CHILD ABUSE AND NEGLECT
USER MANUAL SERIES

The Role of First Responders in Child Maltreatment Cases: Disaster and Nondisaster Situations

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

The Role of First Responders in Child Maltreatment Cases: Disaster and Nondisaster Situations

Richard Cage
Marsha K. Salus

2010

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

Table of Contents

PREFACE **1**

ACKNOWLEDGMENTS **3**

1. PURPOSE AND OVERVIEW **7**

2. RECOGNIZING CHILD MALTREATMENT **11**

Types of Child Maltreatment 12

Child Fatalities 19

Domestic Violence and Child Maltreatment 20

Substance Abuse and Child Maltreatment 21

3. INITIAL RESPONSE AND INVESTIGATION **25**

Responsibilities of First Responders in Cases of Suspected Child Maltreatment 26

Interviewing the Alleged Child Victim 28

Interviewing Adults 37

Documenting Interviews 40

Observing the Scene 41

Collecting Physical Evidence 43

Assessing Safety and Developing a Safety Plan 45

Understanding the Next Steps 47

4. TESTIFYING IN COURT **53**

Preparation for Court 53

During the Trial 53

The Juvenile Court Process 55

The Criminal Court Process 58

5. RESPONDING IN DISASTERS 61

Factors for First Responders 61

Agency Preparations 66

Agency Response 69

Conclusion 71

ENDNOTES 73

APPENDICES:

APPENDIX A—GLOSSARY OF TERMS 81

APPENDIX B—RESOURCE LISTINGS OF SELECTED NATIONAL ORGANIZATIONS CONCERNED WITH CHILD MALTREATMENT AND WITH FIRST RESPONDERS 87

APPENDIX C—STATE TELEPHONE NUMBERS FOR REPORTING SUSPECTED CHILD MALTREATMENT 95

APPENDIX D—REFERENCE GUIDE FOR RESPONDING TO CASES OF SUSPECTED CHILD MALTREATMENT 97

APPENDIX E—SIGNS OF POSSIBLE PHYSICAL ABUSE 101

APPENDIX F—DISTINGUISING PHYSICAL ABUSE FROM NONINTENTIONAL INJURY 105

APPENDIX G—COMMON FOLK-MEDICINE PRACTICE INJURIES THAT MAY RESEMBLE ABUSE 109

APPENDIX H—CRITERIA FOR DISTINGUISHING SIDS FROM FATAL CHILD MALTREATMENT 111

APPENDIX I—DOMESTIC VIOLENCE EXPOSURE ASSESSMENT 115

APPENDIX J—INTERVIEWING NONOFFENDING ADULTS 117

APPENDIX K—MEMORANDUM OF UNDERSTANDING 119

APPENDIX L—HOME VISIT SAFETY TIPS 121

APPENDIX M—CASE STUDIES 123

APPENDIX N—ASSESSING DISASTER SURVIVOR IMMEDIATE NEEDS WORKSHEET 141

APPENDIX O—CONTINUITY OF OPERATIONS PLAN (COOP) OUTLINE 143

Preface

Each day, the safety and well-being of some children across the Nation are threatened by child abuse and neglect. Intervening effectively in the lives of these children and their families is not the responsibility of any single agency or professional group, but rather is a shared community concern.

Since the late 1970s, the *Child Abuse and Neglect User Manual Series* has provided guidance on child protection to hundreds of thousands of multidisciplinary professionals and concerned community members. The *User Manual Series* offers a foundation for understanding child maltreatment and the roles and responsibilities of various practitioners in its prevention, identification, investigation, and treatment. Through the years, the manuals have served as valuable resources for building knowledge, promoting effective practices, and enhancing community collaboration.

Since the last update of the *User Manual Series* in the early 1990s, a number of changes have occurred that dramatically affect each community's response to child maltreatment. The changing landscape reflects increased recognition of the complexity of issues facing children and families, new legislation, practice innovations, and systems reform efforts. Significant advances in research have helped shape new directions for interventions, while ongoing evaluations help determine "what works."

The Office on Child Abuse and Neglect within the Children's Bureau of the Administration for Children and Families, U.S. Department of Health and Human Services, has developed this third edition of the *User Manual Series* to reflect the increased knowledge and the evolving state of practice on child protection. The updated and new manuals are comprehensive in scope while also succinct in presentation and easy to follow, and they address trends and concerns relevant to today's professional.

This manual, *The Role of First Responders in Child Maltreatment Cases: Disaster and Nondisaster Situations*, is for those professionals who have the primary responsibility for the initial on-scene response to situations in which child abuse or neglect may have occurred, even when the initial call may be for another situation, such as domestic violence or a drug offense. In most jurisdictions, emergency medical technicians, child protective services caseworkers, and law enforcement officers generally are considered the first responders for child maltreatment cases. This manual is designed to be a practical guide to help those in the field and includes step-by-step guidelines for investigating possible child maltreatment. The manual also provides information for first responders when responding to cases of possible child maltreatment in disaster situations, including how first responders and their agencies can prepare for disaster situations. While this manual will be useful to all first responders, some portions may be more relevant to particular types of first responders.

The Role of First Responders in Child Maltreatment Cases: Disaster and Nondisaster Situations builds upon the information presented in *A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice*. Readers are encouraged to read that manual as it provides an understanding of what constitutes child maltreatment, its underlying causes, and how the child protection system works. Other manuals in the series that also may be of help are *Child Protective Services: A Guide for Caseworkers* and *Child Protection in Families Experiencing Domestic Violence*.

User Manual Series

This manual—along with the entire *Child Abuse and Neglect User Manual Series*—is available from Child Welfare Information Gateway. For a full list of available manuals and ordering information, contact:

Child Welfare Information Gateway
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
Phone: (800) 394-3366
Fax: (703) 225-2357
E-mail: info@childwelfare.gov

The manuals also are available online at **http://www.childwelfare.gov/pubs/usermanual.cfm**.

ACKNOWLEDGMENTS

Authors

Lieutenant Richard Cage, M.A., has been a police officer in the State of Maryland for more than 30 years. For 26 years, he was assigned to the Child Abuse/ Sexual Offense Unit of his department. Lieutenant Cage retired as the commander of the Pedophile Division in February 2003. He has conducted numerous training workshops on investigative techniques for child sexual abuse cases throughout the United States and abroad and is recognized nationally for his training expertise in the field. In 1988, he was a member of the Surgeon General's Planning Committee for the Development of Protocol on Child Abuse. Lieutenant Cage is a past member of the board of the American Professional Society on the Abuse of Children.

Marsha K. Salus, M.S.W., is a social work consultant. She has worked in the child welfare field for more than 30 years. She began her career as a child protective services (CPS) caseworker and then became a CPS supervisor. She has developed several national curricula for child welfare workers and supervisors, including a number of preservice and inservice training programs for child welfare workers and supervisors in a variety of States. In addition, she has provided training on all aspects of family violence to multidisciplinary audiences around the country. Ms. Salus has assisted State and local CPS agencies in program development and evaluation, and she has worked with several States to establish standards of practice for child welfare supervision. She has also authored or co-authored numerous manuals in the *Child Abuse and Neglect User Manual Series*.

Contributing Authors

Jeannie Newman, M.I.B.S., M.S.W., formerly a consultant with ICF International, has held policy and direct practice positions in child welfare and family programs. She also has cultivated an extensive network in various related professional fields, including domestic violence and mental health. She was the Project Manager for the *Child Abuse and Neglect User Manual Series.*

Matthew Shuman, M.S.W., a consultant with ICF International, has more than 11 years experience in the human services field. He previously worked as an analyst in the Office of the Secretary of the Department of Health and Human Services for a variety of child welfare issues, including foster care, adoption, and child care. He also has written and edited various child welfare publications, including other manuals in the *User Manual Series.*

Lindsay Ritter Taylor, formerly a consultant with ICF International, worked on projects relating to various child welfare and juvenile justice issues. She helped write issue briefs highlighting findings from

the *National Survey of Child and Adolescent Well-being,* a national sample of children involved with the child welfare system. Additionally, she worked with the ICF technical assistance and evaluation teams on the *Improving Child Welfare Through Systems of Care* grant project.

Acknowledgment of Prior Editions

This manual is an update and expansion of the 1992 publication *The Role of Law Enforcement in the Response to Child Abuse and Neglect* by Donna Pence and Charles Wilson. The first edition of the manual was published in 1979 as *The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect* by Diane Broadhurst and James Knoeller. The prior work informed and contributed to the content of this publication.

Reviewers

Detective Frank Darley, Montgomery County Police, Pedophile Division, Rockville, MD

Officer Kimberly Foster, Montgomery County Police Training Academy, Rockville, MD

Kathy Pinto, Howard County, MD, Department of Social Services

Sandra Slappey, Child Welfare Information Gateway

Don Weber, Sussex County Emergency Medical Services, Georgetown, DE

Sarah Webster, Texas Department of Protective and Regulatory Services (retired)

Technical Advisory Panel

The following were members of the January 2001 Technical Advisory Panel for the *User Manual Series* contract. The organizations identified reflect each member's affiliation at that time.

Carolyn Abdullah
FRIENDS National Resource Center
Washington, DC

Lien Bragg
American Public Human Services Association
Washington, DC

Sgt. Richard Cage
Montgomery County Police Department
Wheaton, MD

Diane DePanfilis, Ph.D.
University of Maryland at Baltimore School of Social Work
Baltimore, MD

Pauline Grant
Florida Department of Children and Families
Jacksonville, FL

Jodi Hill
Connecticut Department of Children and Families
Hartford, CT

Robert Ortega, Ph.D.
University of Michigan School of Social Work
Ann Arbor, MI

Nancy Rawlings
Kentucky Cabinet for Families and Children
Frankfort, KY

Barry Salovitz
Child Welfare Institute/National Resource Center on Child Maltreatment
Glenmont, NY

Sarah Webster
Texas Department of Protective and Regulatory Services
Austin, TX

Ron Zuskin
University of Maryland at Baltimore School of Social Work
Baltimore, MD

Additional Acknowledgments

The third edition of the *User Manual Series* was developed under the guidance and direction of Irene Bocella, Federal Task Order Officer, and Catherine Nolan, Director, Office on Child Abuse and Neglect.

This manual was developed and produced by ICF International, Fairfax, VA, under Contract Number HHS-282-98-0025.

CHAPTER 1
Purpose and Overview

In This Chapter

- Child maltreatment statistics
- Roles of first responders
- Purpose of manual

Child abuse and neglect affect children, families, and communities throughout the United States. According to 2008 data from the National Child Abuse and Neglect Data System (NCANDS):

- An estimated 772,000 children were victims of abuse or neglect.
- An estimated 3.3 million referrals of abuse or neglect, concerning approximately 6 million children, were received by child protective services (CPS) agencies. Of those referrals, 62.5 percent were accepted for investigation or assessment.
- Nationally, 73.3 percent of child victims experienced neglect (including medical neglect), 16.1 percent were physically abused, 9.1 percent were sexually abused, and 7.3 percent were psychologically maltreated. Additionally, 9 percent of victims experienced "other" types of maltreatment, including abandonment and congenital drug addiction. A child could be identified as a victim of more than one type of maltreatment.[1]

National Incidence Study of Child Abuse and Neglect (NIS)

In addition to the NCANDS data, the U.S. Department of Health and Human Services also collects data through NIS. The most recent study, NIS-4, reviewed data collected from 2005–2006 and has shown an overall decrease in the incidence of child maltreatment since NIS-3, which used data from 1993. According to NIS-4, approximately 1.25 million children experienced neglect during the study year, as opposed to 1.55 million children from NIS-3. NIS-4 also provides data about types of maltreatment; victim, family, and perpetrator characteristics; report sources; and investigations. NIS uses different methodologies than NCANDS to collect and assess data; NCANDS collects annual state-level administrative data on official reports of child maltreatment, while NIS estimates more broadly the incidence of child maltreatment in the United States by including both cases that are reported to the authorities and those that are not.

To view the full NIS-4 report, visit **http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html**.

Many community professionals are involved in the identification, investigation, prevention, and treatment of child maltreatment. First responders, including emergency medical technicians (EMTs), law enforcement officers, and CPS workers, often are the first professionals to arrive at a scene where child maltreatment may have occurred or where children may be at risk for being abused or neglected. When first responders encounter a suspected case of child maltreatment, their initial objectives are to evaluate and address immediate medical and psychological needs, to assess and ensure the safety of victims, and to secure the scene in order to collect and preserve evidence.

The Roles of First Responders

The following are the general roles of first responders:

- **EMTs**. People's lives may depend on the quick reactions and competent care of EMTs and paramedics, who often are the first to arrive at the scene of an incident. When dispatched to a scene, EMTs must determine the nature and the extent of the patient's condition, give appropriate emergency care, and transport the patient to a medical facility, if necessary. Before arriving at the scene, EMTs might not be alerted to the possibility of child maltreatment.[2]
- **Law enforcement officers**. Because of their presence in the community, law enforcement officers often encounter situations that involve child maltreatment. For example, they may be called to emergencies such as domestic violence, child fatalities, or incidents of serious physical harm to a child. Law enforcement officers also may see evidence of harm to a child during drug or other arrests. The role of law enforcement in child maltreatment cases is to determine if a violation of criminal law occurred, identify and apprehend the alleged offender, file appropriate criminal charges, and remove children from their families when their immediate safety is in jeopardy.[3] The patrol officer—and sometimes a law enforcement detective or investigator specializing in the investigation of child abuse and neglect—usually provides the initial law enforcement response. In some situations, law enforcement officers may conduct joint investigations of suspected child maltreatment with CPS caseworkers.
- **CPS caseworkers**. CPS is the central agency in each community child welfare system and plays the lead role in coordinating communication and services among the various disciplines responsible for addressing child maltreatment. It is the agency legally mandated in most States to respond to reports of possible child abuse or neglect. CPS caseworkers conduct investigations or initial assessments regarding suspected child maltreatment, assess the risk to and safety of children, and develop individualized case plans. They also provide or arrange for and coordinate services to achieve safe, permanent families for children who either have been maltreated or who are at risk of maltreatment. In most communities, CPS responds to reports of suspected child abuse or neglect 24 hours a day.[4]

For more detailed descriptions of the roles and the responsibilities of all the professionals involved in a community's response to child abuse and neglect, see *A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice*, which is available at **http://www.childwelfare.gov/pubs/usermanuals/foundation/index.cfm**.

First responders should also be aware of their role as mandatory reporters. As of January 2008, 48 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands designate certain professions as being mandated to report suspected cases of child maltreatment. Eighteen States and Puerto Rico designate all persons as mandatory reporters, with 16 States and Puerto Rico also specifying certain professions.[5] First responders should be aware of their State, local, agency, and professional responsibilities for reporting child abuse and neglect. To search State statutes regarding mandatory reporting and other child welfare issues, visit the Child Welfare Information Gateway website at **http://www.childwelfare.gov/systemwide/laws_policies/state/**. For information about State child maltreatment reporting hotlines, see Appendix C, *State Telephone Numbers for Reporting Suspected Child Maltreatment*.

This manual builds the foundation for successful outcomes when first responders encounter incidents, including disaster situations, in which child maltreatment might be suspected. Specifically, this manual:

- Helps first responders recognize the various types of child maltreatment and the signs that may indicate that maltreatment has occurred
- Provides an overview of the initial response and investigation in cases of suspected child abuse or neglect
- Explains how first responders should prepare for and provide testimony in court for child abuse and neglect cases
- Outlines how first responders and their agencies can respond to child maltreatment cases in emergencies and disasters, including how to prepare for such situations.

First responders should recognize that not *all* the information in this manual necessarily pertains to their particular job duties or responsibilities. For instance, EMTs would not attempt to elicit a confession, nor would law enforcement or CPS perform a medical exam. Additionally, the scope of this manual does not cover actions to be taken either by law enforcement or by CPS caseworkers beyond their first response (e.g., follow-up interviews). First responders should respond to cases of alleged child maltreatment and conduct investigations according to their agency and jurisdictional guidelines. Also note that presenting information and suggestions in this manual does not necessarily imply endorsement by the Office on Child Abuse and Neglect or any other Federal agency, nor are they an official interpretation of Federal or other requirements.

CHAPTER 2
Recognizing Child Maltreatment

In This Chapter

- Federal child welfare laws
- Recognizing the types and signs of child maltreatment
  - Physical abuse
  - Neglect
  - Psychological abuse
  - Sexual abuse
- Child fatalities
- Co-occurring issues
  - Domestic violence
  - Substance abuse

First responders have various levels of experience and training regarding the detection of possible child abuse and neglect. While some effects of child maltreatment are easily observable, many require a more indepth assessment by first responders. The physical, emotional, and behavioral effects of child abuse or neglect are wide-ranging, but many of these also may be caused by something other than maltreatment. First responders should be able to recognize and to assess any possible maltreatment within the context of other problematic situations that may occur in the home, such as domestic violence or substance abuse.

Federal Child Welfare Laws

State laws, sound professional standards for practice, and strong philosophical underpinnings should guide any intervention into family life on behalf of children. The key principles guiding State child protection laws are based largely on Federal statutes, primarily the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), and the Adoption and Safe Families Act (ASFA) of 1997 (P.L. 105-89). CAPTA provides definitions and guidelines regarding child maltreatment issues, and ASFA promotes three national goals for child protection:

- **Safety** – All children have the right to live in an environment free from abuse and neglect. The safety of children is the paramount concern that must guide child protection efforts.
- **Permanency** – Children need a family and a permanent place to call home. A sense of continuity and connectedness is central to children's healthy development.
- **Well-being** – Children deserve nurturing families and environments in which their physical, emotional, educational, and social needs are met. Child protection practices must take into account each child's needs and should promote the healthy development of family relationships.

For additional information on Federal and State child welfare laws, visit the Child Welfare Information Gateway website at **http://www.childwelfare.gov/systemwide/laws_policies/**.

Appendix D, *Reference Guide for Responding to Cases of Suspected Child Maltreatment*, synthesizes key points from this chapter and Chapter 3, *Initial Response and Investigation*, into a two-page handout.

Types of Child Maltreatment

There are four commonly recognized forms of child maltreatment—physical abuse, neglect, psychological abuse, and sexual abuse. The definitions of these types of child maltreatment may vary depending on the State or the locality in which the first responder works. First responders should become familiar with the definitions that apply in their jurisdictions.

Additionally, the signs of child maltreatment listed in this manual, such as the behavioral clues listed in Exhibit 2-1, do not indicate absolutely that child maltreatment has occurred. They are meant to act as general guidelines for identifying the *possibility* of each type of maltreatment. Actual child maltreatment, as well as the perpetrator's identity, can be determined only after a thorough response and investigation.

Physical Abuse

The physical abuse of children includes any nonaccidental physical injury caused by the child's caretaker. Physical abuse can vary greatly in frequency and severity.[6] It may include injuries sustained from burning, beating, kicking, or punching. Although the injury is not an accident, neither is it necessarily the intent of the child's caretaker to injure the child. Physical abuse may result from punishment that is inappropriate to the child's age, developmental level, or condition. Additionally, it may be caused by a parent's recurrent lapses in self-control that are brought on by immaturity, stress, or the use of alcohol or illicit drugs.[7] Caretakers may physically abuse children during discipline or as a way to "teach the child a lesson."

Exhibit 2-1
Behavioral Clues That May Indicate Possible Child Maltreatment

Children who possibly are maltreated may:

- Be aggressive, oppositional, or defiant
- Cower or demonstrate a fear of adults
- Act out, displaying aggressive or disruptive behavior
- Be destructive to self or others
- Come to school too early or not want to leave school, indicating a possible fear of being at home
- Show fearlessness or extreme risk-taking
- Be described as "accident prone"
- Cheat, steal, or lie (may be related to too high expectations at home)
- Be a low achiever
- Be unable to form good peer relationships
- Wear clothing that covers the body and may be inappropriate in warmer months, such as wearing a turtleneck sweater in the summer (Be aware that this may possibly be a cultural issue instead.)
- Show regressive or less mature behavior
- Dislike or shrink away from physical contact (e.g., may not tolerate physical praise, such as a pat on the back).[8]

Signs of possible physical abuse include:

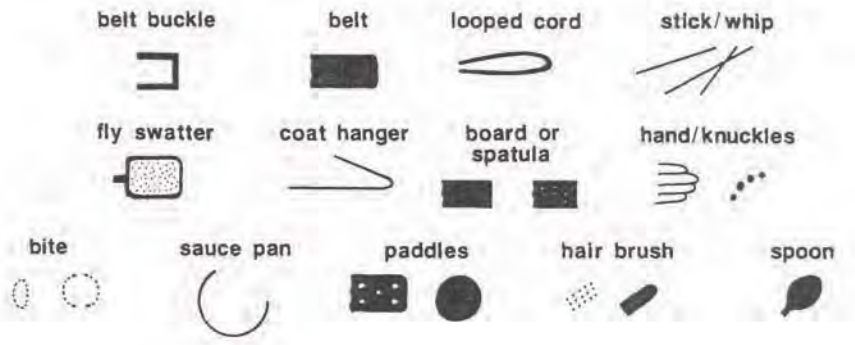
- Fractures unexpectedly discovered in the course of an otherwise routine medical examination (e.g., discovering a broken rib while listening to the child's heartbeat)
- Injuries that are inconsistent with, or out of proportion to, the history provided by the caretaker or with the child's age or developmental stage (e.g., a 3-month old burning herself by crawling on top of the stove)
- Multiple fractures, often symmetrical (e.g., in both arms or legs), or fractures at different stages of healing
- Fractures in children who are not able to walk
- Skeletal trauma (e.g., fractures) combined with other types of injuries, such as burns
- Subdural hematomas, which are hemorrhages between the brain and its outer lining that are caused by ruptured blood vessels
- Burns on the buttocks, around the anogenital region, on the backs of the hands, or on both hands, as well as those that are severe.[9]

Some injuries that may have been caused by physical abuse have distinct marks. Exhibit 2-2 shows marks that may be indicative of physical abuse. Some

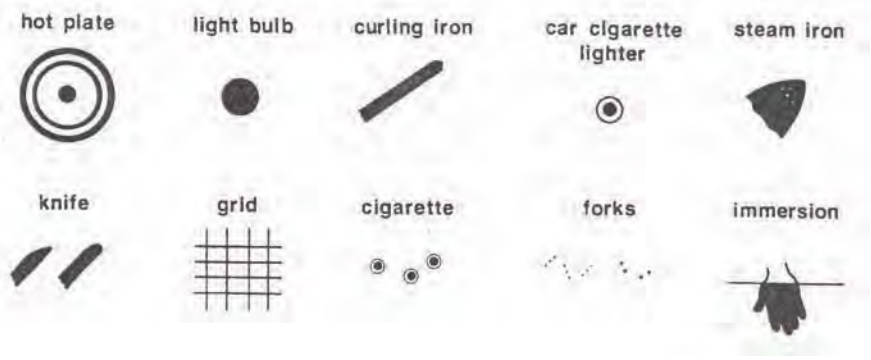
Exhibit 2-2
Marks from Burns or Instruments[10]

Injuries from physical abuse may appear in distinct shapes, especially in cases involving an instrument or burns.

Marks from Instruments:



Marks from Burns



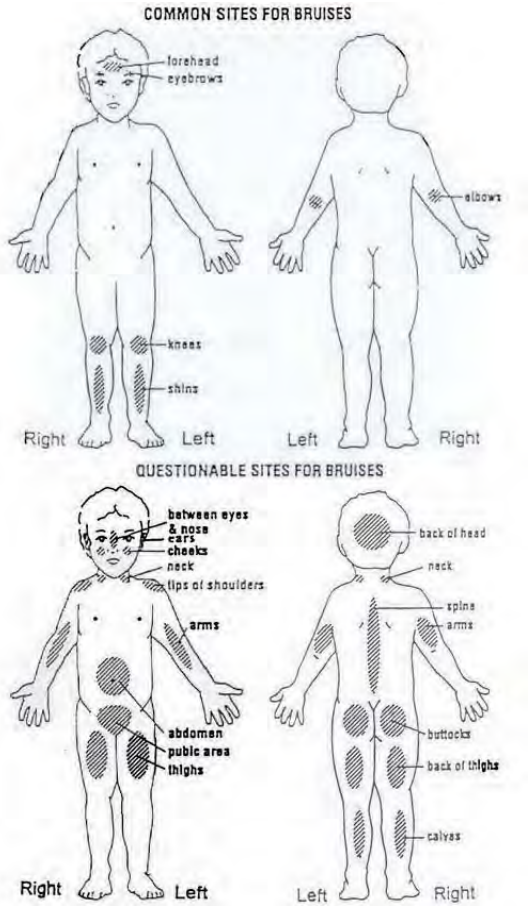
Reprinted from *Pediatric Clinics of North America*, volume 37, C.F. Johnson, Inflicted Injury Versus Accidental Injury, pp. 791–814, 1990, with permission from Elsevier.

injuries, however, may not be visible without a complete medical examination. For instance, injuries caused by abuse directed to the abdomen or to the head often are undetected because many of the injuries are internal. For a more complete list of the possible physical signs of child abuse, see Appendix E, *Signs of Possible Physical Abuse.*

The first response in child physical abuse cases is handled predominately by social service agencies, such as child protective services (CPS). Many jurisdictions across the country have interagency agreements and protocols that define when a joint investigation by law enforcement and CPS will be conducted. Some have put guidelines in place for law enforcement to respond

Distinguishing Physical Abuse from Nonintentional Injury

Children may receive bruises during the course of play or while being active. The areas that are bruised most commonly during normal play include the leading or bony edges of the body, such as knees, elbows, forearms, or eyebrows. The soft tissue areas, such as cheeks, buttocks, and thighs, are not normally injured during play. Additionally, bruises received during the normal course of childhood activity rarely are in distinct shapes, such as a hand, a belt buckle, or adult teeth marks. Bruises in soft tissue areas or in distinct shapes may be indicative of physical abuse.



Graphic reprinted from *Reaching Out: Working Together in Identifying and Responding to Child Victims of Abuse* by RIMER/PRAGER. 1998. Reprinted with permission of Nelson, a division of Thomson Learning: www.thomsonrights.com. Fax 800 730-2215.

For more information about how to distinguish physical abuse from accidental injury, see Appendix F, *Distinguishing Physical Abuse from Nonintentional Injury,* or visit **http://www.ncjrs.gov/pdffiles1/ojjdp/160938.pdf**. Additionally, some common folk-medicine practices may give the appearance of physical abuse. See Appendix G, *Common Folk-Medicine Practice Injuries That May Resemble Abuse,* for an explanation of some of these practices.

to all physical abuse cases involving young children, as well as to all cases of serious physical abuse. Serious physical abuse cases generally are defined as those requiring medical treatment or hospitalization. A response by law enforcement is also often required in cases involving any blows to the face or the head or the use of a particular instrument (e.g., clubs, bats, sticks, chains), which can indicate an attempt to do serious harm.

Neglect

Neglect involves a caregiver's failure to meet the basic needs of a child, such as food, clothing, shelter, medical care, or supervision. Types of neglect include physical, environmental, emotional, and educational neglect, as well as inadequate supervision. Neglect follows a continuum from mild to severe and often is very difficult to define.[11] Most laws today include some mention of "failure or inability to provide" in their definitions. There is still a lack of consensus, however, as to what constitutes failure to provide adequate food, shelter, protection, or clothing. Some State definitions include "failure or inability to protect," which refers to a situation in which a child is exposed to someone who may harm him, such as being left with a parent's drug dealer or a known child molester.[12] In addition, parents might be accused of failing to provide a safe environment by not protecting a child from unsanitary or hazardous living conditions.

Caregivers may not provide proper care for a variety of reasons, including a lack of knowledge or understanding about meeting the child's needs, inadequate bonding with the child, or impairment due to substance abuse or to mental illness. Although there are cases of co-occurring maltreatment and poverty, living in poverty, in and of itself, does not mean that a child is being neglected.

Signs of Possible Neglect

Children who possibly are neglected may:

- Seem inadequately dressed for the weather (e.g., wearing shorts and sandals in freezing weather)
- Appear excessively listless and tired (due to no routine or structure around bedtimes)
- Report caring for younger siblings (when they themselves are underage or are developmentally not ready to do so)
- Demonstrate poor hygiene or smell of urine or feces
- Seem unusually small or thin or have a distended stomach (indicative of malnutrition)
- Have unattended medical or dental problems, such as infected sores or badly decayed or abscessed teeth
- Appear withdrawn
- Crave unusual amounts of attention, even eliciting negative responses in order to obtain it
- Be chronically truant.[13]

Additionally, the first responder should check the home environment for signs of neglect, such as health or safety hazards, no heat, or unsanitary conditions.

For more information on neglect, refer to *Child Neglect: A Guide for Prevention, Assessment, and Intervention* at **http://www.childwelfare.gov/pubs/usermanuals/neglect/index.cfm**.

Psychological Maltreatment

Psychological maltreatment by a caretaker includes blaming, belittling, or rejecting a child; constantly treating siblings unequally; and demonstrating a persistent lack of concern for the child's welfare.[14] It often accompanies physical abuse. The five categories of psychological maltreatment are:

- Spurning (e.g., belittling, ridiculing)
- Terrorizing (e.g., threatening)
- Isolating (e.g., confining the child from any family or friends)
- Exploiting or corrupting (e.g., encouraging or permitting prostitution or substance abuse)
- Denying emotional responsiveness (e.g., failing to express or to show affection).[15]

Psychological maltreatment often causes behavior problems in children and, in some cases, may cause developmental lags, psychosomatic symptoms (i.e., bodily symptoms caused by a mental or emotional disturbance), and other effects, such as speech disorders. First responders may not detect the physical or behavioral signs of psychological maltreatment easily.

Sexual Abuse

Sexual abuse is defined as adult sexual behavior with a child. It can include fondling a child's genitals, making the child fondle the adult's genitals, digital penetration, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. Sexual abuse also may be committed by a person younger than age 18. This occurs when that person is significantly older than the victim or is in a position of power or control over the child, such as an older youth babysitting a child or a sibling. Sexual abuse may take place within the family (referred to as incest), by a parent's boyfriend or girlfriend, by a caretaker outside the family (e.g., family friend, babysitter), or by a stranger. Contrary to the myth of abuse by strangers, however, sexually abused children

Signs of Possible Psychological Maltreatment

Children who possibly are psychologically maltreated may exhibit:

- Extremes in behavior (e.g., manically happy or very depressed)
- Withdrawal (e.g., no verbal or physical communication with others)
- Self-destructive behavior (e.g., cutting oneself)
- General destructive behavior
- Cruelty to others, including animals
- Rocking, thumb-sucking that is developmentally inappropriate, or head-banging
- Enuresis (i.e., wetting one's pants) or soiling at an age or a developmental level when such behavior is inappropriate
- Substance abuse
- Physical manifestations, such as frequent stomachaches or headaches or an unexplained weight loss or gain.[16]

usually know their abusers and have some form of a relationship with them.[17]

Child sexual abuse can come to the attention of authorities in a number of ways. The child might disclose the abuse to the authorities, to another adult, or to a child, or may display abnormal behaviors (e.g., inappropriate sexual behaviors, such as constantly rubbing the genital area). Additionally, the child may have unexplained injuries or other medical conditions that could be caused by sexual abuse.[18]

Additional Information About Sexual Abuse

The following information about sexual abuse may be helpful for first responders:

- The average age of sexual abuse victims is 9 years.
- Boys tend to be older than girls when their sexual abuse starts.
- Boys are more likely than girls to be abused by nonfamily members and women; girls are more likely than boys to be abused by family members and men.
- Multiple episodes of sexual abuse happen in one-half to three-fourths of cases.
- Girls are more likely to be abused sexually than boys are.
- Sexual abuse is more common in families that lack cohesion, are more disorganized, and are more dysfunctional.
- Children are at a higher risk for being sexually abused if they live with only one birth parent or do not have a strong relationship with their mother.
- Children with a disability are at a greater risk of being sexually abused.
- Sexual abuse does not appear to be related to socioeconomic status.[19]

Signs of Possible Sexual Abuse

Children may have been sexually abused if they:

- Have bruises in the inner thigh or genital area
- Have difficulty walking or sitting
- Complain of genital or anal itching, pain, or bleeding
- Frequently vomit
- Become pregnant at a young age
- Have any sexually transmitted diseases.[20]

Additionally, children may have been sexually abused if they exhibit:

- Exceptional secrecy
- More sexual knowledge than is age appropriate, especially in younger children
- Indepth sexual play with peers that is not developmentally appropriate
- Extreme compliance or withdrawal
- Overt aggression
- An inordinate fear of males or females
- Seductive behavior
- Sleep problems or nightmares
- Crying without provocation
- A sudden onset of wetting or soiling of pants or bed
- Suicide attempts or thoughts of wanting to kill themselves
- Numerous attempts at running away from home
- Cruelty to animals (especially those that would normally be pets)
- Setting fires and enjoying watching them burn
- Self-mutilation (e.g., cutting or scratching to draw blood).[21]

The Internet and Child Sexual Abuse

A relatively recent phenomenon is the sexual abuse of children via the Internet. Children of all ages now have access to computers at home and in schools and libraries. Computers are invaluable tools for learning, but there is a growing problem of children's exposure (accidentally or intentionally) to pornography, as well as to online solicitations from sexual offenders. One study indicated that 49 percent of youths being solicited and 44 percent of those unintentionally exposed to pornography did not report the incidents.[22]

The following information may be useful to first responders who encounter possible online sexual abuse:

- Online offenders primarily target adolescents, not young children who often do not have the same type of access to the Internet and developmentally are not as interested in relationships, sex, or romance as adolescents.
- One study found that only 5 percent of offenders pretended to be teens when they met their potential victims online, and many victims expressed love or close feelings for the offenders.
- Girls are more likely to be online victims than boys, but boys who identify as gay or question their sexual orientation may be particularly susceptible as well.
- Youth with histories of offline sexual or physical abuse seem to be considerably more likely to receive online aggressive sexual solicitations.[23]

Internet crimes can be reported to the Cyber Tipline (**http://www.cybertipline.org** or 1-800-843-5678), which is a federally funded system operated by the National Center for Missing & Exploited Children.

Child Fatalities

The ultimate tragedy in a child maltreatment case is the death of a child. In 2008, an estimated 1,740 children died from abuse or neglect. This is a rate of 2.33 deaths per 100,000 children, which is comparable to the rate of 2.32 per 100,000 children in 2007.[24] The rates for child fatalities are much higher for younger children. In 2008, 79.8 percent of child fatality victims were younger than 4 years.[25] It has been estimated that many child deaths that are determined to be accidental, caused by disease, or classified as having some other cause were actually the result of child maltreatment. For example, studies of child deaths in Colorado and North Carolina found that approximately 50 percent and 62 percent, respectively, of child deaths caused by child maltreatment were not recorded as such.[26]

Child fatalities from maltreatment usually result either from chronic neglect or abuse or from a single, severe incident of abuse or neglect. In 2008, 39.7 percent of child fatalities were attributable to multiple types of maltreatment, 33.4 were caused by neglect only (including medical neglect), and 22.9 were due to physical abuse only.[27] When children die from neglect, it often is because they have been without proper nourishment, medical treatment, or supervision.[28] Additionally, acute incidences of neglect, such as leaving a young child unsupervised in a bathtub, near a pool, in a room with a loaded gun, or in some other potentially dangerous environment, may lead to a child's death.[29] The most common injury that results in a child fatality is severe head trauma.[30]

Child Death Review Teams

Child death review teams (also known as child fatality review teams) examine the causes and circumstances of child maltreatment fatalities and other suspicious child deaths. Forty-nine States and the District of Columbia have child death review teams.[31] Teams consist of multidisciplinary professionals, including CPS workers, coroners or medical examiners, prosecutors, law enforcement personnel, and others. The information gained through the reviews may be used to help family members receive services, correctly classify the causes of deaths, prosecute suspected perpetrators, and develop recommendations to prevent future deaths and improve child safety.

For more information about child death review teams, visit the National Center for Child Death Review Policy and Practice website *(***http://www.childdeathreview.org/***).*

Sudden Infant Death Syndrome (SIDS)

SIDS is the "sudden death of an infant under one year of age which remains unexplained even after a thorough case investigation, including performance of a complete autopsy, an examination of the death scene, and a review of the clinical history."[32] SIDS is not child maltreatment. External suffocation, vomiting and choking, minor illnesses, or vaccines or immunizations do not cause SIDS, and it is not contagious. In addition, SIDS is unexpected, usually occurring in apparently healthy infants aged 1 month to 1 year. Most deaths from SIDS occur by the end of the sixth month, with the greatest number taking place between ages 2 and 4 months. SIDS is the leading cause of death in the United States among infants between the ages of 1 month and 1 year.[33]

In sudden, unexplained infant deaths, investigators, including medical examiners and coroners, use forensic medicine, which is the application of medical science for legal purposes, to arrive at a diagnosis. Often, the cause of an infant's death only can be determined by carefully collecting and evaluating information from the death scene and by conducting forensic tests. The child and family's history of previous illnesses, accidents, or behaviors also must be reviewed carefully. It is important to note that SIDS is not listed as the cause of every unexplained infant death. Basic steps that first responders can take when responding to the death of an infant are outlined in Chapter 3, *Initial Response and Investigation*, and criteria for distinguishing SIDS from death caused by child maltreatment are presented in Appendix H, *Criteria for Distinguishing SIDS from Fatal Child Maltreatment*. For additional information, visit **http://www.sidscenter.org**.

Domestic Violence and Child Maltreatment

Over the past few decades, there has been a growing awareness of the co-occurrence of domestic violence and child maltreatment. Children who live in families experiencing domestic violence are at risk of exposure to traumatic events, neglect, and direct abuse. Research suggests that in an estimated 30 to 60 percent of families where either domestic violence or child maltreatment is identified, both may exist.[34] A review of CPS cases in two States identified domestic violence in more than 40 percent of cases in which there was the critical injury or death of a child.[35] Research indicates, however, that child welfare workers are not identifying the occurrence of domestic violence in their cases.[36] This also may be happening in other professions working with these families. One study found that although 31 percent of female caregivers self-reported at least one incident of domestic violence in the past year, child

welfare workers only identified it in 12 percent of those cases.[37]

Caregivers who are victims of domestic violence may be abused to the point of being unable or unwilling to keep their abusers from also abusing the children. This may be considered neglect in some States and is often referred to as "failure or inability to protect the child from harm." In some cases, abused caregivers are afraid to defend the children in their care because doing so might put the caregiver's or children's lives in further danger or provoke more abuse. Whether caregivers are charged with "failure or inability to protect" often depends on whether the caregivers knew or should have known that their children were being abused.[38]

Because of the coexistence of domestic violence and child maltreatment, first responders called to a domestic violence complaint should be alert to the possibility of child abuse or neglect, look for signs of possible child maltreatment, and assess the safety of the victim *and* the children. Children can be harmed in cases of domestic violence even if they are not the actual targets of the violence. For information about interviewing children in cases of domestic violence and factors to consider when assessing their safety, see Chapter 3, *The Initial Response and Investigation*.

For more information on the co-occurrence of domestic violence and child maltreatment, see *Child Protection in Families Experiencing Domestic Violence* at **http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/**, the National Resource Center for Child Protective Services at **http://www.nrccps.org/resources/domestic_violence.php**, and The Greenbook Initiative at **http://www.thegreenbook.info/**.

Substance Abuse and Child Maltreatment

Even though it may be exacerbated by other problems, such as domestic violence or mental illness, there already is a strong relationship between substance abuse and child maltreatment. The 2007 National Survey on Drug Use and Health reports that 8.3 million children live with at least one parent who abused or was dependent on alcohol or an illicit drug during the previous year. This includes 13.9 percent of children aged 2 years or younger, 13.6 percent of children aged 3 to 5 years, 12.0 percent of children aged 6 to 11 years, and 9.9 percent of youths aged 12 to 17 years.[40] These children face a heightened risk of maltreatment.[41] One study, for example, showed that children of parents with a substance

Risk Factors for Maltreatment

Factors that may place a child at increased risk for being abused or neglected include:

- Being born prematurely or having a low birth weight
- Being perceived as unusual or different in terms of appearance or temperament
- Being unhealthy or having congenital abnormalities
- Having a physical, emotional, or developmental disability
- Being irritable or displaying behaviors that are contrary to the expectations of the parents
- Living in poverty
- Living in an environment in which there is drug abuse, crime, or violence
- Having young parents
- Living in a single-family home
- Having parents who lack education
- Having parents who abuse substances.[39]

use disorder are nearly three times more likely to be abused and more than four times more likely to be neglected than children of parents who do not abuse substances.[42] Additionally, while estimates vary, most studies suggest that parental substance abuse is a contributing factor for between one-third and two-thirds of children involved with CPS.[43]

Methamphetamine Use and Its Impact on Children

Methamphetamine is a powerfully addictive drug, and individuals who use it can experience serious health and psychiatric conditions, including memory loss, aggression, violence, psychotic behavior, and potential coronary and neurological damage.[44] Methamphetamine is also known by ever-changing street names, such as speed, ice, crystal, crank, tweak, glass, bikers' coffee, poor man's cocaine, chicken feed, shabu, and yaba.[45] Methamphetamine use in the United States has become an issue of great concern to professionals working with children and families. In 2007, there were an estimated 529,000 current users of methamphetamine aged 12 or older. Approximately, 5.3 percent of the population reported using this drug at least once in their lifetime.[46]

Like children of parents with any substance use disorder, children whose parents use methamphetamine are at a particularly high risk for abuse and neglect. What compounds the problem for children of methamphetamine users is that the drug is relatively easy to make, and therefore, many of these children are exposed to the additional risks of living in or near a methamphetamine lab. During 2008, an estimated 1,025 children were injured, killed at, or affected by methamphetamine labs.[47] The manufacture of methamphetamine involves the use of highly flammable, corrosive, and poisonous materials that create serious health and safety hazards. Children affected by methamphetamine labs may exhibit symptoms such as chronic cough, skin rashes, red or itchy eyes, agitation, inconsolable crying, irritability, or vomiting.[48]

Many communities have Drug Endangered Children (DEC) programs that assist CPS caseworkers, law enforcement, and medical services to coordinate services for children found living in environments where drugs are made. For more information on DEC programs, visit **http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html**.

For more information about methamphetamine, visit **http://www.childwelfare.gov/systemwide/substance/drug_specific/meth.cfm**, **http://www.methresources.gov/**, or **http://www.ncsacw.samhsa.gov/**.

For more information on child maltreatment in substance-abusing families, see *Protecting Children in Families Affected by Substance Use Disorders* at **http://www.childwelfare.gov/pubs/usermanuals/substanceuse/**, or the National Center on Substance Abuse and Child Welfare at **http://www.ncsacw.samhsa.gov/**.

Signs of Methamphetamine Use and Manufacture[49]

With the increased use of methamphetamine, first responders are now more likely to work with clients who are users or manufacturers of this drug. The following information can assist them in identifying methamphetamine use or manufacturing.

Signs of possible methamphetamine use include:

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech
- Euphoria (an exaggerated feeling of well-being)
- Hyperactivity
- Dry mouth
- Tremors (shaking hands)
- Dilated pupils
- Lack of appetite
- Insomnia or lack of sleep
- Bruxism (teeth-grinding)
- Depression
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Formication (the sensation of bugs crawling on the skin)
- The presence of white powder, straws, or injection equipment.

Signs that methamphetamine is possibly being manufactured in a home include:

- Laboratory equipment (e.g., flasks, rubber tubing, beakers, large amounts of coffee filters)
- Large quantities of pills containing ephedrine or pseudoephedrine (e.g., certain cold medicines)
- A chemical odor
- Chemicals not commonly found in a home (e.g., red phosphorous, acetone, liquid ephedrine, ether, iodine, phenylacetone [P2P])
- Unusually large quantities of household chemicals (e.g., lye, paint thinner)
- Chemicals usually found on a farm (e.g., anhydrous ammonia)
- Residue from the manufacture of methamphetamine (usually of a maroon color) in bathtubs, sinks, toilets, or on the walls
- Containers used for purposes not originally intended (e.g., glass milk or beer bottles with unfamiliar liquids)
- No visible means of income
- Unusual security precautions (e.g., extra locks, barred or blacked-out windows, expensive alarm systems).

Safety Issues When Encountering a Suspected Methamphetamine Lab

First responders should use extreme caution and seek assistance from law enforcement, fire/rescue personnel, hazardous materials crews, or other appropriate individuals or groups if they are visiting a home that has a suspected methamphetamine lab because these homes may have:

- Individuals under the influence of methamphetamine or other drugs and/or who may be armed
- Defense systems, including explosive devices and other booby traps
- Vicious animals
- Dangerous and volatile chemicals. [50]

First responders who enter a methamphetamine lab that has not been properly ventilated and cleaned—or who are not properly equipped to avoid exposure to chemicals (i.e., have respirators, protective clothing)—may experience shortness of breath, coughing, chest pain, dizziness, vomiting, lack of coordination, burns, and, in some cases, death. If first responders do come into contact with possibly dangerous chemicals, they should wash the exposed skin with liquid soap and water or, depending on the type of chemical exposure, a chemical solution. They also should remove contaminated shoes and clothing. First responders should also be knowledgeable about agency protocols for the evacuation, decontamination, and health screenings for children and others found at the home, including which, if any, of the child's possessions (e.g., medications, eyeglasses) should be retrieved from the home and how they should be decontaminated.

First responders who determine they are in a home that has a suspected methamphetamine lab should immediately leave the residence, taking care not to:

- Touch anything in the lab
- Turn on or off any electrical switches (e.g., lights)
- Eat or drink anything
- Open, move, or sniff containers with suspected chemicals
- Smoke anywhere near the home
- Alarm or act in a way that could be perceived as aggressive by others in the home (i.e., suddenly running from a room, pushing someone aside), especially suspected methamphetamine users, who may experience paranoia and extremely aggressive behavior.[51]

CHAPTER 3
Initial Response and Investigation

In This Chapter

- Responsibilities of first responders in cases of suspected child maltreatment
- Questions to be considered during an assessment or investigation
- Interviewing the alleged child victim
- Interviewing adults (alleged offenders and non-offenders)
- Documenting interviews
- Working in multidisciplinary teams
- Observing the scene
- Collecting physical evidence
- Assessing safety and developing a safety plan
- Next steps in the process
- First responders' roles in child fatalities

First responders who discover signs of possible child maltreatment, or who are in a situation in which child maltreatment may have occurred, should first ensure the safety of the child. They immediately should assess whether there are any significant and immediate threats to the child or others at the scene, including the first responders themselves. If there is any threat to safety, first responders should take immediate action to establish a safe environment. Once the scene is safe, first responders should begin an investigation and assess the future safety of the child and other family members.

Response and Investigation During Disasters

The response and investigation steps described in this chapter may not be wholly applicable during disaster or other emergency situations. During disasters, response and investigation protocols may be very different than during "normal" circumstances. First responders should be familiar with their agencies' protocols and use their own judgment regarding their safety and the safety of the families with which they are working. For more information, see Chapter 5, *Responding in Disasters*.

Appendix D, *Reference Guide for Responding to Cases of Suspected Child Maltreatment*, synthesizes key points from this chapter and Chapter 2, *Recognizing Child Maltreatment*, into a two-page handout.

Responsibilities of First Responders in Cases of Suspected Child Maltreatment

While the responsibilities and initial investigation methodologies of first responders often overlap, there are also important differences. Exhibit 3-1 outlines the responsibilities of each first responder when attending to a possible case of child maltreatment, and exhibit 3-2 summarizes the key questions each type of first responder should consider in these cases.

Exhibit 3-1
Responsibilities in Child Maltreatment Cases

Emergency Medical Technicians (EMTs)	Law Enforcement*	Child Protective Services (CPS)
• Ensure emergency medical needs are met • Identify and report possible child maltreatment • Preserve evidence • Testify in court.	• Receive reports of child abuse and neglect • Conduct investigations of reports of child maltreatment when there is a suspicion that a crime has been committed • Identify and report suspected child abuse and neglect • Examine the crime scene • Collect and preserve evidence • Take statements and confessions • Determine whether a crime occurred and if there is sufficient evidence to prosecute alleged offenders • Assist in securing the protection of the child • Testify in court.	• Receive reports of child abuse and neglect • Determine whether the child is safe and, if not, develop a plan to ensure the child's protection in the least intrusive manner • Conduct investigations and initial assessments regarding suspected child maltreatment • Report maltreatment to law enforcement if there is a suspicion that a crime has been committed per State and local statutes • Determine whether the child suffered maltreatment or is threatened with harm • Determine if maltreatment is likely to occur in the near future and, if so, determine the level of risk • Determine if the family has any emergency needs that must be met • Testify in court.

*Some of the responsibilities listed for law enforcement may not be the responsibility of the first law enforcement officer at the scene. A detective or a specially trained investigator may be assigned the case later to complete the investigation.

Exhibit 3-2 Primary Questions That Should Be Considered During an Initial Assessment or Investigation[52]			
EMTs	**Law Enforcement**	**CPS**	**All**
• Does anyone need medical care or assistance? • Have the injuries been documented? How? • Should referrals be made to CPS or law enforcement? • Have any statements that were made by anyone at the scene been documented? How? Where?	• Did a crime occur? • Who is the alleged offender? • Is there evidence to arrest the alleged offender? • Do sources of corroboration or witnesses exist? • Have all witnesses been interviewed? • Have signed witness statements been collected?	• Did the child suffer maltreatment, or is the child threatened by harm as defined by the State reporting law? • Do sources of corroboration or witnesses exist? • Is maltreatment likely to occur in the near future? If so, what is the level of risk? • Are there emergency family needs that must be met? • Are agency services necessary to protect the child and to reduce the risk of maltreatment occurring in the future?	• Is the child safe? If not, what measures are necessary to ensure the child's safety? • Has all physical evidence been obtained, preserved, or photographed? • Are there any other possible victims (e.g., siblings)? • Should the child be taken into protective custody? (If yes, EMTs should refer the case to CPS or to law enforcement.)

Objectivity of First Responders

First responders should begin each case with objectivity. One of the biggest problems confronting many first responders is jumping to conclusions before all the facts have been presented and assessed. First responders can minimize this by initially developing several theories of what actually happened in each case. Examples of theories include:

- The injuries occurred exactly as they were reported.
- The reporter was confused or misunderstood.
- This is an intentionally false report.

First responders should explore each of their theories thoroughly through interviews and evidence collection.

Interviewing the Alleged Child Victim

The child interview often is the focal point of the investigation. Many forms of child maltreatment leave few or no physical marks or evidence, and child interviews may be crucial to the case. Conducting these interviews can be challenging, but training and experience can assist first responders in gathering accurate, helpful information. What follows is information about the basics of conducting child interviews, developmental considerations, and tips on how to conduct culturally competent interviews.

Interview Basics

This section provides basic information about conducting an interview with an alleged victim of child maltreatment. It includes guidelines for the first responder to follow during the interview, as well as the types of questions that should be asked.

Before the Interview

The interview with the alleged victim should take place immediately after the allegations have been made, when possible.[53] The first responder should prepare the child for the interview before it begins. Some techniques that may be used include:

- Having the first responder introduce herself and her role to the child
- Explaining the purpose of the interview in developmentally appropriate language
- Discussing confidentiality and its limits
- Explaining that it is okay for the child to say that he does not know the answer
- Communicating concern for the child's safety
- Allowing the child to practice answering open-ended questions.[54]

It is important to gain the trust of the child and establish a rapport prior to beginning the interview. The child may be more likely to share information if he trusts the first responder. To build trust, the first responder can begin an interview by talking about general topics, such as the child's favorite television show or a toy he likes.[55] It also is a good idea to interview the child in a comfortable and secure environment, such as a child advocacy center or a private room at the child's school. Ideally, the alleged child victim interview will be conducted without the child's parent or other caretaker present in order to ensure that the child's statement is his own and not influenced by others. It may be necessary to reassure the child that the parent or caretaker is nearby and available if necessary or appropriate.

Confidentiality

Although the first responder needs to establish trust with the child, it is important that she does not mislead the child about whether the information will be kept secret. The first responder should be open with the child about the limits of confidentiality so that the child does not feel betrayed later in the process.[56] What this generally means is that anything the child tells the first responder that relates to an incident of alleged maltreatment must be disclosed to the proper authority. First responders should become familiar with confidentiality policies in their agencies and jurisdictions.

Interview Guidelines

Some basic guidelines for conducting interviews with children are to:

- Avoid jumping to conclusions
- Be at the child's eye level (e.g., sitting on the floor with him), if possible
- Leave a comfortable space between the interviewer and the child
- Create a child-friendly environment (e.g., have toys available)
- Use body diagrams or dolls to help the child clarify body parts that are discussed
- Be mindful of responder's facial expressions and body language
- Minimize the use of yes or no and multiple-choice questions
- Follow up all closed-ended questions with open-ended questions (types of questions are discussed later in this chapter)
- Listen carefully and completely (i.e., do not rush the child)
- Assess the child's understanding of key concepts (e.g., being able to tell the truth, understanding timeframes), which will help to establish credibility as the interview proceeds into sensitive areas
- Reduce vocabulary problems by using the child's vocabulary, when appropriate, and clarifying any areas of confusion
- Avoid using double negatives (e.g., "So your father didn't not hit you with the belt?")
- Observe the child's nonverbal communication and body language
- Document the interviewer's and child's words carefully and completely, perhaps by audio- or videotaping the interview
- Be attuned to the developmental capabilities and limitations of the child as the interview progresses.[57]

During the interview, first responders should assess the child's statements for accuracy and for how they match other information or evidence that is collected. The accuracy of the interview may be influenced by:

- The child's age and developmental stage
- The child's understanding of events
- The child's emotional state
- The first responder's style and request for details
- The structure and nature of the questions.[58]

To ensure that facts are gathered in a way that will be admissible in court, the first responder should carefully control the interview. This means that the first responder's statements and body language should be neutral, alternative explanations for the child's statements should be explored thoroughly, and the interview should be documented in such a way that it can bear scrutiny in court.[59]

Types of Interview Questions

The first responder should be aware of the types of questions used during the interview. *Open-ended* questions (e.g., "What happened to your arm?"), which allow the child to develop an answer that goes beyond yes or no, are often preferred during an interview. The goal of asking open-ended questions is to allow the child to tell the first responder, in his own words, what happened. The child's response is more credible when the first responder asks him open-ended questions. The standard open-ended question for all first responders should be, "What can you tell me about what happened?" The first responder can

Ways to Calm an Anxious Child

A first responder can use the following techniques to try to calm an anxious child:

- Respond as quickly as possible to the child's signs of distress by approaching the child and by showing interest in what the child is feeling
- Do not hug or touch the child unless he says it is okay to do so
- "Listen" to what the child is saying with words and actions (e.g., nod, summarize what the child said when appropriate)
- Take the child's feelings—especially fear—seriously
- Be as relaxed as possible when helping the child calm down
- Restate to the child what he is saying to make sure he is understood
- Provide appropriate outlets for strong emotions, including anger, frustration, sadness, and loneliness (e.g., letting the child use a punching bag, go to a quiet corner, play with a tape recorder, run in a special "running space," paint)
- Be there for the child; the first responder's presence and care can be reassuring. [60]

follow that up with, "Can you tell me more about that?"

Closed-ended questions (e.g., "Is your arm hurt?") tend to restrict the information that the child provides to a fixed set of responses, such as yes or no. Multiple-choice questions (e.g., "Were you hit one, two, or three times?") are a type of closed-ended question. Closed-ended questions can encourage young children to guess the answer even when they do not understand the question. They provide information to the child rather than the child providing the information. With multiple-choice questions in particular, none of the choices may be correct, but the child may choose one simply to please the first responder.[61] Though not as preferred as open-ended questions, close-ended questions can still be used appropriately during an interview (e.g., at the end of an interview to clarify information provided or omitted by the child).

The first responder should not ask leading questions (e.g., "Did daddy hurt your arm?"). Direct questions or statements (e.g., "I see you have a mark on your arm.") may, however, be necessary at times to direct the child to provide more information. The first responder should follow every direct question or statement with open-ended probes, such as, "Tell me what happened," or "Who hurt your arm?" If the child responds that it was "his daddy" who hurt him, then the open-ended probe would be, "Can you tell me more about how daddy hurt your arm?" Additionally, when the child fails to mention important information, prompts may be necessary. For example, if the child uses a "family word" for something, such as using "the bad boy room" to mean the hallway closet, the first responder may need to clarify the statement by asking a question such as, "Where is the bad boy room?"[62]

End of the Interview

At the end of the interview, the first responder should thank the child for his time and praise him for working hard. The praise should be for the effort and not for the content of what was said. If the child is upset, the first responder should offer support and empathy. She can ask the child what he thought of the interview and can attempt to dispel any misperceptions. The first responder also should make sure that the child does not feel that what happened was his fault. Even if the child did not struggle or try to keep the abuse or neglect from happening or, in cases of sexual abuse, if

he enjoyed the sexual activity, the first responder still needs to reassure the child that he is not at fault.[63] In addition, the first responder should let the child know what the next steps will be.[64] This will vary depending on the type of maltreatment and the particular child and family. Additionally, the first responder should make sure that the child is safe if the disclosure of information puts the child in jeopardy (i.e., the alleged perpetrator would further harm the child because of the disclosure).

Developmental Considerations

Most children go through a series of normal developmental stages and changes. First responders should be aware of the developmental levels of children, particularly when conducting interviews, to ensure that they ask questions that can be understood by the children and have more context for the answers they receive. The developmental considerations that follow in this section for preschool-aged and young children and for older children and adolescents are based on the typical characteristics of children of those age ranges. Children, however, may move through developmental levels at different times. For example, a 14-year-old child, especially one who was maltreated, may be at a developmental level typically associated with a child who is 9 or 10 years old.

Preschool-aged and young children. The following are important considerations for interviewing children in this age range:

Investigating Sexual Abuse

In 2008, 9.1 percent (69,184) of child maltreatment victims were sexually abused. Although sexual abuse victims may be of any age, older children are more likely to be victims. Additionally, almost two thirds of sexual abuse perpetrators were family members, with 27.1 percent being a parent, 8.8 percent being an unmarried partner of a parent, and 29.4 percent being another relative.[65]

In order to work effectively on sexual abuse cases, first responders should:

- Have a thorough understanding of child development and be able to communicate effectively with children of all ages
- Understand that familial child sexual abuse does exist, as well as the dynamics associated with it
- Be able to distinguish between true, confused, and false statements
- Remain neutral and attempt to obtain as much factual information as possible.[66]

Working on sexual abuse cases can be very emotionally trying for first responders. Common responses include anger, disgust, and denial. First responders should not let their emotions affect the way they handle a case. They should remain objective and follow up on several theories. If first responders are not able to control their emotions, they should not be assigned to conduct interviews during a sexual abuse investigation.[67]

Investigating child sexual abuse cases presents extremely challenging circumstances for first responders because:

- Sexual abuse generally occurs in secret and with no witnesses. Child victims may be sworn to secrecy or the abuser may threaten to harm the child, his family, or his pet if he tells.
- Child victims may care for their abusers and may not want to see any harm come to them. It takes a tremendous amount of courage for a child to come forward and to speak up against an adult abuser, especially if it is a loved family member or friend.
- Sexual abuse rarely occurs only once. Generally, the grooming process (i.e., preparing the child for eventual sexual abuse by befriending them, giving them presents, etc.), which is sometimes called conditioning, and the sexual assaults occur on numerous occasions over a period of time.
- The child victim often is confused by the circumstances and rarely can tell a coherent story about how the abuse began. What may have started as a backrub or a wrestling game can slowly progress over a period of time into sexual assault.

First responders should try to determine the following information during the child interview in sexual abuse cases:

- How and where the child was touched
- If threats, promises, or requests were made
- If other victims or offenders were involved
- When and how often the abuse occurred
- Where the abuse occurred.[68]

Although a medical examination should be conducted later to look for signs of sexual abuse and to collect evidence, most child victims will not display physical signs of abuse. This may be due to delayed disclosure or because the nature of the abuse is not such that it would leave physical trauma (e.g., fondling, performing oral sex).[69]

Secondary Traumatic Stress (STS) in First Responders

First responders who work on child maltreatment cases may be at risk of developing STS, which is a condition caused by indirect exposure to trauma through a firsthand account of a traumatic event (e.g., interviewing or witnessing a child who has been severely abused).[70] STS is also known as vicarious trauma or compassion fatigue. The symptoms of those experiencing STS may be similar to the stress symptoms experienced by the direct victim, such as increased fatigue or illness, social withdrawal, difficulty sleeping, feelings of hopelessness, re-experiencing the event, anxiety, and sadness.[71] Symptoms may be experienced in both their personal and professional lives. STS is different than what is commonly referred to as "burnout" as the latter is usually caused by work issues, such as long-term involvement in a nonsupportive work environment, large caseloads, and excessive paperwork.[72]

First responders who believe they are experiencing STS should consult with a mental health professional and/or seek other support. They can help prevent STS by maintaining a personal/professional life balance, practicing stress management, spending time with family and friends, and taking personal time. Agencies can assist first responders experiencing STS by destigmatizing the condition (e.g., promoting openness and discussion about it) and encouraging affected workers to seek support.[73]

- **Children's thinking tends to be very concrete, and their ability to think abstractly is still developing**. Irony, metaphor, and analogy are beyond their grasp. Therefore, first responders should not assume that children understand all the concepts presented to them.
- **Children generally do not organize their thinking or speech logically**. Instead, they say whatever enters their mind with little censoring or consideration. Therefore, their narratives tend to be disjointed and rambling, resulting in the need for first responders to sort out relevant from irrelevant data. It generally is beyond young children's cognitive capacities to do this alone. First responders, however, should not ask them leading questions (e.g., "Isn't it true that your uncle hit you with his belt?").
- **Children's understanding of space, distance, and time generally may not be logical or linear**. Since they probably have not learned units of time measurement, their memory may not work chronologically. To help them place the time of an incident, first responders should use reference points, such as birthdays, holidays, summer, night, day, lunchtime, bedtime, television shows, and before and after school.
- **Children generally are egocentric**. They think the world revolves around them and relate all that happens to personal issues. These children usually do not think about what effect their actions will have on others, or they may think everything, including the maltreatment, is their fault.
- **The attention span of children is limited**. Long interviews often are not possible because these children cannot concentrate or sit in one place for long periods of time. First responders should be flexible, conducting several short sessions over a brief period of time.
- **Many children are afraid to talk with an unfamiliar person without a parent present**. First responders should work slowly to help children separate from the parent, when possible. If this process is difficult, the interview may need to begin with a nonoffending parent present, when appropriate, and work toward separate interviews at a later time once the child feels more comfortable. First responders should be

flexible and follow the children's lead as long as it is within the protocol and the policies established by their agency.

- **Children often are more compliant, suggestible, and easily confused than older children**. First responders should be careful not to ask questions or to make statements that would influence the way children recount their situation.[74]

Older children and adolescents. Children in this age range:

- Usually have a greater preference for a same-gender interviewer
- May be awkward or embarrass easily
- Encompass a wide variety of physical and emotional developmental levels (e.g., some may look like adults, whereas others look more like children)
- May be in a stage where they are asserting their independence from adults and authority figures; they may not want to talk about the incidents or to tell the whole story.[75]

Culturally Competent Child Interviews

Children who have been abused or neglected may suffer from trauma, may have been threatened into keeping secrets, and may feel frightened and intimidated by the entire interview process.[76] When language and cultural differences enter the mix, achieving enough rapport to elicit full and accurate information may seem nearly impossible.[77] The following are tips for conducting a culturally competent interview with a child:

- **Gather information about the child's background before conducting the interview, if possible.** Answers to the following questions will help the first responder understand the extent to which the child is rooted in his culture and how much of an adjustment needs to be made in the standard interviewing process.
  - What language or languages are spoken at home?
  - What language does the child prefer to speak with siblings and friends?
  - Is the child an immigrant or a child of an immigrant? If so, from where, and what were the circumstances of the immigration?
  - Who lives at the home? Who else stays there?
  - What is the child's religion? How observant is the child's family?
  - Are the members of the family acculturating at different rates? If so, is it leading to conflict?
- **Select a neutral setting for the interview.** Although this may not be possible for the first responder, she should consider conducting the

Truth and Lying in Preschool-aged Children

Issues of truth and lying are particularly complex in the preschool years. Children in this age group may tell lies to avoid a problem or punishment, to impress adults, or to get attention. Research varies, however, on whether children can manufacture stories based on information that they have not learned or experienced. Despite their occasional tendency to tell false stories, children in the preschool years usually know the difference between fact and fantasy and between the truth and a lie. Gentle probing and nonleading questions from first responders usually will help children reveal what is true and what is false. First responders also should keep in mind that children can become easily confused about what happened.[78]

Interviewing Children in Cases of Domestic Violence

If child maltreatment and domestic violence may be co-occurring, first responders should incorporate questions about domestic violence into the interview and assessment. First responders should keep in mind that children receive messages, either directly or indirectly, that domestic violence is a "family secret." Children often are uncomfortable and frightened of talking about it. Some children may be afraid that discussing the violence will create additional problems at home, such as additional violence or the separation of their parents. Other children may align with the abuser and attempt to provide protection by not discussing the violence or even by blaming the victim or themselves. It is critical to tell children that the violence is not their fault and that their feelings are normal. First responders should begin direct inquiry regarding domestic violence with a general statement, which may help the child feel more at ease. An example of this would be stating, "Sometimes when moms and dads (or boyfriends) fight, they get angry, sometimes even too angry. They may start to yell at each other or even hit each other. I know fights can be scary. I want to ask you a few questions about whether your parents fight and what you think about it. Would that be OK?"

First responders may want to consider asking alleged victims of domestic violence for suggestions on interviewing the children about it in order to have an initial understanding of the children's likely attitude or behavior. They should keep in mind, however, that caretakers often underestimate the effects that domestic violence has on their children.[79] First responders should assist the children and, whenever possible, the nonoffending parents in developing positive and effective methods to protect themselves. Where appropriate, safety plans need to include tips for children, such as what to do and who to contact for help in domestic violence situations. See Appendix I, *Domestic Violence Exposure Assessment*, for recommendations on interviewing children who may be affected by domestic violence.

interview in a place of worship, a school, or some other place familiar to the child. If possible, law enforcement officers should be dressed in plain clothes because many members of immigrant groups do not see the police as their allies.

- **Build rapport and establish trust.** To gain trust, the first responder should explain her role, credentials, and experience carefully. The first responder should be clear about the purpose of the conversation and explain it in simple terms and without professional jargon. Language confusion will be more acute and more frequent when the family's native language is not English. In addition, depending on its culture, the family may trust certain professionals and not others (e.g., trust a doctor or nurse more than a social worker or law enforcement officer).
- **Express empathy and warmth.** Some Spanish-speaking cultures, for example, view professionals from the United States as cold, disinterested, and rejecting. The warmer the connection between the first responder and the child, the more comfortable the child will be in correcting the first responder if the first responder makes a mistake, such as providing inaccurate information about the incident during the interview. Also, the child tends to be more forthcoming with information.
- **Audiotape or videotape the interview**. When an interpreter is used, an audiotape or videotape of the interview should be made. This record of the interview will be helpful should the translation of certain words be questioned in court.[80]

The first responder should also keep in mind that even though she may expect the child to reveal sensitive

information, personal matters may be discussed only indirectly, if at all, in the child's culture.

Interviewing Children with Disabilities

Children with disabilities are more likely to be abused or neglected than children who do not have disabilities and are also less likely to report their maltreatment.[81] When interviewing children with disabilities, first responders should recognize and understand the children's unique characteristics, competencies, and limitations.[82] As part of their normal training, first responders can familiarize themselves with various types of disabilities and how they may affect interviews and other areas of the response. If possible and if time permits, first responders should also gather information about the individual child prior to the interview. This information may include whether the child:

- Uses sign language, wears a hearing aid, or reads lips
- Is at a developmental level different from his age
- Has problems focusing or paying attention
- Uses a wheelchair or other adaptive equipment
- Has impaired or unusual speech
- Needs to be accompanied by a support person.[83]

Although children with disabilities may have certain difficulties providing information about suspected maltreatment, they can provide valuable information. First responders can obtain useful and accurate information by keeping the following in mind during the interview:

Factors to Consider When Interviewing Native American Children

When working with Native American children and families about possible child maltreatment, CPS caseworkers should ensure that they understand and follow the regulations set forth in the Indian Child Welfare Act. Additionally, first responders should keep the following in mind:

- Native American children may use their native language when describing people, body parts, or the situation in general. The first responder should implicitly or explicitly give children permission to communicate in whichever language they are most comfortable using and seek translating services when necessary.
- Silence and pausing before responding are common among Native Americans. The first responder should allow the child to speak at his own pace.
- Native American children may be particularly attuned to nonverbal communication (e.g., facial expressions), so the first responder should pay attention to how her nonverbal cues may be interpreted.
- In Native American culture, not making eye contact may be an expression of respect.
- Native American children may mark life events by seasons, ceremonies, and daily activities rather than by dates or days of the weeks.
- The sense of community in his culture might cause a Native American child to not make allegations against or implicate an elder or other community member.
- There may be a historical distrust of legal and social authorities that may discourage full participation in the interview process.[84]

For additional information about working with Native American children and families, visit the National Indian Child Welfare Association website at **http://www.nicwa.org,** and Child Welfare Information Gateway at **http://www.childwelfare.gov/systemwide/cultural/families/indian.cfm** and **http://www.childwelfare.gov/management/training/curricula/caseworkers/topical/amer_indian.cfm**.

- Use simpler language and shorter sentences, but do not necessarily treat them like younger children or babies
- Recognize that children with disabilities may have various levels of capabilities across different areas (e.g., they may be developmentally delayed with language but have age-typical cognitive abilities)
- Use mostly open-ended questions in the beginning, as is best with all child interviews
- Be especially careful about using yes/no questions or asking the same question repeatedly because children with disabilities may be less assertive or feel more of a need to be compliant or obedient.[85]

Interviewing Adults

After interviewing the alleged victim of child maltreatment, the first responder, when possible, should proceed to interview the adults in the home or wherever the alleged maltreatment occurred or was reported. (Throughout this section, the word adult is used to signify parents, caregivers, or other adults who may be of interest in the case.) The first responder should begin by interviewing the nonoffending adults and then the adults suspected of the maltreatment. The offending or the nonoffending adult may not be a parent, but a relative, friend, neighbor, boyfriend, or girlfriend. Additionally, an adult who initially is not suspected of being an offender may be suspected at a later time. The first responder should keep in mind that approximately 80 percent of offenders are parents, but this should not preclude the first responder from considering other adults in the investigations.[86] Exhibit 3-3 provides statistics on the types of relationships child maltreatment offenders have to their victims.

Interviewing Nonoffending Adults

In cases of alleged child maltreatment in which the maltreatment took place between one adult and the child without the knowledge or the participation of the other adults, the nonoffending adult may be a good source of information. The primary purpose of these interviews is to:

- Find out what, if anything, the adult knows about the alleged maltreatment

Interviewing Siblings

First responders should interview the alleged victims' siblings in order to:

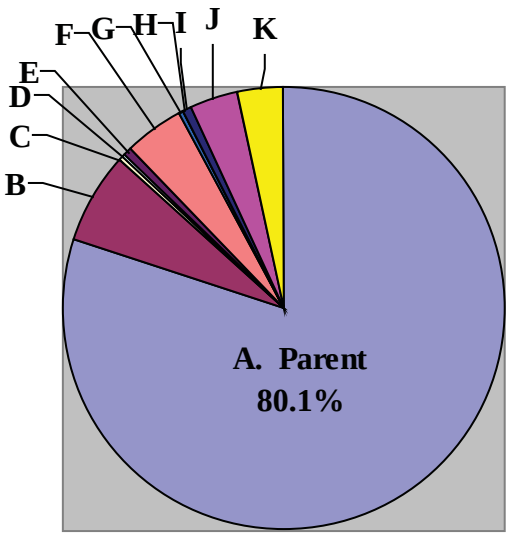
- Determine whether the siblings have experienced maltreatment
- Assess their levels of vulnerability
- Gather corroborating information about the nature and the extent of any maltreatment of the identified child
- Gather further information about the family that may assist in assessing the risk to the identified child and the siblings.

First responders should interview siblings using the same sensitivity and with similar styles of questions (mostly open-ended) as used in the interview of the alleged victim. First responders also should evaluate the objectivity of the siblings.[87]

- Gather information related to the risk of maltreatment and the safety of the child
- Gather information regarding family strengths or protective factors
- Determine the adult's capacity to protect the child.[88]

The first responder should interview the nonoffending adult as soon as possible after the allegations have been made so that the statements will not be affected by contact with the alleged abuser. The first responder should provide the nonoffending adult with basic information about the allegations without offering all the details. If there is evidence corroborating the child's allegations, the first responder should let the nonoffending adult know that she believes the child. The first responder should then explain to the nonoffending adult the process for the investigation and emphasize the importance of gathering information and evidence. Throughout this discussion, the first responder should note whether the adult appears to believe the child and for whom

Exhibit 3-3
Offenders by Relationship to Victims, 2008[89]



- A. Parent 80.1%
- B. Other Relative 6.5%
- C. Foster Parent 0.4%
- D. Residential Facility Staff 0.2%
- E. Child Daycare Provider 0.5%
- F. Unmarried Partner of Parent 4.4%
- G. Legal Guardian 0.2%
- H. Other Professionals 0.1%
- I. Friends or Neighbors 0.5%
- J. Other 3.7%
- K. Unknown or Missing 3.3%

the nonoffending adult expresses concern (the child or the alleged abuser).[90]

The following are basic questions that the first responder should ask nonoffending adults:

- What happened?
- How did the maltreatment happen?
- Who maltreated the child?
- Who was with the child?
- Who saw the maltreatment happen?
- Where did the maltreatment happen?
- Where were the other household members?
- When did the maltreatment occur?

Appendix J, *Interviewing Nonoffending Adults*, provides additional questions that the first responder can ask nonoffending adults in the home.

Interviewing the Alleged Offender

The primary goal of interviewing the alleged offender is to gather as much information as possible that verifies, clarifies, or refutes the maltreatment allegations. The first responder should interview the alleged offender last. This allows the first responder to question the suspect with information gathered through interviews with the alleged victim and others.[91] Before the interview, the first responder should gather additional information about the alleged offender and the family in relation to the risk to and the safety of the child. This information, coupled with the information collected during interviews with the alleged victim and nonoffending adults, will help the first responder develop a more complete picture of the situation.

During the interview, the alleged offender should be presented with the allegations and with specific information that was relayed during interviews with the victim and others. First responders use various methods to elicit a confession or gather additional information. For example, the first responders could appeal to the suspect's sense of loyalty to his family or to the suspect's love for the child (e.g., "Telling us what happened that day is the best way to help your son.").[92] The first responder should evaluate the alleged perpetrator's reaction to allegations of maltreatment, as well as to the child and the child's condition.

If the alleged offender is unable to provide information to refute the allegations, law enforcement or CPS will attempt to obtain a confession or an admission. If the alleged offender confesses, the law enforcement officer should follow the appropriate guidelines for documenting the confession and for arresting the suspect. If it is a CPS worker who obtains the admission, law enforcement may be called, depending on the severity of the maltreatment. If the suspect does not confess, it may be useful to offer him the chance to take a polygraph examination. *Most importantly, the first responder should follow agency or department protocols and procedures when making these decisions.*[93] Exhibit 3-4 presents a checklist for conducting interviews with alleged offenders.

The first responder may need to ask follow-up questions to clarify what occurred if the alleged offender describes any of the following:

- A disclosure by the alleged offender that maltreatment did take place
- No explanation for an injury or suspect incident
- An explanation for an injury that is inconsistent with either the severity or the type of injury observed
- Different or changing explanations for an injury or incident
- A delay in obtaining medical treatment for an injury.[94]

Exhibit 3-4
Checklist for the Alleged Offender Interview for Law Enforcement and CPS Investigations

During an alleged offender interview, the first responder should:

- **Maintain the element of surprise.** This works to the advantage of the first responder.
- **Choose the location of the interview carefully.** The location of the interview may enhance confession rates. The police station or the CPS office, for example, may be conducive to a confession or an admission.
- **Know the basic information about the maltreatment.** The first responder should attempt to have knowledge of the modus operandi (a characteristic method of operation or procedure) of the suspect (e.g., usually says certain phrases during the maltreatment, uses a particular object to hit the child), as well as the who, what, when, where, and how of the maltreatment. The first responder should have already established a timeline for the maltreatment.
- **Be knowledgeable about the evidence and other information about the case.** When possible, the first responder should know about the available evidence and information about the case, including marks on the child, previous interviews with witnesses and victims, opportunity, and information about the scene of the maltreatment.
- **Make sure the alleged offender knows that the first responder believes the child, if appropriate.** The first responder should confront denial gently, allow the suspect room to deny, listen carefully, test the denial, and strongly present the suspect with corroborative information, if pertinent and appropriate.
- **Be patient during the interview.** The first responder should take the time to conduct a thorough and accurate interview.
- **Conduct the interview with a sensitive, empathetic style.** This can create an environment conducive to a suspect's confession or admission.
- **Obtain a signed, written statement or an audio- or videotaped statement.** The first responder should be mindful of her agency's policy on audio- or videotaping.

Documenting Interviews

Gathering and documenting accurate information from the alleged victim and from other family members and collateral sources are imperative to the success of a child abuse or neglect case. Inaccuracies in children's statements, as recorded by the first responder, may be used to discredit the children later. Also, adult victims often are given time to review their statements before signing them to correct inaccuracies; child victims, however, usually are not given that opportunity. The first responder taking statements from an alleged child victim should attempt to clarify and understand the accuracy of the statements. Properly documenting the information, however, can sometimes be difficult. Conducting interviews and writing down questions and responses may be cumbersome and distracting to those being interviewed, as well as to the first responder conducting the interviews. Additionally, child victims often communicate their maltreatment in fragmented and disjointed sentences.

The following guidelines are recommended for documenting interviews:

- Follow the agency's or department's protocols
- Give the child permission to correct statements

Miranda Rights

Before questioning a suspect in custody, a law enforcement officer generally reads the suspect his Miranda rights, which state:

> You have the right to remain silent. If you give up the right to remain silent, anything you say can and will be used against you in a court of law. You have the right to an attorney. If you desire an attorney and cannot afford one, an attorney will be obtained for you before police questioning.[95]

The purpose of the Miranda warning is to protect an individual's Fifth Amendment right against self-incrimination. Information provided by a suspect is inadmissible at trial if those statements are made without a Miranda warning being provided before questioning or if the questioning continues after the suspect indicates that he wants an attorney present. A law enforcement officer does not have to read a suspect his Miranda rights, however, during "noncustodial" interviews (i.e., the suspect is not under arrest). If the law enforcement officer does not have to read the suspect his Miranda rights, the interview tends to be less hostile. *Miranda rights only apply to statements made to law enforcement, not statements to CPS workers or EMTs.*

- Document both the questions and answers, when possible
- Listen carefully to answers
- Read answers back to the child for clarification, when appropriate
- Write notes clearly and concisely
- Quote direct statements, when possible
- Videotape or photograph the crime scene to confirm accuracy
- Try to have an investigative team of one interviewer and one note taker.

Observing the Scene

When gathering information for the case, the first responder should observe the identified child victim, the other family members or adults, and the environment, including the scene of the alleged abuse. Everything that is viewed, heard, smelled, or otherwise observed at the scene is important information that must be documented. Specific areas for observation are:

- The physical condition of the child, including any observable effects of maltreatment
- The emotional status of the child, including mannerisms, signs of fear, and developmental status
- The reactions of the parents or caregivers to the first responder's concerns
- The emotional and behavioral status of the parents or caregivers during the interview process
- The interactions between family members, including verbal and body language
- The physical status of the home or site of maltreatment, including cleanliness, structure, safety hazards, signs of excessive alcohol use, and signs of illicit drug use (e.g., drug paraphernalia, evidence of a methamphetamine lab)

Multidisciplinary Teams

If the goals of all first response agencies are to be achieved, EMTs, law enforcement officers, and CPS caseworkers should work with each other to eliminate any unnecessary duplication of effort, to promote proper and expeditious collection and preservation of evidence, and to develop a coordinated system for identifying and investigating reports of child maltreatment. This is best accomplished through a team approach in which professionals share information, assign investigative tasks, and participate in a collaborative decision-making process.[96] The use of multidisciplinary teams for the investigation of child maltreatment has become an effective approach in various jurisdictions across the country. There are many benefits to this type of approach, including:

- Increasing the early identification of child maltreatment
- Reducing trauma to child victims by minimizing the number of interviews the child must experience
- Preventing duplication and minimizing the number of interviews and court appearances by first responders
- Allowing first responders to provide necessary support to the alleged victim, as well as to one another
- Helping provide a clearer picture of the situation
- Allowing for more thorough investigations and for increasing the likelihood of achieving a positive case outcome
- Preserving and enhancing the quality of the evidence needed for decision-making and successful prosecution.[97]

To facilitate this process, the first responders' agencies should develop protocols or memoranda of understanding (MOUs) that guide the investigative process and that specify timeframes and roles and responsibilities of the professionals involved in child protection. In jurisdictions where there is a lack of coordination among professionals involved in the child protection system, there often are conflicting opinions as to who should conduct the interview of the alleged offender during the investigation. For example, in cases of severe child physical abuse and sexual abuse, law enforcement may prefer that CPS not interview the alleged offender prior to law enforcement's involvement. However, a CPS investigator may be the first and only responder to a case because the law enforcement agency cannot respond immediately or is not available to conduct the interview of the alleged offender for several days. MOUs can assist collaborating agencies in determining the roles and responsibilities of each. For more information on MOUs, refer to Appendix K, *Memorandum of Understanding*.

First responders should be aware of the potential barriers to a multidisciplinary approach. A review of the literature on co-involvement of law enforcement and CPS in child welfare cases found that barriers include concerns about the other's investigation techniques and protocols and about the privacy and confidentiality of families.[98] To help establish a team approach, first responders should have a clear understanding of each other's roles, including the limitations of these roles, as well as the expertise that each profession can bring to the case.[99] They also should trust and respect one another and understand that they are all working toward the common goal of keeping children and families safe.

For more information about agencies and communities working together to prevent and respond to cases of child maltreatment, see *Community Partnerships: Improving the Response to Child Maltreatment* at **http://www.childwelfare.gov/pubs/usermanuals/partners/.**

- The climate of the neighborhood, including the level of violence or drug use, and the accessibility of transportation, and methods of communication (e.g., cell phone coverage).[100]

The first responder should note in her report any observations of these circumstances.

Collecting Physical Evidence

The first responder also plays an important role in the collection and preservation of physical evidence. After ensuring that the child is protected from additional harm or injury, the first responder should ensure that the area in and around the scene is contained and that evidence is collected and documented according to agency and department protocols. Some evidence, such as semen, must be collected immediately and in a way that avoids contamination, destruction, or deterioration of quality.

Obtaining as much physical evidence as possible is especially important if a case goes to trial. In maltreatment cases, there often may not be any witnesses, and the focus of the case may need to be on the testimonies of the alleged victim and alleged perpetrator and the available evidence. In cases of neglect, physical evidence may be especially difficult to collect. In these cases, the first responder should observe the scene for any unhealthy conditions in the home, a lack of food, or unclean or hazardous materials. Additionally, if enough evidence is collected, it may even eliminate the need for the child to testify, which can be a traumatic event.

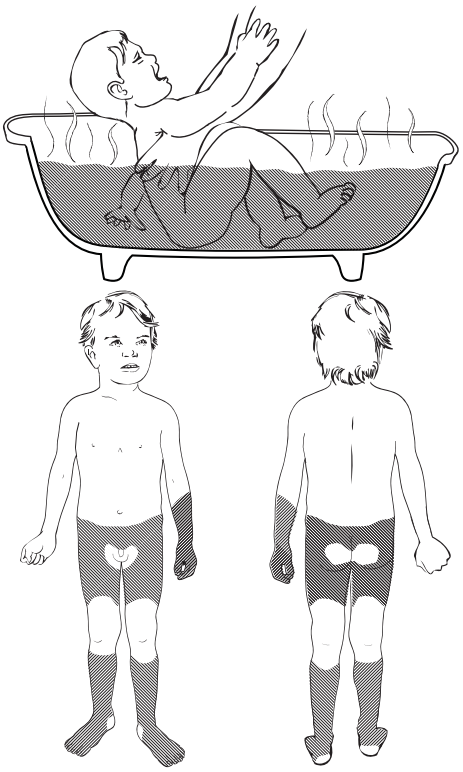
A lack of physical evidence does not mean that the allegation is necessarily false. However, physical evidence that corroborates a victim's statement can enhance a case. The first responder is most likely to obtain physical evidence if she acts quickly and does not give the alleged offender a chance to destroy or tamper with the evidence. Even if the suspect is in custody, it is important to act quickly because he may be able to have someone else destroy the evidence.[101]

Every incident of neglect, physical abuse, or sexual abuse of a child occurs at a specific location. The first responder must realize that she is standing in a potential crime scene and should obtain or make note of any evidence. The following may be useful evidence in the investigation of cases of suspected child maltreatment:

- Broken items or holes in the wall
- Stains from blood or semen (visible with a black light)
- Minute evidence, such as hair, fibers, blood, or semen
- Lures, such as toys or games
- Sexual aids, such as lubricants, dildos, and vibrators
- Drugs or alcohol
- Adult or child pornography or other sexually explicit material in print or on a computer (e.g., letters, diaries, books that discuss sexual activity with children)
- Cameras and film processing equipment
- An address book containing the alleged victim's information
- Bedding
- Clothing
- Contents of trash cans
- Bills, bank records, and receipts, which may be used to show items that were purchased by the suspect for the victim
- Phone records

Immersion Burns

Immersion burns occur when a child is placed in extremely hot liquid. These burns have a "water line," or sharp demarcation border. Symmetric burns with distinct edges (e.g., burns of the same height on both legs) are very suspicious. Doughnut-shaped burns can occur when a child is forced to sit in a bathtub of hot water. This causes parts of the body, usually the buttocks, to rest on the bottom of the tub, where they will not burn. The diagram illustrates the appearance and cause of doughnut-shaped burns.



First responders who suspect a child has an immersion burn immediately should begin to gather information and evidence from the scene. First responders should take 360-degree (front, sides, and back) photographs of, or even videotape, the victim so the burn pattern can be documented and be evaluated by medical experts. They also should interview the caregiver suspected of immersing the child and ask questions such as:

- How was the water turned on?
- How long was it on?
- How did the child come into contact with the water?

If possible, first responders should videotape the scene of the immersion, preferably with the suspect showing his exact actions. If that is not possible, first responders still should videotape or photograph the scene. It also is important to document the hot water heater settings; the measurements of the tub, the sink, or any other water container in which the child was placed; and the temperature of the hot water when running. For more information on burns, see Appendix E, *Signs of Possible Physical Abuse*, and Appendix F, *Distinguishing Physical Abuse from Nonintentional Injury*, or visit **http://www.ncjrs.org/pdffiles/91190-6.pdf**.

Types of Evidence

Physical evidence, which is essentially an object or part of an object, is just one of several types. Other types include:

- **Direct evidence**, which is based on personal knowledge, such as the testimony of an eyewitness
- **Demonstrative evidence**, which is something that represents an object and includes items such as photographs, x-rays, and diagrams
- **Circumstantial evidence**, which is indirect evidence from which an inference can be drawn (e.g., a child with a bruise on her back shaped like an adult handprint).[102]

- Weapons or other implements used to abuse a child (e.g., belts, cords, coat hangers, other instruments matching the injuries inflicted)
- Other items noted by the alleged victim or the witnesses during the interviews. [103]

Assessing Safety and Developing a Safety Plan

When the first responder arrives at a scene of possible child maltreatment, her first responsibility is to ensure the safety of the alleged victim. She should only proceed once the child's immediate safety is established. The first responder needs to make decisions throughout the response and investigation about whether the child is safe and what plans need to be made to ensure the child's safety. If the child is at imminent risk of being harmed, the first responder should develop, with the help of the child and family, if appropriate, a safety plan. For EMTs and law enforcement, this will mean involving CPS.

Assessing Child Safety

A child is considered unsafe when he is at imminent risk of serious harm. There are two key points during the initial assessment or investigation at which the first responder should evaluate the child's safety. The first is during the initial contact with the child and family. At that point, the first responder should decide whether the child will be safe during the initial assessment or investigation by asking herself, "Is the child in danger right now?" The first responder should assess the family situation, the caregiver's behavior or condition, and the child's condition, including emotions and physical circumstances, for significant and immediate safety threats. Examples of these threats include currently hitting or otherwise hurting the child, head and face injuries, premeditated maltreatment, bizarre cruelty, young children left unsupervised, or the parent being intoxicated or unable to perform parental duties.[104] If the child is at immediate risk, a non-CPS first responder should contact CPS; all first responders should follow applicable protocols for the removal of either the offender or the child from the home.

The second point at which the first responder should conduct a safety assessment is at the end of the interview process. At this point, the first responder should evaluate the information and determine if the child is safe. When assessing the safety of the child, the first responder should:

- Identify the behaviors or conditions that increase concern for the child's safety and consider how they affect each child in the family
- Identify the behaviors or conditions (e.g., strengths, resiliencies, support, resources) that may protect the child

Search Warrants

For many child maltreatment cases, interview testimony may be the only evidence available to the prosecution. Additional evidence may exist, but may be overlooked during the investigation. In child maltreatment cases, law enforcement often underutilizes search warrants as a means of obtaining additional evidence.[105] When law enforcement officers obtain and execute search warrants properly, they can discover important evidence and improve the defensibility of the evidence in court. The primary use of search warrants is to obtain physical evidence from the crime scene or from a suspected offender's house, vehicle, or other setting. Law enforcement also can use search warrants to obtain evidence from the body of the alleged perpetrator. For example, if a child noticed a mole, birthmark, or tattoo on the suspect, law enforcement can use a search warrant to photograph these marks. In addition, law enforcement can use search warrants to collect DNA evidence from the alleged perpetrator. A law enforcement officer may conduct a warrantless search, however, in certain circumstances, such as if he finds an injured or deceased child and is looking for other victims or the perpetrator, or if he is ensuring public and officer safety.[106]

To gather enough information to establish probable cause to obtain a search warrant, the law enforcement officer may need to obtain consent to access the crime scene and collect "plain view" evidence. The plain view doctrine states that an officer may collect evidence when the officer has lawful access to the scene, the object is in plain view, and its incriminating nature is immediately apparent.[107] The law enforcement officer should attempt to gain written consent from the appropriate person to view the area and, once received, ask family members or other witnesses to give a tour of the scene and provide information such as routines, sleeping arrangements, and disciplinary methods. If consent is not given or is withdrawn, the first responder should discontinue the search.[108]

The evidence seized through the use of search warrants can be essential for corroborating the victim's statements. It also is advisable to photograph or to videotape the location of a search prior, during, and after the search is conducted. This is important for protecting investigators from later claims that they damaged property or planted evidence and for documenting where certain pieces of evidence were found.[109]

Although CPS caseworkers are often key personnel in child maltreatment responses and investigations, they do not have the same authority as a law enforcement officer to enter a home or conduct a search. Caseworker authority varies by jurisdiction and agency, but the following are common elements:

- Caseworkers can interview individuals involved in the case (e.g., the child, family members, the reporter, teachers, neighbors) and can interview the child without the parents being present.
- In some cases, parents can refuse entry of the caseworker into their home. The caseworker, however, can request the assistance of the court or law enforcement to gain entry.
- If the initial report or information gained during the CPS investigation indicates that there has been criminal conduct, the caseworker may need to file a cross-report to the appropriate law enforcement agency or prosecutor's office to initiate a criminal investigation.
- A child may not be removed from his home without a court order. To receive a court order, the agency must file a petition, and a hearing must be held. An exception is made, however, when CPS determines that the child's living conditions place him in *imminent threat* of substantial physical harm. In those cases, the caseworker may proceed with an emergency removal and then schedule a court hearing as soon as possible (usually within 72 hours) to sustain the action.

- Examine the relationships among the risk factors and determine if, when combined, they increase safety concerns
- Determine whether family members or other community partners are able to address safety concerns without CPS intervention
- Consider the services required to address the specific behaviors or conditions for each risk factor directly affecting the child's safety
- Identify who is available (e.g., CPS, other community partners) to provide the needed services or interventions in the frequency, timeframe, and duration required by the family to protect the child
- Evaluate the family's willingness to accept—and its ability to use—the intervention or services at the level needed to protect the child.[110]

Sometimes services or interventions are not available or accessible at the level needed or within the timeframe necessary to protect the child, or the caregivers are unable or unwilling to accept the services. In these cases, the first responder should consider whether the offending caregiver should be asked or be required to leave the home and if the nonoffending caregiver can protect the child. If not, the first responder should consider whether out-of-home care and court intervention are needed to ensure the child's protection. In either case, the first responder should develop a safety plan for the child.

Developing a Safety Plan

When there is an imminent risk of moderate to serious harm to the child, the first responder should develop a safety plan with the child and, if appropriate, with the family. The plan should include interventions that:

- Have a direct and immediate impact on one or more of the risk factors determined during the assessment to cause the child to be unsafe, such as removal of the alleged perpetrator
- Are accessible to the family
- Are available in the frequency and for the duration with which they are needed to control the risk factors
- Fill the gaps in the caregiver's protective factors and strengths in order to ensure the child's protection.[111]

When possible, the first responder should conduct the safety assessment jointly with the nonoffending caregiver and the child, if age appropriate. By jointly developing a safety plan, the first responder and the caregiver can assess the feasibility of the caregiver carrying out the safety plan.

Understanding the Next Steps

When a report of child maltreatment is filed, possibly by a first responder, CPS makes several decisions. First, CPS must decide if the report meets the statutory criteria for child abuse or neglect, which may vary by jurisdiction. Then, it must investigate to ascertain if the maltreatment can be substantiated. CPS will interview the child if he is old enough to respond to questions, even if he had already been interviewed by another first responder. CPS will then contact the family and others who may have additional information about the incident. CPS typically will make one of two findings—substantiated or unsubstantiated. A substantiated finding means that there is sufficient evidence to prove that an incident of abuse or neglect occurred. A finding of unsubstantiated means that there is

For more information on conducting assessments and investigations, see *Child Protective Services: A Guide for Caseworkers* at **http://www.childwelfare.gov/pubs/usermanuals/cps/index.cfm**.

insufficient evidence to conclude that a child was abused or neglected, but it does not always mean that maltreatment did not occur. Some States may have a third category—inconclusive, unable to determine, or unfounded. CPS also determines if the child is safe in the home and, if not, what the least intrusive interventions are to ensure the child's safety. Finally, CPS determines if there is a risk of maltreatment occurring in the future. If a risk of abuse or neglect exists, CPS must offer or provide services to reduce the risk. Exhibit 3-5 provides an overview of the CPS process.

In some States, the court system may become involved, particularly if the child is removed from the home. A juvenile or family court usually is responsible for cases involving child maltreatment. In cases of sexual abuse, extreme physical abuse, or death, however, complaints increasingly are filed in criminal court. In some instances, the first responder may be asked to appear in court as a witness. This is discussed in more depth in Chapter 4, *Testifying in Court*.

Reasonable Efforts to Keep a Family Together

When CPS workers identify safety interventions and develop safety plans, they are required to make "reasonable efforts" to keep families together, when safe and appropriate. This means that CPS workers must exhaust all the less intrusive methods of ensuring child safety before moving to more intrusive methods. The sequence of least intrusive safety interventions is:

- In-home services, perhaps combined with partial out-of-home services (e.g., daycare services)
- The removal of the offending caregiver
- Relative or kinship care
- Out-of-home placement.

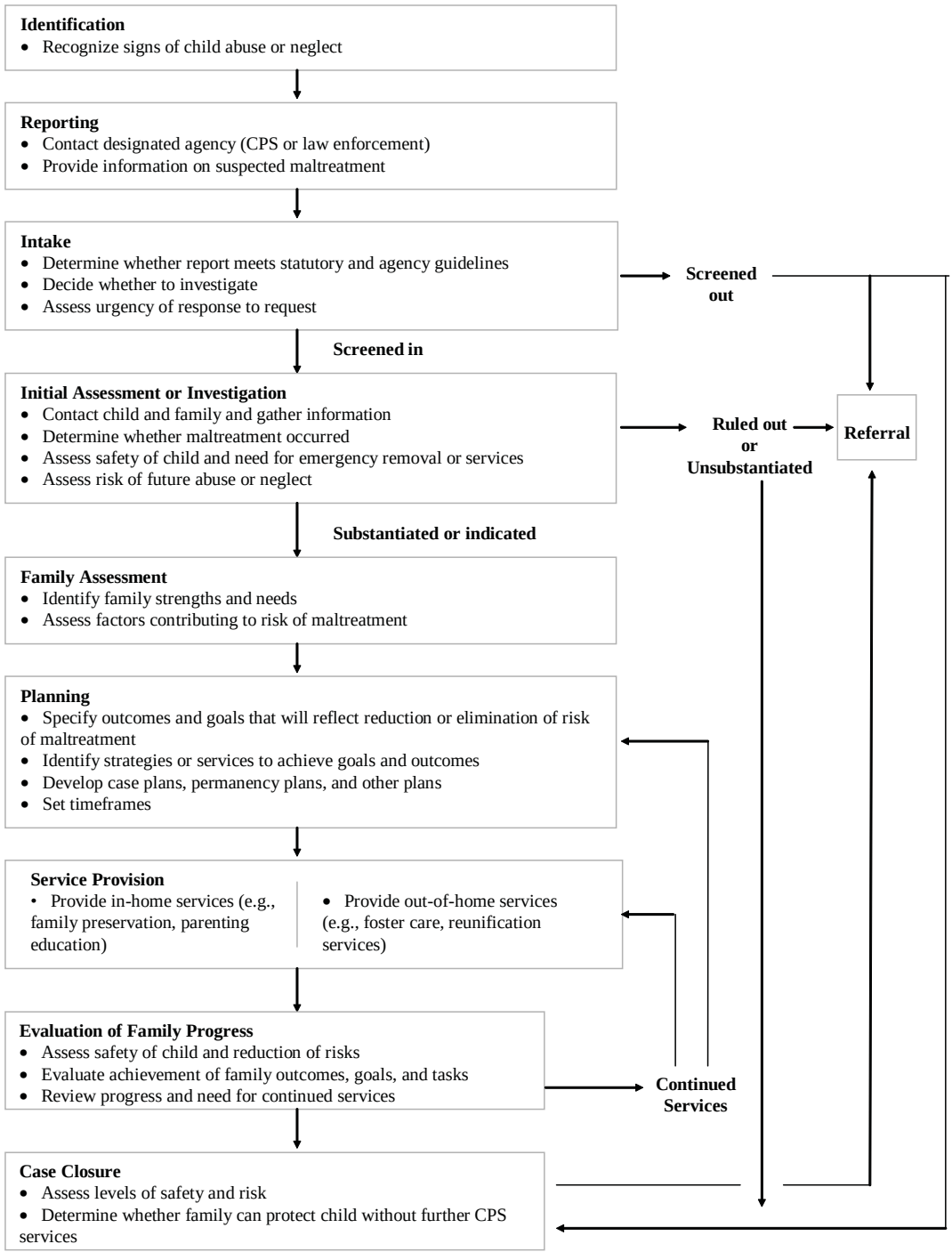
Most States indicate that when certain factors are present in a case, they constitute enough of a threat to a child's safety that reasonable efforts are not required to prevent placement. These factors may include:

- Abandonment
- Torture
- Chronic abuse or neglect
- Some forms of sexual abuse
- Killing of another person or the child's sibling
- Having had parental rights terminated for another child.

First responders should become familiar with the exceptions that apply in their jurisdictions.

First responders must be aware of their surroundings when responding to possible cases of child maltreatment and ensure that they are safe. See Appendix L, *Home Visit Safety Tips*, for information about enhancing safety during response and investigation.

Exhibit 3-5
Overview of the CPS Process



The Role of First Responders in Investigating Child Fatalities

When a child fatality occurs, the role of law enforcement is to investigate the cause of death, to determine if a crime took place and, if so, who is responsible. It is important that all sudden and unexplained deaths be investigated so that innocent people can be cleared of suspicion or any guilty individuals can be caught. CPS often is involved in child fatality investigations when a parent or other household member is a suspect. The role of CPS in child fatality cases is to help determine if child maltreatment was involved, to determine who was responsible for the maltreatment, and to ensure the safety of other children in the household. Law enforcement, however, should be the lead agency in child fatality investigations.[112]

Medical personnel are required to contact law enforcement immediately if they suspect that a child fatality may have resulted from child maltreatment, but they should not let the parents know of their suspicions. (For more information about which individuals are required to report suspected child maltreatment, visit Child Welfare Information Gateway at **http://www.childwelfare.gov/systemwide/laws_policies/state/**.) Medical personnel also should take note of any statements made by the parents or other caretakers and pass these along to law enforcement officers.

It is important that first responders be both thorough and sensitive when conducting investigations of child fatalities. The child may have died accidentally or as a result of a medical condition, and it is important not to traumatize the parents further. First responders should balance this sensitivity, however, with the need to conduct a thorough investigation. Law enforcement should approach every child fatality investigation with one of the hypotheses being that the child was the victim of maltreatment.[113] This will help to ensure that evidence is collected properly and that a thorough investigation is conducted. First responders can explain to the parents that causes of death can only be determined through an investigation and that the investigation, including postmortem examination and clinical history reviews, will help them understand how their child died and how that may affect others in their family (e.g., if there is a genetic medical condition).[114]

When investigating child fatalities, first responders should keep in mind several important issues, including:

- There often is a delay between the incident of maltreatment and the death of the child. This may be even more likely if the child suffered from head trauma or internal injuries to the chest or abdomen.
- Child fatalities often occur in the child's home and have no witnesses.
- The weapons used in child maltreatment fatalities usually are not traditional weapons, such as knives or firearms, but are more often hands, feet, household items, or scalding water.
- Evidence in the house, such as fingerprints or DNA, is not always helpful if it was a household member who fatally maltreated the child. This is because that person normally would touch items in the house.
- The victim may have suffered from internal injuries, which are not readily apparent upon initial investigation. Some injuries only can be determined by the use of x-rays, MRIs, and CT scans.
- Suspicion of maltreatment initially should not be communicated to the family or to any witnesses, friends, or relatives.[115]

The Role of First Responders in Investigating Child Fatalities (continued)

In cases of an infant death, first responders should take note of the position of the infant, marks on the body, body temperature, the type of crib and any defects, the amount and placement of clothing and bedding, the room's temperature, the type of ventilation and heating, and the reaction of the caregivers.[116] This information can help determine whether the infant death was caused by child maltreatment, a medical condition, an accident, or is unexplained (i.e., sudden infant death syndrome).

For child fatalities that lack witnesses, it is important to establish that the suspect was the only person with the child at the time the injury occurred and that the injury was not accidental. Additionally, in cases in which a child may have died from lack of supervision, it is important to obtain evidence that establishes that the caretaker did not provide reasonable supervision and that this lack of supervision resulted in the death of the child.[117] First responders also should take into account the possibility that another child in the house caused the victim's death.[118]

In addition to a criminal investigation into the child's death, most States have some type of child fatality review team to examine deaths that occurred or may have occurred due to child maltreatment. Child deaths also may be reviewed by internal agency committees, coroners' inquests, or the courts. Child welfare workers who have a case that is reviewed may experience increased stress caused by factors such as re-exposure to the traumatic event, the intensity of the review, and the critical nature of the inquiry (i.e., perceiving the agency or team as finding fault with how they responded to the case).[119]

For additional information on investigating child fatalities, visit **http://www.ncjrs.gov/pdffiles1/ojjdp/209764.pdf**. For more information about investigating the death of an infant, see Appendix H, *Criteria for Distinguishing SIDS from Fatal Child Maltreatment*.

Appendix M, *Case Studies*, provides examples of how first responders can respond to cases of physical neglect, environmental neglect, physical abuse, and sexual abuse. Appendix D, *Reference Guide for Responding to Cases of Suspected Child Maltreatment*, is a handy format that highlights many of the topics covered in this manual.

CHAPTER 4
Testifying In Court

In This Chapter

- Preparing for court
- Guidelines for testifying
- What to expect during the trial
- The juvenile court process
- The criminal court process

First responders often are required to testify in court about cases of suspected child maltreatment. This provides them with an opportunity to present the information and evidence they have collected during their response and investigation. Testifying in court can be an intimidating experience for those who are new to it, as well as for those who have testified many times. This chapter provides an overview of the court process.

Preparation for Court

The most basic rule for testifying is to show up to court on time, well-groomed, and dressed appropriately. The first responder should wear clean and professional clothing. Prior to attending court, the first responder should ensure that the case file is organized, complete, and current. This includes making certain that the evidence and interview logs are complete and include information on dates, times, and locations. The first responder should thoroughly review and be familiar with the information in the case file. Prior to the trial, the prosecutor might meet with the first responder to discuss the case and prepare the first responder for possible questions. It is helpful to prosecutors to know the first responder's answers to questions prior to asking them in court.

During the Trial

The prosecuting party, which might be called the prosecutor, District Attorney, Commonwealth Attorney, Corporation Counsel, or State's Attorney, may question first responders in several stages, including direct examination, cross-examination, and rebuttal examination. This questioning generally is open-ended. This allows the witness to explain the answers fully in order to present the court with evidence to support that party's position. Direct examination usually includes the following:

- The witness's name is called, and then she approaches the witness stand
- She takes an oath and swears to answer truthfully
- The attorney may ask for the following:
  - The witness's name, occupation, and place of employment
  - The length of time at her current job, title, and type of work

Guidelines for Testifying

The following are guidelines to testifying in court:

- **Be prepared.** Have a thorough knowledge of the case. This will help the first responder to be more confident and more persuasive.
- **Listen to each question and pause before answering.** The first responder should not let the attorney rush her.
- **Ask for clarification if needed.** If the first responder is asked a question she does not understand, she should have the attorney repeat, clarify, or rephrase it.
- **Answer only the question asked.** The first responder should not volunteer additional information or discuss tangential subjects.
- **Do not be afraid to respond "I don't know."** If the first responder does not know the answer to a question, she should not be afraid to say so. This may enhance the first responder's credibility.
- **Do not give an opinion unless asked to do so.** The first responder should only testify to the facts within her personal knowledge and experience. She should be specific and give exact times and dates. She should describe events step-by-step rather than narrate long stories.
- **Avoid taking sides.** The first responder's responsibility is to present the evidence truthfully and accurately.
- **Speak a little louder, slower, and more distinctly than normal.** This helps the judge, attorneys, and others to understand the responses. The answer must be spoken; the first responder should not shrug her shoulders or nod her head.
- **Make eye contact.** If a jury is present, the first responder should make eye contact with them while answering questions.
- **Use an open body posture.** The first responder should keep her hands on the witness table for the jury to view. This gives an open, truthful, and confident appearance.
- **Use appropriate language.** Never use professional jargon or slang.
- **Always tell the truth.** The first responder should not compromise her credibility.[120]

  - Her job qualifications
  - How she knows the child or family
  - What happened at specific times and places
  - Any other pertinent information.

During the direct examination, it is important that the first responder carefully listen to all questions that are asked and to request clarification if a question is not fully understood. The first responder should be polite and respectful to all court personnel. Additionally, the first responder should be aware that she is not expected to know the answers to every question. If the first responder does not know or remember the answer, she should state this. It is important to be honest. Mistakes may be made in any investigation, and the first responder should not attempt to cover up these mistakes.[121]

After direct examination, the first responder is subjected to cross-examination, which usually is conducted by the alleged offender's attorney. The purpose of cross-examination is to find inconsistencies or fault in the first responder's testimony and to expose

any weaknesses. The attorney typically uses closed-ended questions that require a yes or no response. If the first responder tries to give a more complete, explanatory answer, it usually is not allowed. Being cross-examined can be one of the most difficult parts of testifying. Typically, the attorney tries to cast doubt on the thoroughness of the investigation and the first responder's interpretation of the facts. The attorney also may allude to the possibility that the judgment and the actions of the first responder were clouded by her opinions about the alleged offender. The first responder should not become angered by statements made by the defense team and should stay in control of her emotions at all times. She should remember not to take the cross-examination personally; the defense attorney is doing his job.

Defense attorneys use various techniques during cross-examination. If the first responder understands these techniques, it will be easier to keep her poise when answering questions. Exhibit 4-1 describes common techniques used during cross-examination.

If the prosecutor believes that a rebuttal is needed after the cross-examination, he will conduct a redirect examination. The focus of the redirect examination is to address issues raised on cross-examination that need to be cleared up or answered more completely.

The Juvenile Court Process

Juvenile courts typically hear cases of child maltreatment, delinquency, and status offenses (i.e., cases in which an action is a crime only if the offender is a minor, such as underage drinking), as well as those involving adoptions and terminations of parental rights (TPRs). In alleged child maltreatment

Exhibit 4-1
Types of Questions Used During Cross-Examination

The following are types of questions that attorneys may use strategically during cross-examination:

- **Leading Questions.** A leading question suggests by its wording that the answer should be either yes or no and has wording that attempts to guide the first responder's answer. For example, in a neglect case where one of the allegations is that a baby was left at home without adult supervision, the defense attorney might ask, "Isn't it true that the baby's 14-year-old sister was in the home whenever the mother went out?" In this case, the answer may be yes, but the first responder may want to explain that the sister is not mature enough to care for the baby. The first responder usually will be allowed to explain an answer when only a yes or a no would be misleading. If this is the case, the first responder should begin her response by saying that the question requires an explanation rather than by answering yes or no and then trying to explain. If the attorney insists on a yes or no response, the first responder should turn to the judge and ask if she may continue. If the explanation is not permitted, the prosecutor can give the first responder an opportunity to give a complete answer during redirect testimony.
- **Rapid-fire questions.** The defense attorney hopes to confuse or to upset the witness by asking a string of leading questions in rapid succession (e.g., "Isn't it true that there were other adults in the house at the time of the maltreatment? Isn't it true that they could have committed the abuse? Was it your bias toward my client that made him the primary suspect?"). Since each question requires an answer, the first responder has control over the pace of the response. The first responder should pause to think about each question before answering. The first responder should also ask for the question to be repeated or clarified if necessary.
- **Compound questions**. The first responder may be asked a question that contains multiple parts. For example, "You saw the bruises on the child and the belt in the living room and assumed that the father caused the bruises, isn't that true?" The prosecutor should object to the question. If the prosecutor does not object, the first responder should say that he does not understand the question and that it requires a two-part answer or request that the question be repeated. Witnesses do not have to answer compound questions. [122]

cases, the juvenile court determines whether there was maltreatment, orders any necessary services for children and families, and monitors the interventions. While not all first responders will be involved in all aspects of the juvenile court process, the following sections outline the key stages, which may vary across jurisdictions.

Petition for Removal

A child protection proceeding begins with the filing of a petition for removal, which contains the key facts of the child maltreatment case. In most States, only child protective services (CPS) can file the petition, but some also permit other public officials or private citizens to do so. Once the petition is filed, it must be served (presented) to the caretakers accused of maltreatment. Ideally, no child should be removed from a family until after a petition is filed and the court has conducted an initial hearing at which the parents were present and had an opportunity to be heard. In reality, however, most removals are authorized without the parents present, and the first hearing is conducted after the removal has occurred. This may occur in emergency circumstances where the child should be immediately removed from the home for safety reasons. In this case, a petition would be filed after the removal. CPS workers and law enforcement officers should be familiar with the protocols in their jurisdiction.

Initial Hearing

The first event in court after the filing of a petition is the initial hearing. Ideally, it should occur on the first day following the filing of the petition, upon removal of the child, or as soon as possible thereafter. The main purpose of the initial hearing is to determine whether the child should be placed in substitute care or remain with or be returned to the parents pending further proceedings. The critical issue is whether services or other measures can be put in place to ensure the child's safety.

Pretrial Conferences

Some courts use pretrial conferences, also known as settlement conferences, in child maltreatment cases. These are opportunities for the parents, their attorneys, and the child's advocates to discuss a way to settle the case that would make a trial unnecessary. In courts where there are no formal pretrial conferences, these negotiations often occur among attorneys by phone or at the courtroom and as late as right before the scheduled adjudication. The judge may or may not participate, depending on the jurisdiction and the nature of the case, and some judges will initiate such negotiations themselves. It is important, however, that provable allegations of significant child maltreatment not be negotiated away.

Discovery

Discovery is a pretrial process that allows each party to obtain information about the case from the other parties. It is intended to avoid "trial by ambush," to narrow the contested issues, and to expedite settlement. Discovery in child maltreatment cases usually involves the parents' and child's attorneys asking CPS and other relevant agencies for their records. In most States, they are entitled to those records. While details of the initial and investigative reports are revealed, the name of the reporter is not.

Adjudication Hearing

If the case is not settled by agreement of the parties, it will go to adjudication, in which the court decides whether CPS can prove the maltreatment allegations in its petition. The CPS attorney will present evidence through the testimony of the first responders or other witnesses, including any experts. Documents such as medical records or photographs also may be entered into evidence. The attorneys for the parents and the child will have the right to question or cross-examine the witnesses and to present evidence. The parents may testify, as may other family members or neighbors who have knowledge of the facts alleged in

the petition or of the care the parents provided their children.

Disposition Hearing

At the disposition hearing, the court decides whether the child needs help from the court—and, if so, what services will be ordered—as well as whether the child should be:

- Left with or returned to the parents, usually under CPS supervision
- Kept in an existing placement
- Moved to a new placement
- Placed in substitute care for the first time if removal was not ordered previously.

The court also may enter orders providing for visitation schedules or for controlling the conduct of the parent (e.g., having supervised visits, mandating counseling). It also can order CPS to conduct follow-up visits with the family to ensure the child's protection. As a part of the preparation process for this hearing, CPS should talk with the parents and develop with them a case plan for the family. In some States, the court must approve the case plan. In all States, the plan must be discussed and refined at the disposition hearing, and any disagreements regarding its terms must be resolved.

Review Hearing

The review hearing is an opportunity to evaluate the progress that has been made toward completing the case plan and any court orders and to revise the plan as needed. If no progress has been made, and none seems likely, it is a chance to change the goal of the plan. For example, it may not be possible to reunite the child with his family because the parents have repeatedly not complied with their drug treatment requirements, which indicates that they would not safely be able to care for the child. Therefore, alternative options must be explored. Review hearings should guide the case to permanency for the child. Unless a permanent placement is accomplished on or before the date of the permanency hearing, the court must continue to review the case periodically.

Permanency Hearing

The permanency hearing is the point at which a definitive decision is made about the child's permanent placement. In making this determination, the court must weigh which option is in the child's best interest.[123] In some cases, concurrent planning may be pursued. Under concurrent planning, an alternative, permanent placement is developed at the same time as family reunification is attempted. With this approach, the child can be moved quickly to a stable home if reunification with the birth family cannot take place.

Termination of Parental Rights

Because the stakes are so high, TPR hearings are the most formal, longest, and frequently appealed of all child maltreatment proceedings. Biological parents whose parental rights are terminated as a result of child maltreatment have no right to have contact with the child, knowledge of the child's whereabouts, pictures of the child, or information regarding the child. In addition to losing legal rights to the child, parents whose rights have been terminated generally have no further responsibilities to the child, except to pay child support that is past due. The grounds for TPR are specified in the statutes of each State, and CPS caseworkers are advised to familiarize themselves with these. Federal statutes also describe specific situations, such as when a parent has murdered a child's sibling, in which CPS must file a TPR petition.

Adoptions

A child is eligible to be adopted once the TPR is granted by the courts. In most States, the case remains involved with the juvenile court during and after the adoption process to ensure that CPS is complying with

the requirements of the Adoption and Safe Families Act, incorporating Federal adoption legislation into practice, and accessing a variety of adoption subsidies and post-adoption services for eligible children.

Appeals

Parents and CPS have the right to appeal some decisions of the juvenile court in child abuse and neglect and TPR cases. At the very least, they have the right to appeal at the conclusion of any adjudication, disposition, or TPR trial. Some States may allow appeals from other trial court orders or decisions, but generally, only final decisions are appealed or accepted for appellate review.

The Criminal Court Process

Some cases of child abuse or neglect may be heard in criminal courts because they constitute a crime, as defined by the State. Cases typically heard in criminal courts include sex offenses or those that result in the death of, or serious injury to, a child. However, not all cases that are considered criminal are tried in the criminal courts due to a number of reasons, such as whether the criminal case would interfere with rehabilitating the family or the possibility of traumatizing the child further by having him testify. As with the juvenile court process, first responders may not be involved in all aspects of the criminal court process. Though the criminal court process may vary across jurisdictions, the following is an outline of the key stages.

Arrest, Bail, and Other Conditions of Release

Criminal prosecutions most commonly begin with an arrest. The defendant then is brought before a judicial officer (a judge, magistrate, or commissioner) who informs him of the charges against him and determines the conditions of his release pending trial. The defendant will be notified of the conditions that must be met to be released from police custody before the trial. A defendant with a stable residence and employment history and no significant prior record often is released on his own recognizance or with a written promise to appear at subsequent court dates. For a defendant who seems less reliable, a cash bond may be required. The defendant can post the full amount of the bond in cash or property or secure a bondsman for a percentage of that amount. If the defendant flees, the bondsman is obligated to pay the full amount of the bond. The judge also has the discretion to impose other conditions of release, including the defendant having no contact with the child or other parent or not returning to the residence. In some cases, the judge may decide to hold the defendant without bail pending trial.

Preliminary Hearings

The purpose of a preliminary hearing is to determine whether there is probable cause to believe that the defendant committed the alleged offense and that he should be tried on that charge. If the judge finds no probable cause, the case will be dismissed. If the judge finds probable cause, the case will be transferred to the trial court for resolution.

Witnesses, including first responders, sometimes are called to testify and are cross-examined at preliminary hearings. In some States, evidence of criminal conduct by the defendant is presented at a preliminary hearing to a grand jury instead of a judge. The grand jury then determines whether the evidence is sufficient to constitute probable cause. If so, the grand jury will issue an indictment that puts the case before the trial court. Only the prosecutor and the State's witnesses, usually the investigating law enforcement officer, appear before the grand jury. Neither the defendant nor the defense attorney has the right to be present at that proceeding.

Discovery

Discovery refers to the process of obtaining information about the charge from the opposing party and, at times, other sources. In some States, the defendant may be entitled to access first responders' records, particularly if they contain information or evidence that may be helpful to the defense. For the most part, the reporter's identity is not released, but, in some jurisdictions, the reporter's identity can be released to certain departments or under specific circumstances (e.g., the reporter made a knowingly false report).[124]

Plea Bargaining

Plea bargaining is a negotiated resolution that avoids trial and concludes the case. Without it, courts could not handle on a timely basis all the cases to be tried. Plea bargaining has the added benefit in child abuse and neglect cases of eliminating the need for the child to testify and of speeding the resolution of the case, both of which relieve the child's anxiety. Nevertheless, there also may be negative consequences to a plea bargain. Depending on the sentence, the child victim may feel betrayed, disbelieved, or unsafe. In addition, the public may perceive that child maltreatment is not taken as seriously as other crimes.

Trial

If no plea bargain is reached, the case goes to trial. In a criminal trial, the rules of evidence are applied strictly, and the prosecutor has a greater burden of proof. In order to convict, the jurors must unanimously find "beyond a reasonable doubt" that the defendant committed the alleged offense (i.e., there is no other logical explanation). This is a much higher burden of proof than the "clear and convincing evidence" standard (i.e., it is highly probable) in termination of parental rights trials in some States. It is higher still than the "preponderance or greater weight of the evidence" standard (i.e., there is more evidence supporting one side of the case) in civil cases generally and in child abuse and neglect cases in some States.

The criminal court case may be concluded well after the disposition hearing in the child abuse and neglect case, in which the court decides if the child needs help from the court and, if so, what services will be provided. Additionally, the outcome of the criminal court case can be inconsistent with the case plan and the best resolution of the child abuse and neglect case. The opposite also can be true, and the criminal sentence can augment and enhance the case plan and the prospects for a positive outcome. In communities where the same prosecutor represents the public interest in both criminal and child abuse and neglect cases, there is greater likelihood of a coordinated approach to resolving both matters.

The previous sections on the juvenile and criminal court processes were adapted from Chapter 4 of *Working with the Courts in Child Protection*, which can be found in its entirety at **http://www.childwelfare.gov/pubs/usermanuals/courts/**. For additional information about legal issues related to child welfare, visit the website of the National Child Welfare Resource Center on Legal and Judicial Issues at **http://www.abanet.org/child/rclji/courtimp.html**, the website of the National Council of Juvenile and Family Court Judges at **http://www.ncjfcj.org/**, and Child Welfare Information Gateway at **http://www.childwelfare.gov/systemwide/courts/**.

CHAPTER 5
Responding in Disasters

In This Chapter

- Factors for first responders
  - Child responses to disasters or other trauma
  - Self-care
- Agency preparation
- Agency response

Responding to a case of possible child maltreatment can be complex and stressful. The difficulty of this situation can be compounded in the midst of or directly after an emergency, such as natural disasters (e.g., hurricanes, floods), manmade disasters (e.g., terrorist attacks, hazardous materials), or urgent medical emergencies (e.g., outbreaks of infectious disease). As communities try to cope during or in the aftermath of a disaster, some individuals may react in ways that could harm themselves and others. Some studies have shown increases in rates of child maltreatment and domestic violence after disasters.[125] Additionally, there may be a short-term increase in alcohol and drug abuse, which increases the risk for child maltreatment, among other social problems (e.g., domestic violence, driving under the influence).

Although much of the information provided in this manual can be applicable in disasters, first responders will have other factors to consider as they respond to possible cases of child maltreatment during disasters. These factors include more pronounced immediate safety concerns, being unable to communicate with their agency or other agencies or service providers, and additional emotional trauma, both for the alleged victim and the first responder. This chapter provides information about the additional factors that first responders should consider, as well as ways first responder agencies can better prepare for disasters.

Factors for First Responders

Although no one can prepare for all the situations that may arise during a disaster, research and reports from the field can provide first responders with information that may assist them if a disaster were to occur. This section highlights issues, such as child responses to trauma and disaster, self-care, and changes a community may experience post-disaster, to help first responders prepare for and respond to a disaster.

Child Responses to Disasters or Other Trauma

Children may react to trauma, such as disasters, immediately or days or even weeks later. Many children experience a loss of trust in adults or a fear that the event may occur again. The following describes reactions children and adolescents may have, according to their age, either immediately or some time after a traumatic event:

Ages 5 years and younger. Reactions may include a fear of being separated from the parent, crying, whimpering, screaming, immobility or aimless motion, trembling, frightened facial expressions, excessive clinging, and regressive behaviors (e.g., thumb-sucking, bedwetting, fear of darkness). Children at this age tend to be strongly affected by their parents' reactions to the traumatic event.

Ages 6 to 11 years. Reactions may include extreme withdrawal, disruptive behavior, inability to pay attention, regressive behaviors, nightmares, sleep problems, irrational fears, irritability, problems in school, outbursts of anger and fighting, complaints of stomachaches or other bodily symptoms that have no medical basis, depression, anxiety, and feelings of guilt and emotional numbing or "flatness."

Ages 12 to 17 years. Reactions may be similar to those of adults and include flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, antisocial behavior, withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, confusion, extreme guilt over perceived failure to prevent injury or loss of life, and revenge fantasies.[126]

Children may react differently to disasters or other trauma based on the characteristics of the event, the child, and the child's family and community. See Exhibit 5-1 for more details on these characteristics.

The disaster may interfere with first responders' capacity to respond to the suspected child maltreatment in the manner described previously in this manual. They may need to adjust their response based on the particular circumstances of the maltreatment and disaster. Conducting a full investigation of possible child maltreatment may not be possible during a disaster, but the following are ways a first responder can assist children during a disaster:

- Protect the children from
  - Further harm
  - Traumatic sites and sounds
  - Onlookers and media
- Be kind, but firm, in directing them
  - Away from the disaster site
  - Away from injured survivors
- Keep children together with family and friends (when this will not compromise the safety of the child)
- Identify children in acute distress
  - Stay with them until they are calm
  - Recognize they may tremble, ramble, become mute, or exhibit erratic behavior, including rage, loud crying, or remaining completely still

Exhibit 5-1
Experiencing Disasters: The Risk of Trauma-related Problems[127]

The following characteristics influence to what extent a child may experience problems after a disaster or other traumatic event:

	Characteristic of the Event	Characteristic of the Individual	Characteristic of the Family and Community
Increase risk of trauma-related problems	• Includes multiple or repeated events (e.g., numerous aftershocks, ongoing domestic violence or physical abuse) • Causes physical injury to the child • Involves physical injury or death to a loved one, particularly the mother • Results in dismembered, dead, or disfigured bodies • Destroys home, school, or community • Disrupts community infrastructure (e.g., a hurricane) • Is perpetrated by a family member • Has a long duration (e.g., flood).	• Is female • Is a younger child (the younger the child, the more vulnerable) • Has a subjective perception of physical harm • Has a history of previous exposure to trauma • Has no cultural or religious anchors • Has no shared experience with peers (experiential isolation) • Has a low IQ • Has a pre-existing psychiatric disorder (especially anxiety related).	• Affected directly by the trauma • Are anxious (primary caregivers) • Are continually threatened and disrupted • Are chaotic or overwhelmed • Are physically isolated • Are distant or absent (caregivers).
Decrease risk of trauma-related problems	• Is a single event • Perpetrated by a stranger • Does not disrupt family or community structure • Has a short duration (e.g., tornado).	• Is cognitively capable of understanding abstract concepts • Has healthy coping skills • Is educated about normative posttraumatic responses • Receives immediate posttraumatic interventions • Has strong cultural or religious belief systems.	• Are intact and nurturing • Have not been traumatized (caregivers) • Are educated about normative posttraumatic responses • Have strong cultural and religious belief system • Possess mature and attuned parenting skills.

- Be tolerant of difficult behavior and strong emotions
- Act in a way that supports and reassures the child.[128]

First responders also can help children or adults address immediate needs or concerns (e.g., obtaining food or shelter, finding a family member) by guiding them in:

- Identifying the most immediate needs or concerns
- Discussing an action plan and setting reasonable goals
- Taking action to address the need.

Aside from meeting immediate needs or concerns, this process can also help individuals, including first responders, cope with feelings of loss of control or failure.[129]

First responders who encounter a child who is emotionally overwhelmed (e.g., appears disoriented, is unresponsive, is uncontrollably shaking) can attempt to stabilize and orient the child. Being with a parent or other family member who is calm and coping well is an important way to help calm a child. If the child's family is unavailable, or if they appear to be emotionally overwhelmed and not able to calm the child, first responders can try to stabilize them using a "grounding" technique (i.e., helping them focus on nondistressing thoughts or things outside of themselves). First responders should request that the distressed individual:

- Sit in a comfortable position
- Breathe in and out slowly and deeply throughout the process
- Name five nondistressing items he can see (e.g., a table, a cloud)
- Name five nondistressing sounds he can hear (e.g., his own breathing, the wind blowing)
- Name five nondistressing things he can feel (e.g., the blanket on his body, his feet against the floor).[130]

If first responders are attempting to ground younger children, they can make alternative, more developmentally appropriate requests, such as naming five colors they can see or imagining a favorite playground or storybook character. If this process does not calm the individual, first responders should consult with medical or mental health professionals.[131]

Psychological First Aid

The National Child Traumatic Stress Network and the National Center for PTSD (Post-Traumatic Stress Disorder) developed the *Psychological First Aid (PFA) Field Operations Guide* to assist mental health and other disaster response workers who provide early assistance to children and adults affected by a disaster or other emergency. Basic objectives of PFA include:

- Enhancing immediate and ongoing safety
- Calming and emotionally orienting overwhelmed and distraught survivors
- Offering practical information and assistance to meet survivors' immediate needs and concerns
- Connecting survivors as soon as possible with social support networks
- Providing information that may help survivors cope effectively with the psychological impact of the disaster.[132]

Appendix N features the *Assessing Disaster Survivor Immediate Needs Worksheet* from this guide. The complete guide can be found at **http://www.nctsnet.org/nctsn_assets/pdfs/pfa/2/PsyFirstAid.pdf**.

For additional information about providing services to children affected by disasters, visit the Child Welfare Information Gateway website at **http://www.childwelfare.gov/management/disaster_preparedness/**.

Self-care for First Responders

In addition to ensuring the safety of children and families, first responders should ensure that they are taking care of their own mental and physical health and safety throughout and after their work during disasters, during which a "normal" case may be compounded by mass casualties, destruction, chaos, or other impending danger. (Note: Some of this information also will be applicable for nondisaster situations, when responding to possible cases of child maltreatment may also be stressful and emotional for the first responder.) Responding during a disaster can affect an individual's mental and physical health immediately or days, weeks, or months after the event.

The stress of working during a disaster takes a toll on first responders. Being involved in a disaster undoubtedly will affect an individual, and first responders may exhibit normal feelings and reactions, such as:

- Being profoundly sad, grief stricken, and angry
- Not wanting to leave the scene until the work is finished
- Trying to override stress and fatigue with dedication and commitment
- Denying the need for rest and recovery time.[133]

First responders also may exhibit stress symptoms during or after the disaster that disrupt their normal life and for which they should seek assistance. Exhibit 5-2 lists some of these symptoms.

While responding during a disaster, first responders can take several steps to help them stay focused and manage their stress, including:

- Pacing themselves
- Taking frequent breaks, when appropriate

Exhibit 5-2
Stress Symptoms That May Be Experienced by First Responders in Disasters[134]

Physical	Cognitive	Emotional	Behavioral
• Chest pain*	• Confusion	• Anxiety	• Intense anger
• Difficulty breathing*	• Nightmares	• Guilt	• Withdrawal
• Shock symptoms*	• Disorientation	• Grief	• Emotional outburst
• Fatigue	• Heightened or lowered alertness	• Denial	• Temporary loss or increase of appetite
• Nausea/vomiting	• Poor concentration	• Severe panic (rare)	• Excessive alcohol consumption
• Dizziness	• Memory problems	• Fear	• Inability to rest
• Profuse sweating	• Poor problem solving	• Irritability	• Change in sexual functioning
• Rapid heart rate	• Difficulty identifying familiar objects or people	• Loss of emotional control	
• Thirst		• Depression	
• Headaches		• Sense of failure	
• Visual difficulties		• Feeling overwhelmed	
• Clenching of jaw		• Blaming others or self	
• Nonspecific aches and pains			

* Seek medical attention immediately if you experience these. Symptoms of shock include shallow breathing, rapid or weak pulse, nausea, shivering, pale and moist skin, mental confusion, and dilated pupils.

- Taking care of each other
- Eating and drinking enough
- Communicating with loved ones
- Recognizing and accepting their limitations
- Limiting on-duty rotations to 12 hours per day, if possible
- Using counseling assistance programs, if available
- Participating in memorials, rituals, or other methods of expressing their feelings.[135]

These steps may vary, of course, depending on the specifics of the disaster.

First responders may have multiple roles during the course of a disaster. In addition to their professional or volunteer role as a first responder, they also may be victims. The first responder agency should recognize that some staff may not be physically or emotionally available to assist with the disaster response because they or their family have been affected and require immediate and long-term assistance.[136]

Agency Preparations

First responder agencies at the Federal, State, and local levels should have plans that outline how their operations will continue or be adapted during and after a disaster or other emergency. This section explores how agencies can prepare for disasters by developing Continuity of Operations Plans (COOPs), coordinating with key partners, and training staff about agency protocols and how to respond.

Assessing Possible Disasters

Before agencies can plan how they will react to a disaster or other emergency, they first must determine what types of events they might need to react to and how those events may affect their operations. Agency staff can develop a list of potential disasters for their area. For example, a large, urban area in the Northeast may want to consider the effects of blizzards, hurricanes, terrorist attacks, or an epidemic and a small, rural community in the Midwest that is adjacent to a chemical plant might be more prone to flooding, tornados, and chemical exposure. This does not mean that agencies should *only* plan for the most obvious types of disasters, but they may want to dedicate more planning time to disasters that are more likely in their area. Additionally, the agency should consider disasters of different scopes (e.g., a localized fire at the child welfare agency versus widespread fires throughout the community). When determining the possible effects of a disaster, the agency should also review how the disaster might affect partner agencies and how that might affect its own ability to provide services.

Developing a Disaster Plan

The disaster plan will assist the agency in continuing to provide services and respond to cases in the event of a disaster. The plan, at a minimum, should contain information about who has the authority to activate the plan, essential functions that should be performed and by whom, the members of the emergency management team, and the communication process.[137] This disaster plan may include a COOP, or the entire plan may be part of a COOP. A COOP outlines how an organization will maintain its essential functions in the event of a disruption or emergency. Appendix O, *Continuity of Operations Plan (COOP) Outline,* is a COOP guide developed by the Federal Emergency Management Agency (FEMA).

An essential component of the planning process is determining how agency files and data can be securely stored and how they can be accessed during or after a disaster. In a review of the challenges encountered

Federal Requirements Regarding Child Welfare Disaster Planning

In 2006, the Child and Family Services Improvement Act (P.L. 109-288) mandated that in order to receive funding, States must describe in their Annual Progress and Services Reports how their child welfare systems would respond to a disaster. Specifically, States must outline how they will:

- Identify, locate, and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster
- Respond to new child welfare cases in areas adversely affected by a disaster and provide services in those cases
- Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster
- Preserve essential program records
- Coordinate services and share information with other States.[138]

and lessons learned about protecting and educating children during and after Hurricanes Katrina and Rita, the U.S. Government Accountability Office (GAO) reported that data and record management was a key issue. Louisiana was in the process of developing a statewide child welfare information system, but it did not have extensive case information in a central database. Accordingly, child welfare agencies had difficulty contacting foster parents because their case records were limited and often inaccessible for weeks after the storm, and some court proceedings related to adoption and reunifications were delayed because records were inaccessible or had to be recreated by the caseworkers from memory.[139]

To prepare for a disaster, agencies should store critical information in a statewide or other central database that is backed up and accessible in an emergency. Information that may need to be accessed in an emergency includes:

- Disaster plan details
- Case and client records
- Contact information for staff, families, providers, and youth
- Human resources information (e.g., employee information, payroll systems).[140]

Agencies may want to assign and set aside time and resources for one person to oversee the development of the disaster plan. This person would be responsible for:

- Ensuring the plan is developed through a collaborative process
- Communicating the plan within the agency and community
- Coordinating the plan with any statewide or other local emergency management processes
- Ensuring agency involvement in any State or local practices or drills
- Reviewing and updating the plan periodically based on stakeholder feedback and changes in policies or circumstances.[141]

Coordinating with Key Partners

As first responders know, disasters rarely affect only one service provider or group within a community. A comprehensive response to a disaster usually will require the assistance of multiple agencies, organizations, and individuals at the local, State, and Federal levels. Working with partners at all levels will help the agency:

Key Questions to Consider When Developing a Disaster Plan

The following are some questions agencies should consider when developing a disaster plan:

- When certifying and approving caregivers, do you ask where they will evacuate to in a disaster and collect that location's contact information?
- Do you know where your workforce will evacuate to during a disaster and collect that location's contact information?
- How often will the agency update the above information?
- Is there a personnel requirement that the agency staff check in within a certain timeframe after a disaster? How would they contact the agency?
- How will the agency transmit information to caregivers and staff (e.g., via a toll-free hotline, website)?
- Can the agency issue paychecks during an emergency? How?
- Are all critical documents in a centralized, accessible system, including documents that might not have originated in the agency but are critical to client well-being and services (e.g., court orders, birth certificates)?
- How will the disaster affect funding levels for the agency?
- How will the agency use the media in getting messages to the public?
- What types of training do staff need?
- How will the agency coordinate volunteers or other outside support?
- What partners should the agency include in the development of its plan?
- Will the disaster in the agency's State or locality affect the service delivery system or assistance provided during and after the disaster by neighboring States and localities?[142]

- Be knowledgeable about emergency response plans at various levels
- Determine how the agency's disaster plan or services may be incorporated into or complement partners' plans
- Clarify the agency's role in the response to a disaster
- Establish who has decision-making authority and in what circumstances
- Share information about who the liaisons between the partners are
- Determine where emergency services are located during a disaster, as well as if and how the agency can assist
- Advocate for the needs of agency clients, staff, and volunteers
- Seek agency participation in emergency response drills
- Establish data-sharing agreements to help locate displaced children and families after a disaster.[143]

It is important that agencies know *before* a disaster occurs which partners they will need to work with and how they will work together. One of the lessons learned from the GAO's review of the response to the Gulf Coast hurricanes was that standing agreements among State child welfare officials and the American Red Cross and FEMA regarding coordination and data sharing could have expedited recovery efforts. For example, GAO reported that by the time Louisiana officials had developed a memorandum of understanding (MOU) with the Red Cross to search its shelters for foster children, the Red Cross had closed its shelters.[144] (For more information about MOUs, see Appendix K, *Memorandum of Understanding*.)

Partnering with Community and Faith-Based Organizations

A recent study about the role of community and faith-based organizations in the responses to Hurricanes Katrina and Rita indicates that it is important to include these organizations in the disaster planning process. Child welfare agencies can determine which community and faith-based organizations are in their area, the nature of their work, their capabilities, how they may fit into the agency disaster response, and prior experience, if any, in disaster planning or response.[145] Then the agency can work with appropriate organizations to craft and revise the disaster response plan and train them in pertinent disaster response methods and issues.

Training Staff

First responder agencies should provide comprehensive training to staff about the agency's response and operations during a disaster. Agencies can provide training to new staff during their orientation and provide ongoing training at regular intervals to existing staff. Additionally, agencies should include contracted staff in disaster preparedness and response training. The following are important topics to cover during these trainings:

- The agency's disaster plan
- How the plan will be adapted to changing circumstances (e.g., in different types and scopes of disasters)
- The emergency management team and the delegation of authority
- The roles and expectations of various staff, including when and how they are to check in with the agency if a disaster occurs
- How to communicate with other staff and agencies during a disaster
- Critical personal and professional items they should have on hand in case a disaster occurs (e.g., flashlight, walking shoes, caseload list).[146]

Agency Response

During a disaster, first responder agencies need to recognize and assess the immediate needs of the community. It is essential that the agencies remain in contact and coordinate their efforts, hopefully following the steps and protocols laid out in their disaster plans. Although much of this information

Disaster Preparation for Children and Families

In addition to ensuring their staff are properly trained for disasters, child welfare agencies should encourage children, youth, and families involved with their agency to develop their own disaster plans that include:

- Where they would go in an evacuation
- Contact information for themselves and an emergency contact
- What they need to take with them (e.g., medication, documents)
- How they will check in with the agency.

Agencies should provide training and information to families about how to develop their plans, what to do in the event of a disaster, and how their children may react.[147]

may already be outlined in their disaster plans, agencies should ensure they are taking the following steps during disasters, where appropriate:

- Establish contact with families, providers, children, and youth in the child welfare system by methods such as operating a call-in line or contacting or coordinating with other systems that may be in contact with them
- Maintain a database to track contact with clients, including whether their whereabouts or conditions are known
- Identify children who are separated from their families
- Conduct an initial assessment of the locations and needs of individuals involved with the child welfare system
- Provide information, support, and services for these families, including what services are available near their current location.[148]

First responder agencies should recognize that their staff will have personal needs during and after a disaster. Agencies can assist their staff by providing additional support, such as flexible hours and making sure their basic needs are met (e.g., advocating for them having priority for emergency housing). Additionally, agencies may want to have counseling available for staff to help them to overcome the stress and emotional toll of the disaster and to process the situation.

In the wake of a disaster, child welfare agencies may want to consider providing additional programs and services to children and families, including:

- Trauma services for children, youth, and families
- Assistance for medically fragile children and their caregivers
- Additional time for service visits
- Child care for families seeking help
- Extra assistance for foster families.[149]

A critical component of an agency's post-disaster plan is determining the strengths and weaknesses of its approach during the disaster. The agency should conduct debriefing sessions to capture information about how the agency responded and if it met the needs of children and families. The debriefing sessions should include managers, staff, clients, partnering agencies, and other stakeholders. Important areas to assess include:

- Service delivery
- Collaboration with partners
- Contracted services
- Communication
- Management of staff
- Information systems.[150]

Reconnecting Families After an Emergency

To assist States, Tribes, counties, and other child welfare agencies in helping families who have become separated during a disaster, the National Resource Center for Child Welfare Data and Technology (NRCCWDT) developed the Reconnect Families Database. This system, which was based on a database application developed in Louisiana after Hurricane Katrina, helps child welfare agencies track children's whereabouts and well-being and identify those who have not yet been reunited with their families. It allows agencies to track children, adult family members, placement providers, and agency workers. Additional information about the Reconnect Families Database can be found on the NRCCWDT website at **http://www.nrccwdt.org/resources/disaster/disaster_db.html**.

The agency should analyze the information gathered during these sessions and use it to amend its disaster plan, as necessary.

Conclusion

First responders play an invaluable role in preventing, identifying, and responding to child maltreatment in both nondisaster and disaster situations. The ability of first responders to assess situations, provide immediate assistance to children and families, conduct interviews, and collect evidence is critical to the successful investigation and, if necessary, prosecution of suspected cases of child abuse and neglect. Since they often respond to and investigate the same cases, it is essential for each type of first responder to understand the roles and responsibilities of the others. By working collaboratively, first responders can enhance outcomes for children and families.

The following documents may be useful in helping child welfare and other agencies prepare for and respond to disasters:

- *Coping with Disasters and Strengthening Systems: A Framework for Child Welfare Agencies* (**http://muskie.usm.maine.edu/helpkids/rcpdfs/copingwithdisasters.pdf**)
- *Disaster Preparedness Resource Guide for Child Welfare Agencies* (**http://www.caseyfoundation.com/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Other/DisasterPreparednessResourceGuideforChildWelf/DisasterPrep.pdf**)
- *Preventing Child Abuse and Neglect in Disaster Emergency Shelters* (**http://www.nrccps.org/resources/disaster_emergency_shelters.php)**
- *Ready for Anything: A Disaster Planning Manual for Runaway and Homeless Youth Programs* (**http://www.ncfy.com/publications/pdf/ready_for_anything.pdf**)

The following organizations offer useful resources that address disaster preparedness and response:

- American Bar Association Center on Children and the Law (**http://www.abanet.org/child/disater/disater_materials.html**)
- National Resource Center for Child Welfare Data and Technology (**http://www.nrccwdt.org/resources/disaster/disaster.html**)
- National Resource Center for Permanency and Family Connections (**http://www.hunter.cuny.edu/socwork/nrcfcpp/disaster_relief.html**).

Endnotes

1 U.S. Department of Health and Human Services, Administration for Children and Families (ACF). (2010). *Child maltreatment 2008*. Available: http://www.acf.hhs.gov/programs/cb/pubs/cm08/index.htm.

2 U.S. Department of Transportation, National Highway Traffic Safety Commission. (1998). *EMT-paramedic national standard curriculum*. Available: http://www.nhtsa.dot.gov/people/injury/ems/EMT-P/disk_1%5B1%5D/.

3 Hammond, B., Lanning, K., Promisel, W., Shepherd, J., & Walsh, B. (2001). *Law enforcement response to child abuse.* Available: http://www.ncjrs.org/pdffiles/162425.pdf.

4 Goldman, J., & Salus, M. K. (2003). *A coordinated response to child abuse and neglect: The foundation for practice*. Available: http://www.childwelfare.gov/pubs/usermanuals/foundation/index.cfm.

5 Child Welfare Information Gateway. (2008a). *Mandatory reporters of child abuse and neglect*. Available: http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm.

6 Goldman, J., & Salus, M. K. (2003).

7 Crosson-Tower, C. (2003).

8 Crosson-Tower, C. (2003). *The role of educators in preventing and responding to child abuse and neglect*. Available: http://www.childwelfare.gov/pubs/usermanuals/educator/index.cfm; Crosson-Tower, C. (2002a). *When children are abused: An educator's guide to intervention*. Boston: Allyn & Bacon.

9 Loiselle, J. (2002). Physical abuse. In A. P. Giardino & E. R. Giardino (Eds.), *Recognition of child abuse for the mandated reporter* (3rd ed., pp. 1–21). St. Louis, MO: G.W. Medical Publishing; Farley, R. H., & Reece, R. M. (2002). *Recognizing when a child's injury or illness is caused by abuse*. Available: http://www.ncjrs.gov/pdffiles1/ojjdp/160938.pdf; Children's Hospital Boston, Child Protective Team. (2004). *Injuries and behaviors indicative of abuse*. Available: http://www.child-protection.org/CPTtext/tProviders/tInjuries.htm; Massachusetts Department of Social Services. (2002). *Investigation training: Evidence and indicators of maltreatment*. Boston: Author.

10 Johnson, C. F. (2002). Physical abuse: Accidental versus intentional trauma in children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 249–268). Thousand Oaks, CA: Sage; Johnson, C. F. (1990). Inflicted injury versus accidental injury. *Pediatric Clinics of North America, 37*, 791–814.

11 Crosson-Tower, C. (2003).

12 Dubowitz, H. (2000). What is child neglect? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 10–14). Thousand Oaks, CA: Sage; DePanfilis, D. (2004). *Child neglect: Working to increase safety and well-being.* Presented at the Meeting of the Family Advocacy Training Section, Soldier & Family Support Branch, Department of Preventive Health Services, Army Medical Department Center & School, San Antonio, TX; Zuravin, S. (2001). Issues pertinent to defining child neglect. In T. D. Morton & B. Salovitz (Eds.), *The CPS response to child neglect: An administrator's guide to theory, policy, program design and case practice* (pp. 2-1–2-

22). Duluth, GA: National Resource Center on Child Maltreatment.

[13] Crosson-Tower, C. (2003); Crosson-Tower, C. (2002a); Dubowitz, H., Black, M., Starr, R. H., & Zuravin, S. (1993). A conceptual definition of child neglect. *Criminal Justice and Behavior*, *20*(1), 8–26.

[14] Crosson-Tower, C. (2003).

[15] Hart, S., & Brassard, M. (1991). Psychological maltreatment: Progress achieved. *Development and Psychopathology, 3*(1), 61–70; Hart, S., Brassard, M., & Karlson, H. (1996). Psychological maltreatment. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 72–89). Thousand Oaks, CA: Sage.

[16] Crosson-Tower, C. (2003); Hart, S., & Brassard, M. (1991).

[17] Goldman, J., & Salus, M. K. (2003).

[18] Christian, C. W., & Rubin, D. M. (2002). Sexual abuse. In A. P. Giardino & E. R. Giardino (Eds.), *Recognition of child abuse for the mandated reporter* (3rd ed., pp. 23–37). St. Louis, MO: G.W. Medical.

[19] Berliner, L., & Elliott, D. M. (2002). Sexual abuse of children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 55–78). Thousand Oaks, CA: Sage.

[20] Christian, C. W., & Rubin, D. M. (2002).

[21] Crosson-Tower, C. (2002a).

[22] Crosson-Tower, C. (2003); Crosson-Tower, C. (2002b). How has the Internet put children at risk for abuse? In *When children are abused: An educator's guide to intervention* (p. 56). Boston: Allyn & Bacon.

[23] Wolak, J., Finkelhor, D., Mitchell, K. J., & Ybarra, M. L. (2008). Online "predators" and their victims: Myths, realities, and implications for prevention and treatment. *American Psychologist, 63*, 111–128; Wolak, J., Finkelhor, D., & Mitchell, K. J. (2004). Internet-based sex crimes against minors: Implications for prevention based on findings from a national study. *Journal of Adolescent Health, 35*, 424.e11–424.e20; Mitchell, K. J., Finkelhor, D., & Wolak, J. (2001). Risk factors for and impact of online sexual solicitation of youth. *Journal of American Medical Association, 285*, 3011–3014; DeLamater, J., & Friedrich, W. N. (2002). Human sexual development. *Journal of Sex Research, 39*, 10–14.

[24] U.S. Department of Health and Human Services, ACF. (2010).

[25] U.S. Department of Health and Human Services, ACF. (2010).

[26] Child Welfare Information Gateway. (2008b). *Child abuse and neglect fatalities: Statistics and interventions*. Available: http://www.childwelfare.gov/pubs/factsheets/fatality.cfm; Herman-Giddens, M., Brown, G., Verbiest, S., Carlson, P., Hooten, E., Howell, E., et al. (1999). Underascertainment of child abuse mortality in the United States. *Journal of the American Medical Association.* Available: http://jama.ama-assn.org/cgi/content/full/282/5/463#TABLEJOC80539T1; Crume, T., DiGuiseppi, C., Byers, T., Sirotnak, A., & Garrett, C. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990–1998. *Pediatrics.* Available: http://pediatrics.aappublications.org/cgi/reprint/110/2/e18.pdf.

[27] U.S. Department of Health and Human Services, ACF. (2010).

[28] Walsh, B. (1994). The role of law enforcement in fatal child abuse cases. *The APSAC Advisor, 7*(4), 25–28.

[29] Walsh, B. (2005). *Investigating child fatalities*. Available: http://www.ncjrs.gov/pdffiles1/ojjdp/209764.pdf.

[30] Walsh, B. (1994); Alexander, R. C., Levitt, C. J., & Smith, W. L. (2001). Abusive head trauma. In R. Reece & S. Ludwig (Eds.), *Child abuse: Medical diagnosis and management* (2nd ed., pp. 47–80). Philadelphia: Lippincott, Williams, & Wilkins.

[31] Child Welfare Information Gateway. (2008b).

[32] Willinger, M., James, L. S., & Catz, C. (1991). Defining the sudden infant death syndrome (SIDS): Deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatric Pathology, 11*, 677–684, p. 681.

[33] U.S. Department of Health and Human Services, Centers for Disease Control and

Prevention (CDC). (2005). *Facts about SIDS*. Available: http://www.hhs.gov/nvpo/factsheets/fs_tableVII_doc5.htm.

[34] Appel, A. E., & Holden, G. W. (1998). Co-occurring spouse and child abuse: Implications for CPS practice. *APSAC Advisor, 11*(1), 11–14; Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*(2), 134–154.

[35] Spears, L. (2000). *Building bridges between domestic violence organizations and child protective services*. Available: http://new.vawnet.org/Assoc_Files_VAWnet/BCS7_cps.pdf.

[36] Kohl, P. L., Barth, R. P., Hazen, A. L., & Landsverk, J. A. (2005). Child welfare as a gateway to domestic violence services. *Children and Youth Services Review, 27*, 1203–1221.

[37] Kohl, P. L., et al. (2005).

[38] Lemon, N. K. D. (1999). The legal system's response to children exposed to domestic violence. *Future of Children, 9*(3), 67–83.

[39] Farley, R. H., & Reece, R. M. (1996); Whitman, B. (2002). Psychological and psychiatric issues. In A. P. Giardino & E. R. Giardino (Eds.), *Recognition of child abuse for the mandated reporter* (3rd ed., pp. 137–156). St. Louis, MO: G.W. Medical.

[40] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (2009, April). Children living with substance-dependent or substance-abusing parents: 2002–2007. *The NSDUH Report*. Available: http://oas.samhsa.gov/2k9/SAparents/SAparents.htm.

[41] DeBellis, M. D., Broussard, E. R., Herring, D. J., Wexler, S., Moritz, G., & Benitez, J. G. (2001). Psychiatric co-morbidity in caregivers and children involved in maltreatment: A pilot research study with policy implications. *Child Abuse & Neglect, 25*, 923–944; Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 25*, 1627–1640; Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect, 20*, 191–203.

[42] Kelleher, K., Chaffin, M., Hollenberg, J., & Fischer, E. (1994). Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample. *American Journal of Public Health, 84*, 1586–1590.

[43] U.S. Department of Health and Human Services, ACF. (1999). *Blending perspectives and building common ground. A report to Congress on substance abuse and child protection*. Available: http://aspe.hhs.gov/hsp/subabuse99/subabuse.htm.

[44] Otero, C., Boles, S., Young, N. K., & Dennis, K. (2004). *Methamphetamine: Addiction, treatment, outcomes and implications*. Rockville, MD: U.S. Department of Health and Human Services, SAMHSA.

[45] U.S. Department of Justice, Drug Enforcement Administration. (n.d.). *Methamphetamine*. Available: http://www.usdoj.gov/dea/concern/meth.html#3.

[46] U.S. Department of Health and Human Services, SAMHSA. (2008). *Results from the 2007 National Survey on Drug Use and Health: National findings*. Available: http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.cfm#TOC.

[47] Office of National Drug Control Policy. (2010). *Drug endangered children*. Available: http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html.

[48] Otero, C., et al. (2004).

[49] Illinois State University, School of Social Work. (2001). *Signs of client methamphetamine use and caseworker safety procedures*. Available: http://www.drugfreeinfo.org/PDFs/strengthensupervision.pdf.

[50] Society for Public Health Education, The American College of Medical Toxicology, & U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry (ATSDR). (2007). *Helping communities combat clandestine methamphetamine laboratories*. Available: http://www.acmt.net/cgi/page.cgi?_id=136.

[51] Society for Public Health Education, The American College of Medical Toxicology, & U.S. Department of Health and Human Services, ATSDR. (2007).

[52] Goldman, J., & Salus, M. K. (2003).

[53] Cage, R. L., & Pence, D. M. (1997). *Criminal investigation of child sexual abuse*. Washington, DC: U.S. Department of Justice, Office of Justice Programs (OJP), Office of Juvenile Justice and Delinquency Prevention (OJJDP).

[54] U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Child Health and Human Development (NICHD). (2000). *NICHD researchers improve techniques for interviewing child abuse victims*. Available: http://www.nichd.nih.gov/new/releases/interviewing.cfm; Baker, L. L., Jaffe, P. G., Berkowitz, S. J., & Berkman, M. (2002). *Children exposed to violence: A handbook for police trainers to increase understanding and improve community responses*. Available: http://www.lfcc.on.ca/police-us.PDF.

[55] Saywitz, K. J., & Coulborn Faller, K. (2002). *Interviewing child witnesses and victims of sexual abuse*. Washington, DC: U.S. Department of Justice, OJP, OJJDP.

[56] Lanning, K. V. (2002). Criminal investigation of sexual victimization of children. In J. E. B. Meyers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 329–347). Thousand Oaks, CA: Sage.

[57] U.S. Department of Health and Human Services, NIH, NICHD. (2000); Saywitz, K. J., & Coulborn Faller, K. (2002); Lanning, K. V. (2002); Baker, L. L., et al. (2002).

[58] Saywitz, K. J., & Goodman, G. S. (1996). Interviewing children in and out of court: Current research and practice implications. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 297–318). Thousand Oaks, CA: Sage; Kolko, D., Brown, E., & Berliner, L. (2002). Children's perceptions of their abusive experience: Measurement and preliminary findings. *Child Maltreatment, 7*(1), 42–55.

[59] North Carolina Division of Social Services, & Family and Children's Resource Program. (2002). Forensic interviewing and child welfare. *Children's Services Practice Notes*. Available: http://www.practicenotes.org/vol8_no1.htm.

[60] National Child Welfare Resource Center for Family-Centered Practice. (2002). *Children, families, and workers: Facing trauma in child welfare*. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/BPNPWinter02.pdf; Cohen, E., & Walthall, B. (2003). *Silent realities: Supporting young children and their families who experience violence*. Available: http://www.lfcc.on.ca/SilentRealities.pdf.

[61] Coulborn Faller, K. (1999). Questioning children who may have been sexually abused: An integration of research into practice. In K. Couldborn Faller (Ed.), *Maltreatment in early childhood: Tools for research-based intervention* (pp. 37–58). New York: Hawthorn Press.

[62] U.S. Department of Health and Human Services, NIH, NICHD. (2000).

[63] Lanning, K. V. (2002).

[64] Saywitz, K. J., & Coulborn Faller, K. (2002).

[65] U.S. Department of Health and Human Services, ACF. (2010).

[66] Cage, R. L., & Pence, D. M. (1997).

[67] Lanning, K. V. (2002).

[68] Cage, R. L., & Pence, D. M. (1997).

[69] Heger, A. (2000). Making the diagnosis of sexual abuse: Ten years later. In A. Heger, S. J. Emans, & D. Muram (Eds.), *Evaluation of the sexually abused child: A medical textbook and photographic atlas* (2nd ed., pp. 1–10). New York: Oxford University Press.

[70] North Carolina Division of Social Services, & Family and Children's Resource Program. (2005, June). Traumatic stress and child welfare workers. *Children's Services Practice Notes*. Available: http://ssw.unc.edu/fcrp/Cspn/vol10_n3/sts.htm.

[71] International Society for Traumatic Stress Studies. (2005). *Indirect traumatization in professionals working with trauma survivors*. Available: http://www.istss.org/AM/Template.cfm?Section=ResourcesforProfessionals&Template=/CM/ContentDisplay.cfm&ContentID=1625.

[72] Siegfried, C. B. (2008). *Child welfare work and secondary traumatic stress*. Available: http://www.nctsnet.org/nctsn_assets/pdfs/cwt3_sho_sts.pdf.

[73] Siegfried, C. B. (2008).

[74] Saywitz, K. J., & Goodman, G. S. (1996); Kolko, D., et al. (2002); DePanfilis, D., &

Salus, M. (2003). *Child protective services: A guide for caseworkers*. Available: http://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf.; U.S. Department of Health and Human Services, NIH, NICHD. (2000); Saywitz, K. J., & Coulborn Faller, K. (2002); Lanning, K. V. (2002).

[75] Berliner, L. (2000). How do I interview older children and adolescents about sexual abuse? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 65–69). Thousand Oaks, CA: Sage.

[76] Sattler, J. (1998). *Clinical and forensic interviewing of children and families.* San Diego, CA: Sattler, Inc.

[77] Fontes, L. A. (2000). *Interviewing children from immigrant families about maltreatment*. Newbury Park, CA: Sage; Fontes, L. A. (2005a). Interviewing diverse children about maltreatment. *Child abuse and culture: Working with diverse families.* New York: Guilford Press.

[78] Saywitz, K. J., & Goodman, G. S. (1996); Kolko, D., et al. (2002); DePanfilis, D., & Salus, M. K. (2003).

[79] Bragg, H. L. (2003). *Child protection in families experiencing domestic violence*. Available: http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/.

[80] Fontes, L. A. (2005b). Interviewing immigrant children and families about child maltreatment: Setting the stage. *Protecting Children*, *20*(1), 37–46; U.S. Department of Health and Human Services, NIH, NICHD. (2000); Veith, V. (2002). Cultural sensitivity in the forensic interview process. *American Prosecutors Research Institute* [Online]. Available: http://www.ndaa-apri.org/publications/newsletters/update_volume_15_number_1_2002.html.

[81] Lamb, M. E., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2008). Interviewing children with intellectual and communicative difficulties. In *Tell me what happened: Structured investigative interviews of child victims and witnesses*. West Sussex, England: John Wiley & Sons; Westcott, H. L., & Jones, D. P. H. (1999). Annotation: The abuse of disabled children. *Journal of Child Psychology and Psychiatry, 40*, 497–506.

[82] Lamb, M. E., et al. (2008).

[83] Anderson, J., & Heath, R. T. (2006a). Forensic interviews with children who have developmental disabilities: Part 1 of 2. *American Prosecutors Research Institute Update*. Available: http://ndaa.org/pdf/update_vol_19_number_1_2006.pdf.

[84] Blahauvietz, S. (2005). Key factors in forensic interviews with Native American children. *National Center for Prosecution of Child Abuse Update*. Available: http://ndaa.org/pdf/update_vol_18_number_6_2005.pdf.

[85] Anderson, J., & Heath, R. T. (2006b). Forensic interviews with children who have developmental disabilities: Part 2 of 2. *American Prosecutors Research Institute Update*. Available: http://ndaa.org/pdf/update_vol_19_number_2_2006.pdf; Lamb, M. E., et al. (2008).

[86] U.S. Department of Health and Human Services, ACF. (2010).

[87] DePanfilis, D., & Salus, M. K. (2003); Cage, R. L., & Pence, D. M. (1997).

[88] DePanfilis, D., & Salus, M. K. (2003).

[89] U.S. Department of Health and Human Services, ACF. (2010).

[90] Cage, R. L., & Pence, D. M. (1997).

[91] Cage, R. L., & Pence, D. M. (2001). *Criminal investigation of child sexual abuse*. Washington, DC: U.S. Department of Justice, OJP, OJJDP.

[92] Cage, R. L., & Pence, D. M. (1997).

[93] Cage, R. L., & Pence, D. M. (1997).

[94] Loiselle, J. (2002).

[95] American Bar Association. (n.d.). *Criminal law: The police & your rights*. Available: http://www.abanet.org/publiced/practical/criminal/miranda_rights.html.

[96] U.S. Department of Justice, Attorney General's Task Force on Family Violence. (1984). *Attorney General's Task Force on Family Violence Final report*. Available: http://www.eric.ed.gov/PDFS/ED251762.pdf.

[97] Lanning, K. V. (2002); Baker, L. L., et al. (2002).

[98] Cross, T. P., Finkelhor, D., & Ormrod, R. (2005). Police involvement in child protective services investigations: Literature review and secondary analysis. *Child Maltreatment, 10*, 224–244.

[99] Lanning, K. V. (2002).

[100] DePanfilis, D., & Salus, M. K. (2003).

[101] Walsh, B. (1995). Law enforcement: The use of search warrants in cases of crimes against children. *The APSAC Advisor, 8*(1), 3–7.

[102] Jones, W. G. (2006). *Working with the courts in child protection*. Available: http://www.childwelfare.gov/pubs/usermanuals/courts/.

[103] Cage, R. L., & Pence, D. M. (1997); Kosid-Uthe, J. (1992). Appendix I: Considerations in obtaining and using expertise search warrants in cases of preferential child molesters. In K. V. Lanning (Ed.), *Child molesters: A behavioral analysis for law enforcement officers investigating cases of child sexual exploitation*. Washington, DC: National Center for Missing and Exploited Children.

[104] Holder, W. (2000). How do I assess risk and safety? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 227–232). Thousand Oaks, CA: Sage.

[105] Walsh, B. (1995).

[106] U.S. Department of Justice, OJP, OJJDP, & University of Southern Maine, Edmund S. Muskie Institute of Public Affairs. (1996). *Child maltreatment & abuse investigation for law enforcement officers*. Available: http://muskie.usm.maine.edu/helpkids/rcpdfs/COPS.pdf.

[107] U.S. Department of Justice. (2002). *Searching and seizing computers and obtaining electronic evidence in criminal investigations*. Available: http://www.usdoj.gov/criminal/cybercrime/s&smanual2002.htm.

[108] U.S. Department of Justice, OJP, OJJDP, & University of Southern Maine, Edmund S. Muskie Institute of Public Affairs. (1996).

[109] Walsh, B. (1995).

[110] DePanfilis, D., & Salus, M. K. (2003).

[111] DePanfilis, D., & Salus, M. K. (2003).

[112] Walsh, B. (2005).

[113] Walsh, B. (2005).

[114] American Academy of Pediatrics Committee on Child Abuse and Neglect. (2006). Distinguishing sudden infant death syndrome from child abuse fatalities. *Pediatrics, 107*, 437–441.

[115] Walsh, B. (2005).

[116] American Academy of Pediatrics Committee on Child Abuse and Neglect. (2006).

[117] Walsh, B. (2005).

[118] Walsh, B. (2005).

[119] Regehr, C., Chau, S., Leslie, B., & Howe, P. (2002). Inquiries into deaths of children in care: The impact on child welfare workers and their organization. *Child and Youth Services Review, 24*, 885–*902.*

[120] American Association for Protecting Children. (1998). *Child sexual abuse curriculum for social workers.* Denver, CO: Author; American Bar Association, National Legal Resource Center for Child Advocacy and Protection. (1989). *Resource guide to legal practice in dependency cases*. Washington, DC: Author.

[121] Nusbaum-Feller, J., Davidson, H., Hardin, M., & Horowitz, R. (1992). *Working with the courts in child protection*. Available: http://www.childwelfare.gov/pubs/usermanuals/courts_92/index.cfm.

[122] Nusbaum-Feller, J., et al. (1992).

[123] Child Welfare Information Gateway. (2003). *Determining the best interests of the child: Summary of state laws*. Available: http://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interestall.pdf.

[124] Child Welfare Information Gateway. (2008a).

[125] World Health Organization, Department of Injuries and Violence Prevention. (2005). *Violence and disasters*. Available: http://www.who.int/violence_injury_prevention/publications/violence/violence_disasters.pdf; Curtis, T., Miller, B. C., & Berry, E. H. (2000). Changes in reports and incidence of child abuse following natural disasters. *Child Abuse and Neglect, 24*, 1151–1162.

[126] U.S. Department of Health and Human Services, NIH, National Institute of Mental Health (NIMH). (2001). *Helping children and adolescents cope with violence and disasters*. Available: http://www.nimh.nih.gov/publicat/violence.cfm; Osofsky, J. D. (1995). The effects of exposure to violence on young children. *American Psychologist, 50*, 782–788; Pynoos, R. S., Steinberg, A. M., & Goenjian, A. K. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B. A. Van der Kolk,

A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 331–358). New York: Guilford Press; Marans, S., & Adelman, A. (1997). Experiencing violence in a developmental context. In J. D. Osofsky (Ed.), *Children in a violent society* (pp. 202–222). New York: Guilford Press; Vogel, J. M., & Vernberg, E. M. (1993). Part 1: Children's psychological responses to disasters. *Journal of Clinical Child Psychology, 22*, 464–484; Garbarino, J., Kostelny, K., & Dubrow, N. (1991). What children can tell us about living in danger. *American Psychologist, 46*, 376–383; Duncan, R. D., Saunders, B. E., Kilpatrick, D. G., Hanson, R. F., & Resnick, H. S. (1996). Childhood physical assault as a risk factor for PTSD, depression, and substance abuse: Findings from a national survey. *American Journal of Orthopsychiatry, 66*, 437–448; Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse & Neglect, 19*,1401–1421; Roth, S. H., Newman, E., Pelcovitz, D., Van der Kolk, B. A., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 10*, 539–555; Morrison, J. A. (2000). Protective factors associated with children's emotional responses to chronic community violence exposure. *Trauma, Violence, and Abuse: A Review Journal, 1*, 299–320.

127 Dobson, C., & Perry, B. D. (n.d.). *The impact of Katrina on children: Special comments for first responders and helping professionals*. Available: http://www.childtrauma.org/CTAMATERIALS/SecondaryTrauma_Katrina.pdf.

128 U.S. Department of Health and Human Services, NIH, NIMH. (2006). *Helping children and adolescents cope with violence and disasters: What rescue workers can do*. Available: http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-rescue-workers/index.shtml.

129 National Child Traumatic Stress Network, & National Center for PTSD. (2006). *Psychological first aid: Field operations guide* (2nd ed.). Available: http://www.nctsnet.org/nctsn_assets/pdfs/pfa/2/PsyFirstAid.pdf.

130 National Child Traumatic Stress Network, & National Center for PTSD. (2006).

131 National Child Traumatic Stress Network, & National Center for PTSD. (2006).

132 National Child Traumatic Stress Network, & National Center for PTSD. (2006).

133 U.S. Department of Health and Human Services, SAMHSA. (2005). *Tips for managing and preventing stress: A guide for emergency and disaster response workers*. Available: http://mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf.

134 U.S. Department of Health and Human Services, CDC, National Institute for Occupational Safety and Health (NIOSH). (2001). *Traumatic incident stress: Information for emergency response workers*. Available: http://www.cdc.gov/niosh/docs/2002-107/.

135 U.S. Department of Health and Human Services, SAMHSA. (2005); U.S. Department of Health and Human Services, CDC, NIOSH. (2001).

136 O'Brien, M., Webster, S., & Herrick, A. (2007). *Coping with disasters and strengthening systems: A framework for child welfare agencies*. Available: http://muskie.usm.maine.edu/helpkids/rcpdfs/copingwithdisasters.pdf.

137 O'Brien, M., Webster, S., & Herrick, A. (2007).

138 U.S. Department of Health and Human Services, ACF. (2006). *New legislation: The Child and Family Services Improvement Act of 2006 (Public Law 109-288)* (ACYF-CB-IM-06-05). Available: http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2006/im0605.htm.

139 U.S. Government Accountability Office. (2006). *Lessons learned for protecting and educating children after the Gulf Coast hurricanes* (GAO-06-680R). Available: http://www.gao.gov/new.items/d06680r.pdf.

140 O'Brien, M., Webster, S., & Herrick, A. (2007).

141 O'Brien, M., Webster, S., & Herrick, A. (2007).

142 Weisner, C. D. (2005). *Former child welfare leader offers insights on lessons learned from Hurricane Katrina at COA's Public Agency Roundtable*. Available: http://www.coanet.org/Files/Roundtable Luncheon.pdf.

143 O'Brien, M., Webster, S., & Herrick, A. (2007).

144 U.S. Government Accountability Office. (2006).

[145] De Vita, C. J., Kramer, F. D., Eyster, L., Hall, S., Kehayova, P., & Triplett, T. (2008). *The role of faith-based and community organizations in post-hurricane human service relief efforts*. Available: http://aspe.hhs.gov/hsp/08/PostHurricaneRelief/report.pdf.

[146] Lind, C. (2005). *Managing in emergencies: Enhancing collaboration for human services*. Available: http://76.12.61.196/publications/feskatrina1.pdf; O'Brien, M., Webster, S., & Herrick, A. (2007).

[147] O'Brien, M., Webster, S., & Herrick, A. (2007).

[148] O'Brien, M., Webster, S., & Herrick, A. (2007).

[149] O'Brien, M., Webster, S., & Herrick, A. (2007).

[150] O'Brien, M., Webster, S., & Herrick, A. (2007).

APPENDIX A
Glossary of Terms

Adjudicatory Hearings – held by the juvenile and family court to determine whether a child has been maltreated or whether another legal basis exists for the State to intervene to protect the child.

Adoption and Safe Families Act (ASFA) – signed into law November 1997 and designed to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. The law requires CPS agencies to provide more timely and focused assessment and intervention services to the children and families that are served within the CPS system.

CASA – court-appointed special advocates (usually volunteers) who serve to ensure that the needs and interests of a child in child protection judicial proceedings are fully protected.

Case Closure – the process of ending the relationship between the CPS worker and the family that often involves a mutual assessment of progress. Optimally, cases are closed when families have achieved their goals and the risk of maltreatment has been reduced or eliminated.

Case Plan – the casework document that outlines the outcomes, goals, and tasks necessary to be achieved in order to reduce the risk of maltreatment.

Caseworker – see Child Protective Services Caseworker.

Central Registry – a centralized database containing information on all substantiated/founded reports of child maltreatment in a selected area (typically a State).

Child Abuse Prevention and Treatment Act (CAPTA) – see Keeping Children and Families Safe Act.

Child Protective Services (CPS) – the designated social services agency (in most States) to receive reports, investigate, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as departments of social services.

Child Protective Services (CPS) Caseworker – an individual employed by a CPS agency to receive reports, investigate, and/or provide intervention and treatment services to children and families in which child maltreatment has occurred.

Concurrent Planning – identifies alternative forms of permanency by addressing both reunification or legal permanency with a new parent or caregiver if reunification efforts fail.

Cultural Competence – a set of attitudes, behaviors, and policies that integrates knowledge about groups of people into practices and standards to enhance the quality of services to all cultural groups being served.

Differential Response – an area of CPS reform that offers greater flexibility in responding to allegations of abuse and neglect. Also referred to as "dual track" or "multi-track" response, it permits CPS agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's needs for services and support. See Dual Track.

Dispositional Hearings – held by the juvenile and family court to determine the legal resolution of cases after adjudication, such as whether placement of the child in out-of-home care is necessary, and the services the children and family will need to reduce the risk of maltreatment and to address the effects of maltreatment.

Dual Track – term reflecting new CPS response systems that typically combine a nonadversarial, service-based assessment track for cases in which children are not at immediate risk with a traditional CPS investigative track for cases where children are unsafe or at greater risk for maltreatment. See Differential Response.

Emergency Medical Technician (EMT) – a first responder who has been trained and certified in providing certain medical care to patients in need of immediate medical attention before and, if needed, during transport to a health care facility.

Emotional Maltreatment – see Psychological Maltreatment.

Evidence – information or items, such as testimony, written documents, and physical items, that are presented to prove or to disprove an allegation.

Family Assessment – the stage of the child protection process during which the CPS caseworker, the community treatment provider, and the family reach a mutual understanding regarding the behaviors and conditions that must change to reduce or eliminate the risk of maltreatment, the most critical treatment needs that must be addressed, and the strengths on which to build.

Family Group Conferencing – a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model brings the family, extended family, and others important in the family's life (e.g., friends, clergy, neighbors) together to make decisions regarding how best to ensure the safety of the family members.

Family Unity Model – a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model is similar to the Family Group Conferencing model.

First Responder – a professional whose responsibilities include the initial response to the scene of child maltreatment. Types of professionals who are first responders include child protective services (CPS) caseworkers, law enforcement officers, and emergency medical technicians (EMTs).

Guardian ad Litem – a lawyer or lay person who represents a child in juvenile or family court. Usually this person considers the best interest of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. A lay person who serves in this role is sometimes known as a court-appointed special advocate or CASA.

Home Visitation Programs – prevention programs that offer a variety of family-focused services to pregnant mothers and families with new babies. Activities frequently encompass structured visits to the family's home and may address positive parenting practices, nonviolent discipline techniques, child development, maternal and child health, available services, and advocacy.

Immersion Burn – a type of burn whereby an individual is forced into extremely hot liquid. These burns have a "water line" or sharp demarcation border.

Immunity – established in all child abuse laws to protect reporters from civil law suits and criminal prosecution resulting from filing a report of child abuse and neglect.

Initial Assessment or Investigation – the stage of the CPS case process during which the CPS caseworker determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan if needed to ensure the child's protection, and determines services needed.

Intake – the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interview Protocol – a structured format to ensure that all family members are seen in a planned strategy, that community providers collaborate, and that information gathering is thorough.

Keeping Children and Families Safe Act – the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) included the reauthorization of CAPTA in its Title I, Sec. 111. CAPTA provides minimum standards for defining child physical abuse and neglect and sexual abuse that States must incorporate into their statutory definitions in order to receive Federal funds. CAPTA defines child abuse and neglect as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Kinship Care – formal or informal child placement by the juvenile court and child welfare agency in the home of a child's relative.

Law Enforcement Officer – an individual who is given the authority to uphold Federal, State, and/or local laws, which may include responding to and investigating possible crimes, pursuing and apprehending individuals who break laws, and issuing citations. Law enforcement officers may include police officers, sheriffs and deputies, detectives, and State and Federal agents.

Liaison – a person within an organization who has responsibility for facilitating communication, collaboration, and coordination between agencies involved in the child protection system.

Mandated Reporter – individuals required by State statutes to report suspected child abuse and neglect to the proper authorities (usually CPS or law enforcement agencies). Mandated reporters typically include professionals, such as educators and other school personnel, health care and mental health professionals, social workers, childcare providers, and law enforcement officers.–Some States identify all citizens as mandated reporters.

Miranda Rights – read by law enforcement officers upon the arrest of a suspect and state that a suspect does not have to speak to police and that the suspect can request an attorney. These rights are designed to protect the Fifth Amendment rights of individuals to not self-incriminate.

Modus Operandi – a habitual method of procedure or operation, often in reference to how an individual commits a crime.

Multidisciplinary Team – established between agencies and professionals within the child protection system to discuss cases of child abuse and neglect and to aid in decisions at various stages of the CPS case process. These terms may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Neglect – the failure to provide for the child's basic needs, including physical, educational, or emotional. *Physical neglect* can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). *Educational neglect* includes failing to provide appropriate schooling, failure to address special educational needs, or allowing excessive truancies. *Psychological neglect* includes the lack of any emotional support and love, chronic inattention to the child, exposure to spouse abuse, or drug or alcohol abuse.

Open-Ended Question – a type of question used during an interview that allows the respondent to express what is most relevant and important to him,

as opposed to a question that directs the respondent (e.g., What did you do to your daughter's arm when you entered the room?). An example of an open-ended question is "What happened this afternoon?"

Out-of-Home Care – child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside their families, usually under the jurisdiction of juvenile or family court.

Parent or Caretaker – person responsible for the care of the child.

Physical Abuse – the inflicting of a nonaccidental physical injury. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the result of over-discipline or physical punishment that is inappropriate to the child's age.

Primary Prevention – activities geared to a sample of the general population to prevent child abuse and neglect from occurring. Also referred to as "universal prevention."

Protective Factors – strengths and resources that appear to mediate or serve as a buffer against risk factors that contribute to vulnerability to maltreatment or against the negative effects of maltreatment experiences.

Protocol – an interagency agreement that delineates joint roles and responsibilities by establishing criteria and procedures for working together on cases of child abuse and neglect.

Psychological Maltreatment – a pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs. This can include parents or caretakers using extreme or bizarre forms of punishment or threatening or terrorizing a child. Psychological maltreatment is also known as emotional abuse or neglect, verbal abuse, or mental abuse.

Response Time – a determination made by CPS and law enforcement regarding the immediacy of the response needed to a report of child abuse or neglect.

Review Hearings – held by the juvenile and family court to review dispositions (usually every 6 months) and to determine the need to maintain placement in out-of-home care or court jurisdiction of a child.

Risk – the likelihood that a child will be maltreated in the future.

Risk Assessment – the measurement of the likelihood that a child will be maltreated in the future; frequently carried out through the use of checklists, matrices, scales, and other methods.

Risk Factors – behaviors and conditions present in the child, parent, or family that will likely contribute to child maltreatment occurring in the future.

Safety – absence of an imminent or immediate threat of moderate to serious harm to the child.

Safety Assessment – a part of the CPS case process in which available information is analyzed to identify whether a child is in immediate danger of moderate or serious harm.

Safety Plan – a casework document developed when it is determined that the child is in imminent danger or at risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child, and identifies, along with the family, the interventions that will control the safety factors and ensure the child's protection.

Secondary Prevention – activities targeted to prevent breakdowns and dysfunction within families that have been identified as being at risk for abuse and neglect.

Service Agreement – the casework document developed between the CPS caseworker and the family that outlines the tasks necessary to achieve risk reduction goals and outcomes.

Service Provision – the stage of the CPS casework process when CPS and other providers deliver specific services geared toward reducing the risk of maltreatment.

Sexual Abuse – inappropriate adolescent or adult sexual behavior with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (for example a babysitter, a parent, or a daycare provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Substantiated – an investigation disposition concluding that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. A CPS determination means that credible evidence exists that child abuse or neglect has occurred.

Sudden Infant Death Syndrome (SIDS) – the sudden death of an infant younger than one year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

Tertiary Prevention – treatment efforts geared to address situations where child maltreatment has already occurred, with the goals of preventing additional maltreatment and its harmful effects.

Testify – to provide testimony in court. See Testimony.

Testimony – the statement made by a witness in court. For example, a CPS caseworker may provide testimony in court about what she saw when she entered a house due to a report of child abuse.

Treatment – the stage of the child protection case process when specific services are provided by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Unsubstantiated (not substantiated) – an investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that the child has been maltreated or is at risk of maltreatment. A CPS determination means that credible evidence does not exist that child abuse or neglect has occurred.

APPENDIX B

Resource Listings of Selected National Organizations Concerned with Child Maltreatment and with First Responders

Listed here are several representatives of the many national organizations and groups dealing with various aspects of child maltreatment. First are several representatives of the many national organizations and groups that may act as first responders to child abuse and neglect cases. Visit **http://www.childwelfare.gov/pubs/usermanual.cfm** to view a more comprehensive list of resources and visit **http://www.childwelfare.gov/organizations/index.cfm** to view an organization database. Inclusion on this list is for information purposes and does not constitute an endorsement by the Office on Child Abuse and Neglect nor the Children's Bureau.

EMS/EMT/Medical Examiners Organizations

Emergency Medical Services for Children National Resource Center

address: 8737 Colesville Road, Suite 400
Silver Spring, MD 20910

phone: (202) 476-4927

fax: (202) 476-6845

e-mail: emscinformation@cnmc.org

website: http://www.childrensnational.org/EMSC/

Works with State health departments, medical-based universities, and stakeholder organizations to improve the pediatric emergency care infrastructure throughout the United States and its territories.

EMS Village

website: http://www.emsvillage.com/

An interactive community with information relevant to EMS providers.

National Association of EMTs

address: P.O. Box 1400
Clinton, MS 39060-1400

phone: (601) 924-7744
(800) 34-NAEMT

fax: (601) 924-7325

e-mail: info@naemt.org

website: http://www.naemt.org/

Represents and serves emergency medical services personnel through advocacy, educational programs, and research.

National Association of Medical Examiners

address: 430 Pryor Street, SW
Atlanta, GA 30312

phone: (404) 730-4781

website: http://www.thename.org/

Fosters the professional growth of physician death investigators and disseminates professional and technical information on the medical investigation of violent, suspicious, and unusual deaths.

National Registry of Emergency Medical Technicians

address: Rocco V. Morando Building
6610 Busch Boulevard
P.O. Box 29233
Columbus, OH 43229

phone: (614) 888-4484

fax: (614) 888-8920

website: http://www.nremt.org

National certification agency that establishes uniform standards for training and examination of personnel active in the delivery of emergency ambulance service.

Law Enforcement Organizations

International Association of Chiefs of Police

address: 515 North Washington Street
Alexandria, VA 22314

phone: (703) 836-6767

(800) THE IACP

fax: (703) 836-4543

e-mail: information@theiacp.org

website: http://www.theiacp.org/

Develops and disseminates information on administrative, technical, and operational practices for use in police work as well as fostering police cooperation and the exhange of information among police officers.

International Crime Scene Investigators Association

address: PMB 385
15774 S. LaGrange Road
Orland Park, IL 60462

phone: (708) 460-8082

e-mail: info@icsia.org

website: http://icsia.org/

Provides information to assist law enforcement personnel who are involved in the processing of crime scenes and provides public forums for crime scene investigators to communicate with one another.

National Association of Police Organizations

address: 317 South Patrick Street
Alexandria, VA 22314

phone: (703) 549-0775

fax: (703) 684-0515

e-mail: info@napo.org

website: http://www.napo.org/

Promotes the interests of America's law enforcement officers through legislative and legal advocacy, political action, and education.

National Center for Community Policing

phone: (800) 892-9051

website: http://www.cj.msu.edu/~people/cp/

Facilitates organizational change within police agencies and the development of community partnerships to institutionalize community policing.

National Center for Prosecution of Child Abuse

address: American Prosecutors Research Institute
44 Canal Center Plaza, Suite 110
Alexandria, VA 22314

phone: (703) 549-9222

fax: (703) 836-3195

e-mail: ncpca@ndaa.org

website: http://www.ndaa.org/ncpca_home.html

Serves as a central resource for training, expert legal assistance, court reform, and information on criminal child abuse investigations and prosecutions.

National Criminal Justice Reference Service

address: P.O. Box 6000
Rockville, MD 20849-6000

phone: (800) 851-3420

(877) 712-9279 (TTY)

fax: (301) 519-5212

website: http://ncjrs.gov/

Provides justice and substance abuse information to support research, policy, and program development for various groups, including law enforcement.

National Sheriffs' Association

address: 1450 Duke Street
Alexandria, VA 22314-3490

phone: (703) 836-7827

fax: (703) 836-6541

website: http://www.sheriffs.org/

Provides programs to enable sheriffs, their deputies, chiefs of police, and others in the field of criminal justice to perform their jobs in the best possible manner and to better serve the people of their jurisdictions.

Emergency Response Organizations

Federal Emergency Management Agency

address: 500 C Street, SW
Washington, DC 20472

phone: (800) 621-FEMA (3362)

(800) 462-7585 (TTY)

fax: (800) 827-8112

e-mail: FEMA-Correspondence-Unit@dhs.gov

website: http://www.fema.gov/

Seeks to reduce the loss of life and property and protect the United States from all hazards, including natural disasters, acts of terrorism, and other manmade disasters, by leading and supporting the Nation in a risk-based, comprehensive emergency management system of preparedness, protection, response, recovery, and mitigation.

Child Welfare Organizations

American Humane Association
Children's Division

address: 63 Inverness Drive, East
Englewood, CO 80112-5117

phone: (303) 792-9900

fax: (303) 792-5333

email: info@americanhumane.org

website: www.americanhumane.org/protecting-children/

Conducts research, analysis, and training to help public and private agencies respond to child maltreatment.

American Professional Society on the Abuse of Children

address: P. O. Box 30669
Charleston, SC 29417

phone: (843) 764-2905

(877) 40A-PSAC

fax: (803) 753-9823

e-mail: apsac@comcast.net

website: www.apsac.org

Provides professional education, promotes research to inform effective practice, and addresses public policy issues. Professional membership organization.

American Public Human Services Association

address: 810 First Street, NE, Suite 500
Washington, DC 20002-4267

phone: (202) 682-0100

fax: (202) 289-6555

website: www.aphsa.org

Addresses program and policy issues related to the administration and delivery of publicly funded human services. Professional membership organization.

AVANCE Family Support and Education Program

address: 118 N. Medina
San Antonio, TX 78207

phone: (210) 270-4630

fax: (210) 270-4612

website: www.avance.org

Operates a national training center to share and disseminate information, material, and curricula to service providers and policy-makers interested in supporting high-risk Hispanic families.

Chadwick Center for Children and Families

address: 3020 Children's Way
MC 5016
San Diego, CA 92123

phone: (858) 966-5814

fax: (858) 966-8535

e-mail: chadwickcenter@chsd.org

website: http://www.chadwickcenter.org/

Strives to protect children and strengthen families through excellence in prevention, treatment, education, public policy, advocacy, and research.

Child Welfare League of America

address: 2345 Crystal Drive, Suite 250
Arlington, VA 22202

phone: (703) 412-2400

fax: (703) 412-2401

website: http://www.cwla.org

Provides training, consultation, and technical assistance to child welfare professionals and agencies while educating the public about emerging issues affecting children.

National Black Child Development Institute

address: 1313 L Street, NW, Suite 110
Washington, DC 20005-4110

phone: (202) 833-2220

fax: (202) 833-8222

e-mail: moreinfo@nbcdi.org

website: http://www.nbcdi.org

Operates programs and sponsors a national training conference through Howard University to improve and protect the well-being of African-American children.

National Center on Substance Abuse and Child Welfare

address: 4940 Irvine Boulevard, Suite 202
Irvine, CA 92620

phone: (866) 493-2758

fax: (714) 505-3626

e-mail: ncsacw@cffutures.org

website: http://www.ncsacw.samhsa.gov

Assists local, State, and Tribal agencies in improving systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems.

National Children's Advocacy Center

address: 210 Pratt Avenue
Huntsville, AL 35801

phone: (256) 533-5437

fax: (256) 534-6883

website: www.nationalcac.org

Provides prevention, intervention, and treatment services to physically and sexually abused children and their families within a child-focused team approach.

National Child Welfare Resource Center for Organizational Improvement

address: Edmund S. Muskie School of
Public Service
P.O. Box 9300, 34 Bedford Street
Portland, ME 04104-9300

phone: (800) HELPKID (435-7543)
(207) 780-5646 (TTY)

fax: (207) 780-5817

website http://muskie.usm.maine.edu/helpkids/

Helps child welfare agencies improve management and operations, expand organizational capacity, and promote service integration through training, technical assistance, research, and evaluation.

National Indian Child Welfare Association

address: 5100 SW Macadam Avenue, Suite 300
Portland, OR 97239

phone: (503) 222-4044

fax: (503) 222-4007

website: www.nicwa.org

Disseminates information and provides technical assistance on Indian child welfare issues. Supports community development and advocacy efforts to facilitate tribal responses to the needs of families and children.

National Resource Center for Child Protective Services

address: 925 #4 Sixth Street, NW
Albuquerque, NM 87102

phone: (505) 345-2444

fax: (505) 345-2626

website: http://www.nrccps.org/

Assists jurisdictions with system and practice issues that help improve the prevention, reporting, assessment, and treatment of child abuse and neglect. Provides consultation, technical assistance, and training in all areas of child protective services.

Prevent Child Abuse America

address: 500 N. Michigan Avenue,
Suite 200
Chicago, IL 60611

phone: (312) 663-3520

fax: (312) 939-8962

e-mail: mailbox@preventchildabuse.org

website: http://www.preventchildabuse.org

Conducts prevention activities such as public awareness campaigns, advocacy, networking, research, and publishing. Also provides information and statistics on child abuse.

Shaken Baby Syndrome Prevention Plus

address: P.O. Box 205
Groveport, OH 43125

phone: (800) 858-5222

fax: (614) 836-8359

e-mail: sbspp@aol.com

Develops, studies, and disseminates information and materials designed to prevent shaken baby syndrome and other forms of physical child abuse and to increase positive parenting and child care.

For More Information

Child Welfare Information Gateway

address: 1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024

phone: (800) 394-3366
(703) 385-7565

fax: (703) 385-3206

e-mail: info@childwelfare.gov

website: http://www.childwelfare.gov/

Collects, stores, catalogs, and disseminates information on all aspects of child maltreatment and child welfare to help build the capacity of professionals in the field. A service of the Children's Bureau.

For The General Public

Childhelp

address: 15757 North 78th Street
Scottsdale, AZ 85260

phone: (800) 4-A-CHILD (child abuse hotline)
(800) 2-A-CHILD (TDD child abuse hotline)
(480) 922-8212

fax: (480) 922-7061

website: http://www.childhelp.org

Provides crisis counseling to adult survivors and child victims of child abuse, offenders, and parents, and operates a national hotline.

National Center for Missing and Exploited Children

address: Charles B. Wang International
Children's Building
699 Prince Street
Alexandria, VA 22314-3175

phone: (800) 843-5678 (24-hour hotline)
(703) 274-3900

fax: (703) 274-2220

website: www.missingkids.com

Provides assistance to parents, children, law enforcement, schools, and the community in recovering missing children and raising public awareness about ways to help prevent child abduction, molestation, and sexual exploitation.

Parents Anonymous

address: 675 West Foothill Boulevard,
Suite 220
Claremont, CA 91711

phone: (909) 621-6184

fax: (909) 625-6304

e-mail: parentsanonymous@parents
anonymous.org

website: www.parentsanonymous.org

Leads mutual support groups to help parents provide nurturing environments for their families.

APPENDIX C

State Telephone Numbers for Reporting Suspected Child Maltreatment

Each State designates specific agencies to receive and investigate reports of suspected child abuse and neglect. Typically, this responsibility is carried out by child protective services (CPS) within a Department of Social Services, Department of Human Resources, or Division of Family and Children Services. In some States, police departments also may receive reports of child abuse or neglect.

Many States have local or toll-free telephone numbers, listed here, for reporting suspected maltreatment. **The reporting party must be calling from the same State where the child allegedly is being maltreated for most of the following numbers to be valid.**

For States not listed, or when the reporting party resides in a different State from the child, please call **Childhelp, 800-4-A-Child** (800-422-4453), or your local CPS agency. States occasionally change the telephone numbers; to view the most current contact information, including State Web addresses, visit **http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172**.

Alabama (AL)
334-242-9500

Alaska (AK)
800-478-4444

Arizona (AZ)
888-SOS-CHILD
(888-767-2445)

Arkansas (AR)
800-482-5964

Colorado (CO)
303-866-5932

Connecticut (CT)
800-842-2288
800-624-5518 (TDD)

Delaware (DE)
800-292-9582

District of Columbia (DC)
202-671-SAFE (7233)

Florida (FL)
800-96-ABUSE
(800-962-2873)

Hawaii (HI)
808-832-5300

Idaho (ID)
800-926-2588
208-332-7205 (TDD)

Illinois (IL)
800-252-2873
217-524-2606

Indiana (IN)
800-800-5556

Iowa (IA)
800-362-2178

Kansas (KS)
800-922-5330

Kentucky (KY)
800-752-6200

Maine (ME)
800-452-1999
800-963-9490 (TTY)

Massachusetts (MA)
800-792-5200

Michigan (MI)
800-942-4357

Mississippi (MS)
800-222-8000
601-359-4991

Missouri (MO)
800-392-3738
573-751-3448

Montana (MT)
866-820-5437

Nebraska (NE)
800-652-1999

Nevada (NV)
800-992-5757

New Hampshire (NH)
800-894-5533
603-271-6556

New Jersey (NJ)
877-652-2873
800-835-5510 (TDD/TTY)

New Mexico (NM)
800-797-3260
505-841-6100

New York (NY)
800-342-3720
518-474-8740
800-369-2437 (TDD)

Oklahoma (OK)
800-522-3511

Pennsylvania (PA)
800-932-0313

Puerto Rico (PR)
800-981-8333
787-749-1333

Rhode Island (RI)
800-RI-CHILD
(800-742-4453)

South Carolina (SC)
803-898-7318

Tennessee (TN)
877-237-0004

Texas (TX)
800-252-5400

Utah (UT)
800-678-9399

Vermont (VT)
800-649-5285

Virginia (VA)
800-552-7096
804-786-8536

Washington (WA)
866-END-HARM
(866-363-4276)
800-562-5624
800-624-6186 (TTY)

West Virginia (WV)
800-352-6513

APPENDIX D

Reference Guide for Responding to Cases of Suspected Child Maltreatment

The following handy reference guide for first responders in cases of suspected child maltreatment contains highlights of the information provided throughout this manual and addresses signs of possible abuse, interviewing the alleged victim and perpetrator, assessing for risk, and testifying in court.

Signs of possible physical abuse (Chapter 2)

- Fractures unexpectedly discovered in the course of an otherwise routine medical examination (e.g., discovering a broken rib while listening to the child's heartbeat)
- Injuries that are inconsistent with, or out of proportion to, the history provided by the caretaker or with the child's age or developmental stage (e.g., a 3-month old burning herself by crawling on top of the stove)
- Multiple fractures, often symmetrical (e.g., in both arms or legs), or fractures at different stages of healing
- Fractures in children who are not able to walk
- Skeletal trauma (e.g., fractures) combined with other types of injuries, such as burns
- Subdural hematomas, which are hemorrhages between the brain and its outer lining that are caused by ruptured blood vessels
- Burns on the buttocks, around the anogenital region, on the backs of the hands, or on both hands, as well as those that are severe

Signs of possible psychological maltreatment (Chapter 2)

- Extremes in behavior (e.g., manically happy or very depressed)
- Withdrawal (e.g., no verbal or physical communication with others)
- Self-destructive behavior (e.g., cutting oneself)
- General destructive behavior (e.g., setting fires)
- Cruelty to others, including animals
- Rocking, thumb-sucking that is developmentally inappropriate, or head-banging
- Enuresis (i.e., wetting one's pants) or soiling at an age or a developmental level when such behavior is inappropriate
- Substance abuse
- Physical manifestations, such as frequent stomachaches or headaches or an unexplained weight loss or gain

Signs of possible sexual abuse (Chapter 2)

Children may have been sexually abused if they:

- Have bruises in the inner thigh or genital area
- Have difficulty walking or sitting
- Complain of genital or anal itching, pain, or bleeding
- Frequently vomit
- Become pregnant at a young age
- Have any sexually transmitted diseases

Additionally, children may have been sexually abused if they exhibit:

- Exceptional secrecy
- More sexual knowledge than is age appropriate, especially in younger children
- Indepth sexual play with peers that is not developmentally appropriate
- Extreme compliance or withdrawal
- Overt aggression
- An inordinate fear of males or females
- Seductive behavior
- Sleep problems or nightmares
- Crying without provocation
- A sudden onset of wetting or soiling of pants or bed
- Suicide attempts or thoughts of wanting to kill themselves
- Numerous attempts at running away from home
- Cruelty to animals (especially those that would normally be pets)
- Setting fires and enjoying watching them burn
- Self-mutilation (e.g., cutting or scratching to draw blood)

Behavioral clues that may indicate possible child maltreatment (Chapter 2)

- Be aggressive, oppositional, or defiant
- Cower or demonstrate a fear of adults
- Act out, displaying aggressive or disruptive behavior
- Be destructive to self or others
- Come to school too early or not want to leave school—indicating a possible fear of being at home
- Show fearlessness or extreme risk-taking
- Be described as "accident prone"
- Cheat, steal, or lie (may be related to too high expectations at home)
- Be a low achiever
- Be unable to form good peer relationships
- Wear clothing that covers the body and that may be inappropriate in warmer months, such as wearing a turtleneck sweater in the summer (Be aware that this may possibly be a cultural issue instead.)
- Show regressive or less mature behavior
- Dislike or shrink away from physical contact (e.g., may not tolerate physical praise, such as a pat on the back)

Signs of possible neglect (Chapter 2)

- Seem inadequately dressed for the weather (e.g., wearing shorts and sandals in freezing weather)
- Appear excessively listless and tired (due to no routine or structure around bedtimes)
- Report caring for younger siblings (when they themselves are underage or are developmentally not ready to do so)
- Demonstrate poor hygiene or smell of urine or feces
- Seem unusually small or thin or have a distended stomach (indicative of malnutrition)
- Have unattended medical or dental problems, such as infected sores or badly decayed or abscessed teeth
- Appear withdrawn
- Crave unusual amounts of attention, even eliciting negative responses in order to obtain it

Risk factors for maltreatment (Chapter 2)

- Born prematurely or low birth weight
- Perceived as unusual or different in terms of appearance or temperament
- Be unhealthy or with congenital abnormalities
- Have a physical, emotional, or developmental disability
- Be irritable or display behaviors that are contrary to the expectations of the parents
- Live in poverty
- Live in an environment in which there is drug abuse, crime, or violence
- Live in a single-family home
- Have parents who lack education
- Have parents who abuse substances

Child interview guidelines (Chapter 3)

- Avoid jumping to conclusions
- Be at the child's eye level, if possible
- Leave a comfortable space between the interviewer and the child
- Create a child-friendly environment (e.g., have toys available)
- Use body diagrams or dolls to help the child clarify body parts that are discussed
- Be mindful of responder's facial expressions and body language
- Minimize the use of yes or no and multiple-choice questions
- Follow up all closed-ended questions with open-ended questions (types of questions are discussed later in this chapter)
- Listen carefully and completely (e.g., do not rush the child)
- Assess the child's understanding of key concepts (e.g., being able to tell the truth, understanding timeframes), which will help to establish credibility as the interview proceeds into sensitive areas
- Reduce vocabulary problems by using the child's vocabulary, when appropriate, and clarifying any areas of confusion
- Avoid using double negatives (e.g., "So your father didn't not hit you with the belt?")
- Observe the child's nonverbal communication and body language
- Document the interviewer's and child's words carefully and completely, perhaps by audio- or videotaping the interview
- Be attuned to the developmental capabilities and limitations of the child as the interview progresses

What to observe at the scene (Chapter 3)

- The physical condition of the child, including any observable effects of maltreatment
- The emotional status of the child, including mannerisms, signs of fear, and developmental status
- The reactions of the parents or caregivers to the first responder's concerns
- The emotional and behavioral status of the parents or caregivers during the interview process
- The interactions between family members, including verbal and body language
- The physical status of the home or site of maltreatment, including cleanliness, structure, safety hazards, signs of excessive alcohol use, and signs of illicit drug use (e.g., drug paraphernalia, evidence of a methamphetamine lab)
- The climate of the neighborhood, including the level of violence or drug use, and the accessibility of transportation, telephones, or other methods of communication

What to be aware of during alleged offender interview (Chapter 3)

- A disclosure by the alleged offender that maltreatment did take place
- No explanation for an injury or suspect incident
- An explanation for an injury that is inconsistent with either the severity or the type of injury observed
- Different or changing explanations for an injury or incident
- A delay in obtaining medical treatment for an injury

Guidelines for documenting interviews (Chapter 3)

- Follow the agency's or department's protocols
- Give the child permission to correct statements
- Document both the questions and answers, when possible
- Listen carefully to answers
- Read answers back to the child for clarification, when appropriate
- Write notes clearly and concisely
- Quote direct statements, when possible
- Videotape or photograph the crime scene for accuracy
- Try to have an investigative team that consists of one interviewer and one note taker

What to obtain or make note of (Chapter 3)

- Broken items or holes in the wall
- Stains from blood or semen (visible with a black light and/or luminol)
- Minute evidence, such as hair, fibers, or semen
- "Souvenirs" of the alleged abuser, such as items of a child's clothing or pictures of the child
- Lures, such as toys or games
- Sexual aids, such as lubricants, dildos, and vibrators
- Drugs or alcohol
- Adult or child pornography, in print or on computer
- Cameras and film processing equipment
- An address book containing the victim's information
- Bedding
- Clothing
- Contents of trash cans
- Bills, banks records, and receipts, which may be used to show items that were purchased by the suspect for the victim
- Phone records
- Work records showing if the suspect was available to spend time with the child at the time of the maltreatment
- Weapons or other implements used to abuse a child (e.g., belts, cords, coat hangers, other instruments matching the injuries inflicted)
- Other items noted by the victim or the witnesses during the interviews

Questions to ask nonoffending adults (Chapter 3)

- What happened?
- How did the injury happen?
- Who injured the child?
- Who was with the child?
- Who saw the injury happen?
- Where did the injury happen?
- Where were the other household members?
- When did the injury happen?

Conducting a safety assessment (Chapter 3)

- Identify the behaviors or conditions that increase concern for the child's safety and consider how they affect each child in the family
- Identify the behaviors or conditions (e.g., strengths, resiliencies, support, resources) that may protect the child
- Examine the relationships among the risk factors and determine if, when combined, they increase safety concerns
- Determine whether family members or other community partners are able to address safety concerns without CPS intervention
- Consider the services required to address the specific behaviors or conditions for each risk factor directly affecting the child's safety
- Identify who is available (e.g., CPS, other community partners) to provide the needed services or interventions in the frequency, timeframe, and duration required by the family to protect the child
- Evaluate the family's willingness to accept—and its ability to use—the intervention or services at the level needed to protect the child

Elements of a safety plan (Chapter 3)

- Direct and immediate impact on one or more of the risk factors determined during the assessment to cause the child to be unsafe
- Accessible to the family
- Available in the frequency and for the duration with which they are needed to control the risk factors
- Fills the gaps in the caregiver's protective factors and strengths in order to ensure the child's protection

Guidelines for testifying (Chapter 4)

- Be prepared
- Listen to each question and pause before answering
- Ask for clarification if needed
- Answer only the question asked
- Do not be afraid to respond "I don't know"
- Do not give an opinion unless asked to do so
- Avoid taking sides
- Speak a little louder, slower, and more distinctly than normal
- Make eye contact
- Use an open body posture

APPENDIX E

Signs of Possible Physical Abuse[1]

The following discusses signs of possible physical abuse. While much of this information can be valuable to all first responders, some of it may be beyond the experience of first responders who do not have an extensive medical background.

Bruises

- Color
  - Bruises go through a cycle of color. They initially are red, violet, black, or blue and later turn brown, green, or yellow. The color is affected by the depth and the placement of the bruise, as well as by the skin color and the quality of the light at the location where the bruise is being viewed.
  - Estimating the age of a bruise by its color cannot be done with much precision, but in general:
    - A bruise with any yellow is usually older than 18 hours.
    - Red, blue, purple, or black colors in a bruise may occur anytime from within 1 hour of bruising to resolution (i.e., when the bruise coloration disappears).
    - A red color may be present at any stage of the bruise.
    - Bruises of identical age and cause on the same person may not appear with the same coloration and may not change color in the same manner.
- Site
  - Ears and buttocks usually are not injured accidentally.
  - Knees, shins, foreheads, and elbows are normal bruising areas, particularly for toddlers.
- Shape
  - Bruises caused by pinching often have a symmetrical pattern.
  - Loop-shaped marks can be caused by whipping a child with a cord or belt; there is no disease or accident that looks like a loop or belt mark.
  - Cords or ropes tied around a child's ankles or neck may result in a bruise or a rope burn.
  - If a child is slapped or hit, a mark in the shape of the offender's fingers or hand may be left.

[1] Children's Hospital Boston, Child Protective Team. (2004). *Injuries and behaviors indicative of abuse*. Available: http://www.child-protection.org/CPTtext/tProviders/tInjuries.htm; Massachusetts Department of Social Services. (2002, March). *Investigation training: Evidence and indicators of maltreatment*. Boston, MA: Author.

- Placement
  - Loose tissues, with little bony structure underneath (e.g., eyelids, genitals), bruise most easily and retain bruises longest; injuries at those locations often are not accidental.
  - The first responder should be suspicious if a caretaker delays seeking treatment for a child with a genital injury. For example, the injury may have been caused by pinching a boy's penis to punish him for touching himself or by using a string or rubber band around the penis (causing grooves) to prevent the child from wetting the bed.
  - Some individuals mistake the presence of Mongolian spots (birthmarks) as an indicator of abuse. These spots usually are grayish-blue, clearly defined spots on the buttocks, back, or extremities. They are most common in African-American and American Indian babies.

Lacerations

- Lacerations are tears or cuts in the skin.
- In cases of abuse, they often occur on soft tissue areas, such as the abdomen, the throat, the buttocks, and the thighs.
- Some areas of the body are normally protected from lacerations by being inside or covered by other body parts (e.g., the side of the arm that normally lies against the body when in a standing position). It is difficult to fall and injure these areas.
- Lacerations of the ear, the nose, or the throat do not tend to occur accidentally.
- A torn frenulum of the upper lip (the tissue that connects the upper lip to the upper gum) may be an indicator of abuse if there is no reasonable explanation, especially in the case of infants.

Bites

- Human bites appear as oval or horseshoe-shaped marks in which tooth impressions look like bruises facing each other.
- If the distance between the canines (the third tooth on each side) is greater than 3 centimeters, the bite is most likely from an adult. Adult bite marks are a sign of serious danger to a child.
- Depending on the location of the bite, the victim's teeth should be examined and measured to exclude the possibility of a self-inflicted bite.
- A forensic odontologist or pathologist should evaluate the size, contour, and color of the bite marks, as well as make molds of the suspected abuser's teeth and of the bite itself, if possible. Each individual has a characteristic bite pattern.

Burns/Scalds

- Immersion burns occur when a child is placed in extremely hot liquid. These burns have a "water line" or sharp demarcation border. Symmetrical burns with sharp edges (e.g., sock-shaped burns of the same height on each leg) are very suspicious. The first responder should document if there is an absence of splash marks, which may indicate that the child did not fall into the liquid and try to get out.
- Doughnut-shaped burns can occur when a child is forced into a bathtub. This causes parts of the body, usually the buttocks, to rest on the bottom of the tub, where they will not burn.
- Splash burns can occur when the offender throws hot liquid at the child. Unintentional splash burns are usually on the head or top of the chest and run downward and may be caused by a child reaching upward to grab a pot handle. Liquids that are thrown at a child hit at a horizontal angle, causing the burns to be concentrated on the child's face or chest and run toward the back

of the body. Splash burns on the back or buttocks are highly suspicious.

- Cigarette burns usually appear on the trunk, external genitalia, or extremities. They also often appear on the palms of the hands or soles of the feet. Cigarette burns usually are symmetrical in shape. Impetigo blisters (caused by a bacterial infection) are irregular and can be ruled out by testing for signs of strep. When there are intentional cigarette burns on a child, there often are multiple burns in various stages of healing (i.e., indicating that the burns occurred at various times).

- Chemical burns are caused by household products. Some parents or caretakers force children to drink lye derivatives (toilet bowl cleaner, detergents, or oils), which causes chemical burns of the mouth and throat, vomiting, and esophageal damage.

Fractures and Dislocations

- Fractures usually are inflicted by an abuser on nonambulatory children (i.e., those who are not able to walk).

- Ninety percent of all abusive fractures in children 2 years of age or younger include the ribs.

- The following are types of fractures and dislocations that may be indicative of abuse:

  – Metaphyseal fractures, in which a chip of the metaphysis (a piece of bone that grows during childhood) is pulled off by a ligament, can only occur when a jerking force is applied to the extremities (e.g., by shaking or swinging a child by the arms or legs).

  – Spiral fractures, which are diagonal fractures usually caused by the twisting of an extremity, are common in children because they have more pliant bones. Spiral fractures can occur in small children by twisting their own leg or ankle in an accidental injury (e.g., getting their feet caught in the slats of a crib). Thus, spiral fractures are not always indicative of abuse.

  – Periosteal elevation occurs when an infant's extremities are twisted or shaken, causing the periosteum (a type of connective tissue) to be separated from the bone and blood to collect in the new space.

  – Rib fractures can be caused by a caretaker forcefully squeezing the baby. Victims may present with signs of respiratory distress, but they are usually asymptomatic.

Internal Injuries

- Might be indicated by:

  – Abdominal, chest, flank, or back pain;

  – Visible bruising of the chest or abdomen;

  – Distended, swollen abdomen or tense abdominal muscles;

  – Dyspnea (labored breathing);

  – Pleuritic pain (a type of chest pain);

  – Nausea or vomiting.

Neurological Damage (Skull Fracture, Brain or Spinal Cord Damage, and Intracranial Hemorrhage)

- Serious life-threatening skull injuries, with the exception of epidural hematomas (a type of brain hemorrhage), do not result from a child falling from a short height, such as a bed or crib.

- Skull fractures are more likely in young children. Any pressure from cerebritis (inflammation of the brain) or hemorrhage can separate fontanelles (one of two soft spots on an infant's skull).

- Brain injury in young children is more likely due to their having an increased subarachnoid space (the space between the middle and innermost membranes covering the brain).

- Subgaleal hematoma (bleeding beneath the scalp caused when the scalp separates from the skull) is often a sign of skull fracture. Diagnostic images of the skull should be taken. It may be caused by jerking or twisting a child's hair —especially in girls with pigtails—and may be indicated by a bald spot.

- Alopecia (a partial or complete loss of hair) may be caused by neglect if the child lies on his back for long periods of time.

Shaken Baby Syndrome

- This occurs when a child has been held around the upper thorax (under the arms) and shaken back and forth with great force. It also occurs when the child is held upside down by the feet and is shaken up and down.

- Many infants die from shaken baby syndrome, especially if there is a delay in getting treatment. Those who survive often have permanent brain damage and may be paralyzed, be developmentally delayed, or develop cerebral palsy.

- There is often an absence of externally visible injuries, but retinal bleeding may occur. Subdural hematoma (a hemorrhage between the brain and its outer lining that is caused by ruptured blood vessels) and metaphyseal lesions (when a piece of a bone that grows during childhood chips off) are common effects of shaken baby syndrome.

APPENDIX F

Distinguishing Physical Abuse From Nonintentional Injury[1]

The following table outlines methods to determine if a child's injury may be nonintentional or caused by maltreatment. While much of this information can be applied by all first responders, some of it may be beyond the experience of first responders who do not have an extensive medical background.

Injury	Possible Nonintentional Cause	Steps to Confirm
Bruise	Accidental fall	• Check the location of the bruises; bruises on knees, shins, forehead, or elbows are usually unintentional. • In the case of black eyes, check for bruises on the forehead; bruises to the forehead often drain through soft tissues to give appearance of black eyes 24–72 hours afterward. • Check to see whether the bruises on a single surface are clustered (e.g., multiple bruises on the right arm); one bruise on a single surface is usually accidental. • Consider whether the explanation for the injury correlates with the developmental age and motor skills of the child (e.g., could a 1-month-old child crawl to the edge of the stairs and fall?) • Check for discrepancies between the bruise and the explanation provided by the caretaker and others.
Bite Mark	Bitten by an animal or a child	• Check to see whether the flesh is torn or just compressed; torn flesh is usually an animal bite, and compressed flesh is usually a human bite. • Measure the distance between the center of the canines (the third tooth on each side); if it is greater than 3 centimeters, the bite is most likely from an adult. • Check for discrepancies between the injury and the history provided by the caretaker and others.

[1] Children's Hospital Boston, Child Protective Team. (2004). *Injuries and behaviors indicative of abuse*. Available: http://www.child-protection.org/CPTtext/tProviders/tInjuries.htm; Massachusetts Department of Social Services. (2002, March). *Investigation training: Evidence and indicators of maltreatment*. Boston, MA: Author.

Injury	Possible Nonintentional Cause	Steps to Confirm
Burn	Accidental spilling of hot liquid	• Check the location of the splash burns; unintentional burns are most likely to occur on the front of the head, neck, trunk, and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body. • Check for discrepancies between the burn and the history provided by the caretaker and others.
	Brushing against a cigarette	• Check the location of the burns; they are usually unintentional if found on the child's face and arms. • Check the shape of the burn; it is usually unintentional if it is more elongated than round and has a higher degree of intensity on one side. • Check for discrepancies between the burn and the history provided by the caretaker and others.
	Accidentally falling into a hot bath	• Check for clear lines of demarcation on the skin and those that are parallel (e.g., the same height on both legs); unintentional burns have no clear, straight line demarcating the burned and unburned skin (e.g., a sock-like burn on a child's leg may indicate an intentional burn). • Check the depth of the burn through the skin; unintentional burns are not as deep as forced burns because an unrestrained child generally can remove himself from the burning environment (i.e., the child would try to get out of the hot water quickly). • Check to see whether the buttocks and feet are burned, but not the hands; it is impossible for a child to unintentionally fall into a tub without his hands going into the water. • Doughnut-shaped burns may indicate abuse. These burns occur when parts of the body, usually the buttocks, rest on the bottom of the tub and thus will not burn. A patch of unburned skin is created in the center of the burn (like the hole in a doughnut) and may be a sign that the child was forced to sit in the tub. • Check for signs of burns from splashing; an unrestrained child will splash when in water that is too hot. • Check for discrepancies between the burn and the history provided by the caretaker and others.
	Accidentally coming into contact with a burning object	• Check the location of the burn; some areas of the body, such as the buttocks or the back, are more difficult for a child to self-inflict a burn. • Check the depth of the burn; unintentional burns are usually deep on one edge of the burn. • Check the pattern margins of the burn; unintentional burns usually do not have crisp margins or defined shapes. • Check for discrepancies between the burn and the history provided by the caretaker and others.

Injury	Possible Nonintentional Cause	Steps to Confirm
Fracture	• Birthing trauma (fractured collarbones are most common) • Little league elbow (pain in the elbow due to excessive throwing) • Fractures from passive exercises for therapeutic reasons (e.g., the caregiver is manipulating the child's legs as part of a physical therapy regimen) • Other accidental trauma, such as a fall	• Ensure the explanation of the injury matches the injury and the developmental level of the child. • Check for discrepancies between the fracture and the history provided by the caretaker and others.
Head Injury	• Birth trauma causing effusion (the accumulation of fluid in a body space) • Posttraumatic hypopituitaris (the deficiency of one or more hormones of the pituitary gland) • Insect bite on head (usually forehead)	• Check the onset of the injury; injuries from birth traumas should become apparent shortly after birth. • Check for discrepancies between the injury and the history provided by the caretaker and others. Note: Subdural hematomas (hemorrhages between the brain and its outer lining that are caused by ruptured blood vessels) found in an infant or toddler without adequate explanation may indicate abuse.
Eye Injury	• Chemical burns • Object accidentally hitting the eye	• Check for signs of the child having been slapped around the ear, during which the adult's fingers also may have struck the child's eye. • Check for discrepancies between the injury and the history provided by the caretaker and others.
Ear Injury	• Accidental injury from inserting a cotton swab	• Check whether the laceration is of the external auditory meatus (the outer opening of the ear canal); this injury can only occur by inserting a pointed object into the ear. • Check for discrepancies between the injury and the history provided by the caretaker and others.
Nasal Injury	• Accidental injury from inserting an object into the nose	• Check whether the objects are found in more than one site (e.g., in the ears as well); if found only in the nose, this is common for a normally developing child. • Check for discrepancies between the injury and the history provided by the caretaker and others.
Tooth Injury	• Accidentally falling or striking the mouth with a hard object	• Check for discrepancies between the injury and the history provided by the caretaker and others.
Poisoning	• Accidentally giving toxic doses of vitamins and minerals to cure an illness • Unintentionally feeding a baby improperly diluted formula • Accidental ingestion of medicines, household cleaners, etc.	• Check with the caretaker about the cause of the poisoning; unintentional poisoning may be a form of neglect that can be treated with education and support. • Check for discrepancies between the condition and the history provided by the caretaker and others.

APPENDIX G

Common Folk-Medicine Practice Injuries That May Resemble Abuse[1]

Injury	Ritual	Country/Region/ Ethnic Group
Circular burns, about 6–8cm in diameter; often multiple	Can result from "cupping," in which a cup of ignited alcohol is placed over a part of the body. As the heated area cools, the skin is sucked into the cup, producing redness and burns.	Mexico
Subdural hematomas (hemorrhages between the brain and its outer lining that are caused by ruptured blood vessels)	Remedies for *caida de mollera*, or "fallen fontanelle," can cause subdural hematomas. The fontanelle is one of two soft spots on an infant's skull, and some believe that it can become depressed if an infant is pulled away from a nipple (breast or bottle) too quickly. The most dangerous folk remedy for fallen fontanelle is hanging the child over a basin of hot water and tapping the child's feet.	Mexico
Light, linear bruising with petechiae (pinpoint-sized red spots on the skin), usually between the ribs on both the front and back; also may be seen on the neck, both sides of the spine, or along the inner arms	Although they resemble strap marks, these linear bruises may actually be the result of the folk-medicine practice of Cao Gio (coining). This practice is used to relieve symptoms such as fever, chills, headaches, and vomiting and includes massaging the skin with oil and stroking it with the edge of a coin until bruising occurs. It is believed that coining forces the "bad wind," or noxious substances, from the body. Normally, this practice should not cause undue concern about child abuse.	Vietnam Cambodia China Hmong people

[1] Massachusetts Department of Social Services. (2002, March). *Investigation training: Evidence and indicators of maltreatment*. Boston, MA: Author.

Injury	Ritual	Country/Region/ Ethnic Group
Light bruising, petechiae (pinpoint-sized red spots on the skin), or abrasions on both sides of the spine, behind both knees, in the bend of both arms, and on the chest from just above the nipple to the clavicle	These bruises may be the result of the folk-medicine practice of Tzowsa (spooning). This employs a similar method to coining, but a spoon is used. If a raised area appears, cupping treatment has probably also been used. This treatment is believed to alleviate pain.	Hmong people
Intense, isolated, nonsymmetrical bruises anywhere on the body, but often found between the eyes on the forehead, along the trachea, in a necklace pattern around the base of the neck, bilaterally on the upper chest or arms, or along the spine	These bruises may be the result of the folk-medicine practice of Bat Gio (pinching) in which Pinching Tiger Balm, a mentholated ointment, may be massaged into the area before it is pinched. It is very commonly used to exude the "bad wind" for localized pain, lack of appetite, heat exhaustion, dizziness, fainting, blurred vision, cough, fever, or any other minor illness.	Southeast Asia
Second- and third-degree burns on the foot and ankle	In this practice, an analgesic balm, such as Icy Hot, may be applied to a child's foot, which is then held under running water. This home treatment is based on a hot-cold theory of disease that is held in many Latin American cultures, and it is performed in an effort to cure a child's sprained ankle. Because there is a clear line of demarcation, it may resemble an immersion burn.	Latin America
Burns or scars, usually 0.5–1cm in diameter (like cigarette burns), located randomly around the lower rib cage or in a definite pattern around the umbilicus (belly button)	These burns may be part of a folk medicine therapy in which pieces of burning string are lowered onto the child's skin in order to cure abdominal pain or fever.	Southeast Asia

APPENDIX H

Criteria for Distinguishing SIDS from Fatal Child Maltreatment[1]

The following table outlines methods to determine if a child's death may be caused by SIDS. While *some* of this information can be applied by all first responders, some of it may be beyond the experience of first responders who do not have an extensive medical background.

	Consistent with SIDS	Less Consistent with SIDS	Concern for Child Maltreatment
Circumstances Surrounding Death	• An apparently healthy infant who was fed and put to bed is later found lifeless (silent death). • EMS resuscitation efforts are unsuccessful.	• The infant is found not breathing, but after EMS transports the infant to the hospital, the infant lives for hours or days. • There is a family history of illness or substance abuse.	• The family's and child's histories are not typical of SIDS, have discrepancies, or are unclear.
Age of Child	• The infant is 0–7 months of age. (Most SIDS deaths occur between 2 and 4 months of age, and 90 percent occur before 7 months of age.)	• The infant is 8–12 months of age.	• The infant is more than 12 months of age.

[1] U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2002, December). *Recognizing when a child's injury or illness is caused by abuse*. Available: http://www.ncjrs.gov/pdffiles1/ojjdp/160938.pdf.

	Consistent with SIDS	Less Consistent with SIDS	Concern for Child Maltreatment
Physical Examination and Lab Studies at Time of Death	• The infant has bloody, watery, frothy, or mucous-filled nasal discharge. • The infant has postmortem lividity in dependent areas (i.e., blood settles in portions of the body that are lower, causing a purplish red discoloration). • There are marks on pressure points (places where a blood vessel runs near a bone). • There is no skin trauma. • The baby appears well cared for.	• The infant has organomegaly of the viscera (abnormal enlargement of certain internal organs) or diagnostic signs of a disease process (by physical examination, laboratory tests, imaging studies).	• The infant has skin injuries or traumatic injuries to body parts (e.g., mucous membranes of the eyelids, scalp, inside of the mouth, ears, neck, trunk, anus or genitals, extremities). • There is evidence of malnutrition, neglect, or fractures. • The infant has a closed head wound or a subdural hematoma (a hemorrhage between the brain and its outer lining that is caused by ruptured blood vessels).
History of Pregnancy, Delivery, and Infancy	• There was prenatal care. • The mother used cigarettes during pregnancy. • The infant was premature or had a low birth weight. • The infant showed minor defects with regard to feeding and general temperament. • The infant has less height and weight gain after birth than normal. • The infant is a multiple (e.g., twin, triplet). • History of spitting, gastrointestinal reflux, thrush, pneumonia, illnesses requiring hospitalization, tachypnea (rapid breathing), tachycardia (rapid heart rate), or cyanosis (a blue coloration of the skin and mucous membranes). • There are no signs of problems or difficulty before the death.	• There was prenatal care. • The child has a history of recurrent illnesses or multiple hospitalizations (i.e., a "sickly" or "weak" baby). • There is a previous, specific diagnosis of organ system disease.	• There was little or no prenatal care. • The mother arrived late at the hospital for delivery, or the birth occurred outside of the hospital. • The child received little or no well-baby care, including immunizations. • The mother used cigarettes, drugs, or alcohol during and after the pregnancy. • The child was described as hard to care for or discipline.

	Consistent with SIDS	Less Consistent with SIDS	Concern for Child Maltreatment
Death Scene Investigation	• The crib or bed is in good condition. • There are no dangerous bedclothes, toys, plastic sheets, pacifier strings, pillows stuffed with pellets, cords, bands, or other possible means of entanglement or suffocation. • The caregiver provides an accurate description of the child's position, including whether there is head or neck entrapment. • The room is a normal temperature. • No toxins or insecticides are present. • The room has good ventilation.	• The crib or bed is defective, or there are inappropriate sheets, pillows, or sleeping clothes. • Dangerous toys, plastic sheets, pacifier cords, or pellet-stuffed pillows are present. • It is evident that the child did not sleep alone. • The room has poor ventilation or heat control. • Toxins or insecticides are present. • The conditions are unsanitary.	• The living conditions either are chaotic, unsanitary, or crowded or are extremely orderly (to a compulsive degree of neatness). • There is evidence of drug or alcohol use by the caretakers. • There are signs of a struggle in the crib or other equipment. • The bedclothes are bloodstained. • There is evidence of hostility, discord, or violence between the caretakers. • The caretaker admits harm or accuses another caretaker of harming the child.
Previous Infant Death in Family	• There are no previous unexplained or unexpected infant deaths.	• There are one or more previous unexplained or unexpected infant deaths.	• There are one or more previous unexplained or unexpected infant deaths.
Autopsy Findings	• No adequate cause of death is determined during the exam. • The results of the skeletal survey, toxicological findings, chemistry studies, microscopic examination, and metabolic screen are normal. • There are changes in certain organs that are thought to be more commonly seen in SIDS than in non-SIDS deaths (e.g., subtle changes in the liver, such as blood forming in the liver).	• Subtle changes in the liver, the adrenal glands, or the myocardium (the heart muscle).	• The death is caused by a trauma. • There are external bruises, abrasions, or burns. • There is evidence of malnutrition and fractures. • There are abnormal body chemistry values. • There are abnormal toxicological findings.

	Consistent with SIDS	Less Consistent with SIDS	Concern for Child Maltreatment
Previous Involvement of Department of Social Services or Law Enforcement	• No	• Yes	• Yes

APPENDIX I

Domestic Violence Exposure Assessment[1]

First responders can use the following assessment questions when interviewing children who may have been exposed to domestic violence.

Type and Frequency of Exposure

- What kinds of things do your mom and dad (or his/her girlfriend or boyfriend) fight about?
- What happens when they argue?
- Do they yell at each other or call each other bad names?
- Does anyone break or smash things when they get angry? Who?
- Do they hit one another? What do they hit each other with?
- How does the hitting usually start?
- How often do your mom and dad argue or hit?
- Have the police ever come to your home? Why?
- Have you ever seen your mom or dad get hurt? What happened?

Risks Posed by the Exposure

- Have you ever been hit or hurt when your mom and dad (or his/her girlfriend or boyfriend) are fighting?
- Has your brother or sister ever been hit or hurt during a fight between your mom and dad (or his/her boyfriend or girlfriend)?

[1] Ganley, A. L., & Schechter, S. (1996). *Domestic violence: A national curriculum for child protective services.* San Francisco, CA: Family Violence Prevention Fund; Children's Hospital Boston, Child Protective Team. (2004). *Injuries and behaviors indicative of abuse*. Available: http://www.child-protection.org/CPTtext/tProviders/tInjuries.htm; Massachusetts Department of Social Services. (2002, March). *Investigation training: Evidence and indicators of maltreatment*. Boston, MA: Author; Bragg. L. (1998). *Domestic violence protocol for child protective services intervention.* Charlotte, NC: Mecklenburg County Department of Social Services.

- What do you do when they start arguing or when someone starts hitting?
- Has either your mom or dad hurt your pet?

Impact of the Exposure

- Do you think about your mom and dad (or his/her girlfriend or boyfriend) fighting a lot?
- Do you think about the fighting when you are at school? While you are playing? When you are by yourself?
- How does the fighting make you feel?
- Do you ever have trouble sleeping at night? Why? Do you have nightmares? If so, what are they about?
- Why do you think they fight so much?
- What would you like them to do to make it better?
- Are you afraid to be at home? To leave home?
- What or who makes you afraid?
- Do you think it is okay to hit when you are angry? When is it okay to hit someone?
- How would you describe your mom? How would you describe your dad?

Protective Factors

- What do you do when your mom and dad (or his/her girlfriend or boyfriend) fight?
  - *If the child has difficulty responding to this question, the first responder can ask if the child has*:
    - Stayed in the room
    - Left the room or hidden
    - Gotten help
    - Gone to an older sibling
    - Asked his parents to stop
    - Tried to stop the fighting.
- Have you ever called the police when your parents are fighting? What did the police say?
- Have you ever talked to anyone about your parents' fighting? Who? What did that person say?
- Is there an adult you can talk to about what is happening at home? Who?
- What makes you feel better when you think about your parents' fighting?

APPENDIX J

Interviewing Nonoffending Adults[1]

Questions about the child:

- What did the child say about the maltreatment?
- Has the child exhibited any unusual behaviors before or after the disclosure of maltreatment? If yes, please describe the unusual behaviors.
- Has the child been abused or neglected previously or had allegations of abuse been reported to child protective services before? If yes, what happened before, or what did the child say previously?
- What else is going on in the child's life?
- (If sexual abuse) What type of exposure has the child had to sexual material (e.g., movies, television, magazines, computer images)?
- What is the child's medical history?

The first responder also should note:

- How the nonoffending parent describes the child's feelings and behaviors
- If the nonoffending parent demonstrates empathy for the child's condition and experience
- If the nonoffending parent has the capacity to protect the child
- The nonoffending parent's opinion about the vulnerability of the child.

Questions about the alleged offender:

- What was the alleged offender's reaction to the allegations?
- Has the alleged offender made any statements about the allegations?

[1] Cage, R. L., & Pence, D. M. (1997). Criminal investigation of child sexual assault. *Portable guide to investigating child abuse*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

- Does the alleged offender have a history of drug or alcohol abuse?
- (If sexual abuse) Does the alleged offender have scars, tattoos, or birthmarks? (This can help corroborate the victim's statement.)
- (If sexual abuse) Has the alleged offender ever had a sexually transmitted disease?
- What is the alleged offender's medical history?
- (If sexual abuse) Does the alleged offender use pornography, sexual aids or implements, or birth control devices, or engage in unusual sexual practices?
- Have prior accusations been made against the alleged offender?

Questions about the relationship between the child and the alleged offender:

- Can you describe the relationship between the child and the alleged offender? Are there any problems between them?
- Can you think of any reason why the child would lie about the alleged offender?
- How much time does the alleged offender spend alone with the child? When has he spent time with the child? Can anyone else verify this?
- What types of discipline do you and the alleged offender consider appropriate?
- Who in the family has child care responsibilities?
- What are the alleged offender's child care responsibilities?
- How are cultural beliefs incorporated in family functioning?
- What role does religion play in the family? How does it affect child-rearing practices?
- What are the sleeping arrangements in the home?
- How are decisions made in the family? Who usually makes decisions about the children?
- How does the family communicate? How is affection expressed?

APPENDIX K

Memorandum of Understanding[1]

What is a memorandum of understanding?

A memorandum of understanding (MOU) is a written agreement that clarifies the relationships and the responsibilities between two or more organizations that share services, clients, and resources.

Why is it important to have an MOU?

MOUs help strengthen partnerships by delineating roles of individuals, agencies, and other groups.

What is actually included in an MOU?

MOUs can address a variety of issues and topics. Content areas to consider including in an MOU are:

- Purpose statement
- Clarification of agency roles
- Referrals across agencies
- Assessment protocols
- Parameters of confidentiality
- Case management intervention
- Interagency training of staff
- Agency liaison/coordination
- Process for resolving interagency conflicts
- Periodic reviews of the MOU.

[1] Bragg, H. L. (2003). *Child protection in families experiencing domestic violence*. Available: http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/.

How do we know our agency is ready to develop an MOU?

Agencies that work together (or should work together) to reduce child maltreatment are excellent candidates for creating an MOU. In agencies that are experiencing strained relationships between potential partners, the process of writing an MOU provides a unique opportunity to address misperceptions and differences and to work jointly to resolve gaps in service delivery.

What strategies should we undertake as we begin the MOU development process?

Depending on existing relationships between agencies, one strategy may include inviting key supporters to meetings to explore the feasibility of MOU development. An additional strategy may include inviting an outside consultant to facilitate a mutual partnership that leads to the development of an MOU.

What are the potential problems that arise during the MOU development process?

Problems may arise concerning misperceptions about each other's goals, missions, and philosophies. Professionals from child welfare agencies often report that the MOU meetings helped them understand the other organizations' language and history and provided a context to consider other philosophies and missions. Additional problems may include differing confidentiality policies, assessment decisions, and levels of intervention.

APPENDIX L

Home Visit Safety Tips[1]

Families experiencing multiple issues (e.g., substance abuse, mental health problems, domestic violence, criminal behavior) can pose dangers for first responders going into homes to respond to cases that may involve child maltreatment. While on a home visit, first responders—particularly those who are not law enforcement officers—should remember the following safety tips:

- Ensure that the CPS supervisor knows the time and place of the appointment and the expected time of return.
- Dress appropriately and in a manner that blends into the community.
- Walk close to buildings or close to the curb in an effort to have at least one safe side. Stay away from bushes, alleys, and dark corners, if possible.
- Know the route in and out of the area by examining a map or by talking with others beforehand. Do not wander or appear lost or confused.
- Park as close to the home as possible and in a way that helps ensure an easy exit. Keep the car keys in hand while entering and exiting the home so they are easily available.
- Be aware of your surroundings at all times. Enter and leave homes carefully, noticing doors, windows, neighbors, loiterers, and anything or anyone that may be a risk to safety.
- If unsure of the safety or surroundings of the location, move to another spot by suggesting taking a break or getting a cup of coffee and finish talking there.
- Attempt to keep a clear path to an exit.
- Be aware of dogs that may pose a threat.
- Follow intuition and take action if feeling afraid or threatened. Leave the home or call 911 if necessary.
- Have access, if possible, to technology that may assist with safety issues (e.g., GPS systems, cell phones).

[1] California Attorney General's Office, Crime and Violence Prevention Center. (n.d.). *Recognizing clandestine meth labs*. Available: http://www.stopdrugs.org/recognizinglabs.html; KCI The Anti-Meth Site. (n.d.). *Is there a meth lab cookin' in your neighborhood?*. Available: http://www.kci.org/meth_info/neighborhood_lab.htm; Salus, M. K. (2004*). Supervising child protective services caseworkers*. Available: http://www.childwelfare.gov/pubs/usermanuals/supercps/supercps.pdf.

In cases where drugs and alcohol may be an issue in the family or the surrounding community:

- Go to the home with another caseworker or law enforcement officer, particularly in an area known for drug dealing.
- Know the local signs that indicate a drug deal is occurring. In such situations, do not enter the home without law enforcement personnel.
- Be aware of homes or other living environments that may be used as a clandestine drug factory. Do not attempt to investigate such places alone, and immediately contact law enforcement if such a lab is suspected. Anyone without proper training and protective gear should stay at least 500 feet away from any suspected laboratory. The following are signs of a possible lab:
  - Strong or unusual chemical odors
  - Laboratory equipment, such as glass tubes, beakers, funnels, and Bunsen burners
  - Chemical drums or cans in the yard
  - A high volume of automobile or foot traffic, particularly at odd hours
  - New, high fences with no visible livestock or other animals.
- If one or both parents appear to be intoxicated, high, incoherent, or passed out, ensure the safety and supervision of the children, which may require their immediate removal from the home. Once that has been accomplished, it is appropriate to reschedule the appointment. It may be appropriate to call the supervisor for guidance.

APPENDIX M

Case Studies

The following are four examples of scenarios—one each for physical neglect, environmental neglect, physical abuse, and sexual abuse—that first responders may face. These case studies include general guidelines for responding to each situation. The cases are intended to provide a framework for first responders and do not represent all of the steps a first responder should take. It is important to note that these examples were written by and for law enforcement professionals, but may be helpful to other types of professionals.

The inclusion of these guidelines and methodologies does not necessarily imply endorsement by the U.S. Department of Health and Human Services.

Physical Neglect Case

Synopsis	A 911 call is placed to the local police department at 10:00 p.m. by a concerned neighbor alleging that a mother left her 4-year-old daughter and 5-year-old son home alone. The neighbor describes the mother's vehicle and reports that it is not in front of the apartment complex. The neighbor overheard the children crying, which prompted her to call the police. A patrol car is dispatched to the address. Upon arriving on the scene, the officer finds the children home alone.
Initial Response	• Conduct a quick background check to see if any previous charges have been filed or if child protective services (CPS) has had previous involvement with this family. • Try to coordinate the response with any other first responders, if needed, in order to arrive at the home simultaneously. • The safety of the children is the first priority. Check the environment for potentially harmful objects, such as poisons or electrical hazards. • If the children are verbal and can communicate information, conduct a basic interview to obtain the parent's location. Ask questions about what and when the children last ate. This may provide information on potential maltreatment, as well as help to begin a timeline for how long the parent has been gone.
Theories	• Develop multiple theories of the neglect situation, such as: – The complaint is true as alleged – The parent is injured and unable to respond – The parent is temporarily detained, (e.g., is taking laundry out of the dryer downstairs). • Follow up on each theory: – Confirm that the vehicle is not in the parking lot – Check with the neighbors or any relatives who may be nearby – Consider possible vehicle breakdown – Look for evidence of a laundry basket and soap – Have someone check the apartment laundry room – Check the parent's name through the local emergency call system (accidents, ambulance) – Contact the property manager for emergency contact information – Check for evidence of when the parent may have last been in the apartment (food warm or cooking, cigarette warm, oven warm, bathtub wet) – Consider the possibility of foul play – Document any drugs or alcohol or related paraphernalia in plain view. • Check for a phone in the residence and look for contact information, such as outgoing or incoming calls on the caller ID. • If the phone has redial buttons, they should be utilized to ascertain who was called last (cab, relative, work). • Begin calling contact numbers. Neighbors are excellent resources for contact information. • Have local department personnel run names and addresses through the Haines Directory, which provides addresses and phone numbers for every residence in a jurisdiction and under whose name the property is listed. Other police patrol units often can drive by addresses where telephone contact cannot be made. • Contact the local CPS agency: – Advise and standby – The family history may be known to CPS caseworkers – Coordinate with the on-call CPS caseworker to determine a placement for the children if no family members can be located. • After waiting an appropriate time for parents to return to the home, remove the children as the last resort. Leave an identification card and emergency number for the parent to contact upon return.

Interview	**Parent interview:** • When and if the parent returns, conduct an interview: – Listen for an explanation. – Allow time to assess the information and to give thought to the theories developed. – Gently probe the parent based on her statements. For example, "You said your car broke down. Tell me more about that?" or "You said you went to the store and left the children sleeping. Tell me more about that?"
Action	• Determine how the case will be handled (e.g., referral to CPS, temporary removal of children, charges filed).

Environmental Neglect Case

Synopsis	An anonymous call is received via the CPS hotline alleging that there are three children younger than age 4 who are living in what the caller describes as "a house with a known meth lab inside." The anonymous caller alleges that numerous individuals are observed trafficking in and out of the residence at all hours of the day and night. The caller rarely observes the children outside and can only report the approximate ages of the children. The caller describes the children as an infant, a 2-year-old, and a 4-year-old. No further information is available. If true, the environmental conditions could be hazardous to the well-being of the children. The facts, as presented, also constitute the serious crime of narcotics distribution. A coordinated response is absolutely essential to the safety and well-being of all professionals involved, as well as to reduce the potential for injury to the children upon entry into the residence. A cautious approach to this investigation is recommended. (See Appendix L, *Home Visit Safety Tips*, for more information about safely approaching and entering a home.)
Initial Response	• Prior to any response to the residence, perform the following enquiries: – The local police and CPS should check their records for available information on the suspect residence, including prior involvement in the system. – Police should check the computer system for "caution flags" on the residence. All available police reports written on occupants can be queried. – Arrest records and criminal histories should be obtained on all known occupants of the residence. – The Motor Vehicle Administration can be queried for identifying information on vehicle ownership. – Police should check the undercover narcotics divisions for available information on the residence. – Undercover officers can check with known informants for additional information. – Local land tax records can be queried for property ownership. – Police and CPS agencies can make a coordinated decision as to the level of the emergency and the appropriate response. • Police may want to send an undercover officer to the home for a drug purchase and assessment prior to any CPS intervention. • Local uniform beat officers can be queried for knowledge of the neighborhood.
Theories	• Develop multiple theories of the neglect situation, such as: – The complaint is true as alleged – The anonymous caller mistakenly provided wrong information – The complaint is deliberately false. • Follow up on each theory.

Action	• Analyze all the available data collected prior to entry into the residence. • Consider a neighborhood canvass to obtain additional information. • Obtain police surveillance. • Plan the police and CPS response: – A coordinated plan is essential – The police will generally provide personnel and legal authority for entry into the residence (e.g., a search warrant) in cases where probable cause of a crime exists – Pre-raid checklists and personnel should be on hand – Police personnel will make entry into the residence – Evidence will be seized and necessary arrests will be made. • The children will need to be protected and turned over to the local CPS agency standing by. At no time should the CPS worker be placed in jeopardy during a controlled drug raid and search. • In those instances where the first responders lack the sufficient information to substantiate drug involvement, a subsequent safety plan must be developed. • Always approach the residence with a cautious safety plan. Plain clothes or uniformed police officers should approach the residence and make the initial contact. CPS personnel should be located nearby to respond when entry safety has been assessed.

Entering a Home Suspected to Be Involved with Drug Distribution or Manufacture

CPS caseworkers who do not have police backup and support are advised to wait until local law enforcement agencies are available before entering a residence suspected of being involved in the distribution or manufacture of drugs. Entry without sufficient support could put the personal safety of the CPS caseworker and the children at risk.

For more information on meth labs and substance use disorder, refer to *Protecting Children in Families Affected by Substance Abuse or Addiction* at **http://childwelfare.gov/pubs/usermanual.cfm**.

Physical Abuse Case: Hitting

Synopsis	A fourth grade teacher at the local elementary school contacts the CPS hotline and reports that a 9-year-old male student in her class came to school this morning with a large red mark on his face. When asked by the teacher what had happened to his face, the student responded that he fell off his bicycle. The teacher explained to the intake worker that the red mark looks very similar to a handprint. The student is normally very talkative, but seems withdrawn and fearful of talking more about the red mark.
Initial Response	• Check to see if there is an open CPS case on the child or family or if there are any prior referrals to CPS. • Meet with the principal or other authorized school personnel to gain access to a quiet, private interview room. • If available, the teacher who made the report should be interviewed.
Theories	• Develop multiple theories of how the injury occurred: – The complaint is true as alleged – The injury was sustained in a fall – The injury was inflicted by a sibling, other family member, or a classmate – The injury claim is deliberately false. • Follow up on each theory: – Visually examine the red mark on the child – Conduct a child interview – Interview the siblings, parents, classmates, or others, where appropriate.

Interview	**Child interview:** Look at the injury on the child's face. Attempt to determine if the mark resembles a handprint. Take photographs. • Ask open-ended questions. Note both the verbal response and the child's body language. **Sibling interview (for siblings who are not suspects):** • Siblings should be interviewed separately. • Provide privacy for the interviews. • Separate rooms and vehicles may provide the only privacy available at the school. **Alleged suspect interview:** • The element of surprise should be utilized. • The location of the interview (e.g., school, home) should be determined. • Allow the alleged suspect to give an explanation. • Gently probe the suspect about how the injury occurred. • Determine whether the injury as viewed fits the explanation provided. • If another explanation is given for the cause of the injury, follow up on this explanation by visually examining the alleged site of the injury (if possible) and taking photographs. • An abusive parent or sibling will usually blame the injured child for causing the situation. • If the suspect denies causing the injury, present him with the information that has already been obtained (e.g., hand measurements, witness information, time, location, opportunity). • Most guilty suspects will admit to the temporary loss of control and slapping the child in anger. State that you understand his loss of control, thank him for sharing the information, and tell him that it was helpful. This may help him to share additional information. • While taking statements or admissions: – Allow the parent or sibling to provide details of the incident – Compare the explanation to the injury – Follow department procedures for taking statements (initialed, signed). • If possible or necessary, obtain a medical history of the child to rule out medical causes for the injury. (See Appendix F, *Distinguishing Physical Abuse from Nonintentional Injury*, for more information.)

Action	• Determine what actions should be taken by CPS or law enforcement agencies: – CPS may decide that the situation can be handled best with family counseling and follow-up services – Law enforcement may elect to close its investigation with the recommendation that CPS works with the family – Arrest may be considered depending on the family history and the risk of potential injury to other family members. – Local prosecutors should be consulted to ensure that the injuries sustained meet the State or local statute's definition of child maltreatment. • Medical exam of the child often is legally mandated for any arrest for child physical abuse: – First responders should check their agency's and State's regulations – Even if an exam is not mandated, the first responder should consult with medical staff about what additional treatment, if any, is recommended. • Photographs and measurements should be taken and documented appropriately. • Follow-up photographs should be taken to document the approximate age of bruises, should they develop. • Determine if arrangements need to be made for the child. Arrangements for the child should be made prior to leaving the school. Possible arrangements include: – The child remains in school and follows his normal schedule. – The child goes to a friend's house after school. – The child is temporarily cared for by others.

Sexual Abuse Case: Incest

Synopsis	A local middle school counselor contacts the child abuse hotline and reports that a 12-year-old female student from her seventh grade class reported that her father sexually abused her. The abuse allegedly started at age 9 and continued until the present. The last incident involved sexual intercourse and occurred 2 days ago. The child is fearful of telling her mother and is worried about her family.
Initial Response	• Establish the required response time and arrange for any other first responders to arrive simultaneously. • Meet with the principal or other authorized school personnel to gain access to a quiet, private interview room. • As the reporter, the school counselor should be interviewed: – Discuss the method of disclosure – Obtain the questions asked and responses given – Obtain a written statement from the counselor (signed, initialed, and dated) – Direct the counselor not to discuss the interview with the other parties at this time.
Theories	• Develop multiple theories of the sexual abuse: – The complaint is true as alleged – The counselor misunderstood the information – The child is making a false complaint. • Follow up on the theories developed: – Interview the child – Locate witnesses – Corroborate information – Locate and collect evidence from the crime scene.
Interview	**In general:** • The details of *each* incident of sexual abuse can provide corroboration of facts and are important for establishing credibility for the victim. Attempt to establish a timeline for separate incidents, including: – The last incident – The time before the last incident – Other remembered incidents – The location of any other household members during each assault (mother working late, mother at store, brother playing outside).

Interview	**Child interview:** • Locate a private place in the school to conduct the interview. • A joint interview with CPS and law enforcement is recommended to minimize the number of times the child is interviewed. • Explain to school personnel that they should not be present during the interview because they may be subpoenaed for court and the details could be embarrassing for the child. • Conduct a forensically sound interview: – Follow agency guidelines for establishing interview rules. – Skilled interviewers try to obtain as much narrative from the child as possible. Begin with basic probes, such as: • Do you know why we came to talk with you? • Please tell me what you told your counselor. • Please tell me what happened with your father. • Most children older than age 5 can provide narrative responses to open-ended questions (e.g., "Tell me everything that happened in the bedroom, from the beginning to the middle to the end."). However, children may be embarrassed, ashamed, or scared of providing many intricate details about sexual foreplay and acts. It therefore may be necessary to ask more direct or focused questions. Remember that direct and focused questions should always be followed by open-ended probes (e.g., "Tell me more about the room." or "Tell me more about the touch."). *Exhibit M-1 provides examples of detailed questions to ask the victim.* **Nonoffending parent interview:** • Make contact with the nonoffending parent prior to leaving the school. A nonoffending parent who is at work can be contacted at work and asked to meet the first responders at the parent's residence. • Tell the nonoffending parent: – "We are at your child's school, and your child is physically fine." – "We are looking into a matter that we cannot discuss over the telephone." • Most nonoffending parents will respond immediately when a serious matter is raised about their child. • A very small percentage will call the other parent and have him or her respond as well. However, because the nonoffending parent has no information, he or she usually assumes it is something about school and will not call the other parent. • If the parent is not able to return to the home, arrange for an immediate meeting place. • Assess the nonoffending parent's abilities to believe the child and to protect the child from further abuse. • Prevent the destruction of evidence.

Interview	• Attempt to obtain the following information from the nonoffending parent: – Observations of the situation – Knowledge of the relationship between the father and daughter (e.g., attitude or behavioral changes such as the daughter not wanting to stay home alone with the father) – Timeline information, such as the nonoffending parent's work schedule (any late hours), which can be compared to the timeline given by the child – Relationship with spouse (e.g., domestic violence, fear, sexual problems). • Assess the reaction of the nonoffending parent. The nonoffending parent usually will be understandably in denial. She may accuse the first responders of making up the allegations or of misunderstanding the information. – Do not overreact to anger or to initial disbelief on the part of the nonoffending parent. First responders want and need information. Every word from the nonoffending parent can be critical to the case. – Allow the initial denial, and then proceed with questions. Examples of questions that may be asked include: • "Can you tell us about your spouse?" • "Does your spouse get up in the night?" Possible responses may include, "Yes, he gets up to smoke a cigarette" or "He goes to the bathroom." – Questions also may need to be asked regarding domestic violence, fear, and sexual problems. – If the alleged victim provided a description of the alleged perpetrator's underclothing (e.g., boxer shorts with hearts, green shirt), have the nonoffending parent corroborate these facts. Items will be seized and collected from the residence. – If the victim provided a description of the father's anatomy (e.g., penis, moles, tattoo, shaved pubic hair), have the nonoffending parent confirm. – Use your skill and knowledge to keep an open mind, and do not overwhelm the nonoffending parent with information: • Do not let prior experience or current knowledge of the case immediately lead you to preconvict the suspect. For example, do not say to the nonoffending parent, "We know he did this. We know he is a child molester. We know this happened." • Nonoffending parents have many initial reactions, but they usually want to provide helpful information during the initial interview to determine the truth. First responders want this information and must maintain rapport. – Allow time for the nonoffending parent to begin to acknowledge that the incident might be true. – Nonoffending parents will often unknowingly provide corroborative information (e.g., "I took my son shopping last weekend," "I worked late on Thursday," "He has two pairs of boxer shorts with hearts on them," or "He gets up to smoke a cigarette at about 2:00 in the morning."). – Explain in a diplomatic manner that you would like to conduct a search of the residence for evidence. Law enforcement can have the nonoffending parent sign a consent-to-search form. (Follow department guidelines for consent to search legal issues.) This generally is not difficult at this stage of the investigation.

Interview	– If the nonoffending parent refuses to allow the first responders to conduct a search, law enforcement should obtain a search warrant. (Follow department guidelines for search warrant applications.) – Understand that this is a serious crime and that all evidence should be seized from the crime scene. The nonoffending parent should not be allowed to interfere with or to destroy evidence. CPS and law enforcement may have someone stand by at the residence to prevent evidence destruction while time is taken to obtain a search warrant. **Alleged suspect interview:** • Evaluate the information previously reported and collected for: – Corroboration or noncorroboration of the alleged victim's statement – Clarification of previously reported information that may have been misunderstood – Indication of false statements – Crime scene evidence. – Obtain the suspect's work schedule. • Plan when and where the suspect will be interviewed. • The element of surprise is critical. Do not warn the suspect by contacting him prior to the interview, thus giving him time to delay. • The suspect may live with the victim, and so the interview should be conducted on the same day that the accusations are made in order to: – Protect the victim and other household members – Prevent further criminal behavior in the community – Prevent threats and intimidation of the victim and the witnesses – Prevent the destruction of evidence – Prevent a false alibi from being established – Prevent the suspect and the nonoffending parent from pressuring the victim to retract or recant the statement. • Maintain a professional demeanor. A calm and systematic approach should be used to establish factual information. • Follow department guidelines for Miranda rights issues.

Interview	• The following statements may be helpful when interviewing the suspect: – "Sir, we are conducting a sensitive investigation. Is there someplace we can talk privately?" (Suspects will find a private place to talk if they are confronted at work.) – "Sir, we were at your daughter's school today, and she reported a problem." – "Sir, she told us that there had been some inappropriate contact." (Most guilty suspects will not ask for the details of what is meant by inappropriate contact because they already know the answer.) – "Sir, we have interviewed your wife, and we know that she was at work late on Thursday" **or** "We know what happened at home." – "Sir, we have conducted an investigation, and we have corroborative evidence from your home and the beach house." • During the interview, alleged suspects may respond with one or more of the following statements: – "I don't know what to say." – "I may have gone into her room one time." – "Could I have done this and not remember?" – "Could I have been drinking and not remember?" – "I don't recall ever touching her." – "Could I have done this accidentally?" • Be patient and let the suspect know that you believe the victim. The following statements may be used: – "Sir, we know this happened. We just want to know how it got started." – "Sir, we know that you would never deliberately hurt your daughter." – "Sir, you have a problem, and we need to talk about what happened." – "Sir, we have evidence to match to your DNA. We collected the sheets, pants, underwear.." – "Sir, I know you don't feel good about what happened. I think you would agree that you owe this to your family." • Expect denial and numerous stalling techniques: – "Why would I do that?" – "I don't know why she is saying that." – "I love my daughter and would not hurt her." – "I don't know what to say." • Note the behavior and body language of the suspect during the interview. Most guilty suspects make little eye contact and generally look down during direct assertions of guilt. Innocent individuals often are highly insulted at the insinuation that they molested a child. • Do not rush the interview. Plan on spending a minimum of 2 hours with the suspect. Possible child molesters must be interviewed thoroughly and completely.

Interview	• Remember to use silence as a tool during the interview. There is no need to fire repetitive questions one after another during an interview: – Looking up at the suspect and writing down notes also provides time to think of additional questions – Remember, suspects have no idea what information the first responder knows or what she is thinking. • Do not lose patience and assume the suspect is not going to provide a confession or admission. Most suspects want to unburden themselves by admitting their guilt. Several approaches can be used: – Ask the suspect what he thinks should happen to someone who touches a child. The answer is usually a projection of what he would like to see happen to himself. For example, the suspect may say, "They should probably get some psychological counseling" or "They need help." – Provide the suspect with a "bridge to cross," which can allow the suspect the ability to confess while still saving face. For example, ask the suspect if this could have happened by accident. Examples of suspect statements that indicate a desire to confess include: • "I may have touched her by accident while wrestling." • "I may have accidentally gone into the wrong bedroom." • "I was drinking alcohol and thought it was my wife." • "I was drinking alcohol and don't remember." • "I don't recall ever doing this." • "Could I have done this and not remember?" • "I was just rubbing her back and my hand slipped down." • "I accidentally fell and my mouth landed on her privates." • "I wanted to teach her about sex." • "I would never deliberately hurt my child." • "If you want me to say I did this, then I did." • "She wanted me to touch her." • "She put her body on me." – Recognize the above statements as a desire to confess, and follow up with open-ended probes. For example, use the following probes in response to the above statements: • "Tell me more about the wrestling." • "Tell me more about the time you accidentally went into the wrong bedroom." • "Tell me more about the time you were drinking." • "Tell me more about rubbing her back." • "Tell me more about your hand accidentally slipping down." • "Tell me more about the time you accidentally fell onto her body." • "Tell me more about how she wanted you to touch her." • "Tell me more about how you wanted to teach her."

Interview	– Allow the confession to contain excuses and minimization during the initial statement. Details can be obtained later in the written documentation. • Maintain a professional tone and demeanor throughout this interview process. Child molesters may be more willing to confess to those who listen and do not make personal judgments. • Try to obtain a confession because: – It may be the only available evidence. – It may lead to other physical evidence. – It may corroborate the statements of the victim. – It relieves the child of the burden of carrying the entire case in court. – It may lead to the discovery of other victims. – It generally will convince the nonoffending parent of the suspect's guilt. – It may prevent the child from needing to testify. – It may prevent further child abuse. – It may prevent recantation pressure on the child. – It provides the prosecutor with evidence needed to go forward with the court case.
Action	• If appropriate, take the child to a local hospital to be examined for: – Genital trauma – Forensic evidence • Semen (within 72 hours of assault) • Saliva • Hair transfer from suspect to victim • Trace evidence (e.g., fibers, material found under fingernails) • Bite marks or scratches • Bruises and blood. • Investigate the crime scene: – Photograph the entire crime scene. – Sketch the crime scene, including measurements. – Locate items to be seized, such as the victim's clothing. – Using an evidence vacuum with filters, vacuum the areas in the room for the suspect's hair or other evidence. – Utilize forensic illumination (such as luminol) for detecting semen or blood. – Number and photograph items in the location where they were found. – Collect all bed sheets, covers, and pillow cases and fold them inward to prevent hair and fibers from falling off. – Locate, photograph, and collect the suspect's clothing. – Take any computers to check for further evidence, such as child pornography. – Identify sounds, lights, odors, and other corroborative information provided by the victim (e.g., door squeaks, floor creaks). – All separate crime scenes must be identified and included in processing (e.g., basements, vehicles).

	– Forensic evidence can be located many days, weeks, or months after the alleged incident. Many cases have been solved by locating forensic evidence, such as blood or semen on carpets, rugs, wooden floors, mattresses, and bedcovers, months or years after the crime took place. Evidence may be where it is not expected. For example, victims often pull covers over themselves after the assault. Therefore, saliva and semen may be present on the underside of bed covers. – Attempt to reconstruct the crime for the purposes of locating forensic evidence, as is done in other serious crime scenes (e.g., the suspect knelt on the floor beside the bed while touching the child; suspects often will masturbate in this position.). – Maintain the chain of custody of seized evidence. Dates, times, locations, and persons who collected the evidence must be recorded for all items seized. Follow department protocols for this. There also should be an evidence inventory list, which is an itemized list of the evidence that was seized. Maintain a separate log for the chain of custody of all seized evidence. – Be prepared for a delay in receiving the evaluation results of the forensic evidence. Have a general knowledge of what was identified and collected from the crime scene (e.g., possible semen, hair, clothing, pajamas, underwear). This information will be beneficial when interviewing the suspect. • Determine what the next steps should be: – Decide if the child is safe in her home or if she should be placed with a relative or in another out-of-home setting. • If a confession is obtained, the suspect should be arrested and placed in custody, unless the law enforcement officer is conducting a noncustodial interview and the suspect was not Mirandized. In this case, the suspect should be allowed to leave, even for a short time (e.g., 1 hour) to show the court that he was not arrested. An arrest warrant or physical arrest could occur shortly after the suspect or the first responder leaves the interview scene. • At some point, law enforcement may want to use a polygraph as a part of the interview. (The use of polygraphs is beyond the scope of this manual.)

Exhibit M-1
Alleged Sexual Abuse Victim Interview Dialog

The following are portions of a typical interview of an alleged sexual abuse victim. *Please note that because of the nature of the alleged abuse, the interview questions and answers are graphic.*

Interviewer: Tell me everything that happened the last time. Start at the beginning and tell me what happened.

Child: I was sleeping and heard the bedroom door open. The floor makes noise when you walk on it.

Interviewer: Tell me more about the noise.

Child: The door creaks a little. The floor makes a squeaking noise.

Interviewer: Tell me more about what happens after you hear the floor creak **or** Then what happens?

Child: He touched me.

Interviewer: Tell me what happens right before he touches you.

Child: He pulls my covers down.

Interviewer: What happens right after he pulls your covers down?

Child: Then he touches my privates.

Interviewer: What clothes are you wearing?

Child: Pajamas.

Interviewer: Tell me what happens with the pajamas **or** Tell me what happens after he pulls your pajamas down **or** What else are you wearing?

Child: Underwear.

Interviewer: Tell me what happens with the underwear **or** What happens after he pulls down your underwear?

Child: He touches me.

Interviewer: Where does he touch you? (Note: the child may have a personal name for that part of her body. Examples include vagina, vulva, private, thing. The first responder may want to use anatomical drawings for clarification.) **or** What does he touch you with?

Child: His fingers.

Interviewer: Where is your father while this is taking place?

Child: He's on the bed.

Interviewer: Tell me what happened before he got on the bed.

Child: He took his pants off.

Interviewer: Tell me about his clothes (outer and under) **or** Tell me what happens when he gets on the bed **or** Tell me what happens right before the touch **or** Tell me what happens right after the touch.

Child: He put it in.

Interviewer: He put what in?

Child: His thing (penis, pee pee, dick). (Note: if the child is young and saw the penis, have her draw it on paper prior to using an anatomical drawing for body part identifications. It may be helpful to use anatomical drawings for clarification.)

Interviewer: Tell me what happens right before he put it in **or** What is he wearing? **or** Then what happened? **or** Where is his body? **or** Where is your body? **or** Tell me what happened after he put it in? **or** Then what happened?

Child: He licked my neck and breasts.

Interviewer: Then what happened?

Child: He just made a noise and stopped.

Interviewer: Tell me more about the noise **or** Tell me what you heard, tasted, or smelled **or** Then what happened?

Child: He got off and left.

Interviewer: What about the clothes?

Child: He put them back on.

Interviewer: Then what happened?

Child: I went to sleep.

Interviewer: What about your clothes?

Child: I pulled them back up.

Interviewer: Did he say anything? **or** Who was home when this happened?

Child: My brother.

Interviewer: Where was your mother (and any other household members)?

Child: Mom was working late; my brother was sleeping.

Interviewer: Did this ever happen any other time or any other place?

Child: Last week on vacation.

Interviewer: Let's talk about last week **or** Tell me more about that time **or** Tell me what you were wearing **or** Tell me what he was wearing **or** Tell me what you heard, smelled, tasted **or** Where was the rest of your family?

APPENDIX N

Assessing Disaster Survivor Immediate Needs Worksheet[1]

Instructions: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

Date: _____ Responder: _____

Survivor Name(s): _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
☐ Extreme disorientation	☐ Acute stress reactions	☐ Headaches	☐ Inability to accept or cope with death of loved one(s)
☐ Excessive drug, alcohol, or prescription drug use	☐ Acute grief reactions	☐ Stomachaches	☐ Distressing dreams or nightmares
☐ Isolation or withdrawal	☐ Sadness or tearfulness	☐ Sleep difficulties	☐ Intrusive thoughts or images
☐ High-risk behavior	☐ Irritability or anger	☐ Difficulty eating	☐ Difficulty concentrating
☐ Regressive behavior	☐ Anxiety or fear	☐ Worsening of health conditions	☐ Difficulty remembering
☐ Separation anxiety	☐ Despair or hopelessness	☐ Fatigue or exhaustion	☐ Difficulty making decisions
☐ Violent behavior	☐ Feelings of guilt or shame	☐ Chronic agitation	☐ Preoccupation with death or destruction
☐ Maladaptive coping	☐ Feeling emotionally numb or disconnected	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____		

[1] National Child Traumatic Stress Network, & National Center for PTSD. (2006). *Psychological first aid: Field operations guide* (2nd ed.). Available: http://www.nctsnet.org/nctsn_assets/pdfs/pfa/2/PsyFirstAid.pdf.

2. Check the boxes corresponding to other difficulties the survivor is experiencing.

- ☐ Past or preexisting trauma/psychological problems/substance abuse problems
- ☐ Injured as a result of the disaster
- ☐ Loved one(s) missing or dead
- ☐ Financial concerns
- ☐ Displaced from home
- ☐ Living arrangements
- ☐ Lost job or school
- ☐ Assisted with rescue/recovery
- ☐ Has physical/emotional disability
- ☐ Medication stabilization
- ☐ Concerns about child/adolescent
- ☐ Spiritual concerns
- ☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

4. Referral

- ☐ Within project (specify) _____
- ☐ Other disaster agencies
- ☐ Professional mental health services
- ☐ Medical treatment
- ☐ Substance abuse treatment
- ☐ Other community services
- ☐ Clergy
- ☐ Other: _____

5. Was the referral accepted by the individual?

- ☐ Yes
- ☐ No

APPENDIX O

Continuity of Operations Plan (COOP) Outline[1]

I. Executive Summary

- Briefly outlines the organization and content of the COOP
- Describes what it is, whom it affects, and the circumstances under which it should be executed
- Discusses the key elements of COOP planning
- Explains the organization's implementation strategies.

II. Introduction

- Explains the importance of COOP planning to the organization
- Discusses the background for planning
- References recent events that have led to the increased emphasis on the importance of a COOP capability for the organization.

III. Purpose

- Explains why the organization is developing a COOP
- Briefly discusses applicable Federal/State/local guidance
- Explains that the COOP is intended to ensure the continuity of functions essential to the mission and duties of the organization.

IV. Applicability and Scope

- Describes the applicability of the plan to the organization as a whole (i.e., management, staff, clients, other stakeholders)
- Outlines the scope of the plan (i.e., the spectrum of potential disasters it covers).

V. Essential functions

Essential functions are those organizational functions and activities that must be continued under any and all circumstances (e.g., provide safe foster homes for children, investigate cases of potential child maltreatment).

[1] Adapted from Federal Emergency Management Agency. (2004). *Continuity of operations plan (COOP) template*. Available: http://www.fema.gov/doc/government/coop/coop_plan_template_instructions.doc.

This section should:

- Identify and prioritize all essential functions
- Establish staffing and resource requirements for each
- Integrate supporting activities from other agencies or departments.

VI. Authorities and References

- Provides a brief overview of the supporting authorities and references that have assisted in the development of this COOP. This may include relevant Federal, State, or local regulations or policies, as well as outside sources (e.g., articles, books) that affect or shape the development and implementation of the COOP.
- References the COOP appendix that provides a full listing of authorities and references.

VII. Concept of Operations

- Explains how the organization will implement its COOP and how it plans to address each critical COOP element
- Should be separated into three phases: activation and relocation, alternate facility operations, and reconstitution.

A. Phase I: Activation And Relocation

- Explains COOP activation procedures and relocation procedures from the primary facility to the alternate facility, if necessary
- Addresses procedures and guidance for personnel who will not be relocating to the alternate facility.

1. Decision Process

- Explains the logical steps associated with implementing a COOP and the circumstances under which a plan may be activated (both with and without warning)
- Identifies who has the authority to activate the COOP.

2. Alert, Notification, and Implementation Process

- Explains the events that should occur after a decision to activate the COOP, including employee alert and notification procedures and the COOP implementation process.

3. Leadership

a. Orders of Succession

- Identifies the orders of succession to key positions within the organization to ensure the organization's ability to manage and direct its essential functions and operations
- Outlines the conditions under which succession will take place, the method of notification, and any temporal, geographical, or organizational limitations of authority.

b. Delegations of Authority

- Identifies, by position, the authorities for making policy determinations and decisions at the agency level, on the front line, and at other organizational locations and levels, as appropriate. Generally, predetermined delegations of authority will take effect when normal channels of direction are disrupted and terminate when these channels have resumed. Such delegations may also be used to address specific competency requirements related to one or more essential functions that are not otherwise satisfied by the order of succession.
- Documents the legal authority for making key decisions
- Identifies the programs and administrative authorities needed for effective operations

- Establishes capabilities to restore authorities upon termination of the event.

c. Devolution/Worst-case Scenario

- Addresses how an organization will identify and conduct its essential functions in the aftermath of a worst-case scenario—one in which the leadership is incapacitated. The organization should be prepared to transfer all of its essential functions and responsibilities to personnel at a different office or location.

B. Phase II: Alternate Facility Operations

- Identifies initial arrival procedures
- Establishes operational procedures for the continuation of essential functions.

1. Mission Critical Systems

- Addresses the organization's mission critical systems necessary to perform essential functions and activities
- Defines these systems and addresses the method of transferring/replicating them at an alternate site.

SAMPLE

The following table shows examples of mission critical systems for a child welfare agency:

System Name	Current Location	Other Location
Child Abuse and Neglect Hotline	Agency HQ	Building X, which is equipped for call forwarding from Agency HQ
Investigations	Agency HQ	Individual caseworkers' homes, if possible, or Building X

2. Vital Files, Records, and Databases

- Addresses the organization's vital files, records, and databases that are necessary to perform essential functions and activities and to reconstitute normal operations after the emergency ceases.

SAMPLE

The following table shows examples of vital files, records, and databases for a child welfare agency, their format, and how they may be able to be accessed during and after an emergency:

Vital File, Record, or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Facility	Hand Carried to Alternate Facility	Backed up at Third Location
Locations of families served	Electronic	X		X
Child maltreatment report records	Hardcopy		X	X
Subsequent investigations	Hardcopy and electronic	X	X	X
Out-of-home placements	Electronic	X		X
COOP	Hardcopy and electronic	X	X	X

C. Phase III: Reconstitution

- Explains the procedures for returning to normal operations, including procedures for returning to the primary facility, if available, or procedures for acquiring a new facility
- Addresses notification procedures for all employees returning to work
- Outlines when and how normal lines of communication and leadership will be resumed
- Describes when and how an after action report can be developed to determine the effectiveness of the COOP and what changes may need to be made to it.

VIII. COOP Planning Responsibilities

- Includes COOP maintenance responsibilities.

SAMPLE

The following table shows examples of COOP maintenance responsibilities:

Task	Assigned Staff
Update COOP annually or after emergency	Agency Director, Emergency Response Committee
Update telephone rosters monthly	Director, Human Resources
Review status of vital files, records, and databases	Director, Data Systems
Develop and lead COOP training	Deputy Director
Plan COOP exercises	Interagency Liaison

IX. Logistics

A. Alternate Location

- Explains the significance of identifying an alternate facility (including staff homes), the requirements for determining an alternate facility, and the advantages and disadvantages of each location.

Alternate facilities should provide:

(1) Sufficient space and equipment

(2) Capability to perform essential functions within 12 hours, up to 30 days

(3) Reliable logistical support, services, and infrastructure systems

(4) Consideration for health, safety, and emotional well-being of personnel

(5) Interoperable communications

(6) Computer equipment and software

B. Interoperable Communications

- Identifies communication systems that are located at the alternate facility. These systems should provide the ability to communicate within the organization and outside the organization.

Interoperable communications should provide:

(1) Capability commensurate with an agency's essential functions

(2) Ability to communicate with essential personnel

(3) Ability to communicate with other agencies, organizations, and customers

(4) Access to data and systems

(5) Communications systems for use in situations with and without warning

(6) Ability to support COOP operational requirements

(7) Ability to operate at the alternate facility within 12 hours and for up to 30 days

(8) Interoperability with existing field infrastructures

X. Test, Training, and Exercises

- Addresses the organization's test, training, and exercise (TT&E) plan:
  - TT&E familiarizes staff members with their roles and responsibilities during an emergency, ensures that systems and equipment are in a constant state of readiness, and validates certain aspects of the COOP
  - Managers may be creative when it comes to COOP readiness and include snow days, power outages, server crashes, and other ad hoc opportunities to assess preparedness.

COOP TT&E plans should provide:

(1) Individual and team training of agency personnel

(2) Internal agency testing and exercising of COOP policies and procedures

(3) Testing of alert and notification procedures

(4) Annual refresher orientation for COOP personnel

(5) Joint interagency exercising of COOPs, if appropriate

XI. Multi-Year Strategy and program Management Plan

- Discusses how the organization will develop its multi-year strategy and program management plan:
  - The plan should address short- and long-term COOP goals, objectives, and timelines; budgetary requirements; preparedness considerations; and milestones or tracking systems to monitor accomplishments
  - It should be developed as a separate document.

XII. COOP Maintenance

- Addresses how the organization plans to update the COOP regularly
- Includes current key evacuation routes, roster and telephone information, and maps and room/building designations of alternate locations.

Appendix A: Authorities and References

- Cites a list of authorities and references that mandate the development of the COOP and helped to develop the COOP.

Appendix B: Operational Checklists

- Contains operational checklists for use during a COOP event. Checklists may be designed to list the responsibilities of a specific position or the steps or equipment required to complete a specific task.

Appendix C: Alternate Location/Facility Information

- Includes general information about the alternate location/facility, such as the address, points of contact, and available resources.

Appendix D: Maps and Evacuation Routes

- Provides maps, driving directions, and available modes of transportation from the primary facility to the alternate location
- Includes evacuation routes from the primary facility.

Appendix E: Definitions and Acronyms

- Provides definitions of key words, phrases, and acronyms used throughout the COOP and within the COOP community.

Appendix F: Agency Contact Information

- Includes the names and contact information, as well as emergency contact information, for all staff.

Appendix G: Partner Contact Information

- Includes the name, contact information, and liaison for all partner agencies or other organizations or individuals that the agency may need to contact during or after an emergency.

To view or obtain copies of other manuals in this series, contact Child Welfare Information Gateway at:

800-394-3366
info@childwelfare.gov
www.childwelfare.gov/pubs/usermanual.cfm