

## Domestic Violence: The Medical Forensic Response

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### Abstract

Each year countless numbers of men, women, and children present to emergency rooms and urgent care centers seeking treatment following acts of domestic violence. Many times law enforcement is not involved until tragedy has struck. Working with emergency department staff can greatly improve victim outcomes and help law enforcement to understand why they may not see any visible injuries. Sexual assault, physical abuse, and strangulation are possible findings after an episode of domestic violence. Careful documentation of symptoms is one of the most important measures to note.

Domestic violence is often thought of as physical conflict between a couple involved in an intimate relationship. In reality domestic violence is much broader in its scope and effect of the community. Domestic violence not only leaves physical and emotional injuries to the individual involved but it has a ripple effect on all of the members of the family. Children and other family members experience the bands of the ripple with each act. The Centers for Disease Control report that 29% of violence perpetrated against women by a lone offender is committed by someone they are intimately involved with such as a husband or boyfriend [1]. What does a number like 29% represent in a single state? According to the Texas Council on Family Violence, 2011 data, 102 women lost their lives to domestic violence/ trauma. There were nearly 180,000 incidences of family violence (reported), 205,793 hotline calls placed and 11,833 adults were sheltered. Nearly 37,500 adults were not sheltered but received non-residential care and 15,674 children required emergency shelter services [2]. These numbers represent only those that are involved in the governmental support system and does not in any way represent those who do not get involved with the system. The issue of domestic violence is not solely a woman's issue as it is reported that the numbers of men reporting abuse is rising. 7.5% of men report that they have been abused by an intimate partner.

Many times it is the local urgent care center or emergency department that first becomes involved with a victim of domestic violence. The patient may present with a wide range of medical complaints such as abdominal pain, headaches, falls of common origin, various body aches, pain, bruising with inconsistent mechanism of injury, and anxiety. Depending on the type of violence inflicted the injuries can appear minor or severe. While hospitals are required to screen all patients for domestic violence, many emergency departments are extremely busy and often don't screen in a manner that is most conducive to honest answers. Ideally the nurse or doctor speaks with the patient privately and with patience and concern. When patients are screen with friends or family present they are often not ready to share that information publicly or the person with them may, in fact, be the person causing the abuse. When patients are taken to another area and given privacy, they will be more likely to answer honestly. If a patient does disclose a history of domestic violence it is important to determine immediate risk/ danger to patient and children. While some states allow the medical personnel to notify police if they suspect domestic violence many only allow reporting without the patients consent if children or elderly persons are victims.

Across the nation, few medical providers have forensic training beyond the most basic of levels. This translates to a brief introduction

during medical school or if they are lucky, a larger exposure during residency. For registered nurses there is very little on the subject in nursing school and much less in clinical rotations. For most providers it is a voluntary course or class that provides them with any forensic training. Sexual assault nurse examiners and forensic nurses are one of the most sought after clinicians when forensic cases are suspected. The evidence is clear that careful and considerate documentation of the patient's statements during the history and physical is critical to improving outcomes both medically and legally. In one case this was clearly demonstrated. The patient is Mary. She is in her late 70's and she presented to a local free standing emergency department in a suburban community. She was triaged by a registered nurse and her husband of 51 years was at her side. Mary was coming in because she had fallen and hurt her hip. Mary's husband added that she had been falling a lot more than usual of late. The nurse noted the concern and completed her assessment by asking: "Do you feel safe from violence in your home?" and the nurse chuckled, "I guess you don't feel to safe if your falling a lot" and went to the next question "As anyone hit, kicked, or slapped you in the past year" and she laughed saying "I feel ridiculous asking such a sweet couple these questions". She marked no to all the questions and moved the patient to the exam room. The nurse gave the doctor a report and he walked into the room saying "well, I hear you're a bit accident prone these days". Mary smiled and remained quiet. The doctor examined Mary and found that she had a number of bruises all over her body in various stages of healing. With each set of bruises, Hank, Mary's husband, was able to report how and when it happened. The area on her left hip was a "missed the chair when she went to sit down" and the marks behind her ear was a run in with an open cabinet door. Each of the explanations made sense. The doctor never talked to Mary away from Hank and Mary rarely responded to the questions. Mary was given some fall safety information and a prescription for mild pain medication and sent home with Hank (Figures 1 and 2).

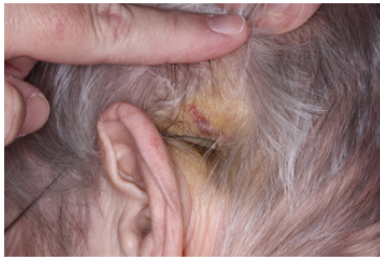
Five days later Mary and Hank go to another emergency department

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**Figure 1:** Bruises on the patient's ear.



**Figure 2:** Area of bruises on the patient's left hip.

and this time the triage nurse is a forensic nurse who happens to be on duty that day. Mary and Hank are in triage and the nurse asks Hank to go to registration and get Mary signed in while she takes her vitals. While Hank is gone the nurse goes over the events leading up to the visit and discovers that some of the history given by Mary is not consistent. The nurse then asks Mary about safety. Mary looks at the nurse for several seconds and then looks to the ground. The nurse repeats the question slowly and with great compassion. Mary looks up and says "what does safe in your home feel like?" The nurse then says, "Safe is no being pushed, hit, talked down to, or hurt in anyway". Mary then says, "No, I don't feel safe in my home". The nurse felt that the Hank would be returning soon so she told Mary they would talk some more later. The nurse shared her concerns with the nurse taking over Mary's care and the doctor. They discussed how they would examine Mary without Hank and together provided safety for Mary in the emergency department. Because Mary was over age 70 and they suspected abuse, they were required to make a report to Adult Protective Services. They also felt that Mary was in immediate danger from Hank so the police were also called. The forensic nurse on call came in and photographed Mary's 39 injuries and documented each of them by size, shape, and color. She also documented Mary's exact statements as to how they happened. The police arrived and took Mary's and Hank's statements and Mary was taken to a local shelter until one of her children out of

state could come and provide assistance. Eleven months later Mary's case went to trial. The forensic nurses, the physician, and Mary all testified about that day. Hank was 81 years old and had recently been placed in a nursing home at the time of the trial. He was found guilty and sentenced to probation for 10 years. Mary moved to California to live with her daughter and son-in-law. The outcome could have been very different had it not been for the few changes between the two emergency departments.

For healthcare providers, utilizing the Forensic Survey [3] as a follow up to the primary and secondary survey [4] can be of great benefit. The primary and secondary surveys include identifying addressing all life-threatening injuries and additional medical findings. The TNCC primary and secondary surveys utilize the alphabet for ease of recall. These surveys cover A thru I of the alphabet and the trauma survey picks up at J and goes to P. The forensic survey for healthcare providers is as follows: **J**: Just the facts as spoken by the patient (if the patient states that she was stabbed by her boyfriend, document exactly what she says and note the statement in quotes), **K**: Keep evidence safe, **L**: Limit contact to those who must be a part of the treatment team and record who was in the room, **M**: Maintain integrity when possible by cutting around points of contact with clothes such as gunshot wounds, stab marks, or patterns of injury on clothing, **N**: No gossip or sharing of information outside the treatment team and law enforcement, **O**: Observe and document everything you see, smell, or hear from the patient, and **P**: Photograph the patient before, during, and post treatment when possible to retain visual documentation for case review as well as investigative evidence.

When healthcare providers are involved in criminal investigations they are often in an environment that is uncomfortable and confusing. When asked, in court about a patient they cared for 12 or 13 months earlier, it is nearly impossible to recall any details that are not in their emergency department notes. Electronic medical records often lack narrative notes that fully explain the patients' physical, mental, and collateral condition. It is important to add such information in cases involving acts of violence as they will be more likely to end up in a court of law.

## References

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