In Child Abuse Case, Everyone Fails

In May 2009, an employee of the New Jersey Division of Youth and Family Services brought a child to an urban medical center for evaluation of possible child abuse that had been reported by the child's maternal grandmother. The infant, who was two-and-a-half months old at the time, was bleeding from the blood vessels of both eyes and had bruises on both sides of his face.

The treating physician, Dr A., ordered a series of x-rays of the entire body and CT of the head. The CT findings were initially read as negative, and the baby was discharged on the same day with a diagnosis of "suspected child abuse." Two radiologists who reviewed the CT results identified fluid on the brain.

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Three weeks later, the infant's parents brought him to another medical center. He was bleeding from the mouth, and a lacerated frenum was diagnosed. Attending physician Dr K. discharged the infant with a notation that the injury had been sustained when the baby's father "tried to put a bottle in the child's mouth."

In mid-July 2009, at the age of 4 months, the child was severely beaten by his father and sustained brain damage. The child was removed from his parents' custody and placed with his grandmother. The father was later convicted of aggravated assault and child cruelty.

The child's grandmother alleged negligence by the defendants in failing to recognize child abuse, which would have resulted in the infant being removed from his home earlier, before the brain damage could occur.

OUTCOME

A $7.4 million settlement was reached. Dr A. and his facility were responsible for $4.5 million; one of the radiologists and her employer, $475,000; the other radiologist and his employer, $750,000; Dr K. and his employer, $1.19 million; and the second medical center and several of its nurses, $560,000.

COMMENT

In this horrible case, there was no failure to diagnose. Dr A. diagnosed "suspected child abuse" during the May 2009 visit. The issue was the management of the case after abuse was suspected.

Suspected child abuse is a "hot potato," and the cases are difficult to manage. Clinicians are trained to spot and treat illness. We are not well equipped to identify short-term safe housing, file court papers to terminate parental rights, conduct home visits, or interview family, friends, and neighbors to determine the best living arrangement for an at-risk patient.

Many clinicians feel that issues of abuse are outside medicine and are more appropriately dealt with by social workers, the courts, and law enforcement. Candidly, managing these cases is taxing. But manage them we must to adequately protect those who cannot protect themselves.

This case proves clinicians will be held accountable for child abuse. The defense attorneys realized the enormous malpractice exposure and consented to the substantial $7.4 million settlement. (This, it should be noted, is in addition to the largest verdict against the State of New Jersey in history: $166 million awarded against the Division of Youth and Family Services. As for the abusive father in this case, he received a paltry jail term of six years.)

So what do we do when evidence of abuse is discovered? How do we proceed? First, in cases when abuse is suspected, it is a bedrock principle that a child can't be returned to the hands of the abuser. But how do we secure the patient's safety after making a diagnosis of "likely child abuse"? As clinicians, we are duty bound to report abuse. Yet, under most circumstances, we do not have an automatic mechanism to emergently remove a child from a dangerous situation under our own authority: With great responsibility comes limited power. Sarcasm aside, there *are* steps we can take

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to safeguard children at risk.

Consider emergency removal through your state's child protection agency. In most cases, a child is removed from an unfit home by a court order. However, when the child is in imminent danger and there is insufficient time to follow this procedure, the child may be removed from the home by the state's child protection agency without parental consent. (New Jersey, where this case occurred, is one such example; see NJSA 9:6-8.29[a].)

Know your state's rules for emergency removal, and have the child abuse hotline number handy. If evidence of child abuse is present, contact the appropriate agency in your state and insist that emergency removal is warranted.

The local police department may be another option. Many states' emergency removal procedures authorize and require local authorities to remove a child who is in imminent danger. Explain your evidence of abuse and the need for emergency action.

Lastly, if your state's protective agency or your local police will not remove the child from the dangerous situation, another option is inpatient admission. Yes, beds are limited and costs are high. But far higher is the cost of a seriously injured child when we fail to act.

In this case, the New Jersey Division of Youth and Family Services was involved. The social workers only performed a background check and missed some 20 arrests on charges of assault and other crimes that the father had logged in Florida.

The first emergency physician who identified abuse faced liability exposure for returning the child to the abuser. He pursued a work-up for child abuse and made a diagnosis of child abuse, yet he did not adopt a disposition consistent with his work-up and diagnosis.

The second physician failed to recognize the significance of a lacerated labial frenum in a 2-month-old. This type of injury is particularly suggestive in children who are not independently mobile and thus incapable of accidental injury. Force sufficient to rip a 2-month-old's lip away from his mouth should have been recognized as abusive force. There is no evidence in the case report that the second physician identified the abuse or acted to stop it.

IN SUM

Recognize and report abuse. Know your state's emergency removal law, and marshal your evidence of abuse to impel state agency workers to act on their power to remove a child from an abusive situation. Above all, do not return a child to his or her abuser. **—DML** **CR**