https://doi.org/10.11622/smedj.2016102>
- Homan, G. J. (2016). Failure to Thrive: A Practical Guide. *American Family Physician*, 94(4), 295-299. <https://www.aafp.org/afp/2016/0815/p295.pdf>
- Kearney, M. K. (2001). *Child witness of domestic violence: third party recovery for intentional infliction of emotional distress*. <https://heinonline.org/HOL/LandingPage?handle=hein.journals/loyolr47&div=21&id=&page=>
- Neeley, G. S. (2000). *The psychological and emotional abuse of Children: Suing parents in tort for the infliction of emotional distress*. <https://heinonline.org/HOL/LandingPage?handle=hein.journals/nkenlr27&div=36&id=&page=>
- Office of Disease Prevention and Health Promotion. (2018). *Healthy People 2020: Social determinants of health*. U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
- Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2030*. Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. <https://health.gov/healthypeople>
- Oldfield, B. J., Casey, M., DeCew, A., Morales, S. I., & Olson, D. P. (2020). Screening for Social Determinants of Health Among Children: Patients' Preferences for Receiving Information to Meet Social Needs and a Comparison of Screening Instruments. *Population Health Management*, 24(1), 141-148. <https://doi.org/10.1089/pop.2019.0211>
- Patel, J. A., Nielsen, F. B. H., Badiani, A. A., Assi, S., Unadkat, V. A., Patel, B., Ravindrane, R., & Wardle, H. (2020). Poverty, inequality and COVID-19: the forgotten vulnerable. *Public Health*, 183, 110-111. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7221360/>
- Pereira, M., & Oliveira, A. M. (2020). Poverty and food insecurity may increase as the threat of COVID-19 spreads. *Public Health Nutrition*, 23(17), 3236-3240. <https://doi.org/10.1017/S1368980020003493>
- Rizvi, M. B., Conners, G. P., & Rabiner, J. (2021). New York State Child Abuse, Maltreatment, and Neglect. In *StatPearls*. StatPearls Publishing, Copyright © 2021, StatPearls Publishing LLC.
- Storjfell, J. L., Winslow, B. W., & Saunders, J. S. D. (n.d.). *Catalysts for Change: Harnessing the Power of Nurses to Build Population Health in the 21st Century*. <https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:8ceaa96a-1c97-4b6c-9ff5-848d7acb5726#pageNum=2>
- Van Lancker, W., & Parolin, Z. (2020). COVID-19, school closures, and child poverty: a social crisis in the making. *The Lancet Public Health*, 5(5), e243-e244. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30084-0/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30084-0/fulltext)
- Weber, G. M., Adams, W. G., Bernstam, E. V., Bickel, J. P., Fox, K. P., Marsolo, K., Raghavan, V. A., Turchin, A., Zhou, X., Murphy, S. N., & Mandl, K. D. (2017). Biases introduced by filtering electronic health records for patients with "complete data." *Journal of the American Medical Informatics Association*, 24(6), 1134-1141. <https://doi.org/10.1093/jamia/ocx071>
- Weiss, T. C. (2020). What happens when we starve? Phases of Starvation. *Disabled World*.

<https://www.disabled-world.com/fitness/starving.php>

WHO Child Growth Standards. (2020). *Burns' Pediatric Primary Care* (7th ed.). Center for Disease Control and Prevention.



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The Role of the Forensic Nurse in Criminal and Civil Cases

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Keywords: Forensic Nurse Consultant, Civil Cases, Criminal Consulting, Testimony, Deposition

Forensic Nurses are important consultants to civil and criminal cases when there is injury or question of injury of a patient. The forensic nurse's training, experience, and education are valued and often requested by the prosecution, plaintiff attorney, or criminal defense. It is imperative that the forensic nurse expert exercises their due diligence as an expert consultant and a witness and adheres not only to the American Nurse Association (ANA) Code of Ethics for Nurses but also to the vision of ethical practice for forensic nurses. It is required that a forensic nurse expert witness be intimately aware of the scope and standards of your practice, national best practices, guidelines, and the standard operating procedures which are based on current evidence-based research and practice.

INTRODUCTION

The role of the forensic nurse consultant is multi-faceted. It is an emerging discipline for nurses who desire to work in collaboration with forensic clinical sciences and criminal justice partners. The forensic nurse possesses an understanding and skill set that relates not only to healthcare and the healthcare

system but also to social, forensic, legal, and public health systems. The forensic nurse may consult on numerous matters through multiple avenues such as the healthcare system, judicial system, educational institution, or insurance industry. The forensic nurse works with patients, community partners, or consulting attorneys when a legal situation arises which involves an assault, crime,

illegal conduct, liabilities, and accidents and uses their nursing skills and resources to evaluate and analyze these medical-legal cases. The forensic nurse cares for patients from all aspects of society and, at times, some of our most "vulnerable, marginalized, and disadvantaged populations" (ANA, 2017, p. 13). The forensic nurse works within their scope of practice as defined in ANA

Forensic Nursing Scope and Standards (ANA, 2017). These standards describe the “who, what, where, when, why, and how” of the forensic nurse’s practice and describes the diversity of forensic nursing. “Forensic nursing occurs “when” a need exists for forensic nursing knowledge, wisdom, caring, leadership, practice, or education, anytime, anywhere” (ANA, 2017).

Criminal and civil consulting are areas where a forensic nurse’s training, experience, and education are valued and often requested by prosecutors, criminal defense attorneys, or civil attorneys. The forensic nurse may or may not be involved in the case as a direct provider of patient care who has experienced violence or trauma or provided care to a criminal suspect or offender. The consulting party may seek out their clinical expertise and background to assist the party in reviewing and analyzing medical evidence, locating other medical experts, and collaborating with other community partners and experts involved with the case.

FORENSIC NURSE AND THE NURSING PROCESS

The forensic nurse also provides expertise to either party in the form of the nursing process. This process is the foundation for forensic nursing standards of practice and can be applied to criminal or civil consultant cases, whether direct patient care or not. The forensic nursing standards of practice are authoritative statements of the nurse’s role and are considered the standard of care, subject to change as new professional practices emerge.

1. Assessment of the case. The forensic nurse collects pertinent data and information of the case and presents the information in an unbiased, ethical, and professional perspective.
2. Analyzes the assessment data. The forensic nurse provides input to the consulting party to determine the

strengths and weaknesses of the case and synthesize information in a clinically relevant manner.

3. Outcomes Identification. The forensic nurse uses clinical expertise and current evidence-based practice to assist the consulting party on medical injury, illness, and sequelae pertinent to the case.
4. Planning. The forensic nurse assists the consulting party with preparation for court and depositions regarding medical forensic evidence and researching best practices for the care of the medical forensic patient.
5. Implementation. The forensic nurse assists the consulting party in implementing the identified strategic plan through research of concepts and science that supports the strategic plan of the consulting party.
6. Coordination of Care. The forensic nurse assists the consulting party in understanding the prescribed medical and nursing care and explains why care or a procedure was prescribed.
7. Health Teaching and Promotion. The forensic nurse articulates and educates the jury or judge regarding the current evidenced-based medical care for the patient, purpose of medical care and treatment, describes the mechanism of injury, or provides an explanation for lack of injury.
8. Evaluation. The forensic nurse assists the consulting party in evaluating evidence and testimony provided and assists the party in determining if a change of strategy or introduction of other medical evidence and testimony is beneficial.

The forensic nurse’s expertise is unique as they can explain medical evidence, terminology, and procedures and discuss exam findings and patient behavior to the judge and jury in accordance with current nursing practice and forensic science. The forensic nurse can also help debunk myths regarding interpersonal violence, explain the mechanism of

injury, and provide alternate reasons for presenting physical findings and behaviors. The forensic nurse must present the information and evidence at a basic level a juror can understand. Most jurors will lack the capacity to take in all the information and evidence and then process and apply it to what it means for the case. “The judge and jury rely on the expert witness to clarify the medical standards, practices, and procedures. Therefore, the testimony should be clear, coherent, and consistent with the standard of care applicable at the time of the incident” (Shigeev, SV et al., 2018). It is a concern of the legal community that not all experts provide ethical testimony or adhere to current and relevant science available. It is a standard of professional performance for the forensic nurse to practice ethically. This means they must adhere to the ANA Code of Ethics for Nurses and the vision of ethical practice for forensic nurses. This includes such important things as fidelity to patients, responsibility to the public, the obligation to science, and dedication to colleagues (Lynch & Duvall, 2011).

FORENSIC NURSE’S ETHICAL RESPONSIBILITY

Before the forensic nurse presents their knowledge and expertise of the science, the expert must be fully aware of the particulars of the case. The forensic nurse expert is responsible for seeking the current, relevant, evidence-based resources to support their practice and, ultimately, their opinion. The forensic nurse must do their due diligence to conduct thorough, independent research that they rely upon when providing an opinion regarding the case and not merely repeat what another “expert” has stated without verifying the veracity of another expert’s opinion. This supports preserving the forensic nurse’s testimony and professional integrity. It is the forensic nurse’s responsibility to ensure the opinion provided during

sworn testimony is to a degree of “scientific certainty.” This requires the forensic nurse to stay within forensic nurses’ scope of practice and to avoid overreach or overstate conclusions or opinions regarding the history, physical exam, and medical care when providing an opinion to the court.



The forensic nurse should articulate relevant and pertinent evidence-based science so that an individual without any medical training or knowledge can understand the significance of the medical and nursing issues of a case. “The forensic nurse educates the judge and jury to assist them in reaching a more appropriate conclusion regarding the facts of the case than they would have without the expert’s testimony” (Ronquillo et al., 2020). Science changes constantly, and it is imperative that the forensic nurse keeps current on the science and evidence-based practice when providing an opinion in court.

The forensic nurse must remember the profession’s ethical responsibilities before taking part in a case. First and foremost, a forensic nurse is “a nurse.” They must adhere to the ethical stan-

dards the nursing profession holds all nurses to honor. The priority must always be for sound, evidence-based patient care and the profession’s ethical obligations. Beyond that, the forensic nurse’s responsibility is to the truth. The forensic nurse’s obligation to ensure they provide the truth, is honest and candid to the court and to the parties involved. It is important to remember that a forensic nurse advocates for sound, evidence-based standards of care and not for the case itself. The responsibility of the forensic nurse is to provide an objective, unbiased, expert opinion but not to advocate for any party.

To meet the ethical and evidence-based standards when preparing for consulting work, whether a forensic nurse testifies or not, it is critical to know the facts of the case. They must know the case cold, whether to testify in court, provide testimony during a deposition, or provide a written report to the consulting party or court. If a forensic nurse is testifying, the medical records will always be present if the nurse needs to review any facts before answering the question. However, to gain credibility with the judge, jury, and attorneys, it is best to respond without referring to the medical record. It is crucial to never respond to a question with a response that is not known to be true. If the answer is unknown, simply say so. It is appropriate for the forensic nurse to ask the questioning attorney to review the medical records to provide a response. Avoid filling in the gaps with a response that is not known to be true, as this can be fatal to the case and detrimental to the forensic nurse’s credibility with the judge and jury.

USE OF A FORENSIC NURSE EXPERT

The most effective use of the forensic nurse expert is to have them testify at

trial. The expert’s knowledge will only come into play as needed to lay the evidentiary foundations to admit certain types of evidence. For example, certain questions are asked of the forensic nurse to determine treatment and diagnosis as part of the medical exam. Any information gleaned from those specific questions may be admissible. This is true even if it typically would qualify as hearsay and would not be admitted as evidence otherwise. This shows how important the role of the forensic nurse is in these types of cases. If the consulting party wishes to use the forensic nurse at trial as an expert, then the attorney must lay the foundation for the forensic nurse as an expert witness. To lay the foundation for the forensic nurse to testify as an expert, the attorney will use the forensic nurse’s Curriculum Vitae (CV) to qualify him/her as an expert. The CV outlines the forensic nurse’s training, education, and experience necessary for the forensic nurse expert to speak to the issues of the case in chief. The CV must be current, accurate, and carefully organized.

In cases where the forensic nurse expert may not have provided direct medical forensic care to the patient, they will not be asked questions about the care delivered in the case. The focus of the testimony will vary depending on the facts of the case. For example, the expert may be called as a witness to testify to the best practices in the world of forensic nursing or to explain why witnesses did certain things that may not make sense to a layperson. The forensic nurse may also be asked to testify to the counterintuitive behaviors that victims of crimes sometimes display. This type of testimony has proven to be crucial in many domestic or sexual violence cases.

TESTIMONY PREPARATION

Testifying as a fact witness in a criminal or civil case has different role expectations. As a fact witness in any case, a forensic nurse typically will only be

asked questions about the care delivered by the forensic nurse during their care of the patient at issue. As referenced above, certain questions are asked of the forensic nurse to determine treatment and diagnosis. Any information gleaned from those questions may be admissible even if it typically would not be. It cannot be stressed enough how important this testimony is, such as sexual violence and domestic violence.

The forensic nurse must be cautious of the differences between a criminal trial and a civil trial. The procedures differ widely between the two. In both civil and criminal cases, a forensic nurse may be subpoenaed to testify in a deposition and then again at trial. A deposition is a part of the discovery process, the fact-finding process that attorneys conduct to learn more about their cases. While both are depositions, criminal depositions are often less contentious than civil depositions because civil cases are less likely to go to trial. Civil cases largely settle, so the attorneys often treat the deposition as a trial. Criminal depositions are generally less contentious but may become very heated during the trial. No matter how contentious the deposition or trial gets, the forensic nurse must always present testimony in an unbiased, objective manner. Cross-examination during deposition or trial can be rather intense. It becomes particularly important that the forensic nurse has done all they needed to do to prepare for testifying.

The forensic nurse should be intimately aware of the scope and standards of forensic nursing practice. It is recommended the forensic nurse take the time to review the current evidence-based practices, community and professional guidelines, and standard policies and operating procedures. These documents are all fair game for both direct examination and cross-examination. It is almost certain to be asked in court by the attorneys if a specific process was

followed and accepted as best practice. Be prepared for either attorney to follow up and ask what those best practices are for the issues raised either during testimony or deposition.

Many witnesses have spoken about the rigors of cross-examination. While it is true that cross-examination can be deeply uncomfortable and often contentious, there are ways a forensic nurse can prepare that are helpful when providing testimony. The importance of knowing the facts of the case and can articulate the best practices in the field cannot be emphasized enough. If properly prepared, the opposing party will have difficulty damaging the forensic nurse's credibility and testimony. Avoid talking over the attorney if their tone becomes combative and argumentative. Let the attorney ask the questions and calmly respond without using an escalating or abrupt tone. Answer the attorney's question, turn to the jury, and respond to them directly while maintaining eye contact with the jurors. It is important to remain calm, cool, and collected regardless of how disrespectful an attorney may become while asking questions. Maintaining credibility is a strong tool, and remaining consistent and composed will go far with the factfinder.

COMMON PITFALLS

Some common pitfalls are specific to an expert witness. The forensic nurse should be very careful not to lecture the jury during testimony. The expert should listen to the question asked very carefully and briefly answer the question unless asked to explain the answer further. The forensic nurse expert avoids irrelevant testimony that may be construed as prejudicial or biased. The expert defines any medical terms that a layperson is unlikely to know and remembers that many of the terms used in the nursing nomenclature are like a foreign tongue to a regular juror. The ability to explain any complex medical terms and procedures in a way that an average person can understand is

very important. Refraining from arguing with the attorneys can be very difficult when it feels like they are completely mischaracterizing what is said during testimony. The forensic nurse's responsibility is to tell the truth in an objective, unbiased manner. It is the responsibility of the consulting attorney who commissioned the testimony to clear up any misunderstandings caused by the opposing party.

CONCLUSION

In conclusion, there are several recommendations a forensic nurse should consider as a consultant in criminal or civil cases:

1. Ensure a hired consultant's clinical expertise is relevant and pertinent to the case.
2. Become intimate with the current best practices, research, clinical guidelines, policies, and procedures of the institution, and know the state nurse practice act to ensure relevant and current information is provided.
3. Do not opine on another expert's area of expertise unless a consultant has the same expertise. Knowing limits and stating so if asked a question outside of established expertise and scope of practice.
4. Limit testimony to the diagnostics results and pertinent tests performed on the patient at the time of care. It becomes shaky ground if a forensic nurse interprets findings outside of the current medical records. The opposing party or consulting party can subpoena other experts who can attest to testing results when it is outside of one's scope of practice.
5. Know the particulars of the case and discuss with consulting attorney what the strategy is for them and the opposing party.
6. Stay calm! Avoiding displaying and voicing argumentative comments and responding in a condescending tone.

A forensic nurse will maintain strong credibility with the jury if they avoid reacting poorly to any rude comments or questions.

- Remember ethical responsibilities. The most important responsibility is to forensic nurse's professional, ethical obligations and the truth.

REFERENCES

- American Nurses Association and International Association of Forensic Nurses. (2017). *Forensic Nursing Scope and Standards of Practice*, 2nd Edition. Silver Spring, MD: ANA and IAFN.
- Lynch, V & Duvall, J. (2011). *The Vision of Ethical Practice*. *Forensic Nursing Science*, 2nd Edition, pp. 630. St. Louis, MO: Elsevier Mosby.
- Robinson, KJ, Nouhan, PP. (2020). *Expert Witness*. StatPearls. Treasure Island (FL): StatPearls Publishing.

- Shigeev SV, Kovalev AV, Fetisov VA, Gusarov AA, Kумыkova LR. (2018). The diagnostic criteria for the improper care of the elderly subjects and their forensic medical significance. *Sud Med Ekspert*, 61(4):48-53. doi: 10.17116/sudmed201861448.



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Human Trafficking, Litigation, and Legal Nurse Consultant

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Keywords: Trafficking, Sex Abuse, Expert, Forensic, Hospitality Industry, Attorney, Hotel

Human trafficking is modern-day slavery recognized by the United Nations as a human rights violation. Trafficking in any form is reprehensible. Federal law defines sex trafficking as “the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act” (National Human Trafficking Hotline, 2021). The hospitality industry is often a haven for human trafficking. “Hospitality companies have both the power and responsibility to make sex trafficking difficult for the offenders” (Rainboth, 2019). Legal nurse consultants have the experience and expertise to aid law firms advance cases to hold industries accountable that fall short in their responsibility to protect victims from this human rights violation.

INTRODUCTION

Human trafficking is modern-day slavery recognized by the United Nations as a human rights violation. Trafficking in any form is reprehensible (McGowan, Hood & Felder, LLC, n.d.). The National Human Trafficking Hotline defines sex trafficking as “a situation

in which an individual is compelled to work or engage in commercial sex through the use of force, fraud, or coercion. If the individual is under the age of 18 and engaging in commercial sex, they are experiencing regardless of force, fraud, or coercion is also taking place” (National Human Trafficking Hotline, 2021). This is a form of modern-day

slavery. Most victims are recruited or deceived into human trafficking or the sex trade. “Traffickers primarily target women and girls, who are disproportionately affected by poverty, the lack of access to education, chronic unemployment, discrimination, and the lack of economic opportunities in countries of origin. Traffickers lure women and

girls into their networks through false promises of decent working conditions at relatively good pay as nannies, maids, dancers, factory workers, restaurant workers, sales clerks, or models. Traffickers also buy children from poor families and sell them into prostitution or into various types of forced or bonded labor” (Cornell Law School, 2021).

Federal law defines sex trafficking as “the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act” (Cornell Law School, 2021). According to a September 2017 report from the International Labor Organization (ILO) and Walk Free Foundation:

- “An estimated 24.9 million victims are trapped in modern-day slavery. Of these, 16 million (64%) were exploited for labor, 4.8 million (19%) were sexually exploited, and 4.1 million (17%) were exploited in state-imposed forced labor” (Human Rights First, 2017).

According to Human Trafficking Search (2021), sex trafficking also includes the commercial sexual exploitation of children or minors. Sex trafficking most often affects people who are vulnerable, including, but certainly not limited to, the following:

1. Poor
2. Homeless
3. Runaways
4. Immigrants
5. Children in foster care
6. Victims of domestic violence and those
7. Displaced by natural disasters

The horrific crime of human trafficking and the sexual exploitation of trafficking victims generates billions of dollars each year in illegal proceeds, making it more profitable than any transnational crime except drug trafficking (United States Department of Justice, 2021).

According to the International Labor Organization and Walk Free Foundation, in a report published in 2017, it was estimated 3.8 million adults were victims of forced sexual exploitation, and 1 million children were victims of commercial sexual exploitation in 2016 (Human Rights First, 2017). Commercial sexual exploitation manifests in numerous forms, such as sex trafficking, prostitution, sex tourism, pornography, early marriage, performance in sexual venues, and online or electronic transmission of children engaged in sexual activities (Office of Juvenile Justice and Delinquency Prevention, 2014). Most victims were women and girls.

In 2014, the National Center for Missing and Exploited Children noted an 846 percent increase from 2010 to 2015 in reports of suspected child sex trafficking – an increase the organization found to be “directly correlated to the increased use of the internet to sell children for sex” (The United States Department of Justice, 2018). Sex trafficking is a widespread problem throughout the United States. While it can happen to anyone, anywhere, certain people are more vulnerable to trafficking to others

Unfortunately, human trafficking is often misrepresented in media, films, and television, which leads to public confusion about it. *The Washington Post* recently published an article about myths surrounding sex trafficking (Goswami & Jesionka, 2021), and my firm blogged on the issue as well.

Myth 1: Victims are only trafficked by strangers

Although most people believe trafficking victims are snatched off the street by a stranger, studies show that in over 60 percent of cases, the victim is familiar with their trafficker. Often this is a family member or other person with a close connection to the victim. This connection makes it easier to coerce the victim into forced labor or sex (Goswami & Jesionka, 2021).

Myth 2: Trafficking only happens in developing countries

Human and sex trafficking happens in just about every country in the world. It occurs in the United States every day. In 2019, every state in the USA reported some instance of trafficking. Per the *Post*, “[t]he U.S.-based trafficking hotline reported being contacted by 22,326 trafficking victims and survivors in 2019; of those, 14,597 people were sex trafficked, and 4,934 were victims of labor trafficking” (Goswami & Jesionka, 2021).

Myth 3: Trafficking increases during sports events

This is a prevalent media storyline that circulates during major sporting events like the Superbowl. According to the *Post*, “[r]esearchers from the University of Texas and the University of Minnesota identified 111 print media articles published between 2009 and 2016 that used the words ‘Super Bowl,’ ‘sex trafficking’ and ‘prostitution.’” However, no “hard connection” between major sporting events and sex trafficking was identified.

One thing the *Post* discovered, however, was that labor trafficking seems to increase before major sporting events. For instance, Amnesty International reported on the exploitation of South Asian workers during the lead-up to the Qatar 2022 World Cup (Goswami & Jesionka, 2021).

Myth 4: Cartels and organized crime are responsible for trafficking

As mentioned earlier, most trafficking victims know their trafficker. And, although gangs and cartels may be common at the border, traffickers can also include family members, neighbors, and in worst cases, the government. For instance, the *Post* mentions China’s Xinjiang region: “Since 2017, more than 1 million Uighurs have been detained in

'reeducation camps for weeks or years, and many are forced to work in factories that provide goods to Western consumers' (Goswami & Jesionka, 2021).

Myth 5: Human trafficking involves moving or traveling across borders

Human and sex trafficking is often confused with human smuggling, which involves illegal border crossings. Human trafficking does not require any movement – a victim can be trafficked in their hometown or even in their own home. Says the *Post*, "The misconception that human trafficking requires the moving of victims across borders is particularly dangerous during this pandemic, given that the opportunities for exploitation have expanded" (Goswami & Jesionka, 2021).

Trafficking victims undergo the worst type of sexual exploitation and abuse. They are forced to perform sexual acts on countless individuals in exchange for a fee (which usually goes to her trafficker or "pimp"). They are also subjected to repeated instances of rape, physical abuse, verbal abuse, exploitation, psychological torment, kidnapping, and false imprisonment. The trafficker often maintains control over the victim by controlling everything in the victim's life (for purposes of this article, we will assume the victim is a female, though it can happen to male and female). Traffickers control victims' money, food, clothes, who they interact with, sanitary supplies, toiletries, etc.

Often, victims are not allowed to eat or sleep without permission. They are kept awake for days with a steady cocktail of drugs and alcohol. This happens because if they are sleeping, they are not making the traffickers money. Food and money are withheld to ensure compliance with the traffickers' demands. Victims are rarely permitted to keep any of the money they earn, and if they try, they may be beaten or have their family members threatened.

When a victim makes money, the trafficker takes it away, effectively making them beg for food, clothes, toiletries, and the like, all while being trafficked. Victims are controlled by the trafficker through physical and psychological manipulations or physical violence when they do not conform to the trafficker's demands.

Sex trafficking occurs in many different environments and locations. In the legal context, one of the primary focuses is determining where the trafficking is taking place. The most likely environment or location gives traffickers (or potential defendants) the ability to carry out their crimes with impunity.

The one industry that routinely provides this type of environment is the hospitality industry. According to the Polaris Project, a nonprofit organization that operates the National Human Trafficking Hotline, some of the most reported venues for sex trafficking are hotels and motels (The Polaris Project, 2012).

Of course, being licensed and practicing in South Carolina, the statistics in South Carolina play a significant role in the way cases are reviewed at McGowan, Hood & Felder, LLC. According to the Office of the South Carolina Attorney General's 2020 Human Trafficking Task Force Report, in South Carolina, the second most likely sex trafficking venues are hotels and motels. It has long been recognized that exploiters and traffickers use hotel and motel rooms when setting up "dates" between victims of sex trafficking and individuals purchasing sex. In the transactional cycle of hotel sex trafficking, traffickers pay for a location where they

can offer human beings for sale; buyers pay the traffickers to use them for their pleasure; traffickers pay the venues with the buyers' money, and the cycle repeats.

Traffickers have long capitalized on the seclusion and privacy of hotel rooms and the hotel industry's refusal to adopt anti-trafficking policies to train staff on what to look for and how to respond or establish a safe and secure reporting mechanism. As aptly stated in a thesis by a Cornell University Student on the issue, "the hospitality industry is undoubtedly involved in the sex trafficking industry... and therefore [has] an inherent responsibility to deter the crime and can be liable for failing to do so" (Cavagnaro, 2017). Indeed, many hotel defendants have failed to take any steps to address publicly or even comment on the frequent sex trafficking at their businesses.

In 2013, the International Hotel Group ("IHG"), one of the largest hotel companies worldwide, commissioned an external assessment of human rights risks most relevant for the travel and hospitality sector (both globally and regionally) by working with external human rights research firm Verisk Maplecroft. Human Trafficking was among the risks identified. IHG has stated, "In 2013, we commissioned an external assessment of human rights risks most relevant for the travel and hospitality sector globally and regionally. The risks identified included human trafficking, forced labor, child labor, and working conditions. In 2015 and 2016, we built on this information to identify the modern slavery risks most relevant to IHG. To carry out this assessment we looked across four different areas of risk: (i) risks of modern

Sex trafficking occurs in many different environments and locations. In the legal context, one of the primary focuses is determining where the trafficking is taking place.

slavery affecting colleagues in our own organisation including our hotels, (ii) risks of modern slavery occurring in our corporate or hotel supply chains, (iii) risks of modern slavery such as human trafficking occurring in or around our IHG branded hotels, (iv) risks of modern slavery occurring at different stages of the hotel lifecycle and within supply chains of our hotel owners” (International Hotel Group, n.d.).

IHG represents that its various risk assessment mechanisms have helped it identify higher-risk locations since 2013. This study and investigation are common knowledge in the hotel industry and among hotels named defendants in trafficking lawsuits.

In a speech given in September 2012, President Obama stated that human trafficking “ought to concern every person, because it is a debasement of our common humanity. It ought to concern every community because it tears at our social fabric. It ought to concern every business because it distorts markets. It ought to concern every nation because it endangers public health and fuels violence and organized crime” (The White House Office of the Press Secretary, 2012).

Despite efforts by the United Nations, the White House, and non-governmental organizations to promote policies and procedures to prevent human trafficking, these incidents continue to happen in hotels – whether luxury, economy or otherwise. The hospitality industry has known the prevalence of human trafficking for the entire twenty-first century, but it has done little to prevent it.

Without the complicity of hotels, where illicit sexual encounters are taken off the street and cloaked in anonymity, the sex trafficking industry would not prosper. This obvious fact has been touted by experts and justices of

the United States Supreme Court. In 2015, Justice Antonin Scalia, joined in dissent by Chief Justice John Roberts and Justice Clarence Thomas, noted that “Motels...are also a particularly attractive site for criminal activity ranging from drug dealing and prostitution to human trafficking offering privacy and anonymity on the cheap, they have been employed as...rendezvous sites where child sex workers meet their clients on threat of violence from their procurers.” *City of Los Angeles, Calif. v. Patel*, 135 S. Ct. 2443, 2457 (Levander & Guterl, 2015).



In 2012-2016, Seventy-Three percent of the National Human Trafficking Hotline calls involved sex trafficking revealed the offending venue was a hotel/motel (National Human Trafficking Hotline, 2017). Two percent reported a combination of sex and labor trafficking. A Polaris Project survey of trafficking victims found that “75% of survivors responding to Polaris’ survey reported coming into contact with hotels at some point during their exploitation . . . Unfortunately, 94% also disclosed that they never received any assistance, concern, or identification from hotel staff” (Polaris, 2021)

Despite the combined efforts of governmental and non-governmental organizations to combat human trafficking, the hospitality industry continued to lag in its efforts to prevent it. Even estimates by attorneys for the hospitality industry indicate eight out of ten arrests for human trafficking occur in or around hotels.

The 2016 Trafficking in Persons Report issued by the United States Department of State also confirmed that human trafficking occurs in the hospitality industry in the United States. Between 2007 and March 2015, more than 1,400 human trafficking cases were reported to the National Human Trafficking Resource Center.

The hospitality industry’s complicity is essential to the perpetuation of human trafficking. It allows traffickers to remain transient, collect profits, and evade detection. Sex trafficking ventures move from place to place, so they are less visible to law enforcement. Similarly, sex traffickers also want to keep their victims moving from place to place to isolate them from any possible means of escape or rescue.

Traffickers are aware of the seclusion and anonymity attendant with booking rooms at hotel chains – quite simply, they know it is unlikely they will be disturbed. Due to the hospitality industry’s failure to embrace anti-trafficking policies and practices, children and other vulnerable persons are trafficked for sex in hotels throughout the United States.

Hotel employees, however, are uniquely situated to identify and report suspicious activity on hotel property. Indeed, there is often numerous indications traffickers (and the adults and children who are victimized) exhibit during their stay at a hotel from check-in to check-out. With proper training and other reason-

able security measures, hotel owners and operators could prevent trafficking on their properties. A successful trafficking protocol should start with the hotel's front desk staff as they are usually first in line to observe signs of human trafficking, but it should include all hotel employees.

The well-known and easily identifiable signs of sex trafficking, or "red flags" of sex trafficking, include:

1. Paying for rooms with cash or pre-paid credit cards;
2. A guest lingering just outside the room for long periods of time (i.e., the trafficker waiting outside as the "Johns" are inside the room abusing victims);
3. Multiple guests coming and going from the hotel or motel—particularly several adult males who do not check into a room;
4. Minor children paying for hotel or motel rooms;
5. Excessive foot traffic going in or out of a particular room or area of the hotel or motel;
6. A significantly older boyfriend or older men being present at the hotel with a younger female;
7. Staying at an hourly or extended stay with few possessions;
8. Requesting a room overlooking the parking lot;
9. Requesting room or housekeeping services such as additional towels or new linens, but denies hotel/motel staff entry into a room;
10. Presence of excessive drugs, alcohol, or sex paraphernalia;
11. Requesting information on the local sex industry;
12. Guests frequently entering and emerging from rooms with no luggage or identification;
13. Cars parked backward in the parking lot or garage to make the license plate not visible to patrol cars

Victims also often show signs of abuse and exploitation that are observable to those in the hospitality industry, including:

1. Poor hygiene, malnourishment, sleep deprivation, untreated illness, injuries, and fatigue;
2. Evidence of verbal threats or physical violence;
3. Fearful, nervous, anxious, or submissive demeanors;
4. Being constantly monitored or followed by a man, often older than the victim;
5. No knowledge of the current or past location (The Polaris Project, 2012)

Attorney Michael Rainboth stated, "Hospitality companies have both the power and responsibility to make sex trafficking difficult for the offenders" (Dinan, 2019). Yet, they repeatedly fail to heed the call or repeatedly fail to execute their policies. Instead, they continue to facilitate sex trafficking crimes at their hotels, seemingly because they are more interested in profiting from traffickers' continued business.

One can reasonably argue the motivation for this ongoing willful blindness (and ongoing failure to act) is quite simply limitless corporate greed. Hotels and hotel brands, knowing the obvious dangers associated with human trafficking, nevertheless ignored (and continue to ignore) obvious signs of human trafficking out of unfettered fealty to their profit margins and a corresponding complete disregard for the value of human life.

The overt policy of willful blindness to sex trafficking by hotel brands communicates the perverse but clear message from hotel owners that the more sex trafficking is allowed at a hotel (which results in higher profits), the less likely the hotels or hotel brands are to investigate.

So, how does a legal nurse consultant (LNC) assist attorneys and use their unique resources to prosecute trafficking cases?

ASSESSMENTS

Trafficking victims are often reticent to act out against their trafficker. This reticence can result from fear, but it is also a type of Stockholm syndrome built on their continuous conditioning by traffickers. LNCs, through training and experience, assess trafficking victims and develop strategies to help victims cope with their fear and emotions and open up about their victimization.

EXPERTS

Trafficking victims have unique experiences and psychological issues. LNCs understand this and help identify people who can provide immediate assistance and ongoing therapy. Trafficking victims usually have pre-existing trauma, and the plan for their care needs to be trauma-based – a concept LNCs understand. Legal nurse consultants can also identify experts in different areas to assist attorneys in prosecuting cases (hospitality industry, sex abuse, psychological issues, pre-existing trauma, etc.).

SANE

Nurses with sexual assault nurse examiner certifications (SANE) can conduct forensic exams to collect valuable evidence to prosecute the abusers. While this type of exam is usually performed in an ER and not by LNCs working with a law firm, LNC's understanding of this process is beneficial to attorneys without medical training. Unfortunately, SANE exams are less likely to occur in the real world with a sex trafficking victim due to their transient nature and typical unwillingness to leave their trafficker voluntarily.

FORENSIC INTERVIEWS

Though the collection of physical evidence is highly time-sensitive, forensic questioning can be accomplished at any time. LNCs, again relying on their training and experience, can gain invaluable information from victims through interviews. This information assists attorneys in identifying individuals or institutions that were complicit through action or inaction. LNCs are also trained to determine if the victim would be more comfortable with a male or female interviewer. If, for instance, a female has been victimized by a male, she may feel more comfortable with a female LNC, and there are other situations where the victim may prefer a male. Luckily excellent male and female LNCs are available.

ADVICE

Legal nurse consultants advise litigation teams on resources that can be brought into play. Resources can include mental health counseling for the victims and expert witnesses to offer expert testimony. Direct assessments performed by nurses help tailor resources to maximize victim recovery and monetary recovery through litigation.

ADVOCACY

Though the last category discussed, victim advocacy is one of the most vital roles played by LNCs. LNCs are trained to assess victim needs and, because of this, are great victim advocates. Civil litigation creates a tremendous amount of stress and mental turmoil as victims are required to retell, and by so doing, relive their experiences. LNCs help ensure victims do not experience unnecessary mental anguish as justice is pursued against their traffickers.

As this summary of the roles LNC plays shows, LNCs are invaluable to law firms prosecuting trafficking cases. In addition, more often than not, LNCs are better suited than others to handle

these issues, especially since the LNC understands not only litigation but also medicine, working with experts, counseling, forensic exams, victim advocacy, etc.

REFERENCES

- Administration for Children & Families. (2021, April 30). *Fact Sheet: Human Trafficking*. Retrieved from Administration of Children & Families: <https://www.acf.hhs.gov/otip/fact-sheet/resource/fshumantrafficking>
- Anthony, B. (2018, July). *On-Ramps, Intersections, and Exit Routes: A Roadmap for Systems and Industries to Prevent and Disrupt Human Trafficking*. Retrieved from Polaris Project: <https://polarisproject.org/wp-content/uploads/2018/08/A-Roadmap-for-Systems-and-Industries-to-Prevent-and-Disrupt-Human-Trafficking-Hotels-and-Motels.pdf>
- Cavagnaro, G. (2017). *Sex Trafficking: The Hospitality Industry's Role and Responsibility*. Cornell University.
- Cornell Law School. (2021). *Legal Information Institute*. Retrieved from law.cornell.edu: https://www.law.cornell.edu/uscode/text/22/7102#9_A
- Cornell Law School. (2021). *Legal Law Institute*. Retrieved from law.cornell.edu: <https://www.law.cornell.edu/uscode/text/22/7101>
- Dinan, E. (2019, December 29). *Lawsuit alleges hotels ignore sex trafficking*. Retrieved from fosters.com: <https://www.fosters.com/news/20191229/lawsuit-alleges-hotels-ignore-sex-trafficking>
- Global Estimates of Modern Slavery*. (2017). Retrieved from International Labor Office: https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/publication/wcms_575479.pdf
- Goswami, S., & Jesionka, N. (2021, February 26). *Five myths about human trafficking*. Retrieved from The Washington Post: https://www.washingtonpost.com/outlook/five-myths/five-myths-about-human-trafficking/2021/02/26/aa8f210c-7707-11eb-948d-19472e683521_story.html
- Homeland Security. (2019, February 11). *Maintaining Our Commitment to Combatting Human Trafficking*. Retrieved from Homeland Security: <https://www.dhs.gov/science-and-technology/blog/2019/02/11/maintaining-our-commitment-combatting-human-trafficking#>
- Human Rights First. (2017, January 07). *Human Trafficking by the Numbers*. Retrieved from humanrightsfirst.org: <https://www.humanrightsfirst.org/resource/human-trafficking-numbers>
- Human Trafficking Search. (2021, April 30). *What is Human Trafficking*. Retrieved from Human Trafficking Search: <https://humantraffickingsearch.org/what-is-human-trafficking/>
- International Hotel Group. (n.d.). *IHG Modern Slavery Statement 2018*. Retrieved April 2021, from International Hotel Group: https://www.ihgplc.com/-/media/ihg/Files/responsible-business/2018-responsible-business/downloads/2018/ihg_rbr_modern_slavery_2018_digital.ash
- International Labor Organization. (2014). *Forced labour, modern slavery and human trafficking*. Retrieved from International Labor Organization: <https://www.ilo.org/global/topics/forced-labour/lang-en/index.htm>
- Levander, C., & Guterl, M. (2015, July 2). *Are Hotels Dangerous*. Retrieved from The New York Times: <https://www.nytimes.com/2015/07/02/opinion/are-hotels-dangerous.html>
- McGowan, Hood & Felder, LLC. (n.d.). *Sex Trafficking*. Retrieved from <https://www.mcgowanhood.com/>: <https://www.mcgowanhood.com/sex-trafficking/>
- National Human Trafficking Hotline. (2017). *National Hotline Cases Occurring in Hotels and Motels: United States 1/1/2012-12/31/2016*.
- National Human Trafficking Hotline. (2021). *Report Trafficking*. Retrieved from humantraffickinghotline.org: <https://humantraffickinghotline.org/report-trafficking>
- National Human Trafficking Hotline. (2021, April 30). *What is Human Trafficking*. Retrieved from National Human Trafficking Hotline: <https://humantraffickinghotline.org/>
- Office of Juvenile Justice and Delinquency Prevention. (2014). *Commercial Sexual Exploitation of Children and Sex. Literature Review: A Product of the Model Programs Guide*, 1-12.
- Polaris. (2021). *Hotels & Motels Recommendations*. Retrieved from polarisproject.org: <https://polarisproject.org/hotels-motels-recommendations/>
- South Carolina Human Trafficking Report. (n.d.). *2020 Annual Report: Office of the South Carolina Attorney General*. Retrieved from <http://humantrafficking.scag.gov/wp-content/uploads/2021/01/2020-SCHTTF-Annual-Report.pdf>

The Polaris Project. (2012). *Human Trafficking in Hotels and Motels Victim and Location Indicators*. Retrieved April 2021, from The Polaris Project: <https://ncjtc-static.fvtc.edu/Resources/RS00002856.pdf>

The United States Department of Justice. (2018, September 26). *Justice News*. Retrieved from justice.gov: <https://www.justice.gov/opa/speech/statement-acting-assistant-attorney-general-john-gore-civil-rights-division-subcommittee>

The United States Department of Justice. (2018, September 26). *Statement of Acting Assistant Attorney General John Gore for the Civil Rights Division Before the Subcommittee on Border and Maritime Security Committee on Homeland Security*. Retrieved from Justice News: <https://www.justice.gov/opa/speech/statement-acting-assistant-attorney-general-john-gore-civil-rights-division-subcommittee>

The White House Office of the Press Secretary. (2012, September 25). *Fact Sheet: the Obama Administration Announces Efforts to Combat Human Trafficking at Home and Abroad*. Retrieved from White House Office of the Press Secretary: <https://obamawhitehouse.archives.gov/the-press-office/2012/09/25/fact-sheet-obama-administration-announces-efforts-combat-human-trafficki>

US Department of State. (n.d.). *Office to Monitor and Combat Trafficking in Persons 2016. Trafficking in Persons Report*. Retrieved April 2021, from US Department of State: <https://2009-2017.state.gov/j/tip/rls/tiprpt/countries/2016/258888.htm>

US State Department. (n.d.). *President's Interagency Task Force to Monitor and Combat Trafficking in Persons*. Retrieved April 2021, from US Department of State: <https://2009-2017.state.gov/j/tip/response/usg/index.htm>



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A Generalist View of Forensic Nursing Practice:

More than a Box of Swabs

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Keywords: Forensic, Evidence, Violence, Forensic Nursing, Sexual Assault, Rape, SANE, Sexual Assault Nurse Examiner

BACKGROUND

Forensic nurses care for individuals impacted by violence amongst diverse patient populations and serving persons of all ages, genders, and socioeconomic backgrounds. Forensic nurses have specialized training to simultaneously care for patients experiencing a unique intersection of nursing and legal needs. They provide interventions utilizing an evidence-based approach to the medical forensic examination using a trauma-informed standard of care and crisis intervention. Many individuals perceive that forensic nurses are only trained to collect DNA evidence (such as swabs

and clothing) for sexual assault patients and package said evidence into a box. In reality, forensic nurses have extensive expertise in evidence collection, effective documentation practices, and forensic photography. Forensic nurses bring a nuanced understanding of the complex workings of the legal process and systems to care for patients and may serve both civil and criminal courts and provide expert testimony regarding their findings. Many forensic nurses also practice as legal nurse consultants. Collaboration between legal nurse consultants and forensic nurses with an expanded scope of expertise (beyond

sexual assault care) can aid legal nurse consultants in the complex analysis and evaluation of medico-legal cases involving victims of other forms of violence.

Forensic nursing is a specialized nursing field providing care for victims of violence across the lifespan, including sexual assault, domestic/intimate partner violence, human trafficking, death investigation, the abuse and neglect of children, elders, and other vulnerable populations. Forensic nurses are experts in navigating the unique medical needs of patients traumatized by violence. Despite the actual diversity of care forensic nurses provide,

most individuals are only familiar with the sexual assault nurse examiner or SANE role. Training and education for the SANE role have been supported by the Violence Against Women Act (VAWA), initially enacted in 1994 and is up for reauthorization in 2021. (<https://www.congress.gov/bill/117th-congress/house-bill/1620/text>) VAWA created awareness for female victims of violence and allocated grant funding for services, training, and research mainly for rape or sexual assault survivors. As a result, there was a massive surge in the advancement of forensic nursing, specifically SANE services, during the late 1990s and early 2000s in the United States. As a direct result of VAWA, all states currently provide funding to collect evidence for victims of sexual assault. Now, in 2021, the field of forensic nursing has become

so synonymous with SANE nursing or the care of rape victims that many do not understand how broad and diverse the specialty of forensic nursing truly is. SANE nursing is a subspecialty within the diverse and complex field of forensic nursing (See Diagram 1). There is currently no national mandate to ensure that all medical and health care facilities provide access to SANE care, let alone a generalist forensic response.

Rape is a term often used interchangeably with sexual assault to describe forced sex acts. Sexual assault is a broader term that encompasses all forms of sexual violence and provides greater clarity within the context of legal discussions. For example, in North Carolina, first-degree forcible rape specifies “vaginal intercourse,” and separate charges are used for a first-degree sexual

offense that provides equivalent penalties for other violent sexual acts

(NC First-degree forcible rape: https://www.ncleg.gov/enactedlegislation/statutes/pdf/bysection/chapter_14/gs_14-27.21.pdf).

(NC First-degree forcible sexual offense: https://www.ncleg.gov/enactedlegislation/statutes/pdf/bysection/chapter_14/gs_14-27.26.pdf).

For the purposes of this article, the authors will use the term sexual assault rather than rape. VAWA provides the revenue source and authority to guarantee that all states provide free collection of evidence following a sexual assault. No other federal funding stream guarantees the medical examination and collection of evidence from patients victimized by other crimes such as domestic violence, elder abuse, child abuse, assault, or human trafficking. While all states may have compensation funds available to victims experiencing other forms of violence, states vary in eligibility requirements for funding access and restrictions on coverage amounts (<https://www.benefits.gov/benefit/4416>). For example, some states require that the victim cooperates with law enforcement investigations to be eligible for compensation. *Violence exists on a spectrum. When only one specific form of sexual violence is guaranteed a medical forensic examination, a disparity in care and sustainability for forensic programs is the direct result.*

THE GENERALIST PERSPECTIVE

Within our current standard and model of health care, all victims of violence are not equally treated and cared for by an experienced forensic nurse. While a great deal of focus has been spent on training nurses to care for the victims of sexual assault, there has been far less focus on the need for forensic nurses to provide forensically focused care to



Diagram 1: Forensic Nursing Overview

Table 1: Forensic Nursing Definitions Source: <https://www.goafn.org/glossary>

Correctional Nursing	<p>The practice and delivery of nursing care within the criminal justice system, including county jails, state and federal prisons, juvenile detention centers, and substance-abuse treatment centers. Central to this area of forensic nursing is the development of a therapeutic relationship with the inmate as a patient. The ability to differentiate the need for medical care vs the desire for secondary gain, the need for attention to personal security at all times, and balancing humanity and criminal behavior of the inmate are essential to the role of the correctional nurse. Increased autonomy and strong assessment skills are vital for nurses working in these settings.</p> <p>References: American Nurse Association. (2007). Corrections nursing: Scope & standards of practice. Silver Spring, MD. Schoenly, L. (2013). Context of correctional nursing. In Essentials of Correctional Nursing, NY: Springer Publishing, LLC.</p>
Domestic Violence	<p>Incidents of interspousal physical or emotional abuse perpetuated by one of the spouses upon the other spouse.</p> <p>Reference: Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd Ed.). Thousand Oaks, CA.</p>
Elder Abuse	<p>An intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult (physical, sexual, verbal, emotional or psychological, neglect, financial abuse or exploitation).</p> <p>Reference: Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/elderabuse</p>
Forensic Nursing	<p>The application of the nursing process to public or legal proceedings and the application of forensic health care in the scientific investigation of trauma and/or death related to abuse, violence, criminal activity, liability, and accidents.</p> <p>Reference: Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd Ed.). Thousand Oaks, CA.</p>
Intimate Partner Violence	<p>Any behavior within an intimate relationship that causes physical, psychological, or sexual harm.</p> <p>Reference: Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/elderabuse</p>
Neglect	<p>Failure or refusal of the caregiver to provide necessities, such as shelter, food, water, clothing, personal hygiene, medicine, access to medical care or a safe environment [4]</p> <p>Reference: Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd Ed.). Thousand Oaks, CA.</p>
Physical Abuse	<p>Use of physical force or violence that results in pain and/or injury and/or distress, including slapping, hitting, biting, kicking, pushing, shoving, shaking, pinching, burning, striking with an object, inappropriate use of drugs and/or physical restraints, force feeding, and/or using physical “punishment.”</p> <p>Reference: Department of Health and Human Services. National Center on Elder Abuse. (2015). Types of abuse. Retrieved 9/17/2018 from http://ncea.acl.gov/FAQ/index.html</p>
Psychological or Emotional Neglect	<p>Purposeful interaction with the intent to inflict anguish, distress, or pain, including verbal assaults, insults, threats or humiliation.</p> <p>Reference: Department of Health and Human Services. National Center on Elder Abuse. (2015). Types of abuse. Retrieved 9/17/2018 from http://ncea.acl.gov/FAQ/index.html</p>
Rape	<p>Penetration, however slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without consent.</p> <p><i>Important Note:</i> The legal definition of “rape” is defined differently in each state.</p> <p>Reference: U.S. Department of Justice. (2013). Crime in the U.S. [Data file]. Retrieved from https://ucr.fbi.gov</p>
Sexual Assault	<p>Any sexual act, attempt to obtain and sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion.</p> <p>Reference: Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd Ed.). Thousand Oaks, CA.</p>
Trauma Informed Care	<p>Framework that uses empowerment and a strength-based model to respond to the effects of trauma on an individual; a framework that analyzes the effect of the environment of trauma survivors and guides the response of the organizations and individuals providing care in the organization.</p> <p>Reference: Hopper, E.K., Bassuk, E.L. & Oliver, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3(2), 80-100.</p>
Victim	<p>The person that is acted upon and usually adversely affected by and outside incident. In forensic nursing, the victim may be the client, the decedent, or perpetrator, the family, significant others, the suspect, the accused and/or falsely accused, the community and/or the public in general.</p> <p>References: American Nurses Association. (2009). Forensic Nursing: Scope & Standards of Practice. Silver Spring, MD: Nursesbooks.org. Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). Family violence across the lifespan (3rd Ed.). Thousand Oaks, CA.</p>

other patient populations experiencing violence. While nearly one in five women and one in 71 men in the United States experienced rape at some point in their lives, the numbers for domestic or intimate partner violence are far more prevalent. “Approximately one in three women and one in ten men 18 years of age or older experience domestic violence” (The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report., 2011) annually, and over 1500 deaths in the United States are attributed to domestic violence annually (Smith et al., 2018). While some healthcare facilities may have an experienced SANE available 24/7 to provide care to sexual assault patients, others may only have a SANE intermittently or not at all. Even fewer forensic nurses are available and educated to specifically care for the victims of intimate partner violence (previously known as domestic violence), even though intimate partner violence (IPV) has a higher prevalence and impact on public health.

Additionally, SANE care is further sub-specialized into adult/adolescent or pediatric care, requiring distinct and separate education and training. As the care of pediatric populations is so specific, many facilities only provide medical forensic examinations to patients older than the age of thirteen as they may not have adequate staff coverage of individuals trained to provide pediatric SANE specialty care. As a result, healthcare institutions generally have a SANE nurse respond to patients on an “as needed” basis if and when a sexual assault patient older than age thirteen presents. Usually, those seeking services in more urban or suburban well-funded facilities will find a SANE nurse available to provide care. The more rural areas with less funding available often will not have the services available.

SANE examinations are limited to an acute response, typically within five to seven days following an assault. Sexual

SANE examinations are limited to an acute response, typically within five to seven days following an assault.

assault cases that present outside of this window generally are not provided a forensic response simply because the arbitrary window for evidence collection has passed. The forensic response includes trauma-informed care, forensic documentation, and follow-up services that meet victims of violence’s unique and pressing needs. Non-sexual assault cases are routinely not provided a forensic response, even though violence occurs across a spectrum. Additionally, patients don’t always fit into neat categories. It is not uncommon for a victim of interpersonal or domestic violence to simultaneously be the victim of sexual assault.

Victims of violence who present for healthcare at most facilities in this country do not ordinarily have specialized care by a forensic nurse incorporated into their patient care plan. Generalized forensic nursing programs do not exist in the vast majority of our health care facilities. Forensic nursing experts recognize and implement trauma-informed care (TIC) for patients. Trauma-informed care is an approach to care that uses evidence-based critical thinking and recognizes that trauma creates a unique set of circumstances that directly impact the patient care experience and potential recovery. However, TIC training for health care providers has not yet met the extensive need within the generalized patient population. Facilities that provide limited or no forensic services for their patient populations fail to meet patient needs for trauma-informed services.

An additional challenge faced by SANEs is that SANEs are frequently asked or expected to care for other types

of victims of violence, often without additional training, because these cases use the same skills for evidentiary examination and forensic documentation. While there may often be an overlap of sexual assault in the context of an interpersonal assault; the care and needs of a patient experiencing other forms of violence (such as elder abuse, domestic violence, and strangulation) have additional complexities and considerations for the medical forensic examination and require additional specialized training. There is a need for guidelines, systematic algorithms, and focused care plans for forensic patients (Pasqualone & Michel, 2015). When the scope of services is limited to sexual assault, SANE nurses are often placed in the uncomfortable position of being asked to care for all victims of violence without adequate training, infrastructure, and support. Health care organizations may be vulnerable to legal action when standards of care are not equitable.

Additionally, forensic nurses who perform this role on an as-needed basis can also not develop the mastery and expertise a trained, full-time forensic healthcare provider can offer. This has contributed to extraordinary attrition rates within SANE nursing and diminished access to care for patients creating a national crisis and shortage of SANE nurses (United States Government Accountability Office, 2016). Several forensic nursing programs across the country have identified this disparity in care and lack of necessary education. These generalist forensic nursing programs have expanded their scope of services and ensured that forensic staff has the additional education needed

to care for these varied and complex patient populations. They offer a systematic, organized method to address the medico-legal needs of all forensic patients. While many healthcare organizations currently struggle to provide sustainable SANE care due to attrition, volume, and funding (United States Government Accountability Office, 2016), others thrive with the expansion of forensic services for all victims of violence as part of their organizational philosophy. By expanding their scope of services to include victims of a violence beyond sexual assault for adults and adolescents, forensic nurses have developed a new sustainable model of care integrated into the infrastructure and care plans most facilities utilize.

FACTORS TO CONSIDER

Ideally, generalist forensic nurses should practice within a full-time role to develop the expertise and skillsets necessary to address the medico-legal complexities of care of patients experiencing violence. Forensic nurses expected to provide services as a “part-time gig” above and beyond their regular nursing role are placed in an untenable position. Currently, many SANE nurses are located and practice within emergency departments, as this is generally where sexual assault patients are present. The attrition rate for SANE nursing has not been formally researched, and anecdotally the rate is one of the highest in any nursing specialty. Adequate staffing and training for SANE nurses are rare, let alone training on a broader scope to fully include other necessary forensic skill sets to fully integrate within the complex healthcare system. Rather than utilizing inexperienced, or only on-call staffing models, a department of highly trained forensic nurses working full time can assist every part of the healthcare organization to “case manage” the medico-forensic needs of patients, whether it is trauma-related such as a gunshot wound, child abuse or neglect,

the facilitation of patients to the medical examiner for an autopsy, or even organ donation needs. These same highly trained forensic nurses can also serve as an expert resource/collaboration with legal nurse consultants to support both the plaintiff and defense counsels.

SUMMARY

There currently exists a “hit or miss” approach to forensic care services within the United States. When a patient presents for care following the violence, a medical forensic examination by a trained forensic nurse is not guaranteed. If a SANE nurse is unavailable, patients may be examined by untrained clinicians or even transferred to other facilities, often several hours away, to seek further care and expert evidence collection. Additionally, most locations only offer SANE services to their communities. Therefore, only patients within the narrowly defined parameters of sexual assault and within the window of time for evidence collection are seen. This disparity of care occurs in urban, suburban, and rural locations but occurs more frequently in rural communities. These communities often cite low patient volumes of sexual assault patients as a rationale for limiting services, despite the consistent research stating otherwise. The prevalence of violence in our society is currently a public health crisis, with the top three leading causes of death in the United States for people ages 15-34 the direct result of preventable violence (CDC, 2018). All victims of violence must be provided care by trained experts capable of addressing their medical and legal needs in a consistent trauma-informed manner. The generalist forensic nurse provides a standardized expanded care approach that embraces the generalized forensic scope of services for all victims of violence and serves to eliminate disparities in care. It is a paradigm shift designed to eliminate inequities between victims of violence and address the unsolved sustainability

crisis for forensic programs. *The general perspective considers that all victims of violence deserve the same medical forensic examination as those experiencing sexual assault.*

FURTHER READING

- ♦ Dolezal, T., McCollum, D., & Callahan, M. (2009). Hidden costs in health care: The economic impact of violence and abuse. <https://www.ccasa.org/wp-content/uploads/2014/01/Economic-Cost-of-VAW.pdf>
- ♦ Pasqualone, G., & Michel, C. (2015). Forensic Patients Hiding in Full View. *Critical Care Nursing Quarterly*, 38(1), 3–16. <https://doi.org/10.1097/cnq.0000000000000043>
- ♦ For more information on the generalist perspective and forensic nursing, please visit the Academy of Forensic Nursing at www.goafn.org

REFERENCES

- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey: 2010 summary report*. Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/NISVS_Report2010-a.pdf
- Block, R., Christensen, M., Ettinger, B., Ismailji, T., Kelley, S., McCollum, D., & Mouton, C. (2007, March). *Building Academic Capacity and Expertise in the Health Effects of Violence and Abuse A Blueprint for Advancing Professional Health Education* (C. Mitchell, Ed.). Academy on Violence and Abuse. https://avahealth.org.presencehost.net/file_download/inline/2b137058-043d-48a4-9b23-0bb1f59bec7f
- Boatright, A. C. (2017). Transforming Care for Victims of Violence. *JONA: The Journal of Nursing Administration*, 47(6), 301–302. <https://doi.org/10.1097/nnn.0000000000000483>
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. *10 Leading Causes of Injury Deaths by Age Group Highlighting Violence-Related Injury*

Deaths, United States (2018). Available: https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_violence_2018_1100w850h.jpg

Freire-Vargas, L. (2018). Violence as a Public Health Crisis. *AMA Journal of Ethics*, 20(1), 25–28. <https://doi.org/10.1001/journalofethics.2018.20.1.fred1-1801>

Goll-McGee, B. (1999). The Role of the Clinical Forensic Nurse in Critical Care. *Critical Care Nursing Quarterly*, 22(1), 8–18. <https://doi.org/10.1097/00002727-199905000-00003>

Huecker, M. R., King, K. C., Jordan, G. A., & Smock, W. (2021, February 17). *Domestic Violence - StatPearls - NCBI Bookshelf*. NCBI National Center for Biotechnology Information. <https://www.ncbi.nlm.nih.gov/books/NBK499891/#:%7E:text=According%20to%20the%20CDC%2C%201,sexual%20violence%20during%20their%20lifetimes>

Pasqualone, G., & Michel, C. (2015). Forensic Patients Hiding in Full View. *Critical Care Nursing Quarterly*, 38(1), 3–16. <https://doi.org/10.1097/cnq.0000000000000043>

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M. J., & Chen, J. (2018, November). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief—Updated Release*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Speck, P., Faugno, D., Mitchell, S., Thimsen, K., Johnson, J., Sievers, V., Bachmeier, B., Gill-Hopple, K., Rossi, C., Holbrook, D., Trujillo, A., Bell, K., Ingram-Jones, T., & Lewis-O'Connor, A. (2018). Position Paper: Expansion of Forensic Nursing [Unpublished Manuscript]. Consensus Document from End Violence Against Women International Cadre of Forensic Nurses

The National Intimate Partner and Sexual Violence Survey: 2010 summary report. (2011, November). National Center for Injury Prevention and Control Centers for Disease Control and Prevention Atlanta, Georgia. https://www.cdc.gov/violenceprevention/pdf/NISVS_Report2010-a.pdf

Thomas, T. L., Nobrega, J. C., & Britton-Susino, S. (2020). Rural health, forensic science and justice: A perspective of planning and implementation of a sexual assault nurse examiner training program to support victims of sexual assault in rural underserved areas. *Forensic Science International: Reports*, 2, 100053. <https://doi.org/10.1016/j.fsir.2019.100053>

United States Government Accountability Office. (2016, March). *SEXUAL ASSAULT*

Information on Training, Funding, and the Availability of Forensic Examiners (GAO-16-334). GAO US Government Accountability Office. <https://www.gao.gov/assets/gao-16-334.pdf>

Zweig, J., Farrell, L., Walsh, K., & Yu, L. (2020). Community Approaches to Sexual Assault: VAWA's Role and Survivors' Experiences. *Violence Against Women*, 27(1), 30–51. <https://doi.org/10.1177/1077801220949696>



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Gun Shot Wounds: Implications for Forensic Nurses

Christine Foote-Lucero, MSN, RN, CEN, SANE-A, SANE-P

Keywords: Gun Shot Wounds, Forensic Nursing, Firearms

INTRODUCTION AND EPIDEMIOLOGY

Violence and its associated trauma are widely recognized as critical health problems. Violence is no longer solely within the purview of law enforcement but rather a mutual responsibility of healthcare and the law. While all nurses will likely care for patients affected by violence, forensic nurse examiners (FNE) specifically care for patients whose illness, injury, or even death stem from violence, maltreatment, abuse, neglect, or exploitation (Lynch & Duval, 2012). Forensic nursing, DNA

technology, and an improved understanding of trauma-informed care have combined to significantly improve the care of the patient after sexual assault, but there are many other patients who are assaulted or injured who do not receive the benefit of a thorough and comprehensive medical-forensic examination. Consequently, it is important that the FNE expand its services to other vulnerable populations, including patients who have been injured because of domestic violence, child abuse, elder abuse, strangulation, human trafficking, gunshot wounds (GSW), and stab-

blings (Reed, Symonds, Stier, Peluso, & Watson, 2020). The charts from these patient care encounters can have significant medicolegal and forensic implications. As stated by Reed et al. (2020), "An understanding of the potential pitfalls of consent, gathering and preserving evidence, chain of custody, reporting, documentation, and photographing injuries is important not just for the patients but also for the health care provider responsible for their care, the institution where the patients receive their care, and the safety of the community" (p. 311).

Gunshot wounds are complex and violent. According to the Centers for Disease Control and Prevention, unintentional gun death occurs four times more often in the United States than in other high-income countries. In 2019, there were 39,707 firearm-related deaths in the United States, which is equivalent to about 109 people dying from a firearm-related injury each day. Firearm-related injuries are among the five leading causes of death for people ages 1-64 in the United States. There are few intentional self-inflicted firearm-related injuries seen in hospital emergency departments. Most people who use a firearm in a suicide attempt die from their injury. Males account for 86% of all victims of firearm death and 88% of non-fatal firearm injuries. Rates of firearm violence also vary by age and race/ethnicity. Firearm homicide rates are highest among teens and young adults (15-34 years of age), as well as among Black, American Indian/Alaskan Native, and Hispanic populations. Firearm suicide rates are highest among adults 75 years of age and older and among American Indian/Alaskan Native and non-Hispanic white populations (Centers for Disease Control and Prevention, 2020).

FIREARM BASICS

All firearms use gunpowder, which propels one or more missiles at a high rate of speed. There are four basic types of firearms: revolver, pistol, shotgun, and rifle. Revolver and pistol are typically referred to as handgun, while shotgun and rifle are typically referred to as rifle (or long rifle). Basic differences between these firearms include the rounds they carry, the rate of fire, features of the barrel, and their function (Di Maio, 1999). The common characteristic of all firearms is a tube of variable length called the barrel. Rifles have a rifled barrel, while handguns have a smooth barrel. An attached chamber receives the cartridge or unit of ammunition, which includes the bullet, propellant, and

This activity is designed to augment the knowledge and skills of legal nurse consultants and assist in their understanding of the analysis of medical malpractice and personal injury claims involving gunshot wounds.

Upon completion of the learning activity the learner will be able to:

- a. Evaluate cases involving gunshot wounds with better understanding of epidemiology and incidence.
- b. Understand the crucial procedures for documentation of injuries and identification of gunshot wounds.
- c. Know the procedures for proper evidence collection and chain of custody for evidence to be used in gunshot wound cases.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until September 1, 2024.

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primer. When a gun's firing pin strikes the primer, a small explosive charge in the primer ignites the gunpowder. The bullet is then accelerated down the barrel to its final velocity due to the high pressures built up by the expanding gases from the combustion of the propellant (Stefanopoulos, Hadjigeorgiou, Filippakis, & Gyftokostas, 2014).

Many times, the two injury terms "penetrating" and "perforating" are used interchangeably, although the terms have different definitions. When a GSW is termed penetrating, typically, the projectiles (or bullets) enter the body, but they do not exit. When a gunshot wound is termed perforating, they have an entry and an exit, which is also referred to as a through and through wound. In addition, bullets, associated fragments, and blast debris may enter a vessel and embolize to the lungs or brain. This is sometimes referred to as missile embolus. Once the bullet or missile enters a vessel, movement of the bullet/fragment could potentially be influenced by anatomical position, respiratory patterns, blood flow, and/or gravitational forces (Folio, 2010).

Ultimately, the deciding factor in GSW with respect to mortality is the location of the injury with relationship to vital organs and major vessels.

DOCUMENTATION

According to Riviello (2013), proper documentation of injuries is crucial because many procedures performed during resuscitation, and even wound cleansing techniques, can alter the appearance of wounds. The initial emergency department documentation may be the only accurate description of these wounds. In the process of treating the patient and performing life-saving measures, the GSW can be altered by procedures, such as surgery, excision, or suturing (Apfelbaum, Shockley, Wahe, & Moore, 1998). GSW can also change appearance over time as the injury heals. Therefore, the most important forensic aspect of the initial evaluation is the accurate and systematic description of wounds upon patient arrival. Descriptions should include shape, body location, and size, being as specific as possible. A measuring device such as the American Board of Forensic Odontology (ABFO) ruler

It does not matter if the patient is a victim or a suspect; all patients must receive thorough, appropriate, and unbiased care, although the safety of patients and staff must be considered.



should be used. Documentation should also include characteristics such as the presence of foreign material, color, and patterns. In addition to written documentation, body diagram maps and photo documentation should be standard. A digital camera should suffice for image capture, and department and/or hospital policies should be utilized for image security and storage. A series of three photographs should be taken of each wound: an orientation photo that shows the anatomical location of the wound in reference to the body; an up-close photo; an up-close photo with a measuring device.

Always follow local and state mandatory reporting laws regarding patients affected by GSW. Many jurisdictions require emergency departments to notify local law enforcement of GSWs. Law enforcement investigation may be necessary to ensure that no other victims are in need of assistance, and necessary steps should be taken to ensure that the emergency department and hospital are safe and secure, which may include communicating with hospital security or police personnel. The report should include the date, time, and person reported to (i.e., police officer's name as well as badge number) in the medical record.

The medical history should be obtained directly from the patient, when possible. Any statements made by the patient

should be documented in direct quotes and should pertain to information necessary for medical care, evaluation, and treatment. Avoid questions that are not related to the medical inquiry as the medical history will be very different from the interview obtained by law enforcement. It is important to gather information from the patient about their body position at the time of shooting (i.e., standing, sitting, or lying) as well as a range of fire (estimated distance from the shooter) and interposing factors (objects between the shooter and patient), as these may all lend to the appearance of the wound. If the patient can recall, also document the time of injury, and the number of gunshots heard. It is also imperative to ask questions related to the safety of the patient and staff. This might include gang or trafficking activity, domestic violence, or other crime whereby the suspect may return to attack again. It does not matter if the patient is a victim or a suspect; all patients must receive thorough, appropriate, and unbiased care, although the safety of patients and staff must be considered.

According to Vellema and Scholtz (2005), the interpretation of GSW with respect to entrance and exit, the direction of fire, or type of firearm or ammunition used should not be assumed. Differentiation between

the entrance and exit wounds can be difficult, and information from patients or witnesses may be false or inaccurate. The authors further reference a study of 271 gunshot wound fatalities whereby it was found that trauma specialists had misclassified 37% of single exiting gunshot wounds with respect to the entrance or exit wounds, and 73.6% of multiple gunshot wounds had been misinterpreted with respect to the total number of wounds, as well as erroneous identification of entrance or exit wounds. Therefore, the best practice is to document each wound objectively according to appearance factors such as soot, abraded edges, stellate fractures in the skin, and tattooing. General nursing staff or staff without specialized and dedicated GSW training should never chart entrance and exit in their clinical nursing documentation (ENA TNCC Manual, 7th ed.). Surgical procedures such as drain sites must also be recorded to prevent subsequent interpretive difficulties for the forensic pathologist, should the patient die.

GUN SHOT WOUND INJURY IDENTIFICATION

When someone is shot, the bullet will pass through the skin and produces an entrance wound; it may exit the body (exit wound) or be retained in the body. When the bullet passes through the

skin, it produces a cavity due to the shearing, compression, and stretching of surrounding tissue. The size and shape of the cavity are the results of the kinetic energy of the bullet. Many features of the GSW depend upon the range of fire. The range of fire is the factor that considers the distance of the barrel of the firearm to the patient and includes contact, near contact, intermediate, and distance.

Contact wounds are produced when the muzzle of the weapon is held firmly (hard contact) or loosely (loose contact) against the skin. The wound edges are seared by hot gases, and soot is either embedded (hard contact) or deposited (loose contact) in the circumferential band of the wound and can be wiped off. In contact wounds with bone underlying the injury, the injuries typically appear stellate, whereby the gases are exiting the barrel cause the expansion of subcutaneous tissue, resulting in tearing or lacerating of skin.

Near contact wounds are produced when there is a gap between the gun muzzle and the skin and are usually within a one- or two-centimeter range. In these cases, there is not enough distance for gunpowder grains to exit the barrel and disperse and mark the skin (tattooing or stippling). In angled near-contact wounds, the seared skin and soot may also deposit irregularly and will not be noted circumferentially. The irregular seared skin and soot area will be noted on the side of the wound that made contact with the barrel.

Intermediate-range wounds are marked with tattooing when the gunpowder grains embed in the skin (see Diagram 1). This includes anything past near contact, which is up to 90 centimeters for handguns or 110 centimeters for newer high-velocity cartridges. Tattooing appears as red or brown punctate lesions around the wound entrance that cannot be wiped away. Tattooing is not a powder burn but rather abrasions.

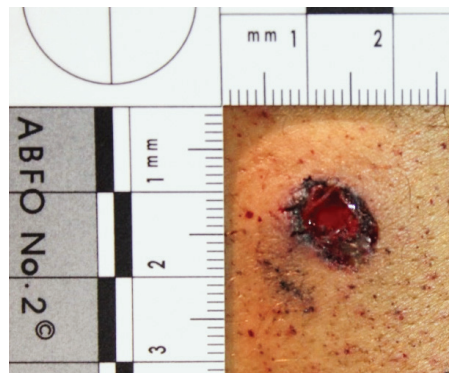


Diagram 1: Stippling surrounding a forearm GSW; the patient reported he was shot at approximately 3 feet.

Distance wounds occur when the distance to the weapon exceeds that of an intermediate wound and is far enough that there is no tattooing or deposition of soot, and the only damage is that from the projectile itself (Apfelbaum, Shockley, Wahe, & Moore, 1998).

In all entrance wounds, seared skin, soot deposition, and tattooing are influenced by body position at the time of the shooting, the area of the body that was shot, muzzle attachments, type of gunpowder, barrel length, and caliber, so while these wound findings are typical, there are factors that can influence the final appearance of the wound. The FNE must understand the complexity of GSW and ensure that descriptions remain objective.

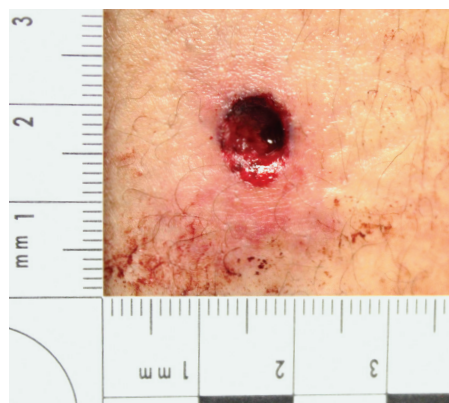


Diagram 2: Entrance wound on the lateral upper arm. Note abrasion collar, which, while seen circumferentially, can most prominently be seen between 4-6 o'clock and assists in determining directionality of the bullet (see also, Diagram 4).

Entrance wounds can vary widely in size but are usually round. They will typically have an abrasion ring or abrasion collar, which is an area of abraded tissue around the entrance where the bullet scrapes the skin as it penetrates the dermis (see Diagrams 2 and 3). However, abrasion rings are not typically seen on the soles of the feet or the palms of the hand. Exit wounds are generally larger and more irregular than entrance wounds; however, while the size of wounds should be included in the documentation, size should never be the sole determinant of whether a wound is an entrance or exit. Exit wounds can appear round, oval, slit-like, stellate, or crescentic-shaped. Deformation and instability of the bullet as it moves through the tissue account for the general appearance of the exit wound.



Diagram 3: Entrance wound on the abdomen. Abrasion collar noted circumferentially.

There are also circumstances that can cause confusion for the FNE, such as a shored exit wound. This is when a bullet emerges through an area of skin that is supported by something, such as a chair, mattress, clothing, wall, door, etc. In these circumstances, the skin surrounding the exit wound is supported as the tissue is being forced outward, and in effect, squeezes the tissue when the bullet emerges, creating a false abrasion ring, and mimicking an entrance wound. Graze wounds occur when a bullet scrapes or grazes over the skin without penetrating deeply. These wounds are generally more elongated or ovoid and may have marginal tears at the edges. If these tears are pointed, they may be used

Forensic Nurse Examiners apply the nursing process in combination with forensic science during the care of patients affected by GSW.

to indicate the direction of the bullet; tears point in the direction the bullet was traveling and away from the direction in which the bullet came (See Diagram 4).

EVIDENCE COLLECTION

Clothing removed from the patient should be placed in brown paper bags or other containers suitable for evidence collection. Each item of clothing should be placed in its own paper bag, rather than plastic, so as not to degrade DNA. In addition, take careful notice not to cut through any bullet holes of the clothing with trauma shears. Many trauma centers ensure that paper bags are readily available in their resuscitation rooms to ease evidence collection for staff. Other objects removed from the patient with evidentiary value should also be labeled and carefully packaged. Any bullets removed should be handled with gauze or hemostats covered with suture booties so as not to damage the

bullet's surface during handling. Typically, every organization has its own policy and procedure when it comes to evidence collection and/or bullet retrieval. Evidence should be kept in its original state unless medical treatment is necessary. Any procedure which alters the original condition of any evidence should be carefully documented within the medical record.

Chain of custody (COC), also termed Chain of Possession (COP), should be maintained for all evidence, at all times, that could potentially be used in a court of law. The COC is considered a legal safeguard mechanism to ensure that the evidence was never tampered with or contaminated. Once the evidence is labeled, the paper bag should be sealed with tape, and the FNE should ensure that their initials, time, and date are placed on the tape once it is sealed. The COC should always be carefully documented in the electronic health record

or paper documentation (based upon hospital protocol). All parties involved with the collection and/or acceptance of the evidence should be accounted for on the COC. According to Slate (2018), collected evidence must remain with the FNE, in plain view, or in a secured location to maintain the COC. Evidence must never be left unattended or be handled by other staff, patients, or persons in the emergency department. The sealed evidence bags may be stored in a secure location, such as a locked storage box or locker, until transfer to authorities is completed.

CONCLUSION

FNEs apply the nursing process in combination with forensic science during the care of patients affected by GSW. This requires that they protect the forensic evidence that links health care to criminal justice. It is crucial to understand that the medical chart is both our best defense and our worse enemy. Interpretive errors regarding GSW are common in the healthcare field; therefore, objective and descriptive documentation is imperative. Forensic nurses are a valuable asset to the assaulted patient, the facility, and the community at large (Reed, Symonds, Stier, Peluso, & Watson, 2020). They should be incorporated into the care of all patients affected by violence.

REFERENCES

- Apfelbaum, J., Shockley, L., Wahe, J., & Moore, E. (1998). Entrance and Exit Gunshot Wounds: Incorrect Terms for the Emergency Department? *Journal of Emergency Medicine*, 16(5), 741-745.
- American College of Surgeons. (2012). Advanced trauma life support for doctors ATLS: manuals for coordinators and faculty. 9th ed. Chicago, IL: American College of Surgeons.
- ATLS Subcommittee; American College of Surgeons' Committee on Trauma; International ATLS working group. (2013). Advanced trauma life support (ATLS®): The Ninth Edition. *The journal of trauma and acute care surgery*, 74(5), 1363.

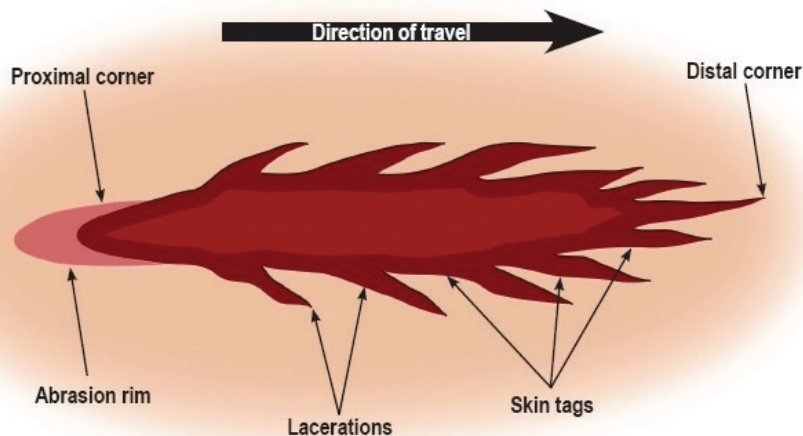


Diagram 4

Source: <https://europepmc.org/article/pmc/6507010>; professional medical illustrator Diana Kryski.

Centers for Disease Control and Prevention. (2020). National Center for Health Statistics: All Injuries. Retrieved from <https://www.cdc.gov/nchs/fastats/injury.htm>

Di Maio VJM. (1999). Gunshot wounds, 2nd ed. Boca Raton, FL: CRC Press.

Emergency Nurses Association. (2014). Trauma nursing core course provider manual (7th ed.). Des Plaines, IL: Emergency Nurses Association.

Folio L.R. (2010) Blast and Ballistics: Types, Background, Terminology. In: Combat Radiology. Springer, New York, NY.

Harle, L. (2019). Forensic pathology Types of injuries Gunshot wounds. In Pathology Outlines-Gunshot wounds. Retrieved from <https://www.pathologyoutlines.com/topic/forensicsgunshotwounds.html>

Heninger MM. (2016). An Unusual Feature of Graze Gunshot Wounds. Academic Forensic Pathology. 6 (2):291-300. DOI: 10.23907/2016.030.

Lynch, V. A., & Duval, J. B. (2011). Forensic Nursing Science. St. Louis: Elsevier

Reed, G., Symonds, A., Stier, A., Peluso, S., & Watson, S. (2020). Prosecutor Preference for Forensic Nurse Testimony: Outcome of Expanding a Forensic Program. Journal Of Emergency Nursing, 310-317.

Riviello, R. (2013). EPs Should Continue to Improve Forensic Skills. American College of Emergency Physicians' Now, ACEP News. 32 (11).

Slate, M. (2018). Evidence Collection for Nurses. Retrieved from: <https://www.rn.org/courses/coursematerial-173.pdf>

Smock W. (2002). Forensic emergency medicine. In: Marx JA, ed. Rosen's Emergency Medicine, 5th ed. St Louis, MO: Mosby.

Stefanopoulos PK, Pinalidis DE, Hadjigeorgiou GF, & Filippakis KN. (2017). Wound ballistics 101: The Mechanisms of Soft Tissue Wounding by Bullets. European Journal of Trauma and Emergency Surgery, 43(5):579-586. doi: 10.1007/s00068-015-0581-1.

Vellema, J., & Scholtz, H. J. (2005). Forensic aspects of ballistic injury. In Ballistic Trauma (pp. 91-121). Springer, London.



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Criminal Case Consultation: Entering the Lion's Den

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Teresa J. Devitt-Lynch, MSN, RN, AFN-BC, SANE-A

Keywords: Criminal Case, Forensic Nurse, Sexual Assault, Medical Malpractice

Criminal case consultation opens the door for legal nurse consultants to evaluate many variables that may exist in a criminal case that the prosecuting attorney has filed. Whether called by the prosecution or the defense, many facets must be considered within the review of the records. The LNC must be cognizant of the scope of practice of the forensic nurse, the scope and standards of that practice, and the ability to identify omissions and failures that may have existed through the medical forensic examination. In comparison, the LNC should be aware that there may present issues that may fall into the criminal arena in any case review.

Lions operate through a hierarchy. The order within the pride falls to the head lion, and the lionesses carry out his will and raise the young. The lion's den, the most protected space among the pride, is guarded and kept free from intruders with prejudice. Anything or anyone foolish enough to trespass finds a judge, jury, and executioner waiting in the dark. Similarly, a criminal case consultation can be a difficult situation in which the environment can turn adversarial, and the consultant may feel as if they are entering the lion's

den. In a criminal proceeding, the judge is the pride male or king of the pride whose duty is to oversee the proceedings, review the accused, and ultimately render judgment. In this article, two case studies will showcase variables that may present themselves in which the legal nurse consultant (LNC) enters the den and becomes the lioness.

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In the following two case studies, one medical malpractice and one criminal, it is apparent that the LNC will experience the pressure of the lion's den, of the court, with the complex variables surrounding both cases. The cases provide evidence of the failure to identify breaches in medical care, omission of forensic standards, a failure to assess injuries appropriately, and the potential sexual assault of a neurocognitively impaired female. The LNC must provide all the information, opine, and support their opinion with evidence-based practice standards. The ability to verbalize the issues at hand regardless of the complexity of the case type assures an adjudication process that has a foundational basis for concern and negligence.

CASE STUDY: TERESA

Potential sexual assault

Plaintiff counsel seeks to identify the merit of a potential negligent death case to the LNC. The case review of Teresa, a woman in her late 50s, who is under the care of a long-term care facility due to the inability to care and provide for her safety at home. She exhibits neurocognitive impairment related to prior strokes and uncontrolled diabetes. Her family admits her to be cared for and remain safe throughout the rest of her lifespan. Suddenly, Teresa dies, no autopsy is completed, and Teresa's cause of death was classified as natural, sudden, and possibly secondary to Chronic Obstructive Pulmonary Disease or Pulmonary Embolus. The initial concerns identified were repeated falls, mismanagement of her diabetes, failure to provide for her safety, and failure to appropriately care for her are all under scrutiny for the cause of her death. In the review, the LNC identified repeated instances in which she is experiencing rectal and vaginal bleeding.

There is mention that she may be "interested" in another resident with an implication that there may be possible sexual encounters between these two

parties. The staff informs the patient to apply petroleum jelly to the rectal tear without the consultation of the attending physician. The staff failed to provide a complete examination and failed to ascertain what events surround the repeated anogenital bleeding or a proper cause. Individuals that have impaired cognition, referred to as vulnerable adults, may lack the capacity to consent to sexual encounters. Injuries may be sustained in consensual and/or non-consensual sexual relations; however, this situation requires additional evaluation. Throughout the review, it becomes apparent there are care-related deficiencies that spark concern for neglect and the potential cause of her death, but what about the anogenital injuries? The patient is no longer living, there is minimal information in the medical record, the male party is unknown, and the neurocognitive capacity is also in question. Could there be a concern for sexual abuse or lack of consent? This raises an issue that must be discussed with counsel to assert that all facets of care are considered in the initial review and moving forward throughout the litigation. This allows the LNC to consult with a sexual assault nurse examiner (SANE), forensic nurse examiner or sexual assault forensic examiner (SAFE) to discuss the injuries sustained and if their implications are congruent with a sexual assault a neurocognitively impaired female.

CASE STUDY: JOHN

Sexual assault criminal case

John has been charged with one count of unlawful sexual penetration in the first degree against his ex-wife, Alice. She alleges John sexually assaulted her at her home. In a criminal case, the LNC must be familiar with the definitions of the laws and specifications which the defendant has been charged with violating. These are the acts the prosecution aims to prove, and the defense either argues innocence, lesser offenses, or a reduction in sentencing.

The LNC reviewed police reports and interviews, Alice's emergency department and the medical forensic examination documentation, chain of custody documents, and the DNA analyst report; these identify the following:

1. The SANE examination was conducted approximately 8 hours post-assault.
2. Alice consented to photography, but no photographs were provided. The attorney was made aware the facility's SANE procedures do not include photography, and the facility lacked written SANE policies & procedures.
3. The SANE documented a posterior fourchette laceration, hymenal erythema, and a "lesion or abrasion" to the labia minora.
4. The SANE evidence kit was sealed with evidence tape approximately 12 hours after the completion of the examination. When questioned by the attorney about the time-lapse, the examining SANE indicated the SANE Manager reviews all kits before sealing and supplying the evidence to law enforcement.
5. Male DNA was extracted from the vaginal sample collected by the SANE, for which John could not be excluded as the contributor.

This case study demonstrates the spectrum of standards and practices with which an LNC must be cognizant of providing a thorough, evidence-based analysis and effectively engaging in trial strategy development related to the medical evidence.

A SANE examination cannot determine consent in adult sexual assault cases, though research suggests multiple anogenital injuries are more likely to be identified in persons who report sexual assault. Consent is a legal term determined by the trier of fact based on the totality of the evidence presented. In this case, the posterior fourchette laceration is indicative of penetrating trauma but

no consent. Erythema is considered a non-specific finding as it may result from either medical conditions or traumatic events. The prosecution would then argue these findings are consistent with and support Alice's allegations of sexual assault. The defense would emphasize that injuries such as these can occur with consensual intercourse. Their presence cannot be directly linked to the person or nature of trauma (intentional, accidental, self-inflicted) applied.

The labia minora finding is vague and ambiguous. An abrasion results from blunt force trauma, whereas lesions result from medical conditions. This finding is of little use to the jury as it cannot be distinguished to be of medical or traumatic means. Furthermore, if the examining SANE cannot discern the difference, how can one expect a jury of non-medical persons to do so? There is room to question the validity of the finding to the labia minora, which could lead the defense attorney to argue exclusion of this or all findings from being presented to the jury. On the other hand, the prosecution may need to develop a strategy to mitigate the potential negative impact of this finding.

There are also administrative and procedural issues at hand, including the absence of a written SANE exam policy and the extended time between the examination and evidence sealing. These findings call into question the quality of care, evidence collection and handling procedures, and employment of evidence-based practices as indicated in higher authority recommendations and standards. The prosecution would need to demonstrate the SANE examination was conducted within the current evidence-based standards, and the time-lapse was of no consequence to evidence integrity and validity. The defense may argue the SANE examination was not performed in compliance with the current standards, and the evidence was vulnerable to contamination

or tampering and should be excluded. If the SANE examination and evidence are excluded, the DNA results may be excluded as well, which could significantly encumber the prosecution's case.

Legal nurse consultants certainly enter the lion's den but are not responsible for the pride. The role of the LNC in criminal cases is to identify, interpret, and educate attorneys with relevant medical evidence. They may also be involved in strategizing the use of the medical evidence in case development or craft tactics to mitigate the effect of medical evidence that may hinder the attorney from providing a solid case for the trier of fact. It is not the LNC's responsibility to ensure a conviction or acquittal. The LNC does not make or break a case, however, their role within the proceedings is critical to ensuring both the education of the prosecution and the jury. Because the LNC is an expert in their field, they should embrace their role in the pride, not run from the den.

REFERENCES

- Carney, A. [ed.] *Abuse Forensic, Legal and Medical Aspects*. ISBN: 9780128157794. Elsevier, 2020.
- Joy, M., & Weiss, K. Consent for Intimacy Among Persons with Neurocognitive Impairment. *Journal of the American Academy of Psychiatry Law* 46:286–94, 2018. DOI:10.29158/JAAPL.003763-18
- Kotze, R., Keith, M., Winterbach, C., Winterbach, H., & Marshal, J. (2018.) The influence of social and environmental factors on organization of African lion (*Panthera leo*) prides in the Okavango Delta. *Journal of Mammalogy*, vol. 99(4): 845-858. <https://doi.org/10.1093/jmammal/gyy076>
- Orellana-Campos, C. (2020). Genital injuries: are they telling us something about sexual violence?. *Revista Brasileira de Ginecologia e Obstetricia*, 42(2), 106-113. Epub April 17, 2020. <https://doi.org/10.1055/s-0040-1701465>
- Schafraan, Lynn H. (2015). Medical forensic sexual assault examinations: What are they, and what can they tell the courts? *The Judge's Journal*, 54(3): 16-20. https://www.legalmomentum.org/sites/default/files/reports/JJ_v54n03_SUM15_Schafraan.pdf

Song, S. H., & Fernandes, J. R. (2017). Comparison of Injury Patterns in Consensual and Non-consensual Sex: Is It Possible to Determine if Consent was Given? *Academic Forensic Pathology*, 7(4), 619–631. doi:10.23907/2017.052

Stark, M. M. (2011). *Clinical forensic medicine: A physician's guide* (3rd ed.). Springer.



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