# Multidisciplinary Protocol for Investigation of Suspected Child Abuse in Coconino County

Revised August 2006
Developed by the Coconino County Interagency Council

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# I. Statement of Purpose

Coconino County hopes to assist children affected by abuse or neglect. We believe the best assistance to victimized children at this time in our County is judicial advocacy. The joint efforts of law enforcement, child protective services, medical, behavioral health and victim advocacy services can significantly reduce the secondary victimization experienced by many children and their families when these systems intervene after a suspected crime has occurred. Joint efforts can also enhance the effectiveness of a judicial response by allowing for a more complete, richer investigation.

# II. Agencies Participating in InterAgency Protocol

Alternatives Center for Family Based Services
ChildhelpUSA
Coconino Coalition for Children
Coconino County Attorney's Office
Coconino County Sheriff's Department
DES – Child Protective Services
Federal Bureau of Investigation
Flagstaff Medical Center Behavioral Health Department
Flagstaff Police Department
Flagstaff Unified School District
Grand Canyon Unified School District
The Guidance Center
National Park Service
Northern Arizona University Police Department
Northland Family Help Center
Page Police Department
Safe Child Center at Flagstaff Medical Center
Victim Witness Services for Coconino County
Williams Police Department
Williams Unified School District

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We also acknowledge other Arizona Counties for sharing segments of their protocols with us and allowing us to incorporate material into our own.

# III. General Guidelines

A joint investigation is required in response to any report of Extremely Serious Conduct Allegations (ESCA) that occurs in Coconino County. The role of Child Protective Services (CPS) is to assure the safety of the child. The role of law enforcement (LE) is to investigate a criminal allegation. Supporting agencies, such as Safe Child Center (SCC) and Northern Arizona Center Against Sexual Assault (NACASA) assist with gathering data and providing children with a neutral, child-friendly environment in which to tell their experiences, be examined, and receive information about services which might be helpful to them and their families. Victim Witness Services (V/WS) is dedicated to delivering crisis intervention, advocacy services and victim compensation to victims of crime. The County Attorney's Office (CCAO) mission is to prosecute crimes against children.

## A. Definitions

**Extremely Serious Conduct Allegation (ESCA)** is defined as:

ARS 13-3623 – Child Abuse
13-3601 felony–Domestic Violence
13-1404 – Sexual Abuse (involving a minor)
13-1405 – Sexual Conduct with a Minor
13-1406 – Sexual Assault (involving a minor)
13-1410 – Molestation of a Child
13-1417 – Continuous Sexual Abuse of a Child
any other act of abuse which may result in serious harm, injury or death to a child

- Indecent Exposure to a person under the age of 15 (13-3506)
- Public Sexual Indecency to a Minor (13-1403)
- Surreptitious photographing, videotaping, filming or digitally recording (13-3019)
- Child Prostitution (13-3212)
- Furnishing harmful items to minors (13-3506)
- Commercial Sexual Exploitation of a Minor (13-3552)
- Sexual exploitation of a minor (13-3553)
- Admitting Minor to public displays of sexual conduct (13-3556)
- Duty to Report Abuse (13-3620)

## B. Process for Joint Investigations

1. Each agency shall respect the response times and systems of the other agencies. (See Appendix G)
2. Each agency shall respond in a manner that preserves evidence, protects the victim and non-offending family and/or witnesses.

3. If there is a disagreement on response, contact the appropriate supervisor of the agency with whom you disagree. Utilize the "chain of command". Be prepared to identify issues and cite relevant statutory or policy conflicts.

4. Relevant information will be shared between agencies throughout the course of the investigation. Reporting Party identification is not legally allowed to be disclosed by CPS.

5. CPS and Law Enforcement shall document in their reports that this is a joint investigation.

6. CPS and Law Enforcement investigators shall monitor and/or participate in forensic interviews conducted by their counterparts whenever possible. If this is not possible, video and audiotapes of the interview shall be made available to the primary investigator by Safe Child, or the agency that did the interview.

7. CPS and law enforcement shall work in consultation with each other throughout the course of the investigation, prosecution and civil processes.

8. Documented consultation/collaboration between agencies (including Safe Child and NACASA) is recommended for case planning.

## C. Interagency Notification

1. If the report of an ESCA has been made to CPS, CPS shall immediately notify a law enforcement representative from the appropriate jurisdiction. (See Appendix R for Contact Information) If the report is first made to law enforcement, law enforcement shall immediately notify the **CPS Hotline designated for Law Enforcement: 877-238-4501** and may also notify a representative from CPS in the proper local office. This notification shall be made to the representative in a manner that assures receipt (verbal relay of information rather than written, phone message or email). Fax or email messaging is recommended as backup confirmation. It is recommended that the agencies notify each other prior to responding to the circumstance, thereby permitting an agreed upon and coordinated response. It is understood that exigent circumstances may require an expedited response to protect the safety of a victim, non-offending family member or witness.

2. CPS should contact the appropriate LE agency and notify that this is a joint investigation that requires a law enforcement response. This does not preclude a CPS professional from directly contacting an investigator.

3. LE will contact the CPS HOTLINE using the law enforcement designated phone number (877-238-4501). The law enforcement professional may also notify a representative from CPS in the proper local office.

4. Mandated reporters of ESCA from allied professional agencies are required to contact either Child Protective Services and/or Law Enforcement when making a report of suspected abuse/neglect. Please refer to Mandated Reporter (Section V) for more information.

### D. Guidelines for First Responders

In order to minimize further trauma and to enhance the fact-gathering process of the investigation, first responders should limit their questioning of the child victim to "minimal facts":

- What happened?
- When did it happen?
- Where did it happen?
- Who did this?

Additional questioning of parents, siblings, or other collateral witnesses may be necessary. Communication with respective supervisors or with the on-call deputy county attorney may also be indicated.

The first responders should follow their respective agency policy regarding further action, such as a medical forensic examination and forensic videotaped interview. Refer to the First Responder Checklist (APPENDIX B)

# IV. Protocols

## A. Law Enforcement

The purpose of law enforcement's response to incidents of physical and sexual abuse involving children is to determine if a crime has been committed and to bring to light those facts and circumstances necessary to bring the perpetrators into the criminal justice system. While pursuing the criminal investigation, law enforcement must be concerned with more than just statutory requirements and case law. Personnel must recognize the needs of the victim, as well as the responsibilities of other organizations involved in the protection, treatment, support and recovery of the victim.

Consequently, law enforcement shall coordinate their efforts with those of Child Protection and the prosecuting agency. During an investigation, CPS and law enforcement should share relevant information, as soon as possible, maintain on-going contact and monitor and/or participate in forensic interviews. Law enforcement shall remain mindful of response timelines which CPS is mandated to follow (see APPENDIX G).

As stated above in General Guidelines, notification between law enforcement and CPS shall occur in such a way as to ensure information has been received. The law enforcement officer is responsible for determining whether or not a criminal investigative response will be initiated.

In Coconino County, there are two advocacy centers designed to provide "one stop" for the investigation process: the Safe Child Center (SCC) located at Flagstaff Medical Center, serves children from birth to 18 and, in certain instances, developmentally disabled young adults; and the Northern Arizona Center Against Sexual Assault (NACASA) which serves victims 16 and older. Videotaped interviews can be conducted by investigators or child forensic interviewers; and medical exams are completed by health care providers with specialized training and knowledge. Victims respond best in a child-friendly, "soft" environment in which all disciplines can come together as a team to provide professional, efficient care and referrals to the victim and his/her family.

It is recommended that law enforcement utilize the Safe Child Center for the investigation of cases of sexual and physical abuse in children and NACASA for sexual abuse victims age 16 and older.

Law enforcement should notify Victim/Witness advocates upon report of a child crime. Options for notifying V/WS include:

1. Request dispatch page a crisis advocate to respond;
2. During office hours- call 928-779-6163 (Monday-Friday 8am-5pm).

Immediately upon report, the Victim Request For, Or Waiver Of, Pre-Conviction And/Or Pre-Adjudication Rights form shall be forwarded to Victim/Witness Services. (5200 E Cortland Blvd. Suite B-5, Flagstaff, AZ 86004 FAX: 214-8775)

Specific Issues for Child Physical Abuse/Neglect:

- Photographs shall be taken either by a law enforcement officer or SCC medical staff, when possible.
- Remember some bruising may be more prominent the day after the injury occurs. Photos shall include a ruler and color bar.

Specific Issues for Child Sexual Assault:

- A sexual assault kit may be considered at NACASA in child victims age 16 and older if an assault occurred within 96 hours of the report and there is a chance of finding biological evidence.

- A sexual assault kit may be considered at Safe Child Center if an assault occurred within 96 hours of the report and there is a chance of finding biological evidence. Each case will be considered individually based on the age of the child and the circumstances of the event.

Every ESCA case shall be submitted to the County Attorney's Office for review for criminal charges and for case tracking purposes. (see APPENDIX I)

## B. Child Protective Services

The primary purpose of Child Protective Services (CPS) is to protect children by investigating allegations of abuse and neglect, promoting the well being of the child in a permanent home, coordinating services to strengthen the family and prevent, intervene and treat abuse and neglect. CPS is primarily responsible for investigating in-home allegations of any act, failure to act, or pattern of behavior on the part of a parent, guardian, or custodian that may result in compromising the safety and well being of the alleged child victim.

The Arizona Department of Economic Security (ADES) is required, by law, to receive reports of child neglect and/or abuse 24 hours/day, 7 days/week and to initiate prompt investigation. CPS Specialists at the CPS Hotline, receive telephone calls at **1-888-767-2445** or TDD 1-800-530-1831 and written reports at P.O. Box 44240, Phoenix, AZ 85064-4240. These specialists screen incoming communications by using "cue questions" (see APPENDIX F). If the communication meets the definition of a report, then the report is given a priority. The report is sent to a field Supervisor who then assigns the report to a CPS Specialist to conduct the investigation. The CPS Response System (also APPENDIX G) guides the specialist regarding timelines and decision-making.

CPS actions rarely result in removal of children from the home. When there are safety concerns, CPS attempts to engage the family to the greatest extent possible in planning for voluntary interventions. After assessing the strengths and risks present in the family, CPS creates a safety plan and after care plan with the family which may include coordination with community and multidisciplinary team members and referrals to services.

When children are found to be in imminent harm, or there is no parent/guardian able or willing to provide care for the child, CPS and law enforcement have the authority to remove them from their home for up to 72 hours, excluding weekends

or holidays. CPS may also remove a child for up to 12 hours to obtain a medical exam, psychological evaluation and/or forensic interview in order to make a determination if maltreatment has occurred. If CPS cannot ensure the safety of the child in the home within that 72 hours time allotted, then a dependency petition is filed with the Coconino County Juvenile Court. The judge has the final decision on making the child a ward of the court through this process. A case plan is developed with the family to assist with either reunification and/or permanency for the child.

In Coconino County, CPS Specialists will coordinate their investigation with law enforcement, sharing relevant information, monitoring and participating in forensic interviews. This will be clearly documented in reports. High Priority or High Risk reports shall be handled with joint law enforcement/CPS investigations where the safety of the child has not been ensured. Other CPS reports may be handled jointly when requested by either agency.

In instances of ESCA, (when allegations, if deemed true, would constitute a felony), CPS and law enforcement will jointly investigate and document their coordination efforts. In the course of investigating a report not alleging current danger, if the CPS Specialist discovers evidence of an ESCA, he/she shall contact immediately the appropriate law enforcement supervisor having jurisdiction or call 911.

When law enforcement does not have sufficient personnel to respond, or a joint interview is otherwise not feasible, CPS may continue to conduct the investigation. CPS should contact the law enforcement agency by telephone or email within 24 hours of determining the outcome. CPS shall make available to law enforcement, upon request, all notes, reports, photographs, and medical records, including all previous CPS contacts regarding the child.

Records from CPS are available to law enforcement and prosecuting agencies , upon request, including a summary of all previous CPS reports concerning the child, family, or perpetrator, whether substantiated or not. When CPS records are provided to law enforcement or prosecution, only the following shall be redacted: Reporting Source, Identifying information of foster parents; Residence or school addresses of victims; Attorney-client privileged material.

Interviews of the child and/or family members will be conducted in accordance with CPS policies and procedures.

## C. Medical Forensic Exams

Medical forensic evaluations are an integral component of the child abuse investigation. Examinations should be conducted by highly trained and qualified

pediatric medical practitioners with special expertise in child abuse evaluation. Such practitioners are expected to conduct a complete medical history and physical examination with special attention given to signs and symptoms of abuse. Expertise is necessary in identifying medical conditions that may be mistaken for abuse. Practitioners are also expected to be willing and competent in providing expert testimony in judicial proceedings.
The investigators should consult with the medical providers in all cases of suspected ESCA. The facts of each ESCA will be collaboratively reviewed to assure that necessary and appropriate medical evaluation is performed in a timely manner.

**A. Purpose of the medical forensic evaluation**

1. To ensure the overall well-being, health, and safety of the child through:

   a. Providing necessary medical treatment for health conditions

   b. Reassuring the child and non-offending parent/caretaker about bodily concerns

   c. Identifying, preserving, and documenting forensically significant findings

2. Avoiding multiple medical evaluations

   a. It is essential that multiple medical examinations are avoided. Multiple medical examinations can be avoided by contacting medical forensic professionals very early in the investigation and coordinating the appointment with team members. The Safe Child Center and NACASA have the necessary equipment (colposcope and high quality digital cameras) along with trained medical experts who can identify, interpret, and document concerning physical findings. Repeated examination incurs unnecessary costs, can be traumatizing to the child, threatens the integrity of possible physical evidence, can lead to inadvertent contamination of the child's story, may delay appropriate medical treatment, and can lead to discrepancies in the medical record about potential physical findings. For these reasons and others, it is highly recommended that suspected child abuse victims are evaluated at an advocacy center such as Safe Child or NACASA.

3. Team Approach

a. It is recommended that members of the multidisciplinary team meet immediately prior to the medical evaluation to share pertinent historical information with the examiner to facilitate expeditious and thorough evaluation. The forensic interview is typically conducted prior to the medical evaluation to assist the examiner in understanding the reason for referral and to minimize duplicate history taking.

## B. Conditions necessitating medical forensic evaluation

1. History

- Suspected or known physical injury
- Presence of sexually transmitted infection (Gonorrhea, Chlamydia, Syphilis, Trichomonas, Genital Herpes, venereal warts, HIV) with or without a history of abuse
- Concerns of suicidal risk
- Physical complaints by the child (anogenital pain/bleeding, genital discharge or problems with elimination)
- Especially vulnerable children: non-verbal, preverbal, developmentally delayed
- Possible DNA/physical evidence

For information on signs and symptoms of abuse and neglect, see Appendix Q "Behavioral and Physical Indicators of Child Abuse and Neglect".

Cases of Extremely Serious Conduct Allegations (ESCA) should, at a minimum, be triaged for immediate medical evaluation.

2. Considerations for suspected sexual abuse

It is recommended that any child disclosing sexual abuse with skin-to-skin contact involving the oral, breast and/or genital area receive a medical forensic evaluation. While 90% of sexual abuse examinations do not result in findings of physical evidence, this should never preclude the necessity of the examination. It is well documented that children tend to under-report and minimize the extent of abusive activities. Physical/sexual contact within the past 96 hours requires immediate medical triage to evaluate need for Code-R (rape kit) collection. This evaluation involves collecting recoverable biologic and trace evidence and documenting injuries. In some cases, the acute time frame may extend beyond 96 hours depending upon the history of contact. Injuries from sexual contact may still be visible days to weeks after the event depending on the nature/extent of the injuries. Victims are advised NOT to bathe or change

clothing prior to the medical evaluation. A vaginal speculum exam in pre-pubertal girls is not required except in cases of suspected foreign object or internal vaginal bleeding. In these cases, the exam is conducted under general anesthesia in the operating room, with parental consent or court order. Guidelines for evaluation of child sexual abuse are followed according to the American Academy of Pediatrics (see APPENDIX C).

### C. Procedure for the medical forensic evaluation

Components of the medical forensic evaluation for child maltreatment usually include the following:

- Review of any available medical records prior to examination
- Complete medical history with emphasis on signs and symptoms of abuse
- Explanation of examination procedure to child and attending family member (non-offending party)
- Parent/supportive person may be in exam room with child
- In cases of extreme physical abuse the children may be transported to a hospital in Phoenix for pediatric intensive care services or be evaluated and treated by the FMC Emergency physician in collaboration with the Safe Child Nurse practitioner. Patients with emergent or life-threatening conditions that are discovered during the physical exam are transported to the FMC Emergency Department located across the street via ambulance.
- History of chief complaint directly from child outside the presence of parent/adult to assist in medical diagnosis and treatment and addressing safety concerns
- Complete head to toe exam with emphasis on areas of the body concerning abuse (i.e. sexual abuse concerns, the examiner will carefully examine anogenital area with colposcope as indicated)
- Collect necessary laboratory specimens for medical diagnosis and treatment (for STI's, pregnancy, other infections)
- Other diagnostic testing such as imaging studies as indicated.
- Collect necessary forensic specimens (clothing, DNA evidence, etc.)
- Capture images on colposcope or other digital camera for medical forensic purposes.
- Written and sketched documentation as indicated
- Medical and behavioral health referrals as clinically indicated
- Treatment of injuries, infections, adhesions.
- Prophylaxis of STI's and pregnancy prevention. Medications obtained from FMC pharmacy or prescriptions given to parents/guardians
- Referral to other medical specialists based on exam findings, for evaluation of medical condition, follow up testing or treatment for severe injuries. Referral to behavioral health services for most patients.

- Comprehensive patient/family education on exam findings, follow-up, treatment, and phone numbers for primary contact MDT members involved in the case.
- Safety of child is of utmost importance and is assessed with CPS and or Law enforcement officer prior to the child leaving Safe Child Center or NACASA
- Differential diagnosis of other medical conditions that may explain findings that mimic signs of child abuse
- Proper handling, preparation and packaging of forensic evidence with chain of custody maintained
- Preparation of a medical report for investigative agencies
- Discussion with child, family members and MDT regarding results of medical evaluation

## D. Consent for medical forensic evaluation

Consent for an exam must be obtained PRIOR to the evaluation by the parent or authorized legal guardian when children are evaluated at the Safe Child Center. As a hospital-based child advocacy center, SCC is bound by HIPPA regulations. Forms may be obtained on the Safe Child website: fmcsafechild.com. HIV testing can only be authorized by the parent or a judge/court order, or by the adolescent him/herself 13 years and older.

## E. Referring a child for medical forensic evaluation

Referrals to the Safe Child Center are made by calling the Safe Child Center's central number (928) 773-2053. During regular business hours, M-F 8-4:30 the office coordinator will gather the necessary intake information and schedule the appointment in a timely manner based on urgency of physical symptoms, disclosure and safety concerns. If there is any question of how urgent the case is medically, the office coordinator contacts the nurse practitioner for assistance. Medical triage is available 24/7 directly through the Safe Child Center. Two forensic nurse practitioners staff the Safe Child Center for medical evaluations and share call for after-hours response. After hours, the nurse practitioner on call is paged through the central number, the practitioner will triage the call, and conduct a medical evaluation (as clinically indicated) directly with the requesting party (emergency department/physician, law enforcement officer, CPS worker, etc.). Medical forensic examinations for cases of suspected child abuse are conducted at the Safe Child Center at Flagstaff Medical Center. In some cases a child will be examined in the Emergency Department at FMC depending on the nature of the injuries and medical stability of the patient. If at any time a field officer/investigator is uncomfortable with the medical stability of a presenting victim the officer should refer the victim immediately to the emergency department. The medical and/or nursing staff in the emergency department will contact the nurse practitioner on

call.

Some cases of serious or unusual maltreatment may require referral to other pediatric medical professionals in or out of the County. The Safe Child Center clinical staff will facilitate appropriate medical referrals. Flagstaff Medical Center will not deny treatment to any child due to inability to pay.

Children aged 16 and over can be referred to NACASA for a medical exam by requesting Dispatch page Victim Witness Services.

## D. Forensic Interviews

The recommended method of gathering information is a videotaped forensic interview by a trained interviewer. It is recognized that exigent circumstances may necessitate a minimal facts interview by a first responder. In this instance, it is preferred that this interview be audio-recorded, and be limited to essential fact-finding and non-leading questions.

Whenever possible, the interview should be conducted at Safe Child Center, a child advocacy center at Flagstaff Medical Center, or on the ChildhelpUSA mobile unit, which are child friendly environments and equipped to videotape and audiotape interviews. It is recommended that the interviewer shall have completed forensic training, have the approval of his/her prosecuting agency, and have skills, ability, and experience. The interviewer should also participate in periodic peer reviews that include reviews of actual videotaped forensic interviews using the "Criteria for Forensic Interview Transcript and Video Recording Interviews" form. The interviewer should also have familiarity with child development, child abuse and neglect dynamics, and child abuse and neglect legal issues.

The interviews should be conducted with a neutral, fact finding approach. The interviewer should be supportive and kind, but remember that his/her role is to collect data that best reflects the child's experience. The interviewer is not a therapist or advocate. Interviewers should recognize that while adhering to an interviewing protocol, methods may need to be modified to accommodate very young children, children with special needs, and children of different cultures and backgrounds.

Interviewers should obtain relevant background information prior to the interview. Children should be interviewed only with the interviewer present. Only in rare circumstances should a child be interviewed in the presence of a third party. Law enforcement or CPS specialists can observe the interview from another location, as well as medical personnel, County Attorney's and or Attorney General's, the child's court appointed Guardian ad Litem, and, in some instances, mental health professionals. Trainees and interns may observe in some circumstances when

they are working directly with another team member and after signing a confidentiality agreement.

Child interviewing protocols which are recognized as fact-finding and supported in the peer reviewed literature are acceptable. In general, the stages of an interview should be conducted as follows: Rapport building, ground rules, free narrative, focus questions, closure. (See APPENDIX D for Guidelines.)

## E. Mandated Reporter Response

(See APPENDIX A)
Educators, child care staff, medical providers, clergy, victim advocates, behavioral health professionals, other service providers, or any person who has the care and treatment of a minor are mandated reporters. This means that if there are any facts from which one could reasonably conclude that a child has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect, the person knowing those facts is required to report to the appropriate authorities. This immediate report is to be made regardless of who the alleged perpetrator is. Your duty is to report, not to investigate. Failure to report a known or suspected child abuse or neglect is a crime punishable under Arizona state law.

A mandated reporter who suspects abuse should ask only these four questions:

- What happened? (nature of the offense, i.e. sexual, physical)
- When did it happen? (last time?)
- Where did it happen? (this is for establishing jurisdiction, not for details)
- Who did this? (collect sufficient information to minimize misunderstanding, i.e. **which** uncle, etc.)

Mandated reporters should:

- document the conversation with child: use exact quotes and include the questions asked of the child; use/repeat the words and language used by the child without adding any of your own vocabulary
- not contact parents (CPS/LE will notify parent)
- refer all inquiries to law enforcement and/or CPS
- contact CPS Hotline and/or Law Enforcement

> Never promise what you cannot control or reassure with inaccurate or unknown information (i.e. "No one is going to jail"). Be calm, kind, supportive and listen carefully. Explain what you are required by law to do for their safety.

**Special Considerations:**

**a). Educators**

Educators are the most frequent reporters of child maltreatment due to their extensive contact with children on a daily basis. They are often the first people to whom children disclose abuse or who suspect abuse because they are well acquainted with the child and may notice behavioral changes or see physical evidence. School personnel and others who care for children, including those employed by private and public schools, child care centers, youth organizations, camps, and after-school programs are included.

1. Reporting

   a. Arizona mandatory reporting law, A.R.S. 13-3620 (see APPENDIX A), requires that school personnel, or any person who has responsibility for the care or treatment of a minor, who **reasonably believes** that a minor has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect **shall immediately report or cause a report to be made.** If school personnel fail to report known or suspected child abuse or neglect, then they have committed a crime that is punishable under A.R.S. 13-3620. Failure to report sexual offenses is a Class 6 felony.

   b. Abuse reports shall be telephoned to the CPS Hotline 1-888-SOS CHILD (or 1-888-767-2445), if the suspect has care, control, or custody of the child; and it is encouraged that reports also be made to law enforcement if the child is believed to be in imminent harm or danger or has visible injuries.

   c. Abuse reports shall be made to law enforcement only if suspect does not have care, custody, or control of the child.

   d. If the suspect is a person certified by the State Board of Education, A.R.S. 15-514(A) requires that a report also be made to the Department of Education in writing as soon as is reasonably practicable but no later than 3 business days after any certified or governing board member first suspects or receives a reasonable allegation of the conduct.

   e. Reports of suspected abuse are required to be followed in writing within 72 hours on either the form supplied by the

school district, or the Child Abuse Reporting Form (see APPENDIX E).

f. Both statutes (A.R.S. 13-3620 and 15-514) grant immunity from civil damages to those making reports, provided the report was made in good faith

2. Gathering Information

a. In order to minimize the number of times the child is interviewed, minimize disclosure trauma, and insure that the most appropriate and qualified professionals conduct the investigation, school personnel should NOT pre-interview children or call in school mental health practitioners to try to determine if the report is credible or if a report should be made.

b. Limit questioning to those four questions listed (Who, What When, Where). Remember, it is not the job of school personnel to investigate or establish beyond a doubt what has occurred. Make every effort to document the child's exact words. DO NOT contact parents. Refer any questions by parents to CPS or law enforcement.

c. School personnel may gather additional demographic information in order to respond to anticipated questions by the CPS Hotline or Law Enforcement. (Refer to APPENDIX F for Hotline Cue Questions) However, you can still make a report without knowing all the information being asked.

3. Third Party Reports

a. In the case of a third party report (someone tells school personnel that a child has been maltreated), the school should make the report based on the information provided and should not call in the child for an interview.

4. Confidentiality

a. Maintain confidentiality of all information regarding the abuse report, except when information is requested by CPS, law enforcement, or the County Attorney.

b. Never promise or reassure the child what you cannot control (eg. "You won't get in trouble"). Be calm, kind, supportive and listen carefully. Explain what you are required by law to do for their safety.

c. You can assist the investigation by providing a safe, private place for law enforcement and/or CPS to speak with a child if they come to the school. CPS/law enforcement may interview a child about abuse allegations without parents or school staff present and schools are required to cooperate with investigators. (See APPENDIX L)

d. It is recommended that principals be advised when child abuse reports are made as the investigating agencies often respond first to the main office. Principals also are the first to receive inquiry calls from parents. Principals should never insist on prior screening of abuse reports as this interferes with school personnel's lawful compliance with the reporting mandate.

(NOTE: Flagstaff Unified School District (FUSD) personnel should refer to the pamphlet entitled "Responsibility of School Personnel for the Reporting of Suspected Child Abuse". FUSD principals and administrators should be familiar with information contained in "Arizona's Child Abuse Reporting Statutes: An Educator's Guide to a Complex Law" by A. Dean Pickett, as well as all FUSD policies and regulations. FUSD has designated Child Abuse Reporting Teams in each building: these teams are NOT investigators, but provide resources and support to staff regarding child abuse reporting issues.)

**b). Mental Health Providers**

Mental health professionals are advocates for victims and children. They may provide primary therapeutic intervention, support, information, and be a source of referral for child abuse allegations. The therapist or service provider may be the first person who hears a disclosure from a victim or third person. Reporting is mandatory. It is important to be familiar with current theory and research on child physical, emotional, and sexual abuse.

1. Reporting

a. Arizona mandatory reporting law A.R.S.1303620 (See APPENDIX A) requires that mental health and social service

professionals and other persons having responsibility for the care and treatment of children whose observation or examination of any child discloses **reasonable grounds to believe** that a child has been abused or neglected, are mandated to report immediately. "Reasonable Grounds" for reporting means if there are any facts from which one could reasonably conclude that a child has been abused, the person knowing those facts is required to immediately report to appropriate authorities. The statute also states that anyone who reports is immune from liability in any civil or criminal proceeding resulting from the report, unless the reporter has been charged with or is suspected of committing the abuse, or is acting with malice.

b. Every mental health agency should establish a procedure for following the law. Every mental health practitioner should be familiar with the reporting requirements by statute and by his/her licensing board.

2. Responding to Abuse Disclosures

a. When it appears that a child is disclosing information that may be considered abuse, the mental health professional should listen carefully and document direct quotes. Ask no leading questions. If the child does not spontaneously provide the information, only the four questions listed above should be asked (WHO, WHAT, WHEN, WHERE).

b. No further questioning should be done at this time. The therapist should remember that his/her role with the family and child is therapeutic, not investigative. Take care not to make promises that cannot be guaranteed.

c. Notify a supervisor (if applicable) of the disclosure. Report immediately to the law enforcement agency in the jurisdiction where the offense took place and to the CPS Hotline. This report should be followed with a written report within 72 hours (see APPENDIX E)

d. If imminent danger is suspected, law enforcement should be contacted immediately.

3. Request for Records

a. Per A.R.S. 13-3620, mandated reporters, including mental health practitioners, may be requested to release records to CPS and/or law enforcement.

b. A mental health practitioner who has any questions regarding the release or requested release of records should contact the County Attorney or Attorney General's Office.

## F. Victim/Witness Services

Victim/Witness Services for Coconino County is a private, not-for-profit, non-governmental agency. Victim/Witness advocates provide adult or juvenile criminal justice system information and support, advocacy, crisis response and social service referrals to assist the victim's emotional recovery from the crime.

Victim advocates assist child victims of physical and sexual abuse and children who have witnessed domestic violence in two ways: 1) On scene crisis intervention; 2) Criminal justice advocacy throughout the investigation and prosecution process.

### A. Crisis Response

1. The primary role of the Victim/Witness crisis advocate is to provide crisis response to victims and witnesses of crimes in the Coconino County area 24-hours a day, seven days a week. Crisis advocates respond to provide emotional support, victims' rights information, assess needs, explore options and provide referrals to other community resources.

2. Crisis advocates are dispatched by local law enforcement or service providers by pager to respond to victims of child abuse, child sexual abuse, or to domestic violence scenes where children are present.

3. Crisis advocates provide victims the following:

   a. Crime Victims' Rights information and explanation of Victim Compensation Benefits

   b. Focus on safety planning with both adults and children in domestic and sexual violence related calls

c. Provide community resource referrals to the parent or lawful representative of child abuse victims such as:
- o Shelters
- o Counseling
- o Community food bank
- o Public health nurses
- o Jail and court information
- o Legal assistance
- o Financial and emergency assistance
- o Order of Protection /Injunctions Against Harassment information

**B. Adult or Juvenile Criminal Justice Advocacy**

1. Advocates provide the victim/victim's lawful representative the following:

a. Information about the various steps a case will take as it progresses through the justice system

b. An explanation of victims' rights, and if the victim/victim's lawful representative wishes to exercise their rights, the advocate will assist them in doing so

c. Act as liaison between law enforcement, the deputy county attorney, and the victim/victim's lawful representative by facilitating communication

d. Provide detailed explanation of the various court proceedings, what those proceedings mean, what could possibly happen during the proceedings, as well as advise the victim/victim's representative of their options as criminal justice events occur

e. Keep the prosecutor apprised of the victim's well being and ensuring the victim/victim's representative has the opportunity to give opinion regarding prosecution and the final disposition of the case

f. Help the victim/victim's lawful representative exercise their rights, including facilitating the victim's wish to make an oral

statement to the court regarding pleas, conditions of release, continuances and sentencing

g. Provide referrals to the Coconino County Victim Compensation Program for assistance with compensable expenses

## C. Additional Supportive Services

1. Victim/Witness advocates provide the following supportive services, when appropriate, during the course of investigation and prosecution:

a. Initiate contact with the victim shortly after being assigned the case to establish rapport with the victim and their family and to assess the need for referral

b. Accompany the victim/victim's lawful representative to meet with investigators and prosecutors in order to provide emotional support

c. Act as an emotional support for the victim/victim's lawful representative during their participation in prosecution by accompanying them to court proceedings and explaining those proceedings

d. Provide short-term crisis intervention for the victim/victim's lawful representative throughout the prosecution of the case

e, Address any safety concerns that the victim/victim's lawful representatives may have throughout the criminal justice process

f. Facilitate security for the victim in court and provide appropriate referrals and safety planning for the victim and the family of the victim

g. Access a safe waiting area for the victim to use during court proceedings away from and out of sight of the defendant and defense witnesses

h. Provide the victim/victim's lawful representative with a courtroom preview prior to trial

i. Act as a liaison between the victim/ victim's lawful representative and their school, employer, landlords, or others to minimize hardships arising from the crime or the victim's participation in prosecution

j. Provide referrals for counseling, housing, financial assistance, food assistance, or other social service needs

k. Insure that all communication with the child is in developmentally appropriate language

l. Provide information and support to the victim's non-offending parent(s) to facilitate their healing and ability to assist the child with his/her healing

# G. County Attorney

## A. Charging Review

1. After the investigation is completed by law enforcement, the police agency submits the departmental report for attorney review. (APPENDIX I)

2. Charging submittals are designated either as Out-of-Custody or In Custody.

   a. Out-of-Custody Charging Submittals
      (1) Aside from the statute of limitations, there is legally no time limit imposed for filing charges.

      (2) Submittals should have a reviewing decision made within 30 days from the date the submittal was received by the County Attorney's Office.

   b. In-Custody Charging Submittals
      (1) The investigating detective/law enforcement detective must make an appointment and meet with a charging attorney to review the case within 48 hours of the Initial Appearance (an Initial Appearance occurs within 24 hours of being booked into jail).

      (2) Charges must be filed via Complaint within 48 hours of an Initial Appearance in order to maintain the bond or release

conditions which were set at the Initial Appearance. The 48 hours does not include weekends and holidays.

(3) If charges are not filed within the 48-hour time frame, the defendant will be released from custody. Any bond or other release conditions that have been imposed at the Initial Appearance will be exonerated or otherwise lifted.

(4) If, at the Initial Appearance, the defendant was released on his/her own recognizance, on bond, or to pretrial services, and charges were not filed, all release conditions will no longer apply and any bond posted will be exonerated.

(5) The County Attorney's Office will review all investigations submitted by law enforcement agencies involving child sexual assaults, sexual abuse, child abuse, aggravated assaults, child exploitation, indecent exposure, child homicide, custodial interference or kidnapping for the possible filing of criminal charges.

**B. Processing Charging Submittals**

1. Once the investigation has been submitted, a reviewing attorney reads the report(s) and decides if the charging submittal is to be furthered for additional investigation, declined for prosecution or charges filed.

a. Submittals furthered for more investigation

(1) The reviewing attorney will list with specificity the information necessary for prosecution.

(2) The submittal is then returned to the investigating agency to complete the investigation, with a copy to CPS.

(3) When the requested further investigation is completed, the law enforcement agency will re-submit the report for the County Attorney's review.

(4) If the agency is not able to pursue the investigation, the County Attorney's Office must be notified in writing within 45 days.

b. Submittals declined for prosecution

(1) The primary reason submittals are declined for prosecution is that they do not meet the office charging standard, i.e. that the submittal, when reviewed as a trial case, has no

reasonable likelihood of conviction.

(2) The County Attorney's Office will not reject a case solely on the basis that a victim or victim's family refuses to cooperate with prosecution.

(3) A letter indicating a decision will be mailed to the victim and/or the victim's lawful representative (i.e. parent or guardian) by the County Attorney's Office.

(4) The submittal is also returned to law enforcement indicating the decision not to file. A copy shall also be sent to CPS.

(5) The victim or the victim's lawful representative has the right to confer with the initial reviewing prosecutor regarding the decision not to prosecute.

(6) All cases that are not filed may be re-evaluated if new evidence is presented.

(7) With the exception of homicide and, as of 2001, any Class 2 Sex Crimes (Chapter 14 or 35.1) cases which have no Statute of Limitations, the Statute of Limitations for any felony allows for prosecution up to seven years from disclosure of the crime. (See A.R.S. §13-107).

c. If a charging submittal is appropriate for prosecution

(1) The reviewing attorney shall issue appropriate charges.

(2) A probable cause determination must be made through either a Preliminary Hearing or a Grand Jury proceeding.

(3) The majority of child physical or sexual abuse cases will be taken to the Grand Jury. Grand Jury proceedings are not open to the public - thus, they do not subject the victim to the stress of testifying.

## C. Post-Charging...The Court Process

1. Team Approach

a. The case will be assigned to a Deputy County Attorney.

b. Victim advocates act as a liaison between the Deputy County Attorney and the victim or the victim's representative. The Deputy County Attorney, in conjunction with the Victim Advocate, will work with the victim, parent, guardian ad litem or the victim' s attorney on the case.

c. Child Protective Services (CPS) is an independent State agency that deals with civil issues involving the child victim. If a case involves CPS intervention, the Deputy County Attorney will attempt to work with the assigned caseworker, recognizing that the goals for the case resolution of the two agencies are not necessarily the same.

d. Prosecution is a team effort among the investigative agency, the prosecutor, the victim advocate, the victim and the witnesses. All members of the team are under a continuing obligation to exchange information about the case. The assigned detective will assist prosecution during the trial.

2. Case Disposition - *Change of Plea*

a. Once the case is assigned to a Deputy County Attorney, the attorney and/or the Victim Advocate will contact the victim as soon as practicable to discuss the process and obtain input as to a possible disposition.

b. Plea guidelines will be utilized in making plea offers in order to provide consistency of dispositions among similar cases.

c. While not all cases are appropriate for plea offers, the majority of cases will involve an offer to plead guilty to a lesser charge. Plea dispositions are advantageous because they ensure finality for the victim, a judgement of guilt by the court, and an order of restitution for any damages incurred by the victim.

d. Any plea offer will be communicated to the victim via communication from the Deputy County Attorney and/or the Victim Advocate. It is the duty of the County Attorney's Office to see that justice is served in the handling of criminal cases. In that endeavor, it is recognized that the opinion of the victim as to what is just in their case may differ from the views of the office.

e. If the victim's view of the disposition diverges from the plea offer, he or she shall be given the opportunity to discuss their disagreement with the Deputy County Attorney and, if necessary,

the assigned attorney's supervisor.

f. If the difference of opinion is still not resolved, the victim has the right and the opportunity to notify the pre-sentence report writer and the court of their opinion.

g. Final disposition of a disputed negotiated plea rests with the discretion of the court to either accept or reject the plea offer.

3. Case Disposition - *Trial.*

a. If the case cannot be resolved via plea agreement, the case is set for trial, the Deputy County Attorney shall meet with the victim in order to acquaint the victim with the trial process.

b. Victim preparation is the responsibility of the Deputy County Attorney with the assistance of the Victim Advocate.

(1) In all but very rare cases, the victims are required to testify in court.

(2) Prior to trial, the victim will be taken into a courtroom and the Deputy County Attorney will explain courtroom protocol and procedures to the victim.

(3) If requested to do so, the Deputy County Attorney will assist the victim in selecting a support person to be present during the victim's testimony, in addition to the Victim Advocate. (The support person cannot otherwise be a witness in the case.)

(4) The Deputy County Attorney will seek appointment of an interpreter or guardian ad litem for a victim in appropriate cases.

(5) Prior to trial, the Deputy County Attorney or the Victim Advocate will discuss the possible outcomes of the trial with the victim and the victim's representative.

c. At the option of the victim, he or she may submit to an interview by the defense attorney.

(1) The Deputy County Attorney will be present at the victim' s request and will actively participate in the interview.

(2) The Deputy County Attorney will make necessary arrangements for any reasonable conditions requested by

the victim, including:

(a) The presence of the Victim Advocate who acts as a support person for the victim, or
(b) The presence of another support person.

(3) The Deputy County Attorney or his/her representative will arrange defense interviews of witnesses at the defense's request.

(a) The Deputy County Attorney or his/her representative will be present and will tape record the interview.

d. Cases involving child sexual and physical abuse often require retention of expert witnesses.

(1) In those cases, the County Attorney's Office will pay reasonable fees for that expertise.

(2) Expert and professional witnesses often have scheduling difficulties. Attempts will be made to give special consideration will be given to these witnesses to accommodate their schedules in coordinating a time for their testimony.

e. Jury Verdicts

A jury has three (3) options in reaching a verdict on any of the charges:

(1) *"Not Guilty"* - in which case the defendant is acquitted, charges are dismissed and defendant is free from future prosecution on that matter;

(2) *"Guilty"* - in which case the defendant is convicted and a date is given for sentencing of the defendant;

(3) *"Hung Jury"* - in which case the jury was unable to reach a unanimous verdict as to the defendant' s guilt or innocence. This results in a mistrial and the case is reset for trial. The case may be re-tried, resolved by plea or dismissed.

f. Sentencing

(1) If the defendant pleads guilty or no contest, or if the jury finds the defendant guilty, the Deputy County Attorney and/or the Victim Advocate will inform the victim of the sentencing procedure. The sentencing date is usually 30 to

60 days after conviction.

(2) The Adult Probation Department will prepare a pre-sentence report for the Judge's review prior to sentencing. The report will include information obtained from departmental reports, the indictment, information or complaint, the plea agreement (if applicable), information regarding the defendant and the victim, victim's input statement, and restitution information.

(3) The victim may be entitled to restitution.

(4) The defendant may seek a continuance of the original sentencing date in order to present mitigating evidence; the state may seek a continuance of the original sentencing date in order to present aggravating evidence; and either side may request a mental examination under Rule 26.5, Arizona Rules of Criminal Procedure.

(5) The victim and/or the victim's lawful representative has a right to be present at sentencing and to address the court.

**D. Post Plea or Trial - Post Conviction Relief and Appeals**

1. The Deputy County Attorney and/or the Victim Advocate will explain to the victim and/or his legal representative the possibility of a review via petition for Post-Conviction Relief (PCR) or an Appeal.

   a. PCR is a legal review of the Change of Plea proceeding and/or representation by the defense attorney. PCR's are handled by a Deputy County Attorney.

   b. An appeal is a legal review of the trial proceedings. Appeals are handled by the Attorney General's Office.

## H. Mental Health

Behavioral health professionals will frequently receive referrals to provide services to abused/neglected children from Child Protection, Victim Witness, Safe Child, or other agencies. It is suggested that therapists utilize evidence-based therapies which have been shown to be most effective with this population. (Resources are available through the National Child Traumatic Stress Network, nctsnet.org, including online education and up to date best practice recommendations.)

Therapies should also reflect knowledge about and sensitivity to the family's culture and values, including traditions and religion.

Therapists' work includes assisting family members to align with the victim to provide emotional support and protection, and assist in minimizing secondary trauma during the investigation process and afterward. The therapist should delay primary trauma intervention until after the forensic interview and investigation has been completed by the appropriate agencies. Supportive therapy and anticipatory guidance should be provided in the meantime. This includes encouraging no contact between the victim and alleged offender, ensuring safety of the victim and other children in the home, and stabilizing the victim's environment by supporting the non-offending care giver.

Therapists should not disclose facts regarding the allegations to the offender, victim, non-offending parent, caretakers or family members prior to the forensic investigation. After the investigation is completed, the non-offending parent/caretaker should be fully informed about the details of the allegations. Professionals involved in the treatment of various parties (i.e. victim, offender, non-offending parents and siblings) should collaborate with each other to support effective treatment.

Therapists should maintain appropriate boundaries in their work with the child and family members: the victim should have a separate therapist from the alleged offender; "no contact" rules should be followed consistently; premature confrontation between a victim and the alleged offender should not occur; the victim therapist should not have direct contact with the alleged offender, with communication occurring only between the respective therapists.

Mental health professionals who prefer not to work with child abuse victims or lack expertise in this area may contact Victim Witness Services or Flagstaff Medical Center Behavioral Health to seek referrals to mental health professionals who specialize in working with child abuse victims, along with professionals who are culturally sensitive to any unique client needs.
As a part of the multidisciplinary team, behavioral health professionals may be asked to participate in case review in order to assist with healing for the child and family. Therapists are not expected to reveal confidential or privileged information. A Confidentiality Agreement is signed by all team members in case review.

## I. Unexplained Infant Death

*-From the Arizona Department of Health Services-*

In 2002, the State of Arizona passed into law two statutes concerning the investigation of

unexplained infant deaths in Arizona. A.R.S. §36-2292 requires the Arizona Department of Health Services to establish protocols for death scene investigations of apparent natural infant deaths. These protocols must specifically address the need for compassion and sensitivity with parents and caregivers, include recommended procedures for law enforcement, and require scene investigations as a component of the infant death investigation. A.R.S. 36-2293 requires that law enforcement officers complete an infant death investigation checklist during investigations of unexplained infant deaths and further requires law enforcement officers to complete the checklist prior to autopsy. The intent of these two statutes was to standardize the process of unexplained infant death investigations throughout the state, and to ensure medical examiners are provided sufficient information from investigators to assist in determining the cause and manner of an infant's death.

Unexplained infant deaths are those for which there is no cause of death obvious when the infant died. Unexplained infant deaths would not include those in which there was a previously diagnosed life-threatening illness that clearly contributed to the death (i.e., complications of pre-maturity, congenital anomaly, infectious disease), or when there is a clear cause of death, immediately known (i.e., accident, homicide, etc.). In cases of an unexplained infant death, a thorough investigation is necessary to accurately determine the cause and manner of the death. That process includes a death scene investigation, interviews with parents and caregivers, a review of the infant's clinical history, and a complete autopsy.

In developing the required investigative protocols, the Unexplained Infant Death Advisory Council reviewed guidelines set forth by national infant death organizations, as well as those of other states where such guidelines exist. This review led the Council to create a short form protocol or checklist titled the "Arizona Infant Death Investigation Checklist (2002)." (See APPENDIX J) The form is a carbon pack triplicate to allow easy distribution. Instructions for completing the checklist are conveniently printed on the reverse side. The Council believes that uniform use of this checklist will standardize the investigation of unexplained infant deaths in Arizona, while also ensuring that pertinent information is gathered and documented in each case. The checklist is to be used by law enforcement officers, but may also be used by other death investigators. Distribution of this form to medical examiners prior to the autopsy will assist medical examiners in accurately determining the cause and manner of death. Data contained in the form may also provide information for researchers examining the causes of unexplained child deaths and stillborn infants.

Although the recognized definition of an "infant" is a child under one year of age, law enforcement officers are encouraged to use the death investigation checklist in any case of an unexplained child death. The unexplained death of a child over one year of age will require the same investigative process, and the checklist may remain a valuable tool to law enforcement and medical examiners in such instances.

## A. Death Scene Investigation

1. The death scene investigation is an essential component of a thorough

investigation of unexplained child deaths. Information gathered during the scene investigation augments information obtained from autopsy and review of the child's clinical history and can help the pathologist interpret postmortem findings. This information will aid in the determination of accidental, environmental, or other unnatural causes of deaths, including child abuse and neglect. Although the ultimate goal of a death scene investigation is to accurately assign a cause of death, equally important goals are the identification of health threats posed by consumer products; identification of risk factors associated with unexplained infant deaths; and using the opportunity to refer families to grief counseling and support groups.

2. The Unexplained Infant Death Advisory Council recommends a thorough death scene investigation by trained investigative personnel, even in cases where a child may have been transported to a hospital or other location. Access to the death scene must take into consideration issues of privacy and standing, as with any other law enforcement investigation. The death scene investigation should include careful observation and documentation, including measurements and photographs. Consideration should be given to lawfully seizing any items deemed to have evidentiary value, or which may assist in determining the cause of the child's death.

## B. Officer Demeanor

1. Parents or caregivers who experience the sudden, unexpected death of a child need compassion, support, and accurate information. Those responsible for determining the cause of death must have both technical skills and sensitivity, as they go about their difficult task. A knowledgeable and sympathetic approach will contribute to gathering necessary information while also supporting parents in crisis. The Unexplained Infant Death Advisory Council recognizes that law enforcement officers know, all too well, that infants and children can die at the hands of parents or caregivers. Such instances, however, are statistically very rare. The vast majority of unexplained infant deaths are attributed to natural causes, not criminal acts. The Council, therefore, recommends that law enforcement officers conduct their investigations with compassion and sensitivity for the parents and caregivers they contact.

2. It is recommended that officers interview parents and caregivers with a non-accusatory demeanor, and withhold judgment until all the facts and medical evaluations are known. In those rare instances where an autopsy or other evidence indicates criminal activity occurred, officers might find it necessary to adopt a different demeanor. Until such time, officers should offer compassion and support to families and caregivers. Recognizing that the grief and feelings of guilt associated with a child's death can be devastating, officers should be familiar with local support groups and be able to provide referral information for long term support.

## J. Drug Endangered Child (DEC)

(Coconino County recognizes that children are affected by exposure to drug use by adults and care givers in their environments. Many of these effects are damaging to the child's physical, emotional and psychological development and well being. At this time we are in the process of assessing our response to drug-endangered children in the county and a protocol addendum will be added to reflect the coordinated efforts of agencies to address these problems.)

## K. Training

Training is required for CPS, LE, and Prosecutors who will be implementing the protocol. Investigators shall attend training developed to execute this protocol. This training will include opportunities for professionals to train together to understand the roles and mandates of each agency involved. Training will be coordinated by the Interagency Council as allowed by funding through the Children's Justice Task Force.

Forensic interviewers should have received training and demonstrate an ability to perform fact-based interviews. Forensic interviewers should receive extensive training in a recognized curriculum meeting current professional guidelines. Forensic interviewers should engage in regular peer review, compliance with formalized protocol guidelines, and consultation with prosecution regarding statutory changes and legal updates.

Medical forensic professionals conducting pediatric examinations shall have specialized training in evaluation of child maltreatment. Examiners should participate in peer review on a regular basis and attend multidisciplinary case review with team members. Examiners are expected to attend local and national child abuse meetings featuring nationally-recognized faculty and stay current on the child abuse medical scientific literature.

Training will be offered on a yearly basis for mandated reporters and first responders and investigators in Coconino County. Training developed and provided by the Children's Justice Act Task Force will be used, along with local resources.

## L. Case Review

Case reviews are held monthly and attended by the professionals involved in the case. Cases can be selected for case review by any MDT member by contacting the MDT case review coordinator (through calling the Safe Child Center).

All disciplines involved in the case should make every effort to attend case review. MDT representatives include law enforcement, prosecution, Child Protective Services, the medical examiner, the forensic interviewer, behavioral health, crime lab, and the victim advocate. In the event that a team member is not able to attend in person they can attend telephonically or have another team member or supervisor from their agency attend. Information about the case is shared by systematically going through the MDT Case Review/Joint Investigation Protocol Compliance form (see APPENDIX N). This format gathers data about the investigation and assures protocol compliance. Each step of the investigation is reviewed including law enforcement response, forensic interview, medical forensic exam, Child Protective Services, coordination of response between agencies, safety issues for the victim, impact of testimony prosecution process, and sentencing outcomes. In addition, the standardized format evaluates treatment and follow up needs for the child and family. If a discipline is absent from case review, the coordinator will contact that professional/agency to inform them of outcomes from the review.

Recommendations made by the MDT case review are communicated at the review session. At the end of each review, time is allotted to follow up on previous cases to ensure that the recommendations were complete.

Summaries of the case reviews are presented to the Family Advocacy Council (FAC) which monitors protocol compliance.

## M. Protocol Compliance

Procedures for tracking protocol compliance will be accomplished through Multi-disciplinary Team meetings and case reviews. On a quarterly basis, the IAC will review and provide oversight and recommendations for protocol compliance. Failure to comply with this published protocol will be forwarded to the appropriate supervisor of the agency not in compliance.

The Coconino County Children's Justice Coordinator will facilitate periodic reviews of the Protocol to ascertain the need for updates. At a minimum, the Coconino County Attorney's Office, CPS, law enforcement, Safe Child and Victim Witness Services shall be involved in this review. Any revisions shall be communicated to CPS, Coconino County law enforcement agencies and pertinent professionals.

## N. Case Tracking

The Children's Justice Coordinator or designee will gather data on the numbers of

cases seen at Safe Child Center and NACASA (16 – 18 year olds) to each agency once each quarter; the County Attorney's Office will track ESCA investigations not evaluated through Safe Child or NACASA. The Coordinator or designee will be responsible for coordinating this process with law enforcement, CPS, and prosecution.

At Safe Child Center, a tracking form (See APPENDIX M) will be completed on each case for internal use to collect data and track cases. Team members will have access to this information for their use with cases. In addition, overall numbers and demographics will be reported quarterly to the entire team at Family Advocacy Council (FAC) meetings and monthly at MultiAgency Briefings.

All ESCA's will be noted on charging requests and all will be submitted to the County Attorney's Office, regardless of whether charging is being requested. The County Attorney's Office will collect the charging requests and tracking forms and tabulate data on a quarterly basis.
Co-location: While co-location is not currently feasible in Coconino County, agency professionals shall take opportunities to interact with each other during joint investigations at Safe Child and other locations, during protocol training, and interact at respective agency settings.

## O. Annual Report

The case tracking forms will be reviewed and data compiled to develop an annual report. This will be submitted to the Governor, the Speaker of the House of Representatives and the President of the Senate within 45 days after the end of the state fiscal year. The Coconino County Attorney, the chief law enforcement officers for each municipality, the Coconino County Sheriff, and CPS shall provide information as outlined in this protocol to the County Attorney's Office within 15 days after the end of the state fiscal year. The IAC Coordinator will assist the County Attorney in preparation of the annual report.

Agencies are responsible by statute for providing the following data to the County Attorney's Office for the purpose of preparing an Annual Report.

The Annual Report shall include:

Law Enforcement

- Number of cases involving an ESCA that were jointly investigated using the criteria set forth in this protocol
- A summary of any barriers and/or challenges encountered by law enforcement and CPS to fulfill the dictates of this protocol

- Number of joint investigations in each law enforcement jurisdiction

County Attorney

- Number of ESCA cases submitted/referred to the County Attorney for prosecution
- Number of ESCA cases submitted by law enforcement that were charged
- Number of ESCA cases submitted to the County Attorney that resulted in trial or plea agreements
- Number of ESCA cases submitted to the County Attorney that resulted in convictions

CPS

- Number of calls to the CPS Hotline involving incidents in Coconino County and the priority levels of those calls
- Number of ESCA calls that were substantiated
- Number of ESCA calls that resulted in removal of children

## P. Dispute Resolution Procedures

In the joint investigation of ESCA, cooperation and mutual respect between agencies and professionals is essential. There may be instances in which conflict occurs both during and after a joint investigation. In this situation, it is advised that the professionals communicate directly with each other, involving their direct supervisors when necessary. Should additional assistance be needed in resolving a conflict, utilizing the "chain of command" is recommended.

The Family Advocacy Council can act as a resource in resolving any multi-agency misunderstandings or conflicts which affect joint investigations or the implementation of this protocol.

## Q. ICWA Compliance

Investigations involving Native American children will meet Indian Child Welfare Act (ICWA) requirements. Notification to appropriate tribal authorities will occur if a child is removed.

# APPENDICES

A. Applicable Statutes and Definitions

B. First Responder Checklist

C. AAP Recommendations: Medical Forensic Evaluation of Alleged Child Abuse

D. APSAC Guidelines: Investigative Interviewing in Alleged Child Abuse

E. CPS Hotline Report Form
Suspected Child Abuse/Neglect Report Form

F. CPS Hotline Cue Questions

G. CPS Response Systems
CPS Priority Response Timelines

H. Temporary Custody Notice Form

I. Law Enforcement Charging Request Form/Investigations Checklist

J. Infant Death Checklist/Instructions

K. Authorization for Release of Records Form

L. Attorney General's O pinion on Interviewing in Schools

M. Safe Child Center Case Tracking Form

N. MDT Case Review Form

O. "Child Abuse and Sex Crimes in Indian Country"

P. Applicable Federal Statutes/Reporting Laws

Q. Physical and Behavioral Indicators of Abuse/Neglect

R. Agency Contact Information

S. Statement of Support

13-3620. Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors; medical records; exception; violation; classification; definitions

A. Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant who is protected under section 36-2281 shall immediately report or cause reports to be made of this information to a peace officer or to child protective services in the department of economic security, except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only. A member of the clergy, christian science practitioner or priest who has received a confidential communication or a confession in that person's role as a member of the clergy, christian science practitioner or a priest in the course of the discipline enjoined by the church to which the member of the clergy, christian science practitioner or priest belongs may withhold reporting of the communication or confession if the member of the clergy, christian science practitioner or priest determines that it is reasonable and necessary within the concepts of the religion. This exemption applies only to the communication or confession and not to personal observations the member of the clergy, christian science practitioner or priest may otherwise make of the minor. For the purposes of this subsection, "person" means:

1. Any physician, physician's assistant, optometrist, dentist, osteopath, chiropractor, podiatrist, behavioral health professional, nurse, psychologist, counselor or social worker who develops the reasonable belief in the course of treating a patient.
2. Any peace officer, member of the clergy, priest or christian science practitioner.
3. The parent, stepparent or guardian of the minor.
4. School personnel or domestic violence victim advocate who develop the reasonable belief in the course of their employment.
5. Any other person who has responsibility for the care or treatment of the minor.

B. A report is not required under this section for conduct prescribed by sections 13-1404 and 13-1405 if the conduct involves only minors who are fourteen, fifteen, sixteen or seventeen years of age and there is nothing to indicate that the conduct is other than consensual.

C. If a physician, psychologist or behavioral health professional receives a statement from a person other than a parent, stepparent, guardian or custodian of the minor during the course of providing sex offender treatment that is not court ordered or that does not occur while the offender is incarcerated in the state department of corrections or the department of juvenile corrections, the physician, psychologist or behavioral health professional may withhold the reporting of that statement if the physician, psychologist or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

D. Reports shall be made immediately by telephone or in person and shall be followed by a written report within seventy-two hours. The reports shall contain:

1. The names and addresses of the minor and the minor's parents or the person or persons having custody of the minor, if known.
2. The minor's age and the nature and extent of the minor's abuse, child abuse, physical injury or neglect, including any evidence of previous abuse, child abuse, physical injury or neglect.
3. Any other information that the person believes might be helpful in establishing the cause of the abuse, child abuse, physical injury or neglect.

E. A health care professional who is regulated pursuant to title 32 and who, after a routine newborn physical assessment of a newborn infant's health status or following notification of positive toxicology screens of a newborn infant, reasonably

believes that the newborn infant may be affected by the presence of alcohol or a drug listed in section 13-3401 shall immediately report this information, or cause a report to be made, to child protective services in the department of economic security. For the purposes of this subsection, "newborn infant" means a newborn infant who is under thirty days of age.

F. Any person other than one required to report or cause reports to be made under subsection A of this section who reasonably believes that a minor is or has been a victim of abuse, child abuse, physical injury, a reportable offense or neglect may report the information to a peace officer or to child protective services in the department of economic security, except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only.

G. A person who has custody or control of medical records of a minor for whom a report is required or authorized under this section shall make the records, or a copy of the records, available to a peace officer or child protective services worker investigating the minor's neglect, child abuse, physical injury or abuse on written request for the records signed by the peace officer or child protective services worker. Records disclosed pursuant to this subsection are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from a report required or authorized under this section.

H. When telephone or in-person reports are received by a peace officer, the officer shall immediately notify child protective services in the department of economic security and make the information available to them. Notwithstanding any other statute, when child protective services receives these reports by telephone or in person, it shall immediately notify a peace officer in the appropriate jurisdiction.

I. Any person who is required to receive reports pursuant to subsection A of this section may take or cause to be taken photographs of the minor and the vicinity involved. Medical examinations of the involved minor may be performed.

J. A person who furnishes a report, information or records required or authorized under this section, or a person who participates in a judicial or administrative proceeding or investigation resulting from a report, information or records required or authorized under this section, is immune from any civil or criminal liability by reason of that action unless the person acted with malice or unless the person has been charged with or is suspected of abusing or neglecting the child or children in question.

K. Except for the attorney client privilege or the privilege under subsection L of this section, no privilege applies to any:

1. Civil or criminal litigation or administrative proceeding in which a minor's neglect, dependency, abuse, child abuse, physical injury or abandonment is an issue.

2. Judicial or administrative proceeding resulting from a report, information or records submitted pursuant to this section.

3. Investigation of a minor's child abuse, physical injury, neglect or abuse conducted by a peace officer or child protective services in the department of economic security.

L. In any civil or criminal litigation in which a child's neglect, dependency, physical injury, abuse, child abuse or abandonment is an issue, a member of the clergy, a christian science practitioner or a priest shall not, without his consent, be examined as a witness concerning any confession made to him in his role as a member of the clergy, a christian science practitioner or a priest in the course of the discipline enjoined by the church to which he belongs. Nothing in this subsection discharges a member of the clergy, a christian science practitioner or a priest from the duty to report pursuant to subsection A of this section.

M. If psychiatric records are requested pursuant to subsection G of this section, the custodian of the records shall notify the attending psychiatrist, who may excise from the records, before they are made available:

1. Personal information about individuals other than the patient.

2. Information regarding specific diagnosis or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

N. If any portion of a psychiatric record is excised pursuant to subsection M of this section, a court, upon application of a

peace officer or child protective services worker, may order that the entire record or any portion of the record that contains information relevant to the reported abuse, child abuse, physical injury or neglect be made available to the peac officer or child protective services worker investigating the abuse, child abuse, physical injury or neglect.

O. A person who violates this section is guilty of a class 1 misdemeanor, except if the failure to report involves a reportable offense, the person is guilty of a class 6 felony.

P. For the purposes of this section:

1. "Abuse" has the same meaning prescribed in section 8-201.
2. "Child abuse" means child abuse pursuant to section 13-3623.
3. "Neglect" has the same meaning prescribed in section 8-201.
4. "Reportable offense" means any of the following:

(a) Any offense listed in chapters 14 and 35.1 of this title or section 13-3506.01.

(b) Surreptitious photographing, videotaping, filming or digitally recording of a minor pursuant to section 13-3019.

(c) Child prostitution pursuant to section 13-3212.

(d) Incest pursuant to section 13-3608.

13-3620.01. False reports; violation; classification

A. A person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect or a person acting with malice who coerces another person to make a false report of child abuse or neglect is guilty of a class 1 misdemeanor.

B. A person who knowingly and intentionally makes a false report that a person has violated the provisions of subsection A of this section is guilty of a class 1 misdemeanor.

# Extremely Serious Conduct
# DEFINITIONS OF ABUSE

AN EXTREMELY SERIOUS CONDUCT ALLEGATION PURSUANT TO A.R.S. 8-201(2) MEANS AN ALLEGATION OF CONDUCT BY A PARENT, GUARDIAN OR CUSTODIAN OF A CHILD THAT, IF TRUE, WOULD CONSTITUTE ANY OF THE FOLLOWING:

- SEXUAL CONDUCT WITH A MINOR
- SEXUAL ABUSE
- MOLESTATION OF A CHILD
- CHILD PROSTITUTION
- COMMERCIAL SEXUAL EXPLOITATION OF A MINOR
- CHILD ABUSE (PHYSICAL ABUSE AND SEVERE NEGLECT)
- DEATH OF A CHILD
- CERTAIN DOMESTIC VIOLENCE OFFENSES THAT RISE TO THE LEVEL OF A FELONY (PURSUANT TO A.R.S. 13-3601)

"Abuse" pe r A.R.S.8-201 means the infliction of or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by sever anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to section 8-821 and is caused by the acts or omissions of an individual having care, custody, and control of a child. Abuse shall include inflicting or allowing sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553 or child prostitution pursuant to section 13-3212.

**PHYSICAL ABUSE**

"PHYSICAL INJURY" per A.R.S. 13-3623 means the impairment of physical condition and includes any:

> skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, physical conditions with imperils health or welfare.

"SERIO US PHYSICAL INJURY" means physical injury which creates:

a reasonable risk of death; or that causes serious or permanent disfigurement; of serious impairment of health; or loss or protracted impairment of the function of any bodily limb or organ.

**NEGLECT**

"NEGLECT OR NEGLECTED" means th e inability or unwillingness of a parent or guardian or custodian or a child to provide that child with supervision, food, clothing, shelter or medical care IF that inability or unwillingness causes substantial risk of harm to the child's health or welfare, except if the inability of a parent or guardian to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services.

"Substantial Risk of Harm" means actual, tangible and measurable harm or risk of harm to the child which may include physical, emotional, medical, sexual or other types of harm to the child.

**SEXUAL ABUSE**

SEXUAL ABUSE (A.R.S. 13-1404) A person commits sexual abuse by intentionally or knowingly engaging in sexual contact with a person fifteen or more years of age without the consent of that person or with any person who is under fifteen years of age if that sexual contact involves only the female breast.

SEXUAL CONTACT WITH A MINOR (A.R.S. 13-1405) A person commits sexual Conduct with a minor by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person who is under eighteen years of age. (This statue has been interpreted by the courts to include attempts to engage in this behavior, even if the attempt is only verbal.)

SEXUAL ASSAULT (A.R.S. 13-1406) A person commits sexual assault by intentionally or knowingly engaging in sexual intercourse, oral sexual contact with any person with consent of such person.

CHILD PROSTITUTION (A.R.S. 13-3212) A person commits child prostitution by knowingly:

Causing any minor to engage in prostitution; using a minor for purposes of prostitution; permitting a minor under such person's c ustody or control to engage in prostitution; receiving any benefit for or on account of procuring or placing a minor in any place or in the charge or custody of any person for the purposes of prostitution; receiving any benefit pursuant to an agreement to participate in the proceeds of prostitution of a minor; financing, managing,

supervising, controlling or owning, either alone or in association with others, prostitution activity involving a minor; transporting or financing the transportation of any minor through or across this state with the intent that such minor engage in prostitution.

COMMERCIAL SEXUAL EXPLOITATION OF A MINOR (A.R.S. 13-3552) A person commits commercial sexual exploitation of a minor by knowingly:

Using, employing, persuading, enticing, inducing, or coercing a minor to engage in or assist others to engage in exploitive exhibition or other sexual conduct for the purpose of producing any depiction or live act depicting such conduct; using, employing, persuading, enticing, or coercing a minor to expose the genitals or anus or areola or nipple of the female breast for financial or commercial gain; permitting a minor under such person's custody or control to engage in or assist others to engage in exploitive exhibition or other sexual conduct for the purpose of producing any visual depiction or live act depicting such conduct; transporting or financing the transportation of any minor through or across this state with the intent that such minor engage in prostitution, exploitive exhibition or other sexual conduct for the purpose of producing a visual depiction or live act depicting such conduct.

SEXUAL EXPLOITATION OF A MINOR (A.R.S. 13-3553) A person commits sexual exploitation of a minor by knowingly:

Recording, filming, photographing, developing, or duplicating any visual depiction in which a minor is engaged in exploitive exhibition or other sexual conduct; distributing, transporting, exhibiting, receiving, selling, purchasing, electronically transmitting, possessing, or exchanging any visual depiction in which a minor is engaged in exploitative exhibition or other sexual conduct.

## EMOTIONAL ABUSE

A.R.S. 8-821 permits a CPS Specialist or peace officer to take temporary custody of a child who is suffering serious emotional damage which can only be diagnosed by a medical doctor or psychol0gist. The child shall be immediately examined and after the examination the child shall be released to the custody of the parent, guardian, or custodian unless the examination reveals abuse.

The legal definition of emotional abuse is contained in A.R.S. 8-201: "serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to section 8-821 and which is caused by the acts or omissions of an individual having care, custody and control of a child".

## ADDITIONAL DEFINITIONS

1. "Sexual contact" means any direct or indirect touching, fondling, or manipulation of any part of the genitals, anus or female breast by any part of the body or by any object or causing a person to engage in such conduct.
2. "Without consent" includes any of the following:
The victim is coerced by the immediate use or threatened use of force against a person or property; the victim is incapable of consent by reason of mental disorder, mental defect, drugs, alcohol, sleep, or any other similar impairment of cognition and such condition is know or should have reasonably been known to the defendant; the victim is intentionally deceived as to the nature of the act; the victim is intentionally deceived to erroneously believe that th person is the victim's spou se.
3. "Spouse" mea ns any person who is legally married and cohabiting.
4. "Sexual int ercourse" means penetration into the penis, vulva, or anus by any part of the body or by any object or masturbatory contact with the penis or vulva.
5. "Oral sexu al contact" means oral contact with the penis, vulva or anus.
6. "Exploitive exhibition" means the actual or simulated exhibition of the genitals or pubic or rectal areas of any person for the purpose of sexual stimulation of the viewer.
7. "Producing" means financing, directing, manufacturing, issuing, publishing, or advertising for pecuniary gain.
8. "Sexual conduct means actual or simulated:
Sexual intercourse including genital-genital, oral-genital, anal-genital, oral-anal, whether between persons of the same or opposite sex; penetration of the vagina or rectum by an object except one does as a part of a recognized medical procedure; sexual bestiality; masturbation for the purpose of the sexual stimulation of the viewer; sadomasochistic abuse for the purpose of the sexual stimulation of the viewer; defecation or urination for the purpose of sexual stimulation of the viewer.
9. "Simulated" mea ns any depicting of the genitals or rectal areas that give the appearance of sexual contact or incipient sexual conduct.
10. "Visual depi ction" includes each visual image that is contained in an undeveloped film, videotape, or photograph or data stored in any form and that is capable of conversion into a visual image.
11. "Prostitution" means engaging in or agreeing or offering to engage in sexual conduct with any person under a fee arrangement with that person or any other person.
12. "Sexual conduct" means sexual contact, sexual intercourse, or oral sexual contact, or sadomasochistic abuse.
13. "Sadomasochistic abuse" means flagellation or torture by or upon a person who is nude or clad in undergarments or in revealing or bizarre costume or

## First Responder Checklists

### Law Enforcement Checklist

__Limit questioning to :
What Happened?
When did it Happen?
Where did it Happen?
Who did this?
__Make appropriate notification (CPS Hotline or LE dispatch) to initiate joint investigation (Law Enforcement HOTLINE # 877-238-4501)
__Consult with medical provider at Safe Child (928-773-2053)
__Follow agency protocol....Contact appropriate detective or supervisor to coordinate forensic interview/exam
__Collect and preserve evidence, following current best professional practices
__Ensure that photographic evidence is obtained when appropriate
__Assess and ensure safety
__Notify Victim Witness Services

### CPS Checklist

__Identify time lines
__Make appropriate notification (CPS Hotline or LE dispatch) to initiate joint investigation
__Follow agency protocol.... Contact appropriate detective or supervisor to coordinate forensic interview/exam
__Assess and ensure safety

### Mandated Reporter Checklist

__Limit questioning to:
What Happened?
When did it Happen?
Where did it Happen?
Who did this?
__Make appropriate referral: CPS Hotline (888-767-2445) or Law Enforcement dispatch
__If ESCA is in-home, DO NOT contact parents or guardian; CPS or LE is responsible for this
__Document exactly what was asked of child and child's responses
__Complete and submit appropriate agency and/or Hotline forms

AMERICAN ACADEMY OF PEDIATRICS

## CLINICAL REPORT

Guidance for the Clinician in Rendering Pediatric Care

Nancy Kellogg, MD; and the Committee on Child Abuse and Neglect

# The Evaluation of Sexual Abuse in Children

**ABSTRACT. This clinical report serves to update the statement titled "Guidelines for the Evaluation of Sexual Abuse of Children," which was first published in 1991 and revised in 1999. The medical assessment of suspected sexual abuse is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data. The role of the physician may include determining the need to report sexual abuse; assessment of the physical, emotional, and behavioral consequences of sexual abuse; and coordination with other professionals to provide comprehensive treatment and follow-up of victims.** ***Pediatrics*** **2005;116:506–512;** ***child sexual abuse, sexually transmitted diseases, medical assessment.***

ABBREVIATIONS. AAP, American Academy of Pediatrics; STDs, sexually transmitted disease.

## INTRODUCTION

Few areas of pediatrics have expanded so rapidly in clinical importance in recent years as that of sexual abuse of children. What Kempe called a "hidden pediatric problem"[1] in 1977 is certainly less hidden at present. In 2002, more than 88 000 children were confirmed victims of sexual abuse in the United States.[2] Studies have suggested that each year approximately 1% of children experience some form of sexual abuse, resulting in the sexual victimization of 12% to 25% of girls and 8% to 10% of boys by 18 years of age.[3] Children may be sexually abused by family members or nonfamily members and are more frequently abused by males. Boys are reportedly victimized less often than girls but may not be as likely to disclose the abuse. Adolescents are perpetrators in at least 20% of reported cases; women may be perpetrators, but only a small minority of sexual abuse allegations involve women.

Concurrent with the expansion of knowledge, education about child abuse became a mandated component of US pediatric residencies in 1997.[4] Pediatricians will almost certainly encounter sexually abused children in their practices and may be asked by parents and other professionals for consultation. Knowledge of normal and abnormal sexual behaviors, physical signs of sexual abuse, appropriate diagnostic tests for sexually transmitted infections, and medical conditions confused with sexual abuse is useful in the evaluation of such children. All child health professionals should routinely identify those at high risk for or with a history of abuse. Because the evaluation of suspected victims of child sexual abuse often involves careful questioning, evidence-collection procedures, or specialized examination techniques and equipment,[5] many pediatricians do not feel prepared to conduct such comprehensive medical assessments. In such circumstances, pediatricians may refer children to other physicians or health care professionals with expertise in the evaluation and treatment of sexually abused children. Because the scope of practice of some nonphysician examiners is limited to assessment, documentation, and collection of forensic evidence,[6] close coordination with a knowledgeable physician or pediatric nurse practitioner is necessary to provide complete assessment and treatment of physical, behavioral, and emotional consequences of abuse. In other circumstances, the community pediatrician may be asked to evaluate a child for sexual abuse to determine if a report and further investigation are warranted. In some circumstances, pediatricians may conduct comprehensive assessments of suspected victims of child sexual abuse when no other resources are available in their community.

Because pediatricians have trusted relationships with patients and families, they may provide essential support and guidance from the time that abuse is detected and subsequently as the child and family recover from the physical and emotional consequences of abuse. Because of this trusted relationship, the pediatrician may also gain information from the child or family that is valuable to the investigation, evaluation, and treatment of the victim. However, a close relationship between the pediatrician and the family may pose potential tension, prompting the pediatrician to refer the child to a specialist to avoid conflict with the family. Furthermore, although pediatricians must care for sexually abused children in their practice, many report inadequate training in the recognition of red flags for sexual abuse and a lack of a consistent approach to evaluating suspected abuse.[7] Consultation with a pediatric specialist who has extensive training and professional experience in the comprehensive assessment of victims of sexual abuse may be necessary. These guidelines are intended for use by all health professionals caring for children. Additional guide-

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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lines are published by the American Academy of Pediatrics (AAP) for the evaluation of sexual assault of the adolescent.[8]

## DEFINITION

Sexual abuse occurs when a child is engaged in sexual activities that he or she cannot comprehend, for which he or she is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society.[1] The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.[1] As many as 19% of adolescents who are regular Internet users have been solicited by strangers for sex through the Internet; built-in filters and monitoring are less effective than parent-child communication in preventing online predation.[9] Sexual abuse includes a spectrum of activities ranging from rape to physically less intrusive sexual abuse.

Sexual abuse can be differentiated from "sexual play" by determining whether there is a developmental asymmetry among the participants and by assessing the coercive nature of the behavior.[10] Thus, when young children at the same developmental stage are looking at or touching each other's genitalia because of mutual interest, without coercion or intrusion of the body, this is considered normal (ie, nonabusive) behavior. However, a 6-year-old who tries to coerce a 3-year-old to engage in anal intercourse is displaying abnormal behavior, and appropriate referrals should be made to assess the origin of such behavior and to establish appropriate safety parameters for all children involved. Among nonabused children 2 to 12 years of age, fewer than 1.5% exhibit the following behaviors: putting the mouth on genitals, asking to engage in sex acts, imitating intercourse, inserting objects into the vagina or anus, and touching animal genitals.[11] Children or adolescents who exhibit inappropriate or excessive sexual behavior may be reacting to their own victimization or may live in environments with stressors, boundary problems, or family sexuality or nudity.[12] Some sexually abused children will display a great number of sexual behaviors and a greater intensity of these behaviors.[12] However, there is a significant proportion of sexually abused children who do not display increased sexual behavior. Research has shown that there are 2 responses to sexual abuse: one that reflects inhibition and the other that reflects excitation, and it is in the latter group that more sexual behavior is observed.[13]

## PRESENTATION

Sexually abused children are seen by pediatricians in a variety of circumstances such as: (1) the child or adolescent is taken to the pediatrician because he or she has made a statement of abuse or abuse has been witnessed; (2) the child is brought to the pediatrician by social service or law enforcement professionals for a nonacute medical evaluation for possible sexual abuse as part of an investigation; (3) the child is brought to an emergency department after a suspected episode of acute sexual abuse for a medical evaluation, evidence collection, and crisis management; (4) the child is brought to the pediatrician or emergency department because a caregiver or other individual suspects abuse because of behavioral or physical symptoms; or (5) the child is brought to the pediatrician for a routine physical examination, and during the course of the examination, behavioral or physical signs of sexual abuse are detected.

The diagnosis of sexual abuse and the protection of the child from additional harm depend in part on the pediatrician's willingness to consider abuse as a possibility. Sexually abused children who have not disclosed abuse may present to medical settings with a variety of symptoms and signs. Because children who are sexually abused are generally coerced into secrecy, the clinician may need a high level of suspicion and may need to carefully and appropriately question the child to detect sexual abuse in these situations. The presenting symptoms may be so general or nonspecific (eg, sleep disturbances, abdominal pain, enuresis, encopresis, or phobias) that caution must be exercised when the pediatrician considers sexual abuse, because the symptoms may indicate physical or emotional abuse or other stressors unrelated to sexual abuse. More specific signs and symptoms of sexual abuse are discussed under "Diagnostic Considerations." Most cases of child sexual abuse are first detected when a child discloses that he or she has been abused. Children presenting with nonspecific symptoms and signs should be questioned carefully and in a nonleading manner about any stressors, including abuse, in their life. Pediatricians who suspect that sexual abuse has occurred are urged to inform the parents of their concerns in a calm, nonaccusatory manner. The individual accompanying the child may have no knowledge of or involvement in the sexual abuse of the child. A complete history, including behavioral symptoms and associated signs of sexual abuse, should be sought. The primary responsibility of the pediatrician is the protection of the child; if there is concern that the parent with the child is abusive or nonsupportive, the pediatrician may delay in informing the parent(s) while a report is made and an expedited investigation by law enforcement and/or child protective services agencies can be conducted. Whenever there is a lack of support or belief in the child, this information should be provided promptly to child protective services.

## TAKING A HISTORY/INTERVIEWING THE CHILD

The pediatrician should try to obtain an appropriate history in all cases before performing a medical examination. Although investigative interviews should be conducted by social services and/or law enforcement agencies, this does not preclude physicians asking relevant questions to obtain a detailed pediatric history and a review of systems. Medical history, past incidents of abuse or suspicious injuries, and menstrual history should be documented. When children are brought for evaluation by protective personnel, little or no history may be available other than that provided by the child. The medical history

should include information helpful in determining what tests should be done and when, how to interpret medical findings when present, and what medical and mental health services should be provided to the child and family.

The courts have allowed physicians to testify regarding specific details of a child's statements obtained in the course of taking a medical history to provide diagnosis and treatment, although exceptions may preclude such testimony in some cases.[14] Occasionally, children spontaneously describe their abuse and indicate who abused them. When asking young children about abuse, line drawings,[15] dolls,[16] or other aids[17] are generally used only by professionals trained in interviewing young children. The American Academy of Child and Adolescent Psychiatry and American Professional Society on the Abuse of Children have published guidelines for interviewing sexually abused children.[18,19] It is desirable for those conducting the interview to avoid leading and suggestive questions or showing strong emotions such as shock or disbelief and to maintain a "tell-me-more" or "and-then-what-happened" approach. When possible, the parent should not be present during the interview so that influences and distractions are kept to a minimum. Written notes in the medical record or audiotape or videotape should be used to document the questions asked and the child's responses as well as their demeanor and emotional responses to questioning. When audiotaping or videotaping is used, protocols should be coordinated with the district attorney's office in accordance with state guidelines. Most expert interviewers do not interview children younger than 3 years.

## PHYSICAL EXAMINATION

The physical examination of sexually abused children should not result in additional physical or emotional trauma. The examination should be explained to the child before it is performed. It is advisable to have a supportive adult not suspected of involvement in the abuse[20] present during the examination unless the child prefers not to have such a person present. Children may be anxious about giving a history, being examined, or having procedures performed. Time must be allotted to relieve the child's anxiety.

When the alleged sexual abuse has occurred within 72 hours or there is an acute injury, the examination should be performed immediately. In this situation, forensic evidence collection may be appropriate and may include body swabs, hair and saliva sampling, collection of clothing or linens, and blood samples. Body swabs collected in prepubertal children more than 24 hours after a sexual assault are unlikely to yield forensic evidence, and nearly two thirds of the forensic evidence may be recovered from clothing and linens.[21] When more than 72 hours have passed and no acute injuries are present, an emergency examination usually is not necessary. As long as the child is in a safe and protective environment, an evaluation can be scheduled at the earliest convenient time for the child, physician, and investigative team. The child should have a thorough pediatric examination performed by a health care provider with appropriate training and experience who is licensed to make medical diagnoses and recommend treatment. This examination should include a careful assessment for signs of physical abuse, neglect, and self-injurious behaviors. Injuries, including bruises incurred on the arms or legs during self-defense, should be documented in victims of acute sexual assault. Sexual maturity should also be assessed. In the rare instance in which the child is unable to cooperate and the examination must be performed because of the likelihood of trauma, infection, and/or the need to collect forensic samples, an examination under sedation with careful monitoring should be considered. Signs of trauma should preferably be documented by photographs; if such equipment is unavailable, detailed diagrams can be used to illustrate the findings. Specific attention should be given to the areas involved in sexual activity: the mouth, breasts, genitals, perineal region, buttocks, and anus. In female children, the examination should include inspection of the medial aspects of the thighs, labia majora and minora, clitoris, urethra, periurethral tissue, hymen, hymenal opening, fossa navicularis, posterior fourchette, perineum, and perianal tissues. The thighs, penis, scrotum, perineum, and perianal tissues in males should be assessed for bruises, scars, bite marks, and discharge. Any abnormalities should be noted and interpreted appropriately with regard to the specificity of the finding to trauma (eg, nonspecific, suggestive, or indicative of trauma). If the interpretation of an abnormal finding is problematic, consultation with an expert physician is advisable.

Various examination techniques and positions for visualizing genital and anal structures in children and adolescents have been described.[5] Such techniques are often necessary to determine the reliability of an examination finding; for example, different techniques may be used to ensure that an apparent defect or cleft in the posterior hymen is not a normal hymenal fold or congenital variation. In addition, instruments that magnify and illuminate the genital and rectal areas should be used.[22,23] Speculum or digital examinations should not be performed on the prepubertal child unless under anesthesia (eg, for suspected foreign body), and digital examinations of the rectum are not necessary. Because many factors can influence the size of the hymenal orifice, measurements of the orifice alone are not helpful in assessing the likelihood of abuse.[24]

## LABORATORY DATA

Depending on the history of abuse, the examiner may decide to conduct tests for sexually transmitted diseases (STDs). Approximately 5% of sexually abused children acquire an STD from their victimization.[25] The following factors should be considered in deciding which STDs to test for, when to test, and which anatomic sites to test: age of the child, type(s) of sexual contact, time lapse from last sexual contact, signs or symptoms suggestive of an STD, family member or sibling with an STD, abuser with risk factors for an STD, request/concerns of child or fam-

ily, prevalence of STDs in the community, presence of other examination findings, and patient/parent request for testing.[25] Although universal screening of postpubertal patients is recommended,[25] more selective criteria are often used for testing prepubertal patients. For example, the yield of positive gonococcal cultures is low in asymptomatic prepubertal children, especially when the history indicates fondling only.[26] Vaginal, rather than cervical, samples are adequate for STD testing in prepubertal children. Considering the prolonged incubation period for human papillomavirus infections, a follow-up examination several weeks or months after the initial examination may be indicated; in addition, the family and patient should be informed about the potential for delayed presentation of lesions. Testing before any prophylactic treatment is preferable to prophylaxis without testing; the identification of an STD in a child may have legal significance as well as implications for treatment, especially if there are other sexual contacts of the child or perpetrator. The implications of various STDs that may be diagnosed in children are summarized in Table 1; guidelines are also provided by the Centers for Disease Control and Prevention[27] and the AAP.[25,28] The most specific and sensitive tests should be used when evaluating children for STDs. Cultures are considered the "gold standard" for diagnosing *Chlamydia trachomatis* (cell culture) and *Neisseria gonorrhoeae* (bacterial culture). New tests, such as nucleic acid–amplification tests, may be more sensitive in detecting vaginal *C trachomatis*, but data regarding use in prepubertal children are limited. Because the prevalence of STDs in children is low, the positive predictive value of these tests is lower than that of adults, so confirmatory testing with an alternative test may be important, especially if such results will be presented in legal settings. When child sexual abuse is suspected and STD testing is indicated, vaginal/urethral samples and/or rectal swabs for isolation of *C trachomatis* and *N gonorrhoeae* are recommended. In addition, vaginal swabs for isolation of *Trichomonas vaginalis* may be obtained. Testing for other STDs, including human immunodeficiency virus (HIV), hepatitis B, hepatitis C, and syphilis, is based on the presence of symptoms and signs, patient/family wishes, detection of another STD, and physician discretion. Venereal warts, caused by human papillomavirus infection, are clinically diagnosed without testing. Any genital or anal lesions suspicious for herpes should be confirmed with a culture, distinguishing between herpes simplex virus types 1 and 2. Guidelines for treatment are published by the Centers for Disease Control and Prevention.[27]

If a child has reached menarche, pregnancy testing should be considered. A negative pregnancy status should be confirmed before administering any medication, including emergency contraception ("morning after" pills). Guidelines for emergency contraception have been published[29,30]; the AAP is in the process of developing its own guidelines.

## DIAGNOSTIC CONSIDERATIONS

The diagnosis of child sexual abuse often can be made on the basis of a child's history. Sexual abuse is rarely diagnosed on the basis of only physical examination or laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child's genitalia.[31–33] Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly and completely.[34–38] In a recent study of pregnant adolescents, only 2 of 36 had evidence of penetration.[39] Occasionally, a child presents with clear evidence of anogenital trauma without an adequate history. Abused children may deny abuse. Findings that are concerning include: (1) abrasions or bruising of the genitalia; (2) an acute or healed tear in the posterior aspect of the hymen that extends to or nearly to the base of the hymen; (3) a markedly decreased amount of hymenal tissue or absent hymenal tissue in the posterior aspect; (4) injury to or scarring of the posterior fourchette, fossa navicularis, or hymen; and (5) anal bruising or lacerations.[31–36] The interpretation of physical findings continues to evolve as evidence-based research becomes available.[40] The physician, the multidisciplinary team evaluating the child, and the courts must establish a level of certainty about whether a child has been sexually abused. Table 2 provides suggested guidelines for making the decision to report sexual abuse of children based on currently available information. For example, the presence of semen, sperm, or acid phosphatase; a positive culture for *N gonorrhoeae* or *C trachomatis*; or a positive

**TABLE 1.** Implications of Commonly Encountered STDs for the Diagnosis and Reporting of Sexual Abuse of Infants and Prepubertal Children

| STD Confirmed | Sexual Abuse | Suggested Action |
|---|---|---|
| Gonorrhea* | Diagnostic† | Report‡ |
| Syphilis* | Diagnostic | Report |
| HIV infection§ | Diagnostic | Report |
| *C trachomatis* infection* | Diagnostic† | Report |
| *T vaginalis* infection | Highly suspicious | Report |
| *C acuminata* infection* (anogenital warts) | Suspicious | Report |
| Herpes simplex (genital location) | Suspicious | Report‖ |
| Bacterial vaginosis | Inconclusive | Medical follow-up |

* If not perinatally acquired and rare nonsexual vertical transmission is excluded.
† Although the culture technique is the "gold standard," current studies are investigating the use of nucleic acid–amplification tests as an alternative diagnostic method in children.
‡ To the agency mandated in the community to receive reports of suspected sexual abuse.
§ If not acquired perinatally or by transfusion.
‖ Unless there is a clear history of autoinoculation.

TABLE 2. Guidelines for Making the Decision to Report Sexual Abuse of Children

| Data Available | | | | Response | |
|---|---|---|---|---|---|
| History | Behavioral Symptoms | Physical Examination | Diagnostic Tests | Level of Concern About Sexual Abuse | Report Decision |
| Clear statement | Present or absent | Normal or abnormal | Positive or negative | High | Report |
| None or vague | Present or absent | Normal or nonspecific | Positive test for *C trachomatis*, gonorrhea, *T vaginalis*, HIV, syphilis, or herpes* | High | Report |
| None or vague | Present or absent | Concerning or diagnostic findings | Negative or positive | High† | Report |
| Vague, or history by parent only | Present or absent | Normal or nonspecific | Negative | Indeterminate | Refer when possible |
| None | Present | Normal or nonspecific | Negative | Intermediate | Possible report‡; refer, or follow |

* If nonsexual transmission is unlikely or excluded.
† Confirmed with various examination techniques and/or peer review with expert consultant.
‡ If behaviors are rare/unusual in normal children.

serologic test for syphilis or HIV infection make the diagnosis of sexual abuse a near medical certainty, even in the absence of a positive history, if perinatal transmission has been excluded for the STDs. The differential diagnosis of genital trauma also includes accidental injury and physical abuse. This differentiation may be difficult and may require a careful history and multidisciplinary approach. Because many normal anatomic variations, congenital malformations and infections, or other medical conditions may be confused with abuse, familiarity with these other causes is important.[41,42]

Physicians should be aware that child sexual abuse often occurs in the context of other family problems, including physical abuse, emotional maltreatment, substance abuse, and family violence. If these problems are suspected, referral for a more comprehensive evaluation is imperative and may involve other professionals with expertise needed for evaluation and treatment. In difficult cases, pediatricians may find consultation with a regional child abuse specialist or assessment center helpful.

After the examination, the physician should provide appropriate feedback, follow-up care, and reassurance to the child and family.

## TREATMENT

All children who have been sexually abused should be evaluated by a pediatrician and a mental health professional to assess the need for treatment and to assess the level of family support. Unfortunately, mental health treatment services for sexually abused children are not universally available. The need for therapy varies from victim to victim regardless of abuse chronicity or characteristics. An assessment should include specific questions concerning suicidal or self-injurious thoughts and behaviors. Poor prognostic signs include more intrusive forms of abuse, more violent assaults, longer periods of sexual molestation, and closer relationship of the perpetrator to the victim. The parents of the victim may also need treatment and support to cope with the emotional trauma of their child's abuse; parents who are survivors of child abuse should be identified to ensure appropriate therapy and to optimize their ability to assist their own child in the healing process. Treatment may include follow-up examinations to assess healing of injuries and additional assessment for STDs, such as *Condylomata acuminata* infection or herpes, that may not be detected in the acute time frame of the initial examination. The pediatrician may also provide follow-up care to ensure that the child and supportive family members are recovering emotionally from the abuse.

## LEGAL ISSUES

The medical evaluation is first and foremost just that: an examination by a medical professional with the primary aim of diagnosing and determining treatment for a patient's complaint. When the complaint involves the possible commission of a crime, however, the physician must recognize legal concerns. The legal issues confronting pediatricians in evaluating sexually abused children include manda-

tory reporting of suspected abuse with penalties for failure to report; involvement in the civil, juvenile, or family court systems; involvement in divorce or custody proceedings; and involvement in criminal prosecution of defendants in criminal court. In addition, there are medical liability risks for pediatricians who fail to diagnose abuse or who misdiagnose other conditions as abuse. All pediatricians in the United States are required under the laws of each state to report suspected as well as known cases of child abuse. In many states, the suspicion of child sexual abuse as a possible diagnosis requires a report to both the appropriate law enforcement and child protective services agencies. Among adolescents, sexual activity and sexual abuse are not synonymous, and it should not be assumed that all adolescents who are sexually active are, by definition, being abused. Many adolescents have consensual, age-appropriate sexual experiences, and it is critical that adolescents who are sexually active receive appropriate confidential health care and counseling. Federal and state laws should support providing confidential health care and should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.[43] All physicians need to know their state law requirements and where and when to file a written report; an update on child abuse reporting statutes can be accessed at http://nccanch.acf.hhs.gov/general/legal/statutes/manda.cfm. These guidelines do not suggest that a pediatrician who evaluates a child with an isolated behavioral finding (nightmares, enuresis, phobias, etc) or an isolated physical finding (erythema or an abrasion of the labia or traumatic separation of labial adhesions) is obligated to report these cases as suspicious. If additional historical, physical, or laboratory findings suggestive of sexual abuse are present, the physician may have an increased level of suspicion and should report the case. In both criminal and civil proceedings, physicians must testify to their findings "to a reasonable degree of medical certainty."[44] Pediatricians are encouraged to discuss cases with their local or regional child abuse consultants and their local child protective services agency. In this way, families may be spared unnecessary investigations, agencies are less likely to be overburdened, and physicians may be protected from potential prosecution for failure to report. Statutes in each state immunize reporters from civil or criminal liability as long as the report was not made either without basis or with deliberate bad intentions.[45] On the other hand, although no known physicians have been prosecuted successfully for failure to report, there have been successful malpractice actions against physicians who failed to diagnose or report child abuse appropriately.[45]

Because of the likelihood of legal action, detailed records, drawings, and/or photographs should be maintained soon after the evaluation and kept in a secure location. Protected health information for a minor who is believed to be the victim of abuse may be disclosed to social services or protective agencies; the Health Insurance Portability and Accountability Act (HIPAA; Pub L No. 104–191 [1996]) does not preempt state laws that provide for reporting or investigating child abuse. Physicians required to testify in court are better prepared and may feel more comfortable if their records are complete and accurate. Physicians may testify in civil cases concerning temporary or permanent custody of the child by a parent or the state or in criminal cases in which a suspected abuser's guilt or innocence is determined. In general, the ability to protect a child may often depend on the quality and detail of the physician's records.[37]

A number of cases of alleged sexual abuse involve parents who are in the process of separation or divorce and who allege that their child is being sexually abused by the other parent during custodial visits. Although these cases are generally more difficult and time consuming for the pediatrician, the child protective services system, and law enforcement agencies, they should not be dismissed simply because a custody dispute exists. Whenever a careful and comprehensive assessment of the child's physical and behavioral symptoms yields a suspicion of abuse or the child discloses abuse to the physician, a report to protective services should be made. If symptoms or statements are primarily reported by the parent but not supported during an assessment of the child, the physician may wish to refer the family to a mental health or sexual abuse expert. A juvenile court proceeding may ensue to determine if the child needs protection. The American Bar Association indicates that most divorces do not involve custody disputes, and relatively few custody disputes involve allegations of sexual abuse.[44]

## CONCLUSIONS

The evaluation of sexually abused children is increasingly a part of general pediatric practice. Pediatricians are part of a multidisciplinary approach to prevent, investigate, and treat the problem and need to be competent in the basic skills of history taking, physical examination, selection of laboratory tests, and differential diagnosis. An expanding clinical consultation network is available to assist the primary care physician with the assessment of child abuse cases.[46]

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APSAC AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

# PRACTICE GUIDELINES

# Investigative Interviewing in Cases of Alleged Child Abuse

Children are often the principal source of information about allegations of child abuse, particularly child sexual abuse. Most investigative interviews are conducted by child protective service workers, law enforcement officers, or both. These interviews often form the core of the evidence used to determine the veracity of allegations of abuse. However, inadequate or improper interviewing can lead to errors in decision-making about child safety and criminal prosecution. Thus, investigative interviews should maximize the opportunity for the child to describe what may have happened, minimize the potential for misinformation, and encourage collaboration among the professionals involved.

These Guidelines are intended as a framework for professionals who are interviewing and are not an all-inclusive guide. That is, the Guidelines reflect current knowledge and professional consensus about issues related to investigative interviews but are not a standard of practice to which investigators are expected to adhere in all cases. There is no single correct way to interview a child suspected of being a victim of abuse. State statutes, court decisions, and local practice, as well as the specifics of the case, may dictate modifications. Investigators must remain flexible in applying these guidelines and continuously seek out new knowledge.

Where appropriate, these Guidelines should be used in concert with other APSAC Guidelines. The APSAC Guidelines on the Use of Anatomical Dolls in Child Sexual Abuse Assessments (1995) are particularly relevant. The APSAC Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse in Children (Second Edition, 1997) also are relevant.

There will be times when investigators are unable to understand fully what, if anything, has happened to a child and may request the involvement of a mental health practitioner to conduct a more extensive forensic assessment. The mental health professional should be familiar with APSAC's Investigative Interviewing Guidelines and APSAC's Guidelines for the Psychosocial Evaluation of Suspected Sexual Abuse in Children (Second Edition, 1997).

## GUIDELINES

These Guidelines will cover the following topics: the purpose of an investigative interview, professionals qualified to conduct such interviews, important issues related to the child interview, the structure of the child interview, and documentation issues.

### I. Purpose of an Investigative Interview

The purpose of an investigative interview is to elicit as complete and accurate a report from the alleged child or adolescent victim as possible in order to determine whether the child or adolescent has been abused (or is at imminent risk of abuse) and, if so, by whom. Interviewers attempt to collect information that will either corroborate or refute the allegation(s). To accomplish these goals, the interviewer must be impartial and objective, considering all reasonable explanations for any allegation.

### II. The Interviewers

#### A. Disciplines

Law enforcement, child protective service personnel, and child forensic interviewers affiliated with specialized child abuse assessment programs, such as children's advocacy centers, are the primary professionals involved in investigative interviewing of children about possible child abuse. The specific discipline of the interviewer is not as important as his or her knowledge and skill level.

Mental health professionals or medical professionals may also participate in or conduct such interviews, with appropriate training and authorization (Sorenson, Bottoms, & Perona, 1997).

#### B. Training and Prerequisite Knowledge

Investigative interviewing in cases of alleged abuse requires specialized knowledge. This knowledge can be acquired in a variety of ways (e.g., formal course work, individual reading, workshops and conferences, professional experience and supervision), and should include familiarity with basic concepts of child development, communication abilities of children, dynamics of abuse and offenders, categories of information necessary for a thorough investigation, legally acceptable child interviewing techniques, and the use of interview aids (such as drawings or anatomical dolls). Specialized knowledge is especially important when young children are interviewed.

### III. Context of the Child Interview

#### A. Timing of the Interview

The initial child interview should occur as close in time to the event in question as feasible. Whenever possible, the child interview should also be timed to maximize the child's capacity to provide accurate and complete information. This often involves consideration of the child's physical and mental state (e.g., alert, rested), immediate safety concerns, and the possible impact of delays on the child's ability to recall and report an experience.

#### B. Parent/Legal Guardian Notification

Investigators should follow local protocol and legal requirements regarding parental notification about the interview. However, prior parental notification may sometimes be contraindicated, especially in cases of suspected intrafamilial abuse, because family members may attempt to influence the child's report, prevent the interview, or destroy evidence. If the decision is made to interview the child at an advocacy center or similar location, interviewers must be sure they have the legal authority to transport the child to the site.

### C. Location of Interview

Choosing the location of the interview with the child is important. It is recommended that the interview occur in a neutral environment whenever possible (National Network of Children's Advocacy Centers (NCCAN), 1994; Reed, 1996). The setting should be private, informal, and free from unnecessary distractions (Saywitz & Nathanson, 1992; Goodman, Bottoms, Rudy, & Schwartz-Kenny, 1991). Sometimes interviews are conducted at the child's school. If this option is selected, arrangements can be worked out with school officials concerning the child's availability and who will be present during the interview. Law enforcement officers should, if at all possible, arrive in unmarked cars and wear plain clothes. Other interviews take place in a children's advocacy center or similar facility (NNCAC, 1994). These sites are specifically designed to accommodate children and are often equipped with audio and video recording or observation capability.

If no other option exists to conducting an interview where the suspected abuse may have occurred, it is important to ensure that the suspected offender is neither present nor in the vicinity.

### D. Documentation of Interview

Accurate documentation of investigative interviews is extremely important. Electronic recording (videotaping, audiotaping) is the most comprehensive and accurate method of documentation, but is not universally endorsed (Myers, 1994; 1998; Stern, 1992). In addition, electronic recording is sometimes not possible for logistical reasons or because of local policy. If used, written documentation should be as close to verbatim as possible for questions and answers about possible abuse.

### E. Number of Interviews

The number of interviews should be governed by the number necessary to elicit complete and accurate information from the child. One comprehensive investigative interview is sometimes sufficient; many abused children provide detailed reports about abuse in a single interview (Bradley & Wood, 1996). Other children, however, need more than one interview (Carnes, Wilson, & Nelson-Gardell, 2000; Sorenson & Snow, 1991). A policy that limits the investigative or fact-finding process to a single interview is unsupported.

Multiple investigative interviews should not be conducted simply because professionals fail to share information with each other, but may be necessary to afford the child an opportunity to give complete information or because later findings suggest additional incidents or offenders. Multiple interviews, however, may carry risks for creating memory errors or acquiescence to presumed interviewer expectations. Multiple interviews, especially when conducted by different interviewers, may also be associated with increased child distress. Care should be taken when deciding to interview a child who has already been interviewed on more than one occasion.

### F. Participants in the Interview

#### 1. Investigative personnel

A single interviewer is generally preferable, although in many jurisdictions and in individual cases, child protection workers, police investigators, or special child interviewers may conduct investigative interviews jointly. If more than one interviewer is present, a lead interviewer should be designated, with the nonlead interviewer playing a minimal, direct role. It is desirable to appoint the most experienced or most capable professional to be the primary interviewer. Closed-circuit TV and two-way mirrors can be used to enable other professionals to monitor the interview while out of sight.

### 2. Advocates or support persons

Many states have Victims' Bill of Rights that grant children the right to have a support person present during interviews conducted in the course of a criminal investigation. A supportive person (e.g., teacher, counselor) may also enhance child cooperation in a child protection investigation. If advocates or other supportive persons are to be present, it is advisable to instruct them to refrain from direct involvement in the interview process.

### 3. Parents

In general, because of possible detrimental influence to the interview process, parents should not be present during the interview. Young children and their parents may find this difficult. Parental anxiety may be allayed if an advocate or support person is present during the interview or if parents are offered a debriefing after the interview. For a very young child who is having trouble separating from a parent, it may be necessary to have the parent present during the initial stages of the interview. If possible, the parent should leave before issues of possible abuse are discussed.

### 4. Suspected offender

No one suspected of committing abuse should be present or in the vicinity during an investigative interview. This precaution should preclude the suspected offender from accompanying the child to and from the interview site.

### 5. Other children

Except in rare circumstances, siblings and other suspected victims should be interviewed separately. In all but rare cases, it is also inadvisable to share with a child information obtained from another alleged victim.

## G. Pre-interview Data-Gathering

### 1. Cultural background

In cases in which the child is a member of an unfamiliar cultural group, building rapport with the child and eliciting an accurate account of the facts may be enhanced if the interviewer develops some understanding of the child's culture and the cultural standards for parenting. Relevant cultural standards may include common parental practices around discipline and genital care; cultural definitions and expectations in regard to child abuse, violence, and sexual assault; and actions that might be expected when abuse, violence, or sexual assault is suspected (Fontes, 1995). If the child or family has recently immigrated, the interviewer should ascertain the degree to which the child and family have assimilated into the dominant culture, the child's level of English proficiency, and cultural or familial norms that may inhibit abuse reporting or impede the interviewer's ability to build rapport with the child.

If the child is not proficient in English and a bilingual interviewer is unavailable, an experienced professional interpreter should translate the interview questions and responses for the interviewer and child. The interpreter should be cautioned about the importance of precise translations of what is said.

### 2. Children with special needs

The interviewer should inquire whether the child has any special needs that may be relevant to the interview process. If so, accommodations should be arranged before the interview begins.

For children taking medication, the interviewer can ascertain whether the medication is likely to affect the child's behavior or ability to relate or communicate, and the interview can be scheduled accordingly. If there are interview-related concerns about the effects and duration of the medication, the interviewer may consider consulting with medical personnel prior to the interview.

If the child uses adaptive equipment, such as a wheelchair, helmet, hearing aid, or computer, the equipment is typically regarded as an extension of the child's body. The interviewer should ask permission before attempting to touch or adjust the equipment, and should evaluate how, if at all, it may affect the interview.

If a child is developmentally delayed, the degree of delay and the child's mental age can be ascertained through consultation with the child's teacher, parents, or others who are familiar with the child. Even with this information, the investigator should attempt to establish, during the initial stages of the interview, that the investigator and child are accurately communicating. Investigators should also be aware that some developmentally delayed persons are very attuned to questioners' wishes and will sometimes reply in a manner they believe the questioner desires.

### 3. Information about the allegation

It is customary practice to know the specifics of the allegation before the interview. This information orients the investigator, suggests possible avenues of inquiry, and assists the investigator in understanding the child's communications. However, investigative interviews are intended to elicit information from the child, not merely to confirm prior suspicions. In some jurisdictions, it is standard practice that investigative interviews begin with interviewers blind to the allegations (Cantlon, Payne, & Erbaugh, 1996).

## H. Stance of Interviewer

### 1. Interviewer bias

Interviewers should approach the interview with an open mind about what may have happened. An interviewer's determination to confirm a particular hypothesis, without consideration of plausible, alternative explanations, may impair the capacity to receive and objectively interpret information from the child and may lead to substantial interviewer error (Sorenson, Bottoms, & Perona, 1997). Likewise, the presence of unusual or seemingly inexplicable elements in the child's account should not result in an automatic dismissal of the child's report without consideration of possible explanations for such statements (Dalenberg, 1996; Everson, 1997).

### 2. Role of authority

It is preferable that the interviewer de-emphasize his or her authority and appear warm and supportive, without being effusive (Carter, Bottoms, & Levine, 1995; Reed, 1996).

### 3. Stereotype induction

Interviewers should take care to avoid negative statements or characterizations of suspected abusers. Children may be more susceptible to suggestion of wrong-doing by individuals who *have been negatively portrayed (Ceci & Bruck, 1995).*

### I. Use of Interview Aids

A variety of interview aids or media may assist the child in describing details of his or her experience. Each case is unique and may require the use of one or more communication tools. Any tool can be misused. It is therefore important that investigators have specific knowledge or training in the use of these media, and be aware of what is legally acceptable in the specific jurisdiction. Special care should be given to avoiding the use of leading and suggestive questioning techniques with interview aids like dolls and drawings (Boat & Everson, 1996).

#### 1. Anatomical dolls

Dolls can be an excellent communication/clarification tool, if used appropriately (Boat & Everson, 1996; Everson & Boat, 1994; Steward, Steward, Farquhar, Myers, Welker, Joye, Driskill, & Morgan, 1996). Interviewers considering the use of dolls in their interviews should review APSAC's Guidelines on the Use of Anatomical Dolls in Child Sexual Abuse Assessments.

#### 2. Drawings

Children's drawings are more appropriately used as tools of communication rather than as media to be interpreted by interviewers. They are to assist the child in relaying information to the interviewer. Thus, they are generally used in conjunction with a verbal explanation of the drawing. Drawings produced by the child during the substantive portions of the interview should be described in the documentation of the interview, labeled by the interviewer, and retained as evidence (Faller, 1996; Pence & Wilson, 1994).

#### 3. Anatomical drawings

Commercially purchased anatomical drawings or freehand drawings done by the investigator can be used as "body maps." Using these, the child can identify the names and/or functions of body parts and can indicate the location of possible sexual touching or physical injuries. These drawings should be appropriately labeled and retained as evidence.

#### 4. Other media

A wide range of other aids or media (hand puppets, dolls, doll houses, flash cards, blocks, etc.) may be useful in assessing the child's developmental level and in assisting the child to communicate (Faller, 1993). Many materials designed for sexual abuse prevention or treatment are inappropriate for use in the investigative process because of their suggestive nature.

## IV. The Child Interview

### A. Overview

Although there is substantial consensus among experts in the field on the fundamental principles of forensic interviewing (e.g., the importance of tailoring the interview to the child's developmental level, emphasizing narrative invitations and open-ended questioning), it is important to reiterate that there is no single, correct method for conducting child investigative interviews in cases of alleged abuse. A number of interview protocols have been proposed in recent years (e.g., Boat & Everson, 1988; Bourg, Broderick, Flagor, Kelly, Ervin, & Butler, 1999; Home Office, 1992; Horowitz, 1992; Morgan, 1995; Orbach, Hershkowitz, Lamb, Sternberg, Esplin, & Horowitz, 2000; Steinmetz, 1997; Yuille, Hunter, Joffer, & Zaparnuik, 1993), but there is currently little empirical support for one protocol over another. (Refer to Poole & Lamb, 1998, and Hewitt, 1999, for comparisons of several interview protocols as well as excellent discussions of interview principles.) The following guidelines derived from research and practice may be useful in interview planning.

## B. Interview Process

### 1. Preparation

Preparation for the interview may include reviewing the allegations or concerns in the case, developing a list of the specific topics and hypotheses to be addressed; arranging a method of interview documentation; ensuring that interview tools or aids are available; and attending to the bathroom needs of the child.

### 2. Atmosphere

The tone of the interview is set from the moment the child meets the interviewer. The interviewer needs to appear relaxed and nonthreatening. Likewise, if possible, the setting should be child-friendly. The interviewer should convey interest in the child and in what he or she has to say.

### 3. Pace and duration

The pace of the interview is primarily established by the child. The interviewer should proceed slowly, if necessary, without displaying frustration or annoyance if the child is reluctant to talk or to attend to the topic. The child should not be pressured to respond to questions.

As a general interview rule, shorter is preferable to longer, especially with younger children. The interviewer should be aware of signals indicating fatigue or loss of concentration and breaks can be taken as needed. If the interview is being electronically recorded, a policy should be established about whether the equipment continues to run during the break.

### 4. Clarifying terminology

A potential source of miscommunication is the failure to clarify terms the child uses especially in the substantive portions of the interview. Terms such as "daddy," "pee-pee," and "have sex" may have idiosyncratic meanings to the child that require clarification. Depending upon the child's developmental level, the child can be asked to describe, show, or draw what is meant. It is often advisable to hold such clarifying questions till later in the interview in order to avoid interrupting the child's narrative account. Ideally, the interviewer should use the child's terms during the interview.

### 5. Questioning strategies

#### a. Overview

The overall goal of questioning is to elicit as much detail from the child as possible, and to minimize the introduction of information from the interviewer that might be incorporated by the child (Faller, 2000; Poole & Lamb, 1998). Once a possible concerning event is identified (refer to Section C-6 below on introducing the topic of concern), recommended practice is to begin broadly with an "open invitation to talk" about the event in question (e.g., "Tell me everything about the time your uncle babysat you."). Additional prompts follow to encourage more detail in the child's account (e.g., "What happened next?" "Tell me more about . . . ."). These narrative invitations are followed by open-ended questions (e.g., who, what, when, where) to focus the child's attention on certain aspects of his or her account in an attempt to elicit further detail. Specific questions, which may take yes/no or multiple choice form, are frequently necessary next (especially for younger children) to fill in or clarify aspects of the child's report. As the child provides more information during the open-ended and specific questioning phases of the interview, the interviewer should attempt to return to a narrative descriptive where possible (e.g., "Tell me more about that.").

It may be useful to envision the questioning process as a funnel whose broad end is represented by narrative invitations and whose narrow end is represented by highly specific, yes/no questions. One begins the interview at the top of the funnel and works down, always looking for an opportunity to recycle back up to the top of the funnel.

Specific categories of questions will be discussed in more detail below:

**b. Narrative invitations**

Narrative invitations are broad invitations to talk or prompts to continue talking (e.g., "Tell me all about . . . ." "What happened next?" "You mentioned that it happened once in the bathroom. Tell me about that."). They are designed to encourage the child to talk "in paragraph form" about an event or topic, without input or interruption from the interviewer. Children generally need practice in giving narrative responses. Such an opportunity can be provided during rapport building by inviting narrative descriptions of neutral topics (e.g., "Tell me all about school;" "Tell me more about your favorite subject.") (Sternberg et al., 1997). Young children, especially those under age 5 or 6, often have difficulty providing narrative responses. Children also often have difficulty providing narrative descriptions about traumatic or painful events. Despite these disadvantages, narrative invitations are the preferred starting point in questioning because of the detail, with minimal inaccuracy, such questioning may elicit (Lamb, 1994).

**c. Open-ended questioning**

These are questions that allow a broad range of responses while typically introducing or suggesting minimal information from the interview. They primarily include who, what, when, where and how questions (e.g., "What did he do when you told him 'no'?" "Where was your mom when that happened?" ) Open-ended questions are useful throughout the interview process as a method of providing some structure or focus to the child's recall typically without being overly suggestive or leading.

**d. Specific, closed questions**

Specific, closed questions are yes/no and multiple choice follow-up inquiries to elicit additional details from the child. They are usually necessary after narrative and more open-ended techniques have been exhausted. Specific, closed questions are useful to cue the child's memory, but should be used judiciously and phrased carefully to reduce the amount of information suggested in the question (e.g., "Was there any touching with mouths?" rather than "Did he lick your pee-pee?"). It is also good practice to follow such questions, as appropriate to the child's response, with a narrative invitation or open-ended question to encourage spontaneous detail (e.g., "Did you ever tell somebody about Mr. Smith hurting you?" "Who did you tell?" "Tell me about that."). Multiple choice questions should typically include all relevant options or a catch-all category (e.g., "Was he in the house, in the yard, or someplace else?").

**e. Leading and suggestive questions**

There continues to be substantial disagreement in the field on how leading and suggestive questions are defined (Everson, 1999). Leading questions are often defined as questions that direct a child to respond in a certain way (e.g., "He touched your pee-pee, didn't he?"). Suggestive questions are commonly seen as providing new information that the child has not already mentioned (e.g., "Did sticky stuff ever come out of his penis?").

### f. Cognitive interviewing

If the child indicates that something has happened and is developmentally able (usually by around age eight), the interviewer may use cognitive interviewing strategies (Saywitz, Geiselman, & Bornstein, 1992). Using this technique, the interviewer can encourage the child to reconstruct the context of the abuse, by either asking the child to picture him/herself in the situation or by using media (e.g., drawing the place or reconstructing it in a dollhouse). The child is encouraged to provide the interviewer with detailed information about the place where the abuse occurred, then to recount the abusive event from the very beginning, then the middle, and then the end. The child is advised to include all details, no matter how small or apparently insignificant. Older children may also be asked to recount the event again, but from the end to the beginning.

## C. Interview Components

The following are common components in many child investigative interviews:

### 1. Introduction of self and role

Using language and terminology appropriate to the child's developmental level, the interviewer should introduce him/herself and provide a brief, neutral explanation of his/her role (e.g., "My job is to talk to children about . . . ."). It may also be necessary to reassure the child that he/she is not being interviewed because the child is in trouble or has done something wrong.

The interviewer can inform the child about how and why the interview will be documented (e.g., "I have a tape recorder to help me remember what we talked about.").

### 2. Rapport-building

Generally, rapport-building involves a brief discussion about neutral topics, such as school, friends, and favorite activities. This discussion can provide the child with an opportunity to practice giving narrative responses in preparation for later stages of the interview (Poole & Lamb, 1998; Sternberg et al., 1997).

### 3. Developmental screening

During conversational interaction with the child, especially in the early stages of the interview, the interviewer may make note of the child's capacity to provide a narrative account, knowledge of relevant concepts (e.g., prepositions), ability to understand and respond to questions, use of language, attentional capacity, and emotional and behavioral reactions to specific interview topics and to the interviewer. These observations enable the interviewer to speak to the child in developmentally appropriate language. The choice of words, sentence structure, and complexity of questions should generally mirror the child's communication style.

### 4. Competency check

Many jurisdictions require interviewers to assess the young child's understanding of the difference between the truth and a lie and the importance of telling the truth as a demonstration of the child's competency to provide credible testimony (Myers, 1997). If so, interviewers should rely on age-appropriate techniques and use concrete rather than abstract examples in this assessment (refer to Hewitt, 1999; Lyon & Saywitz, 1999).

A second type of indicator of a young child's competency as a witness involves his or her ability to provide accurate information about events known to have occurred (Boat & Everson, 1988). This assessment can be made by questioning the child about a memorable event about which the interviewer has independent knowledge (e.g., a prior interview, a recent birthday party).

### 5. Ground rules

The interviewer may explain the expectations or "rules" of the interview and may practice the rules or attempt a brief assessment to ensure the child's understanding (Reed, 1996; Saywitz et al., 1992). The following are appropriate ground rules:

a. The interviewer may inform the child that the purpose of the interview is to talk about "true things and about things that really happened."

b. The interviewer may say he or she will be asking the child a lot of questions and it is okay if the child does not know or remember all the answers. The child may be told it is important that the child not guess, but tell the interviewer, "I don't know" or "I don't remember."

c. If the interviewer makes a mistake, it is okay for the child to correct the interviewer.

d. If the interviewer asks the child about a topic that is "too hard" or stressful to talk about, the child should let the interviewer know so the interviewer can consider asking the question in a different way.

e. If the child describes a particular event, he or she can be reminded that the interviewer was not present and needs the child's help to understand what happened.

### 6. Introducing the topic of concern

The topic of possible abuse can be introduced in a number of ways, depending upon case characteristics and the child's developmental level. For example, children may be asked if they know why they are being interviewed or be presented with a statement (e.g.,"I understand something may have happened to you; tell me about it from the beginning to the end.") If a child does not respond to such general prompts, the interviewer may provide more specific information in the opening question (e.g., "I understand you had to go to the doctor. Is there a reason you had to go?").

Another recommended strategy is to focus the discussion primarily through open-ended questions on the likely context or the likely individual(s) involved should maltreatment have occurred (Boat & Everson, 1988; Faller, 2000). The interviewer may use case-specific information, including the specific allegations, in guiding this questioning. Examples of context-focused questions include the following: "Tell me about bathtime. What happens? Does anyone help you? Do you like bathtime?" Person-focused questions include questions on the relationship and activities with a range of individuals in the child's life, such as the following: "What are some things you like/don't like to do with Daddy (Mommy, your brother)?" "Do you and your daddy (mommy, etc.) have any secrets?"

Anatomical drawings and dolls may be useful during this phase to conduct a body part inventory for the purpose of the following: (a) assessing the child's labels and knowledge of (sexual) functions; (b) focusing the discussion from the myriad of possible topics to bodies and body experiences; and (c) conveying permission to the child to discuss sensitive topics like private parts (Everson & Boat, 1994). Dolls and drawings can also be useful as visual aids for more direct inquiries about the child's personal experiences with private parts after other less direct techniques have been tried (e.g., "Do you have one [vagina]?" "Has anything ever happened to yours?" "Has it ever been hurt?") (APSAC, 1995).

### 7. Eliciting detailed description of concerning events

If children mention or suggest the occurrence of a concerning event, they should ideally be encouraged to provide a narrative description in their own words (Poole & Lamb, 1998; Sternberg. Lamb, Davies, & Wescott, 2002; Sternberg, et al., 1997; Yuille, et al., 1993). Narrative prompts (e.g., "Tell me more about that;" "Then what?") and open-ended questions should be the main questioning strategy, allowing a minimum of interruptions of the child's response by the interviewer. More specific questions, including yes/no and multiple choice questions, may also be necessary, especially later in the interview and for younger children.

Three topics merit special attention in the interviewer's attempt to elicit information:

#### a. Detailed information about possible abusive event(s)

This includes as many specific details about physically or sexually abusive acts as can be elicited using who, what, where, and when questions as are developmentally appropriate. The interviewer may find it useful to ask the child questions calling for "sensory" detail (e.g., what, if anything, was seen, heard, felt, smelled, or tasted) after first trying narrative prompts to elicit spontaneous details.

#### b. Contextual detail

Information about the context of the abuse (e.g., when and where the abuse occurred, details about the child or suspect's clothing, and information about any instruments or items present or used in the abuse) is another potential source of corroborative evidence. The latter includes paddles, belts, creams, sex toys, photographs, magazines, videotapes, articles of clothing, costumes, and computer software. If identified in a timely manner, such items may be recovered by law enforcement agents.

#### c. Other persons' knowledge of possible abuse

The child may be asked whether any other individuals were present before, during, or immediately after the concerning event(s). The child should also be asked whether/whom he or she told about the alleged abuse.

If the child says he or she has told another person about what happened, the interviewer can clarify under what conditions the report was made, and exactly what was said.

Anatomical drawings and dolls may be useful during this phase of the interview to clarify what the child is attempting to describe verbally or as a cross-check on the child's account using a different medium (APSAC, 1995).

It is preferable to focus on one event at a time if more than one concerning event has been suggested. During this phase, the interviewer may also attempt to clarify any unusual or ambiguous elements in the child's account as well as to address plausible, alternative hypotheses about the allegations (Poole & Lamb, 1998; Yuille et al., 1993).

### 8. Closure

The interviewer should attempt to conclude the interview on a positive note, usually by shifting the discussion to more neutral topics. The child may also be thanked for his/her effort and given the opportunity to ask questions. The interviewer can briefly describe what, if anything, will happen next, but care should be taken not to make promises about events beyond the interviewer's control.

If the child has not made a disclosure and concerns about possible abuse continue to exist, the child should be seen for another interview or referred for another evaluation. The interviewer may also consider helping the child identify an adult from whom the child could seek aid should additional safety concerns arise, and older children might be given the interviewer's business card.

## V. Special Issues for Law Enforcement Investigators

### A. Line-ups

In the past, children have not done well when confronted with traditional police procedures such a line-ups (Parker & Carranza, 1989; Peters, 1991). Not only is the process unfamiliar to most children, but also many are intimidated by the presence of their offender or even his or her photograph. If the investigator will be conducting a line-up as part of the investigation or will be preparing the child for a post-interview line-up, it is recommended that preliminary exercises be done with the child to enhance his or her knowledge of the process (Goodman et al., 1991). By clarifying expectations, children are better able to respond accurately to questions about the perpetrator's identity.

If in-person line-ups are believed to be too threatening or intimidating to the child, the investigator, after consultation with the prosecuting attorney, can videotape the line-up and have the child view the videotape at a safe location. Care should be taken not to influence the child or make the child feel guilty if he or she cannot identify the suspect.

### B. Pretext Conversations

Pretext conversations involve having the victim place a telephone call to the suspect to confront the suspect with the allegation. The call is recorded by investigators. This technique is most often used when the victim is an adolescent, although younger children have also been able to conduct pretext conversations. Investigators must consider several decisions before attempting this technique. First, is it legal? Some states do not allow one-party consent for taping telephone calls. Second, is it necessary for the case? If the same information and investigative goals can be met through other means, those options should be used first. Further, do the child and parent or guardian agree to this? Does the child have the ability to carry on a conversation to elicit incriminating statements from the offender? How can it backfire? What are the emotional risks for the child, and how likely is it that a guilty offender will guess what is going on and use the opportunity to profess his or her innocence?

### C. Identification by Child of Physical Evidence

At some point during the investigation, it may be necessary to show the child items for the purpose of identification. If photographs were taken of the child, alone or with the offender, with other children, or with both, the law enforcement officer will need to confirm the identity of those pictured, where the photo was taken, and the presence of any witness to the photography not pictured. If the interviewer has photographs prior to the interview, he or she should not ask the child if photos were taken, but rather state that there are some photographs he or she wishes the child to look at and answer questions about. The investigator should be aware that this may be embarrassing or difficult for the child. The photos may be mounted on typing paper in a folder, one to a page with evidence number or letter beneath each photo. No part of the photograph should be covered. After completion of the interview, this folder should be made a part of the child's interview documentation.

Videotapes can be presented in the same straightforward manner. Prior to this process, the decision on how many photographs or how much of the video should be shown to the child needs to be discussed by the investigator and prosecuting attorney.

## ACKNOWLEDGEMENTS

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These Guidelines will be updated periodically. Any comments or suggestions should be addressed to Donna Pence, through APSAC, 30 North Michigan Avenue, Suite 1512, Chicago, IL 60602.

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PS-077 (2-02)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Administration for Children, Youth and Families
Child Protective Services (CPS)

child abuse hotline

# CHILD ABUSE HOTLINE REPORT

*Mandated reporting sources must follow-up all telephone reports to Child Protective Services (CPS) with a written statement within seventy-two (72) hours, A.R.S. §13-3620.* **Completing this form fulfills the written requirement for mandated reporting sources. Reports made in good faith are immune from civil or criminal liability. Mail to: Child Abuse Hotline, P.O. Box 44240, Phoenix, AZ 85064-4240. To report child abuse, call the Hotline at 1-888-767-2445.**

| DATE REPORTED TO CPS CHILD ABUSE HOTLINE | TIME REPORTED |
|---|---|
| | |

REPORTING SOURCE'S NAME AND/OR AGENCY

| REPORTING SOURCE'S PHONE NO. | CHILD ABUSE HOTLINE CALL NO. *(If known)* | CPS SPECIALIST'S NAME *(If known)* |
|---|---|---|
| | | |

## AS REQUIRED IN A.R.S. § 13-3620, THE REPORT SHALL CONTAIN:

1. The names and addresses of the minor and his/her parents or person or persons having custody of such minor, if known.

2. The minor's age and the nature and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect.

3. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

PARENT, GUARDIAN OR CUSTODIAN'S NAME

ADDRESS *(No., Street, City, State, ZIP)*

| HOME PHONE NO. | WORK PHONE NO. |
|---|---|
| | |

PARENT, GUARDIAN OR CUSTODIAN'S NAME

ADDRESS *(No., Street, City, State, ZIP)*

| HOME PHONE NO. | WORK PHONE NO. |
|---|---|
| | |

| CHILD'S NAME | DATE OF BIRTH |
|---|---|
| | |

CHILD'S ADDRESS *(No., Street, City, State, ZIP)*

| CHILD'S NAME | DATE OF BIRTH |
|---|---|
| | |

CHILD'S ADDRESS *(No., Street, City, State, ZIP)*

| CHILD'S NAME | DATE OF BIRTH |
|---|---|
| | |

CHILD'S ADDRESS *(No., Street, City, State, ZIP)*

| CHILD'S NAME | DATE OF BIRTH |
|---|---|
| | |

CHILD'S ADDRESS *(No., Street, City, State, ZIP)*

PS-077 (2-02) - REVERSE

# CHILD ABUSE HOTLINE REPORT

ALLEGATION OF ABUSE AND/OR NEGLECT *(e.g., nature and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect)*

**SUSPECT ABUSE, REPORT IT. NOW! 1-888-SOS-CHILD**

Arizona's Statewide Toll-Free Child Abuse Hotline

# Suspected Child Abuse/Neglect Report Form

Today's Date: _____

Circle Day of Week: **M** **Tu** **W** **Th** **F**

| CHILD INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | First Name | | Middle Name | | AKA | |
| Social Security No. | Ethnicity | Date of Birth | Age | Grade | Height | Weight |
| Home Address | | City | | Zip | Home Phone | |

| COMPOSITION OF FAMILY ( WHO LIVE IN HOUSEHOLD) | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | First Name | Gender | Relation to Student | Work Phone | Cell Phone / Pager No. | ✓ If Alleged Perpetrator |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| ALLEGED PERPETRATOR(S) AND/OR WITNESS(ES) (IF NOT LISTED ABOVE) | | | | | |
|---|---|---|---|---|---|
| Last Name | First Name | Gender | Relation to Student | Address/Phone No. | ✓ If Alleged Perpetrator |
| | | | | | |
| | | | | | |
| | | | | | |

Nature of suspected abuse or neglect: (Check ☑ all that apply)

☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐ Other

How and when did school/agency become aware of the situation (include name of personnel who first learned of abuse).

_____

_____

_____

What were the child's responses to the following four questions (use exact quotes and verbatim language).

1. What happened? _____

_____

_____

2. Who did it? _____
3. When did it happen? _____
4. Where did it happen? _____

Additional information volunteered by the child (use exact quotes and verbatim language whenever possible). **Note:** Please attach additional pages whenever needed.

_____

_____

_____

Observation of the child's injury(ies) (if any): _____

_____

**CJP-04-03**

**Continued Reverse Side ⇒**

Describe child's demeanor at time of disclosure and note recent changes observed: _____

_____

Other information that might be helpful (such as the child's assessment of his/her risk): _____

_____

1. Contact Appropriate Police Agency: (List ☑ agency contacted)

***Contact made with:***

☐ _____ Police Department
( ) -
Officer _____ Badge # _____
DR # _____

***Other agency, if any, notified:***

☐ _____
( ) -
Officer _____ Badge # _____
DR # _____

2. Contact Child Protective Services (CPS): **1-888-767-2445**

CPS Intake Worker _____ CPS Office Assigned _____

3. Within 72 hours of receiving report, mail a copy of this form to:
CPS Intake
P.O. Box 44240
Phoenix, Arizona 85064-4240

**School/Agency Name**

**Address** **City** **Zip**

**Phone**

**Name of Person Who Received Disclosure**

**Name of Coordinator**

**Signature(s) of person(s) completing this report:**

**Name/Title** **Date**

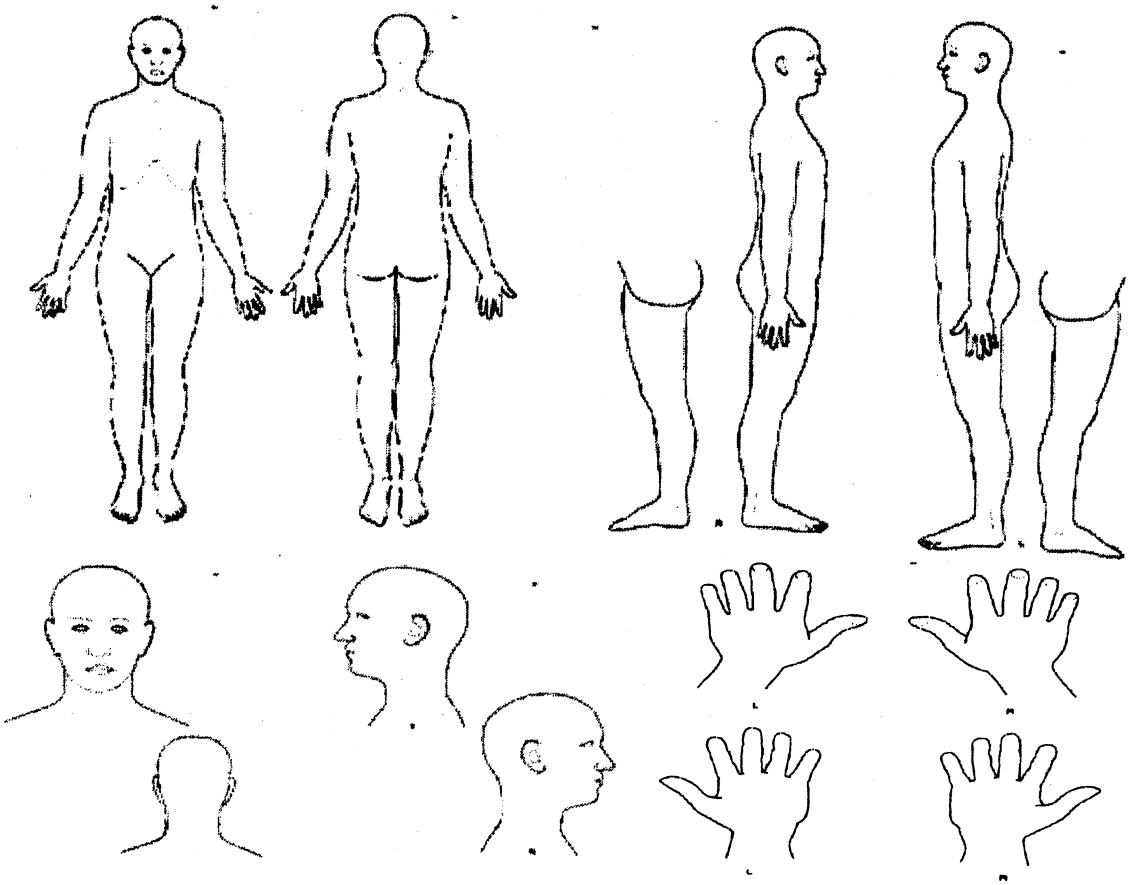
**Name/Title** **Date**

**Name/Title** **Date**

**Name/Title** **Date**

Check ☑ those that apply and record child's physical injury(ies), including shape, size, type (letter), and color (number) as appropriate, on the diagrams of the child to show location of the injury(ies).

☐ **A = Burn** ☐ **B = Bruise** ☐ **C = Laceration** ☐ **D = Fracture** ☐ **E = Other**
☐ **1 = Bright Red** ☐ **2 = Purple** ☐ **3 = Blue** ☐ **4 = Green** ☐ **5 = Yellow**



# CPS Cue Questions

## *PRE-SCREENING CUE QUESTIONS:*

1. May I have your name, phone number and relationship to the child? (Assure the reporting source they can remain anonymous. Explain that CPS will not be able to contact him/her for additional information without a name and phone number).
2. What is your concern about the child? How old is the child?
3. What is the family's home address? Does the child live there? If not, where can we locate the child, i.e., school, day care, relative, etc.? Who is living in the home?
4. Do you know who abused or neglected the child? If so, who? (This includes staff of a licensed or certified DES facility/foster or childcare home or a licensed DHS Level I, II, or III Behavioral Health Treatment facility). Do you know when he/she will see the child next?
5. Did the (parent, guardian or custodian) know about the abuse or neglect?
6. Is the (parent, guardian or custodian) letting the child see this person?

## *CUE QUESTIONS*

**IF IT IS DETERMINED TO HAVE ALL OF THE ELEMENTS OF A REPORT FOR FIELD INVESTIGATION (i.e. a child victim, maltreatment by a parent, guardian or custodian and the child can be located), CHECK CPSCR AND GATHER REPORT DEMOGRAPHICS.**

- Include the address of the child, the name of the apartment complex, trailer park and directions as needed.
- When gathering ethnicity, ask the caller if they have reason to believe any family members may be Native American. If so, what tribe?

**PHYSICAL ABUSE CUE QUESTIONS:**

1. Describe the injury (size, shape, color and location).
2. Do you know when the injury occurred? Has abuse occurred before? How often does the abuse occur?
3. What did the child say happened or how did the injury occur?
4. Do you know if the child was seen by a medical doctor? If so, what is the name and phone number of the doctor? If the source is a medical doctor, is the injury consistent with the explanation?
5. Were there any witnesses? If so, who?

**If the call concerns a licensed or certified DES facility/foster or child care home or a DHS Level I, II or III Behavioral Health Treatment facility, ask:**

6. Did the injury occur as a result of restraint?
7. What kind of restraint was used?
8. Why was the child restrained?
9. Will the staff person have contact with the child or other children in the facility?

10. Do you know the name of the licensing specialist? If so, what is the name and phone number?
11. Do you know the name of the child's case manager? If so, what is the name and phone number?

**EMOTIONAL ABUSE CUE QUESTIONS:**

1. Specifically, what is the person doing? (to have the impact on the child).
2. Have you noticed a change in the child's behavior?
3. What signs or behaviors is the child exhibiting?
4. Do you think the child's behavior is related to what the parent, guardian or custodian is doing? If so, how?
5. Do you know if the child has seen a medical doctor, psychologist or mental health professional? If so, what is the name and phone number? Do you know the diagnosis?

**NEGLECT CUE QUESTIONS:**

**A. INADEQUATE SUPERVISION**

1. Is the child alone NOW? If yes, how long has the child been alone? Where is the person who is suppose to be watching the child? When will the person return? Have you called the police?
2. If the child is not alone, who is watching the child now? What are your concerns about the person who is watching the child?
3. Do you know how often and when this happens?
4. What happens when the child is alone or inadequately supervised?
5. Does this child know how to contact the parent, guardian or ustodian?
6. Does the child have emergency numbers and know how to use the phone?
7. Do you know if anyone is checking on the child? If so, what is the name and phone number? How often?

**If the call concerns a licensed or certified DES facility/foster or child care home or DHS Level I, II or III Behavioral Health Treatment facility, ask:**

8. What supervision was being provided at the time of the exual conduct or physical injury between the children?
9. Did the facility/foster or child care home know that the child may physically or sexually assault another child?
10. Did the staff/foster or child care home person know that the child may physically or sexually assault another child?
11. What steps were been taken to prevent the child from assaulting other children?
12. What steps are being taken to restrict contact between the child and other children?
13. Do you know the name of the licensing specialist? If so, what is the name and phone number?

14. Do you know the name of the child's case manager? If so, what is the name and phone number?

## B. SHELTER

1. When was the last time you saw the child or the home?
2. Describe any health or safety hazards where they live. Has anything happened to the child?
3. Do you know how long they have been in this situation?
4. Do you know why they live like this?

## C. MEDICAL CARE

1. What are the child's symptoms?
2. Is the parent, guardian or custodian aware of the problem?
3. Do you know when they last saw a medical doctor? Who was the medical doctor? If so, why?
4. Do you know the reasons the person is not getting medical care for the child?

**If reporting source is a medical doctor or doctor's representative ask only the following questions:**

5. What is the medical or psychiatric condition or diagnosis of this child and when did it begin?
6. What medical care and/or medication (including psychiatric) is needed?
7. What will happen if the child does not receive the medical care?
8. What are your concerns about the parent, guardian or custodian response to the problem?

## D. FOOD

1. What makes you believe the child is not getting enough food? Describe the physical condition of the child?
2. Do you know if someone else is feeding the child? If so, who?
3. When was the last time you saw the child or have you been in the home? If so, describe the food you saw.
4. Do you know if the child has seen a medical doctor? If so, what is the name and phone number?

## E. CLOTHING

1. Describe what the child is wearing and the weather conditions?
2. What effect is it having on the child?

## F. METHAMPHETAMINE LABS

1. Where was the parent, guardian or custodian "cooking" the drug?
2. Was the child present?

3. If they were not cooking in the home, where were they cooking?
   - Proximity to the home?

4. Where were they venting the drug fumes?
5. Where are the chemicals stored?
6. What is the proximity to the children and the children's access to the chemicals/meth?
7. Is there any drug or chemical residue? If yes, where?
8. What is the condition of the home?

## G. SAFE HAVEN NEWBORN

1. Is the parent or agent who delivered the newborn still present?
2. Did the parent express an intent to return for the newborn infant?
3. Does the child appear to be a newborn infant? (Under seventy-two hours old)
4. What is the newborn's condition?
5. Does the infant need immediate medical attention? If so, have you called 911?
6. Did the parent or agent offer any information about themselves or the newborn?

Did the parent or agent say why they brought the newborn to a Safe Haven?

## SEXUAL ABUSE CUE QUESTIONS:

1. Why do you think the child has been sexually abused or is at risk of sexual abuse? (activities, physical signs or behaviors)
2. Who saw these activities, signs or behaviors?
3. Has the child told anyone? If so, who and when?
4. What is the child saying about sexual abuse?
5. Do you know where and when this last occurred?
6. Do you know what contact this person has with the child?
7. Do you know if the child ***has*** seen a medical doctor? If so, what is the name and number?

## ABANDONED CUE QUESTIONS:

1. Do you know where the parent is now?
2. When did the parent last have contact with the child?
3. When do you think the parent is coming back?
4. What arrangements did the parent make for care of this child?

5. How long are you able or willing to care for the child? Are there relatives available? If so, what is the name, address, phone number?
6. Are the parent's willing to make other arrangements for the child?

**IF THE PARENT IS THE SOURCE AND WANTS THE CHILD REMOVED FROM THE HOME, ASK THE PARENT:**

7. Would you be willing to work with CPS to make alternative arrangements (other than CPS placement) for the care of your child?

**DRUG EXPOSED INFANTS CUE QUESTIONS:**

1. Has the child or mother been tested? If so, what are the results?
2. What is the name of the medical doctor and/or hospital?
3. What is the parental history of drug use? (What drugs, when was last drug use, used during what trimester)?
4. What is the parental history of drug treatment?
5. Describe the medical and physical condition of the child?

    a. Birth weight
    b. Gestational age
    c. Apgar score
    d. Prenatal care
6. Have preparations been made in the home for the new baby?

**NON-SEXUAL EXPLOITATION CUE QUESTIONS:**

1. Describe how the child is being exploited.
2. What reason was given for the exploitation?
3. How long has this been going on?

**POTENTIAL ABUSE AND NEGLECT CUE QUESTIONS:**

1. Describe behaviors (of the parent, guardian, custodian or child) that give you reason to believe that abuse or neglect may occur.
2. Has abuse or neglect happened before? If so, when and where?
3. Has the _____ (parent, guardian or custodian) expressed concerns about hurting or not being able to care for the child?

## ***CLOSURE CUE QUESTIONS***

1. Do you know what school or child care facility the child attends? If so, what is the name of the school or child care facility? Dismissal/pick-up time?
2. Has the child expressed concerns about going home? If so, what did the child say to you?
3. Has law enforcement been notified? DR/Badge number?
4. Does the child have any of these special needs or problems?
   a. Bizarre behavior
   b. Extremely angry or volatile
   c. Physically ill
   d. Mentally ill
   e. Language other than English
5. Does the _____ (parent, guardian or custodian) have any of these special needs or problems:
   a. Bizarre behavior
   b. Extremely angry or volatile
   c. Physically ill
   d. Mentally ill
   e. Language other than English
6. SUBSTANCE ABUSE:
   A) Does anyone in the home abuse drugs or alcohol? If yes:
      - who?
      - what drugs?
      - how often?
7. DOMESTIC VIOLENCE:
   A) Is there domestic violence in the home? If yes:
      - who is the abuser? the victim?
      - how often does the domestic violence occur?
      - when was the last incident?
      - have the police been called? If yes, what was the outcome?
      - have there been any injuries to adults and or children? If yes, please describe them.
      - where are the children during the domestic violence?
8. Does any other person living in the home or involved with the family have a language barrier?
9. Do you know if CPS or any other agency has been involved with this family?
10. If this report is assigned for field investigation, are there any issues we need to be aware of to ensure the worker's safety, i.e., guns, dogs, etc.?

**A.R.S. §41-1010 CUE QUESTIONS**

1. Is there any reason to believe that substantial harm will result from disclosure of your name? If so, what is the substantial harm?
   - Request specific reasons, if known.
     May we have your name and phone number

the condition of being fettered, bound, or otherwise physically restrained on the part of one so clothed.

## DEATH OF A CHILD – HIGH RISK

**101 Death of a child due to neglect**

**111 Death of a child due to physical abuse or suspicious death**

**SRT 2 Hours**
**MRT 24 Hours**

## PHYSICAL ABUSE

**201 PHYSICAL ABUSE – HIGH RISK – Severe/life threatening injuries requiring emergency medical treatment and/OR parent presents severe physical harm to a child NOW**

**SRT 2 Hours**
**MRT 24 Hours**

Injuries **REQUIRING EMERGENCY MEDICAL TREATMENT** which may include:

Head injury with risk of Central Nervous System damage
Internal injury
Multiple injuries or multiple plan injuries (battering)
Severe facial bruises
Fractures or bruises in a non-ambulatory child
Fractures
Instrumentation injury with risk of impairment
Immersion burns
Second and third degree burns
Parent, guardian or custodian provides prescribed/non-prescribed or illegal drugs or alcohol to a child under the age of six (6) and the child is exhibiting symptoms of the drug or alcohol

Child under the age of six (6) observed or reported to be struck in the head, face, neck, genitals or abdomen which could likely cause an injury

Child under the age of twenty-four (24) months is shaken (Shaken baby syndrome)

Physical abuse by a parent, guardian or custodian who has a previous substantiated Priority 1 or High Risk report

Parent, guardian or custodian threatens or presents serious bodily harm to a child NOW

**202 – PHYSICAL AUBSE – MODERATE RISK**
**Serious/multiple injuries which may require medical treatment and/r a child at risk for serious physical abuse if no intervention is received**

**SRT 48 Hours**
**ART 24 Hours**
**MRT 72 Hours**

Injuries **THAT MAY REQUIRE MEDICAL TREATMENT** which may include:

- Multiple injuries or multiple plan injuries
- Injuries to torso or extremities
- Injury to child under age one (1)
- Fractures
- Parent, guardian or custodian provides prescribed/non-prescribed or illegal drug or alcohol to a child six (6) years of age or older and the child is exhibiting symptoms of the drug or alcohol
- Munchasusens Syndrome by Proxy
-

Low Risk injury to child under the age of six(6)

Child six (6) year of age or older observed or reported to be struck in the head, face, neck, genitals or abdomen which could likely cause an injury

Parent, guardian or custodian present serious bodily harm to a child or fears or threatens to harm child if no intervention received and he or she has a previous substantiated report of physical abuse

Newborn child (under 3 months of age) born to parents whose parental rights have been previously terminated

**203 – PHYSICAL ABUSE – LOW RISK**
**Injuries not requiring medical treatment and/or parent threatens physical harm if no intervention is received**

**SRT 72 Hours**
**ART 48 Hours**
**MRT 72 Hours Excluding Weekends & Holidays**

Injuries **NOT REQUIRING MEDICAL TREATMENT** which may include:

- First degree or cigarette burns
- Injury to buttocks or scalp (i.e. hair loss)
- Injury to bony body parts (i.e. shins, knees, elbows, etc)
- Single or small bruises
- Parent, guardian or custodian provides prescribed/non-prescribed or illegal drugs or alcohol to a child and the child is exhibiting symptoms of the drug or alcohol
- Bleeding (i.e. hit in the face bloody nose)

• NOT Eligible for Family Builders

Parent, guardian or custodian fears or threatens to harm a child if no intervention is received

**Appendix F**
**CPS RESPONSE SYSTEM**

Please note that while all CPS risk reports may be jointly investigated with Law Enforcement, CPS reports assigned the following Risks require special Law Enforcement contact: 100, 101, 201, 301, 401, 202, 302 (only sexual contact between children), 402, 403, and (when determined to be substantiated) 203.

**204 – PHYSICAL ABUSE - POTENTIAL RISK**
**Child at risk of physical injury due to stressors in the home**

**SRT 7 Consecutive Days**
**ART 72 Hours Excluding Weekends & Holidays**

Home environment stressors place child at risk of physical abuse which may include domestic violence, mental illness, substance abuse, history of physical abuse with no current injury, etc.

**NEGLECT – REPORTS ARE SCREENED FOR "SUBSTANTIAL RISK OF HARM"**

**301 – NEGLECT – HIGH RISK**
**Severe/life threatening situations requiring emergency intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care.**

**SRT 2 Hours**
**MRT 24 Hours**

Delayed or untreated medical condition which is life threatening or permanently disabling which may include Infant Doe, comatose state or debilitation from starvation or possible non-organic failure to thrive

Child of any age who is alone and cannot care for self or for other children due to physical, emotional or mental inability (This includes a parent, guardian or custodian who is incarcerated or hospitalized.)

Child under the age of six (6) is alone NOW

Child six (6) to nine (9) years of age is alone for three (3) hours or longer or unknown when parent, guardian or custodian will return

Imminent harm to child under the age of six (6) due to inadequate supervision by parent, guardian or custodian

Neglect results in serious physical injury or illness requiring emergency medical treatment. Failure to use child restraints pursuant to ARS 28-907 are not reports.

Imminent harm to child due to health or safety hazards in living environment which may include exposure to the elements.

Child assessed as suicidal by qualified mental health professional and parent, guardian or custodian is unwilling to secure needed emergency medical treatment including psychiatric treatment

No parent willing to provide immediate care for a child and child is with a caregiver who is unable or unwilling to care for the child NOW or child is left to his or her own resources

History of extensive gestational substance abuse to child under three (3) months of age or mother or child tests positive for non-prescribed or illegal drug or alcohol withdrawal symptoms

Child under two (2) months of age displays non-prescribed or illegal drug or alcohol withdrawal symptoms

Mother is using cocaine, heroin, methamphetamines or PCP and is breastfeeding a child

**302 – NEGLECT - MODERATE RISK – Serious/non-life threatening situations requiring intervention due to the absence of a parent, or a parent who is unable due to physical or mental limitations or is unwilling to provide minimally adequate care**

**SRT 48 Hours**
**ART 24 Hours**

Child age eleven (11) to thirteen (13) years of age caring for a child age (6) or younger for twelve (12) hours or longer

Living environment presents health or safety hazards to a child under the age of six (6) which may include human/animal feces, undisposed garbage, expose wiring, access to dangerous objects or harmful substances, etc

Due to inadequate supervision or encouragement by parent, guardian or custodian sexual conduct or physical injury occurs between children. This includes a licenses or certified DES facility or a licensed DHS Level I, II or III Behavioral Health Treatment facility

No parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child less than ONE (1) week

Newborn child (under 3 months of age) born to parents whose parental rights have been previously severed.

**303 – NEGLECT – LOW RISK**
**Situations which may require intervention due to the absence of a parent, or a parent is unable due to physical or mental limitations or is unwilling to provide minimally adequate care, which includes exploitation of a child**

**SRT 72 Hours**
**ART 48 Hours**
**MRT 72 Hours Excluding Weekends & Holidays**

Delayed or untreated medical problem cause child pain or debilitation that is not life threatening AND parent, guardian or custodian is unwilling to secure medical treatment.

Child under the age of nine (9), who is not alone at the time of the report, but has been left alone within the past fourteen (14) days

Parent, guardian or custodian demonstrates an inability to care for a child within the past thirty (30) days including leaving a child with inappropriate or inadequate caregivers

Living environment presents health or safety hazards to a child six (6) years of age or older which may include human/animal feces, undisposed garbage, exposed wiring, access to dangerous objects or harmful substances etc.

Food not provided and child chronically hungry

Significant developmental delays due to neglect

Use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities

Parent, guardian or custodian is not protecting child from a person who does not live in the home AND who abused a child * NOT Eligible for Family Builders

No parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child beyond ONE (1) WEEK UP TO THIRTY (30) DAYS (Reporting source will need to call back if beyond thirty 30) days.) NOT Eligible for Family Builders

**304 – NEGLECT - POTENTIAL RISK**
**Child at risk of neglect due to stressors in the home**

**SRT 7 Consecutive Days**
**ART 72 Hours Excluding Weekends & Holidays**

Parent, guardian or custodian has no resources to provide for child's needs (supervision, food, clothing, shelter and medical care) and child's needs may be neglected

Home environment stressors place child at risk of neglect which may include mental illness, substance abuse, etc.

Living environment is likely to present a health or safety hazard to a child

Child adjudicated dependent due to finding of incompetency or not restorable to competency pursuant to ARS 8-201 * NOTE eligible for Family Builders

Sexual conduct or physical injury between children and unknown if parent, guardian or custodian will protect * NOT Eligible for Family Builders if sexual conduct; eligible if it involves physical injury

Complaint by law enforcement or officer of juvenile court alleging dependency due to a delinquent or incorrigible act committed by a child under age eight (8) {ARS 8-201}

## SEXUAL ABUSE

### 401 – SEXUAL ABUSE – HIGH RISK
**Physical evidence of sexual abuse reported by medical doctor or child reporting sexual abuse within the past seven (7) days.**

**SRT 2 Hours**
**MRT 24 Hours**

Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven (7) days

Child reporting vaginal or anal penetration or oral sexual contact (oral contact with the penis, vulva or anus) within past seventy-two (72) hours AND has not been examined by a medical doctor

### 402 – SEXUAL ABUSE – MODERATE RISK
**Sexual behavior or attempted sexual behavior occurring 8 days or up to 1 year ago and/or child is exhibiting indicators consistent with sexual abuse**

**SRT 48 Hours**
**ART 24 Hours**
**MRT 72 Hours**

Sexual behavior within the past eight (8) to fourteen (14) days including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor

Attempted sexual behavior or sexual behavior when last occurrence is unknown or when last occurred beyond fourteen (14) days and up to one (1) year including sexual abuse, sexual assault, sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor

Parent, guardian or custodian suggests or entices a child to engage in sexual behavior, but there is no actual touching including encouraging a child to view pornographic materials

Child is exhibiting physical or behavioral indicators which are consistent with sexual abuse AND there are indicators the behavior is caused by parent, guardian or caretaker

Child is living in the home with a person convicted of a sexual offense against a child

### 403 – SEXUAL ABUSE – LOW RISK
**Sexual behavior or attempted sexual behavior occurring beyond 1 year and perpetrator currently has access to a child**

**SRT 72 Hours**
**ART 48 Hours**
**MRT 72 Hours Excluding Weekends & Holidays**

Parent, guardian or custodian sexually abused a child in the past AND is now living in a home with a child

Attempted sexual behavior or sexual behavior when last occurrence was beyond one (1) year including sexual abuse, sexual assault, sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor and the perpetrator currently has access to the child

NOT Eligible for Family Builders

## SEXUAL ABUSE – POTENTIAL RISK
**N/A**

## EMOTIONAL ABUSE

## EMOTIONAL ABUSE – HIGH RISK
N/A

## 502 – EMOTIONAL AUBSE - MODERATE RISK –
**Child diagnosed by a mental health professional as exhibiting symptoms of emotional abuse caused by a parent**

**SRT 48 Hours**
**ART 24 Hours**
**MRT 72 Hours**

Child diagnosed by qualified mental health professional as exhibiting severe anxiety, depression, withdrawal or untoward aggressive behavior which could be due to serious emotional damage by parent, guardian or custodian

## 503 – EMOTIONAL ABUSE – LOW RISK
**Parent demonstrates behavior which may result in emotional trauma to a child**

**SRT 72 Hours**
**ART 48 Hours**
**MRT 72 Hours Excluding Weekends & Holidays**

Parent, guardian or custodian demonstrates behavior or child reports parent, guardian or custodian behavior which is likely to have the effect of fear, rejection, isolation, humiliation or debasement of a child

## EMOTIONAL ABUSE - POTENTIAL RISK -
N/A

## TRACKING CHARACTERISTICS (action request communication) DOES NOT REQUIRE AN INVESTIGATION, BUT MAY REQUIRE AN ACTION

**TB** Notice that a family or alleged abusive person known to another state CPS is residing in or believed to be relocating to Arizona

**TD** Request for courtesy assessment from another state CPS to ensure the safety of a child

**TE** Runaways from other states or shelter due to out-of-state request, or courtesy ICPC shelter

**TF** Court ordered pick up (domestic relations)

**TG** Mental health treatment needed, but cannot be obtained without CPS intervention

**PI** Physical Injury Between Children

**SX** Sexual Conduct Between Children

## TRACKING CHARACTERISTICS CON'T REQUIRES AN INVESTIGATION AND MUST INCLUDE AT LEAST ONE (1) REPORT ALLEGATION

**AB** Child Abandonment
**DV** Domestic Violence
**FR** False Report Indicated
**NF** Near Fatality – an act certified by a physician, placed the child in serious or critical condition (Federal definition)
**SEN** Substance Exposed Newborn
**TH** Child in care, custody and control of DES via court order or Voluntary Foster Placement Agreement
**TJ** Administrative ordered investigation
**TK** Court ordered investigation
**TL** Private dependency petition
**TM** Substance abuse contributes to the maltreatment
**TN** DES certified child care home
**TO** Family resides on Indian Reservation or Military Base
**TP** Family Assistance Administration (AFDC teenage parent recipient) report
**TSH** Safe Haven Newborn
**TSX** Sexual Conduct Between Children
**TPI** Physical Injury Between Children

## AGGRAVATING FACTORS (Requires documentation in the case record by the supervisor)

**A1** Child victim placed in temporary custody by law enforcement or court order

**A2** Parent, guardian or custodian is described as volatile or dangerous

**A3** Ability to locate child victim is time limited

**A4** Family in crisis NOW

**A5** Chronicity including previous validated or undetermined investigated reports

**A6** Special needs of child victim place child victim at greater risk

**A7** Child victim in care, custody and control of DES via court order or Voluntary Foster Placement Agreement

**A8** Administrative directive for quicker response time

**A9** Child victim expressing fear of maltreatment if going home

## MITIGATING FACTORS (REQUIRES DOCUMENTATION IN THE CASE RECORD BY THE SUPERVISOR)

**M1** No perpetrator access to child victim during the determined response time

**M2** Child victim hospitalized or in other safe environment and will remain there during the determined response time

**M3** Maltreatment occurred thirty (30) days or longer prior to report for child victim age one (1) or older

**M4** Family receiving treatment related to report allegation and, in the opinion of the treatment provider, the child victim will be safe during the determined response time

**M5** Law enforcement report and no contact with CPS by phone at time of law enforcement response; may mitigate up to Potential Risk Standard Response Time

# CPS Priority Response Timelines

The Central Intake Unit (Hotline) prioritizes incoming CPS reports according to several factors which include:

- Immediacy of danger to child
- Severity of allegations
- Perpetrator access
- Age of child

Central Intake will also flag reports that meet the criteria for an Extremely Serious Allegation report that will notify the responding CPS office/investigator, that a joint investigation is required.

The priority responses range from a Priority 1 (P1) report to a Priority 4 (P4) report. The priority responses break down as follows:

- Priority 1 (P1): child is in immediate danger and a response to assess the child's safety is required within 2 hours of receiving the report
- Priority 2 (P2): risk to child is high and a response to assess child's safety is required within 48 hours of receiving the report
- Priority 3 (P3): risk to child is moderate and a response to assess child's safety is required within 72 hours of receiving the report
- Priority 4 (P4): risk to the child is low and a response to assess the child's safety is required within 7 days

The CPS investigator is required to make contact with the child in the required time frame of a report.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

# TEMPORARY CUSTODY NOTICE

On *(date)* _____ , at *(time)* ____ AM /PM, temporary custody of *(child's name)* _____

was taken at *(address)* _____ by *(agency)* _____

**Describe the specific reason(s) temporary custody is necessary** _____

**Check the circumstances (imminent risk factor) that most clearly describes the reason temporary custody was necessary:**

- ☐ Medical or psychological examination required to diagnose abuse or neglect.
- ☐ No caregiver is present and the child cannot care for himself or herself or for other children in the household.
- ☐ A child has severe or serious non-accidental injuries that require immediate medical treatment.
- ☐ A child requires immediate medical treatment for a life-threatening medical condition or a condition likely to result in impairment of bodily functions or disfigurement, and the child's caregiver is not willing or able to obtain treatment.
- ☐ A child is suffering from nutritional deprivation that has resulted in malnourishment or dehydration to the extent that the child is at risk of death or permanent physical impairment.
- ☐ The physical or mental condition of a child's caregiver endangers a child's health or safety.
- ☐ A medical doctor or psychologist determined that a child's caregiver is unable or unwilling to provide minimally adequate care.
- ☐ The home environment has conditions that endanger a child's health or safety, such as unsanitary disposal of human waste, animal feces or garbage, exposed wiring, access to dangerous objects, or harmful substances that present a substantial risk of harm to the child.
- ☐ A medical doctor or psychologist determined that a child's caregiver has emotionally damaged the child; the child is exhibiting severe anxiety, depression, withdrawal, or aggressive behavior due to the emotional damage; and the caregiver is unwilling or unable to seek treatment for the child.
- ☐ The child's caregiver has engaged in sexual conduct with a child, or has allowed the child to participate in sexual activity with others.
- ☐ Other circumstances place a child at imminent risk of harm requiring removal *(describe specific circumstance)*. _____

The Department of Economic Security, Child Protective Services (CPS) must:

- ☐ Return your child within **72 hours** (not including weekends and holidays) unless CPS files a legal paper, called a petition, with the Juvenile Court. If a petition is filed, your child will be kept in the temporary custody of CPS.
- ☐ Return your child within **12 hours** if your child was removed to be examined by a medical doctor or psychologist, unless abuse or neglect is diagnosed, **and**
- ☐ Inform you of the right to give a verbal or written response to the allegations and have them included in the investigation report. Any documentation you give and what you say or write will be included in the case record and can be used in court proceedings.

☐ **A Preliminary Protective Hearing will be held on** *(date)* _____ *(time)* _____

***OR***

☐ **Location** *(court name)* _____ *(address)* _____

**You will be notified if CPS files a petition and a Preliminary Protective Hearing is set. CPS will provide you a written notice of the date, time and location of the hearing within 24 hours after the petition is filed.**

If a petition is filed, you have the right to have an attorney represent you. The Juvenile Court will appoint an attorney to represent you if you qualify financially. The court may also appoint an attorney or a guardian ad litem to represent your child's best interest.

Before the Preliminary Protective Hearing, you must meet with your attorney. Prior to the Preliminary Protective Hearing, a meeting will be held to try to reach an agreement about placement of your child, what services should be provided and visitation with your child. The availability of reasonable services will be considered. The child's health and safety will be a main concern at this meeting.

Other people may attend this meeting including: child, relatives, other interested persons with whom the child might be placed, witnesses, advocates or a person who has knowledge of your child or an interest in the welfare of your child.

It is your responsibility to participate in all services determined reasonable and necessary by the court. If you do not, the court may hold further hearings to terminate your rights as a parent. This means your child will never be returned to you.

Services available to parents, guardians and custodians, and agencies to contact for assistance are listed on the back of this form.

CHILD PROTECTIVE SERVICES SPECIALIST'S NAME *(Please print)* _____ AREA CODE AND PHONE NO. ( )

ARIZONA DEPARTMENT OF ECONOMIC SECURITY'S ADDRESS *(No., Street, City, State, ZIP)* _____

CHILD PROTECTIVE SERVICES SUPERVISOR'S NAME *(Please print)* _____ AREA CODE AND PHONE NO. ( )

**METHOD OF NOTICE:** On *(date)* _____, at *(time)* _____ *AM/PM*, I served notice to *(parent, guardian or custodian) (print name)* _____

Method used: ☐ given directly ☐ left at residence ☐ other *(specify)* _____

Address where mailed/left/given *(No., Street, City, State, ZIP)* _____

**ASK: Is the child or child's parents of American Indian heritage/ancestry?** ☐ Yes ☐ No ☐ Unknown

PARENT, GUARDIAN OR CUSTODIAN'S SIGNATURE _____

CHILD PROTECTIVE SERVICES SPECIALIST'S SIGNATURE *(Or law enforcement officer)* _____ DATE

Equal Opportunity Employer/Program This document available in alternative format by contacting (602) 542-3598 Disponible en español en la oficina local.

Rev. 09/27/04

## Information for Parents and Guardi

**PURPOSE.** This form is required by Arizona law to notify the parent, guardian or custodian when a child is removed from his/her custody and placed in temporary custody prior to filing a Dependency Petition or for psychological or physical examination. This form also provides additional resources and services available to the parent, guardian or custodian.

You may call the Parent Assistance Statewide Hotline, 1-800-732-8193, or Phoenix (602) 542-9580, for more information on the Juvenile Court system and how to obtain legal assistance.

You may call the Family Advocacy Office at 1-877-527-0765, to request a review of the child's removal. In order to ensure sufficient time for review of the removal, please make this call within 48 hours *(not including weekends and holidays)* of receiving this notice.

You have the right to call the Office of the Ombudsman-Citizen's Aide, if you have a complaint about CPS actions. The Ombudsman-Citizen's Aide will impartially investigate the complaint, inform you of the results of the investigation and provide you with referrals for additional assistance. To contact the Ombudsman-Citizen's Aide call: 1-800-872-2879, or Phoenix (602) 277-7292.

You have the right to participate in the mediation program in the Office of the Attorney General if a dispute arises between you and CPS. Mediation will be arranged when requested by a family member or CPS. To contact the mediation program call: Phoenix - (602) 542-4192; Tucson - (520) 628-6504; Flagstaff - (520) 773-0474.

**Services and Programs**

Services provided are child-centered and family-focused to promote family preservation, independence and self-sufficiency. Programs available include, but are not limited to:

**In-Home Services:** Directed at strengthening the family unit to enhance parenting skills including:

- Intensive family preservation
- Parent aide services
- Parent skills training
- CPS child care
- Referrals to community services
- Counseling
- Peer self-help
- Services to high-risk infants and their families

**Out-of-Home Placement:** Placements provided for children who are unable to remain in their homes including:

- Relative homes
- Foster homes
- Group homes
- Residential treatment centers
- Independent living subsidy arrangements
- Community placements
- Selected placements, as ordered by juvenile court
- Adoption
- Guardianship

**Child Protective Services is referring you to the following services:** _____

_____

**Additional service needs will be assessed prior to the Preliminary Protective Hearing.**

**COMPLETION AND DOCUMENTATION.**

1. This notice must indicate the date and time that the child was placed in temporary custody, and the child's name.
2. Describe the specific reason why temporary custody is necessary must be indicated or stated.
3. Check the specific factors that constitute imminent danger that corresponds to the reason the child was removed.
4. The CPS Specialist's and CPS Supervisor's names, phone numbers, and address of the local CPS office must be completed.
5. Method of Notice section must be completed. One method of notice must be checked and this section must be signed by the CPS Specialist or law enforcement officer who took temporary custody of the child.
6. If the parent, guardian or custodian is served directly, he/she should be asked to sign the form. If he/she refuses, write in "Refuses to Sign" on the signature line.
7. Leave a copy of the form with the parent, guardian or custodian even if the parent refuses to sign.

**DISTRIBUTION.**

1. The original is given to the parent, guardian or custodian:
   a. Immediately if he/she is present at the removal;
   b. Within 24 hours if out-of-state (mailgram);
   c. As soon as possible if residence is unknown at time of removal.
2. A copy is sent to the Assistant Attorney General to file with the petition.
3. A copy is retained in the case record.

**RETENTION.** A copy of the form is retained in the permanent case record.

☐ **THIS CASE WAS PREVIOUSLY DECLINED OR RETURNED FOR FURTHER ACTION**

**PLEASE NOTE: IN ORDER TO COMPLY WITH DPS REPORTING REQUIREMENTS, CHARGING REQUESTS RESULTING FROM AN ARREST MUST NOW INCLUDE ALL BOOKING CHARGES AND STATUTES ON THIS FORM.**

# CHARGING REQUEST

**TO: Coconino County Attorney** **FROM:**

**DR#:** _____ **OFFENSE DATE#:** / / **CHARGING REQUEST:** / /

**ARREST DATE:** / / **OR NEVER ARRESTED FOR THIS OFFENSE:** ☐

**ESCA CRIME?** ☐ *YES* ☐ *NO* ☐ *UNSURE* **JOINT INVESTIGATION WITH CPS?** ☐ *YES* ☐ *NO*

| SUSPECT NAME (Last, First, Middle) | SUSPECT'S RESIDENCE ADDRESS | | |
|---|---|---|---|
| | CITY | ST | Zip |

| DOB / / | HGT | WGT | SEX | HAIR | EYES | RACE | SSN | DL # and STATE | SID # | FBI # |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

Suspect is (check box): ☐ ***IN CUSTODY*** ☐ ***NOT in Custody*** ☐ ***PLEASE ISSUE AN ARREST WARRANT***

| SUSPECT NAME (Last, First, Middle) | SUSPECT'S RESIDENCE ADDRESS | | |
|---|---|---|---|
| | City | ST | Zip |

| DOB / / | HGT | WGT | SEX | HAIR | EYES | RACE | SSN | DL # and STATE | SID # | FBI # |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

Suspect is (check box): ☐ ***IN CUSTODY*** ☐ ***NOT in Custody*** ☐ ***PLEASE ISSUE AN ARREST WARRANT***

| Charge Codes | Counts | Charge Code | Counts |
|---|---|---|---|
| | M☐ F☐ | | M☐ F☐ |
| | M☐ F☐ | | M☐ F☐ |
| | M☐ F☐ | | M☐ F☐ |

| VICTIM NAME (Last, First, Middle) | VICTIM'S RESIDENCE ADDRESS | | |
|---|---|---|---|
| | City | ST | Zip |

| DOB / / | HGT | WGT | SEX | HAIR | EYES | RACE | SSN | Home Phone ( ) - | Work Phone ( ) - | Other Phone ( ) - |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| VICTIM NAME (Last, First, Middle) | VICTIM'S RESIDENCE ADDRESS | | |
|---|---|---|---|
| | City | ST | Zip |

| DOB / / | HGT | WGT | SEX | HAIR | EYES | RACE | SSN | Home Phone ( ) - | Work Phone ( ) - | Other Phone ( ) - |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

COMMENTS* (please advise if decline is being sought):

# INFORMATION REQUIRED WITH CHARGING REQUEST

**IF ANY OF THE CHARGES ARE LISTED BELOW, YOU *MUST* INCLUDE THE INFORMATION REQUESTED BEFORE WE CAN REVIEW THE CHARGING REQUEST. PLEASE MARK THE APPROPRIATE BLANKS INDICATING THAT THE INFORMATION IS INCLUDED IN THE CHARGING REQUEST.**

| ***CHARGE CATEGORY:*** | ***INFORMATION NEEDED*** |
|---|---|
| **EVERY CASE:** | ☐ Criminal History<br>☐ Audio / Video Tapes (complete list on reverse side)<br>☐ Witness Statements<br>☐ All Supplements<br>☐ All photos (2 copies OR via CDROM OR via email)<br>☐ 911/dispatch tapes (check if at least requested but not received at time of charging request.) |
| **CHILD CRIMES:** | If **an ESCA** crime (Extremely Serious Conduct Allegation) as defined in: ARS 13-3623 (Child Abuse), 13-3601 (Fel DV), 13-1404 (Sex Abuse), 13-1405 (Sex Con w/Minor), 13-1406 (Sex Assault-Min), 13-1410 (Child Molest), 13-1417 (Cont. Sex Abuse of Child), ***or*** any other act which may result in *serious harm, injury or death* to a child; 13-3506 (Indecent exposure to 0-14 yr old); 13-1403 (public sex indecency – minor); 13-3019 (surrept. photo…), 13-3212 (child prostit), 13-3506 (furnishing harmful items), 13-3552 (Com. Sex Exploit), 13-3553 (Sex Exploit), 13-3556 (admit minor to pub disp), 13-3620 (duty to report abuse)<br>☐ Check box on front of **Charging Request Form**<br>☐ Joint investigation to be conducted with CPS must be documented in DR. *If no joint investigation done,* officer must document in DR why joint investigation not conducted<br>☐ Conduct Safechild interview<br>☐ Was law enforcement contacted by CPS? ☐ **Yes** ☐ **No;**<br>**If No, did law enforcement contact CPS?** ☐ **Yes** ☐ **No**<br>☐ Is officer requesting that charges be filed? ☐ **Yes** ☐ **No;** ☐ **For Review only?**<br>☐ Please check other boxes in categories Agg Asslt / DV / Drug / Sex Assault, etc. where applicable |
| **AGGRAVATED DUI:** | ☐ KQ<br>☐ ***If Suspect's license is out of state:*** Certified copy of MVD from state they reside<br>☐ ***If Agg. DUI w/minor:*** Victim Notification Sheet with date of birth of minor<br>☐ UA's Lab Results<br>☐ DUI Drugs: UA Flash test results<br>☐ DUI Drugs: DRE report<br>☐ Blood draw: copy of warrant / LE Phlebotomist report<br>☐ 911/dispatch tapes if phone / anonymous caller / report |
| **DRUGS:** | ☐ Flash test or lab results<br>☐ Indicate in report what paraphernalia was used for<br>☐ Approximate weight of drugs |
| **VIOLATION OF ORDERS OF PROTECTION or AGG HARASSMENT or DV AGG ASSAULT or AGG ASSAULT or AGG DV:** | ☐ Certified copy of Order of Protection or IAH and Affidavit or Service upon Suspect (*If VOP or AGG HARR)*<br>☐ Certified copy of prior DV convictions (after 1/1/99) (*If DV case)*<br>☐ Medical Records for Victim<br>☐ Victim Notification Sheet completed |
| **SEX CRIMES:** | ☐ All medical records / photos regarding offense<br>☐ SAN/SART records<br>☐ Safe-child records<br>☐ **All physical evidence has been forwarded to crime lab for analysis** |
| **PROPERTY CRIMES:** | ☐ List and value amount of all property involved<br>☐ Restitution amount<br>☐ List all recovered evidence |
| **FORGERY/CREDIT CARD:** | ☐ Copies of all checks/credit card receipts in issue<br>☐ Verification from bank/check/credit card holder of forgery |

***Submitting Officer's Name:***

***Date:*** / /

# DESCRIBE ALL AUDIO/VIDEO/CD-ROM's SUBMITTED

## VIDEOS:

| | |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

## AUDIO CASSETTES:

| | |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

## CD-ROM's:

| | |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

**Submitting Officer's Signature** _____ **Date** _____
**Acknowledging Charging attorney's signature** _____ **Date** _____

# FLAGSTAFF P.D.
# INVESTIGATIONS CHECKLIST

## CHILD ABUSE

DR NUMBER:

| | | |
|---|---|---|
| ☐ CPS NOTIFIED? | BY WHOM: | IF NO, WHY? |
| ☐ FORENSIC INTERVIEW CONDUCTED? | BY WHOM: | IF NO, WHY? |
| ☐ FORENSIC INTERVIEW TAPED? | BY WHOM: | IF NO, WHY? |
| ☐ PHYSICAL EXAM PERFORMED? | BY WHOM: | IF NO, WHY? |
| ☐ LONG BONE SCAN PERFORMED? | ☐ YES ☐ NO | IF NO, WHY? |
| ☐ VICTIM/WITNESS NOTIFIED? | ☐ YES ☐ NO | IF NO, WHY? |
| ☐ SAFE CHILD UTILIZED? | ☐ YES ☐ NO | IF NO, WHY? |
| ☐ PHOTOGRAPHS TAKEN? | ☐ YES ☐ NO | IF NO, WHY? |
| ☐ D/V SUPPLEMENTAL INITIATED? | ☐ YES ☐ NO | IF NO, WHY? |
| ☐ COUNTY ATTORNEYS NOTIFIED? | ☐ YES ☐ NO | IF NO, WHY? |

# ARIZONA INFANT DEATH INVESTIGATION CHECKLIST

**Scene Investigated by** _____ **Agency** _____ **Phone Number** _____ **County** _____

**A. General Information**

1. Infant's name _____ Sex ____ Age _____ Date of birth _____
2. Date of death _____ Time of death _____AM/PM Location _____
3. Father's name _____ Age ____ Occupation _____
4. Mother's name _____ Age ____ Occupation _____
5. Are there siblings? ☐ Yes, ☐ No If yes, list ages _____
6. Home address (if different from location of death) _____
7. Pediatrician (family physician) _____ Physician's Phone _____

**B. Past History**

1. Birth weight _____lbs _____oz Was infant premature? ☐ Yes, ☐ No If yes, number of weeks premature _____
2. Place of Birth (Hospital and City/State) _____
3. Any problems with pregnancy and delivery? ☐ Yes, ☐ No If yes, explain _____
4. During pregnancy, did anyone: ☐ Smoke? Who? _____ ☐ Use drugs? Who? _____What? _____
5. Has infant ever required hospitalization or emergency care? ☐ Yes, ☐ No If yes, explain: When? _____ Where? _____, Why? _____
6. Anything unusual about sleeping habits or breathing? ☐ Yes, ☐ No Has infant turned blue or stopped breathing? ☐ Yes, ☐ No Has infant had seizures or convulsions? ☐ Yes, ☐ No If yes, explain _____
7. Any other medical problems or concerns? ☐ Yes, ☐ No If yes, explain _____
8. Has infant been immunized? ☐ Yes, ☐ No If yes, are immunizations up to date? ☐ Yes, ☐ No, ☐ Unknown Date of last immunization _____
9. Have there been other child deaths in this family or relatives of the immediate family? ☐ Yes, ☐ No If yes, where? _____ Cause of death(s)_____ Age(s) at death _____

**C. Recent History**

1. Was the infant ☐ Breast-fed ☐ Bottle-fed ☐ Both? Last feeding _____AM/PM What was last feeding? _____
2. Recent illness? ☐ Yes, ☐ No If yes, what? ☐ Appetite change, ☐ Cough, ☐ Diarrhea, ☐ Ear infection, ☐ Fever, ☐ Irritability/listlessness, ☐ Sniffles, ☐ Vomiting, ☐ Weakness/ "floppiness", ☐ Wheezing, ☐ Other _____ Were medications or home remedies given? ☐ Yes, ☐ No If yes, what _____* Amount_____ Time _____ AM/PM
3. Was there recent exposure to chemicals? ☐ Yes, ☐ No If yes, what _____ When _____
4. Is anybody in the house sick? ☐ Yes, ☐ No If yes, who _____ Illness_____
5. Was there a history of a recent fall or injury? ☐ Yes, ☐ No If yes, explain _____
6. Was the infant in anyone else's care in the last 48 hours? ☐ Yes, ☐ No If so, whom? _____
7. Last date infant was seen by a medical provider _____ Where? _____ Reason for visit _____

**D. Scene**

1. Last seen alive_____ AM/PM Was infant behaving normally? ☐ Yes, ☐ No If no, describe: _____
2. Who discovered the infant? Name_____ Relationship _____ Time _____AM/PM
3. Position infant was in when found? ☐ Abdomen, ☐ Back, ☐ Side Position when put to bed? ☐ Abdomen, ☐ Back, ☐ Side What was the infant wearing? _____ How was the infant covered? _____
4. Were the nose and mouth obstructed? ☐ Yes, ☐ No If yes, with or by what? _____
5. Describe infant's sleeping environment ☐ Crib, ☐ Bed, ☐ Sofa, ☐ Other _____ Type of mattress ☐ Soft, ☐ Hard, ☐ Waterbed, ☐ Exposed plastic covering Were any of the following found in infant's bed? ☐ Pillow, ☐ Blankets, ☐ Cushions, ☐ Toys, ☐ Pets, ☐ Other_____
6. Was the infant sleeping alone? ☐ Yes, ☐ No If no, with whom? ☐ Child, ☐ Adult, ☐ More than one person Temperature of room _____ sleeper(s)_____ Drug or alcohol used? ☐ Yes, ☐ No If yes, what? _____
7. Was the infant ☐ Warm, ☐ Cool
8. Were attempts made to revive the infant? ☐ Yes, ☐ No If yes, by whom? _____ Time of attempt _____AM/PM Method of attempt ☐ CPR, ☐ Shaken, ☐ Other_____
9. Does anyone in the immediate household or daycare facility smoke? ☐ Yes, ☐ No If yes, identify relationship _____

Comments: (Use this space to elaborate on questions above or to note anything unusual)

_____

_____

_____

*Use "Comments" section if more space is needed. Collect all medication/home remedy containers for submission to Medical Examiner.

White = First Responder Canary = Medical Examiner Pink = ADHS

# ARIZONA INFANT DEATH SCENE INVESTIGATION CHECKLIST INSTRUCTIONS

Scene Investigated by- Name of the person responsible for the death scene investigation.
Agency: Name of the agency that the person works for. Phone Number: Telephone number where the scene investigator can be reached.
County: County of the infant death investigation.

## A. GENERAL INFORMATION

1. Infant's Name- Include the infant's first, middle and last names. Also known as (a.k.a.) can be added if this is appropriate. Sex- Indicate whether the infant is male or female. Age- Age of the infant in months or days at the time of death. Date of Birth- Month, date and year of the infant's birth.
2. Date of Death- Actual date of the infant's death. Time of Death- Actual time infant died. Location- Identify where the infant's death occurred, (i.e. home, day care, relative's home, etc.) Give the address, including city.
3. Father's Name- Indicate the first, middle and last names of the infant's father. Age of the father in years. Usual occupation of the father.
4. Mother's Name- Indicate the first, middle and last names of the infant's mother. Age of the mother in years. Usual occupation of the mother.
5. Siblings- If yes, indicate ages.
6. Home Address - If different from the location of death, indicate the home address, including city and state.
7. Pediatrician (Family Physician)- Name of the physician who was providing the infant's ongoing health care. Phone- Indicate the physician's phone number.

## B. PAST HISTORY

1. Birth Weight- Weight of the infant at the time of birth in pounds and ounces. Prematurity- If premature, indicate# of weeks premature.
2. Place of Birth- Indicate the hospital and City/ State where the infant was born.
3. Difficulty with pregnancy/delivery- Answer yes or no. If yes, explain.
4. Smoking during pregnancy- Indicate if any household member smoked tobacco during this pregnancy. If yes, identify relationship to infant. Drugs during pregnancy- Indicate if any household member abused drugs during this pregnancy. If yes, identify relationship to infant and type of drug.
5. Hospitalization/ Emergency Care- Indicate if the infant has been admitted to the hospital or seen in an emergency room. Explain the reasons for hospital admission or emergency room visit.
6. Indicate if infant had any unusual sleeping habits, if infant ever turned blue or stopped breathing, and if infant had seizures or convulsion. If yes, explain.
7. Other medical conditions noted- Answer yes or no. If yes, explain.
8. Immunization- Indicate if the infant received any immunizations. Indicate if immunizations are up to date and the date of last immunization.
9. History of other child deaths in the family. If yes, identify where, cause of death, and age of child at death.

## C. RECENT HISTORY

1. Type of feeding- What type of feeding did the infant regularly receive? Check appropriate box. Last feeding- Indicate the time of the last feeding. What- Indicate what the infant consumed.
2. Recent Illness- Answer yes or no. If yes, check the box corresponding to the condition. Other-Describe other conditions not listed. Medicine- Indicate name of medication or home remedy. Amount- Amount infant was given. Time- Indicate the time medicine was given to infant. Collect all medication or home remedy containers for submission to Medical Examiner.
3. Chemicals- Indicate if the infant was exposed to any chemicals or noxious agents. What- Describe chemical. When- Give date of exposure.
4. Sickness in the household- Indicate if family members or close contacts have exposed the infant to any recent illnesses. Who – Indicate relationship. Illness– Type of illness.
5. Injury or fall- Indicate if the infant had a recent accident. If yes, explain.
6. Recent caregivers- Answer yes or no. If yes, indicate relationship with infant.
7. Last date infant was seen by medical provider– Indicate date. Where- Indicate medical center or physician name. Reason- Indicate why infant was seen.

## D. SCENE - (Ask person who discovered the infant)

1. Last seen alive- Indicate the time and circle AM or PM. Behavior - Indicate if infant's behavior was normal. If no, describe infant's behavior.
2. Who discovered the infant- Name and relationship of the individual and time this occurred.
3. Position when found- Indicate infant's position when found. (Check the appropriate box) Position when put to bed-Indicate the position of the infant when put to sleep. (Check the appropriate box) Clothing-Describe what was infant wearing. Covering- Describe how was infant covered.
4. Nose or mouth obstruction- Answer yes or no. If yes, indicate what was causing the obstruction.
5. Infant's sleeping environment- Describe the infants sleeping environment. Other category may include infant carrier, car seat, floor, sofa, swing, etc. Items in bed with infant- Note any items in the bed or immediate sleeping environment. Room Temperature- Indicate if room was cold, hot or normal.
6. Sleeping arrangement- Indicate if infant was sleeping alone. If no, identify co-sleepers. Weight – estimate weight of co-sleepers(s). Drug or alcohol usage- Indicate if co-sleepers used drugs or alcohol. Answer yes or no. If yes, explain.
7. Infant's temperature- Check appropriate box.
8. Attempts to revive infant- Check appropriate box. If yes, note by whom. Time of attempt- Indicate time. Method of attempts- Check appropriate box. Other– Describe other types of attempts if not listed.
9. Household or day care smokers- Answer yes or no. If yes, indicate the relationship to infant.

**COMMENTS**
Use this space to elaborate on questions above or anything unusual. List the medication or home remedies identified in Section C #2. Attach additional sheets when necessary.

**ROUTING INSTRUCTIONS** – First responders keep the original. Send yellow copy to County Medical Examiner's Office. Send pink copy to Arizona Department of Health Services. The address is listed below. Please call (602) 542-1875 if any additional information is needed.

**Arizona Department of Health Services**
**Office of Women & Children's Health**
**Unexplained Infant Death Council**
**150 N. 18th Avenue, Suite 320 Phoenix, AZ 85007**
**Fax: (602) 542-1843**

## AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

You are hereby authorized and directed to deliver and/or furnish to the County Attorney's office, or to any representative of theirs, upon presentation of this original authorization or a photocopy thereof, any and all written or oral medical information, medical reports, x-rays, hospital charts, notes, orders or other hospital records, records of treatment, copies of prescriptions, medical or hospital bills, tests and any other records or information concerning the physical condition, past, present, or future, *including the global set,* of the person named below.

☐ *By checking this box, this patient authorizes providing the requesting party with Flagstaff Medical Center's (FMC) patient 'encounter list', which are all dates this patient presented themselves to FMC for treatment.*

The County Attorney, or any representative of the County Attorney, is authorized to make a copy of all documents, photographs, x-rays and other materials.

I hereby waive any and all confidential or privileged communications, documents, or other materials.

Dated this _____ day of _____, 200___.

_____ _____

Patient's Signature Parent/Guardian, if Patient is a minor

_____

Patient's Printed Name

Patient Number

_____

Address

City, State, Zip

**STATE OF ARIZONA**

**OFFICE OF THE ATTORNEY GENERAL**

| | |
|---|---|
| ATTORNEY GENERAL OPINION<br><br>by<br><br>TERRY GODDARD<br>ATTORNEY GENERAL<br><br>May 26, 2004 | No. I04-003<br>(R04-003)<br><br>Re: Law Enforcement Interviews of Students at Public Schools |

TO: The Honorable Slade Mead
Arizona State Senate

The Honorable Linda Lopez
Arizona House of Representatives

## Questions Presented

You have asked the following questions related to the authority of law enforcement officers to interview students at public schools and the authority of school boards to adopt parental notification policies for such interviews:

1. Whether a school official must comply with a law enforcement officer's demand to interview a student;

2. Whether a school official must comply with a law enforcement officer's directive to refrain from contacting the parents of a student whom the officer intends to interview; and whether a school official may be held criminally liable for disregarding such a directive;

3. Whether a school official must comply with a law enforcement officer's directive to refrain from informing a student whom the officer intends to interview that the student has the right to consult his or her parents before answering the officer's questions; and whether a school official may be held criminally liable for disregarding such a directive;

4. Whether a school official must comply with a parent's demands to (a) inform the parent whenever a law enforcement officer seeks to interview the child/student, and (b) prohibit the officer from interviewing the child/student unless the parent is present; and

5. Whether a school official must advise a student of juvenile *Miranda* rights before interviewing the student regarding acts that constitute crimes.

**Summary Answers**

1. If law enforcement officers[1] are seeking only to interview a student, the officers are subject to regular school policy regarding access to students. Law enforcement officers making an arrest or serving a subpoena or a search warrant, however, generally have the right to immediate access to a student.

2. Although Arizona law does not require that school officials notify parents before law enforcement officers interview a student, school officials may generally provide such notice. However, in instances where law enforcement officers seek to interview a student in connection with an investigation of child abuse or other criminal activity by the student's parent, insistence on parental notification and/or

[1]Throughout this opinion, the term "law enforcement officer" includes members of federal, state, and local law enforcement agencies, and anyone acting on their behalf, including school resource officers.

consent is improper. A school official who insists on parental notification under these circumstances may be subject to "criminal liability" for hindering prosecution if the school official acts with the "intent to hinder the apprehension, prosecution, conviction or punishment of another for any [crime]." A.R.S. §§ 13-2511 and -2512. Insistence on parental notification is also inappropriate under circumstances in which delay pending parental notification would jeopardize public safety.

3. School officials must comply with a law enforcement officer's directive to refrain from informing a student that the student may consult his or her parents before answering the officer's questions if the proposed interview relates to an investigation of child abuse or other criminal activity by the student's parent or where delay pending notification of a parent would jeopardize public safety. In other circumstances, a school official may inform a student that he or she may consult with a parent prior to questioning.

4. School officials are not required to comply with unconditional demands from parents for prior notice of, or consent to, police interviews of a student. This issue may appropriately be addressed in school policies as described above.

5. A school official is not required to advise a student of juvenile *Miranda* warnings unless the official is conducting a custodial interrogation and acting in the capacity of a law enforcement officer.

## Analysis

### A. Authority of School Boards to Set Policies Regarding Law Enforcement Interviews.

"School boards have only the authority granted by statute, and such authority must be exercised in a manner permitted by statute." *Campbell v. Harris*, 131 Ariz. 109, 112, 638 P.2d 1355, 1358 (App. 1981); *see also* Ariz. Att'y Gen. Op. I88-062. Rules that school boards prescribe and enforce to govern schools must be consistent with law. A.R.S. § 15-341(A)(1).

Law enforcement officers making an arrest or serving a subpoena or search warrant have the right of immediate access to a student. Ariz. Att'y Gen. Op. I77-211; *see also* Ariz. Att'y Gen. Ops. I82-002, I82-094 (addressing procedures for taking a student into temporary custody). However, law enforcement officers seeking only to interview a student are subject to the school's overall policy regarding access to students who are in class. Ariz. Att'y Gen. Op. I77-211. School policies regarding access to students should make this distinction between law enforcement officers arresting a student and those interviewing a student.

### B. School Parental Notification Policies.

Arizona law neither requires nor prohibits school policies requiring notice to parents before officers interview students. To the extent that schools adopt parental notification policies, they must be flexible enough to take into account a variety of circumstances, including whether the proposed questioning relates to allegations of child abuse or other criminal activity by the student's parent(s), whether the student is suspected of committing a crime or is a possible witness in a criminal investigation, and whether delay pending parental notification will jeopardize public safety.

1. *Questioning regarding possible child abuse or other criminal activity by a parent.*

If a law enforcement officer seeks to interview a student in connection with an investigation

of alleged child abuse by a parent, parental notification is not permitted. *See* Ariz. Att'y Gen. Op. I88-062. Similarly, if a parent or guardian is suspected of some other type of crime and the student has information as a witness, parental notification is inappropriate because it could result in the parent evading arrest, destroying evidence, concealing the crime, or otherwise creating a threat to the community. *See* Wis. Att'y Gen. Op. OAG 5–94. Parental notification under these circumstances could expose school officials to criminal liability, depending on the school official's intent. *See* A.R.S. §§ 13-2511, 13-2512.[2]

2. *Student suspected of criminal activity.*

When a student is suspected of criminal activity, the Fifth Amendment may apply to law enforcement interviews. The Fifth Amendment protection against compelled self-incrimination affords all citizens, including juveniles, the right to refuse to answer questions that a law enforcement officer poses. *State v. Maloney*, 102 Ariz. 495, 498, 433 P.2d 625, 628 (1967). Under *Miranda v. Arizona*, law enforcement officers may not conduct custodial interrogations without first advising criminal suspects that they have the right to remain silent, to consult with an attorney, to have an attorney appointed if they cannot afford an attorney, and that anything they say may be used against them in a court of law. 384 U.S. 436, 444 (1966). Questioning by law enforcement officers may be deemed "custodial" for *Miranda* purposes regardless of the location of the interview if the person being questioned has been deprived of freedom of action in any significant way. *See In re Jorge D.*, 202 Ariz. 277, 280-81, 43 P.3d 605, 608-09 (App. 2002) (custodial questioning of a

[2]A.R.S. § 13-2512(A) provides: "A person commits hindering prosecution in the first degree if, with the intent to hinder the apprehension, prosecution, conviction or punishment of another for any felony, the person renders assistance to the other person." The definition of "rendering assistance" to the other person–the parent in this scenario–includes knowingly "[w]arning the other person of impending discovery." A.R.S. § 13-2510(2). Hindering prosecution in the second degree is the same crime except that it applies to those who hinder prosecution of persons who have committed misdemeanors rather than felonies. A.R.S. § 13-2511.

juvenile at school).

Confessions to law enforcement officers are presumed involuntary—notwithstanding *Miranda* warnings—and to rebut this presumption, the State must show by a preponderance of the evidence that the suspect made the confession freely and voluntarily. *State v. Jimenez*, 165 Ariz. 444, 448–49, 799 P.2d 785, 789–90 (1990). Courts apply a "totality of the circumstances" test in assessing the validity of a confession or of a juvenile's waiver of his Fifth Amendment right against self-incrimination. *Fare v. Michael C.*, 442 U.S. 707, 724–25 (1979). Arizona courts have attached particular significance to whether a parent was present when police interviewed the juvenile. *See In re. Andre M.*, 2004 WL 875629 ¶ 11 (Ariz. Apr. 23, 2004) (noting that a parent "can help ensure that a juvenile will not be intimidated, coerced or deceived during an interrogation"). Although a parent's absence during questioning does not, in itself, render a juvenile's statement to police inadmissible, in that situation "the State faces a more daunting task of showing that the confession was neither coerced nor the result of 'ignorance of rights or of adolescent fantasy, fright or despair' than if the parent attends the interrogation." *Id.*

In light of the significance that Arizona courts place on having a parent present during a juvenile's custodial interrogation, school districts may appropriately adopt policies requiring parental notification prior to a law enforcement interview of a student suspected of committing a crime.

3. *Student is a possible witness in a criminal investigation.*

Fifth Amendment concerns do not present themselves when a student is a potential witness, rather than a suspect, in a criminal investigation. Although parental notification is not required under Arizona law, it is permissible in this situation (unless the child has witnessed criminal activity

relating to the child's parent), and schools may adopt policies requiring such notification.

4. *Public Safety Concerns.*

Parental notification is inappropriate if delay pending notification creates a significant risk to public safety. Such a situation would exist, for example, if law enforcement officers suspect a student of possessing or having information about a handgun on campus. In other instances, delay attendant to a notification/consent policy may result in destruction of evidence or concealment of a crime. Any parental notification policy should be flexible enough to accommodate these types of circumstances and to allow for the exercise of common sense by school officials.[3]

## C. Informing Students that They May Refuse to Participate in a Law Enforcement Interview Without First Speaking with a Parent.

School officials must comply with a law enforcement officer's directive to refrain from informing a student that the student may consult his or her parents before answering the officer's questions if the proposed interview relates to an investigation of child abuse or other criminal activity by the student's parent or if delay pending parental notification would jeopardize public safety. Under other circumstances, a school official may inform a student that he or she may consult with a parent and/or an attorney prior to questioning by the police, notwithstanding a police directive to the contrary.

The parameters regarding these types of communications are not established by caselaw or

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[3]An analysis of potential criminal liability requires specific facts. However, notifying parents under these circumstances, without more, would not subject a person to criminal liability for obstructing criminal investigations or prosecutions. *See* A.R.S. §13-2409. A person violates A.R.S. § 13-2409 when he or she "knowingly attempts by means of bribery, misrepresentation, intimidation or force or threats of force to obstruct, delay or prevent the communication of information or testimony relating to a violation of any criminal statutes to a peace officer . . . ." Under some circumstances, a person could violate A.R.S. § 13-2403 by refusing to aid a peace officer. A person violates A.R.S. § 13-2403 if, "upon a reasonable command by a person reasonably known to be a peace officer," he or she "knowingly refuses or fails to aid" the peace officer in effectuating or securing an arrest or preventing the commission by another of any offense.

by statute but school officials and law enforcement should strive to strike the appropriate balance between the interests of schools in keeping parents informed of matters affecting their children and the needs of law enforcement officers conducting criminal investigations.

**D. Complying with Parental Requests for Notification Prior to Law Enforcement Interviews of the Student.**

As set forth above, school officials may notify parents of a proposed law enforcement interview of their child except when law enforcement authorities suspect a parent of abuse or some other type of crime or when delay pending notification creates a significant risk to public safety. School officials are not required to comply with parental demands regarding parental notification. This issue may, however, be addressed by school policies.

**E. Advising Students of Juvenile Miranda Rights.**

The *Miranda* requirement applies only to custodial interrogation by law enforcement agents. "School principals, though responsible for administration and discipline within the school, are not law enforcement agents." *Navajo County Juvenile Action No. JV91000058*, 183 Ariz. 204, 206, 901 P.2d 1247, 1249 (App. 1995). However, a school official must give *Miranda* warnings if he or she is acting as an agent or instrument of the police. *Id.* Thus, a school official who interviews a student at the request or direction of a law enforcement agency, acts as an instrument of that agency and must advise the student of his or her *Miranda* rights before proceeding with the interview. *Id.*

**Conclusion**

Generally, school officials may notify parents before police interview their children. Any policy requiring parental notice or consent, however, must not apply when any alleged criminal

conduct involves the parent or when advance parental notification creates an unreasonable risk to public safety.

Terry Goddard
Attorney General

# SAFE CHILD CENTER Case Tracking Data Form

1. **Date Seen** _____ **DR/File #** _____

2. **Gender** Male Female **3. Age** 0-6 7-12 13-18 Adult

4. **Referral Source** Flg FBI (Tuba Kayenta Dilkon Hopi) Gallup FBI (Chinle Shiprock WR) Pinetop FBI CCSO Page PD Other _____ Flagstaff PD Williams PD

5. **Race** (circle one) White Black Hispanic Native Amer (tribe) _____ Other _____ **6. Primary Language** (if not English) _____

7. **Disability** No Yes (type) _____ **8. Insurance** AHCCS IHS Private None DK

9. **City of Residence** _____ **10. Admit Source** SCC MU ED

11. **Suspect** Parent/Stepparent Parent boy/girlfriend Other Relative Other known person Stranger Unknown
**Age** <13 13-17 18+ **Gender** Male Female
**Suspect Name(s)** _____
Last/First

12. **Joint Investigation** Yes No (explain) _____

13. **Services** Interview Exam FA VW Other _____

14. **Disclosure** None SA PA SA/PA Neglect Witness: DV SA PA Other
**# Incidents** 1 2-3 Multiple **Mult Perp** Yes No **Mult Victims?** Yes No
**Duration** 1 day <6 mos >6 mos-5 yr >5 yrs Unk **Drugs?** Yes No
**SA Type** Exhibitionism Non-genital Contact Genital Contact Oral Sex Vaginal Penetration Anal Penetration UNK
**SA Force** None Mild(verbal coercion) Moderate(threats, physical intimidation) Severe(restraint, use of force/weapon)

15. **Exam** Nl Indeterminate Diagnostic of Trauma/SA _____

16. **Prosecution** CCAO USAtty Tribal Other _____

17. **MDT** LE_____ CPS_____ FI _____ ME_____ FA _____ MH _____ VW _____

18. **Child Name** _____

19. **Referrals** VW BHS Other Counseling _____ Other Services _____

20. **Outcome** (date, if known) ____None _____Charged _____Conviction (Plea Trial Acquittal Court Dismissal)

**MDT Case Review/ Joint investigation protocol compliance**

Date:

Agency bringing case:

Persons present:

Confidentiality form signed

| | |
|---|---|
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |
| _____ | Y/N |

DR#:

Victim Name:_____

Date of disclosure_____ To Whom:_____

Interagency notification_____ When/how_____

Backup notification made:_____

Type of abuse: PA, SA, _____

Date of abuse:_____

Brief description abuse:_____

_____

_____

Did the first responder limit their questioning to What, When, Where, Who? **Y/N**

Explain_____

_____

Was evidence collected and preserved? Y/N Explain:_____

_____

| | | |
|---|---|---|
| Was the victim seen at Safe Child? | Y/N | Date:_____ |
| Forensic interview conducted? | Y/N | By:_____ |
| Medical forensic exam done? | Y/N | By_____ |
| Was this an acute exam? | Y/N | |

Data gathered by SCC_____

_____

_____

Was case submitted to CAO? Y/N/pending. Expected date:_____

CAO action:_____

Was case tracking form initiated? Y/N _____

Was safety of victim ensured?_____

Did CPS and LE work in consultation with each other throughout the investigation? Y/N/NA explain_____

_____

Did LE and CPS document "joint investigation"? Y/N/NA

Was disclosure made to any mandated reporters: Y/N

Results:_____

Are there training needs identified as a result of this MDT? Y/N

Follow up_____

Was Victim Witness notified? Y/N/NA By Whom_____

Date of notification_____ Services_____

_____

Other support services involved_____

_____

How did the investigators demonstrate cultural competence?_____

_____

How were the behavioral health needs of the victim and family addressed?

_____

_____

# CHILD ABUSE AND SEX CRIMES IN INDIAN COUNTRY

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## CHILD PHYSICAL AND SEXUAL CRIMES IN INDIAN COUNTRY

### I. Who has jurisdiction to investigate criminal activities on Indian reservations?

Native American tribes and the United States Attorney's Office have concurrent jurisdiction over sex crimes and serious physical injury (child abuse) cases in Indian country. As such, both tribal law enforcement and the Federal Bureau of Investigations may investigate such crimes. The two often work together, and cases may be presented both in tribal court (where the penalty is up to a year) and federal court as felonies.

### II. Reporting statutes--Title 18 U.S.C. 1169, Mandatory Reporting

#### *A. Who is Covered?*

(A) physician, surgeon, dentist, podiatrist, chiropractor, nurse, dental hygienist, optometrist, medical examiner, emergency medical technician, paramedic, or health care provider;

(B) teacher, school counselor, instructional aide, teacher's aide, teacher's assistant, or bus driver employed by any tribal, Federal, public or private school;

(C) administrative officer, supervisor of child welfare & attendance, or truancy officer of any tribal, Federal, public or private school;

(D) child daycare worker, headstart teacher, public assistance worker, worker in group or residential, or day care facility, or social worker;

(E) psychiatrist, psychologist, or psychological assistant;

(F) licensed or unlicensed marriage, family or child counselor;

(G) person employed in the mental health profession, or

(H) law enforcement officer, probation officer, worker in a juvenile rehabilitation or detention facility, or person employed in a public agency who is responsible for enforcing statutes and judicial orders.

AND

Supervisors of the above !!

*18 U.S.C. 1169(b)*

***B. If you are a covered reporter . . . What Are Your Legal Responsibilities? [18 U.S.C. 1169 (b)(2)]***

If you are a covered person ((a)(1)) and "Know"or have a "Reasonable Suspicion" that a "child" "Was Abused" or "Actions" are being taken or will be taken that are "Reasonably Expected to Result in Abuse" YOU ARE REQUIRED TO **REPORT !**

***C. How Do You Make a Report & Who Do You Report To?***

"Local Law Enforcement Agency"

The Federal, Tribal or State Law enforcement Agency having the ***primary responsibility*** for the investigation of alleged child abuse within that portion of Indian country. This includes BOTH the tribal law enforcement and the FBI.

"Local Child Protective Services Agency"

That agency of the Federal government, of a State or an Indian tribe having the primary responsibility for child protection on any Indian reservation or within any community in Indian country.

***D. What are the penalties for failure to report? (18 U.S.C. 1169 and 2258)***

- Class B Misdemeanor [Classified as Criminal]--6 mos &/or $ 5,000.00 fine

-Civil Penalties -Potential Revocation of licenses????

### *E. What Are The Liabilities For Unsubstantiated Reports of Child Abuse? ([8 U.S.C. 1169 (d)]*

There is an Immunity Clause in the statute. If the report is based on "Reasonable Belief" and is based on "Good Faith", the reporting party is immune from civil and criminal liability.

## III. Reporting to Law Enforcement

A. All child abuse, sexual abuse and sexual assault cases should be immediately reported to both the local law enforcement and the F.B.I. 25 U.S.C. § 3203 requires that local law enforcement report criminal activity involving an Indian child or Indian abuse suspect to the F.B.I. Concurrent notification will assist in a prompt response by law enforcement. They will work together to investigate the crime.

B. If the hospital does not have the ability to do a comprehensive examination of the victim and collect evidence (including photography), the F.B.I can make arrangements to have the exams done at either Safechild in Flagstaff, the mobile unit based at Safechild (which comes to the reservation), or, in the case of an older adolescent or an adult rape victim, at NACASA (Northern Arizona Center Against Sexual Assault) in Flagstaff. Their medical personnel are very familiar with evidence collection and dealing with young or traumatized victims and are used to testifying in court. **This examination does not cost the hospital or the victim anything.** The FBI will also make arrangements for a forensic interview of the victim, which is a great help in criminal prosecution.

## B. What can the hospital provide law enforcement?

A. The Indian Child Protection and Family Violence Prevention Act (25 U.S.C. §§ 3201-3210) sets forth reporting procedures. Obviously, any requests for medical records must comply with HIPAA and the Privacy Act.

***Privacy Act:*** 25 U.S.C. §3204 states that agencies of any Indian tribe, of any state or of the Federal government that investigate and treat incidents of child abuse may provide information and records to those agencies (including tribal and federal law enforcement) that need to know the information to perform their duties. The FBI will provide a letter to this effect in compliance with the Privacy Act.

***HIPAA*** 45 CFR FBI agents will provide HIPAA compliant forms, releases, court orders or grand jury subpoenas in requesting medical information on patients.

### *B. Waiver of Parental Consent*

Photographs, xrays, medical examinations and interviews of an Indian child alleged to have been subject to abuse in Indian country shall be allowed without parental consent to law enforcement or law enforcement. Law enforcement and CPS may interview the child without parental consent. 25 U.S.C. § 3206

## V. The U.S. Attorney's role in criminal prosecution

The U.S. Attorney's Office, in 2002, hired two specialists to prosecute child and adult sex crimes. It is our responsibility to work as a team with law enforcement, social services, medical personnel and local multi-disciplinary teams to ensure that a just result is obtained. We are mindful of the trauma to the victims in testifying in open court in the presence of the defendant. Consequently, we like to become involved early in the investigation. We work closely with criminal investigators and the FBI agents in the investigation of these crimes, with the goal of obtaining the best evidence possible. This includes corroboration from scene investigations, victim and suspect interviews and medical evidence.

Medical evidence is often not present in many of our child sexual abuse cases. However, the lack of evidence does not mean that the abuse did not happen. It is critical that the medical personnel conducting the examinations be experienced in collecting physical evidence (sexual assault kits), the examination of young children and the literature about the absence of injury. They must also be willing to remain current in the literature and be able and willing to come to court to testify. Federal trials are held in Prescott and Phoenix and may require a two day absence from work (or more). Medical personnel should be aware of this before deciding to conduct the examination.

18 U.S.C.A. § 1169

**Effective: [See Text Amendments]**

United States Code Annotated Currentness
Title 18. Crimes and Criminal Procedure (Refs & Annos)
Part I. Crimes (Refs & Annos)
Chapter 53. Indians (Refs & Annos)

## ➡§ 1169. Reporting of child abuse

**(a)** Any person who--

**(1)** is a--

**(A)** physician, surgeon, dentist, podiatrist, chiropractor, nurse, dental hygienist, optometrist, medical examiner, emergency medical technician, paramedic, or health care provider,

**(B)** teacher, school counselor, instructional aide, teacher's aide, teacher's assistant, or bus driver employed by any tribal, Federal, public or private school,

**(C)** administrative officer, supervisor of child welfare and attendance, or truancy officer of any tribal, Federal, public or private school,

**(D)** child day care worker, headstart teacher, public assistance worker, worker in a group home or residential or day care facility, or social worker,

**(E)** psychiatrist, psychologist, or psychological assistant,

**(F)** licensed or unlicensed marriage, family, or child counselor,

**(G)** person employed in the mental health profession, or

**(H)** law enforcement officer, probation officer, worker in a juvenile rehabilitation or detention facility, or person employed in a public agency who is responsible for enforcing statutes and judicial orders;

**(2)** knows, or has reasonable suspicion, that--

**(A)** a child was abused in Indian country, or

**(B)** actions are being taken, or are going to be taken, that would reasonably be expected to result in abuse of a child in Indian country; and

**(3)** fails to immediately report such abuse or actions described in paragraph (2) to the local child protective services agency or local law enforcement agency,

shall be fined under this title or imprisoned for not more than 6 months or both.

**(b)** Any person who--

**(1)** supervises, or has authority over, a person described in subsection (a)(1), and

**(2)** inhibits or prevents that person from making the report described in subsection (a),

shall be fined under this title or imprisoned for not more than 6 months or both.

**(c)** For purposes of this section, the term--

**(1)** "abuse" includes--

**(A)** any case in which--

**(i)** a child is dead or exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, and

**(ii)** such condition is not justifiably explained or may not be the product of an accidental occurrence; and

**(B)** any case in which a child is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution;

**(2)** "child" means an individual who--

**(A)** is not married, and

**(B)** has not attained 18 years of age;

**(3)** "local child protective services agency" means that agency of the Federal Government, of a State, or of an Indian tribe that has the primary responsibility for child protection on any Indian reservation or within any community in Indian country; and

**(4)** "local law enforcement agency" means that Federal, tribal, or State law enforcement agency that has the primary responsibility for the investigation of an instance of alleged child abuse within the portion of Indian country involved.

**(d)** Any person making a report described in subsection (a) which is based upon their reasonable belief and which is made in good faith shall be immune from civil or criminal liability for making that report.

CREDIT(S)

(Added Pub.L. 101-630, Title IV, § 404(a)(1), Nov. 28, 1990, 104 Stat. 4547, and amended Pub.L. 103-322, Title XXXIII, § § 330011(d), 330016(1)(K), Sept. 13, 1994, 108 Stat. 2144, 2147; Pub.L. 104-294, Title VI, § 604(b)(25), Oct. 11, 1996, 110 Stat. 3508.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

1994 Acts. House Report Nos. 103-324 and 103-489, and House Conference Report No. 103-711, see 1994 U.S. Code Cong. and Adm. News, p. 1801.

1996 Acts. House Report No. 104-788, see 1996 U.S. Code Cong. and Adm. News, p. 4021.

Amendments

1996 Amendments. Pub.L. 104-294, § 604(b)(25), amending Pub.L. 103-322, § 330011(d), amended directory language of section 404(a)(1) of Pub.L. 101- 630, requiring no change in text.

1994 Amendments. Pub.L. 103-322, § 330011(d), as amended Pub.L. 104-294, § 604(b)(25), amended directory language of section 404(a)(1) of Pub.L. 101- 630, requiring no change in text.

Pub.L. 103-322, § 330016(1)(K), substituted "under this title" for "not more than $5,000" wherever appearing.

Effective and Applicability Provisions

1996 Acts. Amendment by section 604 of Pub.L. 104-294 effective Sept. 13, 1994, see section 604(d) of Pub.L. 104-294, set out as a note under section 13 of this title.

1994 Acts. Section 330011(d) of Pub.L. 103-322 provided in part that the amendment made by such section, amending directory language of section 404(a)(1) of Pub.L. 101-630 (which enacted this section), was to take effect on the date section 404(a)(1) of Pub.L. 101-630 took effect; section 404(a)(1) of Pub.L. 101-630 took effect on the date of enactment of Pub.L. 101-630, which was approved Nov. 28, 1990.

LIBRARY REFERENCES

American Digest System

Indians 36.

Corpus Juris Secundum

CJS Indians § 166, Particular Federal Criminal Statutes.

18 U.S.C.A. § 1169, **18 USCA § 1169**

Current through P.L. 109-229 approved 05-31-06



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C

**Effective: [See Text Amendments]**

United States Code Annotated Currentness
Title 25. Indians
Chapter 34. Indian Child Protection and Family Violence Prevention

## ➡§ 3201. Findings and purpose

(a) Findings

The Congress, after careful review of the problem of child abuse on Indian reservations and the historical and special relationship of the Federal Government with Indian people,

**(1)** finds that--

**(A)** incidents of abuse of children on Indian reservations are grossly underreported;

**(B)** such underreporting is often a result of the lack of a mandatory Federal reporting law;

**(C)** multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by persons employed or funded by the Federal Government;

**(D)** Federal Government investigations of the background of Federal employees who care for, or teach, Indian children are often deficient;

**(E)** funds spent by the United States on Indian reservations or otherwise spent for the benefit of Indians who are victims of child abuse or family violence are inadequate to meet the growing needs for mental health treatment and counseling for victims of child abuse or family violence and their families; and

**(F)** there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and the United States has a direct interest, as trustee, in protecting Indian children who are members of, or are eligible for membership in, an Indian tribe; and

**(2)** declares that two major goals of the United States are to--

**(A)** identify the scope of incidents of abuse of children and family violence in Indian country and to reduce such incidents; and

**(B)** provide funds for mental health treatment for Indian victims of child abuse and family violence on Indian reservations.

(b) Purpose

The purposes of this chapter are to--

**(1)** require that reports of abused Indian children are made to the appropriate authorities in an effort to prevent further abuse;

**(2)** establish a reliable data base for statistical purposes and to authorize a study to determine the need for a central registry for reported incidents of abuse;

**(3)** authorize such other actions as are necessary to ensure effective child protection in Indian country;

**(4)** establish the Indian Child Abuse Prevention and Treatment Grant Program to provide funds for the establishment on Indian reservations of treatment programs for victims of child sexual abuse;

**(5)** provide for technical assistance and training related to the investigation and treatment of cases of child abuse and neglect;

**(6)** establish Indian Child Resource and Family Services Centers in each Bureau of Indian Affairs Area Office which will consist of multi-disciplinary teams of personnel with experience and training in the prevention, identification, investigation, and treatment of child abuse and neglect;

**(7)** provide for the treatment and prevention of incidents of family violence;

**(8)** establish tribally operated programs to protect Indian children and reduce the incidents of family violence in Indian country; and

**(9)** authorize other actions necessary to ensure effective child protection on Indian reservations.

CREDIT(S)

(Pub.L. 101-630, Title IV, § 402, Nov. 28, 1990, 104 Stat. 4544.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

References in Text

This chapter, referred to in subsec. (b), was in the original "this title", meaning Title IV of Pub.L. 101-630, Nov. 28, 1990, 104 Stat. 4544, which enacted this chapter and section 1169 of Title 18, Crimes and Criminal Procedure. For complete classification of Title IV to the Code, see Short Title note set out under this section and Tables.

Short Title

1990 Acts. Section 401 of Pub.L. 101-630 provided that: "This title [enacting this chapter and section 1169 of Title 18, Crimes and Criminal Procedure] may be cited as the 'Indian Child Protection and Family Violence Prevention Act'."

LIBRARY REFERENCES

American Digest System

Indians 6, 23(11, 13), 36.

Key Number System Topic No.209.

Corpus Juris Secundum

CJS Indians § 38, General Considerations.

RESEARCH REFERENCES

Treatises and Practice Aids

Federal Procedure, Lawyers Edition § 46:497, Competitive Application Selection Criteria.

25 U.S.C.A. § 3201, **25 USCA § 3201**

Current through P.L. 109-12, approved 05/05/05



END OF DOCUMENT

C

**Effective: [See Text Amendments]**

United States Code Annotated Currentness
Title 25. Indians
Chapter 34. Indian Child Protection and Family Violence Prevention

**➡§ 3202. Definitions**

For the purposes of this chapter, the term--

**(1)** "Bureau" means the Bureau of Indian Affairs of the Department of the Interior;

**(2)** "child" means an individual who--

**(A)** is not married, and

**(B)** has not attained 18 years of age;

**(3)** "child abuse" includes but is not limited to--

**(A)** any case in which--

**(i)** a child is dead or exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, and

**(ii)** such condition is not justifiably explained or may not be the product of an accidental occurrence; and

**(B)** any case in which a child is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution;

**(4)** "child neglect" includes but is not limited to, negligent treatment or maltreatment of a child by a person, including a person responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened thereby;

**(5)** "family violence" means any act, or threatened act, of violence, including any forceful detention of an individual, which--

**(A)** results, or threatens to result, in physical or mental injury, and

**(B)** is committed by an individual against another individual--

**(i)** to whom such person is, or was, related by blood or marriage or otherwise legally related, or

**(ii)** with whom such person is, or was, residing;

**(6)** "Indian" means any individual who is a member of an Indian tribe;

**(7)** "Indian child" has the meaning given to such term by section 1903(4) of this title;

**(8)** "Indian country" has the meaning given to such term by section 1151 of Title 18;

**(9)** "Indian reservation" means any Indian reservation, public domain Indian allotment, former Indian reservation in Oklahoma, or lands held by incorporated Native groups, regional corporations, or village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.);

**(10)** "Indian tribe" and "tribal organization" have the respective meanings given to each of such terms under section 450b of this title;

**(11)** "inter-tribal consortium" means a partnership between--

**(A)** an Indian tribe or tribal organization of an Indian tribe, and

**(B)** one or more Indian tribes or tribal organizations of one or more other Indian tribes;

**(12)** "local child protective services agency" means that agency of the Federal Government, of a State, or of an Indian tribe that has the primary responsibility for child protection on any Indian reservation or within any community in Indian country;

**(13)** "local law enforcement agency" means that Federal, tribal, or State law enforcement agency that has the primary responsibility for the investigation of an instance of alleged child abuse within the portion of Indian country involved;

**(14)** "persons responsible for a child's welfare" means any person who has legal or other recognized duty for the care and safety of a child, including--

**(A)** any employee or volunteer of a children's residential facility, and

**(B)** any person providing out-of-home care, education, or services to children;

**(15)** "related assistance"--

**(A)** includes counseling and self-help services to abusers, victims, and dependents in family violence situations (which shall include counseling of all family members to the extent feasible) and referrals for appropriate health-care services (including alcohol and drug abuse treatment), and

**(B)** may include food, clothing, child care, transportation, and emergency services for victims of family violence and their dependents;

**(16)** "Secretary" means the Secretary of the Interior;

**(17)** "shelter" means the provision of temporary refuge and related assistance in compliance with applicable Federal and tribal laws and regulations governing the provision, on a regular basis, of shelter, safe homes, meals, and related assistance to victims of family violence or their dependents; and

**(18)** "Service" means the Indian Health Service of the Department of Health and Human Services.

CREDIT(S) (Pub.L. 101-630, Title IV, § 403, Nov. 28, 1990, 104 Stat. 4545.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

References in Text

This chapter, referred to in text, was in the original "this title", meaning Title IV of Pub.L. 101-630, Nov. 28, 1990, 104 Stat. 4544, which enacted this chapter and section 1169 of Title 18, Crimes and Criminal Procedure. For complete classification of Title IV to the Code, see Short Title note set out under section 3201 of this title and Tables.

The Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), referred to in par. (9), is Pub.L. 92-203, Dec. 18, 1971, 85 Stat. 688, as amended, which is classified generally to chapter 33 (section 1601 et seq.) of Title 43, Public Lands. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 43 and Tables.

CROSS REFERENCES

"High poverty area" defined as in this section for purposes of Federal implementation grants to local partnerships for School-to-Work Programs, see 20 USCA § 6177.

LAW REVIEW COMMENTARIES

Geographically-based and membership-based views of Indian tribal sovereignty: The Supreme Court's changing vision. Allison M. Dussias, 55 U.Pitt.L.Rev. 1 (1993).

LIBRARY REFERENCES

American Digest System

Indians 6, 23(11, 13), 36.

Key Number System Topic No.209.

25 U.S.C.A. § 3202, **25 USCA § 3202**

Current through P.L. 109-12, approved 05/05/05



END OF DOCUMENT

UNITED STATES CODE ANNOTATED
TITLE 25. INDIANS
CHAPTER 34--INDIAN CHILD PROTECTION AND FAMILY VIOLENCE PREVENTION



Current through P.L. 108-23, approved 05-19-03

§ 3203. **Reporting** procedures

(a) Omitted

(b) Notification of **child abuse reports**

(1) When a local law enforcement agency or local child protective services agency receives an initial **report** from any person of--

(A) the abuse of a child in Indian country, or

(B) actions which would reasonably be expected to result in abuse of a child in Indian country, the receiving agency shall immediately notify appropriate officials of the other agency of such report and shall also submit, when prepared, a copy of the written report required under subsection (c) of this section to such agency.

(2) Where a **report** of abuse involves an Indian child or where the alleged abuser is an Indian and where a preliminary inquiry indicates a criminal violation has occurred, the local law enforcement agency, if other than the Federal Bureau of Investigation, shall immediately **report** such occurrence to the Federal Bureau of Investigation.

(c) Written report of child abuse

(1) Within 36 hours after receiving an initial **report** described in subsection (b) of this section, the receiving agency shall prepare a written **report** which shall include, if available--

(A) the name, address, age, and sex of the child that is the subject of the **report**;

(B) the grade and the school in which the child is currently enrolled;

(C) the name and address of the child's parents or other person responsible for the child's care;

(D) the name and address of the alleged offender;

(E) the name and address of the person who made the report to the agency;

(F) a brief narrative as to the nature and extent of the child's injuries, including any previously known or suspected abuse of the child or the child's siblings and the suspected date of the abuse; and

(G) any other information the agency or the person who made the report to the agency believes to be important to the investigation and disposition of the alleged abuse.

(2)(A) Any local law enforcement agency or local child protective services agency that receives a report alleging abuse described in section 3202(3) of this title shall immediately initiate an investigation of such allegation and

shall take immediate, appropriate steps to secure the safety and well-being of the child or children involved.

(B) Upon completion of the investigation of any report of alleged abuse that is made to a local law enforcement agency or local child protective services agency, such agency shall prepare a final written report on such allegation.

(d) Confidentiality of informant

The identity of any person making a report described in subsection (b)(1) of this section shall not be disclosed, without the consent of the individual, to any person other than a court of competent jurisdiction or an employee of an Indian tribe, a State or the Federal Government who needs to know the information in the performance of such employee's duties.

CREDIT(S)

2001 Main Volume

(Pub.L. 101-630, Title IV, § 404, Nov. 28, 1990, 104 Stat. 4547.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

References in Text

Section 3202(3) of this title, referred to in subsec. (c)(2)(A), was in the original "section 503(3)" meaning section 503(3) of Pub.L. 101-630, and was translated as reading section 403(3), which defines child abuse, to reflect the probable intent of Congress.

Codifications

Subsec. (a) of this section has been codified as "Omitted" because subsec. (a) of section 404 of Pub.L. 101-630, which enacted this section, enacted section 1169 of Title 18, Crimes and Criminal Procedure.

LIBRARY REFERENCES

American Digest System

Indians ⚿6, 23(11, 13), 36.

Key Number System Topic No.209.

Encyclopedias

Indians, see C.J.S. §§ 30, 38 to 42, 44, 45, 135 to 155, 157 to 162, 166 to 169.

25 U.S.C.A. § 3203

25 USCA § 3203

C

**Effective: [See Text Amendments]**

United States Code Annotated Currentness
Title 25. Indians
Chapter 34. Indian Child Protection and Family Violence Prevention

**➡§ 3205. Confidentiality**

Pursuant to section 552a of Title 5, the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. 1232g), or any other provision of law, agencies of any Indian tribe, of any State, or of the Federal Government that investigate and treat incidents of abuse of children may provide information and records to those agencies of any Indian tribe, any State, or the Federal Government that need to know the information in performance of their duties. For purposes of this section, Indian tribal governments shall be treated the same as other Federal Government entities.

CREDIT(S) (Pub.L. 101-630, Title IV, § 406, Nov. 28, 1990, 104 Stat. 4550.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

References in Text

The Family Educational Rights and Privacy Act of 1974 (20 U.S.C. 1232g), referred to in text, is section 513 of Title V of Pub.L. 93-380, Aug. 21, 1974, 88 Stat. 571, which enacted 20 U.S.C.A. § 1232g and provisions set out as notes under 20 U.S.C.A. § § 1221 and 1232g. For complete classification of this Act to the Code, see Short Title of 1974 Amendment note set out under 20 U.S.C.A. § 1221 and Tables.

LIBRARY REFERENCES

American Digest System

Indians 6, 23(11, 13), 36.

Key Number System Topic No.209.

25 U.S.C.A. § 3205, **25 USCA § 3205**

Current through P.L. 109-12, approved 05/05/05



END OF DOCUMENT

**Effective: [See Text Amendments]**

United States Code Annotated Currentness
Title 25. Indians
Chapter 34. Indian Child Protection and Family Violence Prevention

## ➡§ 3206. Waiver of parental consent

(a) Examinations and interviews

Photographs, x-rays, medical examinations, psychological examinations, and interviews of an Indian child alleged to have been subject to abuse in Indian country shall be allowed without parental consent if local child protective services or local law enforcement officials have reason to believe the child has been subject to abuse.

(b) Interviews by law enforcement and child protective services officials

In any case in which officials of the local law enforcement agency or local child protective services agency have reason to believe that an Indian child has been subject to abuse in Indian country, the officials of those agencies shall be allowed to interview the child without first obtaining the consent of the parent, guardian, or legal custodian.

(c) Protection of child

Examinations and interviews of a child who may have been the subject of abuse shall be conducted under such circumstances and with such safeguards as are designed to minimize additional trauma to the child and, where time permits shall be conducted with the advise [FN1], or under the guidance, of a local multidisciplinary team established pursuant to section 3210 of this title or, in the absence of a local team, a multidisciplinary team established pursuant to section 3209 of this title.

(d) Court orders

Upon a finding of reasonable suspicion that an Indian child has been the subject of abuse in Indian country, a Federal magistrate judge or United States District Court may issue an order enforcing any provision of this section.

CREDIT(S)

(Pub.L. 101-630, Title IV, § 407, Nov. 28, 1990, 104 Stat. 4550; Pub.L. 101-650, Title III, § 321, Dec. 1, 1990, 104 Stat. 5117.)

[FN1] So in original. Probably should be "advice".

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

Change of Name

"United States magistrate judge" substituted for "United States magistrate" in subsec. (d) pursuant to section 321 of Pub.L. 101-650, set out as a note under 28 U.S.C.A. § 631.

LIBRARY REFERENCES

American Digest System

Indians 6, 23(11, 13), 36.

Key Number System Topic No.209.

25 U.S.C.A. § 3206, **25 USCA § 3206**

Current through P.L. 109-12, approved 05/05/05



END OF DOCUMENT

C

**Effective: December 27, 2000**

United States Code Annotated Currentness
Title 25. Indians
Chapter 34. Indian Child Protection and Family Violence Prevention

## ➡§ 3207. Character investigations

(a) By Secretary of the Interior and the Secretary of Health and Human Services

The Secretary and the Secretary of Health and Human Services shall--

**(1)** compile a list of all authorized positions within their respective departments the duties and responsibilities of which involve regular contact with, or control over, Indian children,

**(2)** conduct an investigation of the character of each individual who is employed, or is being considered for employment, by the respective Secretary in a position listed pursuant to paragraph (1), and

**(3)** prescribe by regulations minimum standards of character that each of such individuals must meet to be appointed to such positions.

(b) Criminal records

The minimum standards of character that are to be prescribed under this section shall ensure that none of the individuals appointed to positions described in subsection (a) of this section have been found guilty of, or entered a plea of nolo contendere or guilty to, any felonious offense, or any of two or more misdemeanor offenses, under Federal, State, or tribal law involving crimes of violence; sexual assault, molestation, exploitation, contact or prostitution; crimes against persons; or offenses committed against children.

(c) Investigations by Indian tribes and tribal organizations

Each Indian tribe or tribal organization that receives funds under the Indian Self-Determination and Education Assistance Act [25 U.S.C.A. § 450 et seq.] or the Tribally Controlled Schools Act of 1988 [25 U.S.C.A. § 2501 et seq.] shall--

**(1)** conduct an investigation of the character of each individual who is employed, or is being considered for employment, by such tribe or tribal organization in a position that involves regular contact with, or control over, Indian children, and

**(2)** employ individuals in those positions only if the individuals meet standards of character, no less stringent than those prescribed under subsection (a) of this section, as the Indian tribe or tribal organization shall establish.

CREDIT(S)

(Pub.L. 101-630, Title IV, § 408, Nov. 28, 1990, 104 Stat. 4551; Pub.L. 106-568, Title VIII, § 814, Dec. 27, 2000, 114 Stat. 2918.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-687 and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 6336.

2000 Acts. Statement by President, see 2000 U.S. Code Cong. and Adm. News, p. 2717.

References in Text

The Indian Self-Determination and Education Assistance Act, referred to in subsec. (c), is Pub.L. 93-638, Jan. 4, 1975, 88 Stat. 2203, as amended, which is classified principally to subchapter II (section 450 et seq.) of chapter 14 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 450 of this title and Tables.

The Tribally Controlled Schools Act of 1988, referred to in subsec. (c), is part B (sections 5201 to 5212) of Title V of Pub.L. 100-297, Apr. 28, 1988, 102 Stat. 385, which is classified generally to chapter 27 (section 2501 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2501 of this title and Tables.

Amendments

2000 Amendments. Subsec. (b). Pub.L. 106-568, § 814(1), substituted "any felonious offense, or any of two or more misdemeanor offenses," for "any offense" and, at the end, substituted "crimes against persons; or offenses committed against children." for "or crimes against persons.".

LIBRARY REFERENCES

American Digest System

Indians 6, 23(11, 13), 36.

Key Number System Topic No.209.

NOTES OF DECISIONS



1. Generally

In enacting the Indian Child Protection and Family Violence Prevention Act, Congress created a presumption of nexus between an employee's violation of the minimum standard of character required by the Act and appointment to or continued service in a covered position; provision setting forth the standard reflects the view of Congress that prohibiting individuals who have been found guilty of, or entered a plea of no contest or guilty to, a covered crime from holding a covered position promotes the efficiency of the agency's service. Johnson v. Department of Health and Human Services, M.S.P.B.2000, 86 M.S.P.R. 501, review dismissed 243 F.3d 565, affirmed 2001 WL 236919, affirmed 18 Fed.Appx. 837, 2001 WL 706935, certiorari denied 122 S.Ct. 354, 534 U.S. 954, 151 L.Ed.2d 267, affirmed 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836. Merit Systems Protection 143

2. Retroactive effect

Indian Health Service was required to consider crimes committed prior to enactment of the Indian Child Protection and Family Violence Prevention Act when determining whether an employee satisfied the Act's minimum standards of character. Delong v. Department of Health and Human Services, C.A.Fed.2001, 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836.

3. Mitigating circumstances

When employee fails to meet minimum standards of character required by the Indian Child Protection and Family Violence Prevention Act, the Act does not permit Indian Health Service to consider mitigating circumstances that might establish employee's fitness for continued employment in a covered position, notwithstanding employee's criminal record; rather, employee must be removed. Delong v. Department of Health and Human Services, C.A.Fed.2001, 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836.

4. Current employees

Plain language of the Indian Child Protection and Family Violence Prevention Act required Indian Health Service to apply the Act's minimum standards of character to current as well as prospective employees. Delong v. Department of Health and Human Services, C.A.Fed.2001, 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836.

5. Constitutionality

Where federal employee challenged, on substantive due process grounds, provision of the Indian Child Protection and Family Violence Prevention Act setting forth minimum standards of character for federal employees, Court of Appeals would review provision's constitutionality under the rational basis test, not under strict scrutiny; employee did not demonstrate that her federal employment was a fundamental right, nor did she argue that the statute discriminated against her as a member of a suspect class. Delong v. Department of Health and Human Services, C.A.Fed.2001, 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836. Constitutional Law 278.4(2)

6. Due process

Indian Child Protection and Family Violence Prevention Act, which created irrebuttable presumption that federal employee with criminal record was unfit for service and required Indian Health Service to remove her for violation of the Act's minimum standards of character, did not violate employee's substantive due process rights; in creating character standards, Congress created bright-line rule that anyone convicted of an enumerated crime could not serve in a covered position, and character standards admittedly were rationally related to government's interest in protecting Indian children from abuse. Delong v. Department of Health and Human Services, C.A.Fed.2001, 264 F.3d 1334, rehearing and rehearing en banc denied, certiorari denied 122 S.Ct. 2661, 536 U.S. 958, 153 L.Ed.2d 836. Constitutional Law 278.4(3); Indians 4

7. Absolute bar

Under Indian Child Protection and Family Violence Prevention Act, employee's conviction for voluntary manslaughter was absolute bar to employment in position that involved regular contact with Indian children, notwithstanding regulations allowing tribal organizations to conduct their own background checks covering past five years, and listing various factors that were to be considered in evaluating past conduct, inasmuch as employee's offense was crime of violence under Act. Bear Robe v. Parker, C.A.8 (S.D.) 2001, 270 F.3d 1192.

25 U.S.C.A. § 3207, **25 USCA § 3207**

Current through P.L. 109-12, approved 05/05/05



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# BEHAVIORAL AND PHYSICAL INDICATORS OF CHILD ABUSE AND NEGLECT

Note: These are indicators that something is amiss. The presence of indicators does not necessarily mean that maltreatment has occurred.

## PHYSICAL ABUSE

Reports inflicted injury by an adult or significantly older child

Presence of unexplained physical injury

Wary of adults physical contact (hides or withdrawals)

Apprehensive when other children cry

Behavioral extremes (i.e. aggressiveness or withdrawal)

Frightened of parents/afraid to go home

Art work displays violence: adults loom as large, threatening figures, child figures are small and powerless

Play demonstrates violence to dolls, animals

Injures or kills animal(s)

Preoccupation with themes of conflict

Hypervigilence, monitoring the behavior of adults

"Hyper" behavior

Bullying smaller children

The child is overly compliant, eager to please adults, seems to be "too good"

Poor social skills and peer interaction

Complains of soreness or moves uncomfortably

Runs away from home

Indiscriminate in seeking attention and affection from others

Unexplained Bruises and Welts:

- On face, lips or mouth, torso, back, buttocks, thighs, etc.
- Reflecting shape of article used to inflict (i.e. electric cord, hanger, belt buckle) or in clusters
- On several different surface areas
- Regularly appear after absence, weekend or vacation
- Injuries are inconsistent with explanation offered

# BEHAVIORAL AND PHYSICAL INDICATORS OF CHILD ABUSE AND NEGLECT continued

Unexplained Burns:

- Cigar, cigarette burns especially on soles, palms, back or buttocks
- Immersion burns (sock-like, doughnut shaped on buttocks or genitalia)
- Patterned like electric burner, iron, etc.
- Rope burns on arms, legs, neck, or tors

Unexplained Fractures:

- To skull, nose, facial structure
- In various states of healing
- Multiple or spiral fractures

Unexplained Lacerations or Abrasions:

-To mouth, lips, gums, eyes, external genitalia

## PHYSICAL NEGLECT

Begging, hoarding, stealing food/consistent hunger

Extended stays at school (arrival early and late departure)

Constant fatigue, listlessness or falling asleep in class

Alcohol or drug abuse

Frequent stealing from others

Delinquent or self destructive behavior

Frequent absences or tardiness

Assumes adult responsibilities

Poor Hygiene

Inappropriate Dress

Consistent lack of supervision

Unattended physical problems, medical or dental needs

Abandonment

Failure to thrive or achieve expected growth patterns, underweight

## SEXUAL ABUSE

Reports sexual abuse by an adult or significantly older child

Unwilling to change for gym or participate in physical education class

Withdrawal, fantasy or infantile behavior

Bizarre, sophisticated or unusual sexual behaviors or knowledge

Poor peer relationships

Delinquent or run away

Fearful of bathrooms, bedrooms or being alone with an adult

Fearful of same or opposite sex adults

Fearful of closeness, intimacy or touching

Poor boundaries with others (touching without permission, invading body space, etc.)

Difficulty in expressing feelings, low self-esteem, fears of separation and loss

Overly compliant

Excessive risk taking, suicidal thoughts or actions

Sexual aggression to smaller children, toys or pets

Drawings are more precise in anatomical detail, sexual themes are evident

Radical changes in bathroom habits

Withdrawn or chronically depressed

Excessive masturbation or preoccupation with genitals

Sudden excessive weight gain or loss

Difficulty in walking or sitting

Torn, stained or bloody underclothing

Pain or itching in genital area

Bruises or bleeding in external genitalia, vaginal or anal areas

Venereal diseases, especially in pre-teen

Pregnancy

Eating disorders, gagging, anorexia, overeating, nausea, ulcers

Sleep disorders, nightmares

Constipation, fecal retention, fecal impaction

Self-mutilation, disfigurement

Sexual promiscuity

## EMOTIONAL ABUSE

Habit disorders (sucking, biting, etc.)

Anti-social or destructive behavior

Unusual fearfulness, sleep disorders

Behavioral extremes (aggressiveness, extremely passive or compliant)

Attempted suicide

Delayed physical development

Speech disorders

Failure to thrive

Self-harming behaviors

## AGENCY CONTACT LIST
### Coconino County

**CPS HOTLINE:** 1-888-767-2445
**HOTLINE for Law Enforcement:**
1-877-238-4501

**Flagstaff Child Protective Services**
397 Malpais Ln. Suite 11
Flagstaff, AZ 86001
Phone: 779-3681
Fax: 779-2269

**Page Child Protective Services**
PO Box 3323
Page, AZ 86040
Phone: 645-8103
Fax: 645-8136

**Coconino County Attorney's Offic e**
110 E. Cherry Street
Flagstaff, AZ 86001
Phone: 779-6518
On-call Deputy Attorney: 226-3406
Fax: 779-5618/779-6820

**Coconino County Sheriff's Office**
911 E. Sawmill Rd.
Flagstaff, AZ 86001
Phone: 226-5198 (Aft. Hrs)/226-5025
Fax: 226-5029

**Flagstaff Police Department**
911 E. Sawmill Rd.
Flagstaff, AZ 86001
Phone: 774-1414(Aft. Hrs)/213-3374
Fax: 213-3368

**Department of Public Safety Crime Lab**
1140 W. Kaibab Lane
Flagstaff, AZ 86001
Phone: 773-3687
Fax: 773-3665

**Federal Bureau of Investigation**
1665 South Plaza Way Suite 1645
Flagstaff, AZ 86001
Phone: 774-0631
Fax: 226-2605

**Fredonia Marshall's Office**
PO Box 217
Fredonia, AZ 86022
Phone: 643-7241
Fax: 643-7627

**Grand Canyon/National Park Service**
PO Box 1729
Grand Canyon, AZ 86023
Phone: 638-7805

**NAU Police Department**
PO Box 5602
Flagstaff, AZ 86011
Phone: 523-3611
Fax: 523-9483

**Page Police Department**
PO Box 3005
Page, AZ 86040
Phone: 645-2461
Fax:645-4369

**Sedona Police Department**
100 Roadrunner Drive
Sedona, AZ 86336
Phone: 282-3102
Fax: 204-7808

**Williams Police Department**
501 W. Route 66
Williams, AZ 86046
Phone: 635-4461
Fax: 635-1415

**Navajo Nation Police**

Tuba City Criminal Investigations
PO Box 1168
Tuba City, AZ 86045
Phone: 283-3132
Fax: 283-5353

Dilcon Criminal Investigations
HCR-63, Box 786
Dilcon, AZ 86047
Phone: 657-8050
Fax: 657-8054

**Navajo Nation Social Services**

Dilcon Social Services
HCR-63, Box 6089
Winslow, AZ 860
Phone: 657-3322
Fax: 657-8041

Leupp Social Services
HCR-61 Box 49
Winslow, AZ 86047
Phone: 686-3200
Fax:

Tuba City Social Services
PO Box 280
Tuba City, AZ 86045
Phone: 283-3269
Fax: 283-3264

**Hopi Law Enforcement**
PO Box 10
Keams Canyon, AZ 86034
Phone: 738-2236
Fax: 738-2238

**Havasupai Social Services**
Phone: 448-2142 or 2143
Fax:

**Hualapai Social Services**
Phone: 769-2383
Fax: 769-2659

**Safe Child Center**
Flagstaff Medical Center (West Campus)
1200 N. Beaver St.
Flagstaff, AZ 86001
Phone: 773-2053
Fax: 773-2434
Email: FMCSafeChild@nahealth.com
Website: www.FMCSafeChild.com

**Northern Arizona Center Against Sexual Assault**
**(NACASA)**
5200 E. Cortland Blvd B-5
Flagstaff, AZ 86004
Phone: 527-0708
Fax: 214-8775

**Victim Witness Services for Coconino County**
5200 E. Cortland Blvd B-5
Flagstaff, AZ 86004
Phone:779-6163 (M-F, 8-5)
Fax: 214-8775
Pager: 214-5358 (Aft. Hrs)
Website: www.victimwitnessflagstaff.org

**Juvenile Probation**
1001 E. Sawmill Ave
Flagstaff, AZ 86001
Phone: 226-5400
Fax: 226-5456

**Adult Probation**
222 E. Birch
Flagstaff, AZ 86001
Phone: 226-5650
Fax: 773-8705

**US Attorney's Office**
40 N. Central Suite 1200
Phoenix, AZ 85004-4408
Phone: (602)514-7561
Fax: (602)514-7693
Local Office: 556-0833

**Governors Office for Children Youth & Families**
(602)542-1705

**Alternatives Center for Family Based-Services**
823 W. Clay
Flagstaff, AZ 86001
Phone: 214-9050
Fax: 214-9055

**Northland Family Help Center**
2724 E. Lakin Dr. #7
Flagstaff, AZ 86004
Phone: 774-4503
Fax: 527-4288 (Halo House)

**The Guidance Center**
2187 N. Vickey Street
Flagstaff, AZ 86004
Phone: 527-1899
Fax: 527-0618

**Native Americans for Community Action (NACA)**
2717 N. Steves Blvd. Suite 11
Flagstaff, Az 86004
Phone: 526-2968
Fax: 526-0708
www.nacainc.org

**FMC Behavioral Health**
1200 N. Beaver Street
Flagstaff, AZ 86001
Phone: 213-6400
Fax: 213-6409

**Hopi Guidance Center**
Phone: 737-2685
Fax: 737-2697

**Hopi Domestic Violence Program**
Phone: 738-1115
Fax: 738-1119

**Navajo Treatment Center for Children and their Families (NTCCF)**
P.O. Box 2199
Tuba City, AZ 86045
Phone: 283-3261
Fax: 283-3279
Central Admin. Offices: 871-6818

**Northland Hospice**
452 N. Switzer Canyon
Flagstaff, AZ 86001
Phone: 779-1227
Fax: 779-5884

# Statement of Support

Child abuse is recognized as a nationally significant problem and represents a major investigative, prosecutorial and child protection challenge in Coconino County. We, the undersigned, represent a commitment to a comprehensive, multi-disciplinary response to the investigation of child abuse allegations in order to provide the following benefits:

- Improve the community's capacity to protect and serve the best interest of its children;
- Enhance law enforcement, child protection, and prosecution efforts to combat child abuse;
- Maximize the resources of the allied professionals involved in investigation and child protection through open communication and case coordination;
- Ensure that child victims; their siblings and their caretakers are not harmed by the investigation system through excessive interviews, lack of communication between agencies and incomplete investigations.

To this end, we support the Protocol as an effective tool to minimize trauma to children and to serve as a guideline for coordination of efforts with other community agencies.

Terry Lance — 8/24/2006
Coconino County Attorney's Office –Terry Hance, Coconino County Attorney — Date

Kevin Treadway — 8/24/2006
Flagstaff Police Department—Kevin Treadway, Deputy Chief — Date

[signature] — 8/24/06
Coconino County Sheriff's Office—Rex Gilliland, Criminal Investigations Lieutenant — Date

Kathy Paleski — 8/24/06
Northern Arizona University Police Department—Kathy Paleski, Interim Chief — Date

[signature] — 8/25/06
Arizona DES/ACYF District III—Gary Arnold, Program Manager — Date

[signature] — 8/24/06
Flagstaff Medical Center/Safe Child Center—Alice Gagnaire, Vice President — Date

[signature] — 8/24/06
Flagstaff Medical Center/Behavioral Health—Roger Schuler, Vice President — Date

[signature] — 8/24/06
Northern Arizona Center Against Sexual Assault/Victim Witness Services—Kim Musselman, Executive Director — Date

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Page Police Department - Jeremy Hunt, Sergeant Criminal Investigations — Date 082406