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Interactions With Police in the Emergency Care of Children
Ethical and Legal Considerations

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Objectives: Emergency medicine providers may interface with law enforcement personnel (LEP) on behalf of their pediatric patients for a variety of reasons, from reporting child abuse to caring for children who are in police custody. Given the unique nature of caring for minors who may not have legal or medical autonomy, interactions with LEP can raise ethical concerns for emergency providers, specifically with regard to legal representation, developmental immaturity, and the civil rights of children and their parents/guardians.

Methods: We review 4 patient scenarios, based on real cases experienced by the authors, to demonstrate the legal and ethical issues that may arise when LEP are involved in the emergency care of a child. These scenarios discuss parental/guardian visitation for children in police custody in the emergency department (ED), the practice of making arrests on hospital grounds, and police interviews of children in the ED.

Results: Using the ethical principles of autonomy, beneficence, and justice, we offer recommendations for emergency providers on how to advocate for their pediatric patients in LEP custody within the constraints and protections of the law. We also suggest best practices for hospital systems to develop policies surrounding LEP activity in the ED.

Conclusions: These nuanced situations require careful advocacy for the child and a collaborative approach between medical providers and LEP to balance the child's well-being with public safety. We offer recommendations here, and we maintain that clear, widely adopted best practices for the care of minors in LEP custody are long overdue.

Key Words: police, law enforcement, ethics

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Emergency providers may interact with law enforcement personnel (LEP) when treating pediatric patients for a variety of reasons. Police may bring children to the emergency department (ED) who require medical care because of gun violence, motor vehicle collisions, or mental health crises. Other kinds of LEP, such as correctional staff or probation officers, may accompany children who fall ill while already in state custody. Law enforcement personnel may also come to the hospital after being called by medical providers when child abuse, neglect, or human trafficking is suspected or when the personal safety of staff or patients is at risk.

The professional relationship between medical providers and LEP is important to maintain but remains distinct and secondary to the relationship between medical provider and patient. In some instances, LEP may be helpful in providing valuable information to medical providers about the patient's illness or mechanism of injury. However, interactions between LEP and medical providers can become strained and even contentious when providers feel that their legal and ethical obligations to their patients are challenged. This may occur when LEP physically restrain patients against medical providers' wishes or request that medical providers obtain forensic evidence from patients without consent.[1]

While conflicts between LEP and medical providers in EDs have been reviewed previously,[2–4] there remains a gap in the literature regarding the ethical concerns that arise with pediatric patients specifically. Caring for children as opposed to adults is unique in that children are a vulnerable class in need of protection; they lack the developmental and legal agency to advocate for themselves. Accordingly, several professional organizations have provided mandates, policies, and recommendations regarding the human rights of children, including the United Nations and the American Academy of Pediatrics.[5,6] As mandated reporters of child maltreatment and caregivers for children who are not able to make their own medical and legal decisions, emergency providers often step into the role of protector and/or advocate.

Here, we review 4 cases, representing real situations experienced by the authors, to demonstrate ethical issues that may arise when LEP is involved in the care of children, and how emergency providers can advocate for their pediatric patients. (Identifying details have been changed to protect patient confidentiality.) Although individual states have some variation in their laws pertaining to minors, the following cases touch on common themes of these laws. We further use the basic ethical principles put forth in the Belmont Report[7] to help guide suggested best practices in instances where hospital policies or state laws are absent:

- The principle of autonomy respects the right of patients and their parents/guardians to make medical decisions for themselves free of influence or coercion from outside parties.
- The principle of beneficence requires that a medical provider maximize benefit and minimize potential harm to the patient, including from outside parties.
- The principle of justice mandates fair and equal treatment of all patients regardless of their socioeconomic status, race, sex, sexual orientation, or criminal status.

CASE 1: PARENTAL VISITATION OF CHILDREN IN CUSTODY

A 14-year-old Black girl is brought into the ED by police after sustaining a rubber bullet injury to the face. She has a skull fracture with subdural hematoma and seizures. Per the patient, she was present at a community protest when the injury was sustained. Police officers tell medical providers that the patient is currently under investigation for rioting. The patient's parents arrive to the ED, but police require them to stay in the waiting room as the patient is not allowed visitors while under investigation.

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Patients presenting to the ED with such common chief complaints as traumatic injuries, assaults, or psychiatric illness, are often accompanied by LEP. In the ED, patient and parental anxieties are high, and the involvement of LEP can escalate an already tense situation. This is especially true in EDs where a significant portion of patients is Black; multiple studies have demonstrated that Black patients find their interactions with LEP during and after hospitalization to be aggressive and dehumanizing.[8,9] Perceived collusion between LEP and emergency providers is also a concern; in communities where LEP are mistrusted, medical providers run the risk of appearing to be complicit with LEP by allowing interrogations, physical restraints, and visitation restrictions to occur in the ED.[10] Emergency providers must understand the sociocultural setting their patients come from, as well as their legal rights as physician advocates.

When a pediatric patient is in police custody while in the ED, LEP may prohibit visitation from parents/legal guardians to maintain the integrity of police questioning and/or to protect the safety of the patient, public, and hospital staff. However, pediatric patients specifically require the presence of their guardians for safe and effective care. Children younger than 18 years cannot legally consent to medical care unless there is a statutory exception (eg, treatment of a sexually transmitted infection) or if the minor is determined to be emancipated or mature. As LEP cannot consent to medical treatment for youth in their custody, obtaining informed consent for treatment often necessitates parental/guardian presence. The only exception is in the case of life-saving interventions where the emergency privilege to forgo informed consent is invoked.[11] In non–life-threatening situations, the ethical considerations of patient autonomy and justice recommend that the emergency provider advocate for the pediatric patient's parent/guardian to be at the bedside. At the very least, medical consent, medical history, and status updates should be communicated over the phone with parents/guardians, so families are aware of their child's medical condition and remain involved in their care.

Parental presence is also crucial for emotional and behavioral management of a pediatric patient. A child may become needlessly anxious, agitated, and even violent when their parent/guardian is absent. It is well established that parental presence during pediatric care improves procedural outcomes, child anxiety, hospital length of stay, and even life-saving interventions.[12–14] Best practice is compromised when parents/guardians are not allowed to accompany their children in the ED.

In the patient scenario above, close communication between LEP and medical staff could facilitate a better outcome for the patient and family. If LEP inform emergency providers that a patient is under investigation and family are not allowed to the bedside, emergency providers should disclose the patient's critical condition with LEP. With knowledge of a patient's acuity, LEP may agree to allow family to the bedside, where family can receive medical updates and see the patient.

Suggestions for emergency providers are as follows:

1. Discuss the benefits of having a parent/guardian at the patient's bedside with LEP. If LEP continue to prohibit visitation, LEP should meet with the patient's family personally and explain why this is necessary. If the medical provider disagrees with this determination, they should escalate concerns to the appropriate LEP supervisor(s) to advocate for the patient/family.
2. Advocate for the entire hospital system to develop clear guidelines surrounding parental presence during the medical care of children as a best practice. These guidelines should include early and clear communication between LEP and emergency providers regarding the child's legal status and medical condition. The guidelines should also state that if a child is acutely decompensating, family should be allowed at the bedside.
3. Learn about the local context of the ED, specifically community beliefs, hospital policies, and state laws regarding police and the rights of minors.

CASE 2: POLICE INTERVIEWS OF CHILDREN IN THE ED

Police bring a 12-year-old boy to the ED with facial contusions and bruising to the neck, back, and lower extremities. The patient states that he was assaulted and robbed while walking home from school. Police tell the emergency provider that the patient is under arrest for assault of another individual. The patient completes a police interview in the ED without a parent or attorney present.

When a patient is brought to the ED directly from a crime scene, LEP will often accompany the patient. As LEP are charged with investigating crimes and protecting public welfare, their presence at the bedside often leads to spontaneous questioning and information gathering from a patient. When the patient is a child, however, they are likely isolated from their parent/guardian and confined to the ED. This clinical setting may allow LEP to have access to youth that would not otherwise be permitted. In Wisconsin, for example, if LEP are interrogating a child "in custody," the interrogation must be recorded, and LEP must "make every effort to release the juvenile immediately to the juvenile's parent, guardian, legal custodian, or Indian custodian."[15] Law enforcement personnel may use a clinical setting to question a child without labeling him/her "in custody," thus obtaining extra time and information from an unrecorded interview without the presence of an adult legal guardian. Law enforcement personnel interviews of children in the ED without parental/guardian presence or legal representation is unethical in terms of patient autonomy, benevolence, and justice and may lead to wrongful convictions. Furthermore, legal proceedings have found that an individual being questioned in a medical setting where they do not feel like they have the freedom to leave is tantamount to being "in custody."[16]

Multiple studies have shown that children, especially younger than 15 years, are prone to misinterpret their Miranda rights, unwisely waive them, make incriminating statements, and make false confessions.[17] Most states require parents/guardians to be present when a child is interrogated by LEP; however, in some states, there is no law requiring parental permission for LEP to speak with their children, nor are LEP required to notify parents that they are talking to their children.[17,18] A Harvard Law Review report states, "police questioning of minors… threatens the rights of parents… Police interrogation currently creates a substantial risk that children will be removed from their parents after confessing falsely. Questioning may also cause psychological harm that damages the parent-child relationship."[17] Hospital systems must be aware of the risks associated with interrogation of minors on hospital grounds and create policies advocating for the civil rights of children and families.

Interviews by LEP should never be conducted during a medical procedure, which may be distracting and/or painful for the patient and thus result in falsely incriminating statements. The American College of Emergency Physicians policy states, "law enforcement information gathering activities in the ED should not interfere with essential patient care."[19] If an emergency provider is cleaning a wound, repairing a laceration, or splinting a fracture, LEP should wait to conduct their questioning.

Suggestions for emergency providers are as follows:

1. If a child is brought to the ED by police, notify parents/guardians that their child is in the ED, is safe, and is speaking with LEP. Communication with a pediatric patient's parent/guardian as a medical provider is essential and ethically required.

2. Advocate for the entire hospital system to develop clear guidelines surrounding guardian/minor rights during LEP interrogations, considering the local legal context.

CASE 3: ARRESTS MADE ON HOSPITAL GROUNDS

A mother brings her 4-year-old son to the hospital after they were both involved in a motor vehicle collision. The patient's father was driving; he died at the scene. Police respond to the ED to interview the mother and the patient. Per police protocol, a background check on the mother is performed and it is found that she has an unrelated outstanding warrant. Police arrest the mother, and the patient is left alone in the ED without a legal guardian.

If an individual has a warrant that directs their arrest, LEP have a legal duty to execute that warrant. However, there is no law that indicates the timeline of execution. Hospital systems could argue that a medical facility should be considered a safe haven for patients and their families and that arrest made on hospital grounds could unnecessarily traumatize patients and/or deter them from seeking medical care in the future. There is ample evidence that family separation can exacerbate an already traumatic experience.[20] Executions of warrants in the hospital setting may not be necessary at all and, in ethical terms, may erode the patient's and family's trust.

Families with sick children are often in distress and adding further stressors, such as arrests for nonviolent offenses, is detrimental to the child's health outcomes. Best practice involves having a pediatric patient's parents/guardians present for as much of the visit as possible to achieve the best outcomes.[12–14] If a warrant is for a nonviolent offense unrelated to the care of a child, efforts should be made to coordinate warrant execution with the child's well-being. For example, it may be possible to delay an arrest until the child has been discharged from the ED entirely.

When LEP must arrest a patient's parent/guardian in the ED, the arrest should occur outside the patient's room. Witnessing a parental arrest significantly impacts a child's mental health and behavior. In a study of 326 children aged birth to 11 years, children who witnessed the arrest of a parent displayed a statistically significant increase in emotional distress, irritability, sleep disturbances, language disturbances, and toileting regression compared with their peers.[21] Whenever possible, LEP should wait in the ED with the parent to be arrested until another trusted guardian can arrive to the patient's bedside. Law enforcement personnel should also inform the medical team, hospital security, and social worker in advance of any arrest occurring in the ED. Together, decisions can be made regarding the timing and location of the arrest to allow for the best care of the child and the safest environment for ED staff.

Suggestions for emergency providers are as follows:

1. Discuss with LEP the possibility of a warrant execution being delayed until an alternate parent/guardian can be present with the child at the hospital.
2. Advocate for the entire hospital system to work with local LEP to develop clear guidelines surrounding the execution of warrants for nonviolent offenses during medical care.

CASE 4: INFORMATION GATHERING FROM MINORS

A grandmother brings her 8-year-old granddaughter to the ED with concerns that the child has been sexually assaulted by her uncle. Police respond and inform the emergency provider that sensitive crime detectives are not available to interview the patient so they will be conducting the interview themselves. Police officers interview the child alone, without her grandmother, and decide to issue a warrant for the arrest of the patient's uncle.

When there is concern for sexual assault of a minor, families often present initially to the ED. They receive medical care in addition to social and legal resources on next steps, which may involve a criminal investigation. Interviews of the child are conducted by medical providers, who should restrict their questions to the physical signs and symptoms of abuse rather than culpability. This lessens the chance of corrupting a forensic interview through repeated and/or suggestive questioning. In conjunction with the medical evaluation, LEP are also involved and conduct their own interviews of the patient. However, LEP's ethical responsibilities are different from medical providers in that LEP have a duty to protect the safety of the public while medical providers have a duty to protect the safety of the child.[2] This difference can raise ethical issues for medical providers if LEP are perceived as coercing, intimidating, or doubting a child during an interview about sexual assault.

Forensic interviews of minors should be conducted by LEP with a guardian and/or advocate present. Some states have victim accompaniment laws that require all victims of sexual assault, human trafficking, or child sexual abuse be offered a victim advocate.[22] The advocate can be present for all interviews and medical examinations to provide support, counseling, and assistance.

Forensic interviews of children should ideally be conducted by trained professionals who are specialized in child development, trauma, forms of disclosure, and rapport building with minors.[23] Children are more suggestible, easily coerced, and eager to please than adults,[24] and forensic interviews must be carefully conducted in a nonleading, nonaccusatory, and unbiased way. Ideally, a forensic interview occurs only once, as repeated questioning from multiple people can lead to unreliable reports.[23] Inappropriately conducted forensic interviews can have catastrophic consequences, such as wrongful accusation, loss of parental custody, or missed diagnosis of sexual assault.[25]

Often, LEP who initially respond to a case of possible child abuse serve as "screeners" to determine whether it is necessary to involve sensitive crimes detectives, who are specially trained in the forensic interviewing of children. Without specialized pediatric training, these initial "screener" LEP may unintentionally ask leading questions and inappropriately collect information that compromises the official interview when it does occur. There are little data on the numbers of pediatric interviews that occur in this manner and no clear consensus regarding guidelines standardizing law enforcement access to patients. With an ethical responsibility to the patient, emergency providers should advocate that the most experienced professional interviews the child, with a guardian/advocate present.

Law enforcement personnel may also attempt to gather information about a potential abuse case from emergency providers directly, specifically regarding mechanism of injury and/or culpability. These questions from LEP should always be directed at the attending physician. Trainees and ED staff who have not been trained in the proper release of medicolegal information to LEP may inadvertently make incriminating or incorrect statements about a patient or their family. The ethical dilemmas of disclosure are accompanied by the legal constraints of HIPAA, which limits the type and extent of protected health information that can be legally disclosed to LEP.[26] Disclosure to LEP may be further constrained by state law. Ultimately, it is best if the attending physician makes this decision with knowledge of the applicable laws.

Suggestions for emergency providers are as follows:

1. Advocate for LEP who are specifically trained in child forensic interviewing to perform any interviews with children. Ask that a child be interviewed as few times as possible to limit the possibility of confusion or coercion.

2. Ask that an advocate be present on the patient's behalf during the LEP's interview.
3. Educate all ED staff and trainees to recognize medical cases that have legal implications and direct any questions from LEP about these cases to the attending physician.

CONCLUSIONS

Interactions between emergency providers and LEP may become tense when the needs of a criminal investigation are at odds with the medical and psychosocial needs of the patient. This is especially poignant in pediatrics, as youth are a vulnerable population. These nuanced situations require advocacy for the child and family, and a collaborative approach between medical providers and LEP to ensure best and safest care. We offer some recommendations here and maintain that clear, widely adopted best practices for the care of minors in LEP custody are long overdue.

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